

Durable Medical Equipment (DME) Frequently Asked Questions

1. What is durable medical equipment?

Durable medical equipment (DME) is equipment that helps you complete your 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 you can use it multiple times
- Designed to help a medical condition or injury
- Meant for use in your home, although you can also use it outside the home
- Likely to last for three years or more

To be covered by Medicare, DME must be prescribed by a doctor or other primary care provider, in addition to other conditions (see question 4). If you are in a skilled nursing facility (SNF) or are a hospital inpatient, DME is covered under Medicare Part A. Otherwise, it is covered under Part B.

2. What kind of DME does Medicare cover?

Whether you have Original Medicare or a Medicare Advantage Plan, the types of covered equipment should be the same. However, the amount you pay for DME with Original Medicare and with a Medicare Advantage Plan is often different (see question 5).

Examples of DME include wheelchairs, walkers, hospital beds, power scooters, portable oxygen equipment, orthotics, prosthetics, and certain diabetes supplies, among others.

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. Be sure only to use suppliers that are Medicare-approved or are contract suppliers (see question 6) if you have Original Medicare or that are in network for your Medicare Advantage Plan.

3. What kinds of DME does Medicare not cover?

Medicare does not cover

- 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 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 do not get used with equipment. For example, Medicare does not cover incontinence pads, catheters, surgical facemasks, or compression leggings. However, if you receive Medicare home health care, Medicare pays for some disposable supplies—including intravenous supplies, gauze, and catheters—as part of your home health care benefit.
- Modifications to your home, such as ramps or widened doors for improving wheelchair access.
- 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.

4. What are Medicare's rules for DME coverage?

Whether you have Original Medicare or a Medicare Advantage Plan, Medicare only pays for your DME if two conditions are met.

1. Your doctor or other primary care provider must sign an order, prescription, or certificate after a face-to-face office visit.
 - a. 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 you will use the equipment in the home. Your face-to-face office visit must take place **no more than six months before** the prescription is written.
2. 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 areas (see question 6), Medicare usually only pays for DME from a select group of suppliers, known as **contract suppliers**.
- In other areas that are not competitive bidding areas, you can use any supplier that has signed up to bill Medicare. It's best to use a **supplier that accepts assignment** (see question 7) to minimize your costs.

Call 1-800-MEDICARE or visit www.medicare.gov/supplier to get a list of suppliers Medicare has approved in your area and for your item.

If you have a Medicare Advantage Plan (like an HMO or PPO), you must follow the plan's rules for getting your DME. For instance, your plan may require you to receive approval from the plan, use a supplier in the plan's network of suppliers, or use a preferred brand. Contact your plan to find out its rules before you order your DME.

5. How much does DME cost?

If you have Original Medicare and you use an appropriate supplier (see questions 6 and 7), you will pay a 20% coinsurance for your DME.

If you have a Medicare Advantage Plan, your costs will differ depending on your plan. Contact your plan to learn more about your DME costs.

6. What is the competitive bidding program?

Competitive bidding only applies if you have Original Medicare. The Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding program is designed to reduce your out-of-pocket expenses, and helps ensure that you have access to quality DME, supplies, and services from suppliers you can trust. The program affects you if you live in a competitive bidding area **and** you need DME that falls under the competitive bidding program. Most DME items are included in the competitive bidding program. However, a small number of items are excluded, such as nebulizer equipment and supplies. Call 1-800-MEDICARE or visit <https://www.medicare.gov/supplierdirectory/search.html> to find out if your region and items are included in the program. Note that all mail-order diabetic supplies fall under the competitive bidding program and must be provided by a contract supplier (see below).

In a competitive bidding area (CBA), you will almost always seek your DME from a **contract supplier**. A contract supplier must agree to provide covered items under its Medicare contract to any beneficiary who maintains a permanent residence in or visits a competitive bidding area and requests those items from the contract supplier. The only exception to this rule is a skilled nursing facility that has been awarded a contract as a specialty supplier. SNFs that are specialty suppliers may only provide contract items to their own residents. A few other times when you might not use a contract supplier in a CBA include if your doctor gives you a walker or folding manual wheelchair during an office visit even if they are not contract suppliers, or a hospital gives you these items when you are in the hospital or on the day you leave. Medicare will still cover these items as long as you met Medicare requirements for covered care.

The following bullets review how the competitive bidding program works.

- 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. Medicare usually does not pay for your DME if you do not use a contract supplier.
- If you order your diabetic supplies through mail order, you must use a contract supplier. Mail order includes diabetes supplies that are mailed to you by a supplier or that are delivered to your home by a pharmacy. If you pick up your diabetic supplies from a local pharmacy, you are not necessarily covered by the competitive bidding program, but you might be. In this case, you should make sure your pharmacy takes assignment (the Medicare approved amount as

payment in full—see question 7) to reduce your out-of-pocket costs—and that it is a contract supplier if you live in a competitive bidding area.

- Remember, 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—see question 12). 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 Original Medicare, call 1-800-MEDICARE (800-633-4227) or visit www.medicare.gov/supplier to find out the rules you should follow for the DME you need. 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.

7. What does it mean when an Original Medicare DME supplier takes assignment?

If you do not live in a competitive bidding area, or the item you need is not part of the competitive bidding program, then you should get your DME from a supplier who takes assignment in order to pay the least for your DME. Taking assignment means that the supplier accepts Medicare's approved amount for the cost of the equipment. A supplier who takes assignment cannot charge you more than a 20% coinsurance for your DME. You can find an appropriate Original Medicare DME supplier by visiting www.medicare.gov/supplier.

8. If I have Original Medicare, do I need to rent or buy my DME?

Most equipment is initially rented, including many power and manual wheelchairs. But depending on the equipment, you may have to buy it, for instance, if it is an item that is 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 infusion pumps. For rentals (not including oxygen equipment—see question 9), Original Medicare pays 80% of the cost of a monthly rental fee for the equipment for 13 months, and you are responsible for the remaining 20% coinsurance. After 13 months, ownership is typically given to you automatically. If you have Original Medicare, buy your DME, and use approved suppliers, Medicare covers 80% of the cost, and you or your supplemental insurance are responsible for the remaining 20%. Call 1-800-MEDICARE (800-633-4227) to find out the coverage rules for your specific DME.

Note that DME maintenance and repairs are covered differently depending on whether you rent or buy your DME (see question 11).

9. What are Medicare's rules for the coverage of oxygen equipment?

Unlike other types of DME, oxygen equipment is always rented in a five-year cycle. Medicare will pay the supplier a monthly rental fee for the first 36 months (3 years). The fee includes all equipment, oxygen, and supplies. You must pay 20% of each month's rental fee, which includes the equipment, oxygen contents, maintenance, and related supplies. After the 36-month rental period, you pay no more rental fees, although the supplier still owns the equipment. You keep the equipment for up to 24 additional months (2 years). If you use oxygen tanks or cylinders, you must continue to pay a 20% coinsurance for liquid or gaseous oxygen each month.

At the end of five years, you will have the choice either to get new oxygen equipment from your supplier or to change to a different supplier.

Throughout this five-year period, the supplier must keep your equipment in good working order. During the first 36 months of the rental period, the supplier must provide you with supplies and maintenance free of charge. During the last 24 months of the rental period, providers are allowed to bill you for in-home maintenance visits every six months.

10. What are the Medicare's rules for the coverage of power wheelchairs and scooters?

Medicare has specific rules for covering power wheelchairs and power scooters. First, you should speak to your doctor if you think you need a power wheelchair or scooter. Before you get your wheelchair or scooter, you must have an office visit with your doctor **no more than 45 days before** the prescription is written.

The prescription (or DME order) must state that

- Your health makes it very hard to move around in your home even with the help of a walker or cane
- You have significant problems in your home performing activities of daily living, such as getting in and out of bed, bathing, and dressing
- You cannot use a manual wheelchair or scooter, but you can safely use a power wheelchair or scooter
- The required office visit with your doctor took place.

Remember, the equipment must be necessary for you to use in the home, but you can also use it outside the home. You can only get one piece of equipment to address your at-home mobility needs. Your doctor or other provider will determine the equipment you need based on your condition.

As with other types of DME, in order for Medicare to cover your power wheelchair or scooter, you must use the appropriate supplier. If you have Original Medicare, this is either a contract supplier or a supplier who takes assignment. If you have a Medicare Advantage Plan, contact your plan to find out which supplier you should use.

11. Does Medicare cover maintenance and repairs for my DME?

Your DME 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 perform maintenance if it is more complicated and requires a professional. Medicare's coverage of more specialized DME repairs and maintenance depends on whether the supplier owns the equipment or you do.

- **Renting DME:** As long as 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, Medicare will cover the needed repairs or maintenance only if they require a professional and are not covered by a warranty. Medicare will pay the supplier 80% of the Medicare-approved amount, and you will be responsible for the 20% balance. As always, you can save money by going to a supplier who takes assignment. If you live in a competitive bidding area 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.

12. Will Medicare pay for upgrades or special features for my DME?

Medicare generally only covers the most basic level of equipment based on your level of medical need. If you want additional features or upgrades, Medicare may be able to cover more—but only if you also agree to pay more. If 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 refuses the upgrade, it will still pay the amount it would have paid for the basic model of the equipment.

13. How do I replace equipment that is lost, stolen, or worn out?

Replacing equipment means substituting one item for an identical or nearly identical item. For example, Medicare will pay for you to switch from one manual wheelchair to another, but will not pay for you to upgrade to an electric wheelchair or a motorized scooter. Medicare will pay to replace equipment that you rent or own at any time if it is lost, stolen, or damaged beyond repair in an accident or natural disaster, so long as you have proof of the damage or theft. If your equipment is worn out, Medicare will only replace it if you have had the item in your possession for its whole lifetime. An item's lifetime depends on the type of equipment but, in the context of getting a replacement, is **never less than five years** from the date that you began using the equipment. Note that this five-year timeframe differs from the three-year minimum lifetime requirement that most medical equipment and items must meet in order to fall under Medicare's definition of DME. The item must also be so worn-down from day-to-day use that it can no longer be fixed.

14. What do I do if Medicare denies coverage of my DME?

It is your right to appeal if Medicare denies coverage of your DME. There are different appeal processes depending on whether you have Original Medicare or a Medicare Advantage Plan, but you have the same right to appeal under both programs. If you have Original Medicare, you will appeal by following the directions on the Medicare Summary Notice (MSN) you receive. An MSN is a summary of claims. It tells you how much your supplier billed Medicare, how much Medicare paid the supplier, and whether or not Medicare approved the claim. If Medicare denied the claim, follow instructions on the MSN to appeal.

If you have a Medicare Advantage Plan, you will receive an Explanation of Benefits (EOB), which is similar to an Original Medicare MSN. The EOB will tell you if your plan approved or denied coverage for your DME. If your plan denied coverage, follow instructions on the EOB to appeal.

It is important to determine why your DME was denied, as that can help your appeal. There should be a denial note on your MSN or EOB, but you can contact Medicare or your plan for more information. Medicare or your plan may have denied coverage because you did not use the right supplier or you or your provider did not provide the correct documentation. You can involve your provider in the appeal process to add strength to your appeal.

15. How do I file a complaint against my DME supplier?

If you are unhappy with the quality of care you receive or issues you encounter while trying to obtain DME, you can either file a complaint or a grievance. If you have Original Medicare, file a complaint with your DME supplier or by calling 1-800-MEDICARE. If you have a Medicare Advantage Plan, contact your plan's grievance department to file a grievance against one of the plan's DME suppliers.