

## Medicare Minute Teaching Materials – August 2015 Durable Medical Equipment

### 1) What is durable medical equipment?

Durable medical equipment (DME) is primarily used to serve a medical purpose and can help you complete your activities of daily living and facilitate recovery after a hospital stay. It includes a variety of items, including walkers, wheelchairs, and oxygen tanks. Medicare usually covers DME if the equipment is:

- Durable, meaning you can use it again
- Designed to help a medical condition or injury
- Meant for use in your home
- Likely to last for three years or more

### 2) What kind of DME does Medicare cover?

Whether you have Original Medicare or a Medicare Advantage Plan, the rules for which pieces of equipment are covered should be the same. However, the amount you pay for DME with Original Medicare and with a Medicare Advantage Plan is often different. Medicare Part B covers equipment that you use in the home if it qualifies as DME (see question 1). If you are in a skilled nursing facility (SNF) or are a hospital inpatient, DME is covered under Part A. It is important to remember that your doctor needs to prescribe DME for you. DME that Medicare covers includes, but isn't limited to:

- Blood sugar monitors
- Canes (however, white canes for the blind are not covered)
- Commode chairs
- Crutches
- Oxygen equipment and accessories
- Walkers

Medicare also covers certain prescription medications and supplies that you use with your DME, even if they are disposable or can only be used once. For example, Medicare covers medications used with nebulizers. Medicare also covers lancets and test strips used with diabetes self-testing equipment.

### 3) What kind of DME does Medicare not cover?

Medicare does not cover:

- Equipment that is not suitable to use in the home. This includes some types of DME used in hospitals or skilled nursing facilities, like paraffin bath units and oscillating beds.
- Equipment mainly intended to help you outside the home. For example, if you can walk on your own for short distances—enough to get around your house—Medicare does not cover a motorized scooter that you only need for outside the home.

- Most items intended only to make things more convenient or comfortable for you. This includes stairway elevators, grab bars, air conditioners, and bathtub and toilet seats.
- Items that get thrown away after use or that do not get used with equipment. For example, Medicare does not cover incontinence pads, catheters, surgical facemasks, or compression leggings.
- Modifications to your home, such as those for improving wheelchair access, like ramps or widened doors.

#### 4) What are Medicare rules for DME coverage?

Medicare only pays for your DME if two conditions are met. First, your doctor or other primary care provider must sign an order, prescription, or certificate after an office visit that took place within the past six months. In this document, the provider must state that the required office visit occurred, that you need the requested DME to help a medical condition or injury, and that that you will use the equipment in the home. Second, once you have the doctor's order or prescription, you must take it to the right supplier to get coverage. **Be sure only to use suppliers with approval from Original Medicare or your Medicare Advantage Plan.**

If you have Original Medicare, the type of supplier you must use depends on where you live and what type of equipment you need. In many areas, called competitive bidding regions, Medicare usually only pays for DME from a select group of suppliers, known as contract suppliers (see question 5). In other areas, you can use any supplier that has signed up to bill Medicare, but it's best to use a supplier that accepts assignment to minimize your costs. Call 1-800-Medicare or visit [www.medicare.gov/supplier](http://www.medicare.gov/supplier) to get a list of suppliers Medicare has approved for you. Participating providers are identified by a blue M on [www.medicare.gov/supplier](http://www.medicare.gov/supplier). Other approved suppliers listed on Medicare's website may accept assignment on a case by case basis. If you have a Medicare Advantage Plan (like an HMO or PPO), you must follow the plan's rules for getting your DME. Your plan may require you to receive its approval before you order, to order from its network of providers, or to use preferred brands. Contact your plan to find out its rules before you order your DME.

#### 5) What is competitive bidding?

The competitive bidding program affects you if you live in regions called competitive bidding areas. Most DME items are included in the competitive bidding program. However, a small number of items may be left out, such as nebulizer equipment and supplies. The following bullets review how the competitive bidding program works. Call 1-800-Medicare (1-800-633-4227, TTY 1-877-486-2048) or visit [www.medicare.gov/supplier](http://www.medicare.gov/supplier) to find out the rules you should follow for the DME you need.

- If competitive bidding applies to you, it is very important for you to use contract suppliers, which are the only suppliers in the area who can bill Medicare for competitive bidding items.
- You may have to pay the full cost of your DME if you get it from a supplier that is not a contract supplier. However, suppliers who are not contract suppliers must let you know ahead of time and have you sign an **Advance Beneficiary Notice (ABN)**. This notice states that you understand that Medicare will not cover the requested DME and that you will be responsible

for the full cost. If the supplier does not have you sign an ABN, you do not owe money to the supplier for the DME.

- If you have a Medicare Advantage Plan, competitive bidding does not apply to you. Contact your plan to learn which suppliers are in your plan's network. There are times when you don't need to use a contract supplier. For instance, your doctor may give you a walker or folding manual wheelchair during an office visit even if she or he is not a contract supplier or a hospital could give you these items during your hospital-stay or on the day you leave the hospital.

### **6) How much will I pay for my DME?**

If you have Original Medicare, your costs will depend upon whether the competitive bidding program applies to you (see question 5). If competitive bidding applies to you, you must use a contract supplier for your DME. Medicare will pay contract suppliers 80 percent of the cost of your DME, and you or your supplemental insurance will pay the remaining 20 percent. If you have Original Medicare and competitive bidding **does not** apply to you, you will pay the least if you use a supplier who accepts the Medicare amount as payment in full (accepting assignment). Medicare will pay these suppliers 80 percent of the cost of your DME, and you or your supplemental insurance will pay the remaining 20 percent. If you go to a provider who doesn't accept assignment, you may have to pay more. Each Medicare Advantage Plan sets its own rates for DME. Keep in mind that your plan may require you to get approval before you order, to order from its network of providers, or to use preferred DME brands. If you fail to follow these rules, your plan may provide no or reduced coverage for your DME. Contact your plan to find out its rules and your costs before getting your DME.

### **7) If I have Original Medicare, do I need to rent or buy my DME?**

Depending on the equipment, you may have to rent or buy your DME. For example, Medicare requires that you initially rent certain types of equipment, including power and manual wheelchairs. On the other hand, Medicare requires you to buy certain items that are made to fit you. Medicare also allows you a choice to rent or buy certain items, such as certain power wheelchairs, items costing less than \$150, and parenteral/enteral infusion pumps.

Know that most equipment is initially rented. For rentals, Original Medicare pays 80 percent of the cost of a monthly rental fee for the equipment for 13 months; you are responsible for the remaining 20 percent coinsurance. Know that special rules apply for rental of oxygen equipment (see question 9). If you are buying your DME, have Original Medicare, and use approved suppliers, Medicare covers 80 percent of the cost and you or your supplemental insurance are responsible for the remaining 20 percent. Call 1-800-Medicare (1-800-633-4227, TTY 1-877-486-2048) to find out the coverage rules for your specific DME.

### **8) Will Medicare pay for upgrades or special features for my DME?**

Medicare generally covers the most basic level of equipment you need. If you need additional features or upgrades, and your supplier thinks that Medicare may not pay for additional features or upgrades, the supplier should have you sign a waiver form called an Advance Beneficiary Notice (ABN) before you get the items. On the ABN, you must check the box stating you want the upgrades and will agree

to pay their full cost if Medicare denies coverage for them. Even if Medicare does refuse the upgrade, it will still pay the amount it would have paid for the basic model of the equipment. Also, you can appeal the denial if you believe your health requires the upgrade.

### **9) What are the special rules for oxygen equipment?**

If you need oxygen equipment, special rules apply. It's important to learn how Medicare pays for this equipment and covers rentals, repairs, and maintenance. Remember, you must still use the right kind of supplier to obtain coverage and limit your costs. Further, you must always rent your oxygen equipment; you never have the option to buy it.

Equipment is rented in five-year cycles:

- Medicare will pay the supplier a monthly rental fee for the first 36 months. The fee includes all equipment, oxygen, and supplies. You must pay 20 percent of each month's rental fee.
- For the next 24 months, the supplier must allow you to keep the equipment, but Medicare rental payments stop. You pay no more rental fees for the equipment, although the supplier still owns the equipment. If you use oxygen tanks or cylinders, you must continue to pay a 20 percent coinsurance for liquid or gaseous oxygen each month.
- At the end of five years, you will have to choose whether to get new oxygen equipment from your original supplier or to switch suppliers.

If you need oxygen equipment for less than five years, the supplier will take it back when you no longer need it. Keep in mind that during your entire rental period (five years), your supplier must keep your equipment in good working condition and provide you with supplies, parts, and maintenance free of charge. However, during the last 24 months of the rental period, suppliers can bill you for general in-home maintenance visits every six months. You must pay a 20 percent coinsurance for this servicing. Additional charges may apply during this period if you use a stationary or portable oxygen concentrator or transfilling equipment (machines that fill portable tanks in your home).

### **10) What are the special rules for electric (motorized) wheelchairs or scooters?**

In most states, you follow the same rules to get an electric (motorized) wheelchair or scooter as you do for other types of DME. However, if you live in 19 states (AZ, CA, FL, GA, IL, IN, KY, LA, MD, MI, MO, NJ, NY, NC, OH, PA, TN, TX, or WA) and have Original Medicare, your provider or supplier needs to ask for permission from the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) before you can get a power wheelchair or scooter. This process is called prior authorization.

The DME MAC will let you and your provider and supplier know whether it has approved or denied the request within 10 business days (sooner if going without the equipment could harm your health). If the DME MAC approves coverage, your Medicare-participating supplier will provide you with the equipment and charge you coinsurance and deductibles. If the DME MAC denies prior authorization for your equipment, your provider or supplier can request it one more time. Your provider or supplier

should provide additional reasons for your needing the power wheelchair or scooter. If prior authorization is denied again, you can continue to request Medicare coverage. However, you must first obtain the equipment and be prepared to pay for it yourself.

Here's how this might work: before providing you with the wheelchair, the supplier should give you an Advance Beneficiary Notice (ABN). On the ABN, select the box asking your supplier to submit the bill to Medicare. The supplier can charge you the full cost of the equipment in the meantime. If Medicare denies the claim, you can appeal the denial through the Original Medicare appeals process. If you win the appeal, Medicare will either pay the provider or send you a check as reimbursement. The supplier must refund you any amount that Medicare pays it for the equipment.

### **11) Does Medicare cover maintenance and repairs for my DME?**

Your DME equipment may at some point require maintenance and repairs from your supplier. Maintenance means checking, cleaning, and servicing your equipment. If possible, you are expected to do regular maintenance yourself using the owner's manual. However, a supplier should do maintenance if it is more complicated and requires a professional. Medicare's coverage of repairs and maintenance that are more specialized depends on whether the supplier owns the equipment or you do.

- **Renting DME:** As long as Medicare and you are paying a monthly rental fee for your equipment, your supplier must perform all needed repairs and maintenance requiring the work of a professional. The supplier cannot charge you for this work.
- **Owning DME:** If you buy your equipment -- or if you now own your equipment after first renting it -- repairs or maintenance must require a professional and not be already covered by a warranty to qualify for Medicare coverage. Medicare will pay the supplier 80 percent of the Medicare-approved amount, and you will be responsible for the 20 percent coinsurance. You can save money by going to a supplier who takes assignment (see question 4). If you live in a competitive bidding area (see question 5) and own equipment that is on the list of items that you must get from a contract supplier, it is best to get repairs done by contract suppliers.

### **Case Study**

Theresa is 73 years old and receives her health coverage through Original Medicare. She recently underwent surgery on her knee and needed a wheelchair to improve her mobility. Theresa's doctor wrote a prescription for the wheelchair, and Theresa subsequently ordered the wheelchair from a local supplier that was recommended to her by her doctor. After Theresa's wheelchair was delivered, she received a bill. Upon closer examination of the bill, Theresa realized that Medicare had not paid anything for the wheelchair and that she was being charged for the full cost of the equipment.

### **What should Theresa do?**

- Theresa should contact her SHIP for assistance in determining if Medicare was billed for the wheelchair.
  - If Theresa doesn't know how to find her SHIP, she can go to [www.shiptacenter.org](http://www.shiptacenter.org) or call 877-839-2675 for contact information.

- The SHIP counselor should explain the process for obtaining Durable Medical Equipment (DME) and ensure Theresa understands the associated guidelines for obtaining DME, including determining whether or not she lives in a competitive bidding area and using a Medicare-approved supplier to ensure that Medicare covers her DME. The SHIP counselor will also ask Theresa if she was presented with an Advance Beneficiary Notice, and if so, did she check the box stating she wanted the upgrades, agreeing to pay their full cost if Medicare denied coverage for them.
- Based upon this conversation with Theresa, the SHIP counselor will help determine if Medicare was billed improperly or if Medicare denied coverage of the wheelchair.
  - If Medicare was billed improperly, Theresa should ask the supplier to immediately resubmit the claim properly.
  - If coverage of the wheelchair was denied for any reason, the counselor will explain the appeals process to Theresa and assist her, as needed.

### Local SHIP Contact Information

**SHIP toll-free:**

**SHIP email:**

**SHIP website:**

**To find a state SHIP:** Call 877-839-2675 or visit [www.shiptacenter.org](http://www.shiptacenter.org).

*The production of this document was supported by Grant No. 90ST1001 from the Administration for Community Living (ACL). Its contents are solely the responsibility of the SHIP National Technical Assistance Center (SHIP TA Center) and do not necessarily represent the official views of ACL.*