CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3994	**Date: March 9, 2018**
	Change Request 10503

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

I. SUMMARY OF CHANGES: The DMEPOS fee schedule is updated on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. The quarterly update process for the DMEPOS fee schedule is located at Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: April 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 2, 2018

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 3994	Date: March 9, 2018	Change Request: 10503

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

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I. GENERAL INFORMATION

A. Background: 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 update process for the DMEPOS fee schedule is located in Pub.100-04, Medicare Claims Processing Manual, chapter 23, section 60.

Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics and surgical dressings by §1834(a), (h), and (i) of the Social Security Act. Additionally, payment on a fee schedule basis is a regulatory requirement at 42 Code of Federal Regulations (CFR) §414.102 for parenteral and enteral nutrition (PEN), 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 making adjustments to 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, Change Request (CR) 9642, dated June 23, 2016 and Transmittal 3416, CR 9431, dated November 23, 2015.

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.

B. Policy: The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Additionally, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parental nutrition items. There were no Quarter 2, 2018 Rural ZIP code changes, so an April 2018 DMEPOS Rural ZIP code file will not be furnished as part of this update.

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 on the CMS Website at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

As part of this update, we are adding fee schedule amounts for HCPCS code K0903 (For Diabetics Only, Multiple Density Insert, Made By Direct Carving With CAM Technology From A Rectified CAD Model Created From A Digitized Scan Of The Patient, Total Contact With Patient's Foot, Including Arch, Base Layer Minimum Of 3/16 Inch Material Of Shore A 35 Durometer (Or Higher), Includes Arch Filler And Other Shaping Material, Custom Fabricated, Each), effective for claims with dates of service on or after April 1, 2018. The fees for code K0903 are set based on the fees for code A5513 because inserts carved from a digitized scan of the patient's foot were determined to be comparable to inserts made over a positive model of the patient's foot.

Oxygen Volume Adjustments

As part of the 2017 April Quarterly DMEPOS fee schedule update (Change Request 9988), the 'QF' modifier was added to the DMEPOS fee schedule for use with both stationary and portable oxygen when the oxygen flow rate exceeds 4 liters per minute (LPM) and portable oxygen is prescribed. Section 1834(a)(5)(C) and (D) of the Act requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738), and never both. The stationary oxygen QF modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'QF' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount. The 'QF' modifier is billed on both the stationary oxygen and portable oxygen code when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, and there is no difference in the prescribed flow rate for nighttime and daytime use.

Beginning April 1, 2018, the 'QF' modifier is revised to read as follows:

QF PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED

Effective April 1, 2018, the following new oxygen volume adjustment modifier is added to the HCPCS file:

QB PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED

The 'QB' modifier is used in billing to denote when the prescribed amount of oxygen is greater than 4 LPM, portable oxygen is prescribed, and there is a difference in the prescribed flow rate for nighttime and daytime use. In these instances, regulations at 42 CFR 414.226(e)(3)(iii) require that an average of the varying nighttime and daytime flow rates be used in determining the volume adjustment. The 'QB' modifier is used when the average of the nighttime and daytime flow rates exceed 4 LPM and portable oxygen is prescribed.

Section 1834(a)(5)(C) and (D) of the Act also applies to the 'QB' modifier. This section of the Act requires that when there is an oxygen flow rate that exceeds 4 LPM that the Medicare payment amount be the higher of 50 percent of the stationary payment amount (codes E0424, E0439, E1390, or E1391) or the portable oxygen add-on amount (E0431, E0433, E0434, E1392 or K0738), and never both. To facilitate this payment calculation, the 'QB' modifier is added to the DMEPOS fee schedule file effective April 1, 2018 for both stationary and portable oxygen. The stationary oxygen 'QB' modifier fee schedule amounts represent 100 percent of the stationary oxygen fee schedule amount. The portable oxygen 'OB' fee schedule amounts represent the higher of 1) 50 percent of the monthly stationary oxygen payment amount or 2) the fee schedule amount for the portable oxygen add-on amount.

Effective April 1, 2018, the modifier 'QF' should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen for daytime and nighttime differ and the average of the two amounts is greater than 4 liters per minute (LPM) and portable oxygen is prescribed. For

more information on April 1, 2018 changes to the pricing modifiers for oxygen flow rate, please refer to Change Request 10158, titled 'Revised and New Modifiers for Oxygen Flow Rate."

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10503.1	The DME MACs, A/B MACs Part B and/or VDCs shall retrieve the DMEPOS fee schedule file (filename: MU00.@BF12393.DMEPOS.T180101.V0306). The file is available for download on or after March 6, 2018.		X		X					VDC
10503.1.1	Notification of successful receipt shall be sent via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity receiving the file (e.g., contractor name and number).		X		X					VDC
10503.2	The A/B MACs Part A, A/B MACs HHH and/or VDCs shall retrieve the DMEPOS fee schedule file (filename: MU00.@BF12393.DMEPOS.T180101.V0306.FI). The file is available for download on or after March 6, 2018.	X		X						VDC
10503.2.1	Notification of successful receipt shall be sent via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entity receiving the file (e.g., contractor name and number)	X		X						VDC
10503.3	Contractors shall process claims using the files specified in the business requirements (BRs) 1-2 and the effective PEN and Rural Zip code files for dates of service on or after April 1, 2018. There were no Quarter 2, 2018 Rural ZIP code changes and an April 2018 DMEPOS Rural ZIP code file will not be furnished as part of this update. There is no change to the PEN fee schedule file for Quarter 2 and a new PEN fee schedule file will not be furnished as part ot this update.	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10503.4	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X	X	X	

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information: N/A

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Karen Jacobs, Karen.Jacobs@cms.hhs.gov , Anita Greenberg, Anita.Greenberg@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0