Fact sheet

Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Final Rule (CMS-1738-F, CMS-1687-F and CMS-5531-F)

Dec 21, 2021 DMEPOS suppliers, Medicare Parts A & B

On December 21, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that furthers the agency's commitment to strengthen Medicare by expanding access to certain durable medical equipment, such as continuous glucose monitors that increase diabetes treatment choices for people with Medicare. The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) final rule aligns with the key goals of the Administration to create a health care system that results in better accessibility, quality, affordability, empowerment and innovation.

This final rule establishes methodologies for adjusting the Medicare DMEPOS fee schedule amounts and procedures for making benefit category and payment determinations for new items and services that are DMEPOS, therapeutic shoes and inserts, surgical dressings, or splints, casts, and other devices used for reductions of fractures and dislocations under Medicare Part B in an effort to prevent delays in coverage of such items and services. This final rule also classifies adjunctive continuous glucose monitors as durable medical equipment (DME) under Medicare Part B and finalizes certain DME payment provisions that were included in two interim final rules.

The final rule can be downloaded from the Federal Register at: https://www.federalregister.gov/public-inspection/2021-27763/medicare-program-durable-medical-equipment-prosthetics-orthotics-and-supplies-policy-issues-and

DMEPOS Fee Schedule Adjustments (CMS-1738-F)

This final rule establishes the methodologies for adjusting the fee schedule payment amounts for DMEPOS items furnished in non-competitive bidding areas (non-CBAs) on or after the effective date of the rule or the date immediately following the duration of the

COVID-19 public health emergency (PHE), whichever is later, using the information from information from the DMEPOS Competitive Bidding Program (CBP).

CMS will continue paying suppliers the 50/50 blend of adjusted and unadjusted fee schedule rates for furnishing items and services in rural and non-contiguous areas. These rates were informed by stakeholder input. Stakeholders have highlighted certain higher costs and greater travel distances in certain non-CBAs compared to CBAs, the unique logistical challenges and costs of furnishing items to beneficiaries in the non-contiguous areas, the significantly lower volume of items furnished in these areas versus CBAs, and concerns about financial incentives for suppliers in surrounding urban areas to continue including outlying rural areas in their service areas. CMS will continue to monitor payments in rural and non-contiguous areas and all non-CBAs, as well as health outcomes, assignment rates, and other information, and may also consider our payment methodologies toward DMEPOS items and services furnished in rural and non-contiguous areas and non-CBAs in the context of any future changes to the DMEPOS CBP.

For contiguous, non-rural areas, CMS will be paying suppliers 100 percent of the adjusted fee schedule rates using information from the DMEPOS CBP. For the former CBAs, CMS will be paying the single payment amounts (SPAs) established during DMEPOS CBP updated by an inflation adjustment factor on an annual basis.

Of note, since 2019, when the gap in the DMEPOS CBP first began, CMS has been incorporating into these fee schedule rates an update based on changes in the Consumer Price Index for All Urban Consumers (CPI-U). These past annual updates have not included any percentage declines, and the update for 2022 will be at least 5 percent for all areas. For 2022, the former CBAs will receive a 5 percent update and the non-CBA blended fees will receive between 5.1% (the unadjusted fee update) and 5.4% (the adjusted fee update). This final rule does not change these already existing payment methodologies found under § 414.210(g)(4) and § 414.210(g)(10).

DMEPOS Fee Schedule Adjustments for Items and Services Furnished in Rural Areas from June 2018 through December 2018 and Exclusion of Infusion Drugs from the DMEPOS Competitive Bidding Program (CMS-1687-F)

This final rule finalizes and addresses public comments received on the May 11, 2018 interim final rule (83 FR 21912) entitled “Medicare Program; Durable Medical Equipment Fee Schedule Adjustments to Resume the Transitional 50/50 Blended Rates to Provide Relief in Rural Areas and Non-Contiguous Areas.” Specifically, this rule finalizes provisions related to implementation of section 16007(a) of the 21st Century Cures Act (Pub. L. 114-255, December 13, 2016) as well as the increased payments in rural and non-contiguous

areas made from June 2018 through December 2018. In addition, we are finalizing

conforming technical changes to the regulations text to exclude infusion drugs from the DMEPOS CBP.

DME Interim Pricing in the CARES Act (CMS-5531-F)

This final rule finalizes and addresses public comments received on the May 2020 COVID-19 interim final rule with comment period (IFC) section titled “DME Interim Pricing in the CARES Act.” Specifically, this rule finalizes conforming changes to § 414.210(g)(9), consistent with section 3712 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020), which revises the fee schedule amounts for certain DMEPOS items and services furnished during the COVID-19 PHE using a blend of fee schedule amounts adjusted using information from the DMEPOS CBP and unadjusted fee schedule amounts.

Section 3712(a) of the CARES Act mandates that the fee schedule amounts for certain items furnished in rural and non-contiguous non-competitive bidding areas be based on a 50/50 blend of adjusted and unadjusted fee schedule amounts through the duration of the PHE, and section 3712(b) of the CARES Act mandates that the fee schedule amounts for these same items furnished in all other non-competitive bidding areas be based on a 75/25 blend of adjusted and unadjusted fee schedule amounts through the duration of the PHE.

Benefit Category and Payment Determinations for DMEPOS, Therapeutic Shoes and Inserts, Surgical Dressings, Splints, Casts, and Other Devices Used for Reductions of Fractures and Dislocations (CMS-1738-F)

This final rule establishes procedures for making benefit category determinations and payment determinations for new DMEPOS, therapeutic shoes and inserts, surgical dressings, or splints, casts, and other devices used for reductions of fractures and dislocations under Medicare Part B that permit public consultation through public meetings. CMS has established procedures for coding and payment determinations for new DMEPOS under Medicare Part B that permit public consultation in a manner consistent with the procedures established for implementing coding modifications for ICD-9-CM (which has since been replaced with ICD-10-CM as of October 1, 2015), in accordance with Section 531(b) of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (Pub L. 106-554). CMS started using these procedures for Healthcare Common Procedure Coding System (HCPCS) Level II code requests for items and services other than DME in 2005.

Interested parties may monitor CMS’ website at:
https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCSPublicMeetings

for additional information about upcoming public consultation, particularly in regard to new HCPCS Level II codes related to DME, prosthetics, orthotics and other items and services.

Classification and Payment for Continuous Glucose Monitors under Medicare Part B

This final rule classifies adjunctive continuous glucose monitors (CGMs) under the Medicare Part B benefit for DME.

However, CMS is not finalizing the proposed categories of supplies and accessories and fee schedule amounts for three types of CGM systems. After consideration of public comments, CMS does not believe it is necessary at this time to further stratify the types of CGMs beyond the two categories of non-adjunctive and adjunctive CGMs. The fee schedule amounts for the newly covered adjunctive CGMs and related supplies and accessories will be established in accordance with existing regulations for establishing fee schedule amounts for new DME items and services without a fee schedule pricing history at 42 CFR 414.238(b).

HCPCS Level II Code Application Process and Expanded Classification of External Infusion Pumps as DME

For the reasons described below, CMS is not finalizing its proposals regarding (1) the submission and evaluation of Healthcare Common Procedure Coding System (HCPCS) Level II code applications and (2) the proposed revision to our interpretation of the "appropriate for use in the home" requirement in the definition of DME as it applies to certain external infusion pumps.

CMS found it unnecessary to adopt the HCPCS Level II proposal as CMS has already made several administrative changes to the Healthcare Common Procedure Coding System (HCPCS) Level II editorial process that have improved the process and addressed many of the issues discussed in the proposed rule. CMS intends to continue to evaluate our processes, particularly as CMS and stakeholders continue to gain experience with the more frequent coding cycles.

With respect to our proposal related to external infusion pumps, many commenters believed that the proposal to expand classification of external infusion pumps as DME was unclear, needed more development, and raised safety concerns related to decisions regarding what drug therapies could safely be administered in a home/non-facility setting, as well as concerns about cost-sharing and cost-shifting to beneficiaries. After considering the public comments, CMS is not finalizing the proposed expanded classification of external infusion pumps as DME policy.

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7500 Security Boulevard, Baltimore, MD 21244