CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1532	**Date: JUNE 11, 2008**
	Change Request # 6119

SUBJECT: Phase 2 of Manual Revisions to Reflect Payment Changes for DMEPOS Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005

I. SUMMARY OF CHANGES: This second installment of chapter 36 of the Claims Processing Manual provides additional information about the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program for Medicare Contractors and suppliers. This installment does not contain new instructions for Medicare Contractors for this program. Subsequent installments to this chapter will include additional information and instructions for Medicare Contractors and suppliers on this program.

New / Revised Material
Effective Date: July 1, 2008
Implementation Date: July 7, 2008

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	36/20.5.3/Home Health Agencies
R	36/20.5.4/Items Furnished on a Mail Order Basis
R	36/20.5.4.1/Mail-Order Suppliers for Diabetic Supplies
R	36/20.6.1.1.3/Notification to Beneficiaries by Suppliers that Choose to Become Grandfathered Suppliers
R	36/20.6.1.1.4/Notification to Beneficiaries for Suppliers that Choose Not to Become Grandfathered Suppliers
R	36/30.4/Prescirption for Particular Brand, Item, or Mode of Delivery
R	36/40.1/Single Payment Amount
D	36/40.1.1/Adjustments to the Single Pyament Amounts to Reflect Changes in HCPCS Codes
N	36/40.4/Payment for Rental of Inexpensive or Routinely

	Purchased DME
N	36/40.5/Payment for Oxygen and Oxygen Equipment
N	36/40.5.1/Change in Suppliers for Oxygen and Oxygen Equipment
N	36/40.6/Payment for Capped Rental DME Items
N	36/40.6.1/Change in Suppliers for Capped Rental DME Items
N	36/40.7/Payment for Purchased Equipment
N	36/40.8/Payment for Repair and Replacement of Beneficiary-Owned Equipment
N	36/40.9/Payment for Enteral Nutrition Equipment
N	36/40.9.1/Maintenance and Servicing of Enteral Nutrition Equipment
N	36/40.10/Traveling Beneficiaries
N	36/40.10.1/Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items
N	36/40.11/Billing Procedures Related to Advance Beneficiary Notice (ABN) Upgrades under the Competitive Bidding Program
N	36/40.12/Billing Procedures Related to Downcoding Under the Competitive Bidding Program

III. FUNDING:

SECTION A: For Fiscal Intermediaries and 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.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1532	Date: June 11, 2008	Change Request: 6119

SUBJECT: Phase 2 of Manual Revisions to Reflect Payment Changes for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items as a Result of the DMEPOS Competitive Bidding Program and the Deficit Reduction Act of 2005

Effective Date: July 1, 2008

Implementation Date: July 7, 2008

I. GENERAL INFORMATION

A. Background:

This chapter has been developed to provide policies and instructions for the DMEPOS Competitive Bidding Program. This second installment of chapter 36 is to provide additional information for Medicare Contractors and suppliers on this program. Subsequent installments will follow this installment providing additional sections to the chapter that contain more detailed instructions and guidelines.

B. Policy:

Currently, Medicare payment for most DMEPOS is based on fee schedules. However, §302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which amended §1847 of the Social Security Act (Act), mandates a competitive bidding program to replace the current DMEPOS methodology for determining payment rates for certain DMEPOS items subject to competitive bidding under this statute. The statute also mandates that the competitive bidding program be phased in beginning in 2007. The Centers for Medicare & Medicaid Services (CMS) has issued the regulation for the competitive bidding program, which was published on April 10, 2007 (72 Federal Register 17992).

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote 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	
6119.1	Medicare Contractors shall continue to apply all existing instructions for DMEPOS items as applicable, unless otherwise noted in this chapter.	X	X	X	X	X					
6119.2	Medicare Contractors shall apply, if applicable, the rules and requirements pertaining to the DMEPOS competitive bidding program.	X	X	X	X	X					
6119.3	Medicare Contractors shall be knowledgeable that Home Health agencies must submit a bid and be awarded a contract in order to furnish items under the DMEPOS competitive bidding program.	X	X	X	X	X					
6119.4	Medicare Contractors shall be knowledgeable that suppliers should only be sending notifications regarding grandfathering decisions to beneficiaries who maintain	X	X	X	X	X					

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	
	their permanent residence in a competitive bidding area subject to the DMEPOS competitive bidding program.										
6119.5	Medicare Contractors shall be knowledgeable that under the physician authorization process physicians and treating practitioners should document the following: (1) product's brand name or mode of delivery; (2) the features that this product or mode of delivery has versus other brand name products or modes of delivery; and (3) an explanation of how these features are necessary to avoid an adverse medical outcome.	X	X	X	X	X					
6119.6	Medicare Contractors shall be knowledgeable about the payment rules for specific classes of competitively bid items.	X	X	X	X	X					
6119.6.1	Medicare Contractors shall be knowledgeable about the rules regarding change in suppliers for oxygen equipment and capped rental DME.	X	X	X	X	X					
6119.7	Medicare Contractors shall be knowledgeable about the rules regarding traveling beneficiaries and should refer to information in the public use files to determine if an item that they are considering furnishing to a beneficiary is subject to the DMEPOS competitive bidding program.	X	X	X	X	X					
6119.7.1	Medicare Contractors shall be knowledgeable about the rules regarding transfer of title to oxygen equipment or rented DME to traveling beneficiaries.	X	X	X	X	X					
6119.8	Medicare Contractors shall be knowledgeable about the billing procedures related to Advance Beneficiary Notices (ABN) when furnishing upgraded items under the DMEPOS competitive bidding program.	X	X	X	X	X					
6119.9	Medicare Contractors shall be knowledgeable about the billing procedures related to downcoding under the DMEPOS competitive bidding program.	X	X	X	X	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	
6119.10	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"	X	X	X	X	X					

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	
	listserv. Medicare 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. Medicare 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: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): Sabrina Teferi at Sabrina.Teferi@cms.hhs.gov or (410) 786-6884.

Post-Implementation Contact(s): Sabrina Teferi at Sabrina.Teferi@cms.hhs.gov or (410) 786-6884.

VI. FUNDING

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

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

Section B: ***For Medicare Administrative Medicare 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.

Medicare Claims Processing Manual
Chapter 36 – Competitive Bidding

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(Rev. 1532, 06-11-08)

20.5.3 – Home Health Agencies
(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Home health agencies must submit a bid and be awarded a contract for the DMEPOS Competitive Bidding Program in order to furnish competitively bid items directly to Medicare beneficiaries who maintain a permanent residence in a CBA. If a home health agency is not awarded a contract to furnish competitively bid items, then they must use a contract supplier for these items.

20.5.*4* - Items Furnished on a Mail Order Basis
(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

A Medicare beneficiary who maintains a permanent residence in a CBA for which we have done competitive bidding for mail order items may purchase their mail order items from: (1) a mail order contract supplier for that CBA; or (2) a noncontract supplier, if the item is purchased at a storefront. In situations where the beneficiary elects to obtain the item from a local storefront or from a local supplier via a mode of delivery other than mail order and the item is not subject to a competitive bidding program established for non-mail order items, the beneficiary may obtain the item from any Medicare enrolled supplier.

20.5.*4*.1 - Mail-Order Suppliers for Diabetic Supplies
(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Medicare beneficiaries who maintain a permanent residence in a CBA in which CMS has implemented a competitive bidding program for mail order diabetic supplies may purchase their diabetic testing supplies from:

- A mail order contract supplier for the CBA in which the beneficiary resides; or
- Any enrolled Medicare supplier if the diabetic testing supplies are furnished at a storefront and are not subject to a competitive bidding program established for non-mail order diabetic supplies.

Mail order contract suppliers will be reimbursed at the single payment amount for mail order diabetic supplies for the CBA in which the beneficiary maintains a permanent residence. In situations where a competitive bidding program has not been established for non-mail order diabetic supplies, noncontract suppliers that do not furnish items through mail order will be reimbursed at the fee schedule amount for the state in which the beneficiary maintains a permanent residence. Medicare payment will not be made to noncontract suppliers that furnish mail order diabetic testing supplies to Medicare beneficiaries residing in a CBA.

Mail order diabetic suppliers must use the HCPCS modifier KL on each claim to indicate that the item was furnished on a mail order basis. The modifier must be used for both competitive bidding and non-competitive bidding mail order diabetic supplies. Suppliers that furnish mail

order diabetic items that fail to use the HCPCS modifier KL on the claim may be subject to penalties under of the False Claims Act.

20.6.1.1.3 - Notification to Beneficiaries by Suppliers that Choose to Become Grandfathered Suppliers

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

A noncontract supplier that elects to become a grandfathered supplier is responsible for providing notification to its Medicare customers residing in CBAs who are furnished items identified in section 20.6.1. This notification should meet the following guidelines:

NOTE: *This notification should only be sent to beneficiaries who the supplier is currently serving and who maintain a permanent residence in a CBA. The list of zip codes for each CBA, the list of the HCPCS for competitively bid items, and the single payment amounts for these items are located in public use files on the CBIC website at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.*

- *It should state that the supplier is offering to continue to furnish rental DME, oxygen and oxygen equipment and/or related accessories and supplies that it is currently furnishing to the beneficiary (i.e., before the start of the competitive bidding program) and to provide these items to the beneficiary for the remainder of the rental period.*

- It should state that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or to elect to begin receiving the item(s) from a contract supplier after the competitive bidding program begins.

- It should provide the supplier's telephone number so the beneficiary or caregiver may call and notify the supplier of his/her election.

- The supplier should provide notification to the beneficiary at least 30 days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

- The supplier should receive an election from a beneficiary and maintain a record as to whether the beneficiary chose to continue to receive the item from a grandfathered supplier, chose to go to a contract supplier to receive the item or did not respond. The record should indicate, at a minimum, the date that the beneficiary is notified that the supplier elected to become a grandfathered supplier for the item(s), the date the beneficiary made an election (if applicable), and the methods of communication used in the case of each election activity (e.g. letter to the beneficiary).

- The supplier should inform the beneficiary of the end date of service and that arrangements will be made to pick-up the item within 10 days of picking up the item.

- The supplier should remind the beneficiary of the date and time the equipment will be picked up within 2 business days of picking up the equipment.

Recommended Schedule for Suppliers to Notify Beneficiaries of the Necessity to Decide on Arrangements for Choosing to Use a Grandfathered Supplier or Contract Supplier

Notification – Supplier	Number of Days Before the Start Date of the Competitive Bidding Program
Initial Notification in writing	30 days
Notification before picking up equipment	Within 10 days before picking up the equipment.
Final Notification before picking up equipment	Within 2 business days of picking up the equipment

** A sample notification letter will be posted on the CBIC Web site at www.dmecompetitivebid.com.

20.6.1.1.4 – Notification to Beneficiaries for Suppliers that Choose Not to Become Grandfathered Suppliers

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

A noncontract supplier that elects not to become a grandfathered supplier should provide notification to the beneficiary stating the supplier will not continue to furnish, after the start of the Medicare DMEPOS Competitive Bidding Program, the competitively bid item(s) that the beneficiary has been receiving from the supplier. This notification should meet the following guidelines:

NOTE: *This notification should only be sent to beneficiaries who the supplier is currently serving and who maintain a permanent residence in a CBA. The list of zip codes for each CBA, the list of the HCPCS for competitively bid items, and the single payment amounts for these items are located in public use files on the CBIC website at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.*

- It should state that the supplier will not continue to furnish rental DME and/or oxygen and oxygen equipment that it is currently furnishing to the beneficiary *after* the start of the competitive bidding program and that the beneficiary may need to select a contract supplier to continue to receive these items.

- It should inform the beneficiary of the start of the competitive bidding program and the date the supplier plans to pick up the item.

- It should inform the beneficiary that he/she may obtain information about the competitive bidding program by calling 1-800-MEDICARE or accessing www.medicare.gov on the Internet. It should also refer him/her to the supplier locator tool on www.medicare.gov.

- The supplier should provide this written notification to the beneficiary 30 days before the start date from the implementation of the Medicare DMEPOS Competitive Bidding Program.

- The supplier should inform the beneficiary of the end date of service and that arrangements will be made to pick-up the item within 10 days of picking up the item.

- The supplier should remind the beneficiary of the date and time the equipment will be picked up within 2 business days of picking up the equipment.

Recommended Schedule for Suppliers to Notify Beneficiaries to Locate a Contract Supplier

Notification – Supplier	Number of Days Before the Start Date of the Competitive Bidding Program
Initial Notification in writing	30 days
Notification before picking up equipment	Within 10 days before picking up the equipment.
Final Notification before picking up equipment	Within 2 business days of picking up the equipment

** A sample notification letter will be posted on the CBIC Web site at www.dmecompetitivebid.com.

30.4 - Prescription for Particular Brand, Item, or Mode of Delivery

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Contract suppliers are not required to furnish a specific brand name item or mode of delivery to a beneficiary unless prescribed *by a physician or treating practitioner* to avoid an adverse medical outcome. A physician or treating practitioner (that is a physician assistant, clinical nurse specialist, or nurse practitioner) may prescribe, in writing, a particular brand of a *competitively* bid item or mode of delivery for an item if he or she determines that the particular brand or mode of delivery *is necessary to* avoid an adverse medical outcome for the beneficiary. The physician or treating practitioner must document in the beneficiary's medical record the reason why the specific brand or mode of delivery is necessary to avoid an adverse medical outcome.
This documentation should include the following:

- *The product's brand name or mode of delivery;*
- *The features that this product or mode of delivery has versus other brand name products or modes of delivery; and*
- *An explanation of how these features are necessary to avoid an adverse medical outcome.*

If a physician or treating practitioner prescribes a particular brand or mode of delivery to avoid an adverse medical outcome, the contract supplier must either:

(1) Furnish the particular brand or mode of delivery as prescribed by the physician or treating practitioner;
(2) Consult with the physician or treating practitioner to find another appropriate brand of item or mode of delivery for the beneficiary and obtain a revised written prescription from the physician or treating practitioner; or

(3) Assist the beneficiary in locating a contract supplier that can furnish the particular brand of item or mode of delivery prescribed by the physician or treating practitioner.

Any change in the prescription requires a revised written prescription for Medicare payment. A contract supplier is prohibited from submitting a claim to Medicare if it furnishes an item different from that specified in the written prescription received from the beneficiary's physician or treating practitioner.

40.1 - Single Payment Amount

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The single payment amount for each *competitively bid* item in each CBA is based on the bids submitted and accepted for that item. Only bids from qualified suppliers (those that met all quality and financial standards and eligibility and accreditation requirements) are considered in setting the single payment amount. The single payment amount for an item furnished under the competitive bidding program is equal to the median of the bids submitted for that item by qualified suppliers whose composite bids for the product category are equal to or below the pivotal bid for that product category. The single amount is determined by CMS and remains in effect for the duration of a contract period and is not adjusted for inflation. A listing of the single payment amounts will be posted at the CBIC Web site at http://www.dmecompetitivebid.com. *See section 100.5 of chapter 23 of the Claims Processing Manual for instructions regarding adjustments to the single payment amounts as a result of changes in the HCPCS.*

40.4 – Payment for Rental of Inexpensive or Routinely Purchased DME

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The monthly rental payment amounts for inexpensive or routinely purchased DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item.

40.5 – Payment for Oxygen and Oxygen Equipment

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The monthly payment amounts for oxygen and oxygen equipment are equal to the single payment amounts established for the following classes of items:

- *Stationary oxygen equipment (including stationary oxygen concentrators) and oxygen contents (stationary and portable)*
- *Portable equipment only (gaseous or liquid tanks)*
- *Oxygen generating portable equipment (OGPE) only (used in lieu of traditional portable oxygen equipment/tanks)*
- *Stationary oxygen contents (for beneficiary-owned stationary liquid or gaseous equipment)*
- *Portable oxygen contents (for beneficiary-owned portable liquid or gaseous equipment)*

In cases where a supplier is furnishing both stationary oxygen contents and portable oxygen contents, the supplier is paid both the single payment amount for stationary oxygen contents and the single payment amount for portable oxygen contents.

The payment amounts for purchase of supplies and accessories used with beneficiary-owned oxygen equipment are equal to the single payment amounts established for the supply or accessory.

40.5.1 –Change in Suppliers for Oxygen and Oxygen Equipment

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The following rules apply when the beneficiary switches from one supplier of oxygen and oxygen equipment to another supplier after the beginning of each round of competitive bidding:

Noncontract supplier to contract supplier

In general, monthly payment amounts may not exceed a period of continuous use of longer than 36 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 36-month period, at least 10 monthly payment amounts would be made to a contract supplier that begins furnishing oxygen and oxygen equipment in these situations provided that medical necessity for oxygen continues.

For example, if a contract supplier begins furnishing oxygen equipment to a beneficiary in months 2 through 26, payment would be made for the remaining number of months in the 36-month period, because the number of payments to the contract supplier would be at least 10 payments. To provide a more specific example, a contract supplier that begins furnishing oxygen equipment beginning with the 20th month of continuous use would receive 17 payments (17 for the remaining number of months in the 36-month period). However, if a contract supplier begins furnishing oxygen equipment to a beneficiary in month 27 or later, no more than 10 monthly payments would be made assuming the oxygen equipment remains medically necessary.

Contract supplier to another contract supplier

This rule does not apply when a beneficiary switches from a contract supplier to another contract supplier to receive his/her oxygen and oxygen equipment. In this scenario, the new contract supplier is paid based on the single payment amount for the remaining number of months in the 36-month period assuming the oxygen equipment remains medically necessary.

40.6 – Payment for Capped Rental DME Items

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The monthly rental payment amounts for capped rental DME (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first 3 months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 13.

40.6.1 – Change in Suppliers for Capped Rental DME Items
(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The following rules apply when the beneficiary switches from one supplier of capped rental DME to another supplier after the beginning of each round of competitive bidding:

Noncontract supplier to contract supplier

In general, rental payments may not exceed a period of continuous use of longer than 13 months. However, if the beneficiary switches from a noncontract supplier to a contract supplier before the end of the 13-month rental period, a new 13-month period begins and payment is made on the basis of the single payment amounts described in section 40.6. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the new 13-month rental period, the contract supplier is required to transfer title of the capped rental item to the beneficiary. Once the beneficiary switches from a noncontract supplier to a contract supplier, they may not switch back to a noncontract supplier if he/she continues to maintain a permanent residence in a CBA. If, however, the beneficiary relocates out of the CBA to a non-CBA, then he/she may switch to a noncontract supplier and a new 13-month rental period does not begin. See section 40.3 for instructions for payment of grandfathered items.

Contract supplier to another contract supplier

If the beneficiary switches from a contract supplier to a contract supplier before the end of the 13-month rental period, a new 13-month period does not begin. This provision applies in situations where the beneficiary changes suppliers within a CBA and in situations where the beneficiary relocates and switches from a contract supplier in one CBA to contract supplier in another CBA. The contract supplier that the beneficiary switches to is responsible for furnishing the item until medical necessity ends, or the 13-month period of continuous use ends, whichever is earlier. On the first day following the end of the 13-month rental period of continuous use, the contract supplier is required to transfer title of the capped rental item to the beneficiary.

40.7– Payment for Purchased Equipment
(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The payment amount for the purchase of new equipment (identified using HCPCS modifier NU), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 100 percent of the single payment amounts established for these items. This payment amount for the purchase of used equipment (identified using HCPCS modifier UE), including inexpensive or routinely purchased DME, power wheelchairs, and enteral nutrition equipment, is equal to 75 percent of the single payment amounts established for new purchase equipment items.

40.8 – Payment for Repair and Replacement of Beneficiary-Owned Equipment

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Beneficiaries who maintain a permanent residence in a CBA may go to any Medicare-enrolled supplier (contract or noncontract supplier) for the maintenance or repair of beneficiary-owned equipment, including parts that need to be replaced in order to make the equipment serviceable. Labor to repair equipment is not subject to competitive bidding and, therefore, will be paid in accordance with Medicare's general payment rules. Payment for replacement parts that are part of the competitive bidding program for the area in which the beneficiary resides is based on the single payment amount for that replacement part in the CBA in which the beneficiary lives. Payment is not made for parts and labor covered under a manufacturer's or supplier's warranty.

Beneficiaries must obtain replacements of beneficiary-owned competitively bid items that are part of the competitive bidding program for the areas in which the beneficiary resides from a contract supplier unless the item is a replacement part or accessory that is replaced as part of the service of repairing beneficiary-owned base equipment (e.g. wheelchair, walker, hospital bed, continuous positive pressure airway device, oxygen concentrator, etc.). All base equipment that is replaced in its entirety because of a change in the beneficiary's medical condition or because the base equipment the beneficiary was using was either lost, stolen, irreparably damaged, or used beyond the equipment's reasonable useful lifetime (see section 110.2.C of Chapter 15 of the Benefit Policy Manual) must be obtained from a contract supplier in order to receive Medicare payment. The contract supplier is not required to replace an entire competitively bid item with the same make and model as the pRev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08ious item unless a physician or treating practitioner prescribes that make and model. (See section 30.4 of this chapter.).

If beneficiary-owned oxygen equipment or capped rental DME that is a competitively bid item for the CBA in which the beneficiary maintains a permanent residence has to be replaced prior to end of its reasonable useful lifetime, then the replacement item must be furnished by the supplier (contract or noncontract supplier) that transferred ownership of the item to the beneficiary.

Payment for replacement of items that are part of the competitive bidding program for the area in which the beneficiary resides is based on the single payment amount for that item.

40.9 – Payment for Rental Enteral Nutrition Equipment

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The monthly rental payment amounts for enteral nutrition equipment (identified using HCPCS modifier RR) are equal to 10 percent of the single payment amount established for purchase of the item for each of the first 3 months and 7.5 percent of the single payment amount established for purchase of the item for months 4 through 15.

40.9.1 – Maintenance and Servicing of Enteral Nutrition Equipment

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The contract supplier that furnishes the equipment to the beneficiary in the 15th month of the rental period must continue to furnish, maintain, and service the equipment after the 15 month rental period is completed until a determination is made by the beneficiary's physician or treating practitioner that the equipment is no longer medically necessary. The payment for maintenance and servicing enteral nutrition equipment is 5 percent of the single payment amount established for purchase of the item.

40.10 – Traveling Beneficiaries

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

Beneficiaries may travel, for example, to visit family members or reside in a State with warmer climates during winter months. As a result, beneficiaries will need to consider the following three factors when traveling: (1) where to go to obtain a DMEPOS item; (2) identify whether the item is a competitively bid item or not; and (3) determine the Medicare payment amount for that item. Depending on where the beneficiary travels (whether to a CBA or a non-CBA), the beneficiary may need to obtain DMEPOS from a contract supplier in order for Medicare to cover the item. For example, a beneficiary who travels to a non-CBA may obtain DMEPOS, if medically necessary, from any Medicare-enrolled supplier. On the other hand, a beneficiary who travels to a CBA should obtain competitively bid items in that CBA from a contract supplier in that CBA in order for Medicare to cover the item. The chart below shows whether a beneficiary should go to a contract supplier or any Medicare-enrolled supplier when the beneficiary travels.

Beneficiary Permanently Resides	**Travels to**	**Type of Supplier**
a CBA	*a CBA*	*The beneficiary should obtain competitively bid items in that CBA from a contract supplier located in that CBA if the beneficiary wants Medicare to cover the item.*
	a non-CBA	*Medicare will cover DMEPOS, if medically necessary, from any Medicare-enrolled DMEPOS supplier.*
Non-CBA	*a CBA*	*The beneficiary should obtain the competitively bid item from a contract supplier in the CBA if the beneficiary wants Medicare to cover the item.*
	Non-CBA	*Medicare-enrolled DMEPOS supplier*

Suppliers that furnish DMEPOS items to Medicare beneficiaries who maintain a permanent residence in a CBA and who travel to a non-CBA need to be aware of the public use files on the CBIC website at: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home. The public use files contain the zip codes for the CBAs, the HCPCS for competitively bid items, and the single payment amounts for these items. Suppliers will be able to use these files to identify if the beneficiary traveling to the area maintains a permanent residence in a CBA, determine whether the beneficiary is obtaining a competitively bid item, and determine the single payment amount for those items.

The Medicare payment amount is always based on the location in which the beneficiary maintains a permanent residence. For example:

- *If a beneficiary maintains a permanent residence in a CBA and travels outside of the CBA, payment for a competitively bid item for the CBA in which the beneficiary maintains a permanent residence is the single payment amount for that item in the beneficiary's CBA.*
- *When a beneficiary maintains a permanent residence in an area that is not in a CBA and travels to CBA or non-CBA, the supplier that furnishes the item will be paid the fee schedule amount for the area where the beneficiary maintains a permanent residence.*

40.10.1 Traveling Beneficiaries and Transfer of Title of Oxygen Equipment or Capped Rental Items

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

If a beneficiary has two residences in different areas and uses a local supplier in each area or if a beneficiary changes suppliers during or after the rental period, this does not result in a new rental episode. The supplier that provides the item in the 36th month of a rental episode for oxygen equipment or the 13th month of a rental episode for capped rental DME is responsible for transferring title to the equipment to the beneficiary. This applies to "snow bird" or extended travel patients and coordinated services for patients who travel after they have purchased the item.

40.11 – Billing Procedures Related to Advance Beneficiary Notice (ABN) Upgrades under the Competitive Bidding Program

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

In general, an item included in a competitive bidding program must be furnished by a contract supplier for Medicare to make payment. This requirement applies to situations where the item is furnished directly or indirectly as an upgrade. 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 than, the item that is reasonable and necessary under Medicare coverage requirements. An item is indirectly furnished if Medicare makes payment for it because it is medically necessary and is furnished as part of an upgraded item.

The billing instructions for upgraded equipment found in section 120 of chapter 20 of the Medicare Claims Processing Manual (Pub. 100-04) continue to apply under the DMEPOS Competitive Bidding Program.

The following scenarios and chart describe situations where a beneficiary, residing in a competitive bidding area, elects to upgrade to an item with features or upgrades that are not medically necessary.

- ***Upgrades from a bid item to a non-bid item***

In this situation, Medicare payment will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.

- ***Upgrades from a non-bid item to a bid item***
  When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.
- ***Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")***
  In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S".

Upgrade Scenarios for Beneficiaries Residing in a Competitive Bidding Area (CBA)

From *the Medically Necessary Item*	***To*** *the Upgraded Item*	*Must be Furnished by*	*Assignment Mandatory (Y/N)*	*Medicare Payment Based Upon*
Bid Item	*Non-Bid Item*	*Contract Supplier*	*Y*	*Single Payment Amount for the Medically Necessary Item*
Non-Bid Item	*Bid Item*	*Contract Supplier*	*N*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Bid Item in Product Category "S"	*Bid Item in Product Category "U"*	*Contract Supplier for Category "U"*	*Y*	*Single Payment Amount for Category "S" for the Medically Necessary Item*

The following scenarios and chart describe situations where a beneficiary, who does not reside in a competitive bidding area, but travels to a competitive bidding area, elects to upgrade to an item with features that are not medically necessary.

- ***Upgrades from a bid item to a non-bid item***
  In this situation, Medicare payment is only made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item.
- ***Upgrades from a non-bid item to a bid item***
  When upgrading from a non-bid to a bid item, Medicare payment is made to a contract supplier on either an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.

- ***Upgrades from a bid item in one product category (category "S") to a bid item in another product category (category "U")***
  In this case, Medicare payment is only made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S".

Upgrade Scenarios for Beneficiaries Who Do Not Reside In a CBA, But Travel to a CBA

From *the Medically Necessary Item*	***To*** *the Upgraded Item*	*Must be Furnished by*	*Assignment Mandatory (Y/N)*	*Medicare Payment Based Upon*
Bid Item	*Non-Bid Item*	*Contract Supplier*	*Y*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Non-Bid Item	*Bid Item*	*Contract Supplier*	*N*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Bid Item in Product Category "S"	*Bid Item in Product Category "U"*	*Contract Supplier for Category "U"*	*Y*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*

Beneficiary Liability under the Competitive Bidding Program

Under the competitive bidding program, a beneficiary has no financial liability to a non contract supplier that furnishes an item included in the competitive bidding program for a competitive bidding area, unless, prior to receiving the item, the beneficiary selects Option 1 on the ABN and signs the notice. Similarly, beneficiaries who receive an upgraded item from a non-contract supplier in a competitive bidding area are not financially liable for the item unless, prior to giving the beneficiary the upgraded item, the supplier obtains a valid ABN on which the enrollee has selected Option 1 and signed the notice.

In the case of upgrades, for a beneficiary to be liable for the extra cost of an item that exceeds their medical needs, the beneficiary must, select Option 1 and sign a valid ABN prior to receiving the item. See Chapter 20, section 120 of the Medicare Claims Processing Manual for additional information on ABN upgrades.

40.12 - Billing Procedures Related to Downcoding under the Competitive Bidding Program

(Rev. 1532, Issued: 06-11-08, Effective: 07-01-08, Implementation: 07-07-08)

The following downcoding guidelines describe situations where Medicare reduces the level of payment for the prescribed item based on a medical necessity partial denial of coverage for the additional, not medically necessary, expenses associated with the prescribed item. For

beneficiaries who reside in a CBA and for whom Medicare determines that the prescribed item should be downcoded to an item that is reasonable and necessary under Medicare's coverage requirements, the subsequent scenarios and chart detail the type of supplier that can furnish the item and the payment for the item.

- *Downcodes from a non-bid item to a bid item*
  In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the single payment amount for the medically necessary bid item.
- *Downcodes from a bid item to a non-bid item*
  Medicare payment in this downcoding scenario will be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.
- *Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")*
  In this case, Medicare payment will be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment would be equal to 80 percent of the single payment amount for the medically necessary bid item in product category "S".

Downcoding Scenarios for Beneficiaries Residing in a CBA

***From** a Higher Level of Service Item*	***To** a Medically Necessary Item*	*Must be Furnished by*	*Assignment Mandatory (Y/N)*	*Medicare Payment Based Upon*
Non-Bid Item	*Bid Item*	*Any Medicare Enrolled Supplier*	*N*	*Single Payment Amount for the Medically Necessary Item*
Bid Item	*Non-Bid Item*	*Contract Supplier*	*Y*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Bid Item in Product Category "U"	*Bid Item in Product Category "S"*	*Contract Supplier for Category "U"*	*Y*	*Single Payment Amount for Category "S" for the Medically Necessary Item*

The following scenarios and chart describe situations where the prescribed item for a beneficiary that does not reside in a CBA, but travels to a CBA is downcoded to an item that is reasonable and necessary under Medicare's coverage requirements.

- ***Downcodes from a non-bid item to a bid item***
  In this situation, Medicare payment will be made to any Medicare enrolled supplier on an assigned or unassigned basis. Medicare payment will be equal to 80 percent of the

lower of the actual charge or the fee schedule amount for the medically necessary bid item.

- ***Downcodes from a bid item to a non-bid item***
  Medicare payment in this downcoding scenario will only be made to a contract supplier on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary non-bid item.
- ***Downcodes from a bid item in one product category (category "U") to a bid item in another product category (category "S")***
  In this case, Medicare payment will only be made to a contract supplier for the product category "U" on an assignment-related basis. Medicare payment will be equal to 80 percent of the lower of the actual charge or the fee schedule amount for the medically necessary bid item in product category "S".

Downcoding Scenarios for Beneficiaries Who Do Not Reside In a CBA, But Travel to a CBA

From *a Higher Level of Service Item*	***To*** *a Medically Necessary Item*	*Must be Furnished by*	*Assignment Mandatory (Y/N)*	*Medicare Payment Based Upon*
Non-Bid Item	*Bid Item*	*Any Medicare Enrolled Supplier*	*N*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Bid Item	*Non-Bid Item*	*Contract Supplier*	*Y*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*
Bid Item in Product Category "U"	*Bid Item in Product Category "S"*	*Contract Supplier for Category "U"*	*Y*	*Lower of the Actual Charge or Fee Schedule Amount for the Medically Necessary Item*