Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedules

Medicare payment for durable medical equipment (DME), prosthetics and orthotics (P&O), parenteral and enteral nutrition (PEN), surgical dressings, and therapeutic shoes and inserts is equal to 80 percent of the lower of either the actual charge for the item or the fee schedule amount calculated for the item, less any unmet deductible. The beneficiary is responsible for 20 percent of the lower of either the actual charge for the item or the fee schedule amount calculated for the item, plus any unmet deductible. The DME and P&O fee schedule payment methodology is mandated by section 4062 of the Omnibus Budget Reconciliation Act (OBRA) of 1987, which added section 1834(a) to the Social Security Act. OBRA of 1990 added a separate subsection, 1834(h), for P&O. The DME and P&O fee schedules were implemented on January 1, 1989 with the exception of the oxygen fee schedules, which were implemented on June 1, 1989. Section 13544 of OBRA of 1993, which added section 1834(i) to the Social Security Act, mandates a fee schedule for surgical dressings; the surgical dressing fee schedule was implemented on January1, 1994. Section 4315 of the Balanced Budget Act of 1997, which added section 1842(s) to the Social Security Act, authorizes a fee schedule for PEN, which was implemented on January 1, 2002. Section 627 of the Medicare Modernization Act of 2003 mandates fee schedule amounts for therapeutic shoes and inserts effective January 1, 2005, calculated using the P&O fee schedule methodology in section 1834(h) of the Social Security Act. Payment on a fee schedule basis is a regulatory requirement at CFR §414.102 for splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. Effective January 1, 2024, the DMEPOS fee schedule file will include national payment amounts for lymphedema compression treatment items established in accordance with §1834(z) of the Act and regulations at 42 CFR §414.1650.

Section 1834(a)(1)(F)(ii) of the Act mandates the adjustment of fee schedule amounts for certain DME items furnished on or after January 1, 2016, based on information from competitive bidding programs (CBPs). Also, on or after January 1, 2016, fee schedule amounts for enteral nutrients, equipment, and supplies (enteral nutrition) are adjusted based on information from CBPs in accordance with section 1842(s)(3)(B) of the Act.

I. DME Fee Schedule Payment Methodology

The DME fee schedules are calculated for the following DME payment classes:

- INEXPENSIVE AND OTHER ROUTINELY PURCHASED ITEMS (Section 1834(a)(2))

  These items have a purchase price of $150 or less, were routinely purchased (75 percent of the time or more) under the rent/purchase program prior to 1989, are speech generating devices, or are accessories used in conjunction with nebulizers, aspirators, continuous positive airway pressure devices, respiratory assist devices, or speech generating devices. If covered, these items can be purchased new or used and can be rented; however, total payments cannot exceed the purchase new fee for the item.

- FREQUENTLY SERVICED ITEMS (Section 1834(a)(3))

These items require frequent and substantial servicing to avoid risk to the patient's health. Examples of such items are provided in section 1834(a)(3)(A). If covered, these items can be rented as long as the item is medically necessary.

o OXYGEN AND OXYGEN EQUIPMENT (Section 1834(a)(5))

Medicare payment for oxygen and oxygen equipment is made on a monthly rental basis. Onebundled monthly payment amount is made for all covered stationary equipment, stationary and portable contents, and all accessories used in conjunction with the oxygen equipment. An add-on payment may also be made for those beneficiaries who require portable oxygen. Per the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), effective January 1, 2009, Medicare payment for oxygen equipment may not continue beyond 36 months of continuous use. After the 36-month rental cap, Medicare will continue to make monthly rental payments for oxygen contents. In addition, payment for in-home maintenance and servicing of supplier-owned oxygen concentrators and transfilling equipment may be made every 6 months, beginning 6 months after the 36-month rental cap, for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Payment is made monthly for oxygen contents for beneficiaries who own liquid or gaseous oxygen equipment. Effective April 1, 2021, a budget neutrality offset, set forth in section 1834(a)(9)(D)(ii) of the Act, is no longer applied to oxygen payment classes and items in accordance with section 121 of division H of title II of the Consolidated Appropriations Act of 2021 (P.L. 116-260).

o OTHER COVERED ITEMS (OTHER THAN DME) (Section 1834(a)(6))

These are supplies that are necessary for the effective use of DME. Medicare payment is made for the purchase of these supplies, if covered.

o CAPPED RENTAL ITEMS (Section 1834(a)(7))

These are items of DME that do not fall under any of the other DME payment categories. In general, Medicare pays for the rental of these items, when covered, for a period of continuous use not to exceed 13 months, at which point the beneficiary takes over ownership of the equipment. Complex rehabilitative power wheelchairs can be purchased in the first month of use.

For capped rental items other than power wheelchairs, the fee schedule amount is calculated based on 10 percent of the base year purchase price increased by the covered item update. This is the fee schedule amount for months 1 thru 3. Beginning with the fourth month, the fee schedule amount is equal to 75 percent of the fee schedule amount paid in the first three rental months. For power wheelchairs, the fee schedule amount is calculated based on 15 percent of the base year purchase price increased by the covered item update. This is the fee schedule amount for months 1 thru 3. Beginning with the fourth month, the fee schedule amount is equal to 40 percent of the fee schedule amount paid in the first three rental months. The changes to the capped rental payment

methodology for power wheelchairs per the Affordable Care Act of 2010 apply to power wheelchairs in which the first rental month is on or after January 1, 2011. The purchase fee schedule amount for complex rehabilitative power wheelchairs is equal to the rental fee (for months 1 thru 3) divided by 0.15.

Fee schedule amounts are not calculated for customized DME:

o CERTAIN CUSTOMIZED ITEMS (Section 1834(a)(4))

If covered, Medicare payment is made in a lump-sum amount for the purchase of the item; this payment amount is based on the DME Medicare Administrative Contractor (MAC), Part A MAC, or Part B MAC's individual consideration for that item. Customized DME is defined at 42 CFR 414.224, and this definition applies to all DME, including wheelchairs. In the case of wheelchairs, the definition at section 414.224 supersedes the definition written into section 1834(a)(4) of the Act by section 4152(c)(4)(B) of the Omnibus Budget Reconciliation Act (OBRA) of 1990. Section 4152(c)(4)(B)(ii) of OBRA of 1990 provided this as an optional definition for customized wheelchairs. This optional definition was not adopted and the definition at section 414.224 therefore applies to all DME, including wheelchairs.

National Ceiling and Floor Limits for Surgical Dressings and Certain DME

The fee schedule amounts for surgical dressings and the fee schedule amounts for DME items that are not adjusted based on competitive bidding information are calculated on a statewide basis and are limited by national ceilings and floors. The fee schedule ceiling is equal to the median or mid-point of the statewide fee schedule amounts. The fee schedule floor is equal to 85 percent of the median of the statewide fee schedule amounts.

Prosthetics & Orthotics Fee Schedule Payment Methodology

Regional purchase (new) fee schedule amounts are calculated for P&O (section 1834(h)). The P&O payment class includes: ostomy, tracheostomy, and urological supplies; orthotics; prosthetics; prosthetic devices; and certain vision services. The regional fees are equal to the weighted average of the statewide fees in each CMS DME MAC region.

Per OBRA of 1993, effective January 1, 1994, the purchase (new) fee schedule amounts for ostomy, tracheostomy, and urological supplies are calculated using the same methodology as the purchase (new) fee schedule amounts for inexpensive or routinely purchased items of DME. As a result, these items are not subject to regional fee schedules. A fee schedule ceiling and floor, based on the median and 85 percent of the median, respectively, of the local fee schedule amounts are calculated for each item. Thefee schedule amounts for these items are updated by the ostomy, tracheostomy, and urological supplies covered item updates.

National Ceiling and Floor Limits for Prosthetics & Orthotics (P&O)

The P&O regional fee schedule amounts are limited by a ceiling (120% of the average of the regional statewide fees) and a floor (90% of the average of the regional

statewide fees).

Parenteral and Enteral nutrition (PEN) Fee Schedule Payment Methodology

The payment methodology for PEN changed effective January 1, 2002. Section 4315 of the Balanced Budget Act of 1997, which added section 1842(s) to the Social Security Act, authorizes a fee schedule for PEN. The fee schedule for parenteral nutrition is a national fee schedule (i.e., no variation from state to state). Effective January 1, 2016, the fee schedule amounts for enteral nutrition are statewide amounts adjusted based on information from competitive bidding programs.

Lymphedema Compression Treatment Items Payment Methodology

Section 4133 of the Consolidated Appropriations Act (CAA), 2023 established a new benefit category for standard and custom fitted compression garments and additional lymphedema compression treatment items under Medicare Part B. Effective January 1, 2024, national payment amounts developed in accordance with the methodology in section 1834(z) of the Act and regulations at 42 CFR section 414.1650 are added to the DMEPOS fee schedule file. Section 1833(a)(1)(GG) of the Act sets Medicare payment for lymphedema compression treatment items equal to 80 percent of the lesser of the supplier's charge for the item or the payment amount.

Per 42 CFR §414.1650, where Medicaid state plan payment amounts are available for a lymphedema compression treatment item, the Medicare national payment amount for the item is established using 120 percent of the average of Medicaid payment amounts. Where Medicaid state plan payment amounts are not available for an item, the Medicare national payment amount for the item is established using the average of internet retail prices and payment amounts established by TRICARE insurance program. If TRICARE payment amounts are not available for the item, the Medicare national payment amount for the item is established using average internet retail prices.

The national payment amounts for lymphedema compression treatment items are increased on an annual basis beginning on January 1 of the year subsequent to the year in which the payment amounts are initially established based on the percent change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year.

II. Methodologies for Adjusting Fee Schedule Amounts for Certain DME and PEN Codes using Information from DMEPOS Competitive Bidding Programs (CBPs)

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 for the items, based on information from competitive bidding programs (CBPs) for DME. 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 CBPs. The methodologies for adjusting DMEPOS fee schedule amounts using

information from CBPs are established in regulations at 42 CFR §414.210(g). There arethree general methodologies used to establish the adjusted fee schedule amounts:

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

The average of Single Payment Amounts from CBPs located in eight different regions of the contiguous United States are used to establish the fee schedule amounts for the states located in each of the eight regions. These regional SPAs or 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). This methodology applies to enteral nutrition and most DME items furnished in the contiguous United States (i.e., those included in more than 10 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 §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 competitive bidding area (CBA) established for that MSA.

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

The adjusted fee schedule amounts 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 Less Competitive Bidding areas (CBA)

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 (i.e., non-contiguous and contiguous).

4. Transition Payment Rules

Effective January 1, 2016 through June 30, 2016, the adjusted fee schedule amounts were transitioned based on 50 percent of the adjusted payment amount established using competitive bidding information and 50 percent of the unadjusted fee schedule amount. Section 16007(a) of the 21st Century Cures Act of 2016 extended this transition through December 31, 2016. Also, section 16007 of the Cures Act required that payment be based on 100 percent of the adjusted payment amounts in non-bid areas effective January 1, 2017.

Pursuant to the interim final rule with comment period (CMS-1687-IFC) published on Friday, May 11, 2018, effective June 1, 2018 through December 31, 2018, rural and non-contiguous

(Alaska, Hawaii, and United States territories) fee schedule amounts are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Social Security Act.

5. Fee Schedule Adjustments for 2019 – 2024

Beginning January 1, 2019 through December 31, 2020, the adjusted fee schedule amounts for items furnished in non- competitively bid rural and non-contiguous areas are based on a blend of 50 percent of the adjusted fee schedule amount and 50 percent of the unadjusted fee schedule amounts updated by the covered item updates specified in sections 1834(a)(14) and 1842(s)(B) of the Act (CMS- 1691-F). Section 3712(a) of the CARES Act extended the above methodology for items furnished in rural and non-contiguous non-CBAs through December 31, 2020 or through the duration of the COVID-19 Public Health Emergency (PHE), whichever is later. For non-competitively bid areas other than rural or non-contiguous areas, the fee schedules for DME and PEN codes with adjusted fee schedule amounts are based on 100 percent of the adjusted fee schedule amounts from January 1, 2019 through March 5, 2020. Section 3712(b) of the CARES Act requires payment in non-competitively bid areas other than rural or non-contiguous areas be based on a blend of 75 percent of the adjusted fee schedule amount and 25 percent of the unadjusted fee schedule amount from March 6, 2020 through the duration of the PHE. Section 4139 of the Consolidated Appropriations Act, 2023 requires that payment in non-competitively bid areas other than rural or non-contiguous areas continue to be based on a blend of 75 percent of the adjusted fee schedule amount and 25 percent of the unadjusted fee schedule amount through the duration of the PHE or December 31, 2023, whichever is later. Also, payment for items and services furnished in rural and non-contiguous non-competitively bid areas continues to be based on a blend of 50 percent of the adjusted fee schedule amounts and 50 percent of the unadjusted fee schedule amounts in accordance with 42 CFR 414.210(g)(9) for the duration of the COVID-19 PHE or December 31, 2023, whichever is later.

The COVID-19 public health emergency ended on May 11, 2023. Beginning January 1, 2024, the fee schedule amounts for items and services furnished in non-competitively bid areas other than rural or non-contiguous areas is based on 100 percent of the fee schedule amounts adjusted in accordance with §414.210(g). As of January 1, 2024, payment for items and services furnished in rural and non-contiguous non-competitively bid areas continues to be based on a blend of 50 percent of the adjusted fee schedule amounts and 50 percent of the unadjusted fee schedule amounts in accordance with 42 CFR 414.210(g)(2).

Beginning January 1, 2019, the fee schedule amounts for competitively bid items furnished in former CBAs during a temporary gap in the DMEPOS CBP are based on the SPAs in effect in the CBA on the last day before the CBP contract periods of performance ended, increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. If the gap in the CBP lasts for more than 12 months, the fee schedule amounts are increased once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U. This payment adjustment methodology is applied to mail order diabetic testing supplies beginning January 1, 2019. Payment for

non-mail order diabetic testing supplies, beginning January 1, 2019, continues to be based on the SPAs established under the national mail order competition for diabetic testing supplies.

III. Wheelchair Accessories and Seat and Back Cushions used with Complex Rehabilitative Manual Wheelchairs, Certain Manual Wheelchairs, and Group 3 Power Wheelchairs

Section 2 of Patient Access and Medicare Protection Act (PAMPA) of 2015 required that the adjustments to the fee schedule amounts for durable medical equipment using competitive bidding information 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. Section 16005 of the 21st Century Cures Act extended the date through June 30, 2017 and beginning July 1, 2017, CMS established payment for these items based on the standard unadjusted fee schedule amounts. The Further Consolidated Appropriations Act, 2020 required the non-application of fee schedule adjustments based on information from competitive bidding programs for wheelchair accessories and seat and back cushions furnished in connection with complex rehabilitative manual wheelchairs and certain manual wheelchairs currently described by HCPCS codes E1235, E1236, E1237, E1238 and K0008 during the period January 1, 2020 through June 30, 2021. Rulemaking (CMS-1748-F) finalized an exclusion for accessories (including seating systems) and seat and back cushions furnished in connection with Group 3 complex rehabilitative power wheelchairs from the fee schedule adjustments under section 1834(a)(1)(F) of the Act. This fee schedule adjustment exclusion was also extended to wheelchair accessories (including seating systems) and seat and back cushions furnished in connection with complex rehabilitative manual and certain other manual wheelchairs described by HCPCS codes E1161, E1231, E1232, E1233, E1234, E1235, E1236, E1237, E1238, K0005 and K0008. Therefore, payment for these items when furnished in connection with a Group 3 power wheelchair, complex rehabilitative or certain manual wheelchair will continue to be based on the unadjusted fee schedule amounts updated in accordance with section 1834(a)(14) of the Act.

IV. Updating the DMEPOS Fee Schedule

The DMEPOS fee schedules are calculated by CMS. The CMS issues instructions for implementing and/or updating DMEPOS payment amounts on a quarterly basis as necessary. Updates to the payment amounts adjusted using information from the competitive bidding program (CBP) will be made each time the payment amounts under the CBPs are adjusted or additional CBPs or payment amounts are established for the items and services.

The DMEPOS fee schedule files are released to DME MACs, the Pricing, Data Analysis and Coding Contractor (PDAC), A/B MACs Part B, A/B MACs Part A, A/B MACs Part Home Health and Hospice (HHH), Railroad Retirement Board (RRB), Indian Health Service and United Mine Workers via CMS mainframe telecommunication system. The fee schedule for parenteral and enteral nutrition (PEN) is released to the PDAC and DME MACs in a separate file. Also, DMEPOS and PEN fee schedule files are available on the CMS Website for State Medicaid agencies, managed care organizations, and other interested parties.