| CMS Manual System | **Department of Health & Human Services (DHHS)** |
|---|---|
| Pub 100-04 Medicare Claims Processing | **Centers for Medicare & Medicaid Services (CMS)** |
| **Transmittal 2993** | **Date: July 25, 2014** |
| | **Change Request 8694** |

**SUBJECT: Update to Pub. 100-04, Chapter 20 to Provide Language-Only Changes for Updating ICD-10 and ASC X12**

**I. SUMMARY OF CHANGES:** This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 20. Also, reference to the MACs replaces reference to the old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

**EFFECTIVE DATE: ASC X12: January 1, 2012; ICD-10: Upon Implementation of ICD-10**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: ASC X12: August 25, 2014; ICD-10: Upon Implementation of ICD-10**

***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/Table Of Contents |
| R | 20/30.6.4/ DMEPOS Clinical Trials and Demonstrations |
| R | 20/100.2.1/ Completion of Certificate of Medical Necessity Forms |
| R | 20/100.2.3.2/ HHA Recertification for Home Oxygen Therapy |
| R | 20/110.1/ Billing/Claim Formats |
| R | 20/110.5/ DME MACs Only - Appeals of Duplicate Claims |
| R | 20/120/ DME MACs – Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades |
| R | 20/120.1/ Providing Upgrades of DMEPOS Without Any Extra Charge |
| R | 20/130.9/ Showing Whether Rented or Purchased |
| R | 20/140.1/ Billing for Supplies and Drugs Related to the Effective Use of DME |
| R | 20/150/ Institutional Provider Reporting of Service Units for DME and Supplies |
| R | 20/160.1/ Billing for Total Parenteral Nutrition and Enteral Nutrition Furnished to Part B Inpatients |
| R | 20/160.2/ Special Considerations for SNF Billing for TPN and EN Under Part B |
| R | 20/170/ Billing for Splints and Casts |
| R | 20/210/ CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay |
| R | 20/211.2/ Partial Month Stays For Capped Rental Equipment |

**III. FUNDING:**

**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:**

**Business Requirements**
**Manual Instruction**

# Attachment - Business Requirements

| Pub. 100-04 | Transmittal: 2993 | Date: July 25, 2014 | Change Request: 8694 |
|---|---|---|---|

**SUBJECT: Update to Pub. 100-04, Chapter 20 to Provide Language-Only Changes for Updating ICD-10 and ASC X12**

**EFFECTIVE DATE: ASC X12: January 1, 2012; ICD-10: Upon Implementation of ICD-10**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: ASC X12: August 25, 2014: Upon Implementation of ICD-10**

## I. GENERAL INFORMATION

**A. Background:** This Change Request (CR) contains language-only changes for updating ICD-10 and ASC X12 language in Pub 100-04, Chapter 20. Also, reference to the MACs replaces reference to the old contractor types in the sections that are included in this CR.

**B. Policy:** There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

## II. BUSINESS REQUIREMENTS TABLE

*"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.*

| Number | Requirement | Responsibility | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | Shared-System Maintainers | | | | Other |
| | | A | B | HHH | | FISS | MCS | VMS | CWF | |
| 8694.1 | A/B MACs (A and HHH) & DME MACs shall be aware of the updated language for ICD-10 and for ASC X12 in Pub. 100 - 04, Chapter 20. | X | | X | X | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility | | | | |
|---|---|---|---|---|---|---|
| | | A/B MAC | | | DME MAC | CEDI |
| | | A | B | HHH | | |
| | None | | | | | |

## IV. SUPPORTING INFORMATION

**Section A: Recommendations and supporting information associated with listed requirements: N/A**

*"Should" denotes 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):** Not Applicable

**Post-Implementation Contact(s):** Contact your Regional Coordinator.

**VI. FUNDING**

**Section A: 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.

**ATTACHMENTS: 0**

# Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

**Table of Contents**
***(Rev.2993, 07-25-14)***

# Medicare Claims Processing Manual
## Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

### 30.6.4 - DMEPOS Clinical Trials and Demonstrations
***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

The definition of the QR modifier is “item or service has been provided in a Medicare specified study.” When this modifier is attached to a HCPCS code, it generally means the service is part of a CMS related clinical trial, demonstration or study

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- The DME *MACs* shall recognize the “QR” modifier when associated with an oxygen home therapy clinical trial identified by CMS and sponsored by the National Heart, Lung & Blood Institute. DME *MAC*s shall pay these claims if the patient’s arterial oxygen partial measurements are from 56 to 65 mmHg, or whose oxygen saturation is at or above 89%.

The definition of condition code 30 is “qualified clinical trial.” When this condition code is reported on a claim, it generally means the service is part of a CMS related clinical trial, demonstration or study.

The *A/B MACs (HHH)* shall recognize condition code 30, accompanied by ICD-9-CM diagnosis code V70.7 *or ICD-10 diagnosis code Z00.6, as applicable*, in the second diagnosis code position, when associated with an oxygen home therapy clinical trial identified by CMS and sponsored by the National Heart, Lung & Blood Institute. *A/B MACs (HHH)* shall pay these claims if the patient’s arterial oxygen partial measurements are from 56 to 65 mmHg, or whose oxygen saturation is at or above 89%.

### 100.2.1 - Completion of Certificate of Medical Necessity Forms
***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10))***

1. SECTION A: (This may be completed by supplier.)
    a. Certification Type/Date - If this is an initial certification for this patient, the date (MM/DD/YY) is indicated in the space marked "INITIAL". If this is a revised certification (to be completed when the physician changes the order, based on the patient's changing clinical needs), the initial date is indicated in the space marked "INITIAL", and the revision date is indicated in the space marked "REVISED". If this is a recertification, the initial date is indicated in the space marked "INITIAL", and the recertification date is indicated in the space marked "RECERTIFICATION". Whether a REVISED or RECERTIFIED CMN is submitted, the INITIAL date as well as the REVISED or RECERTIFICATION date is always furnished.
    b. Patient Information - This indicates the patient's name, permanent legal address, telephone number, and his/her health insurance claim number (HICN) as it appears on his/her Medicare card and on the claim form.
    c. Supplier Information - This indicates the name of the company (supplier name), address, telephone number, and the Medicare supplier number assigned by the National Supplier Clearinghouse (NSC).
    d. Place of Service - This indicates the place in which the item is being used, i.e., patient's home is 12, skilled nursing facility (SNF) is 31, or end stage renal disease (ESRD) facility is 65. See chapter 23 for place of service codes.
    e. Facility Name - This indicates the name and complete address of the facility, if the place of service is a facility.

f. HCPCS Codes - This is a list of all HCPCS procedure codes for items ordered that require a CMN. Procedure codes that do not require certification are not listed on the CMN.

g. Patient Date of Birth (DOB), Height, Weight, and Sex - This indicates patient's DOB (MM/DD/YY), height in inches, weight in pounds, and sex (male or female).

h. Physician Name and Address - This indicates the treating physician's name and complete mailing address.

i. UPIN - This indicates the treating physician's unique physician identification number (UPIN).

j. Physician's Telephone Number - This indicates the telephone number where the treating physician can be contacted (preferably where records would be accessible pertaining to this patient) if additional information is needed.

2. SECTION B: (This may not be completed by the supplier. While this section may be completed by a non-physician clinician, or a physician employee, it must be reviewed by the treating physician. Contractors publish this requirement about section B in their bulletins at least annually.)

a. Estimated Length of Need - This indicates the estimated length of need (the length of time (in months) the physician expects the patient to require use of the ordered item). If the treating physician expects that the patient will require the item for the duration of his/her life, 99 is entered. For recertification and revision CMNs, the cumulative length of need (the total length of time in months from the initial date of need) is entered.

k. Diagnosis Codes - Listed in the first space is the *diagnosis* code that represents the primary reason for ordering this item. Additional *diagnosis* codes that would further describe the medical need for the item (up to 3 codes) are also listed. A given CMN may have more than one item billed, and for each item, the primary reason for ordering may be different. For example, a CMN is submitted for a manual wheelchair (K0001) and elevating leg rests (K0195). The primary reason for K0001 is stroke, and the primary reason for K0195 is edema.

l. Question Section - This section is used to gather clinical information regarding the patient's condition, the need for the DME, and supplies.

m. Name of Person Answering Section B Questions - If a clinical professional other than the treating physician (e.g., home health nurse, physical therapist, dietician, or a physician employee) answers the questions in section B, he/she must print his/her name, give his/her professional title, and the name of his/her employer, where indicated. If the treating physician answered the questions, this space may be left blank.

3. SECTION C: (This is completed by the supplier.)

a. Narrative Description of Equipment and Cost - The supplier indicates (1) a narrative description of the item(s) ordered, as well as all options, accessories, supplies, and drugs; (2) the supplier's charge for each item, option, accessory, supply, and drug; and (3) the Medicare fee schedule allowance for each item, option, accessory, supply, or drug, if applicable.

4. SECTION D: (This is completed by the treating physician.)

a. Physician Attestation - The treating physician's signature certifies the CMN that he/she is reviewing includes sections A, B, C, and D, the answers in section B are correct, and the self-identifying information in section A is correct.

b. Physician Signature and Date - After completion and/or review by the treating physician of sections A, B, and C, the treating physician must sign and date the CMN in section D, verifying the attestation appearing in this section. The treating physician's signature also certifies the items ordered are medically necessary for this patient. Signature and date stamps are not acceptable.

Certifications and recertifications may not be altered by "whiting out" or "pasting over" and entering new data. Such claims are denied and suppliers that show a pattern of altering CMNs are identified for educational contact and/or audit.

Also suppliers who have questionable utilization or billing practices or who are under sanction are considered for audit.

## 100.2.3.2 - HHA Recertification for Home Oxygen Therapy

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Section 1834(a)(5) of the Act requires patients who receive home oxygen therapy and who at the time such services are initiated have an initial arterial blood gas value of 56 or higher or an initial oxygen saturation at or above 89 percent to be retested between 60 and 90 days after the start of oxygen therapy in order to continue to receive payment. HHAs must initiate the request for the retesting as promptly as possible because the recertification at three months must reflect the results of an arterial blood gas or oxygen saturation test conducted between the 61st and 90th day of home oxygen therapy. Payment for the fourth month of home oxygen therapy is possible only if the patient's attending physician certifies that retesting results establish the continuing medical necessity for the services. The physician must certify based on the test of the patient's arterial blood gas value or oxygen saturation that there is a medical need for the patient to continue to receive oxygen therapy.

Value codes have been assigned for HHA reporting of the arterial blood gas and oxygen saturation. HHAs report value code 58 or 59 on every initial bill for home oxygen therapy and on the fourth month's bill. Information regarding the form locator numbers that correspond to value codes is found in Chapter 25.

For patients receiving oxygen therapy, who are not under a plan of care (bill type 34X), HHAs obtain a physicians recertification of the retesting and maintain a copy in their files for verification.

For patients receiving oxygen therapy, who are under a plan of care (bill types 32X and 33X), HHAs obtain a physician's recertification of the retesting and reflect this on Form CMS-485 or CMS-486 for verification.

*A/B MACs (HHH)* do not continue to make payment where the HHA fails to have the patient retested to determine continuing need of oxygen therapy within the specified time frames.

## 110.1 - Billing/Claim Formats

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

The DME *MAC* and the *A/B MAC (B)* are billed on *the ASC X12 837 professional claim format or if permissible* Form CMS-1500.

The *A/B MAC (A)* (including the *A/B MAC (HHH)*) is billed on *the ASC X12 837 institutional claim format or if permissible Form CMS-1450*.
Note that the *ASC* X12 formats support reporting of the CMNs in the FRM segment

The National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version *D0* and Batch Standard 1.*2* is the HIPAA standard for electronic retail pharmacy drug claims and *related* coordination of benefits (COB).

This standard will be used by all DME *MACs* that process retail pharmacy drug transactions. All other claims submitted to the DME *MCA* by pharmacies, other than retail pharmacy drug claims, must be sent in the *ASC X12 837 professional claim format*.

## 110.5 – DME *MAC*s Only - Appeals of Duplicate Claims

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

The Durable Medical Equipment *Medicare Administrative Contractors* (DME *MAC*s) must afford appeal rights for the initial determination of an item or service only, unless the supplier is appealing whether or not the denied item is actually a duplicate. If a claim is denied as a duplicate, the DME *MAC*s must not afford appeal rights based on coverage, medical necessity, pricing, or any basis on which the supplier can otherwise appeal. The DME *MAC* may only afford appeal rights on claims denied as duplicates if the supplier is appealing because the claim is not, in fact, a duplicate. If a supplier appeals a denied duplicate claim on the basis that the claim is not, in fact a duplicate, the DME *MAC* shall adjudicate the claim in accordance with all other Medicare rules and regulations.

The DME *MAC*s must use the following Medicare Summary Notice (MSN) and *ASC X12 835* remittance messages when denying duplicate claims:

MSN 7.3 – This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate.

Spanish – Este servicio/artículo es un duplicado de otro servicio procesado previamente. No tiene derechos de apelación de este servicio, excepto si cuestiona que este servicio es un duplicado. Haga casa omiso a la información sobre apelaciones en esta notification, en relación a sus derechos de apelación, a menos que este apelando si el servicio fue duplicado.

*Claim adjustment r*eason code 18:- Duplicate claim/service

Remittance advice *r*emark *c*ode N111 – This service was included in a claim that was previously billed and adjudicated. No appeal rights attached except with regard to whether the service/item is a duplicate.

## 120 – DME *MAC*s – Billing Procedures Related To Advanced Beneficiary Notice (ABN) Upgrades

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

This section provides the DME *MACs* billing instructions regarding the use of ABNs and claims modifiers for upgrades for items of DMEPOS.

Federal Regulations at 42 CFR 411.408 and Chapter 30 of this manual establishes the basis for a supplier to issue an ABN to a beneficiary. The purpose of the ABN is to inform a Medicare beneficiary, before he or she receives an item that Medicare will probably not pay for that particular item on that particular occasion. The ABN allows the beneficiary to make an informed consumer decision on whether to accept an item for which he or she may have to pay out of pocket or through supplementary insurance.

Under existing policy, suppliers may collect from a beneficiary a payment amount greater than Medicare's allowed payment amount if the beneficiary, by signing an ABN, agrees to pay extra for a DMEPOS item because the beneficiary prefers an item with features or upgrades that are not medically necessary. This policy applies to both assigned and unassigned claims. When a beneficiary does not sign an ABN, a supplier that accepts assignment cannot hold the beneficiary liable for the cost of medically unnecessary equipment or upgrades unless there is other acceptable evidence that the beneficiary knew or could reasonably have been expected to know that Medicare would not pay for the medically unnecessary equipment or upgrades. With respect to unassigned claims, a signed ABN is necessary to hold the beneficiary liable.

The instructions in this section apply to situations where the ABN is being used for upgrades and applies to both assigned and unassigned claims. An upgrade is an item with features that go beyond what is medically

necessary. An upgrade may include an excess component. An excess component may be an item feature or service, which is in addition to, or is more extensive and/or more expensive than the item that is reasonable and necessary under Medicare's coverage requirements. When a DMEPOS supplier knows or believes that the DMEPOS item does or may not meet Medicare's reasonable and necessary rules under specific circumstances, it is the responsibility of the supplier to notify the beneficiary in writing via an ABN if the supplier wants to collect money from a beneficiary if an item is denied.

When a supplier furnishes an upgraded item of DMEPOS and the supplier expects Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, the supplier must give an ABN to the beneficiary for signature for holding the beneficiary liable for the additional expense. Optional ABN forms are available at: http://www.cms.gov/medicare/bni/#BNINotices.

## A. General Instructions for the Use of ABNs for Upgrading DMEPOS Items

1. An upgrade may be from one item to another within a single Heath Insurance Common Procedure Coding System (HCPCS) code, or may be from one HCPCS code to another. When an upgrade is within a single code the upgraded item must include features that exceed the official code descriptor for that item.
2. The upgrade must be within the range of items or services that are medically appropriate for the beneficiary's medical condition and the purpose of the physician's order. ABNs may not be used to substitute a different item or service that is not medically appropriate for the beneficiary's medical condition for the original item or service. The upgraded item must still meet the intended medical purpose of the item the physician ordered.
3. Use of an ABN to furnish an upgraded item or service, with the beneficiary being personally responsible for the difference between the costs of the standard and upgraded item or service, does not change coverage or payment rules, statutory provisions, or manual instructions for the particular benefit involved.
4. In cases where the DME *MAC*s would make payment for the item the physician ordered on a rental basis, the supplier must furnish the upgrade on a rental basis.
5. A supplier furnishing an upgrade and using an ABN must submit a claim and include information on the claim that identifies the upgrade features. Suppliers must submit a claim for upgraded items and services using the GA modifier on the upgraded line item to indicate that the beneficiary signed an ABN. Suppliers must list upgrade features *using the ASC X12 837 professional claim format or on the paper Form CMS-1500* in Item 19 or as an attachment to the claim for paper claims.
6. Denials should be based on medical necessity.

## B. Billing Instructions:

Suppliers must bill 2 line items for upgraded DMEPOS items where the beneficiary requests an upgrade. Suppliers must bill both lines on the same claim in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item the supplier actually provided to the beneficiary with the dollar amount of the upgraded item. If the supplier has a properly obtained ABN on file signed by the beneficiary, use the GA modifier. If the supplier did not properly obtain an ABN signed by the beneficiary, use the GZ modifier.

Line 2: Bill the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item. Use the GK modifier.

Suppliers should bill their full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the reasonable and necessary item (Line 2). If the upgrade is within a code, suppliers still bill 2 line items, using the same code on both lines, but Line 1 would have the higher dollar amount.

Suppliers must bill both lines on the same claim in sequential order. Line 1 and the associated Line 2 should follow each other.

DME *MAC*s must return/reject applicable assigned claims that have invalid ABN upgrade information using appropriate messages. If the claim is unassigned, DME *MAC*s must issue a denial.

**C. Definitions of Modifiers that May be Associated with ABNs**

GA - Waiver of Liability (expected to be denied as not reasonable and necessary, ABN on file)
GZ - Item or Service not Reasonable and Necessary (expected to be denied as not reasonable and necessary, no ABN on file)
GK - Reasonable and necessary item/service associated with GA or GZ modifier

**D. Medicare Summary Notice (MSN) and Remittance Advice (RA)**

MSN 36.01: Our records show that you were informed in writing, before receiving the service that Medicare would not pay. You are liable for this charge. If you do not agree with this statement, you may ask for a review. *ASC X12 835, remittance advice remark code* M38
MSN 36.02: It appears that you did not know that we would not pay for this service so you are not liable. Do not pay your provider for this service. If you have paid your provider for this service, you should submit to this office three things 1) A copy of this notice, 2) Your provider's bill, and 3) A receipt or proof that you have paid the bill. You must file your written request for payment within 6 months of the date of this notice. Future services of this type provided to you will be your responsibility. *ASC X12 835 remittance advice remark code* M25)
MSN 8.51: You signed an Advanced Beneficiary Notice (ABN). You are responsible for the difference between the upgrade amount and the Medicare payment.

Use the following messages when denying claims due to invalid ABN upgrade information:

MSN 8.53: This item or service was denied because the upgrade information was invalid.
MRN N108: This item/service was denied because the upgrade information was invalid.

## 120.1 - Providing Upgrades of DMEPOS Without Any Extra Charge

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain circumstances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price they would charge for a non-upgraded item. The reason for this may be that a supplier prefers to carry only higher level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products. Also, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines. The supplier may also be accommodating a physician order for an upgrade.

**Policy**

Suppliers are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary that they would charge for a non-upgraded item. This policy allows suppliers to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds what the non-upgraded item that Medicare considers to be medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

**Billing Instructions**

When a supplier decides to furnish an upgraded DMEPOS item but to charge Medicare and the beneficiary for the non-upgraded item, the supplier must bill for the non-upgraded item rather than the item the supplier actually furnished. The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the following modifier:

GL - Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN

*Suppliers must show the upgrade using the ASC X12* 837 *professional claim format*, or *i*n Item 19 of a paper *Form CMS-1500* claim, or as an attachment. *T*the supplier must specify the make and model of the item actually furnished, that is, the upgraded item, and describe why this item is an upgrade

Contractors are to pay based on Medicare's payment amount for the non-upgraded item if it meets Medicare's coverage and payment requirements. A certificate of medical necessity, if applicable, must be completed for the HCPCS code that identifies the non-upgraded item but not for the upgraded item.

MSN Message:

For items accompanied with a GL modifier, use:

| | |
|---|---|
| MSN 8.51: | You are not liable for any additional charge as a result of receiving an upgraded item. |

## 130.9 - Showing Whether Rented or Purchased

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Claims must specify whether equipment is rented or purchased. For purchased equipment, the itemized bill or claim must also indicate whether equipment is new or used. If the provider or supplier fails to indicate on an assigned claim whether equipment was new or used, the contractor processing the claims assumes purchased equipment is used and process the claim accordingly, i.e., they pay on the basis of the used purchase fee. If an unassigned purchase claim does not specify whether the item was new or used, contractors develop the claim with the supplier. The following table indicates the HCPCS modifiers which are added to the equipment code to indicate its status:

| | |
|---|---|
| -BP | The beneficiary has been informed of the purchase and rental options and has elected to purchase the item |
| -BR | The beneficiary has been informed of the purchase and rental options and has elected to rent the item |
| -BU | The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision |
| -KH | DMEPOS item, initial claim, purchase or first month rental |
| -KI | DMEPOS item, second or third month rental |

| | |
|---|---|
| -KJ | DMEPOS item, PEN pump or capped rental months four to fifteen |
| -NR | New when rented (use the 'NR' modifier when an item that was new at the time of rental is subsequently purchased) |
| -NU | New equipment |
| -RR | Rental (use the 'RR' modifier when DME is to be rented) |
| -UE | Used durable medical equipment |

HHAs report the appropriate modifier *using the ASC X12 837 institutional claim format, or on Form* CMS-1450 following the appropriate HCPCS code. *A/B MACs (HHH)* accept 7 positions in this field for data entry purposes.

## 140.1 - Billing for Supplies and Drugs Related to the Effective Use of DME

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Suppliers and providers bill supplies that are necessary for the effective use of DME, including drugs, with the appropriate HCPCS code identifying the supply. HHAs must also report revenue code 0294, "Supplies/Drugs for DME Effectiveness."

Suppliers and providers, other than HHAs, bill supplies and drugs (not including drugs that are necessary for the effective use of implanted DME) that are necessary for the effective use of DME to the DME *MAC*s. HHAs bill the *A/B MACs (HHH).*

Suppliers and providers, other than HHAs, bill for drugs that are necessary for the effective use of implanted DME (HCPCS codes E0751, E0753, E0782, and E0783) to the *A/B MAC (B)*. HHAs bill the *A/B MAC (HHH)*.

The *A/B MACs (HHH)* contact the DME *MAC* or *A/B MAC (B)* as necessary to determine drug prices.

The DME *MAC*s must:

- accept NDC codes for all drugs billed in the NCPDP format;
- accept NDC codes for oral anti-cancer drugs billed in *the ASC X12 837 professional claim format*, NCPDP *format*, and paper *Form CMS-1500*;
- accept HCPCS for all other drugs billed in *the ASC X12 837 professional claim format* and paper *Form CMS-1500* and
- return as unprocessable claims submitted with an invalid NDC using *the appropriate* Remittance Advice Remark Code..

See http://www.wpc-edi.com/codes/Codes.asp for a current list of the Remittance Advice Remark Codes.

## 150 - Institutional Provider Reporting of Service Units for DME and Supplies

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Provider outpatient departments report *service units using the ASC X12 837 institutional claim format or on the* Form CMS 1450 the number of items being billed for orthotic and prosthetic devices.

For purchased DMEPOS items (excluding items requiring frequent and substantial servicing, capped rental items, and oxygen which cannot be purchased) HHAs report *service units using the ASC X12 837 institutional claim format or on the Form CMS-1450* the number of purchased items billed. For rental DME items, including oxygen equipment, HHAs report a separate line for each month billed indicating "1" *on the ASC X12 837 institutional claim format or in the service units field on the Form CMS-1450*.

For oxygen contents (HCPCS codes E0441, E0442, E0443, and E0444), the HHAs report the number of feet or pounds as described by the HCPCS code.

## 160.1 - Billing for Total Parenteral Nutrition and Enteral Nutrition Furnished to Part B Inpatients

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

Inpatient Part A hospital or SNF care includes total parenteral nutrition (TPN) systems and enteral nutrition (EN).

For inpatients for whom Part A benefits are not payable (e.g., benefits are exhausted or the beneficiary is entitled to Part B only), total parenteral nutrition (TPN) systems and enteral nutrition (EN) delivery systems are covered by Medicare as prosthetic devices when the coverage criteria are met. When these criteria are met, the medical equipment and medical supplies (together with nutrients) being used comprise covered prosthetic devices for coverage purposes rather than durable medical equipment. However, reimbursement rules relating to DME continue to apply to such items.

When a facility supplies TPN or EN systems that meet the criteria for coverage as a prosthetic device to an inpatient whose care is not covered under Part A, the facility must bill one of the DME *MAC*s. Additionally, HHAs, SNFs, and hospitals that provide PEN supplies, equipment and nutrients as a prosthetic device under Part B must use the *ASC X12 837 professional claim format or if permissible the Form* CMS-1500 *paper form* to bill the appropriate DME *MAC*. The DME *MAC* is determined according to the residence of the beneficiary. Refer to §10 for jurisdiction descriptions.

*A/B MACs (A and HHH)* return claims containing PEN charges for Part B services where the bill type is 12x, 13x, 22x, 23x, 32x, 33x, or 34x with instructions to the provider to bill the DME *MAC*.

## 160.2 - Special Considerations for SNF Billing for TPN and EN Under Part B

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

The HCPCS code and any appropriate modifiers are required.
*SNFs bill the A/B MAC (B) for TPN and EN under Part B, using the ASC X12 837 professional claim format, or the Form CMS-1500 paper claim if applicable.*

The following HCPCS codes apply.
B4034 B4035 B4036 B4081 B4082 B4083 B4084 B4085 B4150 B4151 B4152 B4153 B4154 B4155 B4156 B4164 B4168 B4172 B4176 B4178 B4180 B4184 B4186 B4189 B4193 B4197 B4199 B4216 B4220 B4222 B4224 B5000 B5100 B5200 B9000 B9002 B9004 B9006 E0776XA B9098 B9099

For SNF billing for PEN, a SNF includes the charges for PEN items it supplies beneficiaries under Part A on its Part A bill. The services of SNF personnel who administer the PEN therapy are considered routine and are included in the basic Part A payment for a covered stay. SNF personnel costs to administer PEN therapy are not covered under the Part B prosthetic device benefit.

If TPN supplies, equipment and nutrients qualify as a prosthetic device and the stay is not covered by Part A, they are covered by Part B. Part B coverage applies regardless of whether the TPN items were furnished by the SNF or an outside supplier. The Part B TPN bill must be sent to the DME *Medicare Administrative Contractor* regardless of whether supplied by the SNF or an outside supplier.

Enteral nutrients provided during a stay that is covered by Part A are classified as food and included in the routine Part A payment sent to the SNF. (See the Medicare Provider Reimbursement Manual, §2203.1E.)

Parenteral nutrient solutions provided during a covered Part A SNF stay are classified as intravenous drugs. The SNF must bill these services as ancillary charges. (See the Medicare Provider Reimbursement Manual, §2203.2.)

## 170 - Billing for Splints and Casts

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

The cost of supplies used in creating casts are not included in the payment amounts for the CPT codes for fracture management and for casts and splints. Thus, for settings in which CPT codes are used to pay for services that include the provision of a cast or splint, supplies maybe billed with separate CPCS codes. The work and practice expenses involved with the creation of the cast or splint are included in the payment for the code for that service.

For claims with dates of service on or after July 1, 2001, jurisdiction for processing claims for splints transferred from the DME *MAC*s to the *A/B MAC (B)*. The *A/B MACs (B)* have jurisdiction for processing claims for splints and casts, which includes codes for splints that may have previously been billed to the DME *MAC*s.

Jurisdiction for slings is jointly maintained by the *A/B MAC*s *(B)* (for physician claims) and the DME *MAC*s (for supplier claims). Notwithstanding the above where the beneficiary receives the service from any of the following providers claims jurisdiction is with the *A/B MAC (A).* An exception to this is hospital outpatient services and hospital inpatient Part B services, which are included in the OPPS payment and are billed to the *A/B MAC (A) using the ASC X12 837 institutional claim format or Form CMS- 1450)*.

Other providers and suppliers that normally bill the *A/B MAC (A)* for services bill the *A/B MAC (B)* for splints and casts.

## 210 - CWF Crossover Editing for DMEPOS Claims During an Inpatient Stay

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

### I. General Information

### A. Background:

In general, the DMEPOS benefit is meant only for items a beneficiary is using in his or her home. For a beneficiary in a Part A inpatient stay, an institutional provider (e.g., hospital) is not defined as a beneficiary's home for DMEPOS, and so Medicare does not make separate payment for DMEPOS when a beneficiary is in the institution. The institution is expected to provide all medically necessary DMEPOS during a beneficiary's covered Part A stay.

**EXCEPTION:** Medicare makes a separate payment for a full month for DMEPOS items, provided the beneficiary was in the home on the "from" date or anniversary date defined below.

For capped rental items of durable medical equipment (DME) where the DME supplier submits a monthly bill, the date of delivery ("from" date) on the first claim must be the "from" or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, etc.).

### B. Policy:

If a beneficiary using DMEPOS is at home on the "from" date or anniversary date, Medicare pays for the DMEPOS for the entire month, even if the "from" date is the date of discharge from the institutional provider.

If a beneficiary using DMEPOS is in a covered Part A stay for a full month, Medicare does not make payment for the DMEPOS for that month.

For capped rental items, if the covered Part A stay overlaps the anniversary date ("from" date on the claim), and the beneficiary is not in the covered Part A stay for the entire month, the date of discharge becomes the new anniversary date ("from" date on the claim) for subsequent claims. In this situation, the supplier must submit a new claim with the date of discharge as the new anniversary date upon the beneficiary's release from the institution. Suppliers should annotate the *claims*, to indicate that the patient was in an institution, resulting in the need to establish a new anniversary date.
The CWF:

- rejects a DME *MAC* claim that contain DMEPOS HCPCS codes when the DME *MAC* claim has a date of service that falls within the inpatient stay;
- considers an inpatient stay to include all days prior to the date of discharge;
- processes a DME *MAC* claim that contain DMEPOS HCPCS codes when the DME *MAC* claim has the same "from" date equal to the date of inpatient discharge;
- validates for a crossover service on a DME *MAC* claim for an inpatient beneficiary based on the "from" date only of the DME *MAC* claim;
- identifies a DME *MAC* claim for maintenance and servicing by the "MS" modifier;
- allows payment for a DME *MAC* claim for maintenance and servicing of capped rental items when a claim contains the "MS" modifier.

The CWF approves to pay maintenance and servicing claims regardless of whether the beneficiary is in an institutional setting or in the home environment.

The changes in the general policy apply to all items of DMEPOS paid by the *DME MACs*, however, changes in anniversary date billing apply only to capped rental DME.
In cases where the anniversary date falls at the end of the month (for example January 31) and a subsequent month does not have a day with the same date (for example, February), the DME *MAC* uses the final date in the calendar month (for example, February 28).

**EXAMPLE 1:**

A beneficiary rents a wheelchair beginning on January 1. The DME *MAC* determines that the wheelchair is medically necessary and that the beneficiary meets all coverage criteria, and so begins to make payment on the wheelchair. The beneficiary enters a covered a hospital on February 15 and is discharged on April 5.

In this example, Medicare pays for the entire month of February, because the patient was in the home for part of the month. However, the DME *MAC* denies the claim for March, because the patient was in a covered hospital stay for the entire month.

Because the anniversary date ("from" date) of the monthly bill was April 1, and the patient was still in the covered hospital stay on that date, the DME supplier must not submit another claim until April 5 (the date of discharge). April 5 becomes the new anniversary date ("from" date) for billing purposes, so the supplier would now bill on the 5th of the month rather than the 1st of the month for the remainder of the capped rental period. The supplier should annotate the *claim* to indicate that the patient was in a hospital on the first claim with the new anniversary date.

**EXAMPLE 2:**

A beneficiary receives oxygen on January 1. On February 28, the patient enters a hospital and is discharged on March 15.

In this example, the DME *MAC* denies a claim dated March 1. The supplier submits a new claim dated March 15, which would then become the anniversary date for billing purposes. The supplier should annotate the *claim* to indicate that the patient was in a hospital on the first claim with the new anniversary date.

**EXAMPLE 3:**

A beneficiary rents a hospital bed beginning on January 1. On March 15, the patient enters a hospital and is discharged on March 25.

In this example, the DME *MAC* pays for the entire month of March.

**EXAMPLE 4:**
A beneficiary rents a wheelchair beginning December 15. On January 1, the patient enters a hospital and is discharged on January 31.

In this example, the DME *MAC* denies the claim dated January 15. The supplier submits a new claim dated January 31, which becomes the anniversary date for billing purposes. The supplier should annotate the *claim* to indicate that the patient was in a hospital on the first claim with the new anniversary date. The February claim would be dated February 28 because there is no 31st day in February.

## 211.2 - Partial Month Stays For Capped Rental Equipment

***(Rev. 2993, Effective: ASC X12 – 01-01-12, ICD-10 – Upon Implementation of ICD-10; Implementation: ASC X12 – 08-25-14, ICD-10 – Upon Implementation of ICD-10)***

### A. General Rule

For capped rental DME items where the DME supplier submits a monthly bill, the date of delivery (the "from" date) on the first claim must be the "from", or "anniversary date", on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated on the 15th of the following months (October 15, November 15, etc.).

The following instructions discuss DME payment when the DME is furnished during a month in which the beneficiary spends part of the month in a SNF, and part of the month in his or her own home. In accordance with DME payment policy, Medicare will make separate payment for a full month for DME items in such situations, provided the beneficiary was in the home on the "from" date or "anniversary date" defined above.

### B. Policy

If a beneficiary using DME is at home on the "from" or "anniversary date", Medicare will make payment for DME for the entire month, even if the "from" date is the date of discharge from the SNF.

If a beneficiary using DME is in a covered Part A stay in a SNF for a full month, Medicare will not make payment for DME for that month.

For capped rental items, if the covered Part A SNF stay overlaps the "from" or "anniversary date" of the Certificate of Medical Necessity (CMN), and the beneficiary is not in the covered Part A SNF stay for the entire month, the date of discharge becomes the new "anniversary date" for subsequent claims. In this situation, the supplier must submit a new claim with the date of discharge as the new anniversary date upon the beneficiary's release from the SNF. Suppliers should annotate *claims*, to indicate that the patient was in a SNF, resulting in the need to establish a new anniversary date.

**NOTES:** The DME *MAC*s must continue to make payment for maintenance and servicing of capped rental items regardless of whether the beneficiary is in a covered Part A SNF stay on the date of service of the maintenance and servicing claim.

The DME *MAC*s must make payment for DME on the date of discharge from a covered Part A SNF stay. Claims must edit based on the "from" date of the claim and not the "through" date of the claim.

**EXAMPLE 1:**

A beneficiary rents a wheelchair beginning on January 1. The DME *MAC* determines that the wheelchair is medically necessary and that the beneficiary meets all coverage criteria, and so begins to make payment on the wheelchair. The beneficiary enters a covered Part A stay in a SNF on February 15 and is discharged on April 5. In this example, Medicare will make payment for the entire month of February, because the patient was in the home for part of the month. However, the DME *MAC* will deny the claim for March, because the patient was in a covered Part A stay in the SNF for the entire month.

Because the anniversary date ("from" date) of the monthly bill was April 1, and the patient was still in the covered Part A stay in a SNF on that date, the DME supplier must not submit another claim until April 5 (the date of discharge). April 5 becomes the new anniversary date ("from" date) for billing purposes, so the supplier would now bill on the 5$^{th}$ of the month rather than the 1$^{st}$ of the month for the remainder of the capped rental period. The supplier should annotate the *claim* to indicate that the patient was in a SNF on the first claim with the new anniversary date.

**EXAMPLE 2:**

A beneficiary receives oxygen on January 1. On February 28, the patient enters a covered Part A stay in a SNF and is discharged on March 15.

In this example, the DME *MAC* would deny a claim dated March 1. The supplier would submit a new claim dated March 15, which would then become the anniversary date for billing purposes. The supplier should annotate the *claim* to indicate that the patient was in a covered Part A stay in a SNF on the first claim with the new anniversary date.

**EXAMPLE 3:**

A beneficiary rents a hospital bed beginning on January 1. On March 15, the patient enters a covered Part A stay in a SNF and is discharged on March 25.
In this example, the DME *MAC* will make payment for the entire month of March.

**NOTE:** The changes in the general policy in this instruction apply to all items of DME paid by the DME *MAC*s. However, changes in "anniversary date" billing requirements only apply to capped rental DME.