

Medicare's Coverage of Durable Medical Equipment - Frequently Asked Questions

1. What is durable medical equipment?

Durable medical equipment (DME) is equipment that helps an individual complete their daily activities. It includes a variety of items, such as walkers, wheelchairs, and oxygen tanks. Medicare usually covers DME if the equipment:

- Is durable, meaning it is able to withstand repeated use
- Serves a medical purpose
- Is appropriate for use in the home, although an individual can also use it outside the home
- And, is likely to last for three years or more

To be covered by Part B, DME must be prescribed by a beneficiary's primary care provider (PCP). If someone is in a skilled nursing facility (SNF) or is a hospital inpatient, DME is covered by Part A.

Whether a beneficiary has Original Medicare or a Medicare Advantage Plan, the types of Medicare-covered equipment should be the same. Examples of DME include:

- Wheelchairs
- Walkers
- Hospital beds
- Power scooters
- Portable oxygen equipment

Under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) category, Medicare Part B also covers:

- Prosthetic devices that replace all or part of an internal bodily organ
- Prosthetics, like artificial legs, arms, and eyes
- Orthotics, like rigid or semi-rigid leg, arm, back, and neck braces
- Certain medical supplies

Medicare also covers certain prescription medications and supplies that a person uses with their 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.

2. What kind of equipment and supplies does Medicare not cover?

There are certain kinds of durable medical equipment (DME) and supplies that Medicare does not cover, including the following:

- Equipment mainly intended to help an individual outside the home. For example, if someone can walk on their own for short distances—enough to get around their house—Medicare does not cover a motorized scooter that they only need outside the home.
- Most items intended only to make things more convenient or comfortable. This includes stairway elevators, grab bars, air conditioners, and bathtub and toilet seats.
- Items that get thrown away after use or that are not used with equipment. For example, Medicare does not cover incontinence pads, catheters, surgical facemasks, or compression leggings. However, if an individual receives home health care, Medicare pays for some disposable supplies—including intravenous supplies, gauze, and catheters—as part of their home health care benefit.
 - Note: Catheters may be covered as prosthetics if they have a permanent condition.
- Modifications to a person's home, such as ramps or widened doors for improving wheelchair access.
 - Note: Some Medicare Advantage Plans may cover minor home modifications or other items as a supplemental benefit.
- Equipment that is not suitable for use in the home. This includes some types of DME used in hospitals or skilled nursing facilities (SNFs), like paraffin bath units and oscillating beds.

Note that Medicaid may cover some forms of equipment that Medicare will not cover.

3. How can a beneficiary get DME covered by Medicare?

Whether an individual has Original Medicare or a Medicare Advantage Plan, Medicare covers their durable medical equipment (DME) if they meet the following two conditions:

1. Their primary care provider (PCP) must sign an order, prescription, or certificate. In this document, their PCP must state that:
 - a. They need the requested DME to help a medical condition or injury
 - b. The equipment is for home use
 - c. And, if applicable, a face-to-face visit occurred
 - i. Their face-to-face visit, when required, must take place no more than six months before the prescription is written. Their provider should know if Medicare requires a face-to-face visit for the item they need.
2. Once the individual has their PCP's order or prescription, they must take it to the right supplier to get coverage. They should be sure only to use suppliers with approval from Original Medicare or their Medicare Advantage Plan.

Note: There is a different process if someone needs coverage for a manual or power wheelchair or scooter (see question 7).

4. From which suppliers should a beneficiary get their DME?

If an individual wants Medicare to help cover their durable medical equipment (DME) costs, it is important to use the right supplier.

Original Medicare DME suppliers

If a beneficiary has Original Medicare, they should get their DME from a **Medicare-approved supplier** that takes assignment. They can call 1-800-MEDICARE for a list of these suppliers in their area.

They should be aware that many suppliers are Medicare-approved but do not take assignment. These suppliers may charge them more than Medicare's approved amount for the cost of services. Medicare will still only pay 80% of its approved amount for services, so they will be responsible for any additional costs.

Individuals should avoid suppliers who have not signed up to bill Medicare for DME, also known as opt-out providers. Medicare will not pay for services they receive from opt-out providers. This means they are responsible for the entire cost. If they use an opt-out DME supplier, the supplier should ask them to sign a private contract confirming that they understand they are responsible for the full

cost of their care. If they do not sign a private contract, they do now owe the supplier for the cost of their DME.

Medicare Advantage DME suppliers

If a beneficiary has a Medicare Advantage Plan, they must follow the plan's rules for getting DME. Their plan may require that they:

- Receive approval from the plan before getting their DME.
- Use a supplier in the plan's network of suppliers.
 - They may get little or no coverage if they use an out-of-network supplier.
- Use a preferred brand.
 - They may pay a higher cost when using a non-preferred brand.

Individuals should contact their plan to learn more about its DME coverage rules before ordering their DME.

5. What are the costs associated with DME?

Renting/Buying: Depending on the type of durable medical equipment (DME) a person needs, Medicare may require that they either rent or buy it.

- Most equipment is initially rented, including many manual and power wheelchairs.
 - Original Medicare covers 80% of the cost of a monthly rental fee for 13 months. The beneficiary pays a 20% coinsurance.
 - After 13 months, ownership is typically given to the person automatically.
- In certain situations, an individual may have to buy their DME. For example, Medicare may require that they purchase an item that is made to fit them.
 - Original Medicare covers 80% of the Medicare-approved amount of the cost of the equipment. The beneficiary pays a 20% coinsurance.
- Medicare allows an individual a choice as to rent or buy certain items, such as some power wheelchairs, items costing less than \$150, and parenteral/enteral infusion pumps.
- Note: There are different rules for oxygen equipment (see question 8).

Repairs/Maintenance: A beneficiary's DME may at some point require repairs and/or maintenance from their supplier.

- Repairs by a supplier involve fixing equipment that is worn or damaged.
- Maintenance means checking, cleaning, and servicing the equipment.

If possible, beneficiaries are expected to do regular maintenance themselves using the owner's manual. However, a supplier should perform maintenance if the task is more complicated and requires a professional. Medicare's coverage of more specialized DME repairs and maintenance depends on whether the beneficiary or the supplier owns the equipment.

- **Renting DME:** As long as the individual is paying a monthly rental fee for their equipment, their supplier must perform all needed repairs and maintenance when a professional is required. The supplier cannot charge them for this work.
- **Owning DME:** If they purchased their equipment or otherwise own it, Medicare covers needed repairs and maintenance when a professional is required and the services are not covered by a warranty.
 - Original Medicare covers 80% of the Medicare-approved amount when a person uses a DME supplier that takes assignment. The individual pays a 20% coinsurance.
- Note: There are separate rules for repairs and maintenance for oxygen equipment (see question 8).

Upgrades/Special Features: Medicare generally only covers the most basic level of durable medical equipment (DME) to meet a beneficiary's medical needs. If someone wants additional features or upgrades, they may have to pay for them out of pocket. For example, Medicare will cover a power wheelchair that a person needs for home use, but if they request a special backrest or tilt function that is not medically necessary, they may need to pay for those features themselves.

That said, Medicare may pay for special features or upgrades when a person's doctor includes them in their DME order or prescription. In this case, their doctor should explain why their health condition justifies the additional feature. For example, if their doctor states that the individual does not have the strength or balance to lift a standard walker without wheels, Medicare should pay for a model with wheels.

If a beneficiary's supplier thinks that Medicare may not pay for additional features or upgrades, the supplier should have them sign a waiver form called an Advance Beneficiary Notice (ABN) before they get the items. On the ABN, they must check the box stating that they want the upgrades and agree to pay their full cost if Medicare denies coverage for them. Even if Medicare refuses the upgrade, it should still pay the amount it would have paid for the basic model of the equipment. The beneficiary

will then receive a bill for remaining costs. If Medicare refuses to cover upgrades, and the supplier failed to provide the person with an ABN, they do not owe the supplier for the added features.

6. What if a beneficiary needs to replace their DME?

Medicare will pay to replace equipment that a beneficiary rents or owns at any time if it is lost, stolen, or damaged beyond repair in an accident or a natural disaster, so long as they have proof of the damage or theft.

Replacing equipment means substituting one item for an identical or nearly identical item. For example, Medicare will pay for a person to switch from one manual wheelchair to another, but it will not pay for someone to replace a manual wheelchair with an electric wheelchair or a motorized scooter.

If an individual's equipment is worn out, Medicare will only replace it if they have had the item in their possession for its whole lifetime. An item's lifetime depends on the type of equipment but, in the context of getting a replacement, it is **never less than five years** from the date that a person began using the equipment. This five-year timeframe differs from the three-year minimum lifetime requirement that most medical equipment and items must meet in order to be considered DME by Medicare. The item must also be so worn from day-to-day use that it can no longer be fixed. Medicare covers repairs for worn DME if the equipment has not reached the end of its lifetime (see question 5). Medicare will pay for repairs up to the cost of replacement.

To be eligible for a DME replacement, an individual's primary care provider must write them a new order or prescription that explains their medical need. It is most cost-effective to use a Medicare-approved supplier who takes assignment (see question 4).

7. What are the special rules for Medicare coverage of manual and power wheelchairs and scooters?

Keep in mind that a beneficiary can only receive Medicare coverage for one piece of equipment that addresses at-home mobility issues. Their PCP will determine whether or not they need a manual wheelchair, a power wheelchair or scooter, or a different

device based on their condition. Once they have their PCP's order or prescription, they must take it to the right supplier to get coverage (see question 4).

Manual wheelchairs: If a beneficiary thinks they need a manual wheelchair, they should first speak to their doctor or primary care provider (PCP). If their PCP determines that it is medically necessary that they use a manual wheelchair, the PCP should sign an order, prescription, or certificate after a face-to-face office visit. The order should say the following:

- The beneficiary's health makes it very hard to move around in their home, even with the help of a walker or cane
- It is difficult for them to perform activities of daily living (such as bathing and dressing) in their home
- They can safely use the wheelchair themselves, or always have someone to help them use it
- The wheelchair will help with a specific medical condition and be used in the home
- And, they had a face-to-face meeting with the doctor
 - This meeting should take place no more than six months before the prescription is written.

Power wheelchairs and scooters

If a beneficiary thinks they need a power wheelchair or scooter, they should first speak to their doctor or PCP. If their PCP determines that it is medically necessary that they use a power wheelchair or scooter, the PCP should sign an order, prescription, or certificate after a face-to-face office visit. The order should say the following:

- The beneficiary's health makes it very hard to move around in their home, even with the help of a walker or cane
- It is difficult for them to perform activities of daily living (such as bathing and dressing) in their home
- They cannot use a manual wheelchair but can safely use a power wheelchair or scooter
- The wheelchair or scooter will help with a specific medical condition and be used in the home
- And, they had a face-to-face meeting with the doctor
 - This meeting should take place no more than 45 days before the prescription is written.

If a beneficiary has Original Medicare and needs a power wheelchair or scooter, their provider or supplier should first contact Medicare and find out if the individual needs to request prior authorization. Prior authorization means that Medicare must be asked for permission before a person can get a certain service or item. This requirement only applies to certain power wheelchairs and scooters.

- Note: If a beneficiary needs a power wheelchair or scooter that is not subject to prior authorization requirements, they may instead need a signed order from their primary care provider for Original Medicare to cover the device.

Their provider or supplier must send the prior authorization request to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The DME MAC will respond within 10 business days (sooner if the individual's health would be harmed by going without equipment), either approving or denying their request.

If the DME MAC approves prior authorization for the beneficiary's equipment, their supplier will provide the equipment, and they will owe their normal Medicare cost-sharing amounts (deductibles and coinsurances). If the DME MAC denies prior authorization for their equipment, their provider or supplier can request such authorization one more time, giving more reasons for why they need the power wheelchair or scooter. If the beneficiary is denied again, it is unlikely that Medicare will pay for their DME.

If a beneficiary chooses to get the DME after a denial of prior authorization, their provider should have them sign an Advance Beneficiary Notice (ABN). This notice states that they understand that Medicare will not cover the requested DME and that they will be responsible for the full cost. The beneficiary should make sure to select the option to ask the supplier to still submit a bill to Medicare. If Medicare denies payment, they have the right to appeal.

8. What are the special rules for Medicare coverage of oxygen equipment rental, repairs, and maintenance?

Medicare's coverage rules for oxygen equipment rental, repairs, and maintenance are different from its rules for other forms of durable medical equipment (DME). Keep in mind that a beneficiary should still use the right kind of supplier to limit their costs (see question 4).

Rental: Unlike other types of DME, oxygen equipment is always rented in a five-year cycle, and the beneficiary never has the option to buy it.

- Medicare will pay the supplier a monthly rental fee for the first 36 months. The fee includes all equipment, oxygen, supplies, and maintenance. The beneficiary must pay 20% of each month's rental fee.
- After the 36-month rental period, they pay no more rental fees, although the supplier still owns the equipment. The beneficiary keeps the equipment for up to 24 additional months. If they use oxygen tanks or cylinders, they must continue to pay a 20% coinsurance for oxygen each month. They will also pay a coinsurance for any needed maintenance during these additional 24 months.
- At the end of five years, the beneficiary will have the choice to either get new oxygen equipment from their supplier or to switch suppliers.

If the individual needs the oxygen equipment for less than five years, the supplier will take it back after they no longer need it.

Repairs and maintenance: Throughout a beneficiary's five-year rental period, the supplier must keep their oxygen equipment in good working condition. During the first 36 months of the rental period, the supplier must provide them with supplies and maintenance free of charge. During the last 24 months, providers are allowed to bill the beneficiary for in-home maintenance visits every six months, and they must pay a 20% coinsurance.

9. What is DME fraud?

Medicare fraud, errors, and abuse involve a wide range of behaviors that result in unnecessary costs to the Medicare program. It is important to recognize potentially fraudulent activities by providers and DME suppliers.

Some examples of DME fraud and abuse might include:

- Someone uses a fraudulent physician's identity, or a physician's stolen identity, to medically certify that an individual needs DME.
- Someone steals a person's Medicare number and uses it to bill Medicare for DME that they do not need and/or was never delivered.
- Someone offers a person a meal or food in exchange for their Medicare number (remember that Medicare only pays for nutritional support for someone who has a feeding tube in place).

- Someone calls an individual or visits their home to offer them “free” equipment that they do not need and then bills Medicare for the equipment.
 - For example, an individual might receive a phone call from a telemarketer who asks if they are experiencing any pain. If they say yes, the caller may ask for their personal information, like their Medicare number, so that the caller can send them a knee or back brace to help with the pain. This is likely a fraudulent call, and the individual should not provide the caller with any personal information. If a person receives a call like this, they should contact their Senior Medicare Patrol (SMP) for assistance reporting it.
- A DME supplier bills Medicare for more expensive DME than the equipment provided.
- A DME supplier continues to bill Medicare for rental payments for a person's DME after it has been returned.

10. How can beneficiaries protect themselves from suspected DME fraud, abuse, or errors?

Beneficiaries should remember the rules about Medicare’s coverage of DME. Medicare will not cover DME unless their doctor has certified that they need it. There must also be documentation in their medical record supporting their medical need for the equipment or supplies. If a person does need DME, they should ask their doctor about whether they meet coverage requirements to get it. If they do, they should get their DME from a supplier that accepts Medicare assignment or, if they have a Medicare Advantage plan, from an in-network supplier.

Beneficiaries should be aware of aggressive marketing that tries to persuade them to change DME suppliers. Before making a decision to change suppliers, they should speak with their doctor and their current supplier to see if there is a need for them to change.

Advise beneficiaries to not respond to ads that offer “free” equipment to Medicare beneficiaries, to be skeptical of offers that seem too good to be true, and to not give any personal information to someone who calls offering DME that they did not ask for.

A beneficiary should protect their Medicare number, and only give their Medicare number to their doctors and other providers. They should be careful when others ask

for their Medicare number or offer free services as long as they provide their Medicare number.

Beneficiaries should check their Medicare Summary Notices (MSNs) if they have Original Medicare, or their Explanations of Benefits (EOBs) if they have a Medicare Advantage plan, and billing statements regularly. They should carefully look for any suspicious charges or errors, keeping in mind that providers are not permitted to routinely waive cost-sharing or offer gifts or financial incentives for beneficiaries to receive services from them. If an individual sees any suspicious charges or has any reason to believe their provider is inappropriately billing Medicare for DME, they should call their provider to see if they have made a billing error.

If an individual suspects a health care provider of DME fraud, they can contact their Senior Medicare Patrol (SMP) by visiting www.smpresource.org or calling 877-808-2468.

11. What are the marketing guidelines that DME suppliers have to follow?

Medicare-approved DME suppliers must follow requirements set by the Centers for Medicare & Medicaid Services (CMS) related to how they can market their products. Some of these requirements include, but are not limited to:

- Suppliers cannot use Medicare's name or logos in a way that suggests that the items or services they provide are approved, endorsed, or authorized by Medicare.
 - Suppliers may be able to use Medicare's name or logo if they get express written permission from Medicare.
- Suppliers cannot call beneficiaries directly without the individual asking them to. There are three exceptions in which a DME supplier can call individuals directly:
 1. If they have given the supplier written permission to contact them by telephone about furnishing a DMEPOS item.
 2. If the DME supplier has already provided them with a Medicare-covered piece of DME, and the supplier is calling them only regarding providing that piece of DME.
 3. If the DME supplier has sold them a piece of Medicare-covered DME in the past 15 months, the supplier may contact them about other items they are able to provide if the person needs them.

- If a DME supplier's contact does not fit the above exceptions, neither the beneficiary nor Medicare is obligated to pay for the items.

If an individual sees marketing by a DME supplier that does not follow Medicare's rules, they should collect proof of the interaction, if possible.

- DME suppliers must have procedures in place to handle complaints from beneficiaries. If someone files a complaint with their DME supplier, they must let the person know within five days that they got the complaint and are investigating it. Within 14 days, the supplier must send the person the result of their complaint and their response in writing.
- Beneficiaries can also call their SMP at 877-808-2468 for assistance reporting inappropriate marketing, if appropriate.