

## Chapter 10 Contents

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## Introduction – Pricing

Pricing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), is based on the fee schedules and payment methodologies provided by CMS.

The major DMEPOS payment methodologies are:

- **Fee Schedules** – applies to the allowed amount for inexpensive or other routinely purchased (IRP) items, those items that require frequent and substantial servicing, other prosthetic and orthotic devices, capped rental items, oxygen and oxygen supplies, parenteral and enteral nutrition (PEN), and therapeutic shoe claims. The CMS provides an annual fee schedule for DMEPOS and updates to those fees as applicable.

*Note: Fee schedules can change as the result of CMS revisions and/or through the application of inherent reasonableness, which is a review to determine if the existing prices are appropriate. The factors used to determine inherent reasonableness include, but are not limited to, price markup, differences in charges cost and utilization.*

- **Drug Pricing** – applies to the allowed amount for drugs that are billable to the DME MAC. The CMS provides a file quarterly with fees for most drugs that are billable to the DME MAC.
- **Single Payment Amount** – applies to the allowed payment amount for an item furnished under a competitive bidding program.

## 1. Fee Schedules

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §§40.1, 50, 50.1, & 190

### DMEPOS Fee Schedule

Most payments of durable medical equipment (DME) are based on a fee schedule calculated by the Centers for Medicare and Medicare Services (CMS). A fee is established for each DMEPOS item by state. Payment is calculated using either the fee schedule amount or the actual charge submitted on the claim, whichever is lower.

The DME fee schedules include items of DME as well as supplies needed to use the DME and are divided into the following categories:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Capped Rental

- Oxygen and Oxygen Equipment
- Ostomy, Tracheostomy, & Urologicals
- Surgical Dressings
- Prosthetics & Orthotics
- Supplies
- TENS
- Therapeutic Shoes

### **PEN Fee Schedule**

The Balanced Budget Act of 1997 § 4315 authorized the Secretary to implement a fee schedule for parenteral and enteral nutrition (PEN) items and services. These items were previously paid on a reasonable charge basis. The PEN fee schedule is effective for claims with dates of service on or after January 1, 2002.

### **Gap Filling**

The fee schedule for items for which charge data is not available is calculated based on:

- Fee schedule amounts for comparable equipment
- Fee schedule amounts of other DME MACs
- Supplier price lists

Where supplier price lists are used, efforts are made to obtain prices in effect during the base year (1986-1987). Mail order catalogs are often used as sources of price information. A deflation factor is applied if the price information is from a period other than the base period. This is done in order to approximate the base year price for gap filling purposes.

## **2. Drug Pricing**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, §§20-20.3*

Effective January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) methodology. Pricing for compounded drugs is performed by the local contractor. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. The CMS supplies contractors with the ASP drug pricing files for Medicare Part B/DME MAC drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B/DME MAC drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. The CMS updates the payment allowance limits quarterly. There are exceptions to this general rule and those that impact the DME MAC are summarized below:

- The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits for infusion drugs furnished through a covered item of durable

medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded. Effective for claims with date of service on or after January 1, 2017, infusion drugs furnished through a covered item of durable medical equipment are no longer an exception to the ASP methodology. Per Section 5004 of the 21<sup>st</sup> Century Cures Act, which was signed into law on December 13, 2016, payment of infusion drugs furnished through a covered item of DME will be based on Section 1847A of the Social Security Act. That means they reimburse based on the ASP methodology.

- The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing file are based on 106 percent of the published wholesale acquisition cost (WAC) or invoice pricing.
- Effective October 26, 2022, the payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, that are first sold on or after January 1, 2005, and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on either the WAC as determined per the Medicare Claims Processing Manual instructions, or invoice pricing. For claims with dates of service before January 1, 2019, the add-on percentage for these WAC-based payments is 6 percent. For claims with dates of service on or after January 1, 2019, the add-on percentage for WAC-based payments determined by MACs for new drugs before an ASP-based payment limit is available is up to 3 percent.

### 3. Single Payment Amount

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 36, §40

The Medicare DMEPOS Competitive Bidding Program (CBP) is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA) (Pub. L. 108-173). The MMA amended section 1847 of the Social Security Act and requires that competitive bidding programs be established and implemented in areas throughout the United States. In general, the statute requires the implementation of a competitive bidding program that replaces the current DMEPOS fee schedule methodology for determining payment rates for certain DMEPOS items in competitive bidding areas (CBAs).

The single payment amount (SPA) is established for each competitive bid item for each CBA based on the bids submitted by DMEPOS suppliers and accepted for that item. The single amount is determined by CMS and remains in effect for the duration of a contract period and is not adjusted for inflation.

A listing of the single payment amounts is posted at the Competitive Bidding Implementation Contractor (CBIC) website at <https://www.dmecompetitivebid.com>.

Starting January 1, 2019, there will be a temporary gap in the DMEPOS CBP that CMS expects will last until December 31, 2020. During the temporary gap period, payment for all items and services that were included in the CBP are based on the lower of the supplier's charge for the item or fee schedule amounts adjusted in accordance with sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Social Security Act. The fee schedule amounts for items furnished in areas that are CBAs as of December 31, 2018, will be adjusted based on the SPAs for each specific CBA, increased by the projected percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending January 1, 2019.

Round 2021 of the DMEPOS CBP was implemented on January 1, 2021, and extends through December 31, 2023. Off-The-Shelf (OTS) Back Braces and OTS Knee Braces are included in Round 2021. CMS did not award contracts to any of the other product categories for Round 2021. For items that were included in Round 2021 but where contracts have not been awarded in Round 2021 of the CBP, pursuant to §414.210(g)(10), the fee schedules for these items and services furnished in CBAs are based on the SPAs in effect in the CBA on the last day before the CBP contract period of performance ended (i.e., December 31, 2018), 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.

The adjusted fee schedule for former CBAs and the former CBA ZIP codes public use files (PUFs) will be available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>.

#### **4. Individual Consideration**

Unusual services and items are generally reported to the DME MAC with miscellaneous HCPCS codes. In these situations, you must include the following documentation with your claim:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

When necessary, consultants' advice will be obtained by the DME MAC.