

Chapter 6: Pricing

Pricing Methodology

NOTE: The beneficiary's permanent address, rather than the location of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider, will determine the amount allowed by Medicare for a particular item or service.

There are three DMEPOS payment methodologies:

- **Fee Schedules** - Section 1834 of the Social Security Act (the Act) requires the use of fee schedules under Medicare Part B for reimbursement of durable medical equipment (DME) and for prosthetic and orthotic devices, beginning January 1, 1989. Payment is limited to the lower of the actual charge for the equipment or the fee established. Parenteral and enteral nutrition (PEN) services paid on or after January 1, 2002, are paid on a fee schedule. Prior to 2002, payment amounts for PEN were determined under reasonable charge rules, including the application of the lowest charge level (LCL) restrictions. Fee schedule amounts are updated annually to apply update factors, however, they can change as a result of the Centers for Medicare & Medicaid Services (CMS) quarterly updates to include new codes and correct errors.
- **Reasonable Charge** - Two criteria in Section 1842 of the Act that must be considered in determining the reasonable charge for a service are: 1) the customary charges for similar services generally made by the physician or other person furnishing such services, and 2) the prevailing charges in the locality for similar services. Therefore, the reasonable charge for a specific service in the absence of unusual medical complications or circumstances may not exceed the lowest of: a) the customary charge for that service; b) the prevailing charge made for similar services in the locality; or c) the actual charge for the service. Reasonable charge amounts are updated annually.
- **Drugs and Biologicals** - Drugs and biologicals not paid on cost or prospective payment basis have been paid based on the lower of the billed charge or 95 percent of the average wholesale price (AWP) as reflected in published sources (e.g., *Red Book*, *Price Alert*, etc.). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) changed the basis for payment of drugs and biologicals not paid on cost or prospective payment basis. Beginning January 1, 2004, through December 31, 2004, such drugs or biologicals are paid based on various standards specified in the statute, although the default standard is 85 percent of AWP. For services furnished on or after January 1, 2005, the payment allowance limit for drugs and biologicals is based on the average sales price (ASP). CMS provides the drugs and biologicals pricing updates on a quarterly basis.

Fee Schedules

Most payments for durable medical equipment (DME) are based on a fee schedule. The fee schedule allowances include the application of national floors and ceilings. DMEPOS are categorized into one of the following payment classes:

- Inexpensive or other routinely purchased DME
- Items requiring frequent and substantial servicing
- Certain customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment

CMS determines the category that applies to each Healthcare Common Procedure Coding System (HCPCS) code and issues instructions when changes are appropriate. In accordance with Section 30(c) of the MMA, the fee schedule update factors for 2004 through 2008 for DME, other than items designated as class III devices by the Food and Drug Administration (FDA), are equal to zero (0) percent. The HCPCS codes for DME designated as class III devices by the FDA are identified on the DMEPOS fee schedule by presence of the **KF** modifier. For additional information on fee schedules, refer to Chapter 20 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf>

Fee schedule allowances, including periodic updates, are posted to the DME MAC A Web site at <http://www.medicarehnic.com/dme/dmfees.shtml>. Suppliers **without** Internet access can obtain the fee schedules and updates by submitting a request **in writing** to the attention of “Freedom of Information” at DME MAC A (refer to Chapter 1 of this manual for the mailing address). Under the Freedom of Information Act (FOIA), there are fees associated with every request, and many of these fees are charged to the requester.

NOTE: Inclusion or exclusion of a fee schedule amount for an item or service does not imply any health insurance coverage.

Reasonable Charge

The income of an individual patient may not be considered in determining the amount of the reasonable charge. Public Law 96-499 requires that reasonable charge payments be based on customary and prevailing charge screens in effect on the date the service is rendered. However, if the service was rendered at any time prior to the current fee year, payment is based on the screens in effect during the preceding fee screen year. To implement this provision, Medicare contractors must complete the following activities:

- Retain the prior year's pricing files in the system so that reasonable charge pricing data is available for two years.
- Price the service based on the date of service on the claim using pricing files in effect for the same year as the date of service.

Durable medical equipment Medicare administrative contractors (DME MACs) update customary and prevailing charge limits at the beginning of each fee screen year (the 12-month period beginning in January), using available statistics on charges for services from claims processed or services rendered during the 12-month period ending June 30 immediately preceding the start of the fee screen year. Customary and prevailing charge screens for a fee screen year are not changed except for the following reasons:

- In individually identified and highly unusual situations where equity clearly indicates that the increases are warranted and requested by the entity furnishing the service
- To correct erroneous calculations
- To establish screens for new services

Customary Charge - The customary charge is the amount that best represents the actual charges made for a given medical service or by other persons who supply other medical and health services to the general public. Customary charges may be established using price lists when there is inadequate charge data. In this case, DME MACs use only the fees charged and the price lists in effect as of December 31 of the data base year. The intent is to use a price list which reasonably replicates the median of the prices charged by the supplier for his/her items and services during the data base year. Where the DME MAC permitted an increase in a customary charge under the equity provision, the increased amount is recognized as the customary charge for the next fee screen year if it exceeds the median of charges made by the physician or other person for the service during the twelve (12) months ending June 30 immediately preceding the start of that fee screen year. The increased amount is the correct customary charge for use in the appropriate prevailing charge calculation(s).

Prevailing Charge - Prevailing charges are those charges that fall within the range of charges most frequently and widely used in a locality for a particular procedure or service. The top of this range establishes an overall limitation on the charges that the DME MAC accepts as reasonable for a given procedure or service, except where unusual circumstances or medial complications warrant an additional charge. For any fee screen year, the prevailing charge limit in a locality for a service must be calculated as the 75th percentile of the customary charges determined for that service. The lowest customary charge which is high enough to include customary charges of the physicians or other persons who rendered 75 percent of the cumulative services is determined as the prevailing charge for the service.

Inflation-Indexed Charge (IIC) - Effective for services rendered on or after October 1, 1985, an additional factor, the inflation indexed charge (IIC), is added to the factors taken into consideration in determining reasonable charges for non-physician services (i.e., prosthetic and orthotic devices not subject to the fee schedules and certain medical supplies used in connection with home dialysis). The IIC is the lowest of the reasonable charge screens for the previous fee screen year updated by an inflation adjustment factor. The reasonable charge screens include the prevailing charge, customary charge, and the IIC. The inflation adjustment factor is based on the current change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending June 30. CMS issues the CPI to DME MACs annually.

For additional information on reasonable charges, refer to Chapter 23 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

Drugs and Biologicals

Examples of drugs and biologicals that are paid based on average wholesale price (AWP) include, but are not limited to, drugs furnished incident to a physician's service, immunosuppressive drugs furnished by pharmacies, drugs furnished by pharmacies under the durable medical equipment benefit, covered oral anti-cancer drugs, and blood clotting factors. A separate AWP is calculated for each drug as defined by a HCPCS code. Within each HCPCS code there may be a single source or there may be many sources, or there may be no source. The AWP is calculated as follows:

- For a single-source drug or biological, the AWP is equal to the AWP of the single product.
- For a multiple-source drug or biological, the AWP is equal to the lesser of: 1) the median AWP of all generic forms of the drug or biological; or 2) the lowest brand name product AWP, which is defined as a product that is marketed under a labeled name that is other than the generic chemical name for the drug or biological.

After determining the AWP, DME MACs multiply it by 0.85 or 0.95, or other percentage, as applicable, and round to the nearest penny. This is the drug payment allowance limit.

Beginning January 1, 2005, the payment limit for Part B drugs and biologicals will be based on the average sales price (ASP). Drugs will be paid based on the lower of the submitted charge or the ASP. These drugs continue to be priced based on date of service, and the payment limits are provided to DME MACs by CMS.

For additional information on drugs and biologicals pricing, refer to Chapter 17 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c17.pdf>

Pricing Gap-Filling

DME MACs must gap-fill the DMEPOS fee schedule for items which charge data are unavailable during the previous database period using the fee schedule amounts for comparable equipment, using properly calculated fee schedule amounts from a neighboring carrier, or using supplier price lists with prices in effect during the database year. DME MACs will gap-fill based on current instructions released each year for implementing and updating the new year's payment amounts. If the only available price information is from a period other than the base period, deflation factors are applied that are included in the current year implementation instructions against current pricing in order to approximate the base year price for gap-filling purposes. After deflation, the result must be increased by 1.7 percent and by the cumulative covered item update to complete the gap-filling. 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, fee schedule amounts are established at 75 percent of the fee schedule amount for new equipment.

For additional information on gap-filling DMEPOS fees, refer to Chapter 23 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c23.pdf>

Payment for Deluxe Features

The payment amount for a given item or service, whether rented or purchased, must be consistent with what is reasonable and medically necessary to serve the intended purpose. Additional expenses for “deluxe” features, or items that are rented or purchased for aesthetic reasons or added convenience, do **not** meet the reasonableness test. Thus, where an item or service is medically necessary and covered under the Medicare program, and the patient wishes to obtain such deluxe features, the payment is based upon the payment amount for the kind of item or service normally used to meet the intended purpose (i.e., the standard item). Usually, this is the least costly item. There may be times when it is determined that the payment amount for a more expensive item or service is reasonable, when the additional expense is for an added feature which is medically necessary in a given case. Under these circumstances, the payment amount will be based on the documentation submitted with the claim(s).

For additional information on payment for deluxe features, refer to Chapter 20 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf>

Individual Consideration

Items that require custom fabrication are unsuitable for grouping together for profiling purposes. Therefore, there are neither customary and prevailing charges nor fee schedules established. Payment for customized items without appropriate HCPCS codes (e.g., those billed with miscellaneous codes) are made in lump-sum based upon individual consideration for each item. In these situations, the supplier must include the **manufacturer's name**, **product name**, and **model number** when submitting claims for these items. Failure to furnish this information will result in a denial.

For additional information on payment of DMEPOS, refer to Chapter 20 of Pub. 100-4, *Medicare Claims Processing Manual*, <http://www.cms.hhs.gov/manuals/downloads/clm104c20.pdf>