

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



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MLN Matters® Number: MM7416

Related Change Request (CR) #: 7416

Related CR Release Date: June 3, 2011

Effective Date: January 1, 2011, for fee schedule amounts for codes effective on that date; otherwise July 1, 2011

Related CR Transmittal #: R2236CP

Implementation Date: July 5, 2011

July Quarterly Update for 2011 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

Providers and suppliers submitting claims to Medicare contractors (carriers, DME Medicare Administrative Contractors (DME MACs), Fiscal Intermediaries (FIs), Medicare Administrative Contractors (MACs), and/or Regional Home Health Intermediaries (RHHIs)) for DMEPOS items or services paid under the DMEPOS fee schedule need to be aware of this article.

Provider Action Needed

This article is based on Change Request (CR) 7416 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) issued instructions updating the DMEPOS fee schedule payment amounts. Be sure your billing staffs are aware of these changes.

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Background

- The DMEPOS fee schedules are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new codes and to revise any fee schedule amounts for existing codes that were calculated in error. The quarterly update process for the DMEPOS fee schedule is documented in the "Medicare Claims Processing Manual," Chapter 23, Section 60 at <https://www.cms.gov/manuals/downloads/clm104c23.pdf> on CMS website.

Key Points of CR7416

Fees Added

The July Quarterly Update for the 2011 DMEPOS Fee Schedule Part B files established fee schedule amounts for Healthcare Common Procedure Coding System (HCPCS) codes A7020, E1831, and L5961, effective for claims with dates of service on or after January 1, 2011.

Note: Claims for codes A7020, E1831, and L5961 with dates of service on or after January 1, 2011, that were previously processed may be adjusted to reflect the newly established fees if you bring those claims to your contractor's attention.

Temporary "K" Codes

The following new K codes will be added to contractor's system effective for dates of service July 1, 2011:

- K0743 – SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
- K0744 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
- K0745 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
- K0746 – ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE GREATER THAN 48 SQUARE INCHES

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Note: The addition of these codes does not imply any health insurance coverage. Medicare contractors will follow their normal processes in determining whether sufficient evidence exists to determine if these items are reasonable and necessary and covered under Medicare.

Code Updates

- HCPCS code E0571 (AEROSOL COMPRESSOR, BATTERY POWERED, FOR USE WITH SMALL VOLUME NEBULIZER) will be made invalid for Medicare claims, effective July 1, 2011.
- The payment category for HCPCS code A4619 (FACE TENT) is being revised as part of this quarterly update to move this nebulizer accessory from the DME payment category for oxygen and oxygen equipment to the DME payment category for inexpensive or other routinely purchased items, effective July 1, 2011. The DMEPOS fee schedule file will be updated to reflect this change.

Payment for Oxygen Contents

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. After the 36-month rental payment period (cap), separate payment may be made for oxygen contents for the remainder of the equipment's reasonable useful lifetime. However, separate payment for oxygen contents ends when replacement stationary oxygen equipment is furnished causing a new 36-month rental payment period to begin. Also, separate oxygen contents payment is allowable for beneficiary-owned stationary or portable gaseous or liquid oxygen equipment. Beginning with dates of service on or after the end date of service for the month representing the 36th payment for the stationary oxygen equipment (codes E0424, E0439, E1390 or E1391), a supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Oxygen Equipment Furnished in Month 36	Monthly Contents Payment after the Stationary Cap
Oxygen Concentrator (E1390, E1391, or E1392)	None
Portable Gaseous or Liquid Transfilling Equipment (K0738 or E0433)	None

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Oxygen Equipment Furnished in Month 36	Monthly Contents Payment after the Stationary Cap
E0424 Stationary Gaseous System	E0441 Stationary Gaseous Contents
E0439 Stationary Liquid System	E0442 Stationary Liquid Contents
E0431 Portable Gaseous System	E0443 Portable Gaseous Contents
E0434 Portable Liquid System	E0444 Portable Liquid Contents

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0433 or E0444) may begin following the stationary oxygen equipment payment cap **AND** before the end of the portable equipment cap (E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable equipment cap for E0431 or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431 or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or is lost, stolen, or irreparable damaged). **Under no circumstances would monthly payment be made for both stationary oxygen equipment and either stationary or portable oxygen contents.**

Proof-of-Delivery Requirements for Oxygen Contents

Following the oxygen equipment payment cap, oxygen content billing should be made on the anniversary date of the oxygen equipment billing.

At all times, the supplier is responsible for ensuring that the beneficiary has a sufficient quantity of oxygen contents and is never in danger of running out of

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contents. A maximum of 3 months of oxygen contents can be delivered to the beneficiary at one time and billed on a monthly basis. In these situations, the delivery date of the oxygen contents does not have to equal the date of service (anniversary date) on the claim, but in order to bill for contents for a specific month (i.e. the second or third month in the three month period), the supplier must have delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. Suppliers should have proof-of-delivery for each actual delivery of oxygen, which may be less than monthly within the three month period. **If the supplier delivers more than one month of oxygen contents at a time (2 to 3), the supplier is not entitled to payment for additional months 2 and 3 if medical need ceases before the date when the supplier would be entitled to bill for those months.**

Payment for Replacement of Equipment After Repairs

Under the regulations at 42 CFR 414.210(e)(4), a supplier that transfers title to a capped rental DME item to the beneficiary is responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program if it is determined that the item will not last until the end of its 5 year reasonable useful lifetime. In making this determination, Medicare contractors may consider whether the accumulated costs of repairing the item exceed 60 percent of the purchase fee schedule amount for the item.

Furthermore, 42 CFR 424.57(14) requires a DMEPOS supplier to maintain or replace a Medicare-covered item it has rented to beneficiaries to its intended status after being repaired. Recent cases have arisen whereupon after multiple repairs, the item continues to malfunction. CR7416 instructs your Medicare contractor to be aware of and educate suppliers of these regulatory requirements to replace DME items for which repairs have not restored the item. Also, after receipt of multiple repair claims, contractors will investigate suspicious claims for replacement equipment billed with its HCPCS code and the RA modifier.

Additional Information

If you have any questions, please contact your Medicare Carrier, DME MAC, FI, RHHI, or A/B MAC at their toll-free number, which may be found at <http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip> on the CMS website.

The official instruction associated with this CR7416 issued to your Medicare Carrier, FI, DME MAC, RHHI or A/B MAC regarding this change may be viewed at <http://www.cms.gov/Transmittals/downloads/R2236CP.pdf> on the CMS website.

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