

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.

Note: The beneficiary's permanent address, not your address, will determine the amount allowed by Medicare for a particular service.

There are three DMEPOS payment methodologies:

- **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 and/or quarterly updates for DMEPOS.

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.

- **Reasonable charge** - applies to the allowed amount for certain dialysis equipment and supplies. Reasonable charge amounts are updated annually.
- **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.

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. A standard 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 fee schedule allowances include the application of national floors and ceilings.

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
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment
- Surgical Dressings

For each class of equipment, payment is based on fees established effective January 1, 1989. These fees are indexed annually. After application of the annual fee update for all categories of DME except prosthetics and orthotics, the national floor and ceiling payment limits are applied. Payment for surgical dressing fees is an exception and is calculated using a 1992 base period.

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. Reasonable Charges

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 23, §80

The manner in which reasonable charge allowances are determined is stipulated by CMS (Internet Only Manuals, Publication 100-04, *Medicare Claims Processing Manual*, Chapter 23). It is not left to the discretion of the DME MAC. The instructions specifically state that the amount allowed by Medicare must be the lowest of:

- The actual charge;
- The supplier's customary charge or the 50th percentile of arrayed and weighted customary charges in the absence of a customary charge for the specific service rendered;
- The prevailing charge; or

- The Inflation-Indexed Charge (IIC)

Data regarding suppliers' fees is obtained by compiling information from claims that have been submitted. Records of all charges are kept on each claim processed during a calendar year. This information identifies the supplier, the type of service, the area in which the service was rendered, and the charge for that service. Effective with the 1995 reasonable charge updates, the data is compiled using beneficiaries' state of residency, rather than the area from which the service was rendered.

Beginning January of each year, the data accumulated from July 1st of the second preceding year through June 30th of the preceding year is arrayed to develop the current year's Annual Pricing Update of Medicare allowances. For example, data accumulated from July 1, 2005, to June 30, 2006, is arrayed to develop the Annual Pricing Update of Medicare allowances for 2007. The annual update reflects the changes in the fees most frequently charged by suppliers for a particular service, within a specific locality, during the 12-month period ending June 30th of the previous year. This time frame is referred to as the base year. The customary and reasonable charge effective for the new annual pricing update does not necessarily reflect the fees currently being charged.

Customary Charges

The customary charge is the charge that best represents the most frequently charged amount by a supplier for a particular service. In order to determine the customary charges for each individual supplier, the actual charges the supplier has submitted for services rendered during the year ending June 30th immediately preceding the start of the Annual Pricing Update (January of each year) for a given service, are arrayed in ascending order and the median charge is calculated. If you do not have at least three charges for a procedure code, then the 50th percentile of all other suppliers' customary charges weighted by frequency will be used as the customary charge.

The lowest actual charge, which is high enough to include the median of the arrayed charge data, is then selected as the suppliers' customary charge for the service. For example, if ABC supplier charges \$12.00 for a particular service 75 times during a calendar year and \$15.00 twelve times for the same service during the same calendar year, \$12.00 would best represent the actual charge made by that supplier.

The following is an example of how charges for a supplier would be arrayed in order to determine the customary charge.

| <u>Charge</u> | <u>Frequency Billed</u> | <u>Cumulative Frequency</u> |
|---------------|-------------------------|-----------------------------|
| \$10.00 | 20 times | 20 |
| \$12.50 | 40 times | 60 |
| \$14.00 | 35 times | 95 |
| \$15.00 | 5 times | 100 |

Based on the cumulative frequency of 100 submitted charges, the median charge would be the 50th charge. In this example, the median charge submitted is \$12.50. There must be at least three (3)

billed charges for the same procedure by the same supplier to establish a customary charge for that procedure within the base year.

Prevailing Charges

The prevailing charge is the 75th percentile of all suppliers' customary charges, within the beneficiary state for a specific service or procedure, weighted by frequency. Prevailing charges are calculated in much the same way as customary charges. The customary charge for each procedure is arrayed in ascending order and weighted by how often the supplier rendered the services as reflected by the data used to calculate the customary charge. The prevailing charge is established at the 75th percentile of these cumulative services. There must be at least four customary charges for a given procedure to establish a prevailing charge for that service.

The proper procedure for establishing prevailing charges is illustrated in the following example:

| <u>Customary Charge</u> | <u>Number of Supplies Rendered by Suppliers with Customary Charges as Indicated</u> | <u>Cumulative Services</u> |
|-------------------------|---|----------------------------|
| \$5.00 | 27 | 27 |
| \$6.00 | 30 | 57 |
| \$7.00 | 25 | 82 |
| <u>\$8.00</u> | <u>18</u> | <u>100</u> |
| TOTAL | 100 | |

In this example, 75 percent of the total of 100 supplies falls at the 75th supply. The 75th supply falls within the cumulative frequency of 82 submitted supplies, therefore \$7.00 becomes the prevailing charge.

Inflation-Indexed Charge (IIC) for Non-Physician Services

The IIC is the lowest of the reasonable charges for the previous Annual Pricing Update year updated by an inflation index factor. [The inflation index factor is based on the change in the Consumer Price Index (CPI).] The reasonable charges include the prevailing charge, customary charge, lowest charge level (if applicable), and the IIC. The IIC calculation does not take into account any reasonable charge limitation resulting from the application of comparability, inherent reasonableness, or the 50th percentile in the absence of a customary charge.

3. 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.
- 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, other than new drugs that are produced or distributed under a new drug application approved by the Food and Drug Administration (FDA), are based on the published wholesale acquisition cost (WAC) or invoice pricing.
- The payment allowance limits for new drugs that are produced or distributed under a new drug application approved by the FDA and that are not included in the ASP Medicare Part B Drug Pricing File or NOC pricing File are based on 106 percent of the WAC or invoice pricing if the WAC is not published. This policy applies only to new drugs that were first sold on or after January 1, 2005.

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
- Suggested retail price

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