CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2755	**Date: August 2, 2013**
	Change Request 8390

SUBJECT: Additional States Requiring Payment Edits for DMEPOS Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics. Update to CR 3959

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to communicate the five (5) additional states which require the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. Those states are Arkansas, Georgia, Kentucky, Mississippi, and Tennessee.

EFFECTIVE DATE: October 5, 2013
IMPLEMENTATION DATE: October 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
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
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:
One-Time-Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-04	Transmittal: 2755	Date: August 2, 2013	Change Request: 8390

SUBJECT: Additional States Requiring Payment Edits for DMEPOS Suppliers of Prosthetics and Certain Custom-Fabricated Orthotics. Update to CR 3959

EFFECTIVE DATE: October 5, 2013
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I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) issued Transmittal 656, Change Request (CR) 3959 on August 19, 2005. This CR instructed Durable Medical Equipment Regional Contractors (DMERCs, since changed to Durable Medical Equipment Medicare Administrative Contractors, or DME MACs) to implement claims processing edits to ensure compliance with CMS regulations found at 42 CFR § 424.57(c)(1). Such regulations require durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers wishing to bill Medicare to operate their business and furnish Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements.

As a result of CR 3959, the DME MACs implemented an edit which was programmed to deny claims for prosthetics and certain custom-fabricated orthotics when those items were furnished by personnel who were not licensed/certified as a orthotist or prosthetist by the State in which they practice. At the time CR 3959 was issued and the DME MACs implemented the edit, there were nine (9) states which required the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. Since that time, five (5) additional states have instituted requirements for the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics. These five (5) states are Arkansas, Georgia, Kentucky, Mississippi, and Tennessee. Since these five (5) states were not originally programmed into the edit implemented via CR 3959, it is possible that DME MACs have been inappropriately paying for prosthetics and certain custom-fabricated orthotics when those items were furnished by personnel who were not properly licensed/certified by the State in which they practice.

DME MACs are instructed to revise the programming edits so that Arkansas, Georgia, Kentucky, Mississippi, and Tennessee are added to the logic, in accordance with CR 3959.

B. Policy: In those fourteen states that have indicated that provision of prosthetics and orthotics must be made by licensed/certified orthotist or prosthetist, Medicare payment may only be made for prosthetics and certain custom-fabricated orthotics when furnished by physicians, pedorthists, physical therapists, occupational therapists, orthotics personnel and prosthetics personnel. These specialties shall bill for Medicare services when State law permits such entity to furnish an item of prosthetic or orthotic.

1. Medical Supply Company with Orthotics Personnel – Specialty Code 51;

2. Medical Supply Company with Prosthetics Personnel – Specialty Code 52;

3. Medical Supply Company with Orthotics and Prosthetics Personnel – Specialty Code 53;

4. Orthotics Personnel – Specialty Code 55;

5. Prosthetics Personnel – Specialty Code 56;

6. Orthotics Personnel, Prosthetics Personnel, and Pedorthists – Specialty Code 57;

7. Physical Therapist – Specialty Code 65;

8. Occupational Therapist – Specialty Code 67;

9. Pedorthic Personnel - Specialty Code B2;

10. Medical Supply Company with Pedorthic Personnel - Specialty Code B3

11. Ocularist – Specialty Code B5; and

12. All Physician Specialty Code listed in the Medicare Claims Processing Manual, Pub 100-04, Chapter 26, §10.8.2.

If a supplier is located in one of the applicable states and wishes to bill Medicare for the prosthetics and custom-fabricated orthotics attached to this CR, it must properly enroll with the National Supplier Clearinghouse (NSC) to ensure the correct specialty code(s) is on file. A copy of the State license should be sent to the NSC if the supplier is in one of the fourteen states requiring a license. If a supplier should need to update its' file with the correct specialty, the supplier must submit a "Change of Information" on Form CMS-855S to the NSC along with all applicable licenses or certifications. The NSC is responsible for maintaining a central data repository for information regarding suppliers, which is transmitted to the four DME MACs. The effective date for the new or revised specialty code for P & O claims will be the date the NSC issues the specialty code. The new or revised specialty code shall not be applied retroactively.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
8390.1	CMS shall provide the DME MACs with an updated listing of the states that require use of an orthotist or prosthetist for furnishing of orthotics or prosthetics. In addition to the current nine (9) states, five (5) new states have been added (AR, GA, KY, MS, and TN).												CMS
8390.2	Contractors shall revise their programming edits so that AR, GA, KY, MS, and TN are added to the logic, in accordance with CR 3959.				X								NSC
8390.3	Contractors shall provide CMS with updates to this listing, as necessary. CMS will then issue a CR to change and/or update the list of states.												NSC
8390.4	The contractor's claims processing system shall note the specific prosthetic and orthotic HCPCS				X								

Number	Requirement	Responsibility											
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		A	B	HHH					FISS	MCS	VMS	CWF	
	Codes previously identified in CR 3959 and shall continue to edit claims from suppliers for the current nine (9) states as well as the additional states identified by the NSC in Business Requirement 8390.1, above.												
8390.5	Contractors shall continue to deny a claim for the attached P & O codes if submitted by a supplier that is located in one of the current states as well as the additional states identified by the NSC in Business Requirement 8390.1 and that does not have at least one of the following specialty codes: 51, 52, 53, 55, 56, 57, 65, 67, B2, B3, B5, or any one the Physician Specialty Codes listed in the Medicare Claims Processing Manual [IOM] Chapter 26, Section 10.8.2. This supplier is not eligible to bill for these P & O Services. (**NOTE:** Any one of these specialty codes requires that a copy of the State License be on file at the NSC).				X								NSC
8390.6	The effective date for a new or revised specialty code for P & O claims shall be the date the NSC issues the specialty code to the supplier. The DME MACs shall not apply the specialty code retroactively.				X								NSC
8390.7	Adjustment claims: Claims previously approved and subsequently adjusted shall be exempt from these edits.				X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
8390.8	MLN Article : A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is				X				

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	FI	CARRIER	RHHI	Other
		A	B	HHH					
	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 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

"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): Alisha Banks, 410-786-0671 or Alisha.Banks@cms.hhs.gov , Kimberly McPhillips, 410-786-5374 or Kim.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), and/or Carriers:
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):
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and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.