CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 353	**Date: JUNE 13, 2008**
	Change Request 6112

SUBJECT: Payment for Complex Rehabilitative Power Mobility Device Services that Span the Implementation Date of DMEPOS Competitive Bidding Programs in Competitive Bidding Areas

I. SUMMARY OF CHANGES: This One-Time Notification provides instructions for payment of claims for purchase of Group 3 single or multiple power option power mobility devices ordered from April 1, 2008 through May 31, 2008.

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/A	

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:
One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 353	Date: June 13, 2008	Change Request: 6112

SUBJECT: Payment for Complex Rehabilitative Power Mobility Device Services that Span the Implementation Date of DMEPOS Competitive Bidding Programs in Competitive Bidding Areas

EFFECTIVE DATE: July 1, 2008

IMPLEMENTATION DATE: July 7, 2008

I. GENERAL INFORMATION

A. Background: The Medicare durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program was mandated by Section 302 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act" or "MMA"). The new program's objectives are: assuring beneficiary access to quality DMEPOS; reducing the amount Medicare pays for DMEPOS items; reducing the financial burden on beneficiaries by reducing the coinsurance they pay for DMEPOS items; and contracting with suppliers who meet quality and financial standards. The competitive bidding program changes the way that Medicare determines the payment amounts for these items and services under Part B of the Medicare program by replacing the current DMEPOS fee schedule payment amounts for selected items in certain areas with payment amounts based on bids submitted by DMEPOS suppliers.

Round I of the program will start on July 1, 2008 in competitive bidding areas (CBAs) defined by zip codes within ten of the largest Metropolitan Statistical Areas (MSAs). The CBAs in Round I include Charlotte-Gastonia-Concord, NS-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Miami Beach, FL; Orlando, FL; Pittsburgh, PA; Riverside-San Bernardino-Ontario, CA; and San Juan-Caguas-Guaynabo, PR. The program will expand to 70 additional MSAs in 2009, and additional areas after 2009. Lists of the Round I DMEPOS Competitive Bidding zip codes are available by state through the use of the "Find a CBA" web feature on the Competitive Bidding Implementation Contractor (CBIC) website:
http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home

The Round I competitive bidding product categories are: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters and Related Accessories; Complex Rehabilitative Power Wheelchairs and Related Accessories; Mail-Order Diabetic Supplies; Enteral Nutrients, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP) Devices, Respiratory Assist Devices (RADs), and Related Supplies and Accessories; Hospital Beds and Related Accessories; Negative Pressure Wound Therapy (NPWT) Pumps and Related Supplies and Accessories; Walkers and Related Accessories and Support Surfaces (Group 2 mattresses and overlays) in the Miami MSA only. Programs for the Oxygen Supplies and Equipment; Rehabilitative Power Wheelchairs and Related Accessories; Enteral Nutrients, Equipment and Supplies; and Hospital Beds and Related Accessories product categories will not be implemented in the San Juan-Caguas-Guaynabo, Puerto Rico CBA during Round I. The program will expand to additional product categories in future Rounds.

B. Policy: This notification provides instructions for payment of claims for purchase of Group 3 single or multiple power option power mobility devices (PMDs) and accessories where the face-to-face examination by the treating physician occurred from April 1, 2008 through May 31, 2008. CMS will provide a one-time transition policy for suppliers who have initiated the process of furnishing a Group 3 single or multiple power option PMD and accessories to beneficiaries residing in Round I CBAs (other than San Juan-Caguas-Guaynabo, Puerto Rico) as long as they have documentation that meets the transition period requirements. The April 1,

2008 transition policy start date provides sufficient time for suppliers to complete the order to delivery cycle and ensures that the physician order is recent and the device remains clinically appropriate for the beneficiary's condition.

This policy is being implemented pursuant to the Secretary's authority under Section 1847 of the Social Security Act and implementing regulations. Without this transition policy, beneficiaries currently waiting for delivery of previously ordered Group 3 single or multiple power option PMD and accessories may experience unnecessary delays in receiving medically necessary items.

To be eligible for the transition policy, the date of the face-to-face examination from the physician for a Group 3 single or multiple power option PMD must have occurred between April 1, 2008 and May 31, 2008. This documentation must be maintained by the supplier, but does not need to be submitted at the time the claim for the PMD is submitted. However, this documentation must be made available to the DME MACs upon request. Claims subject to this transition policy are claims for purchase of Group 3 single or multiple power option PMDs, identified by HCPCS codes K0856 through K0864 and covered accessories furnished to beneficiaries who maintain a permanent residence in the following CBAs:

Charlotte-Gastonia-Concord, NS-SC; Cincinnati-Middletown, OH-KY-IN; Cleveland-Elyria-Mentor, OH; Dallas-Fort Worth-Arlington, TX; Kansas City, MO-KS; Miami-Fort Lauderdale-Miami Beach, FL; Orlando, FL; Pittsburgh, PA; and Riverside-San Bernardino-Ontario, CA

When submitting claims for these complex rehabilitative PMDs and accessories subject to this transition policy, eligible suppliers should use the date of the face-to-face examination as the date of service on the claim. In addition, for these claims only, the supplier should report in the narrative section of the claim the date the PMD was provided to the beneficiary. Under this transition policy, the related accessories used with a complex rehabilitative PMD should be submitted on the same claim form, with the same dates of service as the base Group 3 single or multiple power option PMD code. Suppliers should follow these instructions regarding the date of service reported on the claim only for claims subject to this transition policy. Under normal circumstances, the date of service on the claim must be the date the PMD device is provided to the beneficiary. In order for all other claims that do not meet the specific criteria in this instruction to be considered for coverage and payment, the date of service must be the date the PMD device is furnished to the beneficiary.

Claims for covered items subject to this transition policy will be paid using the applicable 2008 fee schedule amount.

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	
6112.1	DME MACs shall instruct suppliers eligible for the complex rehabilitative power mobility device transition period to submit claims using the date of the face-to-face examination, if the face-to-face examination occurred		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	
	from April 1 thru May 31, 2008, as the date of service on the claim. The actual date that the device and accessories were provided to the beneficiary should be supplied in the narrative section of the claim.										

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	
6112.2	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								

IV. SUPPORTING INFORMATION

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

X-Ref Requireme nt 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): Karen Jacobs at 410-786-2173

Post-Implementation Contact(s): Karen Jacobs at 410-786-2173

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 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.