CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 686	**Date: April 29, 2010**
	Change Request 6743

SUBJECT: Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prosthesis Healthcare Common Procedure Coding System (HCPCS) Code

I. SUMMARY OF CHANGES: HCPCS code L8509 describes a tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type. This type of prosthesis is inserted in a physician"s office or other outpatient setting. Therefore, claims for code L8509 should not be submitted to the DME MAC, but instead should be submitted to the A/B MAC or Part B carrier.

EFFECTIVE DATE: October 1, 2010
IMPLEMENTATION DATE: October 4, 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:
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. ATTACHMENTS:

One-Time Notification

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

Attachment – One-Time Notification

Pub. 100-20	Transmittal: 686	Date: April 29, 2010	Change Request: 6743

SUBJECT: Change in Claims Filing Jurisdiction for Tracheo-Esophageal Voice Prostheses Healthcare Common Procedure Coding System (HCPCS) Code

Effective Date: October 1, 2010

Implementation Date: October 4, 2010

I. GENERAL INFORMATION

A. Background: Currently claims for tracheo-esophageal voice prostheses (Healthcare Common Procedure Coding System (HCPCS) code L8509) are being submitted to the Durable Medical Equipment Medicare Administrative Contractors (DME MAC). Tracheo-esophageal voice prostheses are inserted by licensed health care providers in a physician's office or other outpatient setting. In general, Medicare requires that claims for Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) that are implanted or inserted by a physician be billed to the A/B MAC or Part B carrier because these contractors also handle the claims for the professional services related to inserting or implanting the device. In order to be consistent with this jurisdictional requirement, the Centers for Medicare & Medicaid Services (CMS) is changing the claims filing jurisdiction for this code from the DME MACs to the A/B MACs/Part B carriers, effective October 1, 2010.

Tracheo-esophageal voice prostheses that are changed by the patient/caregiver in the home setting are billed using HCPCS code L8507 (trachea-esophageal voice prostheses, patient inserted, any type, each) and are eligible for coverage under the prosthetic device benefit. The filing jurisdiction for these claims remains with the DME MACs.

B. Policy: HCPCS code L8509 describes a tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type. This type of prosthesis is inserted in a physician's office or other outpatient setting. Effective October 1, 2010, licensed, professional health care providers shall bill claims for HCPCS code L8509 to their A/B MAC (or Part B carrier, as applicable). Medicare does not cover the item if it is shipped or dispensed to the beneficiary, who then takes the item to their physician's office for insertion. The A/B MACs or Part B carriers should deny claims in these instances. Refer to Chapter 15, Section 120, in Publication 100-02, the *Medicare Benefit Policy Manual*:

> "***NOTE:*** *Medicare does not cover a prosthetic device dispensed to a patient prior to the time at which the patient undergoes the procedure that makes necessary the use of the device. For example, the carrier does not make a separate Part B payment for an intraocular lens (IOL) or pacemaker that a physician, during an office visit prior to the actual surgery, dispenses to the patient for his or her use. Dispensing a prosthetic device in this manner raises health and safety issues. Moreover, the need for the device cannot be clearly established until the procedure that makes its use possible is successfully performed. Therefore, dispensing a prosthetic device in this manner is not considered reasonable and necessary for the treatment of the patient's condition."*

Trachea-esophageal voice prostheses identified by HCPCS code L8507 are changed by the patient/caregiver in the home setting. The filing jurisdiction for claims for HCPCS code L8507 remains with the DME MACs.

HCPCS code L8509 is covered as a prosthetic device, and the Medicare allowed payment amount is based on the lower of the actual charge or the fee schedule amount for the item.

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	
6743.1	Effective for claims with dates of service on or after October 1, 2010, the DME MACs shall deny claims containing HCPCS code L8509 as not payable under the contractor's claims jurisdiction area.		X								
6743.1.1	The DME MACs shall use the following messages when denying the claims specified in BR 6743.1: Reason Code 109: Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor; and Remark Code N418: Misrouted claim. See the payer's claim submission instructions. MSN: 11.5: This claim will be submitted to (another carrier, a durable medical Medicare administrative contractor (DME MAC), or Medicaid agency). MSN 11.5 (Spanish): Esta reclamación debe ser sometida a (agencia de seguros de Medicare Parte B, agencia regional de seguros para equipo médico duradero o agencia de Medicaid)		X								
6743.1.2	Medicare contractors shall assign group code OA (Other Adjustment) when denying claims as per BR 6743.1.1.		X								
6743.2	Effective for claims with dates of service on or after October 1, 2010, the A/B MACs and Part B carriers shall accept HCPCS code L8509 for processing.	X			X						
6743.3	The A/B MACs and Part B carriers shall adjudicate claims for HCPCS code L8509 according to Medicare coverage and payment policy, which includes the coverage of HCPCS code L8509 as a prosthetic device.	X			X						
6743.3.1	The A/B MACs and Part B carriers shall base the Medicare allowed payment amount on the lower of the actual charge or the fee schedule amount for HCPCS code L8509.	X			X						
6743.3.2	The A/B MACs and Part B carriers shall deny claims for L8509 when the device was shipped or dispensed directly to the beneficiary, who then took the device to his/her physician's office for insertion.	X			X						
6743.3.2.1	The A/B MACs and Part B carriers shall deny claims	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	
	received from beneficiaries for L8509.										
6743.3.2.2	The A/B MACs and Part B carriers shall use the following MSN message for claims denied for L8509 per BR 6743.3.2: 21.21 - This service was denied because Medicare only covers this service under certain circumstances. 21.21(Spanish) - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.	X			X						
6743.3.2.3	A/B MACs and Part B Carriers shall assign group code CO (Contractor Obligation) when denying claims per BR 6743.3.2.	X			X						
6743.3.2.4	A/B MACs and Part B Carriers shall assign the following Claim Adjustment Reason Code when denying claims per BR 6743.3.2: 50 - These are non-covered services because this is not deemed a "medical necessity" by the payer. **NOTE:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X			X						
6743.3.3	The A/B MACs and Part B carriers shall deny claims for HCPCS code L8509 when they are submitted by pharmacies and other supplier types which are not professional providers.	X			X						
6743.3.3.1	A/B MACs and Part B Carriers shall assign group code CO (Contractor Obligation) when denying claims per BR 6743.3.3	X			X						
6743.3.3.2	A/B MACs and Part B Carriers shall assign the following Claim Adjustment Reason Code when denying claims per BR 6743.3.3: 170 - Payment is denied when performed/billed by this type of provider**.** NOTE**:** Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	X			X						
6743.3.3.3	The A/B MACs and Part B carriers shall use the following MSN messages when denying claims per 6743.3.3: 21.18 - This item or service is not covered when performed or ordered by this provider.	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	
	21.18 (Spanish)- Este servicio no está cubierto cuando es ordenado o rendido por este proveedor; 21.21 - This service was denied because Medicare only covers this service under certain circumstances. 21.21 (Spanish) - Este servicio fue denegado porque Medicare solamente lo cubre bajo ciertas circunstancias.										
6743.3.4	Effective for claims with dates of service on or after October 1, 2010, the A/B MACs and Part B carriers shall deny claims for HCPCS code L8509 when submitted with POS 12 (home).	X			X						
6743.3.4.1	The A/B MACs and Part B carriers shall use the following messages when denying the claims specified in BR 6743.3.4 (Use Group Code PR): Reason Code 5: The procedure code/bill type is inconsistent with the place of service. NOTE: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present; and Remark Code N428: Service/procedure not covered when performed in this place of service MSN: 16.2 – This service cannot be paid when provided in this location/facility MSN (Spanish) 16.2: Este servicio no se puede pagar cuando es suministrado en este sitio/facilidad.	X			X						
6743.4	The CWF shall change the CWF category for L8509 from 60 (DMEPOS – DMERC Submitted) to 67 (Local Carrier Jurisdiction).									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	
6743.5.	A provider education article related to this instruction will be available at	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	
	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.										

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 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 issues regarding the policies associated with this Change Request, please contact Michael Rich at 410-786- 6856 or Michael.Rich@cms.hhs.gov ; for DME MAC issues, contact Wendy Knarr at Wendy.Knarr@cms.hhs.gov ; for A/B MAC and Part B carrier issues, contact Claudette Sikora at 410-786-5618 or Claudette.Sikora@cms.hhs.gov.

Post-Implementation Contact(s): For MACs, please contact your project officers/COTRs; for Part B carriers, please contact your CMS Regional Offices.

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.