DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

REVISED product from the Medicare Learning Network® (MLN):

- "Medicare Enrollment and Claim Submission Guidelines", Booklet, ICN 906764, Downloadable and hard copy

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Calendar Year (CY) 2014 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Note: This article was revised on March 6, 2014, to provide updates regarding HCPCS codes changes that were effective January 1, 2014. The changes are on page 2 (bold). All other information remains unchanged.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for DMEPOS items or services paid under the DMEPOS fee schedule.

What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 8531 to advise providers of the Calendar Year (CY) 2014 annual update for the Medicare DMEPOS fee schedule. The instructions include information on the data files, update factors, and other information related to the update of the DMEPOS fee schedule. Make sure your staffs are aware of these updates.

Background and Key Points of CR8531

The DMEPOS fee schedules are updated on an annual basis in accordance with statute and regulations. The update process for the DMEPOS fee schedule is located in the "Medicare Claims Processing Manual," Chapter 23, Section 60, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.
Payment on a fee schedule basis is required for Durable Medical Equipment (DME), prosthetic devices, orthotics, prosthetics, and surgical dressings by Section1834 (a), (h), and (i) of the Social Security Act (the Act). Also, payment on a fee schedule basis is a regulatory requirement at 42 CFR Section 414.102 for Parenteral and Enteral Nutrition (PEN) and splints, casts, and certain intraocular lenses.

Fee Schedule Files

The DMEPOS fee schedule file will also be available for providers and suppliers, as well as State Medicaid Agencies, managed care organizations, and other interested parties at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/ on the CMS website.

Healthcare Common Procedure Coding System (HCPCS) Codes Added/ Deleted

The following new codes are effective January 1, 2014;

- A7047 in the inexpensive/routinely purchased (IN) payment category;
- E0766 in the frequently serviced (FS) payment category; and
  E1352.

The following new codes are in the prosthetics and orthotics (PO) payment category: L5969, L8679, L0455, L0457, L0467, L0469, L0641-L0643, L0648-L0651, L1812, L1833, L1848, L3678, L3809, L3916, L3918, L3924, L3930, L4361, L4387, and L4397.

The following code is deleted from the HCPCS effective January 1, 2014, and therefore, is removed from the DMEPOS fee schedule files: L0430

The following codes are deleted from the DMEPOS fee schedule files as of January 1, 2014: A4611, A4612, A4613, E0457, E0459, L8685, L8686, L8687, and L8688.

For gap-filling purposes, the 2013 deflation factors by payment category are listed in the following table:

Factor	Category
0.469	Oxygen
0.472	Capped Rental
0.473	Prosthetics and Orthotics
0.600	Surgical Dressings
0.653	Parental and Enteral Nutrition

Specific Coding and Pricing Issues

As part of this update, fee schedules for the following codes will be added to the DMEPOS fee schedule file effective January 1, 2014:

- A4387 Ostomy Pouch, Closed, With Barrier Attached, With Built-In Convexity, (I Piece), Each; and
- L3031 Foot, Insert/Plate, Removable, Addition to Lower Extremity Orthotic, High Strength, Lightweight Material, All Hybrid Lamination/Prepreg Composite, Each.

CMS is adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 as part of this update in order to reflect more current allowed service data. Section 1833(o)(2)(C) of the Act required that the payment amounts for shoe modification codes A5503 through A5507 be established in a manner that prevented a net increase in expenditures when substituting these items for therapeutic shoe insert codes,A5512 or A5513. To establish the fee schedule amounts for the shoe modification codes, the base fees for codes A5512 and A5513 were weighted based on the approximated total allowed services for each code for items furnished during the second quarter of CY2004. For 2014, CMS is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with more current allowed service data for each insert code. The base fees for A5512 and A5513 will be weighted based on the approximated total allowed services for each code for items furnished during the Calendar Year 2012. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2014.

Off-the-Shelf Orthotics

Section 1847(a)(2)(C) of the Act mandates implementation of competitive bidding programs throughout the United States for awarding contracts for furnishing Off-The-Shelf (OTS) orthotics which require minimal self-adjustment for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit the individual. Regulations at 42 CFR 414.402 define the term “minimal self-adjustment” to mean an adjustment that the beneficiary, caretaker for the beneficiary, or supplier of the device can perform and that does not require the services of a certified orthotist,an individual who is certified by the American Board for Certification in Orthotics and Prosthetics, Inc, or by the Board for Orthotist/Prosthetist Certificationor an individual who has specialized training.

As shown in the following table, 22 new codes are added to the HCPCS for OTS orthotics. In addition, as part of the review to determine which HCPCS codes for prefabricated orthotics describe OTS orthotics, it was determined that HCPCS codes for prefabricated orthotics describe items that are furnished OTS and items that require expertise in customizing the orthotic to fit the individual patient. Therefore, it was necessary to explode these codes into two sets of codes. One set is the existing codes revised, effective January 1, 2014, to only describe devices customized to fit a specific patient by an individual with expertise and a second set of new codes describing the OTS items.

Also, as shown in the table that follows for CY 2014, the fee schedule amounts for existing codes will be applied to the corresponding new codes added for the items furnished OTS. The cross walking of fee schedule amounts for a single code that is exploded into two codes for distinct complete items is in accordance with the instructions found in the "Medicare Claims Processing Manual," Chapter 23,

Section 60.3.1, which is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf on the CMS website.

Prefabricated Orthotic Codes Split into Two Codes—Effective January 1, 2014

Fee from Existing Code	Crosswalk to New Off-The-Shelf and Revised Custom Fitted Orthotic Codes
L0454	L0455 and L0454
L0456	L0457 and L0456
L0466	L0467 and L0466
L0468	L0469 and L0468
L0626	L0641 and L0626
L0627	L0642 and L0627
L0630	L0643 and L0630
L0631	L0648 and L0631
L0633	L0649 and L0633
L0637	L0650 and L0637
L0639	L0651 and L0639
L1810	L1812 and L1810
L1832	L1833 and L1832
L1847	L1848 and L1847
L3807	L3809 and L3807
L3915	L3916 and L3915
L3917	L3918 and L3917
L3923	L3924 and L3923
L3929	L3930 and L3929
L4360	L4361 and L4360
L4386	L4387 and L4386
L4396	L4397 and L4396

Further information on the development of new OTS orthotic codes can be found at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/OTS_Orthotics.html on the CMS website.

Neurostimulator Devices

HCPCS codes, L8685, L8686, L8687, and L8688 are not included on the 2014 DMEPOS fee schedule file. They were removed from the file to reflect the change in the coverage indicators for these codes to invalid for Medicare ("I") effective January 1, 2014. However, code L8679 (Implantable Neurostimulator, Pulse Generator, Any Type) is added to the HCPCS and DMEPOS fee schedule file, effective January 1, 2014, for billing Medicare claims previously submitted under L8685, L8686, L8687 and L8688. The fee schedule amounts for code L8679 are based on the established Medicare fee schedule amounts for all types of pulse generators under the previous HCPCS code E0756 Implantable Neurostimulator Pulse Generator which was discontinued effective 12/31/2005. The payment amount is based on the explosion of code E0756 into four codes for different types of neurostimulator pulse generator systems which were not materially utilized in the Medicare program. As such, payment for code L8679 will revert back to the fee schedule amounts previously established for code E0756.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order diabetic testing supplies, without KL modifier, for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the covered item update for CY 2014. 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 are equal to the single payment amounts for mail order Diabetic Testing Supplies (DTS) established in implementing the national mail order Competitive Bidding Program (CBP) under Section 1847 of the Act. The non-mail order payment amounts on the fee schedule file will be updated each time the single payment amounts are updated which can happen no less often than every three years as CBP contracts are recompeted. The national CBP for mail order diabetic supplies is effective July 1, 2013, to June 30, 2016. The program instructions reviewing these changes are Transmittal 2709, Change Request (CR) 8325, dated May 17, 2013, and Transmittal 2661, Change Request (CR) 8204, dated February 22, 2013. You may review the MLN Matters® Articles for these CRs at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8325.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8204.pdf on the CMS website.

Although for payment purposes the single payment amounts replace the fee schedule amounts for mail order DTS (KL modifier), the fee schedule amounts remain on the DMEPOS fee schedule file as reference data such as for establishing bid limits for future rounds of competitive bidding programs. The mail order DTS fee schedule amounts shall be updated annually by the covered item update, adjusted for Multi-Factor Productivity (MFP), which results in update of 1.0 percent for CY 2014. The single payment amount public use file for the national mail order competitive bidding program is available

http://www.dmecompetitivebid.com/palmetto/cbicrd2.nsf/DocsCat/Single%20Payment%20Amounts on the Internet.

CY2014 Fee Schedule Update Factor

For CY 2014, the update factor of 1.0 percent is applied to the applicable CY 2013 DMEPOS fee schedule amounts. In accordance with the statutory Sections 1834(a)(14) and 1886(b)(3)(B)(xi)(II) of the Act, the DMEPOS fee schedule amounts are to be updated for 2014 by the percentage increase in the consumer price index for all urban consumers (United States city average) or CPI-U for the 12-month period ending with June of 2013, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private non-farm business Multi-Factor Productivity (MFP).

The MFP adjustment is 0.8 percent and the CPI-U percentage increase is 1.8 percent. Thus, the 1.8 percentage increase in the CPI-U is reduced by the 0.8 percentage increase in the MFP resulting in a net increase of 1.0 percent for the update factor.

2014 Update to the Labor Payment Rates

The 2014 fees for HCPCS labor payment codes K0739, L4205, and L7520 are increased 1.8 percent effective for claims with dates of service from January 1, 2014, through December 31, 2014 and those rates are as follows:

STATE	K0739	L4205	L7520
AK	$27.40	$31.22	$36.73
AL	14.55	21.68	29.43
AR	14.55	21.68	29.43
AZ	17.99	21.66	36.21
CA	22.32	35.59	41.48
CO	14.55	21.68	29.43
CT	24.30	22.16	29.43
DC	14.55	21.66	29.43
DE	26.79	21.66	29.43
FL	14.55	21.68	29.43
GA	14.55	21.68	29.43
HI	17.99	31.22	36.73
IA	14.55	21.66	35.23
ID	14.55	21.66	29.43

STATE	K0739	L4205	L7520
NC	14.55	21.68	29.43
ND	18.13	31.16	36.73
NE	14.55	21.66	41.04
NH	15.62	21.66	29.43
NJ	19.63	21.66	29.43
NM	14.55	21.68	29.43
NV	23.18	21.66	40.12
NY	26.79	21.68	29.43
OH	14.55	21.66	29.43
OK	14.55	21.68	29.43
OR	14.55	21.66	42.32
PA	15.62	22.30	29.43
PR	14.55	21.68	29.43
RI	17.34	22.32	29.43

STATE	K0739	L4205	L7520
IL	14.55	21.66	29.43
IN	14.55	21.66	29.43
KS	14.55	21.66	36.73
KY	14.55	27.76	37.64
LA	14.55	21.68	29.43
MA	24.30	21.66	29.43
MD	14.55	21.66	29.43
ME	24.30	21.66	29.43
MI	14.55	21.66	29.43
MN	14.55	21.66	29.43
MO	14.55	21.66	29.43
MS	14.55	21.68	29.43
MT	14.55	21.66	36.73

STATE	K0739	L4205	L7520
SC	$14.55	21.68	29.43
SD	16.26	21.66	39.35
TN	14.55	21.68	29.43
TX	14.55	21.68	29.43
UT	14.59	21.66	45.83
VA	14.55	21.66	29.43
VI	14.55	21.68	29.43
VT	15.62	21.66	29.43
WA	23.18	31.77	37.74
WI	14.55	21.66	29.43
WV	14.55	21.66	29.43
WY	20.28	28.89	41.04

2014 National Monthly Payment Amounts for Stationary Oxygen Equipment

CR8531 implements the 2014 national monthly payment amount for stationary oxygen equipment (HCPCS codes E0424, E0439, E1390, and E1391), effective for claims with dates of service on or after January 1, 2014. As required by statute, the payment amount must be adjusted on an annual basis, as necessary, to ensure budget neutrality of the new payment class for Oxygen Generating Portable Equipment (OGPE). The updated 2014 monthly payment amount of $178.24 includes the 1 percent update factor for the 2014 DMEPOS fee schedule.

Please note that when updating the stationary oxygen equipment fees, corresponding updates are made to the fee schedule amounts for HCPCS codes E1405 and E1406 for oxygen and water vapor enriching systems. Since 1989, the fees for codes E1405 and E1406 have been established based on a combination of the Medicare payment amounts for stationary oxygen equipment and nebulizer codes E0585 and E0570, respectively.

2014 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

CR8531 also updates the 2014 payment amount for maintenance and servicing for certain oxygen equipment. You can read more about payment for claims for maintenance and servicing for oxygen equipment in MLN Matters® Articles,MM6792 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6792.pdf and MM6990 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM6990.pdf on the CMS website.

To summarize, payment for maintenance and servicing of certain oxygen equipment can occur every 6 months beginning 6 months after the end of the 36th month of continuous use or end of the supplier's or manufacturer's warranty, whichever is later for either HCPCS code E1390, E1391, E0433 or K0738, billed with the "MS" modifier. Payment cannot occur more than once per beneficiary, regardless of the combination of oxygen concentrator equipment and/or transfilling equipment used by the beneficiary, for any 6-month period.

Per 42 CFR 414.210(5)(iii), the 2010 maintenance and servicing fee for certain oxygen equipment was based on 10 percent of the average price of an oxygen concentrator. For CY 2011 and subsequent years, the maintenance and servicing fee is adjusted by the covered item update for DME as set forth in Section1834(a)(14) of the Act. Thus, the 2013 maintenance and servicing fee is adjusted by the 1 percent MFP-adjusted covered item update factor to yield a CY 2014 maintenance and servicing fee of $68.73 for oxygen concentrators and transfilling equipment.

Additional Information

The official instruction, CR8531 issued to your MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2836CP.pdf on the CMS website.

If you have any questions, please contact your MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

News Flash - Generally, Medicare Part B covers one flu vaccination and its administration per flu season for beneficiaries without co-pay or deductible. Now is the perfect time to vaccinate beneficiaries. Health care providers are encouraged to get a flu vaccine to help protect themselves from the flu and to keep from spreading it to their family, co-workers, and patients. Note: The flu vaccine is not a Part D-covered drug. For more information, visit:

- MLN Matters® Article #MM8433, "Influenza Vaccine Payment Allowances - Annual Update for 2013-2014 Season"
- MLN Matters® Article #SE1336, "2013-2014 Influenza (Flu) Resources for Health Care Professionals"
- HealthMap Vaccine Finder - a free, online service where users can search for locations offering flu and other adult vaccines. While some providers may offer flu vaccines, those that don't can help their patients locate flu vaccines within their local community.
- The CDC website for Free Resources, including prescription-style tear-pads that allow you to give a customized flu shot reminder to patients at high-risk for complications from the flu.