

MEDICARE COVERAGE FOR DURABLE MEDICAL EQUIPMENT (DME)

MEDICARE'S DEFINITION OF DME

- Durable (can withstand repeated use); and
- Appropriate for use in the "home" ("primarily used at home," but not exclusively); and
- "Home" does not include a hospital or skilled nursing facility; and
- Primarily and customarily needed for a medical purpose (generally the DME is not useful to someone who is not sick or injured); and
- Necessary and reasonable for treatment of a condition or injury.

CRITERIA TO QUALIFY FOR DME COVERAGE

- The beneficiary is enrolled in Medicare Part B; and
- Need for DME is documented by practitioner who Certifies Medical Necessity (CMN); and
- Practitioner completes an Order (may be with the assistance of a physical therapist, occupational therapist or speech-language pathologist); and
- After a face-to-face meeting with the treating practitioner (certifications via telehealth are permitted, subject to certain limitations).

DME IN TRADITIONAL MEDICARE

OBTAINING MEDICARE-COVERED DME – GENERALLY

- Ask the prescriber to recommend suppliers they know and have worked with before.
- At <https://www.medicare.gov/medical-equipment-suppliers/> enter beneficiary zip code, then...
 - ✓ Locate the covered item or service on the list
 - ✓ Review the list of suppliers that accept Medicare assignment for that item or service
 - If no suppliers accept assignment, look for enrolled suppliers
 - ✓ Contact several suppliers for information. Have the prescription and doctor's notes ready to provide data
- Can also call 1-800-MEDICARE for assistance.

OBTAINING MEDICARE-COVERED DME – FOR A SPECIFIC ITEM

- A practitioner should prescribe the specific item.
- A practitioner should document the need for that specific item/supply in the medical record.
- The supplier is required to do one of the following:
 - ✓ Give the exact brand/form of item/supply requested, or
 - ✓ Work with the practitioner to find another brand/form the prescriber agrees is both safe and effective.

BENEFICIARY COSTS FOR MEDICARE-COVERED DME

- Annual Part B deductible, if not already met; and
- 20% of the Medicare-approved/allowed amount for Medicare-covered items, if Medicare-enrolled supplier “participates” in Medicare (accepts Medicare “assignment” as the full-price).
- If a Medicare-enrolled supplier does not participate in Medicare (“accept Medicare assignment”), there is no limit on the amount they can charge.
 - Medicare will only pay up to the Medicare-approved/allowed amount.
- If a supplier is not enrolled in Medicare, no payment will be made by Medicare.
- EXAMPLE of charges by various types of suppliers:
 - XYZ supplier has a \$150 walker for sale; Medicare allowed amount is \$100
 - If XYZ is a Medicare-enrolled participating supplier Medicare will pay \$80, beneficiary will be responsible for **\$20**.
 - If XYZ is a Medicare-enrolled non-participating supplier, Medicare will pay \$80, beneficiary may be responsible for up to **\$70** (\$150-\$80).
 - If XYZ is not Medicare-enrolled as a supplier, Medicare will pay nothing, beneficiary may be responsible for up to **\$150**.
- Note: Off-the-shelf knee braces and back braces may have to be purchased through Medicare-determined Competitive Bid Suppliers to be covered by Medicare. Search supplier website at Medicare.gov, above.

DME –TO RENT OR TO PURCHASE?

- Inquire with the supplier about rental or purchase options on each item.
- Inexpensive or customized items are typically purchased.
- Generally, most higher-cost, non-custom DME needed longer-term are rented via a 13-month rental program with ownership then transferring to the beneficiary.

DME – RENTED

- Medicare makes monthly payments (length of time of the payments varies by type of equipment – most are 13 months).
- A supplier picks up the equipment when it requires repair, or it is no longer needed.
- The cost of repairs or replacement parts are the supplier’s responsibility during a rental period.

DME – PURCHASED

- Medicare usually covers the cost of repairs or replacement parts for beneficiary-owned items.
- An item may be replaced if lost, stolen, damaged beyond repair, or used by the individual for more than the “reasonable useful lifetime” of the item.

DME – DELIVERY, SET-UP, TRAINING

Delivery, set-up and training is usually included as part of the Medicare’s payment for DME (whether purchased or rented) when an item is obtained from a Medicare participating supplier.

DME – REPAIRS

- If a beneficiary owns an item, Medicare covers costs to make it serviceable, unless the item is already under manufacturer or supplier warranty.
- If a beneficiary rents an item, the supplier is responsible for all repairs, there is no additional Medicare coverage for repairs.
- No new Certificate of Medical Necessity or Order is required for repairs.
- Medicare covers repairs for most items obtained before someone is eligible for Medicare.
- While repairs are underway, Medicare covers a temporary replacement item.

DME – MAINTENANCE

- Routine testing or cleaning (per an owner’s manual) is not covered.
- Maintenance required by an authorized technician is covered.
- No new Certificate of Medical Necessity or Order is needed for maintenance.
- When ownership transfers to the beneficiary after a rental period ends, maintenance will be covered after the later of:
 - 6 months from the end of the final rental month, OR
 - When the item is no longer covered by a warranty.

DME – REPLACEMENT

- After irreparable damage (e.g., fire, flood)? A beneficiary needs new Certificate of Medical Need and Order
- After a reasonable useful lifetime – minimum of 5 years
- “Reasonable useful lifetime” is defined by Medicare as based on the date the equipment is delivered to the beneficiary, not on the age of the equipment. (Advocacy Tip – A beneficiary may want to ask for a new item, or a newer item with the least wear and tear as possible.)

DME – COVERAGE FOR “UPGRADES”

- Generally, Medicare pays based on a “standard” item.
- However, if added features are medically necessary, additional Medicare payment may be considered “reasonable”.
- A supplier “participating” in Medicare may not charge for features that are not medically required unless:
 - A beneficiary specifically requests an upgraded item;
 - A beneficiary is informed of the amount she/he will be charged, and;
 - An advanced beneficiary notice (ABN) must be provided by the supplier as documentation that beneficiary has made such an informed request.

DME IN DISASTERS OR EMERGENCIES

If items are damaged or lost due to a disaster or emergency:

- In most cases, Medicare will cover the cost of repair or replacement.
- In most cases, Medicare will cover the cost of a rental during repair or replacement.

DME - REQUIRED PRIOR AUTHORIZATION

Prior authorization is required for some items of durable medical equipment, 45 items (suspended during the COVID public health emergency):

- Some power wheelchairs and some “support services” items (including pressure reducing mattresses, mattress overlays, powered air floatation beds)
- Claims for these items must receive prior authorization before the item is furnished, or a claim is submitted, as a condition for payment (supplier should know if an item needs prior authorization).

DME – VOLUNTARY PRIOR AUTHORIZATION

- Advance Determination of Medicare Coverage (ADMC) is available for some customized DME (to determine if medically necessary).
- For items generally with an average purchase of \$1,000 or greater, or average rental fee of \$100/month or greater.
- Caution: If prior authorization is denied, only one re-submission is allowed per six-month period, but the supplier may still submit a claim to Medicare without prior authorization.

INFORMING SUPPLIERS OF BENEFICIARY LIFE CHANGES

There are times when a beneficiary may need to tell a supplier about changes that will affect how and when a beneficiary gets durable medical equipment. Beneficiaries should let a supplier know if they are:

- Changing insurance companies
- Changing doctors
- In the hospital or will soon be admitted to the hospital
- In a nursing home or will soon be admitted to a nursing home
- Traveling
- Moving
- Beneficiary or secondary contact information has changed
- If a beneficiary uses oxygen and needs a portable oxygen concentrator (POC) for travel, they should let a supplier know weeks in advance.

DME - QUESTIONS AND COMPLAINTS

- Contact a supplier to receive a required response to a question or complaint:
 - Within 5 days the supplier must confirm receipt and confirm investigating
 - Within 14 days the supplier must respond with investigation result in writing
- Or, call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048)
Or, mail Medicare Contact Center Operations, PO Box 1270, Lawrence, KS 06044
- For further investigation, submit patient consent in English or Spanish:

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10106.pdf>

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10106S.pdf>

DME - APPEALS

- For Traditional Medicare
<https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals>

DME IN MEDICARE ADVANTAGE PLANS

- Medicare Advantage plans must cover at least the same items and services as traditional Medicare; plans may cover more, not less.
- Beneficiary out-of-pocket DME costs will depend on the Medicare Advantage plan chosen, typically 20% - 50% co-insurance.
- To determine if an item is covered, and the cost to the beneficiary, call the plan and ask for the “Utilization Management Department”.
- To appeal a denial, start the appeal process through the plan. A beneficiary should follow the directions in the plan's initial denial notice and plan materials.

DME EXAMPLES

MEDICARE-COVERED DME

- Hospital Beds
- Manual Wheelchairs and Power Mobility Devices
- Hemodialysis equipment
- Respirators
- Crutches, Canes, Walkers & Commodes (not white canes)
- Sleep Apnea and Continuous Positive Airway Pressure (CPAP) devices
- Oxygen equipment and accessories
- Nebulizers and nebulizer medications
- Blood sugar monitors and test strips
- Infusion pumps, infusion drugs and non-drug supplies
- Speech Generating Devices (SGD)

NON-COVERED DME IN TRADITIONAL MEDICARE

- Equipment designed for comfort/convenience.
- Physical fitness or self-help equipment
- Devices and equipment used for environmental control

BENEFICIARY CHECKLIST: QUESTIONS TO ASK WHEN LOOKING FOR DME SUPPLIERS

- ✓ Do you sell & service “_____” item? Is it in stock or when can you get it?
 - ✓ Are you a Medicare enrolled supplier?
 - ✓ Do you accept Medicare assignment (Medicare allowed charges)?
 - ✓ If not, will you consider accepting assignment in my case?
 - ✓ If not, what is your non-assignment charge?
 - How is the charge imposed – outright payment or rental?
 - Is there an extra charge for necessary delivery/set up/training?
 - ✓ Will you work directly with my prescriber or will I need to intervene?
 - ✓ What is your process for delivery/set up/training of the item?
 - ✓ Will you bill Medicare directly?
 - ✓ Do you have a direct customer service representative I can contact? If so, how?
 - ✓ What are your company policies about customer responsiveness/follow through?
 - ✓ If you are not geographically convenient for me, do you have customer service representatives in my area?
 - ✓ How will you perform maintenance or repairs if I rent the item?
 - ✓ How will you perform maintenance or repairs or if I purchase/own the item?
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Note: Check into and consider positive reviews or concerns raised by other beneficiaries about suppliers through other sources, such as the Better Business Bureau and/or online reviews.

BENEFICIARY RESOURCES

- Locate suppliers at <https://www.medicare.gov/medical-equipment-suppliers/>
- Official Medicare booklets at [Medicare.gov/publications](https://www.medicare.gov/publications):
 - ✓ “Medicare Coverage of Durable Medical Equipment and Other Devices”
<https://www.medicare.gov/sites/default/files/2020-08/11045-medicare-coverage-of-dme.pdf>
 - ✓ “Your Guide to Medicare’s Durable Medical Equipment Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program”
<https://www.medicare.gov/sites/default/files/2021-02/11461-DMEPOS-Competitive-Bidding-Program.pdf>
 - ✓ “Medicare’s Wheelchair & Scooter Benefit”
<https://www.medicare.gov/sites/default/files/2019-11/11046-Medicare-Wheelchair-Scooter.pdf>
- Medicare Competitive Bidding Ombudsman (CBO):
 - ✓ Email: CompetitiveAcquisitionOmbudsman@cms.hhs.gov
 - ✓ Website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Competitive_Acquisition_Ombudsman
- Beneficiary appeals process information: <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals>; <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicareappealsprocess.pdf>
- Medicare Advantage Contract Supplier Standards and Beneficiary Protections, see <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019326>
- Medicare Benefit Policy Manual Chapter 15
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf>
- Medicare Claims Processing Manual Chapter 20
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c20.pdf>
- Medicare Rights Center Oxygen Equipment Toolkit
<https://medicareinteractive.org/pdf/Medicare-Advocacy-Toolkit-Oxygen-Equipment.pdf>
- Medicare Rights Center Power Wheelchair Equipment Toolkit
<https://www.medicareinteractive.org/pdf/Medicare-Advocacy-Toolkit-Power-Wheelchairs.pdf>

CENTER FOR MEDICARE ADVOCACY

The Center for Medicare Advocacy, founded in 1986, is a national, non-profit law organization that works to ensure access to Medicare, health equity, and quality health care. The Center is based in Connecticut and Washington, DC, with additional attorneys around the country.

Based on our work with real people, the Center advocates for policies and systemic change that will benefit all those in need of Medicare, health care coverage and care.

Staffed by attorneys, legal assistants, a nurse consultant, and information management experts, the organization represents thousands of individuals in appeals of Medicare denials. The work of the Center also includes responding to over 7,000 calls and emails annually from older adults, people with disabilities, and their families, and partnering with CHOICES, the Connecticut State Health Insurance Program (SHIP).

Only through advocacy and education can older people and people with disabilities be assured that Medicare and health care are provided fairly:

- We offer education and consulting services to help others advance the rights of older and disabled people and to provide quality health care.
- We draw upon our direct experience with thousands of Medicare beneficiaries to educate policy-makers about how their decisions play out in the lives of real people.

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LOCAL HELP FOR PEOPLE WITH MEDICARE