CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3277	**Date: May 29, 2015**
	Change Request 9177

Transmittal 3257, dated May 15, 2015 is being rescinded and replaced by Transmittal 3277, dated May 29, 2015, to remove Part B MAC responsibility for Business Requirements 9177.4-9177.5. All other information remains the same.

SUBJECT: July Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (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 recurring update notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: January 1, 2015 - for implementation of fee schedule amounts for codes in effect January 1, 2015; July 1, 2015 for all other changes.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

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: 3277	Date: May 29, 2015	Change Request: 9177

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SUBJECT: July Quarterly Update for 2015 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

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IMPLEMENTATION DATE: July 6, 2015

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

B. Policy: This recurring update notification (RUN) provides instructions regarding the July quarterly update for the 2015 DMEPOS fee schedule. 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. Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR §414.102 for parenteral and enteral nutrition (PEN), splints and casts, and intraocular lenses (IOLs) inserted in a physician's office.

Specific Coding and Pricing Issues

As part of this update, fees are established for Healthcare Common Procedure Coding System (HCPCS) code A4602 which was added to the HCPCS file effective January 1, 2015. This item has been paid on a local fee schedule basis prior to this update. Claims for code A4602 with dates of service on or after January 1, 2015 that have already been processed may not be adjusted to reflect newly established fees.

Section 203 of the Achieving a Better Life Experience (ABLE) Act of 2014 amended Section 1834(a)(1) of the Social Security Act to exclude Medicare coverage for vacuum erection systems. As of July 1, 2015 HCPCS codes describing vacuum erection systems are statutorily excluded from Medicare coverage and are not payable when billed to Medicare. The fee schedules for the following vacuum erection system HCPCS codes will be removed from the DMEPOS fee schedule file effective July 1, 2015:

L7900 Male vacuum erection system

L7902 Tension ring, for vacuum erection device, any type, replacement only, each

As part of the January 2015 update, fee schedules for HCPCS code A7048 Vacuum drainage collection unit and tubing kit, including all supplies needed for collection unit change, for use with implanted catheter, each were added to the DMEPOS fee schedule file. In response to questions received on these fee schedule amounts, we are providing the below clarification:

HCPCS code A7048 describes all supplies, including the appropriately sized collection container, that are needed for a collection unit change when draining an implanted catheter. A7048 is used for each single,

complete collection and represents a supply allowance rather than a specifically defined kit. Items included in this code are not limited to pre-packaged kits that are bundled by the manufacturers or distributors. The A7048 supplies include, but are not limited to drainage tubing, gauze, dressings and any number of collection units of various sizes needed to capture the drainage for each, complete drainage collection. Since included in A7048, supplies that are used in a collection change should not be separately billed using miscellaneous codes.

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	
9177.1	The DME MACs, Part B MACs and/or VDCs shall retrieve the DMEPOS fee schedule file (filename: MU00.@BF12393.DMEPOS.T150101.V0514. The file is available for download on or after May 14, 2015.		X		X					VDC
9177.1.1	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					
9177.2	The Part A MACs, HHH MACs and/or VDCs shall retrieve the DMEPOS fee schedule file (filename:MU00.@BF12393.DMEPOS.T150101.V0514.FI). The file is available for download on or after May 14, 2015.	X		X						VDC
9177.2.1	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
9177.3	Contractors shall use the 2015 fee schedule amounts from the DMEPOS fee schedule files(s) of business requirements 1 and 2 to pay claims with dates of service on or after Jan. 1, 2015.	X	X	X	X					
9177.4	Effective for claims with dates of service on or after July 1, 2015, contractors shall deny claims submitted with HCPCS codes L7900 and L7902. Contractors shall use the following group code, claim adjustment reason code, remittance advice remark code, and Medicare Summary Notice (MSN) messages when denying these statutorily excluded services:	X		X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	Group Code -PR – "Patient Responsibility." Claim Adjustment Reason Codes (CARC) 96 - Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Remittance Advice Remark Code (RARC) N425 – "Statutorily excluded service(s)." MSN messages: 16.10 – "Medicare does not pay for this item or service." 16.10 – "Medicare no paga por este artículo o servicio."									
9177.4.1	Contractors shall follow existing procedures for denying statutorily non-covered items, when these codes are billed with the "GY" modifier.	X		X	X					
9177.5	Claims for code A4602 with dates of service on or after January 1, 2015 that have already been processed shall not be adjusted.	X		X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
9177.6	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	X	X	X	X	

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	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.					

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): Anita Greenberg, Anita.Greenberg@cms.hhs.gov, Karen Jacobs, Karen.Jacobs@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