CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2118	**Date: December 9, 2010**
	Change Request 7248

NOTE TO CONTRACTORS: Transmittal 2108, dated November 24, 2010, is rescinded and replaced with Transmittal 2118 dated December 9, 2010, to revise the labor payment rates for codes K0739, L4205 and L7520 in Attachment A. Also, changes were made to the filenames for the DMEPOS Part A and B fee schedule files in business requirements 7248.1 and 7248.2. All other information remains the same.

SUBJECT: CY 2011 Fee Schedule Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

I. SUMMARY OF CHANGES: This recurring update notification provides specific instructions regarding the 2011 annual update for the DMEPOS fee schedule. This Recurring Update Notification applies to chapter 23, section 60.

EFFECTIVE DATE: *January 1, 2011
IMPLEMENTATION DATE: January 3, 2011

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-

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; contractor activities are to be carried out within 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 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. ATTACHMENT:

Recurring Update Notification

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

Attachment – Recurring Update Notification

Pub. 100-04	Transmittal: 2118	Date: December 9, 2010	Change Request: 7248

NOTE TO CONTRACTORS: Transmittal 2108, dated November 24, 2010, is rescinded and replaced with Transmittal 2118, dated: December 9, 2010, to revise the labor payment rates for codes K0739, L4205 and L7520 in Attachment A. Also, changes were made to the filenames for the DMEPOS Part A and B fee schedule files in business requirements 7248.1 and 7248.2. All other information remains the same.

SUBJECT: CY 2011 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Effective Date: January 1, 2011
Implementation Date: January 3, 2011

I. GENERAL INFORMATION

A. Background: The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in Pub.100-04, Medicare Claims Processing Manual, chapter 23, section 60.

B. Policy: This recurring update notification provides instructions regarding the 2011 annual update for the DMEPOS fee schedule. Payment on a fee schedule basis is required for durable medical equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for parenteral and enteral nutrition (PEN).

Fee Schedule Files
The CMS Division of Data Systems (DDS) is scheduled to electronically release the 2011 DMEPOS Fee Schedule Part B file (filename: MU00.@BF12393.DMEPOS.T110101.V1123) to the Pricing, Data Analysis and Coding (PDAC) Contractor , DME MACs, A/B MACs, and local Part B carriers via CMS's mainframe telecommunication system on November 23, 2010. The DDS is scheduled to release a separate 2011 DMEPOS Fee Schedule file (filename: MU00.@BF12393.DMEPOS.T110101.V1123.FI) to the A/B MACs, intermediaries, regional home health intermediaries, Railroad Retirement Board (RRB), Indian Health Service, and United Mine Workers on November 23, 2010. The DMEPOS fee schedule file will also be available on or after November 30, 2010, for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS Website at www.cms.hhs.gov/DMEPOSFeeSched/ The 2011 fee schedule for PEN is scheduled to be released to the PDAC and DME MACs in a separate file (filename: MU00.@BF12393.PEN.CY11.V1123) on November 23, 2010.

HCPCS Codes Added
New DMEPOS codes added to the Healthcare Common Procedure Coding System (HCPCS) file, effective January 1, 2011, are listed in Business Requirement 7248.6 of this Change Request (CR). For these new codes, the fee schedule amounts will be established as part of the July 2011 DMEPOS Fee Schedule Update, when applicable. The DME MACs shall establish local fee schedule amounts to pay claims for the new codes when applicable from January 1, 2011, through June 30, 2011. Please note that the HCPCS codes listed as new codes in this CR are not yet final and are subject to change. The new codes are not to be used for billing purposes until they are effective on January 1, 2011.

For gap-filling purposes, the 2010 deflation factors by payment category are: 0.502 for Oxygen, 0.506 for Capped Rental, 0.507 for Prosthetics and Orthotics, 0.643 for Surgical Dressings, and 0.700 for Parental and Enteral Nutrition

Codes L8693, Q0478 and Q0479 describe items that are subject to the fee schedule for prosthetics and orthotics (PO) and are being added to the HCPCS effective January 1, 2011. These codes fall under the jurisdiction of the local carriers rather the DME MACs. CMS will be calculating the fee schedule amounts for these items so local carriers do not need to gap-fill base fees for these codes.

HCPCS Codes Deleted

The following codes are being deleted from the HCPCS effective January 1, 2011, and are therefore being removed from the DMEPOS fee schedule files:

E0220		K0737	
E0230		L3660	
E0238		L3670	
K0734		L3672	
K0735		L3673	
K0736		L3675	

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Specific Coding and Pricing Issues

Section 1833(o)(2) of the Social Security Act, as amended by section 627 of the Medicare Modernization Act of 2003 (MMA), required the calculation and implementation of fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005. The therapeutic shoes and insert fee schedule amounts were implemented as part of the January 2005 Fee Schedule Update as described in Change Request 3574 (Transmittal 369). As part of the implementation and in accordance with section 1833(o)(2)(C) of the Act, the payment amounts for shoe modification codes A5503 through A5507 were established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). The fees for codes A5512 and A5513 were weighted based on the approximate total allowed services for each code for items furnished during the second quarter of calendar year 2004. As part of this update, CMS is revising the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. Therefore, the fees for A5512 and A5513 will be weighted based on the approximate total allowed services for each code for items furnished during the calendar year 2009. The fee schedules for codes A5503 through A5507 are being revised effective January 1, 2011, to reflect this change.

Power-Driven Wheelchairs

In accordance with section 3136(a)(1) of the Affordable Care Act (ACA) of 2010, effective for claims with dates of service on or after January 1, 2011, payment for power-driven wheelchairs under the DMEPOS fee schedule for power-driven wheelchairs furnished on or after January 1, 2011, is revised to pay 15 percent (instead of 10 percent) of the purchase price for the first three months under the monthly rental method and 6 percent (instead of 7.5 percent) for each of the remaining rental months 4 through 13. Payment amounts will be based on the lower of the supplier's actual charge and the fee schedule amount. As part of this update, the CY 2011 rental fees for power-driven wheelchairs included in the 2011 DMEPOS Fee Schedule Part B file have been revised to represent 15 percent of the purchase price amount. Contractors shall use the 2011 rental fee schedule amounts to pay claims for rental months 1 through 3. In order to pay claims for subsequent rental months, contractors shall use the fee schedule amounts multiplied by 0.4 to establish the 6 percent of purchase price rental amount for months 4 through 13. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B. This attachment identifies those codes where payment, when applicable, should be

made at 15 percent of the purchase price for months 1 through 3 and 6 percent of the purchase price for months 4 through13.

These changes do not apply to rented power-driven wheelchairs for which the date of service for the initial rental month is prior to January 1, 2011. For these items, payment for rental claims with dates of service on or after January 1, 2011, will continue to be based on 10 percent of the purchase price for rental months 2 and 3 and 7.5 percent of the purchase price for rental months 4 through 13.
Also, section 3136(c)(2) of the ACA specifies that these changes do not apply to power-driven wheelchairs furnished pursuant to contracts entered into prior to January 1, 2011, as part of Round 1 of the Medicare DMEPOS competitive bidding program. Change Request 7181, Transmittal 2088, dated November 5, 2010 discussed these changes.

For power-driven wheelchairs furnished on or before January 1, 2006

For power-driven wheelchairs furnished on a rental basis with dates of service prior to January 1, 2006, for which the beneficiary did not elect the purchase option in month 10 and continues to use, contractors shall continue to pay the maintenance and servicing payment amount at 10% of the purchase price. In these instances, suppliers should continue to use the following HCPCS codes, with the MS modifier, for billing maintenance and servicing, as appropriate:

K0010 Standard- Weight Frame Motorized/Power Wheelchair
K0011 Standard- Weight Frame Motorized/Power Wheelchair with Programmable Control Parameters for Speed Adjustment,
Tremor Dampening, Acceleration Control and Braking
K0012 Lightweight Portable Motorized/Power Wheelchair
K0014 Other Motorized/Power Wheelchair Base

The rental fee schedule payment amounts for codes K0010, K0011 and K0012 will continue to reflect 10% of the wheelchair's purchase price.

Single Payment Amount

In the CBA pricing file and the single payment amount public use file, the rental single payment amounts for capped rental DME and rented enteral nutrition equipment are 10 percent of the purchase single payment amount. This payment amount is for rental months one through three. The rental single payment amounts for months 4 through 13 for capped rental DME and for months 4 through 15 for rented enteral nutrition equipment are equal to 75 percent of the single payment amounts paid in the first three rental months. The changes to the power wheelchair payment rules made by section 3136 of the Affordable care Act of 2010 (ACA) do not apply to payment made for items furnished pursuant to competitive bidding contracts entered into prior to January 1, 2011 or for power wheelchairs in which the first rental month occurred before January 1, 2011.

CY 2011 Fee Schedule Update Factor

In accordance with the statutory section 1834(a)(14) of the Act, the DMEPOS fee schedule amounts are to be updated for 2011 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2010. Also beginning with CY 2011, section 3401 of ACA amended section 1834(a)(14) to require that the increase in the CPI-U be adjusted by changes in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business multi-factor productivity (MFP). Furthermore, the amendment specifies the application of the MFP may result in an update "being less than 0.0 for a year, and may result in payment rates being less than such payment rates for the preceding year ". For CY 2011, the MFP adjustment is 1.2 percent

and the CPI-U update factor is 1.1 percent. Thus, the 1.1 percentage increase in the CPI-U is reduced by the 1.2 percentage MFP resulting in a -0.1 percent MFP-adjusted update factor or a 0.1percent reduction to the applicable CY 2011 DMEPOS fee schedule amounts.

2011 Update to the Labor Payment Rates

Included in Attachment A are the CY 2011 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the Consumer Price Index for all urban consumers (CPI- U) for the twelve month period ending with June 30, 2010 is 1.1%, this change is applied to the 2010 labor payment amounts to update for CY 2011. The 2011 labor payment amounts in Attachment A are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2011 through December 31, 2011.

2011 National Monthly Payment Amounts for Stationary Oxygen Equipment

As part of this update, we are implementing the 2011 national monthly payment rates for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service on or after January 1, 2011. We are revising the fee schedule file to include the new national 2011 monthly payment rate of $173.31 for stationary oxygen equipment. As required by statute, the payment rates must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the addition of the new oxygen generating portable equipment (OGPE) class. The revised 2011 monthly payment rate of $173.31 includes the -0.1 percent MFP-adjusted update factor**.** The budget neutrality adjustment and the MFP-adjusted covered item update factor for 2011 caused the 2010 rate to change from $173.17 to $173.31.

When updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2011 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Also updated for 2011 is the payment amount for maintenance and servicing for certain oxygen equipment. Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, Change Request (CR) 6792, dated February 5, 2010 and Transmittal 717, Change Request (CR) 6990, dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR §414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator which resulted in a payment of $66 for CY 2010. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a)(14) of the Act. Thus, the 2010 maintenance and servicing fee is adjusted by the -0.1 percent MFP-adjusted covered item update factor to yield a CY 2011 maintenance and servicing fee of $65.93 for oxygen concentrators and transfilling equipment.

Specific Billing Issues

Section 13543(a) of the Omnibus Budget Reconciliation Act of 1993 removed nebulizers from the frequent and substantial servicing payment category effective for items furnished on or after January 1, 1994. To align with

this requirement, the payment category for code E0575 NEBULIZER, ULTRASONIC, LARGE VOLUME is being revised as part of this update to move the nebulizer from the DME payment category for frequent and substantial servicing to the DME payment category for capped rental items, effective January 1, 2011. The fee schedule file will be updated to reflect this change. The first claim received for each beneficiary for this code with a date of service on or after January 1, 2011 shall be counted as the first rental month in the cap rental period.

Code A7020 INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY is added to the HCPCS file effective January 1, 2011. Items coded under this code are accessories used with the capped rental durable medical equipment cough stimulating device coded at E0482. Pub.100-02, Medicare Benefit policy Manual, chapter 15, section 110.3 provides that payment may be made for replacement of essential accessories such as hoses, tubes, mouthpieces for necessary durable medical equipment only if the beneficiary owns or is purchasing the equipment. Therefore, separate payment shall not be made for the replacement of accessories described by code A7020 until after the 13-month rental cap has been reached for capped rental code E0482.

The following new codes are being added to the HCPCS file, effective January 1, 2011, to describe replacement accessories for Ventricular Assist Devices (VADs):

Q0478 POWER ADAPTOR FOR USE WITH ELECTRONIC OR ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, VEHICLE TYPE
Q0479 POWER MODULE FOR USE WITH ELECTRIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY

Similar to the other VAD supplies and accessories coded at Q0480 thru Q0496, Q0497 thru Q0502, Q0504 and Q0505, we have determined the reasonable useful lifetime for codes Q0478 and Q0479 to be one year. Therefore, as part of this update, we are establishing CWF edits to deny claims before the lifetime of these items has expired. Suppliers and providers will need to add HCPCS modifier RA to claims for codes Q0478 and Q0479 in cases where the battery is being replaced because it was lost, stolen, or irreparably damaged.

Additionally, code Q0489 POWER PACK BASE FOR USE WITH ELECTRONIC/PNEUMATIC VENTRICULAR ASSIST DEVICE, REPLACEMENT ONLY should not be used to bill separately for a VAD replacement power module or a battery charger in instances where the power module and battery charger are not integral and are furnished as separate components.

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	
7248.1	The DME MACs, A/B MACs, carriers and/or EDCs shall retrieve the DMEPOS fee schedule file (filename: MU00.@BF12393.DMEPOS.T110101.V1123) as soon as possible. The file is available for download on or after November 23, 2010.	X	X		X						EDC
7248.1.1	Upon successful receipt of each file, the contractor shall send notification of receipt via EMAIL to	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	
	price_file_receipt@cms.hhs.gov stating the name of the file received and the entity receiving the file (e.g., contractor name and number).										
7248.2	The A/B MACs, FIs, RHHIs and/or EDCs shall retrieve the DMEPOS fee schedule file (filename: MU00.@BF12393.DMEPOS.T110101.V1123.FI) as soon as possible. The file is available for download on or after November 23, 2010.	X		X		X	X				EDC
7248.2.1	Upon successful receipt of each file the contractor shall send notification of receipt via EMAIL to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity receiving the file (e.g., contractor name and number).	X		X		X	X				
7248.3	The DME MACs and/or EDCs shall retrieve the PEN fee schedule file (filename: MU00.@BF12393.PEN.CY11.V1123) as soon as possible. The file is available for download on or after November 23, 2010.		X								EDC
7248.4	Contractors shall use the 2011 DMEPOS fee schedule payment amounts to pay claims for items furnished from January 1, 2011, through December 31, 2011.	X	X	X	X	X					
7248.5	The DME MACs shall use the 2011 PEN fee schedule payment amounts to pay claims for items furnished from January 1, 2011 through December 31, 2011.		X								
7248.6	The HCPCS codes listed below are being added to the HCPCS on January 1, 2011, and shall be added to the CWF categories (in parentheses) as follows: Payment Category A4566 (60) N/A A7020 (04, 60) IN A9273 (60) N/A E0446 (60) N/A E1831 (01, 60) CR E2622 (04, 60) IN E2623 (04, 60) IN E2624 (04, 60) IN E2625 (04, 60) IN L3674 (03, 60) PO L4631 (03, 60) PO L5961 (03, 60) PO L8693 (03, 67) PO Q0478 (03, 67) PO Q0479 (03, 67) PO						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	
7248.7	Contractors shall establish local fee schedule amounts, when applicable, to pay claims for the codes listed in 7248.8, from January 1, 2011, through June 30, 2011.		X								
7248.7.1	If pricing information is not readily available for one or more codes and the DME MACs are not able to establish base local fees for the codes listed in 7248.8 the DME MACs shall consult with CMS central office to determine how pricing should be established for these codes.		X								
7248.8	In accordance with the schedule noted below, base fees for the following codes shall be submitted to DDS/CMS by April 9, 2011, for inclusion in the July DMEPOS fee schedule update: <u>Inexpensive/Routinely Purchased (IN)</u> A7020 <u>Capped Rental (CR)</u> E1831 <u>Prosthetics and Orthotics (PO)</u> L5961		X								
7248.9	For power wheelchairs furnished on or after January 1, 2011, the CY 2011 fees are included in the 2011 DMEPOS Fee Schedule Part B file at the 15 percent of the purchase price amount. Contractors shall use the 2011 fee schedule payment amounts to pay claims for rental months 1 through 3. In order to pay claims for subsequent rental months, contractors shall use the fee schedule amounts multiplied by 0.4 to establish the 6 percent of purchase price rental amount for months 4 through 13. The current HCPCS codes identifying power-driven wheelchairs are listed in Attachment B and include codes K0813 thru K0831 and code K0898 for standard power-driven wheelchairs and complex rehabilitative power-driven wheelchairs including Group 2 power wheelchairs with additional power options and Group 3 and higher power wheelchairs.	X	X			X			X		
7248.9.1	For power wheelchairs in which the first rental month occurred prior to January 1, 2011, rental payments for the codes listed in Attachment B, where applicable, shall continue to be made using 10 percent of the purchase price for rental months 1 through 3 and 7.5 percent of the								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	
	purchase price for rental months 4 through 13. Rental payment amounts at 10 percent of the purchase price for months 1 through 3 shall be calculated using the HCPCS code's published 15 percent of the purchase price rental fee schedule amount divided by 1.5. Rental payment amounts at 7.5 percent of the purchase price for rental months 4 through 13 shall be calculated using the HCPCS code's published 15 percent of the purchase price fee schedule rental amount divided by 1.5 and multiplied by 0.75.										
7248.10	Contractors shall use 2011 allowed payment amounts for code K0739 in Attachment A to pay claims for DME items with dates of service from January 1, 2011, through December 31, 2011.	X	X		X	X					
7248.11	Contractors shall use the 2011 allowed payment amounts for codes L4205 and L7520 in Attachment A to pay claims for orthotic and prosthetic items with dates of service from January 1, 2011, through December 31, 2011.	X	X	X	X	X					
7248.12	The maintenance and servicing fee for certain oxygen equipment shall be $65.93 for claims with dates of service July 1, 2011 thru December 31, 2011. Payment is based on the lower of the supplier's actual charge or the maintenance and servicing fee.	X	X			X	X				HH & H MAC (J14)
7248.13	The CWF shall change the DME payment category for HCPCS code E0575 from CWF category (2), frequently maintained DME (FS), to CWF category (1), capped rental DME (CR)									X	
7248.14	Claims with dates of service prior to January 1, 2011, for code E0575 shall not be counted toward the rental cap once these items are moved to the capped rental category.		X			X					
7248.15	The DME MACs and RHHIs shall change the DME payment category for HCPCS code E0575 from the frequent and substantial servicing (FS) category to the capped rental (CR) category.		X			X					
7248.16	Contractors shall deny claims with dates of service on or after January 1, 2011, for replacement accessories billed using A7020 when the accessories are being replaced during the 13-month rental period for code E0482.		X			X					
7248.17	CWF edits shall be established to reject claims for HCPCS codes Q0478 and Q0479, without corresponding modifier RA, with dates of service within 12 months of date of discharge from the hospital stay in which a ventricular assist device is implanted, as identified by						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	
	ICD-9 code 37.66 (insertion of implantable heart assist system) or 37.63 (repair/replacement of implantable heart system). The shared system maintainers shall adjust the A/B MAC, FI and Carrier systems to accommodate these edits.										
7248.17.1	CWF edits shall also reject claims for HCPCS codes Q0478 and Q0479 with dates of service within 12 months of the date of the service for a previous paid claim for replacement of the item under Part B. The shared system maintainers shall adjust the A/B MAC, FI and Carrier systems to accommodate these edits.						X			X	
7248.17.2	Contractors shall use the following messages: MSN message 16.29 – Payment is included in another service you have received. Reason code 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Group Code: CO	X		X	X						
7248.17.3	A/B MACs, FIs and Carriers shall instruct suppliers and providers to add HCPCS modifier RA to the claim for HCPCS codes Q0478 and Q0479 if the item being replaced was lost, stolen, or irreparably damaged.	X		X	X						
7248.17.4	Claims containing HCPCS modifier RA shall not be rejected by the edits established by requirements 7248.17 and 7248.17.1									X	
7248.18	CWF shall establish an edit to reject claims for HCPCS codes Q0478 and Q0479 and no hospital stay in which a VAD is implanted as identified by ICD-9 code 37.66 or 37.63 has been received in CWF.									X	
7248.18.1	Contractors shall use the following messages: MSN message 8.60 – Payment is denied because there is no hospital stay/surgery on file for implantation of the durable medical equipment or prosthetic device. Reason code 107 – The related or qualifying	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	
	claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Group Code: CO										
7248.19	CWF shall send an Informational Unsolicited Response to the contractors when the Part B or outpatient claim is in CWF as denied for HCPCS code Q0478 or Q0479 and a hospital stay is received with date of discharge that is not within 12 months in which a VAD is implanted as identified by ICD-9 code 37.66 or 37.63. Contractors shall adjust previously denied claims as appropriate based on this unsolicited response.	X		X	X					X	
7248.20	CWF shall send an Informational Unsolicited Response to the contractors when the Part B or outpatient claim is in CWF as denied for HCPCS code Q0478 or Q0479 with modifier RA and a hospital stay is received with date of discharge that is within 12 months in which a VAD is implanted as identified by ICD-9 code 37.66 or 37.63. Contractors shall adjust previously denied claims as appropriate based on this unsolicited response.	X		X	X					X	
7248.21	The DME MACs, A/B MACs, Carriers and FIs shall implement changes to the 2011 DMEPOS fee schedules in accordance with the schedule outlined below.	X	X	X	X	X					

Schedule for changes for 2011 DMEPOS Fees (Local Carriers or DME MACs) or PEN Fees (DME MACs)

Changes to DDS*(Laura Ashbaugh)	DDS Transmit Files	Contractors Implement
April 7	May 5	July 1, 2011
September 15	November 10	January 1, 2012

*DME MACs or local carriers will forward changes to ROs. ROs will forward requests to DDS/Laura Ashbaugh.

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)						
		A/	DM	FI	CA	RH	Shared-System Maintainers	OTHER

		B MAC	E MAC		R R I E R	H I	F I S S	M C S	V M S	C W F	
7248.22	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 1 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	X	X	X					

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:
7248.8	Gap-filled base fees should be submitted using the record format described in section 60.4 of chapter 23 of the Medicare Claims Processing Manual. Base fee schedule amounts submitted to CMS shall not be updated by any update factors other than the 1.7% (1989) update factor for DME and prosthetics and orthotics.
7248.7, 7248.8	Instructions for gap-filling DMEPOS fees are located in section 60.3 of chapter 23 of the Medicare Claims Processing Manual.
7248.12	Instructions regarding payment for maintenance and servicing of certain oxygen equipment furnished in CRs 6792 and 6990.

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

V. CONTACTS

Pre-Implementation Contact(s): Anita Greenberg, Anita.Greenberg@cms.gov, Karen Jacobs, Karen.Jacobs@cms.gov

Post-Implementation Contact(s): Anita Greenberg, Anita.Greenberg@cms.gov, Karen Jacobs, Karen.Jacobs@cms.gov for general issues and Chris Molling, Christopher.Molling@cms.gov for oxygen issues.

VI. FUNDING

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

Attachment (2)

Attachment A

2011 Fees for Codes K0739, L4205, L7520

STATE	K0739	L4205	L7520		STATE	K0739	L4205	L7520
AK	$25.55	$29.11	$34.25		**SC**	$13.56	$20.21	$27.44
AL	13.56	20.21	27.44		**SD**	15.15	20.19	36.68
AR	13.56	20.21	27.44		**TN**	13.56	20.21	27.44
AZ	16.77	20.19	33.76		**TX**	13.56	20.21	27.44
CA	20.81	33.19	38.68		**UT**	13.60	20.19	42.73
CO	13.56	20.21	27.44		**VA**	13.56	20.19	27.44
CT	22.65	20.67	27.44		**VI**	13.56	20.21	27.44
DC	13.56	20.19	27.44		**VT**	14.56	20.19	27.44
DE	24.98	20.19	27.44		**WA**	21.61	29.62	35.18
FL	13.56	20.21	27.44		**WI**	13.56	20.19	27.44
GA	13.56	20.21	27.44		**WV**	13.56	20.19	27.44
HI	16.77	29.11	34.25		**WY**	18.91	26.94	38.26
IA	13.56	20.19	32.85					
ID	13.56	20.19	27.44					
IL	13.56	20.19	27.44					
IN	13.56	20.19	27.44					
KS	13.56	20.19	34.25					
KY	13.56	25.88	35.09					
LA	13.56	20.21	27.44					
MA	22.65	20.19	27.44					
MD	13.56	20.19	27.44					
ME	22.65	20.19	27.44					
MI	13.56	20.19	27.44					
MN	13.56	20.19	27.44					
MO	13.56	20.19	27.44					
MS	13.56	20.21	27.44					
MT	13.56	20.19	34.25					
NC	13.56	20.21	27.44					
ND	16.90	29.05	34.25					
NE	13.56	20.19	38.26					
NH	14.56	20.19	27.44					
NJ	18.30	20.19	27.44					
NM	13.56	20.21	27.44					
NV	21.61	20.19	37.40					
NY	24.98	20.21	27.44					
OH	13.56	20.19	27.44					
OK	13.56	20.21	27.44					
OR	13.56	20.19	39.46					
PA	14.56	20.79	27.44					
PR	13.56	20.21	27.44					
RI	16.17	20.81	27.44					

Attachment B

Power-Driven Wheelchair HCPCS Codes

K0813	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0814	POWER WHEELCHAIR, GROUP 1 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0815	POWER WHEELCHAIR, GROUP 1 STANDARD, SLING/SOLID SEAT AND BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0816	POWER WHEELCHAIR, GROUP 1 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACTIY UP TO AND INCLUDING 300 POUNDS
K0820	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0821	POWER WHEELCHAIR, GROUP 2 STANDARD, PORTABLE, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0822	POWER WHEELCHAIR, GROUP 2 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0823	POWER WHEELCHAIR, GROUP 2 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0824	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0825	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0826	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0827	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0828	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0829	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0830	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0831	POWER WHEELCHAIR, GROUP 2 STANDARD, SEAT ELEVATOR, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 126 TO 300 POUNDS
K0835	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0836	POWER WHEELCHAIR, GROUP 2 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0837	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0838	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0839	POWER WHEELCHAIR, GROUP 2 VERY HEAVY DUTY, SINGLE POWER OPTION

	SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0840	POWER WHEELCHAIR, GROUP 2 EXTRA HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0841	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0842	POWER WHEELCHAIR, GROUP 2 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0843	POWER WHEELCHAIR, GROUP 2 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0848	POWER WHEELCHAIR, GROUP 3 STANDARD, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0849	POWER WHEELCHAIR, GROUP 3 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0850	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0851	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0852	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0853	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0854	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0855	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0856	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0857	POWER WHEELCHAIR, GROUP 3 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0858	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 301 TO 450 POUNDS
K0859	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0860	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0861	POWER WHEELCHAIR, GROUP 3 STANDARD, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0862	POWER WHEELCHAIR, GROUP 3 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 TO 450 POUNDS
K0863	POWER WHEELCHAIR, GROUP 3 VERY HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0864	POWER WHEELCHAIR, GROUP 3 EXTRA HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 601 POUNDS OR MORE
K0868	POWER WHEELCHAIR, GROUP 4 STANDARD, SL:ING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0869	POWER WHEELCHAIR, GROUP 4 STANDARD, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0870	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 to 450 POUNDS
K0871	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 451 TO 600 POUNDS
K0877	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS

K0878	POWER WHEELCHAIR, GROUP 4 STANDARD, SINGLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0879	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY 301 AND 450 POUNDS
K0880	POWER WHEELCHAIR, GROUP 4 VERY HEAVY DUTY, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT 451 TO 600 POUNDS
K0884	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, SLING, SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0885	POWER WHEELCHAIR, GROUP 4 STANDARD, MULTIPLE POWER OPTION, CAPTAINS CHAIR, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 300 POUNDS
K0886	POWER WHEELCHAIR, GROUP 4 HEAVY DUTY, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WIEGHT CAPACITY 301 TO 450 POUNDS
K0890	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, SINGLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
K0891	POWER WHEELCHAIR, GROUP 5 PEDIATRIC, MULTIPLE POWER OPTION, SLING/SOLID SEAT/BACK, PATIENT WEIGHT CAPACITY UP TO AND INCLUDING 125 POUNDS
K0898	POWER WHEELCHAIR, NOT OTHERWISE CLASSIFIED