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April Quarterly Update for 2018 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MLN Matters Number: 10503
Related Change Request (CR) Number: CR10503
Related CR Release Date: March 21, 2018
Effective Date: April 1, 2018
Related CR Transmittal Number: R4004CP
Implementation Date: April 2, 2018

PROVIDER TYPE AFFECTED

This MLN Matters® Article is intended 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 paid under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED

Change Request (CR) 10503 provides the April 2018 Medicare DMEPOS fee schedule quarterly update. It provides specific instructions to your DME MAC for implementing updated Oxygen Volume Adjustments.

When necessary, the DMEPOS fee schedule is updated quarterly, to implement fee schedule amounts for new codes, to correct any fee schedule amounts for existing codes (as applicable) and to apply changes in payment policies. It contains fee schedule amounts for both non-rural and rural areas. Additionally, the parenteral and enteral nutrition (PEN) fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items.

There were no Quarter 2, 2018 Rural ZIP code changes, so an April 2018 DMEPOS Rural ZIP code file will not be furnished as part of this update; and there was no change to the PEN fee schedule file for Quarter 2, 2018 so a new PEN fee schedule file will not be furnished as part of this update.

BACKGROUND

Section 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings be completed on a fee schedule basis. Further, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102s, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

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Additionally, 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, based on information from Competitive Bidding Programs (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.

The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjustments, as well as codes that are not subject to the fee schedule CBP adjustments.

Additional information on adjustments to the fee schedule amounts based on information from CBPs is available in Transmittal 3551, CR 9642, dated June 23, 2016 and Transmittal 3416, CR 9431, dated November 23, 2015. You can find the MLN Matters articles associated with these Change Requests at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9642.pdf , and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9431.pdf, respectively.

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. 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.

The fee schedules public use files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files on the CMS Website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

K0903

As part of this update, CR 10503 is adding fee schedule amounts for HCPCS code K0903 (For Diabetics Only, Multiple Density Insert, Made By Direct Carving With CAM Technology From A Rectified CAD Model Created From A Digitized Scan Of The Patient, Total Contact With Patient's Foot, Including Arch, Base Layer Minimum Of 3/16 Inch Material Of Shore A 35 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient's foot were determined to be comparable to inserts made over a positive model of the patient's foot.

Oxygen Volume Adjustments

As part of the 2017 April Quarterly DMEPOS fee schedule update (Please refer to the

associated MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9988.pdf), the 'QF' modifier (Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed) was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds 4 liters per minute (LPM) and portable oxygen is prescribed.

Section 1834(a)(5)(C) and (D) of the Act requires that when an oxygen flow rate exceeds 4 LPM, the Medicare payment amount be the higher of

- 50 percent of the stationary payment amount (HCPCS codes E0424, E0439, E1390, or E1391); or
- The portable oxygen add-on amount (HCPCS codes E0431, E0433, E0434, E1392 or K0738); and
- Never both.

The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'QF' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount; or 2) The fee schedule amount for the portable oxygen add-on amount. The 'QF' modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, **and there is no difference in the prescribed flow rate for nighttime and daytime use.**

CR 10503 provides that effective April 1, 2018:

- The 'QF' modifier is revised to read as follows:
  - QF – (PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED); and
- The following new oxygen volume adjustment modifier is added to the HCPCS file:
  - QB – (PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED).

Specifically (effective April 1, 2018), the modifier 'QB' should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) **when the prescribed amount of oxygen for daytime and nighttime differ** and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed. For more information on April 1, 2018, changes to the pricing modifiers for oxygen flow rate, please refer to MLN Matters Article MM10158, titled 'Revised and New Modifiers for Oxygen Flow Rate."

Please note that the 'QB' modifier is used in billing to denote when: 1) The average prescribed amount of oxygen is greater than 4 LPM; 2) Portable oxygen is prescribed; and 3) There is a difference in the prescribed flow rates for nighttime and for daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and

daytime flow rates is to be used in determining the volume adjustment. Therefore, the 'QB' modifier is used when the average of the nighttime and daytime flow rates exceed 4 LPM and portable oxygen is prescribed.

In addition, please note that Section 1834(a)(5)(C) and (D) of the Act also applies to the 'QB' modifier. This section of the Act requires that, when the oxygen flow rate exceeds 4 LPM, the Medicare payment amount is to be: 1) The higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391); or 2) The portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738); and 3) Never both.

To facilitate this payment calculation, CR 10503 adds the 'QB' modifier (effective April 1, 2018) to the DMEPOS fee schedule file, for both stationary and portable oxygen.

The stationary oxygen 'QB' modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'OB' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

ADDITIONAL INFORMATION

The official instruction, CR 10503, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4004CP.pdf.

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

Date of Change	Description
March 22, 2018	Initial article released

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