DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9239 **Related Change Request (CR) #: CR 9239**

Related CR Release Date: September 11, 2015 **Effective Date: January 1, 2016**

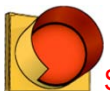
Related CR Transmittal #: R3350CP **Implementation Date: January 4, 2016**

Implementation of Adjusted Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule Amounts Using Information from the National Competitive Bidding Program (CBP)

Provider Types Affected

This MLN Matters® Article is intended for DMEPOS suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for services provided to Medicare beneficiaries.

Provider Action Needed



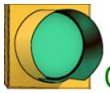
STOP – Impact to You

The adjusted fee schedule amounts for the applicable Healthcare Common Procedure Coding System (HCPCS) codes will be used to pay claims with dates of service on or after January 1, 2016, and will be included in the DMEPOS fee schedule files beginning January 1, 2016.

CAUTION – What You Need to Know

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the Competitive Bidding Program (CBP). Section 1842(s)(3(B) of the Social Security Act (the Act) provides authority for making adjustments to the fee schedule amounts for enteral nutrients,

equipment, and supplies (enteral nutrition) based on information from the CBP. Change Request (CR) 9239 implements the adjusted DMEPOS fees schedule from the CBP.



GO – What You Need to Do

Make sure that your billing staffs are aware of the adjusted DMEPOS fee schedule amounts from the CBP.

Background

Medicare payment for most DMEPOS is based on either fee schedules or single payment amounts (SPAs) established under the CBP in certain specified geographic areas, as mandated by 1847(a) and (b) the Act.

Competitive bidding was phased in with the Round 1 Rebid contracts beginning January 1, 2011, in 9 competitive bid areas (CBAs). Contracts for the Round 1 Rebid expired on December 31, 2013. The Centers for Medicare & Medicaid Services (CMS) is required by law to recompete contracts for the DMEPOS CBP at least once every 3 years. The same 9 CBAs were rebid under the Round 1 Recompete with the contracts and process claims with date of service beginning January 1, 2014. Competitive bidding was phased in with the Round 2 contracts beginning July 1, 2013, in 100 additional CBAs. Beginning with the Round 2 Recompete scheduled to take effect on July 1, 2016, CBAs covering more than one state will be subdivided into CBAs that do not cross state lines, resulting in an increase in the total number of CBAs.

The product categories and HCPCS codes included in each Round of the CBP are available at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home** on the Competitive Bidding Implementation Contractor (CBIC) website.

Section1834(a)(1)(F) of the Act mandates adjustments to the fee schedule amounts for DME furnished on or after January 1, 2016, based on information from the CBP. 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 the CBP. The methodologies for using information from the CBP to adjust the fee schedule amounts for DME and enteral nutrition are set forth in regulations at 42 Code of Federal Regulations (CFR) 414.210(g). There are three general methodologies:

- Adjustment of fee schedule amounts for areas within the contiguous United States, with a special rule for rural areas;
- Adjustment of fee schedule amounts for areas outside the contiguous United States; and

- Adjustment of fee schedule amounts for certain items for all areas in cases where the items have been included in competitive bidding programs in 10 or fewer CBAs.

Fee Schedule Amounts for Areas within the Contiguous United States
This methodology for adjusting the fee schedule amounts uses the average of SPAs from CBPs located in eight different regions of the contiguous United States 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% 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 DME items furnished in the contiguous United States (that is, those included in more than 10 CBAs).

There is also a special rule for areas within the contiguous United States that are designated as rural areas. The fee schedule amounts for these areas will be adjusted to equal the national ceiling amounts described above. Regulations at §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 competitive bidding area established for that MSA.

As a result of these adjustments, the national fee schedule amounts for enteral nutrition will transition to statewide fee schedule amounts.

Fee Schedule Amounts for Areas outside the Contiguous United States
Areas outside the contiguous United States (noncontiguous areas such as Alaska, Guam, Hawaii) are subject to a different methodology that adjusts the 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.

Fee Schedule Amounts for Items Included in 10 or Fewer CBAs
DME items included in 10 or fewer CBAs are subject to a different methodology that adjusts the fee schedule amounts so that they are equal to 110 percent of the average of the SPAs for the 10 or fewer CBAs. This methodology applied to all areas (non-contiguous and contiguous).

Phasing In and Updating Fee Schedule Amounts
The adjustments to the fee schedule amounts will be phased in for claims with dates of service January 1, 2016 through June 30, 2016, so that the fee schedule amount is based on a blend of 50 percent of the current fee schedule amounts (the fee schedule amounts that would have gone into effect on January 1, 2016, if they had not been adjusted based on information from the CBP) and 50 percent of the adjusted fee schedule amount.

For claims with dates of service on or after July 1, 2016, the fee schedule is based on 100 percent of the adjusted fee schedule amount.

In most cases, the adjusted fee schedule amounts will not be subject to the annual DMEPOS covered item update and will only be updated when SPAs from the CBP are updated. Updates to the SPAs may occur at the end of a contract period, as additional items are phased into the CBP, or as new CBPs in new areas are phased in. In cases where SPAs from CBPs no longer in effect are used to adjust fee schedule amounts, the SPAs will be increased by an inflation adjustment factor that corresponds to the year in which the adjustment is made (for example, 2016) and for each subsequent year (for example, 2017, 2018).

The DME MAC and Part B MAC DMEPOS fee schedule file shall be adjusted to include the rural fee and rural fee indicator and these changes will be reflected in the file format and data requirements specified in **Chapter 23**, Section 60.1 of the "Medicare Claims Processing Manual." Similarly, the Fiscal Intermediary (FI) DMEPOS fee schedule file format, outlined in **Chapter 23**, Section 50.2 of the "Medicare Claims Processing Manual," will be updated to include the rural fee and rural fee indicator. Beginning January 1, 2016, the DMEPOS fee schedule file will contain HCPCS codes that are subject to the adjusted payment amount methodology as well as codes that are not subject to the adjustments. The DMEPOS fee schedule file will continue to be updated and available for download on a quarterly basis as necessary.

The parenteral and enteral nutrition (PEN) fee schedule file will accommodate adjusted fees for the enteral HCPCS codes that are state specific. The PEN file layout is outlined in **Chapter 23**, Section 70.1 of the "Medicare Claims Processing Manual."

Additional Information

The official instruction, CR 9239 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3350CP.pdf** on the CMS website.

If you have any questions, please contact your MAC at their toll-free number. That number is available at **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html** under - How Does It Work.