DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

MLN Matters® Number: MM9642 **Related Change Request (CR) #: CR 9642**

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July Quarterly Update for 2016 Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule

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.

Provider Action Needed

Change Request (CR) 9642 advises providers of fee schedule amounts for codes in effect on January 1, 2016, and July 1, 2016, for all other changes. 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 schedules 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 quarterly update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60 (**https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf**).

Payment on a fee schedule basis is required by the Social Security Act (the Act) for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR

Section 414.102, for Parenteral and Enteral Nutrition (PEN), splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. 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 for the items, based on information from Competitive Bidding Programs (CBPs) for DME. The CBP product categories, HCPCS codes and Single Payment Amounts (SPAs) included in each Round of the CBP are available on the Competitive Bidding Implementation Contractor (CBIC) website (**http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home**). The changes for the Calendar Year (CY) 2016 are detailed in **MM9431**.

Adjusted Fee Schedule Amounts

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. The adjustments to the fee schedule amounts have been phased in for claims with dates of service January 1, 2016, through June 30, 2016, so that each fee schedule amount is based on a blend of 50 percent of the fee schedule amount that would have gone into effect on January 1, 2016, if not adjusted based on information from the CBP, and 50 percent of the adjusted fee schedule amount. As part of this update, for claims with dates of service on or after July 1, 2016, the July quarterly update files include the fee schedule amounts based on 100 percent of the adjusted fee schedule amounts. Information from CBPs that take effect on July 1, 2016 is factored into the adjusted fee schedule amounts effective on July 1, 2016, in accordance with the regulations at 42 CFR 414.210(g)(8).

Fee schedule amounts that are adjusted using information from CBPs will not be subject to the annual DMEPOS covered item update, but will be updated in accordance with 42 CFR 414.210(g)(8) when information from the CBPs is updated. Pursuant to 42 CFR §414.210(g)(4), for items where the Single Payment Amounts (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 would go into effect (for example, 2016 for this update) and for each subsequent year such as 2017, and 2018.

There are three general methodologies used in adjusting the fee schedule amounts:

1. Adjusted Fee Schedule Amounts for Areas Within the Contiguous United States

The average of 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 (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). The methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (those included in more than 10 Competitive Bidding Areas (CBAs)).

Also, 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 42 CFR 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.

2. Adjusted Fee Schedule Amounts for Areas Outside the Contiguous United States

Areas outside the contiguous United States (areas such as Alaska, Guam, Hawaii) 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.

3. Adjusted Fee Schedule Amounts for Items Included in 10 or Fewer CBAs

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. This methodology applies to all areas, non-contiguous and contiguous.

In order to apply the rural payment rule for areas within the contiguous United States, the DMEPOS fee schedule file is updated to include rural payment amounts for certain HCPCS codes where the adjustment methodology is based on average regional SPAs. Also, on the PEN file, the national fee schedule amounts for enteral nutrition transitions to statewide fee schedule amounts. For parenteral nutrition, the national fee schedule amount methodology remains unchanged.

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 based on information from the CBPs. ZIP codes for non-contiguous areas are not included in the DMEPOS Rural ZIP code file. The DMEPOS Rural ZIP code file is updated on a quarterly basis as necessary.

Key Points of CR9642

Public Use Files (PUFs)

In October 2015, CMS posted sample 2016 DMEPOS and PEN Medicare payment PUFs that were modified to accommodate the adjusted fee schedule amounts effective January 1, 2016. At that time, CMS communicated that different PUF file formats would be used for the January 2016 Excel file update as opposed to the July 2016 update and all subsequent fee schedule updates. CMS has recently determined that it is necessary to retain separate rural fee fields for each state and not transition, beginning July 1, 2016, to one field titled "Contiguous United States Rural Fee" as previously communicated. Therefore, beginning with the July 2016 update, the July DMEPOS and PEN Excel PUF record layouts will retain

the separate rural fees for each state as implemented January 1, 2016. As discussed above, the phase in of adjusted fees are based on 100 percent of the adjusted fee schedule amounts effective July 1, 2016. The rural fee for the contiguous United States, which is equal to the national ceiling amount, applies to all rural areas within the contiguous United States. However, in any case where the application of the adjusted fee methodology results in an increase in the fee schedule amount that would otherwise apply, the rural adjustment for an area/state is not made. Non-contiguous areas are not subject to rural fees under the CY 2016 DMEPOS fee schedule methodology.

The CY 2016 DMEPOS and PEN fee schedules and the July 2016 DMEPOS Rural ZIP code file PUFs will be available for State Medicaid Agencies, managed care organizations, and other interested parties shortly after the release of the data files at **http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched**.

KU Modifier for Complex Rehabilitative Power Wheelchair Accessories & Seat and Back Cushions

Section 2 of the Patient Access and Medicare Protection Act (PAMPA) mandates that the adjustments to the CY 2016 fee schedule amounts for certain DME based on information from CBPs not be applied to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs prior to January 1, 2017. Group 3 complex rehabilitative power wheelchair bases are currently described by codes K0848 through K0864 of the HCPCS.

As a result, the fees for wheelchair accessories and seat and back cushions denoted with the HCPCS modifier 'KU' are included in the July 2016 DMEPOS fee schedule file and are effective for dates of service January 1, 2016, through December 31, 2016. The fee schedule amounts associated with the KU modifier represent the unadjusted fee schedule amounts (the CY 2015 fee schedule amount updated by the 2016 DMEPOS covered item update factor of -0.4 percent) for these wheelchair accessory codes.

The codes for wheelchair accessories and seat and back cushions affected by this change along with claims processing instructions are available in CR9520 at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3535CP.pdf**. In accordance with that article, if brought to their attention, MACs may adjust claims for the Group 3 complex rehabilitative power wheelchair accessories referenced in Attachment A of related CR9520 for dates of service January 1, 2016, through June 30, 2016.

Discontinuation of KE Modifier for Items in Initial Round 1 CBP

As part of this update, the fees for certain items included in Round 1 CBP, denoted with the HCPCS pricing modifier 'KE', are deleted from the DMEPOS fee schedule file. Program instructions on the implementation of these fees and the list of applicable HCPCS codes were issued via CR6720, dated November 7, 2008 (see related article **MM6720**).

The KE fees were retained on the fee schedule file for dates of service January 1, 2016, through June 30, 2016, because of the phase-in of the adjusted fee schedule amounts, but are no longer needed.

Reclassification of Certain DME Included in CBPs

As part of this update, capped rental fees are established for payment of the following 14 HCPCS codes: E0197, E0140, E0149, E0985, E1020, E1028, E2228, E2368, E2369, E2370, E2375, K0015, K0070, and E0955.

For dates of service on or after July 1, 2016, these HCPCS codes are reclassified from the payment category for inexpensive and routinely purchased DME to payment on a capped rental basis in all areas except the 9 Round 1 Re-compete (Round 1 2014) CBAs. These changes are made to align the payment with the regulatory definition of routinely purchased equipment. Articles **MM8822** and **MM8566** discuss these program instructions.

When submitting claims, suppliers in areas outside of Round 1 Re-compete CBAs that furnish these 14 HCPCS codes on a capped rental basis use the capped rental modifiers KH, KI, and KJ as appropriate. Beginning January 1, 2017, payment for these codes in all geographic areas will be made on a capped rental basis.

Also, certain HCPCS codes for wheelchair options/accessories (E1020, E1028, E2368, E2369, E2370, E2375, K0015, and E0955) that are furnished to be used as part of a complex rehabilitative power wheelchair (wheelchair base codes K0835 – K0864) can be paid under the associated lump sum purchase option set forth in article **MM8566**.

The supplier must give the beneficiary the option of purchasing these accessories at the time they are furnished for initial or replacement. If the beneficiary declines the purchase option, the supplier must furnish the items on a capped rental basis and payment shall be made on a monthly rental basis in accordance with the capped rental payment rules.

Diabetic Testing Supplies (DTS)

The fee schedule amounts for non-mail order DTS without KL modifier for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4258 are not updated by the covered item update. In accordance with Section 636(a) of the American Taxpayer Relief Act of 2012, the fee schedule amounts for these codes were adjusted in CY 2013 so that they were equal to the SPAs for mail order DTS established in implementing the national mail-order CBP under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file are updated each time the single payment amounts are updated. As part of the this update, the non-mail order payment amounts on the fee schedule file for the above codes will be updated, effective July 1, 2016, using the SPAs established under the National Mail-Order Re-compete CBP.

As part of this update, the DTS mail order (with KL modifier) fee schedules for all states and territories are removed from the DMEPOS fee schedule file. The SPAs calculated under the National Mail-Order CBPs replace the mail order fee schedule amounts for diabetic

testing supply codes listed above. The SPAs are available at **http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home**.

The Northern Mariana Islands are not considered an area eligible for inclusion under a national mail order competitive bidding program. However, in accordance with Section 42 Code of Federal Regulations (CFR) 414.210(g) (7), the fee schedule amounts for mail order DTS furnished in the Northern Mariana Islands are adjusted to equal 100 percent of the SPAs established under the national mail-order competitive bidding program (79 FR 66232).

Because the Northern Mariana Islands adjustment is subject to the 6-month transition phase-in period, the adjusted Northern Mariana Island DTS mail order fees, which were based on 50 percent of the un-adjusted mail order fee schedule amounts and 50 percent of the adjusted mail order SPAs, were provided on the DMEPOS fee schedule file in the Hawaii column of the 8 mail-order (KL) DTS codes listed above for dates of service January 1, 2016, through June 30, 2016.

Beginning July 1, 2016, the fully adjusted mail order fees (the SPAs) will apply for mail order DTS furnished in the Northern Mariana Islands. As part of this update, the Northern Mariana Island DTS transition mail-order payment amounts will no longer appear in the Hawaii column of the fee schedule file and the DTS mail order (KL) fee schedules for all states and territories are removed from the DMEPOS fee schedule file as of July 1, 2016.

Specific Coding and Pricing Issues

As part of this update, fees are established for HCPCS codes A6450 and A6451 which were added to the HCPCS file in CY 2004. Claims for codes A6450 and A6451 with dates of service on or after January 1, 2016, that have already been processed may be adjusted to reflect the newly established fees if brought to your MAC's attention.

Additional Information

The official instruction, CR9642 issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3551CP.pdf** on the CMS website.

42 CFR 414.202 is available at **https://www.gpo.gov/fdsys/granule/CFR-2011-title42-vol3/CFR-2011-title42-vol3-sec414-202**.

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.