CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 12068	**Date: June 2, 2023**
	Change Request 13235

SUBJECT: July Quarterly Update for 2023 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update on a quarterly basis the DMEPOS fee schedules, 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: July 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2023

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
R	23/60/Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
R	23/60/1/Record Layout for DMEPOS Fee Schedule
R	23/60/3/Gap-filling DMEPOS Fees
R	23/60/3/1/Payment Concerns While Updating Codes
R	23/60/4 Process for Submitting Revisions to DMEPOS Fee Schedule to CMS

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: 12068	Date: June 2, 2023	Change Request: 13235

SUBJECT: July Quarterly Update for 2023 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

EFFECTIVE DATE: July 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2023

I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the DMEPOS fee schedule 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 Subsection (§)1834(a), (h), and (i) of the Social Security Act (the Act). In addition, 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 and the Consolidated Appropriations Act, 2023

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. 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.

On December 29, 2022, the Consolidated Appropriations Act (CAA), 2023 was signed into law. Section 4139 of this legislation requires that the fee schedule amounts for items and services furnished in non-rural contiguous non-CBAs continue to be based on a blend of 75 percent of the adjusted fee schedule amounts and 25 percent of the unadjusted fee schedule amounts for claims with dates of service for the remainder of the COVID-19 public health emergency or December 31, 2023, whichever is later. Also, payment for items and services subject to the fee schedule adjustments furnished in rural and non-contiguous 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 claims with dates of service for the remainder of the COVID-19 public health emergency or December 31, 2023, whichever is later. In accordance with the provisions of the CAA of 2023, payment for items and services furnished in all areas (i.e., rural, non-contiguous and non-rural contiguous non-CBAs) will continue to be adjusted in the manner required by CAA for claims with dates of service through December 31, 2023.

Fee Schedule Adjustment Relief for Rural and Non-Contiguous Areas

On December 28, 2021, the Centers for Medicare & Medicaid Services (CMS) published a Medicare DMEPOS final rule in the Federal Register (86 FR 73860) docket rule number CMS-1738-F/CMS1687-F/CMS-5531-F. In accordance with this final rule, although the methodology for the 50/50 blended rates described above were initially transitional rates, the methodology is used to establish the fully adjusted fee schedule amounts for rural and non-contiguous non-CBA areas for items furnished beginning on the date immediately following the duration of the emergency period or December 31, 2023, whichever is later. The final rule is available at https://www.cms.gov/medicare/medicare-fee-for-service-payment/dmeposfeesched

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 2023 DMEPOS fee schedules is available in program instructions:

January 2023 Update for DMEPOS Fee Schedule, Transmittal 11722, Change Request 13006

April 2023 Update for DMEPOS Fee Schedule, Transmittal 11910, Change Request 13153

B. Policy: This instruction is for the July 2023 DMEPOS fee schedule. In addition, the PEN fees schedule includes state fee schedule amounts for enteral nutrition items and national fee schedule amounts for parenteral nutrition items.

This instruction provides updates for the following files:

1. No update DMEPOS fee schedule file for July 2023

2. DMEPOS Rural ZIP code file for July (Quarter 3) 2023

3. No updates to the Parenteral and Enteral Nutrition (PEN) fee schedule file for July 2023

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

Specific Coding and Pricing Issues

New Codes Added

No codes are added to the DMEPOS fee schedule file effective July 1, 2023.

Codes Deleted

No codes are deleted from the DMEPOS fee schedule file effective July 1, 2023.

Supplier Education on Power Wheelchair Repair

Contractors shall educate suppliers that Federal regulations at 42 CFR 414.210(e)(4) specify that a supplier that transfers title to a capped rental item, such as a power wheelchair, to a beneficiary remains responsible for furnishing replacement equipment at no cost to the beneficiary or to the Medicare program for the 5-year reasonable useful lifetime for the equipment. In making this determination, the DME MACs may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the item.

Also, contractors shall educate suppliers that they must maintain copies of any manufacturer or supplier warranties for equipment being repaired and furnish this documentation upon request. Federal regulations at 42 CFR 414.210(e)(1) provide that payment may be made for reasonable and necessary charges for maintenance and servicing of beneficiary-owned equipment. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer's or supplier's warranty.

These regulations have been in effect and there is no new policy associated with this change request.

Update to Medicare Claims Processing Manual (Pub. 100-04), Chapter 23, Section 60, 60.1, 60.3, 60.3.1 and 60.4 Gap-filling Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS)

As part of this instruction, updates are made to Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Sections 60, 60.1, 60.3, 60.3.1 and 60.4 to implement regulations effective February 28, 2022 regarding payment determinations for new DMEPOS items and services.

Payment on a fee schedule basis is required for most DME, prosthetic devices, orthotics, prosthetics, surgical dressings, and therapeutic shoes and inserts by §1833(o)(2)(A) and §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 PEN, splints, casts and Intraocular Lenses (IOLs) inserted in a physician's office. Fee schedule amounts must be used in paying all claims for all items and services falling under one of these categories unless one of the following exceptions applies:

- Items included in a competitive bidding program in a competitive bidding area;

- Customized DME as defined in 42 CFR §414.224;

- Maintenance and servicing payments for oxygen equipment and parenteral and enteral infusion pumps;

- Labor associated with repairing beneficiary owned equipment or devices; or

- Parts associated with repairing beneficiary owned equipment or devices that are not described by codes for components or accessories of equipment or devices on the DMEPOS fee schedule files.

As described in more detail in section 60.3.1 and in regulations at 42 CFR 414.110 and 414.236, when HCPCS codes are divided or combined, the fee schedule pricing under the codes being replaced must be mapped to the new codes to ensure continuity of pricing. For situations were new codes are established for items without a pricing history, the fee schedule amounts for these items will generally be established by CMS following the regulations at 42 CFR 414.112 and 414.238 and processes outlined at 42 CFR 414.114 and 414.240. Until the fee schedule amounts are established by CMS using the processes outlined at 42 CFR 414.114 and 414.240, it may be necessary for the MACs to establish interim local fee schedule amounts for payment if new codes are effective for Medicare claims processing purposes before the process used by CMS to establish the national fee schedule amounts is completed.

CMS is also updating Internet Only Manual Publication 100-04, Chapter 23, Sections 60.1 titled Record Layout for DMEPOS Fee Schedule to discontinue a gap-fill indicator that is no longer used. As such, the gap-fill indicator field at position 50 will no longer exist on the file and will be revised to a filler field set to a space.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13235.1	The DME MACs, A/B MACs Part B, A/B MACs Part A, A/B MACs Part Home Health and Hospice (HHH) and/or the Virtual Data Centers (VDCs) shall retrieve the 2023 Rural ZIP code file (filename: MU00.@DMECBIC.RURZIP. C23Q02.V0608) on or after June 8, 2023.	X	X	X	X					VDC
13235.1.1	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
13235.2	Contractors shall use the Rural Zip code file in	X	X	X	X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	requirement 1 to pay claims for items with dates of service beginning July 1, 2023. A July update to the 2023 DMEPOS and PEN fee schedule files is not required.									
13235.3	Contractors shall be aware of the updates to Medicare Claims Processing Manual (Publication 100-04), Chapter 23, Sections 60 Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule, 60.1 Record Layout for DMEPOS Fee Schedule, 60.3 and 60.3.1 Gap-filling DMEPOS Fees, and 60.4 Process for Submitting Revisions to DMEPOS Fee Schedule to CMS.		X		X					
13235.4	Contractors shall educate suppliers about Medicare regulation 42 CFR 414.210(e)(4), the need to maintain copies of any manufacturer or supplier warranties for equipment being repaired, and to furnish this documentation upon request.				X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13235.5	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): 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

60 - Durable Medical Equipment Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

(Rev. 12068; Issued: 06-02-23; Effective: 07-01-23; Implementation: 07-03-23)

The CMS issues instructions for implementing and/or updating the DMEPOS fee schedule payment amounts on a*n* annual basis (January), with quarterly updates as necessary (April*, July* and October). *In addition, special instructions may be issued at any time if necessary for implementation of changes in the statute, regulations, or for other reasons.* The DMEPOS fee schedule is provided to DME MACs, the Pricing, Data Analysis and Coding Contractor (PDAC), and A/B MACs (B) via CMS' mainframe telecommunication system.

Upon successful receipt of the updated file(s), MACs send notification of receipt via email to price_file_receipt@cms.hhs.gov stating the name of the file received and the entities for which they were received (e.g., MAC name and A/B MAC (A) or (HHH) number).

A separate DMEPOS Fee Schedule file is released to A/B MACs (A) and (HHH), Railroad Retirement Board (RRB) and RRB's Specialty MAC, Indian Health Service, and United Mine Workers. This fee schedule is also available on the CMS site (http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html) for other interested parties like the State Medicaid agencies and managed care organizations. The fee schedule for parenteral and enteral nutrition (PEN) is released to the PDAC and DME MACs in a separate file. All annual updates to fee schedules are to be implemented on January 1 for claims with dates of service on or after January 1.

Effective February 28, 2022, national fee schedule amounts for new DMEPOS items and services that are added to the DMEPOS or PEN fee schedule files are established by CMS using the process summarized below and outlined in the regulations at 42 CFR 414.114 and 414.240. As explained in more detail in §60.3 below, MACs shall establish interim local fee schedule amounts for use in paying claims for new items and services billed using codes for miscellaneous items and services and for use in paying claims on an interim basis until the national fee schedule amounts are established.

Process for Establishing National Fee Schedule Amounts – Effective February 28, 2022

If a preliminary determination is made by CMS that a new item or service without a fee schedule pricing history falls under a DMEPOS benefit category, CMS makes a preliminary payment determination for the item or service and posts the preliminary payment determination on the website www.CMS.gov approximately 2 weeks prior to a public meeting. After consideration of public consultation provided at the public meeting on the preliminary benefit category and payment determinations for the item or service, CMS posts final determinations on the website www.CMS.gov and implements the benefit category determinations and payment determinations for items and services through program instructions. Some determinations may be deferred to future cycles of the public consultation process if more time is needed to develop preliminary or final benefit category and payment determinations.

Benefit category determinations are made using the public meeting process described above for an item or service that is the subject of a request for a HCPCS code set modification. Benefit category determinations are also made using the public meeting process in cases where a manufacturer for a new item or service is not requesting a HCPCS code set modification for the item or service, but requests CMS to determine whether the item or service falls under a DMEPOS benefit category. Benefit category determinations are also made using the public meeting process when CMS identifies a need to address whether an item or service falls under a DMEPOS benefit category.

60.1 - Record Layout for DMEPOS Fee Schedule

(Rev. 12068; Issued: 06-02-23; Effective: 07-01-23; Implementation: 07-03-23)

Sort Sequence: Category, HCPCS, 1st Modifier, 2nd Modifier State

Field Name	Pic	Position	Comment
Year	X(4)	1 - 4	Applicable Update Year
HCPCS Code	X(5)	5 - 9	All current year active and deleted codes subject to DMEPOS floors and ceilings
1st Modifier	X(2)	10 - 11	
2nd Modifier	X(2)	12 - 13	
Jurisdiction	X	14	D = DME MAC Jurisdiction L = Local A/B MAC (B) jurisdiction J = Joint DME MAC/A/B MAC (B) jurisdiction
Category	X(2)	15 - 16	IN = Inexpensive/Routinely Purchased FS = Frequently Serviced CR = Capped Rental OX = Oxygen & Oxygen Equipment OS = Ostomy, Tracheostomy & Urologicals SD = Surgical Dressings PO = Prosthetics & Orthotics SU = Supplies TE = TENS TS = Therapeutic Shoes SC = Splints and Casts IL = Intraocular Lenses
HCPCS Action	X	17	Indicates active/delete status in HCPCS file A = Active Code D = Deleted Code, price provided for grace period processing only
Region	X(2)	18 - 19	This amount is not used for pricing claims. It is on file for informational purposes. 00 = For all non Prosthetic and Orthotic Services 01 - 10 = For Prosthetic and Orthotic Services only. This field denotes the applicable regional fee schedule.
State	X(2)	20 - 21	
Original Base Fee	9(5)V99	22 - 28	This amount is not used for pricing claims. It is on file for informational purposes. For capped rental services, this amount represents the base fee after adjustments for rebasing and statewide conversions. The base year for E0607 and L8603 is 1995. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they do not have a true base fee. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will include the Competitive Bidding Rural Fee Amount for specific HCPCS codes. A new indicator field (RURAL FEE INDICATOR) shall be populated with a value of "R" when the Rural Fee is present in this field.

Ceiling	9(5)V99	29 - 35	This amount is not used for pricing claims. It is on file for informational purposes and could be integrated into other processes (i.e., IR review, validation, inquiries). **NOTE**: Since E0607 is priced via national IR, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Since non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are priced using National Mail order single payment amounts, they are not subject to ceilings and floors. Splints, casts and intraocular lenses are national fee schedule amounts not subject to ceilings. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will also be filled with zeros for codes whose fees are adjusted using DMEPOS competitive bid information.
Floor	9(5)V99	36 - 42	This amount is not used for pricing claims. It is on file for informational purposes and could be integrated into other processes (i.e., IR review, validation, inquiries). **NOTE**: Since E0607 is priced via national IR, it is not priced using floors and ceilings. For E0607, this field will be filled with zeros. Since pricing amounts for E1405 and E1406 are developed by summing pricing amounts from source codes, they are not subject to ceilings and floors. Since non-mail order (no-KL) codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 are priced using National Mail order single payment amounts, they are not subject to ceilings and floors. Splints, casts and intraocular lenses are national fee schedule amounts not subject to floors. For these codes, this field will be filled with zeros. Beginning January 1, 2016, this field will also be filled with zeros for codes whose fees are adjusted using DMEPOS competitive bid information.
Updated Fee Schedule Amount	9(5)V99	43 - 49	Amount used for pricing.
Filler	X	50	*Set to spaces*
Pricing Change Indicator	X	51	0 = No change to the updated fee schedule amount since previous release. 1 = A change has occurred to the updated fee schedule amount since the previous release.
Rural Fee Indicator	X(01)		R = Rural Fee is present in the Original Base Fee field
Filler	X(8)	53 - 60	Set to spaces

60.3 - Gap-filling DMEPOS Fees

(Rev. 12068; Issued: 06-02-23; Effective: 07-01-23; Implementation: 07-03-23)

Gap-filling is used in establishing fee schedule amounts for new DMEPOS items or services that do not have a fee schedule pricing history. If a HCPCS code is new and describes items and services that have a fee schedule pricing history (classified and paid for previously under a different code, *including codes for miscellaneous items, e.g., E1399, and including fee schedule amounts established by CMS or the MACs*), the fee schedule amounts for the new code are established using the process included in section 60.3.1 of this manual.

All DMEPOS items and services subject to payment on a fee schedule basis as mandated by sections 1833(o)(2)(A), 1834(a), (h), and (i) of the Social Security and/or by regulations at 42 CFR 414.102 and 414.210 must have national fee schedule amounts established by CMS or interim local fee schedule amounts established by the MACs for use in paying claims for the items and services. Effective February 28, 2022, interim local fee schedule amounts established by the MACs for paying claims on an interim basis are considered a fee schedule pricing history for continuity of pricing purposes under §60.3.1 below for the time before national fee schedule amounts are established, but can be considered by CMS in developing national fee schedule amounts. Once national fee schedule amounts are established for an item or service, the national fee schedule amounts become the new fee schedule pricing history for the item or service for continuity of pricing purposes under §60.3.1 below. Local fee schedule amounts established by the MACs for use in paying claims prior to February 28, 2022 are considered a fee schedule pricing history for continuity of pricing purposes under §60.3.1 below.

The DME MACs or A/B MACs must establish fee schedule amounts for DMEPOS items and services billed using HCPCS codes for miscellaneous items not otherwise classified under the HCPCS (e.g., E1399, L2999, and L8699). Once the fee schedule amounts are established for DMEPOS items and services billed using HCPCS codes for miscellaneous items, these fee schedule amounts would only change when update factors are applied, to correct an error in the calculation of the fee schedule amounts, or based on program instructions.

For DME items, the DME MACs must apply the DME payment method depending on the DME class the item falls under (e.g., the item would be paid on a capped rental basis if it is expensive, not customized, not oxygen and oxygen equipment, and does not require frequent and substantial servicing in order to avoid risk to the patient).

*National fee schedule amounts established by CMS and interim local fee schedule amounts established by t*he DME MACs and A/B MACs Part B shall *be* gap-fill*ed* for items for which charge data were unavailable during the fee schedule data base year using the fee schedule amounts for comparable equipment. Fee schedule amounts for new HCPCS codes for items and services without a fee schedule pricing history are established using existing fee schedule amounts for comparable items when items with existing fee schedule amounts are determined to be comparable to the new items and services. A comparison can be based on, but not limited to the following components: physical, mechanical, electrical, function and intended use, and additional attributes and features. When examining whether an item is comparable to another item, the analysis can be based on the items as a whole, its subcomponents, or a combination of items. A new product does not need to be comparable within each category, and there is no prioritization to the categories.

Examples of Attributes in Each Component Category

- Physical: Aesthetics, Design, Customized vs. Standard, Material, Portable, Size, Temperature Range/Tolerance, Weight

- Mechanical: Automated vs. Manual, Brittleness, Ductility, Durability, Elasticity, Fatigue, Flexibility, Hardness, Load Capacity, Flow-Control, Permeability, Strength

- Electrical: Capacitance, Conductivity, Dielectric Constant, Frequency, Generator, Impedance, Piezo-electric, Power, Power Source, Resistance

- Function and Intended Use: Function, Intended Use

- Additional Attributes and Features: "Smart", Alarms, Constraints, Device Limitations, Disposable, Parts, Features, Invasive vs. Non-Invasive.

If unable to identify comparable item(s), other sources of pricing data can be used to calculate the gap-filled fee schedule amount for the new item. These sources include using supplier or commercial price lists with prices in effect during the fee schedule data base year. Data base "year" refers to the time period mandated by the statute and/or regulations from which Medicare allowed charge data is to be extracted in order to compute the fee schedule amounts for the various DMEPOS payment categories. For example, the fee schedule base year for inexpensive or routinely purchased durable medical equipment is the 12 month period ending June 30, 1987. Supplier price lists include catalogues and other retail price lists (such as internet retail prices) that provide information on commercial pricing for the item. Potential appropriate sources for such commercial pricing information can also include payments made by Medicare Advantage plans as well as verifiable information from supplier invoices and non-Medicare payer data. DME MACs and A/B MACs shall gap-fill based on current instructions released each year for implementing and updating the payment amounts.

If the only available price information is from a period other than the base period, apply the deflation factors that are included in the current year implementation instructions against current pricing in order to approximate the base year price for gap-filling purposes.

The deflation factors for gap-filling purposes are:

Year*	**OX**	**CR**	**PO**	**SD**	**PE**	**SC**	**IL**
1987	0.965	0.971	0.974	n/a	n/a	n/a	n/a
1988	0.928	0.934	0.936	n/a	n/a	n/a	n/a
1989	0.882	0.888	0.890	n/a	n/a	n/a	n/a
1990	0.843	0.848	0.851	n/a	n/a	n/a	n/a
1991	0.805	0.810	0.813	n/a	n/a	n/a	n/a
1992	0.781	0.786	0.788	n/a	n/a	n/a	n/a
1993	0.758	0.763	0.765	0.971	n/a	n/a	n/a
1994	0.740	0.745	0.747	0.947	n/a	n/a	n/a
1995	0.718	0.723	0.725	0.919	n/a	n/a	n/a
1996	0.699	0.703	0.705	0.895	0.973	n/a	n/a
1997	0.683	0.687	0.689	0.875	0.951	n/a	n/a
1998	0.672	0.676	0.678	0.860	0.936	n/a	n/a
1999	0.659	0.663	0.665	0.844	0.918	n/a	n/a
2000	0.635	0.639	0.641	0.813	0.885	n/a	n/a
2001	0.615	0.619	0.621	0.788	0.857	n/a	n/a
2002	0.609	0.613	0.614	0.779	0.848	n/a	n/a
2003	0.596	0.600	0.602	0.763	0.830	n/a	n/a
2004	0.577	0.581	0.582	0.739	0.804	n/a	n/a
2005	0.563	0.567	0.568	0.721	0.784	n/a	n/a
2006	0.540	0.543	0.545	0.691	0.752	n/a	n/a

2007	0.525	0.529	0.530	0.673	0.732	n/a	n/a
2008	0.500	0.504	0.505	0.641	0.697	n/a	n/a
2009	0.508	0.511	0.512	0.650	0.707	n/a	n/a
2010	0.502	0.506	0.507	0.643	0.700	n/a	n/a
2011	0.485	0.488	0.490	0.621	0.676	n/a	n/a
2012	0.477	0.480	0.482	0.611	0.665	n/a	n/a
2013	0.469	0.472	0.473	0.600	0.653	n/a	0.983
2014	0.459	0.462	0.464	0.588	0.640	0.980	0.963
2015	0.459	0.462	0.463	0.588	0.639	0.978	0.962
2016	0.454	0.457	0.458	0.582	0.633	0.969	0.952
2017	0.447	0.450	0.451	0.572	0.623	0.953	0.937
2018	0.435	0.437	0.439	0.556	0.605	0.927	0.911
2019	0.427	0.430	0.431	0.547	0.595	0.912	0.896
2020	0.425	0.427	0.429	0.544	0.592	0.906	0.891
2021	0.403	0.406	0.407	0.516	0.561	0.859	0.845
2022	0.370	0.372	0.373	0.473	0.515	0.788	0.775

* Year price in effect

Payment Category Key:

OX Oxygen & oxygen equipment (DME)
CR Capped rental (DME)
IN Inexpensive/routinely purchased (DME)
FS Frequently serviced (DME)
SU DME supplies
PO Prosthetics & orthotics
SD Surgical dressings
OS Ostomy, tracheostomy, and urological supplies
PE Parental and enteral nutrition
TS Therapeutic Shoes
SC Splints and Casts
IL Intraocular Lenses inserted in a physician's office

IN, FS, OS and SU category deflation factors=PO deflation factors

After deflation, the result must be increased by 1.7 percent and by the cumulative covered item update to complete the gap-filling (e.g., an additional .6 percent for a 2002 DME fee).

Note that when gap-filling for capped rental items, it is necessary to first gap-fill the purchase price then compute the base period fee schedule at 10 percent of the base period purchase price.

For used equipment, establish fee schedule amounts at 75 percent of the fee schedule amount for new equipment.

If within 5 years of establishing fee schedule amounts using supplier or commercial prices, the supplier or commercial prices decrease by less than 15 percent, CMS can make a one-time adjustment to the fee schedule amounts using the new prices. The new supplier or commercial prices would be used to establish the new fee schedule amounts in the same way that the older prices were used, including application of the deflation formula of this section.

60.3.1 - Payment Concerns While Updating Codes

(Rev. 12068; Issued: 06-02-23; Effective: 07-01-23; Implementation: 07-03-23)

The following instructions apply in situations where the CMS CO does NOT provide pricing guidance related to implementation of fee schedule for DMEPOS items and services.

Because a HCPCS code is new does not necessarily mean that Medicare payment on a fee schedule basis has never been made for the item and service described by the new code. *In accordance with regulations at 42 CFR 414.110 and 414.236, if a new HCPCS code is added, CMS and/or MACs make efforts to determine whether the item and service has a fee schedule pricing history. If there is a fee schedule pricing history, the previous fee schedule amounts for the previous code(s) are mapped to the new code(s) to ensure continuity of pricing.*

When the code for an item is divided into several codes for the components of that item, the total of the separate fee schedule amounts established for the components must not be higher than the fee schedule amount for the original item. When there is a single code that describes two or more distinct complete items (for example, two different but related or similar items), and separate codes are subsequently established for each item, the fee schedule amounts that applied to the single code continue to apply to each of the items described by the new codes. When the codes for the components of a single item are combined in a single global code, the fee schedule amounts for the new code are established by totaling the fee schedule amounts used for the components (that is, use the total of the fee schedule amounts for the components as the fee schedule amount for the global code). When the codes for several different items are combined into a single code, the fee schedule amounts for the new code are established using the average (arithmetic mean), weighted by allowed services, of the fee schedule amounts for the formerly separate codes.

60.4 - Process for Submitting Revisions to DMEPOS Fee Schedule to CMS

(Rev. 12068; Issued: 06-02-23; Effective: 07-01-23; Implementation: 07-03-23)

The DME MACs identify instances where revisions to DMEPOS fees are needed and forward requests to CMS via *email* to *the Division of Data Systems.* The *information* must be contained in an ASCII file. The requests must include a narrative description.

The following file specifications are 2003 examples, the actual file names may change each year:

Data Set Name	DMEREV1A.TXT	First Quarter Submission
	DMEREV1B.TXT	Second Quarter Submission
	DMEREV1C.TXT	Third Quarter Submission
	DMEREV1D.TXT	Fourth Quarter Submission

Record Format

Field Name	PIC	Position	Comment
HCPCS Code	X(5)	1 - 5	
Filler	X(1)	6 - 6	Set to Spaces
First Modifier	X(2)	7 - 8	
Filler	X(1)	9	Set to Spaces

Field Name	PIC	Position	Comment
Second Modifier	X(2)	10 - 11	
Filler	X(2)	12 - 13	Set to Spaces
State	X(3)	14 - 16	
Filler	X(1)	17	Set to Spaces
Revised Base Fee	S9(5)V99	18 - 26	1992 level for surgical dressings; *1995 level for PEN;* *2013 level for Splints & Casts;* *2012 level for certain IOLs;* 1989 for all other categories
Filler	X(1)	27	Set to Spaces
Capped Rental Rebasing Indicator	X(1)	28	For Capped Rental Services Only: 0 - IR not applied to original base fee and base fee in effect prior to 1991, base fee is subject to rebasing adjustment 1 - IR applied to original base fee or base fee not in effect prior to 1991, base fee is exempted from rebasing adjustment
Filler	X(1)	29	Set to Spaces
Nature of Fee Revision	X(1)	30	0 = Correction 1 = IR Revision 2 = Other - Please submit supporting documentation.
Filler	X(1)	31	Set to Spaces
IR - Effective Date	9(8)	32 - 39	Field is applicable only to those records where the fee has changed due to an inherent reasonableness decision and the previous field contains a value of "1." Format is YYYYMMDD

The CMS will recalculate current year fee schedule amounts as appropriate and release the entire file in the record layout described in §60.1. An indicator in the record field (Pricing Change Indicator) will identify those instances where pricing amounts have changed. The CMS will also issue instructions for implementing the revised fee schedule amounts with the fee schedule.