

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES PAYMENT SYSTEM

payment**basics**

Revised:
November 2025

Medical equipment needed at home to treat a beneficiary's illness or injury is covered under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) benefit. Medicare spent about \$9.1 billion on DMEPOS in calendar year 2024.

DMEPOS is defined as:

- **Durable medical equipment (DME)**—Items that can withstand repeated use, are primarily and customarily used for a medical purpose, are generally not useful in the absence of illness or injury, and are appropriate for use in the home (e.g., wheelchairs, hospital beds, oxygen equipment).
- **Prosthetics**—Devices that replace all or part of an internal body organ or replace external body parts (e.g., artificial limbs, pacemakers).
- **Orthotics**—Rigid or semi-rigid devices used for the support, alignment, or correction of body structure or function (e.g., braces, splints).
- **Supplies**—Medical supplies necessary for the effective use of DME or prosthetic/orthotic devices (e.g., ostomy supplies, diabetic testing strips).

Medicare Part B covers medically necessary DMEPOS prescribed by a clinician. Medicare does not cover DMEPOS that is unsuitable for use in the home (such as equipment used in hospitals or skilled nursing facilities) or that is intended to help outside the home (such as a motorized scooter for getting around outside the home). In addition, most items that are generally for convenience or comfort (such as grab bars) or disposable supplies not used with DMEPOS (such as incontinence pads) are not covered.

Historically, Medicare paid for all DMEPOS using a fee schedule. Since 2011, CMS has paid for certain types of products in specified areas using rates established under a competitive bidding program (CBP).

Items that have not been included in any rounds of the CBP continue to be paid using the historical DMEPOS fee schedule.

DMEPOS fee schedule

Except for items that have been included in a previous round of the CBP, Medicare pays for DMEPOS using a fee schedule. Fee schedule rates are largely based on supplier charges from July 1986 through June 1987 (updated for inflation) and on information such as unadjusted list prices for products introduced after this period. Medicare payment is equal to 80 percent of the lower of either the actual charge for the item or the fee schedule amount for the item. The beneficiary is responsible for 20 percent coinsurance after meeting the yearly Part B deductible (\$257 in 2025).

CMS calculates the DMEPOS fee schedule amounts for the following DMEPOS payment categories.

- **Inexpensive and other routinely purchased items**—These are items that, between July 1986 and June 1987, were either purchased at a price of \$150 or less, or were bought at least 75 percent of the time; or are accessories used in conjunction with certain nebulizers, aspirators, and ventilators. If covered, these items can be purchased new or used. They can also be rented, but total payment amounts cannot exceed the purchase amount for the item.
- **Frequently serviced items**—If covered, these items can be rented as long as they are medically necessary.
- **Oxygen and oxygen equipment**—One bundled monthly payment amount is made for all covered equipment, oxygen, and accessories. Medicare payment for oxygen equipment may not continue beyond 36 months of continuous use. After the 36-month rental cap, Medicare will continue to pay for oxygen and maintenance but not the equipment itself.

The policies discussed in this document were current as of September 30, 2025. This document does not reflect proposed legislation or regulatory actions.

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- **Other covered items that are necessary for the effective use of DMEPOS**—If covered, Medicare pays for the purchase of these supplies.
- **Capped rental items**—These items are not covered in any other DMEPOS category and are generally expensive items that have historically been rented. If covered, Medicare generally pays for the rental of these items for a period of continuous use not exceeding 13 months. The fee schedule amount is based on the base-year purchase price and varies by rental month.

Fee schedule amounts are not calculated for certain customized items. If covered, Medicare pays a lump-sum amount for the purchase of the item, as determined by the Medicare administrative contractor.

Competitive bidding

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) mandated the phase-in of a CBP for selected DMEPOS. Under the CBP, suppliers that seek to participate are vetted for financial stability and must meet licensure and accreditation requirements. Suppliers submit bids indicating the quantity of a given product that they can provide and the price that they are willing to accept. CMS estimates demand for a product in a competitive bidding area (CBA) and then awards contracts to suppliers, starting with the lowest bid and continuing until enough suppliers are selected to meet projected demand. The bid at which cumulative capacity meets or exceeds demand is referred to as the “pivotal bid.” Only suppliers with bids at or below the pivotal bid are awarded contracts, and the final payment amount, called the single payment amount (SPA), is based on their bids. The Medicare statute mandates that the DMEPOS CBP reduce Medicare expenditures. Accordingly, a key objective of CBP policy is to foster robust competition that leads to SPAs generating savings for both Medicare and its beneficiaries. Medicare payment for items paid under the CBP is 80 percent of the SPA; the beneficiary is responsible for the remaining 20 percent.

CMS initiated the first CBP round in 2011 followed by four rounds through 2018 that expanded it to new areas, added more DMEPOS items, and recompeteted earlier rounds. In 2019 and 2020, there was a temporary gap period during which no rounds of competitive bidding were active.

In 2021, CMS held a CBP round covering 15 product categories in 130 CBAs. Thirteen categories had been included in prior rounds, while off-the-shelf back and knee braces were new items included in that round of CBP. However, CMS did not award new contracts for the 13 previously included categories because the bids came in higher than existing payment amounts and would have increased Medicare spending by \$1.2 billion, inconsistent with the statutory goal of achieving savings. The bids for off-the-shelf back and knee braces produced lower payment amounts than the existing fee schedule, so for these items CMS awarded contracts estimated to save \$934 million.

After the 2021 round, CMS announced it would study the results for the unsuccessful items to refine the program. In 2023, CMS extended this pause with a “temporary gap period” for further evaluation. Since then, payment rates for items that have been included in a previous round of the CBP are paid the prior year’s rates, updated for inflation.

The CBP has driven down the cost of DMEPOS considerably for both Medicare and beneficiaries. Compared with payment rates in the year before competitive bidding, Medicare’s payment rates for some of the highest-expenditure DME products have fallen by an average of nearly 50 percent with no documented effect on beneficiary health outcomes. CMS estimated that the second round of CBP saved Medicare \$2 billion in 2013, lowering beneficiary cost sharing and Part B premiums. In 2021, new CBP contracts for off-the-shelf back and knee braces were estimated to save \$934 million. ■