

## **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 January 1, 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.

### DME Fee Schedule Payment Methodology

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

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

These items have a purchase price of \$150 or less, or are generally purchased 75 percent of the time or more, or are accessories used in conjunction with certain nebulizers, aspirators, and ventilators. 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.

**o FREQUENTLY SERVICED ITEMS (Section 1834(a)(3))**

These items require frequent and substantial servicing. Examples of such items are provided in section 1834(a)(3)(A). If covered, these items can be rented as long as they are medically necessary.

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

Medicare payment for oxygen and oxygen equipment is made on a monthly basis. One bundled 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 will be made every 6 months, beginning 6 months after the rental cap, for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. Payment is made on a monthly basis for oxygen contents for beneficiaries who own liquid or gaseous oxygen equipment.

- 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. They are generally expensive items that have historically been routinely rented. 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 rehabilitation 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 rehabilitation 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 carrier'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 DME and Surgical Dressings

The fee schedule amounts for DME and surgical dressings 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.

#### P&O 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. The fee schedule amounts for these items are updated by the ostomy, tracheostomy, and urological supplies covered item updates.

#### National Ceiling And Floor Limits for 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).

#### 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. This fee schedule is a national fee schedule (i.e., no variation from state to state).

#### Updating the DMEPOS Fee Schedule

The CMS issues instructions for implementing and/or updating DMEPOS payment amounts on a semiannual basis (January and July), with quarterly updates as necessary (April and October). The DMEPOS fee schedule is provided to DME MACs, the Pricing, Data Analysis and Coding Contractor (PDAC), and local carriers via CMS' mainframe telecommunication system. As part of the January fee schedule update, CMS applies the annual covered item update to the fee schedule payment amounts. The national payment amounts for non-mail order (no-KL) diabetic testing supply codes A4233, A4234, A4235, A4236, A4253, A4256, A4258, and A4259 do not receive the annual covered item update as these amounts will be updated each time the single payment amounts established in accordance with Section 1847 of the Act are updated.

The DMEPOS fee schedules are calculated by CMS. A separate DMEPOS Fee Schedule file is released to the intermediaries, regional home health intermediaries, Railroad Retirement Board (RRB), Indian Health Service and United Mine Workers. The fee schedule for parenteral and enteral nutrition (PEN) is released to the PDAC and DME MACs in a separate file. These files are also available through the CMS Website for interested parties like the State Medicaid agencies and managed care organizations.

As part of the annual or July update, CMS provides a list of new items that will be subject to the DME, prosthetics and orthotics, surgical dressings, or PEN fee schedules for which the DME MACs must gap-fill base fee schedule amounts. These gap-filled base fees are submitted to CMS Central Office for inclusion in the following July or January DMEPOS Fee Schedule File Update. The gap-filled codes are contained in the annual and July DMEPOS Fee Schedule file and are identifiable by a gap-fill indicator of "1." These codes have associated pricing amounts of 0 until fees are added to the file in July or January.