Durable medical equipment (DME) is equipment that helps with your daily activities, such as a walker, wheelchair, or oxygen tank. 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, although you can also use it outside the home
- Likely to last for 3+ years

Medicare does not cover items such as home modifications—for example bathtub seats—or items that are thrown away after use—for example, catheters.

What are Medicare’s rules for DME coverage?
Medicare only pays for your DME if two conditions are met:

1. Your doctor must prescribe the DME after an office visit that took place within the last 6 months. Your doctor must state that the office visit occurred and that you need the DME for use in your home to help a medical condition or injury.
2. Once you have your doctor’s prescription, you must take it to the right DME supplier to get Original Medicare or your Medicare Advantage Plan to cover the equipment.

Original Medicare DME suppliers
If you have Original Medicare, it is important to use the right supplier for your DME. Otherwise, Original Medicare will likely not pay for your equipment. The type of supplier you must use depends on where you live and what type of equipment you need.

Contract supplier
In many areas, called competitive bidding areas, Medicare only pays for DME from a select group of suppliers. These are known as contract suppliers. Competitive bidding is a program that was designed to lower DME costs and improve their quality, and many parts of the country participate in this program. The program affects you if you live in a competitive bidding area and you need DME that falls under the competitive bidding program. Call 1-800-MEDICARE or visit www.medicare.gov/supplier to find out if you live in a competitive bidding area and if the equipment you need is included in the program.
Medicare-approved supplier
If you do not live in a competitive bidding area, or the item you need is not part of the program, then you should get your DME from a Medicare-approved supplier that takes assignment. This will ensure that you pay the least for your DME. Taking assignment means that the supplier accepts Medicare’s approved amount for the cost of the DME, and you will not pay more than a 20% coinsurance for your DME. Call 1-800-MEDICARE or visit www.medicare.gov/supplier to find a Medicare-approved supplier for your DME.

Medicare Advantage Plan DME suppliers
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 that you 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.

What can 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 if you have Original Medicare or a Medicare Advantage Plan, but you still have the same right to appeal.

If you have Original Medicare: 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: Appeal by following the directions on the Explanation of Benefits (EOB) you receive. An EOB is similar to an Original Medicare MSN. The EOB will tell you if your plan approved or denied coverage of your DME. If your plan denied coverage, follow instructions on the EOB to appeal.

It is important to find out why your DME was denied, to help your appeal. There should be a denial note on your MSN or EOB, but you can also 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. Involve your provider in the appeal process to add strength to your appeal.