



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

MLN Matters Number: MM10707

Related CR Release Date: June 8, 2018

Related CR Transmittal Number: R4072CP

Related Change Request (CR) Number: 10707

Effective Date: January 1, 2018 for fees for code Q0477, June 1, 2018 for CMS-1687-IFC-related rural and blended fees, July 1, 2018 for all other changes

Implementation Date: July 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 DME, Prosthetics, Orthotics, and Supplies (DMEPOS) items or services paid under the DMEPOS fee schedule.

PROVIDER ACTION NEEDED

Change Request (CR) 10707 provides the July 2018 Medicare DMEPOS fee schedule quarterly update listing fee schedule amounts for 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. Also, the files for this update include the July 2018 DMEPOS Rural ZIP code file containing the Third Quarter 2018 Rural ZIP code changes.

BACKGROUND

Sections 1834(a), (h), and (i) of the Social Security Act (the Act) require payment for 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) §414.102, for parenteral and enteral nutrition, splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office.

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 adjusting 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, CR9431, dated November 23, 2015. You can find the MLN Matters articles associated with these CRs 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.

Key changes in this update are as follows:

Interim Final Rule with Comment Period (CMS-1687-IFC)

The interim final rule with comment period (CMS-1687-IFC) entitled “Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas” was published in the Federal Register on Friday, May 11, 2018. The IFC amends the regulations to increase the fee schedule amounts for items furnished from June 1, 2018 through December 31, 2018, in rural areas and non-contiguous areas (Alaska, Hawaii, and United States territories) not subject to the CBP. This change requires new 2018 rural and non-contiguous fee schedules be calculated for HCPCS codes for certain DME and PEN adjusted using competitive bidding information effective June 1, 2018. The new rural and non-contiguous fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. For areas other than rural or non-continuous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts will continue to be based on 100 percent of the adjusted fee schedule amounts from June 1, 2018 through December 31, 2018.

Because the revised rural and non-contiguous fee schedule amounts are based in part on unadjusted fee schedule amounts, the fees for certain items included in the 2008 Original Round One CBP, denoted with the HCPCS pricing modifier, are added back to the fee schedule file only for items furnished in rural and non-contiguous areas. Background information and a list of the applicable KE HCPCS codes was issued in Transmittal 1630, CR 6270, dated November 7, 2008. (See the related MLN Matters article MM6270 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6270.pdf>.) Beginning June 1, 2018 through December 31, 2018, the rural and non-contiguous KE fee

schedule amounts will be based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted KE fee schedule amount updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act. The non-rural fees for these KE codes will be populated with zeros on the fee schedule file since KE is not a valid option for areas without blended fees.

For certain accessories used with base equipment included in the CBP in 2008 (for example, power wheelchairs, walkers, and negative pressure wound therapy pumps), the unadjusted fee schedule amounts include a 9.5 percent reduction in accordance with Federal law if these accessories were also included in the 2008 CBP. The 9.5 percent fee reduction only applies to these accessories when they are furnished for use with the base equipment included in the 2008 CBP. Beginning June 1, 2018, in cases where accessories included in the 2008 CBP are furnished for use with base equipment that was not included in the 2008 CBP (for example, manual wheelchairs, canes and aspirators), for beneficiaries residing in rural or non-contiguous, non-competitive bid areas, suppliers should append the KE modifier to the HCPCS code for the accessory. Suppliers should not use the KE modifier with accessories that were included in the 2008 CBP and furnished for use with base equipment that was not included in the 2008 CBP when these accessories are furnished to beneficiaries residing in non-rural, non-competitive bid areas.

Also, because the IFC results in a change to the 2018 fee schedule amounts for the various classes of oxygen and oxygen equipment, the annual oxygen budget neutrality adjustment for 2018 is recomputed and the adjustments to the stationary oxygen equipment, mandated by regulations at section 414.226(c)(6), will be applied to the fees on the June 1, 2018 file.

DMEPOS and PEN fee schedule files containing the revised rural and non-contiguous 50/50 blend fees were transmitted in May to the Part B and DME MACs for the June 1, 2018 implementation. However, the DMEPOS Institutional Claim (FI) fee schedule file was not updated with the revised rural and non-contiguous 50/50 blend in June. The July 2018 DMEPOS fee schedule FI file will incorporate the 50/50 blend rural and non-contiguous fees with a June 1, 2018 effective date. As part of the July 2018 DMEPOS fee schedule file update, HHHMACs shall adjust any impacted 50/50 blend claims processed for dates of service between June 1, 2018 and June 30, 2018 that are brought to their attention by the supplier.

MACs will not search for and adjust claims for HCPCS codes with revised 50/50 blend fees appearing on the July 2018 DMEPOS FI file with effective dates of June 1, 2018 for dates of service June 1, 2018 through June 30, 2018. However, they will adjust these claims when you bring them to their attention for dates of service June 1, 2018 through June 30, 2018.

Other Changes

As part of this update, the fee schedules for HCPCS code Q0477 (Power Module Patient Cable for Use with Electric or Electric/Pneumatic Ventricular Assist Device, Replacement Only) are revised and effective for dates of service on or after January 1, 2018. If you resubmit impacted claims, MACs will adjust previously processed claims for code Q0477 with dates of service on or after January 1, 2018.

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 at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>.

ADDITIONAL INFORMATION

The official instruction, CR10707, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4072CP.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
June 11, 2018	Initial article released.

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2017 American Medical Association. All rights reserved.

Copyright © 2018, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.