CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11292	**Date: March 10, 2022**
	Change Request 12654

SUBJECT: April Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: 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 publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60. 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 publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: April 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2022

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: 11292	Date: March 10, 2022	Change Request: 12654

SUBJECT: April Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

EFFECTIVE DATE: April 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2022

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 publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

Payment on a fee schedule basis is required for certain Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by §1834(a), (h), and (i) of the Social Security Act (the Act). Also, 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. The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to fee schedule adjustments using information on the payment determined for these items under the DMEPOS Competitive Bidding Program (CBP), as well as codes that are not subject to the CBP or fee schedule adjustments.

Section 1834(a)(1)(F)(ii) of the Act mandates adjustments to the fee schedule amounts for DME items included in the CBP for payment of the items in areas that are not Competitive Bidding Areas (CBAs). Section 1842(s)(3)(B) of the Act provides authority for adjustments to the fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) based on information from the CBP. The methodologies for adjusting DMEPOS fee schedule amounts under this authority are established at 42 CFR §414.210(g).

The Coronavirus (COVID-19) Aid, Relief, and Economic Security (CARES) Act, 2020

Section 3712 of the CARES Act was signed into law on March 27, 2020. Additional information on section 3712 of the CARES Act is available in Transmittal 10016, Change Request 11784, dated May 8, 2020. The fees in the April 2022 fee schedule update continue to reflect the requirements of the CARES Act. Sections 3712 (a) and (b) of the CARES Act, respectively, require the following:

(a) For items and services subject to the fee schedule adjustments furnished in rural or non-contiguous areas, the fee schedule amounts will continue to be based on a blend of 50 percent of the adjusted fee schedule amounts and 50 percent of the unadjusted fee schedule amounts (i.e., no change from the current fee schedule amounts) through December 31, 2020, or the duration of the COVID-19 public health emergency, whichever is later.

(b) For items and services subject to the fee schedule adjustments furnished in non-rural contiguous non-CBAs, the fee schedule amounts will be based on a blend of 75 percent of the adjusted fee schedule amounts and 25 percent of the unadjusted fee schedule amounts (i.e., an increase in the fee schedule amounts) for claims with dates of service beginning March 6, 2020, and continuing until the end of the COVID-19 public

health emergency.

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 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. 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 MSA. A rural area also includes any ZIP Code within an MSA that is excluded from a competitive bidding area established for that MSA. A former CBA ZIP code file contains the competitive bidding area ZIP codes used in pricing a claim for an item furnished in a CBA and will be updated on a quarterly basis as necessary.

Additional information on the 2022 DMEPOS fee schedules is available in program instruction:

1. January 2022 Update for DMEPOS Fee Schedule, Transmittal 11137, Change Request 12521

B. Policy: The DMEPOS fee schedule file contains fee schedule amounts for non-rural and rural areas. Also, the PEN fee schedule file includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

This recurring update notification provides updates for the following files:

1. There are no updates to the DMEPOS fee schedule file for Quarter 2, 2022
2. DMEPOS Rural ZIP code file for Quarter 2, 2022
3. There are no updates to the Parenteral and Enteral Nutrition (PEN) fee schedule file for Quarter 2, 2022

These updates will also be available as Public Use Files (PUFs) for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule

Specific Coding and Pricing Issues

<u>New Codes Added</u>

New DMEPOS codes added to the Healthcare Common Procedure Coding System (HCPCS) file, effective April 1, 2022 are listed in Business Requirement (BR) 3 of this instruction. The new codes are not to be used for billing purposes until they are effective on April 1, 2022.

<u>Codes Deleted</u>

No codes are deleted from the DMEPOS fee schedule file effective April 1, 2022.

As part of this update, no fee schedules are added to the DMEPOS fee schedule file for new and revised HCPCS codes (A4238, E2102, K1028-K1033, V2525) effective April 1, 2022.

Until public consultation has been obtained on national Medicare benefit category determinations and/or payment determinations for these codes, the Medicare benefit category, coverage and/or payment determinations for these items will be made based on the discretion of the Medicare contractors processing any claims submitted for these items. Also, as explained below, new code E2102 for adjunctive continuous glucose monitors has been classified as DME and new code A4238 as supplies and accessories necessary for the effective use of DME described by code E2102. Public consultation on the national payment

determinations for these two new codes will be obtained using the process established by regulations 42 CFR 414.240. The DME Medicare Administrative Contractors (MACs) and A/B MACs Part B shall establish local fee schedule amounts to pay claims for all of the new codes listed above, when applicable, and payment should be made in accordance with the payment rules associated with each local payment determination (e.g., an item determined to be an expensive item of DME that is reasonable and necessary and not otherwise excluded from coverage by statute, regulations, an NCD or program instructions, must be paid on a capped rental basis in accordance with regulations at 42 CFR 414.229). Program instructions on DMEPOS gap-fill pricing are available in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.3 and 60.3.1.

Continuous Glucose Monitors (CGMs)

On December 28, 2021, the Centers for Medicare & Medicaid Services (CMS) published the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) final rule in the **Federal Register**(CMS-1738-F/CMS1687-F/CMS-5531-F) that addressed the classification and payment of adjunctive continuous glucose monitors (CGMs) under the Medicare Part B benefit for DME. The final rule is available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/dmeposfeesched

This rule expanded the classification of DME to a larger group of non-implantable CGMs, regardless of whether the CGMs are non-adjunctive (can alert patients when glucose levels are approaching dangerous levels, including while they sleep and also replace blood glucose monitors) or adjunctive (can alert patients when glucose levels may be approaching dangerous levels, including while they sleep but do not replace blood glucose monitors), as long as the CGMs otherwise satisfy the regulatory definition of DME (e.g., durable equipment used in the home). CMS is not aware at this time of an adjunctive CGM stand-alone receiver, transmitter and sensor system that meets the DME definition. However, adjunctive CGM supplies and accessories used in conjunction with an insulin pump that also performs the functions of an adjunctive CGM could be classified and covered under the DME benefit in cases where the beneficiary meets the Medicare coverage/medical necessity requirements for both an insulin pump and an adjunctive CGM.

Although the final rule classifies adjunctive CGMs as DME items, section 1862(a)(1)(A) of the Act would still prohibit Medicare payment for these items if they are determined to not be reasonable and necessary for the treatment of the diabetes illness. Until a local or national coverage determination is established for these items, contractors shall make coverage decisions regarding these items on a claim-by-claim basis.

<u>Adjunctive CGM Supplies and Accessories Furnished for Each Month of Use</u>

For dates of service February 28, 2022 through March 31, 2022, suppliers billing for adjunctive CGM supplies and accessories used in conjunction with an insulin pump that also perform the functions of an adjunctive CGM should use HCPCS code A9999 (Miscellaneous DME Supply or Accessory, Not Otherwise Specified) to bill for adjunctive CGM supplies and accessories furnished for each month of use.

Effective April 1, 2022, HCPCS codes A9276 and A9277 are invalid for Medicare use for billing individual CGM supplies and accessories and not reflective of a monthly allowance.

Effective April 1, 2022, the following code is added to the HCPCS file to describe a month's supply of adjunctive CGM supplies and accessories:

- A4238 Supply allowance for adjunctive continuous glucose monitor (CGM), includes all supplies and accessories, 1month supply = 1 unit of service

<u>Adjunctive CGM Monitor or Receiver for Each Month of Use</u>

For dates of service February 28, 2022 through March 31, 2022, suppliers shall use code E1399 (Durable medical equipment, miscellaneous) to describe an adjunctive continuous glucose monitor for this purpose

until code E2102 is effective.

Effective April 1, 2022, HCPCS code A9278 is invalid for Medicare use for billing adjunctive CGM receivers.

Effective April 1, 2022, the following code is added to the HCPCS file to describe the use of an insulin pump with an integrated adjunctive CGM receiver function:

- E2102 Adjunctive Continuous Glucose Monitor or Receiver

For dates of service on or after April 1, 2022, suppliers should bill as a rental (RR) both codes E0784 (External Ambulatory Infusion Pump, Insulin) and E2102 to describe the rental of an insulin pump with integrated adjunctive CGM receiver functionality.

Pricing for Continuous Glucose Monitors (CGMs)

Pricing for one month of adjunctive CGM supplies and accessories submitted under HCPCS code A9999, effective for dates of service February 28, 2022 through March 31, 2022, or A4238, effective for dates of service beginning April 1, 2022, will be based on local fee schedule amounts established by the DME MACs.

Pricing for an adjunctive CGM monitor submitted under HCPCS code E2102, effective for dates of service beginning April 1, 2022, or for E1399 (dates of service February 28 through March 31, 2022), will be based on local fee schedule amounts established by the DME MACs. In accordance with the provisions of the December 28, 2021 final rule, fee schedule amounts for the adjunctive CGM monitor or receiver as well as the monthly supplies and accessories for an adjunctive CGM monitor or receiver shall be established using existing fee schedule amounts for comparable items in accordance with regulations for gap-filling under 42 CFR 414.238(b). The final rule is entitled Medicare Program; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Policy Issues, and Level II of the Healthcare Common Procedure Coding System (HCPCS); DME Interim Pricing in the CARES Act; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas (86 FR 73902).

Additionally, payment for E2102 (or E1399 for dates of service between February 28, 2022 and March 31, 2022), shall only be available for the CGM receiver function of a rented insulin infusion pump if the beneficiary does not already own a CGM receiver of any kind (either adjunctive or non-adjunctive) that is less than five years old and the beneficiary does not already own an insulin pump of any kind that is less than five years old. In addition, switching from an insulin pump without the CGM receiver feature to an insulin pump with the CGM receiver feature does not result in an interruption in the period of continuous use for the insulin pump or the start of a new 13-month rental cap period for the insulin pump for the beneficiary. The supplier shall transfer title of the equipment to the beneficiary on the first day following the end of the 13th month of use by the beneficiary. Regulation 42 CFR 414.229(g) requires the supplier of the insulin pump in the first month must continue to furnish the pump for the remainder of the 13-month capped rental period or until medical necessity for the pump ends, whichever is earlier.

Note: The subject of HCPCS coding and payment for adjunctive CGMs will be included in a future HCPCS public meeting. Announcements of HCPCS public meetings can be found at https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSPublicMeetings

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	
12654.1	The DME MACs, A/B MACs Part B, A/B MACs Part A, A/B MACs Part HHH and/or the Virtual Data Centers (VDCs) shall retrieve the CY 2022 Rural ZIP code file (filename: MU00.@DMECBIC.RURZIP. C22Q02.V0311) on or after March 11, 2022.	X	X	X	X					VDC
12654.1.1	Contractors shall notify CMS of successful receipt via email to price_file_receipt@cms.hhs.gov stating the name of the file received (e.g., DMEPOS) and the entity receiving the file (e.g., include states, contractor/carrier numbers, quarter, and if Part A, Part B, or both).	X	X	X	X					VDC
12654.2	Contractors shall use the Rural Zip code file in requirement 1 to pay claims for items with dates of service beginning April 1, 2022. An April update to the 2022 DMEPOS and PEN fee schedule files is not required.	X	X	X	X					
12654.3	Contractors shall be aware the HCPCS codes listed below are being added to the HCPCS effective April 1, 2022 and shall be added to the Common Working File (CWF) categories (category codes in parentheses) and systems where necessary as follows: 1. A4238 (60) DME MACs 2. E2102 (60) DME MACs 3. K1028 (60, 67) DME MACs, A/B MACs 4. K1029 (60, 67) DME MACs, A/B MACs 5. K1030 (60, 67) DME MACs, A/B MACs 6. K1031 (60, 67) DME MACs, A/B MACs 7. K1032 (60, 67) DME MACs, A/B MACs 8. K1033 (60, 67) DME MACs, A/B MACs 9. V2525 (60, 67) DME MACs, A/B MACs		X		X				X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12654.4	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	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:

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):
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.

ATTACHMENTS: 0