CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 846	**Date: January 28, 2011**
	Change Request 7261

SUBJECT: Additional Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Replacement Parts, Accessories, and Supplies Pricing Logic Established By Change Requests (CRs) 5917 and 6573

I. SUMMARY OF CHANGES: Change Requests 5917 and 6573 established and clarified instructions for carriers / A/B MACs to process and pay claims for replacement parts, accessories, and supplies for prosthetic implants and surgically implemented durable medical equipment (DME) when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and with their local carrier / A/B MAC as a DMEPOS supplier.

This CR adds three new HCPCS codes for replacement parts, accessories, and supplies for implanted prosthetic implants to those codes that are already payable under the guidelines established by CRs 5917 and 6573 effective beginning January 1, 2011.

EFFECTIVE DATE: January 1, 2011
IMPLEMENTATION DATE: July 5, 2011

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 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 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.

IV. ATTACHMENTS:
One-Time Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 846	January 28, 2011	Change Request: 7261

SUBJECT: Additional Healthcare Common Procedure Coding System (HCPCS) Codes Payable Under the Replacement Part, Accessories, and Supplies Pricing Logic Established By Change Requests (CRs) 5917 and 6573

Effective Date: January 1, 2011

Implementation Date: July 5, 2011

I. GENERAL INFORMATION

A. Background: The Centers for Medicare and Medicaid Services (CMS) issued Change Request (CR) 6573, Transmittal 531 entitled "Additional Instructions on Processing Claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items Submitted Under the Guidelines Established in CR 5917" on August 14, 2009. CR 6573 included a revised list of Healthcare Common Procedure Coding System (HCPCS) codes which contractors were to use to determine the items that could be billed to the A/B MACs / Carriers under the guidelines previously established by CRs 5917 and 6573.

This CR provides three additional HCPCS codes for replacement parts, accessories, and supplies for implanted prosthetic implants, which became effective January 1, 2011. These three HCPCS codes may also be separately billed to the A/B MACs / Carriers under the guidelines previously established by CRs 5917 and 6573.

B. Policy: Beginning January 1, 2011, suppliers that are enrolled with the National Supplier Clearinghouse (NSC) as a DMEPOS supplier may bill for HCPCS codes L8693 (Auditory Osseointegrated Device Abutment, Any Length, Replacement Only), Q0478 (Power Adapter for use with Electric or Electric/Pneumatic Ventricular Assist Device, Vehicle Type), and Q0479 (Power Module for use with Electric/Pneumatic Ventricular Assist Device, Replacement Only), and contractors shall process claims containing such codes, according to the instructions previously communicated in CRs 5917 and 6573.

Contractors shall reprocess any claims containing the three HCPCS codes listed directly above submitted by DMEPOS suppliers with dates of service on or after January 1, 2011 through the implementation date of this CR, according to the guidelines established in CRs 5917 and 6573. When claims containing these codes are submitted to the Durable Medical Equipment Medicare Administrative Contractors (DME MACs), they shall be denied.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7261.1	Contractors shall allow suppliers that are dually enrolled with the NSC and with their local carrier / A/B MAC as DMEPOS suppliers to bill for HCPCS codes L8693, Q0478, and Q0479 when billed under the guidelines established by CRs 5917 and 6573, including those furnished to beneficiaries who reside in other States.	X			X						
7261.2	Contractors shall reprocess any claims containing HCPCS codes L8693, Q0478, and Q0479 with dates of service on or after January 1, 2011 through the implementation date of this CR according to the guidelines established in CRs 5917 and 6573.	X			X						
7261.3	CWF shall bypass the locality edit on HUBC records for claims containing HCPCS codes L8693, Q0478, and Q0479.									X	
7261.4	Contractors shall deny any claims containing HCPCS codes L8693, Q0478, and Q0479 using the following Remittance Advice messages: Reason Code 109 - Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. Remark Code N104 – This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov. Group Code CO – Contractual Obligation		X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7261.5	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 article, or a direct link to this article, on their Web site 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 your 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.	X	X		X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For DMEPOS payment policy questions, contact Karen Jacobs at karen.jacobs@cms.hhs.gov. For DMEPOS claims processing questions, contact Eric Coulson at eric.coulson@cms.hhs.gov.

Post-Implementation Contact(s): Your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

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

No additional funding will be provided by CMS; contractor activities are to be carried out within 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 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.