CMS Manual System

Pub 100-20 One-Time Notification

Transmittal 215

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)
Date: MARCH 10, 2006
Change Request 4372

SUBJECT: Payment for Power Mobility Device (PMD) Claims

I. SUMMARY OF CHANGES: Instructions to the DMERC and/or DME Program Safegaurd Contractors (PSC) regarding PMD claims received between January 1, 2006 through April 1, 2006. These PMD claims are paid if they satisfy the requirements of section 1834(a)(1)(E)(iv) of the SSA. Carriers and fiscal intermediaries shall hold claims containing G0372 through March 31, 2006.

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 1, 2006

IMPLEMENTATION DATE: as soon as possible, but no later than two weeks from date of issuance.

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

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 215	Date: March 10, 2006	Change Request 4372

SUBJECT: Payment for Power Mobility Device (PMD) Claims

I. GENERAL INFORMATION

A. Background: The Centers for Medicare & Medicaid Services (CMS) published an interim final rule on PMDs to conform its regulations to §302(a)(2)(E)(iv) of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), which is codified at §1834(a)(1)(E)(iv) of the Social Security Act (SSA). The effective date of the rule was October 25, 2005. For PMDs, the MMA mandated that: (1) a face-to-face examination of the individual be conducted by a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist; and (2) payment may not be made for a motorized or power wheelchair unless the physician or one of these specified treating practitioners has written a prescription for the item. By defining the practitioners allowed to conduct the face-to-face examination, it also effectively removed the current requirement that a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology in order to get a power-operated vehicle.

Apart from the MMA requirements, the other key change made by this regulation is a requirement that the physician or treating practitioner must submit pertinent parts of the medical record (in lieu of the Certificate of Medical Necessity (CMN)) along with the prescription to the Durable Medical Equipment (DME) supplier within 30 days of the face-to-face examination. A separate add-on payment of $21.60 (an add-on payment to the office visit) was established by the rule to recognize the additional physician and treating practitioner work and resources required for submitting pertinent parts of the medical record.

Payment for the history and physical examination is made through the appropriate evaluation and management (E&M) code. This claim, along with the claim for the add-on payment (G0372), goes to the local fiscal intermediary (FI) and carrier contractor. The PMD claim will go to the local durable medical equipment regional carrier (DMERC), the Regional Home Health Intermediary (RHHI), and/or DME Program Safeguard Contractor (PSC).

Title II, Section 222 of the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, 2006 (H.R. 3010) (the Appropriations Act) was signed into law on December 30, 2005. It states, in part:

> SECTION 222. None of the funds made available under this Act may be used to implement or enforce the interim final rule published in the Federal Register by the Centers for Medicare & Medicaid Services on August 26, 2005 (70 Fed. Reg. 50940) prior to April 1, 2006.

Although this section does not allow CMS to use federal funds appropriated under the Appropriations Act to implement or enforce the rule, CMS believes that this section does not affect the validity of the rule. Therefore, CMS is instructing DMERCs and/or DME Program Safeguard Contractor (PSC) that, for claims received between January 1, 2006 through April 1, 2006, contractors shall only pay PMD claims that satisfy the requirements of §1834(a)(1)(E)(iv) of the SSA. Based on the Appropriations Act, CMS is

instructing FI and carrier contractors to hold claims that contain G0372. These claims must be held through March 31, 2006. Carrier contractors will begin to release physician claims with G0372 for processing on April 3, 2006.

B. Policy: Transmittal 128, Change Request 3952, dated October 28, 2005 is still in effect. Due to the Appropriations Act, for claims received between January 1, 2006 through April 1, 2006, DMERCs, RHHIs and/or DME PSCs shall:

- Pay PMD claims based on § 1834(a)(1)(E)(iv) of the SSA: a physician, a physician assistant, nurse practitioner, or clinical nurse specialist must conduct a face-to-face examination of the beneficiary and write a prescription for the item.

- Not require the details of the written prescription defined in the interim final rule. The written prescription needs to be signed and dated by the physician or treating practitioner who performed the face-to-face examination.

- Not auto-deny PMD claims when the EY modifier has been used to indicate that the written prescription with the elements specified in the interim final rule was not received by the DME supplier within 30 days after the face-to-face examination.

- Not require that the written prescription for the PMD be received by the supplier within 30 days after the face-to-face examination.

- Continue to accept the partially completed unsigned CMN and not edit on these partially completed CMNs.

- As defined in Chapter 3 of Pub.100-08, the Medicare Program Integrity Manual (PIM), if data analysis indicates potentially aberrant billing, DMERCs and/or DME PSCs shall continue to follow the guidance as defined in this chapter when performing medical review on claims.

Providers billing a Medicare carrier have the following options during the release of this instruction through March 31, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 code and E/M now on the same claim. Payment for these claims will be held through March 31, 2006.

- Hold all claims containing the G0372 code until after March 31, 2006.

- Submit the E/M service now and bill the G0372 code after March 31, 2006. The E/M service will be paid now. Note that this is not intended to require that FIs or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Providers submitting claims on or after April 1, 2006, must bill the E/M and the G0372 code on the same claim.

A change is needed to the non-OPPS Outpatient Code Editor to make the G0372 code a reportable code on FI claims. This change cannot be completed until July. Critical Access Hospitals billing the FI under method II have the following options during the release of this instruction through July 2, 2006, for submitting the G0372 code and the E/M code:

- Submit the G0372 and E/M now on the same claim. Payment for these claims will be held by Medicare FIs through July 2, 2006.

- Hold all claims containing the G0372 code until after July 2, 2006.

- Submit the E/M service now and bill the G0372 code after July 2, 2006. The E/M service will be paid now. Note that this is not intended to require that FIs or carriers split claims submitted with both the E/M and G0372 code. Rather, the physician or treating practitioner may choose to submit two separate claims for the individual services.

Method II Critical Access Hospitals submitting claims on or after July 2, 2006, must bill the E/M and the G0372 code on the same claim.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4372.1	For claims received between January 1, 2006 through April 1, 2006, contractors shall not auto-deny PMD claims when the EY modifier has been used to indicate that the written prescription with the elements specified in the interim final rule was not received by the DME supplier within 30 days of the face-to-face examination.		X		X					DME PSCs
4372.2	For claims received between January 1, 2006 through April 1, 2006, contractors shall not require the details of the written prescription defined in the interim final rule.		X		X					DME PSCs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4372.3	For claims received between January 1, 2006 through April 1, 2006, contractors shall not require that the written prescription for the PMD be received by the supplier within 30 days after the face-to-face examination.		X		X					DME PSCs
4372.4	Contractors shall continue to accept partially completed unsigned CMNs and not edit on these CMNs.				X					DME PSCs
4372.5	Carriers shall hold claims that contain G0372 through March 31, 2006, for claims received on or after January 1, 2006.			X						
4372.6	FIs shall hold claims that contain G0372 through July 2, 2006, for claims received on or after January 1, 2006.	X								
4372.7	Carriers shall release claims being held with code G0372 beginning April 3, 2006 (stagger the release of these claims if necessary).			X						
4372.8	FIs shall relase claims being held with code G0372 beginning July 3, 2006 (stagger the release of these claims if necessary).	X								
4372.9	Contractors shall contact their CWF hosts prior to releasing the held claims in order to coordinate the release of the claims. If necessary, the release of the claims shall be staggered in order not to inundate CWF.	X		X						
4372.10	Contractors shall note that holding these claims is due to a CMS processing delay and shall not be subject to contractor performance evaluation for claims processing timeliness.			X						
4372.11	Contractors shall add condition code 15 to indicate that holding these claims is due to a CMS processing delay and shall not be subject to contractor performance evaluation for claims processing timeliness.	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4372.12	Contractors shall pay interest if applicable on the E/M claims and G code for claims held over 30 days based on the receipt date of the claims.	X		X						
4372.13	For claims brought to their attention, contractors shall adjust claims auto-denied between January 1, 2006 through April 1, 2006 with the EY modifier.				X					DME PSCs
4372.14	Contractors shall not search their files to retract payment for claims already paid.	X	X	X	X					DME PSCs

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4372.15	A Medlearn Matters provider education article related to this instruction will be available at http://www.cms.hhs.gov/MedlearnProducts/MP/list.asp#TopOfPage shortly after the CR is released. You will receive notification of the article released via the established "medlearn 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 1 week of the availability of the provider education article. In addition, the provider education article must be included in your next regularly scheduled bulletin. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the	X	X	X	X					DME PSCs

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions
Transmittal 128	
4372.6, 4372.8, 4372.9, 4372.11 and 4372.12	For FI claims, this HCPCS could only be reported on Critical Access Hospital method II claims, using type of bill 85x with professional service revenue codes.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** As soon as possible, but no later than two weeks from date of issuance.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

Pre-Implementation Contact(s): Karen Daily, coverage, (410) 786-0189; Patricia Gill, Carriers claim processing, (410) 786-1297; Wil Gehne, FI claims processing, (410) 786-6148. **Post-Implementation Contact(s):** Appropriate RO	

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