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Calendar Year (CY) 2019 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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Note: We revised this article on January 22, 2019, to reflect a revised CR 11064 that was issued on January 18. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same as the changes to the CR had no impact on the substance in the article.

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 provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11064 provides the Calendar Year (CY) 2019 annual 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 billing staffs are aware of these updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) updates the DMEPOS fee schedule on an annual basis in accordance with statute and regulations. Payment on a fee schedule basis is required for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section1834 (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 Regulation (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 Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the adjusted fee schedule amounts under Section 1834(a)(1)(F) as well as codes that are not subject to the fee schedule Competitive Bidding Program (CBP) adjustments.

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The key updates for CY 2019 are as follows:

Fee Schedule Adjustment Methodologies

Section1834(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 CBPs for DME. Section 1842(s)(3)(B) of the Act provides authority for making adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from CBPs.

The methodologies for adjusting DMEPOS fee schedule amounts using information from CBPs are established in regulations at 42 CFR Section 414.210(g). The DMEPOS and PEN fee schedule files contain HCPCS codes that are subject to the adjusted fee schedule amounts as well as codes that are not subject to the fee schedule CBP adjustments. Initial program instructions on these fee schedule adjustments are available in Transmittal 3551, CR9642, dated June 23, 2016 (MM9642 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9642.pdf), and Transmittal 3416, CR9431, dated November 23, 2015 (MM9431 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9431.pdf).

For CY 2019, the following Fee Schedule Adjustment Methodologies apply and fee schedule amounts are based on the area in which the items and services are furnished. Additional discussion of these methodologies is in the CY 2019 End-Stage Renal Disease (ESRD)/ DMEPOS final rule, CMS-1691-F, which is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

1. Fee Schedule Amounts for Areas within the Contiguous United States

Beginning January 1, 2109, through December 31, 2020, the adjusted fee schedule amounts for items furnished in non-competitively bid rural areas 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 non-competitively bid areas other than rural or non-contiguous 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 January 1, 2019, through December 31, 2020.

To determine the adjusted fee schedule amounts, the average of Single Payment Amounts (SPAs) from CBPs located in eight different regions of the contiguous United States are used to adjust the fee schedule amounts for the states located in each of the eight regions. These Regional SPAs or RSPAs are also subject to a national ceiling (110 percent of the average of the RSPAs for all contiguous states plus the District of Columbia) and a national floor (90% of the average of the RSPAs for all contiguous states plus the District of Columbia). This methodology applies to enteral nutrition and most competitively bid DME items furnished in the contiguous United States, that is, those included in more than 10 Competitive Bidding Areas (CBAs). Fees schedule amounts for competitively bid DME items included in 10 or fewer CBAs

receive adjusted fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs.

Additionally, in determining the adjusted fees, the fee schedule amounts for areas within the contiguous United States that are designated as rural areas are adjusted to equal the national ceiling amounts described above. Regulations at section 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 Metropolitan Statistical Area (MSA). A rural area also includes any ZIP Code within an MSA that is excluded from a CBA established for that MSA.

For the January 1, 2020 fee schedule update, the adjusted fee schedule amounts in non-bid areas will receive a Consumer Price Index for all Urban Consumers (CPI-U) update per Section 414.210(g) due to the adjustments being based on SPAs from CBPs that are no longer in effect.

2. Fee Schedule Amounts for Areas outside the Contiguous United States

Fee schedule amounts for items furnished in areas outside the contiguous United States (the noncontiguous areas, such as Alaska, Guam, Hawaii) 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. Areas outside the contiguous United States receive adjusted fee schedule amounts so that they are equal to the higher of the average of SPAs for CBAs in areas outside the contiguous United States (currently only applicable to Honolulu, Hawaii) or the national ceiling amounts described above and calculated based on SPAs for areas within the contiguous United States. For the January 1, 2020 fee schedule update, the adjusted fee schedule amounts in non-bid areas will receive a CPI-U update per Section 414.210(g) due to the adjustments being based on SPAs from CBPs that are no longer in effect.

KE Modifier

Because the 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 KE modifier, appear on the fee schedule file only for items furnished in rural and non-contiguous areas. Instructions and a list of the applicable KE HCPCS codes are available in Transmittal 1630, CR6270, dated November 7, 2008. From June 1, 2018, through December 31, 2020, 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. The KE modifier is not billable for items furnished in former competitive bid areas effective January 1, 2019 (see payment methodology below).

3. Fee Schedule Amounts for former CBAs

The Round 2 Recompete, National Mail-Order Recompete, and Round One 2017 contract periods of performance expire on December 31, 2018. Due to a delay, contracts will not be in effect beginning January 1, 2019, resulting in a gap in the CBP. Beginning January 1, 2019, fee schedule amounts for items furnished in former CBAs are based on the lower of the supplier's charge for the item or fee schedule amounts adjusted in accordance with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Act. A new fee schedule methodology will apply to items and services furnished within former CBAs in accordance with Sections 1834(a)(1)(F) and 1834(a)(1)(G) of the Act. Pursuant to 42 CFR Section 414.210(g), the fee schedules for items and services furnished in former CBAs are based on the SPAs, in effect in the CBA on the last day before the CBP contract periods of performance ended, increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. If the gap in the CBP lasts for more than 12 months, the fee schedule amounts are increased once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. Thus, for dates of service from January 1, 2019, through December 31, 2019, the adjusted fee schedule amounts for former CBAs will be derived based on the SPAs in effect in the CBA as of December 31, 2018, increased by the projected CPI-U change of 2.5 percent.

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 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 ZIP code associated with the permanent address of the beneficiary determines applicability of the adjusted fee schedule amounts in former CBAs. 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.

The following CY 2019 DMEPOS fee schedule and ZIP code Public Use Files (PUFs) will be available for State Medicaid Agencies, managed care organizations, and other interested parties at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html.

1. DMEPOS Fee schedule PUF
2. PEN Fee schedule PUF
3. Rural DMEPOS ZIP code PUF

4. Former CBA Fee schedule PUF
5. Former CBA National mail order diabetic testing supply fee schedule PUF
6. Former CBA ZIP code file PUF

New Codes Added

New DMEPOS codes added to the HCPCS file, effective January 1, 2019, where applicable, are A4563, A5514, A6460, A6461, B4105, E0447, E0467, L8608, L8698, L8701, L8702, V5171, V5172, V5181, V5211, V5212, V5213, V5214, V5215, and V5221. The new codes are not to be used for billing purposes until they are effective on January 1, 2019. As part of this update, fee schedules for the following new codes will be added to the DMEPOS fee schedule file effective January 1, 2019: A4563, A5514, E0447 and E0467.

Beginning January 1, 2019, the DMEPOS fee schedule file also includes fees for the following three home infusion G-codes: G0068, G0069, and G0070.

For other new CY 2019 codes, fee schedule amounts will be established as part of the July 2019 DMEPOS fee schedule update when applicable. The DME MAC shall establish local fee schedule amounts to pay claims for new codes listed from January 1, 2019, through June 30, 2019.

For gap-filling pricing purposes, deflation factors are applied before updating to the current year. The deflation factors for 2018 by payment category are:

- 0.435 for Oxygen
- 0.437 for Capped Rental
- 0.439 for Prosthetics and Orthotics
- 0.556 for Surgical Dressings
- 0.605 for Parental and Enteral Nutrition
- 0.927 for Splints and Casts
- 0.911 for Intraocular Lenses

Codes Deleted

One HCPCS code (K0903) will be deleted from the DMEPOS fee schedule files effective January 1, 2019

Multi-Function Ventilators

Effective January 1, 2019, fees are added for new HCPCS code E0467 (Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions).

Pursuant to 42 CFR 414.222(f), the fee schedule amounts for code E0467 are established using the Medicare fee schedule amounts for ventilators and the average cost of the additional

functions performed by multi-function ventilators. The multi-function ventilator is classified under the frequent and substantial servicing payment category at Section 1834(a)(3) of the Act and payment will be made on a continuous monthly rental basis for beneficiaries who meet the Medicare medical necessity coverage criteria for a ventilator and at least one of the four additional functions of the device. Additional information on this change is in the CY 2019 End-Stage Renal Disease (ESRD)/ DMEPOS final rule, CMS-1691-F which is available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

Therapeutic Shoe Modification Codes

CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes (A5512 or A5513). To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of CY 2004. For 2019, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the CY 2017. The fee schedule amounts for shoe modification codes A5503 through A5507 are revised to reflect this change, effective January 1, 2019.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are not updated by the annual covered item update. In accordance with Section 1834(a)(1)(H) of the Act, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the SPAs for mail order DTS established in implementing the national mail order CBP under Section 1847 of the Act. Initial program instructions on these fees are available in Transmittal 2709, CR8325, dated May 17, 2013 (MM8325 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf) and Transmittal 2661, CR8204 (MM8204 is available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf) dated February 22, 2013. The National Mail-Order Recompete DTS SPAs are available at https://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home.

The non-mail order DTS amounts on the fee schedule will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The CBP for mail order diabetic supplies is effective July 1, 2016, to December 31, 2018. As of January 1, 2019, payment for non-mail order diabetic supplies at the National Mail Order Recompete SPAs will continue in accordance with Section 1834(a)(1)(H) of the Act and these rates will remain in effect until new SPA rates are established under the national mail order program.

Effective January 1, 2019, the fee schedule amounts for mail order DTS (with KL modifier) are adjusted using the methodology for areas that were formerly CBAs during periods when there is a temporary lapse in the CBP. The National Mail-Order Recompete DTS SPAs of December 31, 2018, are increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. For dates of service between January 1, 2019, and December 31, 2019, the National Mail-Order Recompete SPAs are updated by the projected change of 2.5%. The national mail order adjusted fee schedule amounts will be used in paying mail order diabetic testing supply claims in all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the American Samoa.

2019 Fee Schedule Update Factor of 2.3 Percent

For CY 2019, an update factor of 2.3 percent is applied to certain DMEPOS fee schedule amounts. Fee schedule amounts that are adjusted using information from CBPs are not be subject to the annual DMEPOS covered item update, but will be updated pursuant to the applicable adjustment methodologies outlined in 42 CFR Section 414.210(g).

In accordance with the statutory Sections 1834(a)(14) of the Act, certain DMEPOS fee schedule amounts are updated for 2019 by the percentage increase in the CPI- U for the 12-month period ending June 30, 2018, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP). The MFP adjustment is 0.6 percent and the CPI-U percentage increase is 2.9 percent. Thus, the 2.9 percentage increase in the CPI-U is reduced by the 0.6 percentage increase in the MFP resulting in a net increase of 2.3 percent for the update factor.

2019 Monthly Fee Schedule Amounts for Oxygen and Oxygen Equipment

As part of this update, CMS is implementing the 2019 monthly fee schedule payment amounts for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390 and E1391), effective for claims with dates of service from January 1, 2019, through December 31, 2019. As required by statute, the CY 2006 addition of the separate payment classes for Oxygen Generating Portable Equipment (OGPE) and stationary and portable oxygen contents must be annually budget neutral.

For CY 2019, separate payment classes for portable gaseous oxygen equipment only, portable liquid oxygen equipment only, and high flow portable liquid oxygen contents only are established. Higher payments for the two new liquid oxygen classes are established. To implement this change, fees are added for new code E0447 Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 Liters Per Minute (LPM). The initial fee for E0447 is set at 150 percent of the fee for portable oxygen contents. This new high flow oxygen content class allows for the continuation of high flow oxygen volume adjustment payments beyond the initial 36 months of continuous use. In addition, the payment for portable liquid oxygen (code E0434) is set to be equivalent to the rental payment amount for portable concentrators and transfilling equipment (HCPCS codes E1392, K0738 or E0433).

Consistent with the requirements set forth in Section 1834(a) (9)(D)(ii) of the Act, a new methodology is established for ensuring that new payment classes for oxygen and oxygen

equipment are budget neutral.

The new methodology for ensuring the budget neutrality of the OGPE payment class and the two new classes related to liquid oxygen is to apply a budget neutrality off-set (percentage reduction) to all oxygen classes beginning January 1, 2019. This would spread the offset across all oxygen and oxygen equipment, thereby lowering the amount taken from the stationary oxygen payment to pay for the separate classes added via Section 1834(a)(9)(D) of the Act. The offset percentage varies by area and ranges from 6 to 9 percent.

Additional discussion of the addition of the new oxygen payment classes and the application of the annual budget neutrality across all classes of oxygen and oxygen equipment is available in the CY 2019 End-Stage Renal Disease (ESRD)/ DMEPOS final rule, CMS-1691-F, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ESRDpayment/End-Stage-Renal-Disease-ESRD-Payment-Regulations-and-Notices.html.

2019 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

The payment amount for maintenance and servicing for certain oxygen equipment is updated also for 2019. Payment for claims for maintenance and servicing of oxygen equipment was included in Transmittal 635, CR6792, dated February 5, 2010, and Transmittal 717, CR6990, dated June 8, 2010. To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR section 414.210(e)(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in §1834(a) (14) of the Act. Thus, the 2018 maintenance and servicing fee is adjusted by the 2.3 percent MFP-adjusted covered item update factor to yield a CY 2019 maintenance and servicing fee of $72.37 for oxygen concentrators and transfilling equipment.

2019 Update to the Labor Payment Rates

Included in the following table are the CY 2019 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI- U for the twelve-month period ending with June 30, 2019 is 2.9 percent, this change is applied to the 2019 labor payment amounts to update the rates for CY 2019.

The 2019 labor payment amounts in this table are effective for claims submitted using HCPCS codes K0739, L4205, and L7520 with dates of service from January 1, 2019, through December 31, 2019.

2019 Fees for Codes K0739, L4205, L7520

STATE	K0739	L4205	L7520
AK	$29.57	$33.70	$39.65
AL	$15.70	$23.40	$31.77
AR	$15.70	$23.40	$31.77
AZ	$19.42	$23.37	$39.08
CA	$24.09	$38.41	$44.75
CO	$15.70	$23.40	$31.77
CT	$26.22	$23.92	$31.77
DC	$15.70	$23.37	$31.77
DE	$28.90	$23.37	$31.77
FL	$15.70	$23.40	$31.77
GA	$15.70	$23.40	$31.77
HI	$19.42	$33.70	$39.65
IA	$15.70	$23.37	$38.02
ID	$15.70	$23.37	$31.77
IL	$15.70	$23.37	$31.77
IN	$15.70	$23.37	$31.77
KS	$15.70	$23.37	$39.65
KY	$15.70	$29.95	$40.61
LA	$15.70	$23.40	$31.77
MA	$26.22	$23.37	$31.77
MD	$15.70	$23.37	$31.77
ME	$26.22	$23.37	$31.77
MI	$15.70	$23.37	$31.77
MN	$15.70	$23.37	$31.77
MO	$15.70	$23.37	$31.77
MS	$15.70	$23.40	$31.77
MT	$15.70	$23.37	$39.65
NC	$15.70	$23.40	$31.77
ND	$19.57	$33.62	$39.65
NE	$15.70	$23.37	$44.29
NH	$16.87	$23.37	$31.77
NJ	$21.18	$23.37	$31.77
NM	$15.70	$23.40	$31.77
NV	$25.01	$23.37	$43.29
NY	$28.90	$23.40	$31.77
OH	$15.70	$23.37	$31.77
OK	$15.70	$23.40	$31.77
OR	$15.70	$23.37	$45.67
PA	$16.87	$24.07	$31.77
PR	$15.70	$23.40	$31.77
RI	$18.72	$24.09	$31.77
SC	$15.70	$23.40	$31.77
SD	$17.55	$23.37	$42.47
TN	$15.70	$23.40	$31.77
TX	$15.70	$23.40	$31.77
UT	$15.74	$23.37	$49.46
VA	$15.70	$23.37	$31.77

STATE	K0739	L4205	L7520
VI	$15.70	$23.40	$31.77
VT	$16.87	$23.37	$31.77
WA	$25.01	$34.28	$40.73
WI	$15.70	$23.37	$31.77
WV	$15.70	$23.37	$31.77
WY	$21.90	$31.19	$44.29

ADDITIONAL INFORMATION

The official instruction, CR11064, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4209CP.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
January 22, 2019	We revised the article to reflect a revised CR 11064 that was issued on January 18. In the article, we revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same as the changes to the CR had no impact on the substance in the article.
December 14, 2018	Initial article released.