CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 636	**Date: February 5, 2010**
	Change Request 6762

Subject: Instructions for Reprocessing Claims and Recouping Overpayments for Claims for Implanted DME and Implanted Prosthetics Submitted Under the Guidelines Established in Change Request (CR) 5917

I. SUMMARY OF CHANGES: This CR includes instructions for recouping funds for any payments made to DMEPOS suppliers for implanted DME or implanted prosthetics, based on the original list provided in CR 5917. Contractors are instructed to recoup funds for payments made for the HCPCS codes that were deleted when the revised list was published in CR 6573.

New / Revised Material
Effective Date: May 5, 2010
Implementation Date: May 5, 2010

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: 636	Date: February 5, 2010	Change Request: 6762

SUBJECT: Instructions for Reprocessing Claims and Recouping Overpayments for Claims for Implanted DME and Implanted Prosthetics Submitted Under the Guidelines Established in Change Request (CR) 5917

Effective Date: May 5, 2010

Implementation Date: May 5, 2010

I. GENERAL INFORMATION

A. Background:

Change Request (CR) 5917, Claims Jurisdiction and Enrollment Procedures for Suppliers of Certain Prosthetics, Durable Medical Equipment (DME) and Replacement Parts, Accessories and Supplies (DMEPOS), reinstated the Part B carrier/A/B Medicare Administrative Contractor (MAC) jurisdiction for suppliers of replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME, effective for claims with dates of service on or after October 27, 2008. (See Transmittal 1603, Pub. 100-04, issued on September 26, 2008.)

In CR 5917, the Centers for Medicare and Medicaid Services (CMS) instructed the contractors to process and pay claims for replacement parts, accessories and supplies for prosthetic implants and surgically implanted DME when submitted by suppliers that are enrolled with both the National Supplier Clearinghouse (NSC) and their local carrier/A/B MAC.

Although CR 5917 reinstated the local carrier/A/B MAC jurisdiction for claims for these items, the instruction was not clear about the claims filing jurisdiction or the payment rules that apply when the beneficiary resides outside of the local carrier/A/B MAC's jurisdiction. In addition, Attachment A of CR 5917 included an excerpt of the 2008 annual jurisdiction list containing Healthcare Common Procedure Coding System (HCPCS) codes, which CMS previously instructed may be billed to the carrier/A/B MAC as a replacement part, accessory or supply for prosthetic implants and surgically implanted DME. It has since come to CMS' attention that this list included codes for implanted devices, which may not be separately billed to the carrier/A/B MAC by DMEPOS suppliers. Attachment A of CR 5917 was replaced by a revised list of HCPCS codes in Attachment A of CR 6573. (See CR 6573, Transmittal 531, Pub. 100-20.)

Change Request 6573, issued on August 14, 2009, instructed contractors to use the revised list to determine the items that may be billed under the guidelines established in CR 5917. The CR clarified that the filing jurisdiction for claims submitted under the guidelines established in CR 5917 is determined by the supplier's location and that the payment for these items is based on the fee schedule amount for the State where the beneficiary maintains their permanent residence. CR 6573 also instructed the Part B shared system maintainer to update the Multi-Carrier System (MCS), as needed, to implement these policies. This CR includes instructions for recouping funds for any payments made to DMEPOS suppliers for implanted DME or implanted prosthetics, based on the revised list provided in CR 6573.

NOTE: This instruction and the billing guidelines for replacement parts, accessories or supplies for implanted devices established in CR 5917 apply only to DMEPOS suppliers enrolled with the NSC and their local carrier/A/B MAC and does not change the existing carrier/A/B MAC billing rules that apply to physicians, facilities, or other entities that are implanting the devices.

B. Policy:

Implanted DME and implanted prosthetic devices, specifically those with the following HCPCS codes, are not billable by a DMEPOS supplier: E0749, E0782, E0783, A4561, A4562, A7042, L8600, L8603, L8606, L8609, L8610, L8612, L8613, L8614, L8630, L8631, L8641, L8642, L8658, L8659, L8670, L8680, L8682, L8685, L8686, L8687, L8688, and L8690. All DMEPOS claims submitted with dates of service between October 27, 2008 and December 31, 2009 with the previously listed codes shall be reopened and reprocessed. If any payments have been made to DMEPOS suppliers for these items, contactors shall assess overpayments and recoup funds.

II. BUSINESS REQUIREMENTS 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	
6762.1	Contractors shall reopen and reprocess claims for implanted DME or implanted prosthetics submitted by DMEPOS suppliers with the following HCPCS codes, for dates of service between October 27, 2008 and December 31, 2009: E0749, E0782, E0783, A4561, A4562, A7042, L8600, L8603, L8606, L8609, L8610, L8612, L8613, L8614, L8630, L8631, L8641, L8642, L8658, L8659, L8670, L8680, L8682, L8685, L8686, L8687, L8688, and L8690.	X			X						
6762.2	If any payments have been made to DMEPOS suppliers for the claims specified in 6762.1, contractors shall assess overpayments and recoup funds.	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	
6762.3	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						

IV. SUPPORTING INFORMATION

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

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 policy questions, please contact Karen Jacobs at karen.jacobs@cms.hhs.gov or (410) 786-2173. For claims processing questions, please contact Bobbett Plummer at bobbett.plummer@cms.hhs.gov or (410) 786-3321.

Post-Implementation Contact(s): For policy questions, please contact Karen Jacobs at karen.jacobs@cms.hhs.gov or (410) 786-2173. For claims processing questions, please contact Bobbett Plummer at bobbett.plummer@cms.hhs.gov or (410) 786-3321.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers,* use only one of the following statements:

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)*, include the following statement:

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.