Durable Medical Equipment: A Guide for Consumers

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The Medicare Rights Center is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through:

- Counseling and advocacy
- Educational programs
- Public policy initiatives
This toolkit for State Health Insurance Assistance Programs (SHIPs), Area Agencies on Aging (AAAs), and Aging and Disability Resource Centers (ADRCs) was made possible by grant funding from the National Council on Aging.
Learning objectives

- Explain what durable medical equipment (DME) is and what types of DME Medicare covers
- Know when Medicare covers DME
- Understand the competitive bidding program and the type of DME supplier you should use
- Know when you have the right to appeal Medicare’s denial of coverage for DME
Medicare basics
What is Medicare?

- Health insurance for people age 65+ and many of those who have received Social Security disability benefits for 24 months
- People of all income levels are eligible
- Run by the federal government but can be provided by private insurance companies that contract with the federal government
Medicare eligibility: Age

- Individual 65+ is eligible for Medicare if one of the following conditions is met

1. They either receive or qualify for Social Security retirement cash benefits

   OR

2. They currently reside in the United States and are either
   - A U.S. citizen or
   - A permanent U.S. resident who has lived in the U.S. continuously for five years prior to applying
Medicare eligibility: Disability

- Individuals under 65 are eligible for Medicare if they have been receiving Social Security Disability Insurance (SSDI) for 24 months
  - Individuals are Medicare-eligible the first day of the 25th month of receiving SSDI
  - **Exception:** Those who receive SSDI because they have ALS become eligible the first month their SSDI benefits start
Medicare eligibility: ESRD

- Individuals are also eligible for Medicare if they have End-Stage Renal Disease (ESRD)
  - Get dialysis treatments or have had a kidney transplant
  - Have applied for Medicare benefits
  - Have been deemed eligible for SSDI, railroad retirement benefits, or are otherwise considered to be fully insured by Social Security
Medicare options: Original Medicare

- Original Medicare
  - Made up of three parts
  - Part A – hospital insurance/inpatient insurance
    - Administered by the federal government
  - Part B – medical insurance/outpatient insurance
    - Administered by the federal government
  - Part D – prescription drug benefit
    - Provided by private insurance companies that contract with federal government
Medicare options: Medicare Advantage

- Medicare Advantage (Part C)
  - Provided by private insurance companies that contract with federal government to provide Medicare benefits
  - Combines Part A, Part B, and usually Part D benefits in the same plan
  - Not a separate benefit
  - Must provide same benefits as Original Medicare but may offer additional benefits and may have different rules, restrictions, and costs
Durable medical equipment basics
Medicare definition of DME

- Medicare may cover equipment that is
  - Durable, meaning it can be used repeatedly
  - Expected to last three years or more
  - Designed to help a medical condition or injury
  - Suitable for use in the home
Examples of DME

- Medicare can cover
  - Walkers
  - Wheelchairs
  - Hospital beds
  - Power scooters
  - Portable oxygen equipment

- Also: orthotics, prosthetics, and some medical supplies
What does not qualify as DME

- Equipment that is generally thrown away after use, such as incontinence pads, catheters, surgical face masks, and compression leggings
- Equipment that Medicare considers to be for convenience rather than medical need
  - Stairway elevators, grab bars, bathtub seats, raised toilet seats
- Equipment that is not appropriate for home use, like oscillating beds
- Equipment that you would use primarily to get around outside your home
Medicare coverage of DME
Medicare coverage requirements

1. Your doctor or other health provider signs a written order stating the you need equipment to treat an illness or injury, or to function at your best

2. You have a face-to face visit with your doctor or provider that confirms the need for DME
   - Office visit must take place during the 6 months before the prescription is written

3. You use an appropriate supplier
   - Original Medicare rules
   - Medicare Advantage rules
Original Medicare DME coverage

- Medicare Part B covers most DME
  - Specifically: covers DME used in the home
  - Home = house, apartment, or living facility, such as assisted living facility—but not a skilled nursing facility

- Medicare Part A covers DME used during inpatient stays in a hospital or skilled nursing facility (SNF) as part of the payment to the hospital or SNF
  - Not a separate payment
Original Medicare DME costs

- Original Medicare pays 80% of its approved amount for DME
- Individual pays 20% coinsurance
- To pay lowest cost, you should use the right supplier
  - **Contract supplier** in competitive bidding area
  - **Supplier who accepts assignment** if you do not live in a competitive bidding area or if item is not affected by competitive bidding
    - Accept assignment means provider accepts Medicare-approved amount for DME as full payment
- If supplier is not approved by Medicare, it cannot bill Medicare, and you may have to pay full DME cost
Medicare Advantage Plan DME coverage

- If you have a Medicare Advantage Plan you must follow plan rules to obtain DME
- Call plan to learn its rules for getting DME
  - Do you need to use in-network supplier?
  - Do you need to get prior authorization?
  - Is there specific documentation that you or your provider must submit in order to get coverage?
- Remember: MA Plans must cover same services as Original Medicare but may have different rules, restrictions, and costs
Special features

- Medicare does not pay for special DME features or upgrades unless they are medically necessary and a doctor orders them.
- If Medicare denies payment for a special feature that your doctor considers medically necessary, you can appeal.
- You can choose to pay for special features yourself if doctor does not order them or if Medicare denies payment and your appeal is unsuccessful.
Power wheelchairs and scooters
Power wheelchairs and scooters

- Medicare has specific rules for covering power wheelchairs and power scooters
- You should speak with your doctor if you think you need a power wheelchair or scooter
- You must have an office visit with a doctor no more than **45 days before** the DME is ordered
- If you have Original Medicare, you should use a Medicare-approved supplier
- If you have a Medicare Advantage Plan, contact plan to learn which supplier will cover needed DME
Power wheelchair/scooter prescription requirements

- Doctor must sign order or fill out prescription stating that you need a power wheelchair or scooter to function at home
- Prescription must state that
  - Your health makes it very hard to move around home even with help of walker or cane
  - You have significant problems in home performing activities of daily living (for example, getting in and out of bed, bathing, dressing)
  - You cannot use a manual wheelchair or scooter, but can safely use power wheelchair or scooter
  - Required office visit with doctor took place
Competitive bidding
Competitive bidding

- Under national competitive bidding program, Original Medicare selects suppliers to provide DME to Medicare beneficiaries based on supplier estimates of costs
  - Also called **contract suppliers**
  - Must meet quality, financial, and other standards
When competitive bidding applies

1. You have Original Medicare
2. You live in a region affected by competitive bidding program
3. The DME you need is affected by the competitive bidding program
   - If you need an item that is not affected by the competitive bidding program, you can use a Medicare-approved supplier
Competitive bidding costs

- DME from contract suppliers should cost no more than a 20% coinsurance, after you have met Part B deductible
- All contract suppliers required to take assignment
Medicare coverage of diabetic supplies

- Competitive bidding applies to all mail-order diabetic testing supplies for those with Original Medicare
  - If you get mail-order diabetic supplies, make sure to use a national contract supplier
- If you choose not to use mail-order, you can still get your supplies from a local pharmacy that accepts Medicare and takes assignment
If you live in a competitive bidding area, you should use a contract supplier for your DME.

If you use a non-contract supplier, you may need to pay full cost of equipment.

Non-contract suppliers must let you know ahead of time and have you sign an Advance Beneficiary Notice (ABN).

- ABN confirms that you agree to pay in full
- If no ABN is given, you do not owe money to supplier for DME

Medicare will pay for DME from non-contract suppliers in limited situations.

- For instance: certain items from doctors and hospitals, like walkers or folding manual wheelchairs.
If competitive bidding does not apply

- You should use Medicare-certified supplier who accepts assignment
  - Suppliers who accept assignment can charge no more than Medicare’s set 20% coinsurance

- You will likely pay more if you use Medicare-certified supplier who does **not** accept assignment
  - These suppliers are not limited in amount they can bill you

- You should avoid suppliers who are not Medicare-certified
Buying and renting DME
Buy or rent?

- Medicare covers most DME on rental basis
  - After rental period, ownership may transfer to you
- Some equipment is only approved by Original Medicare for individuals to buy
  - Certain rehabilitative equipment
  - Equipment made specifically for you
- Medicare-certified suppliers should know rules for renting or buying and explain them to you
- If you need help deciding whether to buy or rent DME, you should call 1-800-MEDICARE
DME rentals

- Medicare will help pay monthly rental fee for an item for up to 13 months
- After 13 months, ownership of the equipment automatically transfers to you
- Oxygen equipment has different rules
DME rentals: Oxygen equipment

- If you rent oxygen equipment, Medicare will pay supplier a monthly rental fee for up to 36 months.
- After 36-month rental period, you pay no more rental fees, and keep the equipment for up to 24 additional months.
  - You can have oxygen equipment for 5 years in total.
- Supplier will still own equipment and be responsible for most supplies and maintenance.
  - They must keep equipment in good working condition and provide supplies, parts, and maintenance free of charge in most cases.
- At the end of five-year period, you will have to choose whether to get new oxygen equipment from the same supplier or switch suppliers.
  - New rental period begins.
DME rentals: Repair and maintenance

- As long as Medicare is paying monthly rental fee, repairs and maintenance are included in monthly rate.
- Suppliers are responsible for all maintenance and repairs and cannot charge a separate fee.
DME ownership: repairs and maintenance

- Medicare will pay nothing for routine maintenance and servicing of equipment that you could do yourself.
- Medicare will pay 80% of Medicare-approved amount for non-routine maintenance and repairs that are not covered by warranty.
  - You will pay 20%.
- Does not apply to oxygen equipment.
DME replacement

- Original Medicare will replace item once its lifetime has expired, which can be no less than five years
  - Generally, Medicare will not replace item before its lifetime has expired, but will repair item up to cost of replacement
  - Medicare will only cover replacement if a doctor writes a new order or prescription for a different item, to meet a new or enhanced need

- Exceptions
  - Equipment can be replaced at any time if it is lost or stolen, or if it suffers damage due to a specific incident or a natural disaster, like a flood or fire
Appeal rights
DME rights and appeals

- You have the right to appeal Medicare denials
- Original Medicare and Medicare Advantage Plans have a different appeal process
Advance Beneficiary Notice (ABN)

- You should get an ABN if your supplier thinks Medicare will likely deny coverage
  - Supplier is not a contract supplier, and you are seeking DME in competitive bidding area
  - Supplier is not approved by Medicare
  - Supplier is providing upgraded DME, and Medicare will likely only cover basic model
  - You do not meet Medicare’s medical necessity requirements

- Your rights depend on if you received an ABN
  - If you signed ABN, you must pay supplier for full cost of equipment or for cost of upgrade
  - If you did not get ABN, you do not owe supplier for cost of equipment or upgrade
Beginning the appeal – Original Medicare

- Original Medicare
  - Medicare Summary Notice (MSN)
  - Follow appeal instructions on MSN

- Medicare Advantage
  - Explanation of Benefits (EOB)
  - Follow appeal instructions on EOB

- Appeal is strongest if you address the reason for denial in your appeal
  - Usually included on MSN or EOB
If Medicare will not cover DME

- There may be places or charities in your area that can provide low-cost or free medical equipment
- Also: if you qualify for Medicaid, you may be able to receive coverage through your Medicaid insurance
DME complaints and grievances

- A complaint is a report about the quality of care you receive, or issues you encounter when trying to obtain DME
  - Called a grievance in Medicare Advantage

- How to file complaint (Original Medicare)
  - Contact supplier
    - Supplier must send response to complaint within 14 days
  - Call 1-800-MEDICARE
  - Unresolved complaints are referred to Competitive Acquisition Ombudsman (CAO)

- How to file grievance (Medicare Advantage)
  - Contact plan’s grievance and appeals department
    - Must be done within 60 days of event that caused grievance
For more information and help

- **Local State Health Insurance Assistance Program (SHIP)**
  - [www.shiptacenter.org](http://www.shiptacenter.org)
  - [www.eldercare.gov](http://www.eldercare.gov)

- **Social Security Administration**
  - 1-800-772-1213
  - [www.ssa.gov](http://www.ssa.gov)

- **Medicare**
  - 1-800-MEDICARE (633-4227)
  - [www.medicare.gov](http://www.medicare.gov)

- **Medicare Rights Center**
  - 1-800-333-4114
  - [www.medicareinteractive.org](http://www.medicareinteractive.org)

- **National Council on Aging**
  - [www.ncoa.org](http://www.ncoa.org)
  - [www.centerforbenefits.org](http://www.centerforbenefits.org)
  - [www.mymedicarematters.org](http://www.mymedicarematters.org)
  - [www.benefitscheckup.org](http://www.benefitscheckup.org)
Medicare Interactive

- Medicare Interactive
  - [www.medicareinteractive.org](http://www.medicareinteractive.org)

- Web-based compendium developed by Medicare Rights for use as a look-up guide and counseling tool to help people with Medicare
  - Easy to navigate
  - Clear, simple language
  - Answers to Medicare questions and questions about related topics, for example:
    - “How do I choose between a Medicare private health plan (HMO, PPO or PFFS) and Original Medicare?”

- 2 million annual visits and growing
Medicare Interactive Pro (MI Pro)

- Web-based curriculum that empowers professionals to better help clients, patients, employees, retirees, and others navigate Medicare
  - Four levels with four to five courses each, organized by knowledge level
  - Quizzes and downloadable course materials
- Builds on 25 years of Medicare Rights Center counseling experience
- For details, visit [www.medicareinteractive.org/pro](http://www.medicareinteractive.org/pro), or contact Jay Johnson at 212-204-6234 or jjohnson@medicarerights.org

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