

# Medicare Home Health and DME Updates

**Wednesday, June 4, 2025**

**Presented by**

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# About the Center for Medicare Advocacy

The Center for Medicare Advocacy is a non-profit, non-partisan law organization founded in 1986 that works to advance health equity, access to comprehensive Medicare, and quality health care. Based in Connecticut and Washington DC with additional attorneys in California, Maryland, Massachusetts, and Wisconsin.

- Attorneys, advocates, communication and technical experts
- Education, legal analysis, writing, assistance, and advocacy
- Systemic Change - Policy and Litigation
  - Based on our experience with the problems of real people
- Medicare coverage and appeals expertise
- Medicare/Medicaid Third Party Liability Projects

# Agenda

## 1. Welcome

- Matt Shepard (Communications Director, CMA)
- Angel Heinz (Public Policy Manager, Reeve Foundation)

## 2. Durable Medicare Equipment Coverage Overview

- Sheri Denkensohn (Attorney & Disability Advocate, Happy on Wheels)
- Eric Krupa (Supervising Attorney, CMA)

## 3. Home Health Coverage Overview

- Christine Huberty (Attorney, CMA)
- Wey-Wey Kwok (Senior Attorney, CMA)

## 4. Questions and Discussion

# *Medicare Home Health and DME Updates*

Angel Heinz  
Public Policy Manager,  
Christopher & Dana Reeve Foundation




**#VoicesForReeve**





## Our Mission

We are dedicated to curing spinal cord injury by advancing innovative research and improving the quality of life for individuals and families impacted by paralysis.






# Today's Care, Tomorrow's Cure

The Reeve Foundation remains committed to supporting the paralysis community, especially during uncertain times. For more than 20 years, we have operated the National Paralysis Resource Center (NPRC) through a competitive cooperative grant with the Administration for Community Living (ACL) at the U.S. Department of Health and Human Services (HHS).

The Reeve Foundation is the only federally funded entity dedicated to directly supporting the paralysis community.

As the recognized leader in the field, we provide free, comprehensive information and personalized resources directly to the paralysis community. Through our Quality of Life Grants program, we have invested more than \$46 million in nonprofit organizations and projects that empower people living with paralysis, their families and caregivers across all 50 states, Washington D.C., and U.S. territories.



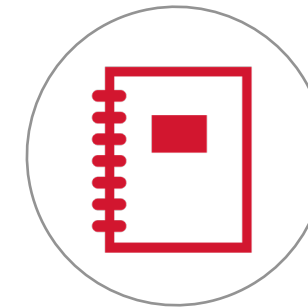
# Today's Care

**Information Specialists**  
**130,000+** families have received one-on-one assistance



**Quality of Life Grants**  
**\$46 million+** awarded to over **3,900** non-profit programs in all **50 states**

**Reeve Summit:  
Where Care, Cure and Community Connect**  
Annual summit with a spectrum of care and cure topics designed for the community and professionals



**Paralysis Resource Guide**  
**235,000+** copies distributed to the Reeve Foundation's community

**Advocacy & Public Policy Program**  
12,000 online advocates for change in all 50 states



**1st** call made when loved one is diagnosed with paralysis



**Health-Related Materials**  
**300,000+** pageviews, video views and downloads of educational content annually

**Military and Veterans Program**  
Supports the specific needs of **service men and women** regardless of when they served or how they were injured



**Peer & Family Support Program**  
**27,000+** people have received support from **560+** certified peer mentors who are also living with paralysis

# We need your help!

- The President's budget proposal released on May 30 calls for the complete elimination of funding to the Paralysis Resource Center, along with other vital programs serving people living with disabilities.
- If Congress adopts this proposal, it will dismantle the only national resource dedicated entirely to supporting people living with paralysis.
- Take action now! Tell your legislators: don't abandon the paralysis and disability community. Reject the President's Budget Proposal and FULLY FUND the PRC in FY2026.
  - Tell your legislators how the PRC has impacted you or your family. They need to know.
  - Always remember YOUR Voice Matters!



Scan the QR Code to Take Action Now!

Or Go to

[www.christopherreeve.org/saveprc](http://www.christopherreeve.org/saveprc)

# Medicare Coverage of DME



# Medicare's DME Definition

- Durable
  - Can withstand repeated use
- Has an expected life of at least 3 years
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to an individual in the absence of an illness or injury
  - E.g., stairway elevators, exercise equipment, and dehumidifiers are excluded
- Is appropriate for use in the home

## “Use in the Home”

- “Home” is a beneficiary’s dwelling, apartment, relative’s home, home for the aged, assisted living facility, intermediate care facility.
- “Home” is not a hospital or skilled nursing facility.
- If a person is “home” for part of a month (but in an institution, or outside U.S. for part of a month), Medicare payment will be made for entire month.

# Coverable DME

- Examples of DME include hospital beds, manual wheelchairs and power mobility devices, hemodialysis equipment, respirators, CPAP devices, oxygen equipment and accessories, nebulizers and nebulizer medications, blood sugar monitors and test strips, infusion pumps and supplies, and speech generating devices.
- Payment may be made for supplies that are necessary for the effective use of the equipment. Such supplies include those drugs and biologicals which must be put directly into the equipment in order to achieve therapeutic benefit.
- Consult national and local coverage determinations for specific questions: [MCD Search](#).

# Medicare Advantage vs. Traditional Medicare Coverage

- DME is traditionally covered under Part B.
- Medicare Advantage Plans must cover all medically necessary services and equipment that traditional Medicare covers.
- Medicare Advantage Plans may have a limited number of in-network suppliers
- Prior authorization
  - In traditional Medicare, required for a limited number of items, mostly power wheelchairs
  - In Medicare Advantage, required much more frequently

# Obtaining DME

- Treating provider is required to order the DME
  - Depending on the circumstances, prior authorization, a Certificate of Medical Necessity (CMN), and/or a face-to-face meeting may be required.
- Ask the ordering provider to recommend a supplier
  - You can also search for a supplier on your own: [Durable Medical Equipment Cost Compare | Medicare.gov](#)
- Delivery, set-up and training should be included when the DME is obtained from a Medicare participating supplier



# Types of Suppliers

- Participating
  - Must accept Medicare allowed charge as full payment
- Non-participating
  - May charge above Medicare rate
  - May agree to accept assignment on a case-by-case basis
- Not enrolled
  - No Medicare payment will be made to the supplier or patient

# Rent vs. Own

- A Medicare enrolled supplier should know when Medicare will purchase or rent for a beneficiary.
- Most items of DME needed longer-term are rented via a 13-month rental program. Thereafter, ownership transfers to the beneficiary.
- Medicare typically purchases inexpensive items and customized items.
- If rented, Medicare makes monthly payments. The supplier will pick up the equipment when it requires repairs or is no longer needed.

# Repairs, Maintenance, and Replacement

- If owned, Medicare covers costs to make the equipment serviceable, unless it is under manufacturer or supplier warranty
- If rented, the supplier is responsible for repairs at no additional cost
- Costs of repair for items obtained before becoming Medicare enrolled should be included
- While repairs are underway, Medicare covers temporary replacement
- Maintenance required by authorized technician is covered, but routine testing and cleaning is not
- Replacement possible if irreparable damage and after a “reasonable useful lifetime.”

# Costs

- Coverage does not equal payment in full
- Costs differ whether in enrolled in traditional Medicare or Medicare Advantage
- Part B typically covers 80% after deductible is met. A Medigap plan may help with these costs.
- Costs vary widely between Medicare Advantage plans. Do your research before making a switch.

# Other Considerations

- Need a specific item? Work with your ordering provider to ensure the order is written with care and documents the need for the specific item
- Medicare or Medicare Advantage denials are appealable. Always request prior authorization and billing denials in writing. Directions to appeal should be provided.
- Complaints? [Filing a complaint | Medicare](#)
- Ongoing temporary gap period for the Competitive Bidding Program. Check for updates here: [DMEPOS Competitive Bidding | CMS](#)



# Medicare's Home Health Benefit

# Coverage Criteria Overview

## Under the Care of an Approved Provider

- Certified Plan of Care every 60 days  
AND
- Initial Face-to-Face Encounter & Certification

## Confined to Home ("Homebound")

- Inability to leave without device or assistance and/or leaving is contraindicated  
AND
- Requires a considerable and taxing effort to leave
- (Not bound to house)

## In need of reasonable and necessary skilled services

At Least One Required In Order To Qualify For Coverage

- Intermittent Skilled Nursing
- Physical Therapy
- Speech Language Pathology
- Continuing Occupational Therapy

# Homebound Requirement

**1<sup>st</sup> Prong** - the patient must **either**:

- Because of illness or injury, need the aid of a supportive device; the use of special transportation; or the assistance of another person to leave their residence; **OR**
- Have a condition such that leaving home is medically contraindicated.

**2<sup>nd</sup> Prong:**

- There must exist a normal inability to leave home;

**AND**

- Leaving home must require a considerable and taxing effort.

# Skilled Service

- **Skilled:** inherent complexity of the service, performed safely and/or effectively only by or under general supervision of qualified professional.
- **Medically reasonable and necessary:** based on an *individualized assessment* of patient's condition, to:
  - Treat patient's illness or injury **OR**
  - Maintain patient's current condition or prevent or slow further deterioration
- **Restoration potential is not the deciding factor** in determining whether skilled services are needed.

*42 C.F.R. § 409.32*

# What is “Intermittent” Skilled Nursing?

- **Less than daily visits**, but at least once every 60 days or, if less frequently, on a predictable, recurring basis,

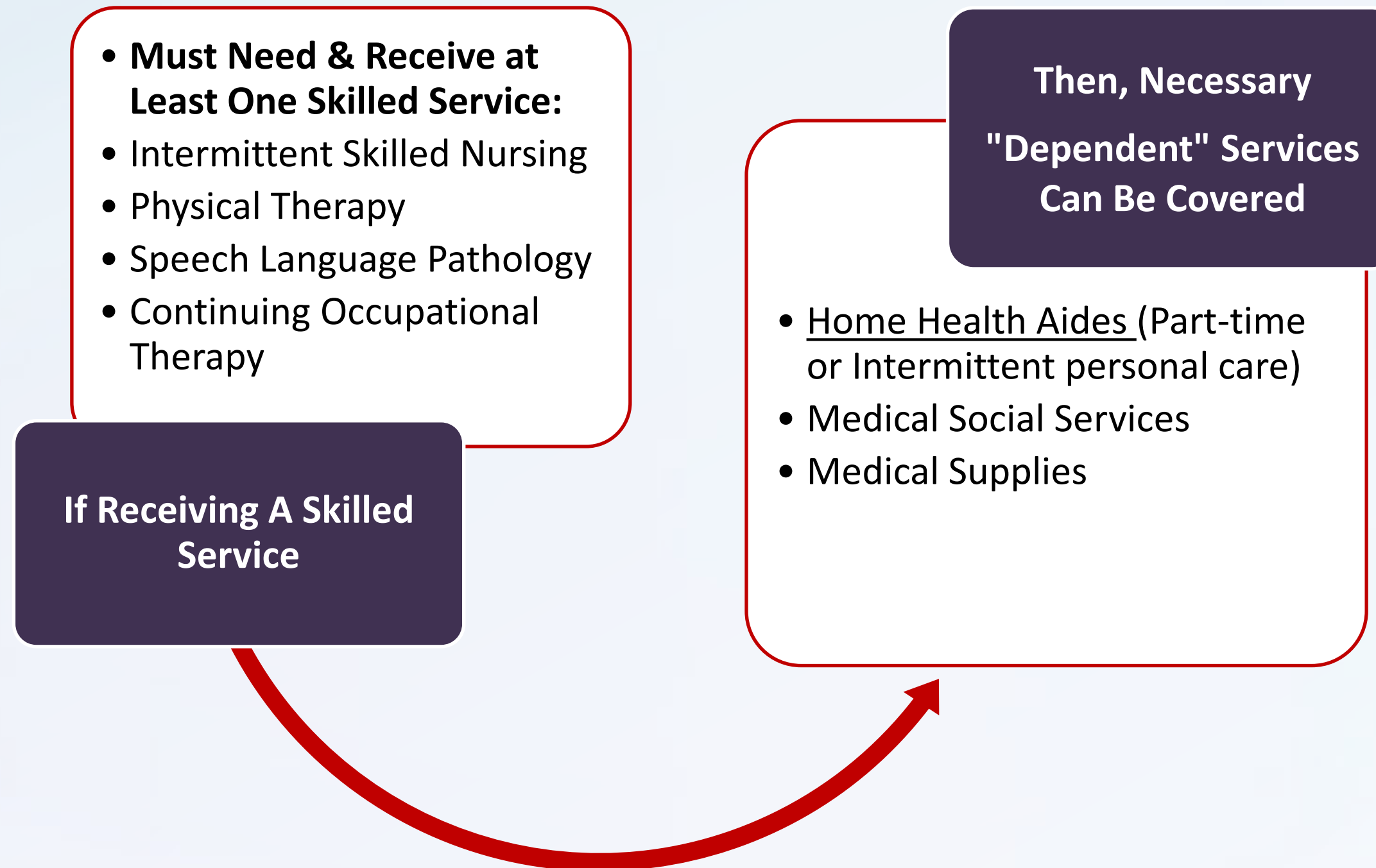
**OR**

- **Daily visits** for up to 21 days
  - Extensions to continue daily nursing possible in exceptional circumstances and if the need for daily care is still expected to have a finite and predictable end point

Exception: **Daily insulin injections** when the individual cannot self-inject and no other able & willing person to inject.



# Covered Services



# Home Health Aides

- Home health aide services defined as hands-on personal care
  - Homemaker services alone are *not* covered
    - Only if incident to hands-on personal care
- “Custodial” Care
  - Medicare Act specifically establishes home health aide (custodial care) as a covered service under the Medicare home health benefit

*42 U.S.C. § 1395x(m); 42 C.F.R. § 409.45(b)*

# Home Health Aides

## How much can be covered – under the law?

- Combined with skilled nursing, can be covered **up to 28 hours &** any number of days per week as long as provided less than 8 hours each day
  - Subject to review on case-by-case basis, coverage may be available for **up to 35 hours** per week

*42 U.S.C. §1395x(m)(7)(b); 42 CFR §409.45(b)*

# Medicare Home Health Coverage – The Law

- Not just a post-acute care benefit
- Coverage available for necessary care to maintain or slow individual's condition, not just to improve
  - *Jimmo v. Sebelius*, No. 11-cv-17 (D.Vt.) Filed 2011; Settled 2013; Corrective Action Plan, 2017
  - Visit the [Jimmo Settlement Agreement](#) webpage for more information

# No Cap on the Home Health Benefit

- Home Health coverage continues to be available so long as skilled care is needed and other threshold criteria are met.

*Medicare Benefit Policy Manual (MBPM), Ch. 7, Sec. 40.1.1*

- Payment can be made for an **unlimited** number of covered visits, and **there is no limit** on continuous recertifications for beneficiaries who continue to be eligible.

*42 C.F.R. § 409.48(a)-(b); MBPM, Chapter 7 Secs. 70.1 & 10.3*



# Why do People Struggle to Access Home Health Care?

- Providers misunderstand and/or misinform about the law
- Payment models & rating systems – incentives and disincentives
- Staffing shortages at home health agencies
  - Home health providers have no obligation to take on new patients if they're unable to provide all the ordered services.
- Medicare-certified providers are not required to serve patients, even if they meet Medicare coverage qualifications. They may not, however, discriminate against an individual due to Medicare status. *42 CFR 489.53(a)(2)*

# Providers' Conditions of Participation

- Require patient involvement in care planning:
  - Includes patients, representatives and aides on an interdisciplinary care team
  - Establishes more communication between patients, care representatives and the home health agency
- Mandate home health agencies identify caregivers and their willingness/ability to assist with care (not just assume it's available).
- Require coordination/integration with all patient's physicians.

*Reference: 42 C.F.R. § 484.2 et. al.*

# Providers' Conditions of Participation

- Discharge and Transfer of Patients
  - Discharge is appropriate only when a physician and home health agency both agree that the patient has achieved measurable outcomes and goals established in the individual plan of care and no longer needs skilled services. (Note: Goal may be maintenance)
  - Home health agencies are responsible to make arrangements for safe and appropriate transfer of a patient to another agency when the patient's needs exceed the HHA's capabilities.

*Reference: 42 C.F.R. § 484.50(d)(3); 42 C.F.R. § 484.50(d)(1)*

# Advocate for Coverage

- Actively participate in the home health agency's assessment.
- Certifying MD can be an important advocate.
- Orders should clearly document skilled needs and goals for home health care.

If improvement is initially expected and that goal has changed to maintenance, **get a new order that clarifies why skilled care is needed to maintain, deter, or slow decline of the patient's condition or function.**

## Advocate for Coverage (cont'd)

- If you are in a Medicare Advantage plan, contact all the agencies that are available in your network to find which one can best serve you.
- Medicare Advantage plans are required to provide everything Traditional Medicare covers.
- Ask the agency if they bill for outlier cases if you need extensive resources from the agency.
- Last resort: Accept less services than the individual qualifies for.



# Appealing Coverage Denials

- **Expedited “Fast” appeals**
  - Can appeal a home health agency’s decision to end (not reduce) ALL Medicare covered care.
  - Beneficiary must get a **Notice of Medicare Noncoverage (NOMNC)** at least 2 calendar days before covered services end, or second to last day of service if care is not provided daily.
  - Request **expedited determination** by Qualified Improvement Organization (QIO) no later than noon of day before effective non-coverage date.
  - Provider must then provide Detailed Explanation of Non-Coverage – including any relied upon Medicare or plan policy or guidelines.
  - QIO decision within 72 hours.
  - If dissatisfied with QIO decision, beneficiary can request **expedited “fast” reconsideration**.
  - Standard appeals timeframes apply after that stage.



# Appealing Coverage Denials

- **Standard Appeals**
  - **Advance Beneficiary Notice (ABN)** – Given when provider expects that Medicare won't or will no longer cover items and services. Effectively shifts liability onto Beneficiary. Only required if services provided.
  - Must ask agency to submit a bill to Medicare to initiate appeals process.
  - Appealing to obtain coverage and payment for services already provided
  - Obtain documentation of services

# Medicare Home Health Law, Regulations & Policies

- **Medicare Act (Law):** *42 USC §1395x(m)*
- **Federal Regulations:** *42 CFR §409.40*
  - Defines skilled nursing and therapies *42 CFR §§409.32-33; §§409.42,44*
  - Defines home health aide coverage and services *42 CFR §409.45*
- **Policies:** [Medicare Benefit Policy Manual, Chapter 7](#)
  - Relied upon by Medicare-certified home health agencies
  - *Section 20* (Skilled Services); *Section 30* (Homebound); *Section 40* (Coverage, including for nursing and therapy to maintain or slow decline); *Section 50* (Aides); *Section 70* (Unlimited duration)

# ***Medicare Website and Resources***

- **Medicare.gov:** The [Care Compare/Home Health](#) tool provides contact information for all Medicare certified home health agencies that serve your zip code.
  - Contact agencies, including those that do **not** have 5 Star Ratings
- [Medicare & Home Health Care Booklet](#) (Aug. 2023) – Official CMS publication. Topics include:
  - Medicare Coverage of Home Health Care
  - Choosing a Home Health Agency
  - Getting Home Health Care – including plan of care and a checklist for care needs

# Resources from the Center for Medicare Advocacy

Available at:

<http://www.medicareadvocacy.org/medicare-info/home-health-care/>

- *Jimmo* Settlement, materials, factsheets
- Medicare Home Health Infographic/Factsheets
- Home Health Tool Kit
- Home Health Brochure
- Self-Help Packets
- Articles on Home Health Topics

# Questions and Discussion

# Thank you for joining us!

For further information, to receive the  
Center's free weekly electronic newsletter, ***CMA Alert***,  
update emails and webinar announcements, contact:

**Communications@MedicareAdvocacy.org**

Or visit

**MedicareAdvocacy.org**

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