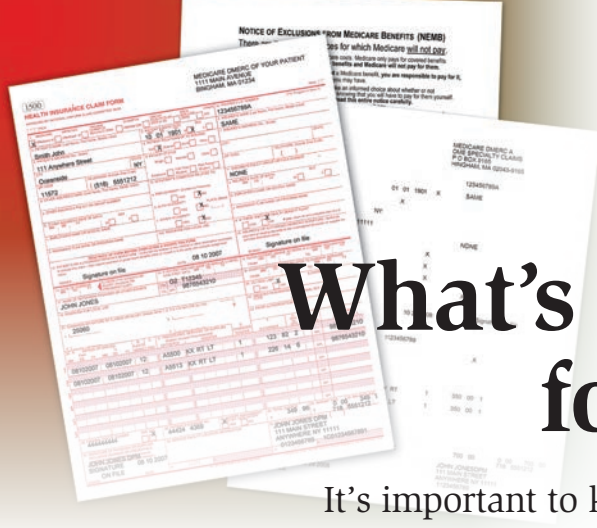

What's New in DME for 2026

It's important to keep up with these new changes.

BY PAUL KESSELMAN, DPM

Medicare, in addition to addressing the challenges that every new year brings, has also instituted innovative programs/policies which may affect your practice. This article will review the perennial issues every year brings, and provide comments on a few noteworthy programs for 2026.

Medicare Deductibles and Premiums

The projected Medicare Part B annual deductible for 2026 will rise from $257 to $288 with the basic monthly premium expected to rise 11.66% from $185 to $206.50. Prescription D annual deductibles and monthly premiums will increase to varying degrees depending on plan coverage. The Part D premiums and deductible changes are in large part due to caps on out-of-pocket maximums recently enacted into law. The COLA (Cost of Living Adjustment) is to rise 2.8% and will barely if at all cover the increases in Medicare premiums and deductibles, as well as the Part B supplement and Part D premiums and deductibles.

Increased premiums and deductibles translate to greater financial responsibilities for patients. Providers must also face the headache of dealing with dual eligible and QMB patients. These challenges make it important to:

1) Educate patients on their financial responsibilities prior to their examinations/treatments. Keep in mind the need for compliance with No Surprise rules (both Federal and State).

2) Collect appropriate amounts based on the insurer's fee schedule (if you are participating) and the surcharges if you are non-participating.

3) Submit claims in a timely fashion to avoid accusations of "double dipping"—that is when your practice collected the deductible from the patient and then you were subsequently paid by Medicare. This situation is due to your office either delaying claim submission or another healthcare provider's claim beating yours in processing. This all too often results in the other provider being "socked" with the deductible. Now begins the issues of calming down your patient and refunding the money to the patient or the other provider. The flip side is that your office did everything right and you are socked with the deductible, and another provider was paid by both Medicare and the patient. Now what do you do?

QMB and Dual Eligibles

For Qualified Medicare Beneficiaries (QMB) and dual eligibles (where Medicaid does not pay the Medicare deductible), the onset of a new year brings on a reset of the guessing game when the patient meets their deductible. One cannot necessarily check the deductible status on these patients. If your practice has many QMB patients, this potentially can result in a re-start of the annual first quarter cashflow crisis.

Employer Sponsored and Individual Exchange Plans

Due to increased premiums, employers are shifting greater cost-sharing to their employees, resulting in higher premiums as well as higher deductibles. Exchange patients face narrower choices and fewer cost sharing options, especially for those at lower economic levels with less governmental supplementation. This all translates to higher costs for all patients either on employee-sponsored or state exchange plans.

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Fee for Service Medicare Fee Schedule

As of the writing of this article, none of the local 2026 Medicare fee schedules have been released. For most physicians not in an alternative payment model, the projected 2026 Conversion Factor will rise by $1.05, reaching $33.40—a 3.26% increase from the current rate of $32.35. Decreases in work RVU for certain procedures and the continuation of sequestration will offset these increases. Additional factors contributing to

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changes in reimbursement for individual procedures include geographic practice cost indices as well as malpractice RVU. When factoring inflation and increased overhead expenses, most economic sources continue to project that net physician reimbursements have decreased significantly (~20%) over the past few decades.

Efficiency Adjustment

Efficiency adjustment is now considered when setting CPT/HCPCS reimbursement rates. This may decrease reimbursement for certain procedures where technology has

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contributed significant automation, resulting in improved procedure efficiency (less time). CMS is also developing a tabulation of codes exempt from this factor to increase their relative valuation. How this will affect lower extremity surgeons is unknown.

Fee for Service DMEPOS

The first quarter 2026 fee schedule is usually released in late December 2025. One can find this on the homepage of your DME MAC, PDAC, or CMS websites. Unlike medical/surgical services, DME is not based on the Medicare Conversion Factor, but on the Consumer Price Index (CPI). As of the end of August 2025, the CPI rose approximately 3%. This may be reflective of a 3% fee schedule increase.

Major tariffs on many imported goods could also affect suppliers who provide products to podiatrists. This has the potential to cause significant wholesale price increases on therapeutic shoes, prefabricated AFOs (e.g., cam walkers), surgical dressings, raw materials used for custom AFOs, and other product categories. It is highly doubtful that any increase in the DMEPOS fee schedule will have any significant impact on increased costs for imported DMEPOS.

Comprehensive Error Rate Testing (CERT) and Target Probe and Educate (TPE)

During the last quarter of 2025, the CERT error rates have gone down, with TPE success stories increasing. This is good news for both providers and DME MAC. Therapeutic Shoe success stories are increasing at least in DME MAC JB for providers who submit documentation to the CGS' Connect program. Suppliers submitting claims to DME MAC B and C are urged to research the Connect program via the JB JC websites. Here you can find out more about this program and how it can reduce your audit exposure for denial or recoupment.

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Cellular Tissue Products (CTP), New LCD, WISeR, and OIG

Several programs related to CTP will be introduced in January 2026—the first a new nationwide program impacting the use of CTP for diabetic foot ulcers (DFU) and venous leg ulcers (VLU). The CTP LCD requirements have been widely discussed. Since the updates to the LCD have been included in the 2026 PFS, and unless there are any last-minute modifications, these "future" LCD changes are expected to take effect on January 1, 2026.

CTP Applied in the Physician's Office

The 2026 PFS stipulates a single national payment rate of $127.28/cm² for CTP that come in sheets. This stipulation, regardless of your costs, ends the reliance of Average Sale Pricing (ASP) for sheet manufactured CTP. Reimbursement for liquid, powder, and gel CTPs are subject to the fee schedule of your local MAC. These CTPs will be included in accordance with the CTP LCD, and their related fees will be provided along with your local MAC fee schedule, which is typically released in late December.

Currently, the WISeR program is limited to selected medical policies and only in six states (New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington).

For now, the reliance on Average Sale Pricing (ASP) to determine the CTP pricing has been discontinued. Starting in 2027, the CTP will be split into four groups, and each group will be designated with its own pricing policy.

Hospital Outpatient Department Application of CTP

As of this writing, the ruling on hospital outpatient departments is still pending regarding 2026.

WISeR Program

Currently, the WISeR program is limited to selected medical policies and only in six states (New Jersey, Ohio, Oklahoma, Texas, Arizona, and Washington). For podiatrists, the only issue the WISeR pilot program targets is CTP for lower extremity non-healing wounds. The WISeR program allows physicians to submit prior authorization requests for CTP. If the provider elects not to participate in the WISeR program, their CTP claims will likely undergo pre-payment review. If your claim is denied, this could result in substantial financial loss. This pilot program, if successful, will no doubt be expanded to target more services. For more on the WISeR program see Nov/Dec 2025 *Podiatry Man-*

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agement. To access, scan the QR code at right.

It behooves any practitioner performing CTP implantation for either DFU or VLU to carefully review the LCD posted on your Medicare carrier's website.

OIG

What precipitated the new LCD and WISeR program were studies revealing an exponential growth in the use of CTP over the past few years ($252M in 2019 to $10B in 2024) as well as an OIG investigation. The latter documented a significant amount (in terms of dollars) of fraud and abuse of CTP. Other studies, while supporting increasing payments, illustrate that the large exponential growth is largely due to a few select providers, thus leaving many suggesting that Medicare is punishing ethical practitioners due to the acts of a few bad apples. A *Medical Economics* podcast by an OIG official is worth listening to. To access, scan the QR code at right.

Competitive Bidding and Consolidated Billing

Competitive Bidding, a program where suppliers bid to see who can provide certain DME services, has been on hiatus for the past year or two but should be back sometime in 2026. It is not yet clear which DME or geographic areas will be affected. All physicians (MD, DO, DPM, OD) under Medicare are exempt from submitting bids. However, all physicians must accept the contract rate in their area for those DMEPOS, subject to competitive bidding. The impact competitive bidding may have can be significant with some previous areas and DMEPOS having seen their fees reduced by 75% or more. What is known is that by statute, any item which is custom-fit or custom-fabricated is exempt from the competitive bid program. Products provided under the Therapeutic Shoe Program are not classified as DME and are excluded from Competitive Bidding because they are a distinct benefit established by Congress. The only impact this program may have for lower extremity physicians is when OTS orthotics such as CAM walkers (not custom fit), ankle sprain braces, or surgical dressings are included in this program.

Consolidated Billing

Understand the implications for patients during hospital stays, those enrolled in home hospice, those residing in Part A SNF, or for those receiving care from a home health agency. Unless otherwise noted, DME payments are bundled into the payments made to these entities. Be sure you properly identify the responsible party prior to rendering services or running up large bills. A recent OIG study of a seven-year period concluded that almost $23M in improper payments for DME were provided during in-patient hospitalization stays.

HCPCS

In the fall of 2025, CMS provided an extensive list of new HCPCS codes and narrative edits to some others. This has minimal impact on podiatric physicians. Due to the government shutdown an updated list is still pending as of November 2025.

Recovery Audit Contractor (RAC)

Cotivity (cotivity.com/about) took over as the DME RAC in mid-2025. As of the fall of 2025, they are just starting to increase the number of random audits. The RAC conducts post-payment audits and receives funding in accordance with a sliding percentage of the funds recovered from healthcare providers. In other words, they are "bounty hunters". Be sure to request an extension from the outset to provide you with adequate time to review charts, receive professional assistance, and/or to obtain legal counsel (if necessary) prior to responding to any RAC audit. Asking the RAC for an extension early on will almost be guaranteed to be met with a favorable response. Waiting until close to the deadline will make you seem more desperate and may result in a denial of an extension.

If your RAC audit involves more than one claim, hiring an expert witness on your own and/or contacting your professional liability carrier is highly recommended. Whoever is responsible to respond to the RAC, be sure that response is comprehensive, legible, tracked through their portal, and provided prior to any imposed deadline. The RAC is continuing both automated and complex audits on therapeutic shoes and AFOs (off-the-shelf, custom fit, and custom-fabricated). Many of these audits are based on medical necessity (same or similar) issues, lack of proper coordination with other physicians, etc.

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Fast Healthcare Interoperability Resources (FHIR)

This pilot HL7 program promises to connect payers, providers, and IT companies in "real time". This program is of great interest to CMS and its collaborative partners, which will make prior authorization happen in real time. This allows DME providers to coordinate the medical notes of the prescribers and DME providers. Because podiatrists are physicians under Medicare and prescribe and dispense, our position is very attractive to CMS and the companies involved in developing FHIR. While it will initially only concentrate on prior authorization, it promises to expand. This may allow FHIR to coordinate appeals (first and second level), audit response, same and similar look-ups and eligibility, and deductible status in real time. CMS and all payers all want this program to succeed as they see this as a cost-saving measure for payers and

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providers. Much more information will be available, including provider surveys, to be distributed by the DME MAC and others in December 2025 and the first quarter of 2026.

Provider Portals

All four DME MACs are requesting that providers interact primarily with the portal for most functions. This no-cost program allows providers to download EOMB, submit prior authorizations and redeterminations, research same or similar, and much more. Check out the Noridian Provider portals and myCGS provider portals on the Noridian and CGS home pages for each of the DME MACs. Each quarter there are at least two or three major updates, many based on subscriber and Medicare Council requests.

Prior Authorization for DME

Medicare continues to expand prior authorization to reduce fraud and abuse in DME. Currently the only orthotic prosthetic prescribed, or prescribed and dispensed, by podiatrists is the off-the-shelf spiral AFO L1951. Both the Noridian and myCGS provider portals provide an easy-to-use format by which to upload the required documentation (your chart notes). This provides an almost seamless way to obtain prior authorization in less than seven workdays. Alternatively, L1952 is the same as L1951, and requires fitting and adjustment by a qualified provider (MD/DO/DPM/CO/CPO). However, L1952 does not require prior authorization. Both L1951 and L1952 share the same fee schedule. Currently, the affirmation rates for all AFOs subject to prior authorization exceeds 80%.

Part B Drugs Move to Part D or Part D Meds move to Part B

Rumors continue about moving specific drugs from Part B (which you can bill out of your office) to Part D (paid by the patient's pharmaceutical plans), or vice versa. Each drug under consideration has its own set of potential advantages and disadvantages regarding these possible changes. How or whether this has an impact on podiatrists or any lower extremity physician remains to be seen.

Lymphedema Act

This almost two-year-old national policy provides qualified patients with three pairs of daytime stockings per anatomical part every six months and two pairs of night-time stockings every two years. The HCPCS codes are day vs. nighttime and anatomically specific. Podiatric physicians may both prescribe and dispense these to qualified patients based on their state scope of practice through the appropriate DME carrier. For more information, please scan the QR code at right.

Medicare Part C Plans

Part C fee schedules are frequently set based on benchmarks from traditional fee-for-service. Hence you can expect changes within these programs. Continued challenges exist dealing with these plans, which are now servicing more than 50% of the Medicare population. This includes fees often at 60% or less of traditional Medicare, not following CCI rules, not following the coverage parameters set out by Medicare, often denying prior authorization requests, despite meeting coverage criteria or providing prior authorization approval and then denying them on claim submission.

The data mining harassments have continued. For most providers, your contract does permit charging and receiving payment for these records prior to submitting any data. UHC recently announced they expect to lose an estimated one million Part C members during the 2026 enrollment process. Where these patients are moving to—other Part C plans or traditional fee-for-service—is unknown in November 2025.

Telehealth

Many providers have reduced or discontinued telehealth services, as regulatory policies return to those in place prior to Covid flexibilities. The government shutdown does not permit the more flexible allowances created by Covid, but which were never made permanent. If you have performed telehealth services during the shutdown and did not submit those claims, please check for updates on how to currently submit those claims—this particularly if the shutdown has ended and Congress has extended more flexible telehealth regulations.

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Summary

Every new year brings with it a reset and chance to start anew. Unfortunately, in the medical field, it also means starting afresh with new deductibles, new copayment limits, patients switching plans, and new coverage policies. It is especially important at this time of the year to check patients' eligibility, deductible and copayment status, as well as checking your top insurance partners for potential coverage changes. Patients deserve to be informed of their financial responsibilities in accordance with the No Surprise Rules. This is especially important to provide prior to embarking on any expensive treatments or services not covered by their plans. PM

Dr. Kesselman is board certified by ABFAS and ABMSP. He is a member of the Medicare Jurisdictional Councils for the DME MACs and a member of the enrollment subcommittee. He is a noted expert on durable medical equipment (DME) and consultant for DME manufacturers worldwide. He is the owner of Park DPM and co-owner of PARE Compliance. He is also co-owner of Codinghelpline.com, a new online forum for coding and reimbursement and was elected to the *PM* Podiatry Hall of Fame.