

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Medicare & Medicaid Services



New Product

[“The Medicare Home Health Benefit”](#) Fact Sheet, downloadable.

MLN Matters® Number: MM9177 **Revised**    Related Change Request (CR) #: CR 9177

Related CR Release Date: May 29, 2015

Effective Date: January 1, 2015 - for implementation of fee schedule amounts for codes in effect on January 1, 2015; July 1, 2015 for all other changes

Related CR Transmittal #: R3277CP

Implementation Date: July 6, 2015

**July Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule**

**This article was revised on May 30, 2015, to reflect the revised CR9177 issued on May 29. In the article, the CR release date, transmittal number and the Web address for accessing the article are revised. All other information remains the same.**

**Provider Types Affected**

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

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## Provider Action Needed

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This article is based on Change Request (CR) 9177 which advises providers of the July 2015 update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your staff is aware of these updates.

## Background

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The DMEPOS fee schedules 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. The quarterly update process for the DMEPOS fee schedule is located in the “Medicare Claims Processing Manual,” Chapter 23, Section 60, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf> on the CMS website.

Section 1834 (a), (h), and (i) of the Social Security Act requires payment on a fee schedule basis for DME, prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician’s office.

## Key Points

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### Specific Coding and Pricing Issues

1. As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602, which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. **Claims for code A4602 that have already been processed and have dates of service on or after January 1, 2015, may not be adjusted to reflect newly established fees.**
2. Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 amended Section 1834(a)(1) of the Social Security Act to exclude Medicare coverage for vacuum erection systems.
3. As of July 1, 2015, HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:
  - a. L7900 Male vacuum erection system; and
  - b. L7902 Tension ring, for vacuum erection device, any type, replacement only, each

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Effective for claims with dates of service on or after July 1, 2015, claims submitted with HCPCS codes L7900 and L7902 will be denied using the following codes:

- Group Code -PR – “Patient Responsibility.”
- Claim Adjustment Reason Codes (CARC) 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code (RARC) N425 – “Statutorily excluded service(s)”.

Also, note that MACs will follow existing procedures for denying statutorily non-covered items, when these codes are billed with the “GY” modifier.

4. As part of the January 2015 update, fee schedules for HCPCS code A7048 (Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each) were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, CMS is providing the following clarification:
  - a. HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter.
  - b. A7048 is used for each single, complete collection and represents a supply allowance rather than a specifically defined kit.
  - c. Items included in this code are not limited to pre-packaged kits that are bundled by manufacturers or distributors.
  - d. The A7048 supplies include, but are not limited to, drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each complete drainage collection.
  - e. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

## Additional Information

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The official instruction, CR 9177, issued to your MAC regarding this change is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3277CP.pdf> on the CMS website.

You may want to review the related MLN Matters® Article, [SE1511](#) (Discontinued Coverage of Vacuum Erection Systems (VES) Prosthetic Devices in Accordance with the Achieving a Better Life Experience Act of 2014).

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If you have questions, please contact your MAC at their toll-free number. The number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Net-work-MLN/MLNMattersArticles/index.html> under - How Does It Work?

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