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July Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

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PROVIDER TYPES AFFECTED

This MLN Matters® Article is for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services that Medicare reimburses under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED

This article informs DME MACs about the changes to the DMEPOS fees schedules that are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

BACKGROUND

Medicare pays for DME, prosthetic devices, orthotics, prosthetics and surgical dressings on a fee schedule basis per Sections 1834(a), (h), and (i) of the Social Security Act (the Act). Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) Section 414.102 for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts under 1834(a)(1)(F) of the Act, as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for certain items furnished on or after January 1, 2016, in areas that are not Competitive Bid Areas (CBAs), based on information from CBPs for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amount for enteral nutrients, equipment and supplies (enteral nutrition) based on information from CBPs.

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The methods for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR 414.210(g). More information on adjustments to the fee schedule amounts based on information from CBPs is available in CR 11570, dated January 3, 2020. Also, with the exception of the changes made by Section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), CR 11570 provides information on the adjusted fee payment basis for items and services furnished from January 1, 2019, through December 31, 2020, in the following three areas: rural and noncontiguous non-CBAs, non-rural and contiguous non-CBAs and in former CBAs during a temporary gap in the DMEPOS CBP.

Due to a delay in announcement of the next round of the CBP, contracts are not in effect in Round 1, Round 2, or the National Mail Order CBAs beginning January 1, 2019, resulting in a temporary gap period in the CBP. Additional program instructions for payment of items furnished in former CBAs is available in CR 11233, dated April 5, 2019.

The ZIP code associated with the address used for pricing a DMEPOS claim determines the rural fee schedule payment applicability for codes with rural and non-rural adjusted fee schedule amounts. The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas. ZIP codes for non-continental Metropolitan Statistical Areas (MSA) are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary. Regulations at 42 CFR 414.202 define a rural area to be a geographical area represented by a postal ZIP code where at least 50 percent of the total geographical area of the ZIP code is estimated to be outside any MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a CBA established for that MSA. During a gap in the CBP, a former CBA ZIP code file will contain the ZIP codes and will be updated on a quarterly basis as necessary.

CR 11810 provides update instructions for the following:

1. DMEPOS fee schedule file
2. PEN fee schedule file
3. DMEPOS Rural ZIP code file containing the Quarter 3, 2020 updates

These files will also be available as Public Use Files (PUFs) for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.

Interim Final Rule with Comment Period (CMS-5531-IFC)

The interim final rule with comment period (CMS-5531-IFC) entitled “Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program” was published in the **Federal Register** on Friday, May 8, 2020. The IFC implements Section 3712 of the CARES Act, which was signed into law on March 27, 2020. Sections 3712(a) and (b) of the CARES Act, respectively, require the following:

a) For items and services subject to the fee schedule adjustments furnished in rural or non-contiguous areas, the fee schedule amounts will continue to be based on a blend of 50 percent of the adjusted fee schedule amounts and 50 percent of the unadjusted fee schedule amounts (that is, no change from the current fee schedule amounts) through December 31, 2020, or the duration of the COVID-19 Public Health Emergency (PHE), whichever is later.

b) For items and services subject to the fee schedule adjustments furnished in non-rural contiguous non-CBAs, the fee schedule amounts will be based on a blend of 75 percent of the adjusted fee schedule amounts and 25 percent of the unadjusted fee schedule amounts (that is, an increase in the fee schedule amounts) for claims with dates of service beginning March 6, 2020, and continuing until the end of the COVID-19 PHE.

DMEPOS and PEN fee schedule files containing the revised non-rural 75/25 blended fees were transmitted in late April to the DME MACs for implementation.

Since the PHE has not ceased, the July 2020 DMEPOS and PEN fee files continue to include the non-rural contiguous non-CBA 75/25 blended fees required by Section 3712(b) of the CARES Act.

Additional information on Section 3712 of the CARES Act is available in CR 11784, dated May 8, 2020.

As the revised fee schedule amounts are based in part on unadjusted fee schedule amounts, the DMEPOS fee schedule files will also temporarily incorporate fee schedule amounts for certain codes billed in conjunction with modifier KE for all areas. Background information on the KE modifier was issued in CR 6270, dated November 7, 2008. In cases where accessories included in the Initial Round One CBP in 2008 are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs where the KU modifier does not apply, canes, and aspirators), for beneficiaries residing in non-rural areas, suppliers should append the KE modifier to the HCPCS code for the accessory.

Further Consolidated Appropriations Act, 2020

The Further Consolidated Appropriations Act, 2020 (Pub. L. 116-94) was signed into law on December 20, 2019. Section 106 of the Act mandates that, during the period beginning on January 1, 2020, and ending June 30, 2021, the adjustments to the Medicare fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs (HCPCS codes E1161, E1231, E1232, E1233, E1234, and K0005) and certain manual wheelchairs currently described by HCPCS codes E1235, E1236, E1237, E1238, and K0008. As a result, KU modifier fees for wheelchair accessory and seat and back cushion HCPCS codes impacted by this change have been added to the DMEPOS fee schedule file as part of this update and are effective for dates of service through June 30, 2021. The fees for items denoted with the HCPCS modifier KU represent the unadjusted fee schedule amounts (that is, the Calendar Year (CY) 2015 fee schedule amount

updated to the present calendar year by the DMEPOS covered item updates). Additional instructions, as well as the applicable complex rehabilitative and certain manual wheelchair accessory codes associated with this provision are listed in Transmittal 10019, CR 11635, dated May 7, 2020.

Other Payment Changes

Effective January 1, 2020, the parenteral nutrition solution code B4185 *Parenteral nutrition solution, per 10 grams lipids* was divided into two HCPCS codes: B4187 *Omegaven, 10 grams lipids* and B4185 *Parenteral nutrition solution, not otherwise specified, 10 grams lipids*. Before this change, all claims for lipids furnished as part of parenteral nutrition fell under code B4185. Payment regulations at 42 CFR 414.110 specify that when there is a single code that describes two or more distinct complete items and separate codes are subsequently established for each item, the fee schedule amounts that applied to the single code continue to apply to each of the items described by the new codes. As required by this regulation, the fee schedule amounts for code B4185 apply to new code B4187 and revised code B4185 effective for items and services furnished on or after July 1, 2020.

ADDITIONAL INFORMATION

The official instruction, CR 11810, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r10168CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
April 12, 2021	We replaced article links with links to related CRs.
June 5, 2020	Initial article released.