CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 14058	**Date: November 25, 2026**
	Change Request 14697

SUBJECT: Calendar Year 2027 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. This recurring update notification applies to publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: January 1, 2027
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2027

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	23/60/3 Gap-filling DMEPOS Fees

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

Manual Instruction

Attachment - Recurring Update Notification

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II. GENERAL INFORMATION

A. Background: 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). Also, 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 fee schedule file also includes 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 adjustments to the fee schedule amounts for DME items included in the DMEPOS Competitive Bidding Program (CBP) for payment of the items in areas that are not included in the CBP. Sections 1834(h)(1)(H)(ii), 1842(s)(3)(B) and 1834(z)(3) of the Act provide authority to adjust the fee schedule amounts for off-the-shelf orthotics, braces and enteral nutrients, equipment, and supplies (enteral nutrition), based on information from the DMEPOS CBP and the national payment amounts for lymphedema compression treatment items. The methodologies for adjusting DMEPOS fee schedule and national payment amounts are established at 42 CFR §414.210(g). The DMEPOS and PEN fee schedule files contain Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the fee schedule adjustments using information on the payment determined for these items under the CBP, as well as codes that are not subject to the CBP or fee schedule adjustments.

1.Payment for Items Furnished in Former Competitive Bidding Areas

Beginning January 1, 2024, there is a gap period in the DMEPOS CBP. All Medicare Round 2021 DMEPOS CBP contracts for Off-the-Shelf (OTS) back braces and OTS knee braces expired on December 31, 2023. During the gap period, payment for items and services that were included in the CBP are equal to 80 percent of the lesser of the supplier's charge or the fee schedule amount for the item. Pursuant to §414.210(g)(10), the fee schedules for items and services furnished in former Competitive Bidding Area (CBAs) are based on the Single Payment Amounts (SPAs) in effect in the CBA on the last day before the CBP contract period of performance ended, increased by the projected percentage change in the Consumer Price Index Urban (CPI-U) for the 12- month period on the date after the contract periods ended. 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. For Calendar Year (CY) 2027, for items where contracts were awarded in Round 2021, the fee schedule amounts for items furnished in areas that were CBAs as of December 31, 2023, are adjusted based on the SPAs for each specific CBA, increased by the projected percentage change in the CPI-U of 3.4

percent for the 12-month period ending January 1, 2027. Also, for items that were included in Round 2021 but where contracts were not awarded in Round 2021 of the CBP, the 2026 adjusted fee schedule amounts are increased by the projected CPI-U of 3.4 percent for CY 2027. The CY 2026 update factor for the fee schedule amounts for items furnished in areas that were former CBAs was 2.8 percent.

Additional information on the gap period is available at https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding

A former CBA ZIP code file contains the CBA ZIP codes used in pricing a claim for an item furnished in a CBA and will be updated on a quarterly basis as necessary. The former CBA ZIP code file includes the ZIP codes for the CBAs included in Round 2021.

2. DMEPOS Rural Zip Codes

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 fee schedule amounts adjusted in accordance with §414.210(g). The DMEPOS Rural ZIP code file contains the ZIP codes designated as rural areas. ZIP codes for non-contiguous Metropolitan Statistical Areas (MSAs) 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 Metropolitan Statistical Area (MSA). A rural area also includes any low population density ZIP Code within an MSA that is excluded from a CBA established for that MSA.

B. Policy: This instruction provides updates for the following files:

1. DMEPOS fee schedule file for 2027

2. DMEPOS Rural ZIP code file for 2027 (Quarter 1)

3. DMEPOS Parenteral and Enteral Nutrition (PEN) fee schedule file for 2027

4. Former CBA fee schedule file

5. Former CBA National Mail Order diabetic testing supply fee schedule

6. Former CBA ZIP Code

Updates to the Medicare DMEPOS fee schedule files are available as Public Use Files (PUFs) for State Medicaid Agencies, managed care organizations, and other interested parties on the CMS website at https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule

Codes Added and Deleted

No new DMEPOS codes are added or deleted from the Healthcare Common Procedure Coding System (HCPCS) file, effective January 1, 2027.

New and Deleted Fee Schedule Amounts

No codes are added or deleted from the DMEPOS fee schedule file, effective January 1, 2027.

Instructions for Gap-filling DMEPOS fees are available in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.3. For gap-filling purposes, the deflation factors in the updated manual section by payment category are:

• 0.328 for Oxygen

• 0.330 for Capped Rental

• 0.331 for Prosthetics and Orthotics

• 0.420 for Surgical Dressings

• 0.457 for Parental and Enteral Nutrition (PEN)

• 0.699 for Splints and Casts

• 0.687 for Intraocular Lenses (IOL)

2027 Fees Update Factor of 2.5 Percent

For CY 2027, an update factor of 2.5 percent is applied to certain DMEPOS fee schedule amounts that are not adjusted using information from CBPs.

In accordance with the statutory sections 1834(a)(14), 1834(h)(4) and 1842(s)(1)(B) of the Act, certain DMEPOS fee schedule amounts are updated for 2027 by the percentage increase in the CPI-U for the 12-month period ending June 30, 2026, adjusted by the change in the economy-wide productivity equal to the 10-year moving average of changes in annual economy-wide private nonfarm business Multi-Factor Productivity (MFP). In the above statutory sections, the productivity measure referenced in section 1886(b)(3)(B)(xi)(II) was published by the United States Bureau of Labor Statistics (BLS) as private nonfarm business MFP. Beginning with the November 18, 2021 release of productivity data, BLS replaced the term multifactor productivity with Total Factor Productivity (TFP).

For CY 2027, the TFP adjustment is 1.0 percent and the CPI- U percentage increase is 3.5 percent. Thus, the 3.5 percentage increase in the CPI-U reduced by the 1.0 percentage increase in the TFP results in a net increase of 2.5 percent for the update factor.

Fees adjusted using information from CBPs will be updated pursuant to the applicable adjustment methodologies outlined in 42 CFR §414.210(g) discussed in the Background section above.

Lymphedema Compression Treatment Items Fee Schedules

National payment amounts for lymphedema compression treatment items are established in accordance with the methodology in section 1834(z) of the Act and our regulations at section 42 CFR 414.1650. For CY 2027, an update factor of 3.5 percent is applied to the national payment amounts for lymphedema compression treatment items which 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. Additional claims processing instructions are available in Change Request (CR) 13286 titled "Implementation of New Benefit Category for Lymphedema Compression Treatment Items."

Therapeutic Shoe Modification Codes

As CMS has done annually, CMS is also adjusting the fee schedule amounts for shoe modification codes A5503 through A5507 to reflect the most 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, A5513 and A5514). 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 calendar year 2004. For 2027, CMS

is updating the weighted average insert fees used to establish the fee schedule amounts for the shoe modification codes with the most current allowed service data for each insert code. The base fees for A5512, A5513 and A5514 will be weighted based on the approximated total allowed services for each code for items furnished during the calendar year 2025. The fee schedule amounts for shoe modification codes A5503 through A5507 are being revised to reflect this change, effective January 1, 2027.

Diabetic Testing Supplies

The fee schedule amounts for non-mail order Diabetic Testing Supplies (DTS) (without KL modifier) for codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, A4259 are not updated by the annual covered item update. In accordance with section 1834(a)(1)(H) of the Act, the fee schedule amounts for these codes were adjusted in CY 2013 so that they are equal to the SPAs for mail order DTS established in implementing the national mail order CBP under section 1847 of the Act. Initial program instructions on these fees are available in Transmittal 2709, CR 8325, dated May 17, 2013 and Transmittal 2661, CR 8204, dated February 22, 2013. The National Mail-Order Recompete DTS SPAs are available at the following website: https://dmeposcompetitivebid.cms.gov/node/670.

The non-mail order DTS amounts on the fee schedule will be updated each time the single payment amounts are updated. This can happen no less often than every time the mail order CBP contracts are recompeted. The National Mail Order Recompete CBP for mail order diabetic supplies was effective July 1, 2016 to December 31, 2018. As of January 1, 2027, payment for non-mail order diabetic supplies at the National Mail Order Recompete SPAs will continue in accordance with section 1834(a)(1)(H) of the Act and these rates will remain in effect until new SPA rates are established under the national mail order program.

Effective January 1, 2027, the fee schedule amounts for mail order DTS (with KL modifier) are adjusted using the methodology for areas that were formerly CBAs during periods when there is a temporary lapse in the CBP. The National Mail-Order Recompete DTS SPAs of December 31, 2018 are increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. 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. For CY 2027, the 2026 adjusted fee schedule amounts are increased by the projected percentage change in the CPI-U of 3.4 percent for the 12-month period ending January 1, 2027. The national mail order adjusted fee schedule amounts will be used in paying mail order diabetic testing supply claims in all parts of the United States, including the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam and the American Samoa. See below for the projected CPI-U used in prior years for updates to the December 31, 2018 National Mail-Order Recompete SPAs:

Calendar Year	Projected Percent Change in CPI-U
CY 2019	2.5
CY 2020	2.4
CY 2021	0.6
CY 2022	5.0
CY 2023	6.4
CY 2024	2.9
CY 2025	2.9
CY 2026	**2.8**

2027 Maintenance and Servicing Payment Amount for Certain Oxygen Equipment

Payment for claims for maintenance and servicing of oxygen equipment was instructed in Transmittal 635, CR 6792, dated February 5, 2010 and Transmittal 717, CR 6990, dated June 8, 2010. 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(e)(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 forth in §1834(a)(14) of the Act. Thus, the 2026 maintenance and servicing fee is adjusted by the 2.5 percent TFP-adjusted covered item update factor to yield a CY 2027 maintenance and servicing fee of $91.82 for oxygen concentrators and transfilling equipment.

2027 Labor Payment Amounts for Repairs & Service Codes

Included in the January 2027 fee schedule file are the CY 2027 allowed payment amounts for HCPCS labor payment codes K0739, L4205 and L7520. Since the percentage increase in the CPI-U for the twelve-month period ending with June 30, 2026 is 3.5 percent, this change is applied to the 2026 labor payment amounts to update the rates for CY 2027. The 2027 labor payment amounts are effective for claims submitted using HCPCS codes K0739, L4205 and L7520 with dates of service from January 1, 2027 through December 31, 2027.

Durable Medical Equipment Benefit for Infusion Pumps and Drugs

On November 9, 2026, the Centers for Medicare & Medicaid Services (CMS) published a final rule, Calendar Year (CY) 2027 Home Health Prospective Payment System Final Rule (91 FR 72139), finalizing changes to the Medicare Part B definition of durable medical equipment (DME) at 42 CFR § 414.202. These changes implement section 6222(a) of the Consolidated Appropriations Act, 2026 (CAA, 2026), which amends the definition of DME at section 1861(n) of the Act to expand coverage under the DME benefit, effective April 1, 2027, to certain external infusion pumps and associated home infusion drugs, as defined in section 1861(iii)(3)(C) of the Act, or other associated supplies that do not meet the "appropriate for use in the home" requirement applied to the definition of DME under §414.202 if the following criteria are satisfied:

1. The prescribing information approved by the Food and Drug Administration (FDA) for the home infusion drug associated with the pump instructs that the drug should be administered by or under the supervision of a healthcare professional.
2. A qualified home infusion therapy supplier (as defined in section 1861 (iii)(3)(D) of the Act) administers or supervises the administration of the drug or biological in a safe and effective manner in the patient's home (as defined in section 1861 (iii)(3)(B) of the Act).
3. The FDA-approved prescribing information instructs that the drug should be infused at least 12 times per year —
    1. intravenously or subcutaneously; or
    2. at infusion rates that the Secretary determines would require the use of an external infusion pump.

Guidance for the DMEPOS MACs on implementation will be available in a new section of the Medicare Benefit Policy Manual, Chapter 15 (Pub.100-02). This guidance will describe the process for DMEPOS MACs to establish and maintain a published list of eligible home infusion drugs, including an application process for manufacturers, suppliers, or other interested parties to request that a drug or biological be added

to the list, a review of applications against the criteria described above, a public comment period, and publication of a final determination.

The DMEPOS MACs have been instructed to publish a list of drugs or biological products before April 1, 2027, that they believe meet the statutory and regulatory requirements. Parties are encouraged to wait to submit an application until that list has published.

III. 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	
14697.1	The CMS shall notify the Medicare contractors via e-mail when the revised payment data in the cloud is available for their retrieval.									CMS, PCS
14697.2	The A/B MACs Part A, A/B MACs for Home Health and Hospice (HHH) shall retrieve the DMEPOS FI fee schedule data from the cloud service and implement it into their testing and production regions. The cloud data will be available on or after December 3, 2026.	X		X						Hybrid Cloud Data Center (HCDC)
14697.3	The DME MACs, A/B MACs Part B shall retrieve the DMEPOS fee schedule data from the cloud service and implement it into their testing and production regions. The cloud data will be available on or after December 3, 2026.		X		X					Hybrid Cloud Data Center (HCDC)
14697.3.1	Upon email notification from CMS, Data Centers shall download the DMEPOS revised payment data from the cloud service and work with Part B MACs to implement it into their testing and production regions.		X							Hybrid Cloud Data Center (HCDC)
14697.4	The DME MACs shall retrieve the PEN fee schedule file from the cloud service and implement it into their testing and production regions. The file will be available				X					

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	on or after December 3, 2026.									
14697.5	Contractors shall retrieve the 2027 Rural ZIP code data from the cloud service on or after December 3, 2026.		X		X					Hybrid Cloud Data Center (HCDC)
14697.6	The A/B MACs Part A, A/B MACs for Home Health and Hospice (HHH) and/or HCDC shall retrieve the 2027 Rural ZIP code data from the cloud service on or after December 3, 2026.	X		X						Hybrid Cloud Data Center (HCDC)
14697.7	Contractors shall use the DMEPOS payment data in business requirements 14697.2 and 14697.3 and the Rural Zip code cloud data in requirements 14697.5 and 14697.6 retrieved from the cloud service to pay claims for items with dates of service beginning January 1, 2027.	X	X	X	X					
14697.8	The DME MACs shall use the PEN fee schedule file in requirement 14697.4 and the Rural Zip code file in requirement 14697.5 to pay claims with dates of service beginning January 1, 2027				X					
14697.9	Contractors shall use the 2027 maintenance and servicing fee for certain oxygen equipment of $91.82 for claims with dates of service January 1, 2027 thru December 31, 2027. Payment is based on the lower of the supplier's actual charge or the maintenance and servicing fee.			X	X	X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14697.10	Contractors shall provide local pricing, if instructed, in accordance with the schedule outlined below. DME MACs or A/B MACs Part B shall forward changes to CMS/Division Data Systems: price_file_receipt@cms.hhs.gov Changes to CMS/Division Data Systems: March 1, 2027; May 3, 2027; Aug 30, 2027, Nov 1, 2027		X		X					

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, section 50.3.3 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part B, A/B MAC Part HHH, DME MAC, A/B MAC Part A

V. 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

VI. CONTACTS

Pre-Implementation Contact(s): Hafsa Vahora, Hafsa.Vahora@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. 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

Medicare Claims Processing Manual
Chapter 23 - Fee Schedule Administration and Coding Requirements

60.3 - Gap-filling DMEPOS Fees
(Rev.)

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, for 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 the DME MACs and A/B MACs Part B shall be gap-filled 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 (e.g., fee schedule amounts comprised of the median of the commercial pricing information adjusted as described below). 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 shown below:

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	0.774
2023	0.359	0.361	0.362	0.460	0.500	0.765	0.752
2024	0.349	0.351	0.352	0.446	0.485	0.743	0.730
2025	0.339	0.342	0.343	0.435	0.473	0.724	0.711
2026	*0.328*	*0.330*	*0.331*	*0.420*	*0.457*	*0.699*	*0.687*

* 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 annual update factors shown below.

DMEPOS Fee Schedule Update Factors for Gap-Filling Purposes
(Updates applied to 1986/87 base year amounts unless otherwise noted)

Update factors mandated by sections 1834(a)(14), 1834(h)(1)(E), 1834(h)(4)(A), 1834(i)(1)(B), and 1842(s)(1)(B) of the Social Security Act

Year	Class III DME	Other DME, Ostomy, Tracheostomy, and Urological Supplies	Parenteral and Enteral Nutrition[1]	Surgical Dressings[2]	Prosthetics, Orthotics, and Other Prosthetic Devices[3]
1989	1.7%	1.7%	n/a	n/a	1.7%
1990	0.0%	0.0%	n/a	n/a	0.0%
1991	3.7%	3.7%	n/a	n/a	0.0%
1992	3.7%	3.7%	n/a	n/a	4.7%
1993	3.1%	3.1%	n/a	3.1%	3.1%
1994	3.0%	3.0%	n/a	3.0%	0.0%
1995	2.5%	2.5%	n/a	2.5%	0.0%
1996	3.0%	3.0%	n/a	3.0%	3.0%
1997	2.8%	2.8%	n/a	2.8%	2.8%
1998	0.0%	0.0%	n/a	0.0%	1.0%

1999	0.0%	0.0%	n/a	0.0%	1.0%
2000	0.0%	0.0%	n/a	0.0%	1.0%
2001	3.7%	3.7%	n/a	3.7%	3.7%
2002	0.0%	0.0%	0.0%	0.0%	1.0%
2003	1.1%	1.1%	1.1%	1.1%	1.1%
2004	2.1%	0.0%	2.1%	0.0%	0.0%
2005	3.3%	0.0%	3.3%	0.0%	0.0%
2006	2.5%	0.0%	2.5%	0.0%	0.0%
2007	0.0%	0.0%	4.3%	0.0%	4.3%
2008	2.7%	0.0%	2.7%	0.0%	2.7%
2009	5.0%	5.0%	5.0%	5.0%	5.0%
2010	0.0%	0.0%	0.0%	0.0%	0.0%
2011	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%
2012	2.4%	2.4%	2.4%	2.4%	2.4%
2013	0.8%	0.8%	0.8%	0.8%	0.8%
2014	1.0%	1.0%	1.0%	1.0%	1.0%
2015	1.5%	1.5%	1.5%	1.5%	1.5%
2016	-0.4%	-0.4%	-0.4%	-0.4%	-0.4%
2017	0.7%	0.7%	0.7%	0.7%	0.7%
2018	1.1%	1.1%	1.1%	1.1%	1.1%
2019	2.3%	2.3%	2.3%	2.3%	2.3%
2020	0.9%	0.9%	0.9%	0.9%	0.9%
2021	0.2%	0.2%	0.2%	0.2%	0.2%
2022	5.1%	5.1%	5.1%	5.1%	5.1%
2023	8.7%	8.7%	8.7%	8.7%	8.7%
2024	2.6%	2.6%	2.6%	2.6%	2.6%
2025	2.4%	2.4%	2.4%	2.4%	2.4%
2026	2.0%	2.0%	2.0%	2.0%	2.0%
2027	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*

[1] Base Year is 1995

[2] Base Year is 1992

[3] Artificial legs, arms, and eyes (prosthetics); leg, arm, back, and neck braces (orthotics); and all other prosthetic devices other than ostomy, tracheostomy, and urological supplies, parenteral and enteral nutrition, and intraocular lenses inserted in a physician's office

Note that when gap-filling for capped rental items, it is necessary to first gap-fill the purchase price and 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.

Gap-filling is not used in establishing fee schedule amounts for new lymphedema compression treatment items that do not have a fee schedule pricing history. Additional information on payment for lymphedema compression treatment items is available at Pub. 100-04 Medicare Claims Processing Manual, Chapter 20, Section 181.1 Payment Policy for Lymphedema Compression Treatment Items.

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.