Durable Medical Equipment: A Guide for Professionals

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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 a beneficiary should use
- Know when a beneficiary has a 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

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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

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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 paraffin bath units and oscillating beds
- Equipment that individuals will use primarily to get around outside their homes
Medicare coverage of DME
Medicare coverage requirements

1. Beneficiary’s doctor or other health provider signs a written order stating the patient needs equipment to treat an illness or injury, or to function at their best

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

3. Beneficiary uses 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, beneficiaries should use the right supplier
  - **Contract supplier** in competitive bidding area
  - **Supplier who accepts assignment** if beneficiary does 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 beneficiary may have to pay full DME cost
Medicare Advantage Plan DME coverage

- Beneficiaries in Medicare Advantage Plans must follow plan rules to obtain DME

- Call plan to learn its rules for getting DME
  - Does member need to use in-network supplier?
  - Does member need to get prior authorization?
  - Is there specific documentation that member or their 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 beneficiary’s doctor considers medically necessary, beneficiary can appeal.
- Beneficiaries can choose to pay for special features themselves if doctor does not order them or if Medicare denies payment and appeal is unsuccessful.
Power wheelchairs and scooters

- Medicare has specific rules for covering power wheelchairs and power scooters
- Beneficiary should speak with doctor if they think they need a power wheelchair or scooter
- They must have an office visit with doctor no more than **45 days before** the DME is ordered
- Beneficiary with Original Medicare should use Medicare-approved supplier
- Beneficiary with Medicare Advantage Plan should 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 beneficiary needs power wheelchair or scooter to function at home

- Prescription must state that
  - Beneficiary’s health makes it very hard to move around home even with help of walker or cane
  - Beneficiary has significant problems in home performing activities of daily living (for example, getting in and out of bed, bathing, dressing)
  - Beneficiary 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
  - The only DME suppliers that can bill Medicare in a competitive bidding area
When competitive bidding applies

- Beneficiary has Original Medicare
- Beneficiary lives in a region affected by competitive bidding program
- The DME required is listed under a DME category affected by the competitive bidding program
  - If beneficiary needs an item that is not affected by the competitive bidding program, they can use a Medicare-approved supplier
Competitive bidding regions

- Most Medicare beneficiaries are affected
- Round 1: began 1/1/2011, includes 9 areas
  - Regions in NC, SC, OH, KY, IN, TX, MO, KS, FL, PA, CA
- Round 2: began 7/1/2013, includes 91 areas
  - Regions in AL, AR, AZ, CA, CO, CT, DE, DC, FL, GA, IA, IL, IN, KS, KY, LA, MA, MI, ME, MD, MO, MN, MS, NC, NE, NH, NJ, NM, NV, NY, OH, OK, PA, RI, SC, TN, TX, UT, VA, WI, WV
- Mail-order diabetic supplies: began 7/1/2013
  - Includes entire United States, including territories
Medicare coverage under competitive bidding

- Remember, Medicare beneficiaries should use **contract suppliers** to get coverage
  - Other Medicare coverage rules for DME apply as they always have
- DME from contract suppliers should cost beneficiaries no more than a 20% coinsurance, after they 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
  - Beneficiary who gets mail-order diabetic supplies should make sure to use a national contract supplier
- Beneficiaries choosing not to use mail-order can still get their supplies from a local pharmacy that accepts Medicare and takes assignment
Competitive bidding: non-contract suppliers

- In most cases, non-contract suppliers in competitive bidding areas cannot bill Medicare for DME
- If beneficiary uses a non-contract supplier, they may need to pay full cost of equipment
- Non-contract suppliers must let people know ahead of time and have them sign an Advance Beneficiary Notice (ABN)
  - ABN confirms that beneficiary agrees to pay in full
  - If no ABN is given, beneficiary does not owe money to supplier for DME
Competitive bidding variations

- 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
  - Also: if beneficiary began renting from a non-contract supplier before competitive bidding started, beneficiary can stay with that supplier if supplier elects to be grandfathered
    - Grandfathered suppliers agree to charge no more than Medicare’s 20% coinsurance
    - It may be cheapest for beneficiary to stay with grandfathered supplier
If competitive bidding does not apply

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

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

- Beneficiaries 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 beneficiary
- Some equipment is only approved by Original Medicare for individuals to buy
  - Certain rehabilitative equipment
  - Equipment made for specific beneficiary
- Medicare-certified suppliers should know rules for renting or buying and explain them to beneficiaries
- If person needs help deciding whether to buy or rent DME, they 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 beneficiary
- Oxygen equipment has different rules
DME rentals: Oxygen equipment

- If beneficiary rents oxygen equipment, Medicare will pay supplier a monthly rental fee for up to 36 months
  - Fee includes equipment, oxygen contents, maintenance, and related supplies
- After 36-month rental period, beneficiary pays no more rental fees but keeps the equipment for up to 24 additional months
  - Beneficiary can have oxygen equipment for 5 years in total
- The supplier will still own equipment and be responsible for most supplies and maintenance
- At the end of five-year period, beneficiary 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
- For oxygen equipment
  - Supplier must keep equipment in good working condition and provide supplies, parts, and maintenance free of charge in most cases
DME ownership: repairs and maintenance

- Medicare will pay nothing for routine maintenance and servicing of equipment that beneficiaries could do themselves.
- Medicare will pay 80% of Medicare-approved amount for non-routine maintenance and repairs that are not covered by warranty.
  - Beneficiary 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 irreparable damage due to a specific incident or a natural disaster, like a flood or fire
Appeal rights
DME rights and appeals

- Individuals have the right to appeal Medicare denials
- Different appeal process for beneficiaries enrolled in a Medicare Advantage Plan, but they have the same appeal rights
Advance Beneficiary Notice (ABN)

- Suppliers should provide beneficiaries with ABN if Medicare will likely deny coverage because
  - Supplier is not a contract supplier, and beneficiary is 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
  - Beneficiary does not meet Medicare’s medical necessity requirements

- Beneficiary’s rights will depend upon if they were given an ABN
  - If they signed ABN, beneficiary must pay supplier for full cost of equipment or for cost of upgrade
  - If they did not get ABN, beneficiary does not owe supplier for cost of equipment or upgrade
Beginning the appeal

- **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 beneficiary addresses the reason for denial in their appeal
  - Usually included on MSN or EOB
If Medicare will not cover DME

- There may be places or charities in beneficiary’s area that can provide low-cost or free medical equipment
- Also: beneficiaries who qualify for Medicaid may be able to receive coverage through their Medicaid insurance
DME complaints and grievances

- A complaint is a report about the quality of care a beneficiary receives or systemic issues they encounter when trying to obtain DME
  - Called a grievance in Medicare Advantage

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

- How to file grievance (Medicare Advantage)
  - Sending letter to 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
  - www.eldercare.gov

- Social Security Administration
  - 1-800-772-1213
  - www.ssa.gov

- Medicare
  - 1-800-MEDICARE (633-4227)
  - www.medicare.gov

- Medicare Rights Center
  - 1-800-333-4114
  - www.medicareinteractive.org

- National Council on Aging
  - www.ncoa.org
  - www.centerforbenefits.org
  - www.mymedicarematters.org
  - www.benefitscheckup.org

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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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