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**FOR FURTHER INFORMATION CONTACT:** Joel Kaiser, (410) 786-4499.

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## I. Background

### A. DME Fee Schedule Payment Methodology

The Medicare Part B (Supplementary Medical Insurance) payment rules for durable medical equipment (DME) are located in section 1834(a) of the Social Security Act (the Act). In accordance with section 1834(a) of the Act, payment for DME is made on a fee schedule basis with items falling into several different payment categories, each with its own unique payment rules. The respiratory assist devices with bi-level capability would be placed in the category for other items of durable medical equipment, or capped rental items, as defined in section 1834(a)(7) of the Act.

Section 1834(a) of the Act provides that Medicare payment for DME is equal to 80 percent of the lesser of the actual charge for the item or the fee schedule amount for the item. It classifies DME into the following payment categories:

- Inexpensive or other routinely purchased DME.
- Items requiring frequent and substantial servicing (FSS).
- Customized items.
- Oxygen and oxygen equipment.

- Other covered items (other than DME).
- Other items of DME (capped rental items).

There are different payment rules for each category of DME. With the exception of customized items, fee schedule amounts are calculated for each item of DME, identified by codes in the Healthcare Common Procedure Coding System (HCPCS). The Medicare payment amount for a customized item of DME is based on the Medicare carrier's individual consideration of that item.

In general, the fee schedule amounts for DME are calculated on a statewide basis using average Medicare payments made in each State from 1986 and 1987 under the former reasonable charge payment methodology. The fee schedule amounts are generally adjusted annually by the change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending June 30 of the preceding year. The fee schedule amounts are limited by a ceiling (upper limit) and floor (lower limit) equal to 100 percent and 85 percent, respectively, of the median of the statewide fee schedule amounts.

Section 13543 of the Omnibus Budget Reconciliation Act of 1993 (OBRA of 1993) (Pub. L. 103-66) amended section 1834(a)(3)(A) of the Act to remove certain ventilators, namely "intermittent assist devices with continuous airway pressure devices," from the DME payment category for items requiring FSS. Payment for an item in the FSS category is made on a monthly rental basis, with rental payments continuing as long as the item remains medically necessary. The conference report for OBRA of 1993 states that "this category is intended to include items which require frequent servicing in order to avoid imminent danger to a beneficiary's health." Those ventilators which were excluded from the FSS category by OBRA of 1993 fall into the payment category for capped rental (CR) items. Payment for items in the CR category is made on a monthly rental basis, with rental payments being capped at 15 months or 13 months, depending on whether the beneficiary, based upon an option that must be offered by the supplier in the 10th rental month, chooses to continue renting the item or take over ownership of the item via the "purchase option" provided by the statute. If the beneficiary chooses the "purchase option," then rental payments continue through the 13th month of use and the title for the equipment transfers from the supplier to the beneficiary. Medicare would then make payments for any necessary

maintenance and servicing of the patient-owned equipment. If the beneficiary chooses to continue renting the equipment, then rental payments continue through the 15th month of use, and the supplier continues to own the equipment. The supplier must continue to supply the rented item to the beneficiary as long as medically necessary. The supplier is entitled to receive a semi-annual maintenance and servicing payment in an amount not to exceed 10 percent of the purchase price for the equipment as determined by the statute. Total Medicare payments made through the 13th and 15th months of rental equal 105 and 120 percent, respectively, of the statutory purchase price for the equipment.

Suppliers of DME must meet the standards specified in 42 CFR 414.57. These standards specify that the supplier "must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries." This requirement applies to items in both the FSS and CR payment categories. Therefore, for rental items in either category, the supplier is responsible for ensuring that the equipment is in good working order. In the case of items for which the patient has selected the purchase option, the patient arranges for the servicing and repair of the patient-owned equipment. Medicare payments are made as needed for maintenance and servicing of patient-owned equipment in the CR category.

It is not necessary for a respiratory therapist to perform the maintenance and servicing of respiratory assist devices. If DME suppliers perform maintenance and servicing of equipment, they are paid by Medicare for this service, regardless of whether the item is in the FSS or CR category. We are confident that this change in payment category will not result in a decrease in the current level of service being provided to the beneficiaries.

### B. HCPCS Coding for Respiratory Assist Devices

On January 1, 1992, code E0452 with the description of "intermittent assist device with continuous positive airway pressure device (CPAP)" was added and became effective in the HCPCS. This code was added to describe respiratory assist devices with bi-level air pressure capability, with or without a back-up rate, and with the ability to switch to CPAP mode. Bi-level pressure capability means that the device can deliver a lower level of pressure when the patient exhales than when the patient inhales, as opposed to CPAP, which is the