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Medicare Beneficiary Coverage for Durable Medical Equipment (DME)

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- Founded in 1986
- Headquartered in CT and Washington, DC
- Staffed by attorneys, advocates, a nurse, and technical experts
- Education, legal analysis, writing and assistance
- Systemic change – Policy & Litigation
  - Based on our experience with the problems of real people
- Medicare appeals
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DME AGENDA

- Medicare **Definition** - Durable Medical Equipment (DME)
- **Examples** of Covered and Not-Covered DME
- **How to qualify** for Medicare-Covered DME
- **Repairs, Maintenance, and Replacement** of DME
- Patient **Costs** for DME
- **Prior-Authorization** – Required and Voluntary
- **A Checklist for How to Obtain** Medicare-Covered Items
- Practice Tips, File Complaints, Advocacy & Case Studies

MEDICARE'S DME DEFINITION

- **Durable**; and
- Appropriate for **use in the "home"** (primarily used at home, but not exclusively); and
- Primarily and customarily needed for a **medical purpose** (generally the DME is not useful to someone who is not sick or injured); and
- **Necessary and reasonable** for treatment of a condition or injury.

MEDICARE'S DME DEFINITION
"DURABLE"

- Can withstand **repeated use**

- **Not covered as DME** –

  Items that are **not durable** in nature, but "expendable" (including incontinence pads, catheters, ace bandages, surgical facemasks)

MEDICARE'S DME DEFINITION
USED IN THE "HOME"

- "Home" is **a beneficiary's dwelling**, apartment, relative's home, home for the aged, assisted living facility, intermediate care facility.
- "Home" is **not a hospital or skilled nursing facility.**
- If a person is "home" for part of a month (but in an institution, or outside U.S. for part of a month), Medicare payment will be made for entire month.

MEDICARE COVERED DME "MEDICAL PURPOSE" EXAMPLES

- Hospital Beds
- Manual Wheelchairs and Power Mobility Devices
- Hemodialysis equipment
- Respirators
- Crutches, Canes,Walkers & Commodes (not white canes)
- Sleep Apnea and Continuous Positive Airway Pressure (CPAP) devices
- Oxygen equipment and accessories
- Nebulizers and nebulizer medications
- Blood sugar monitors and test strips
- Infusion pumps and supplies
- Speech Generating Devices (SGD)

MEDICARE'S DME DEFINITION
"NECESSARY AND REASONABLE"

- For treatment of an illness or injury OR
- To improve the functioning of a malformed body member
- **Is it necessary?** "In most cases", a prescription and medical documentation will establish necessity.
- **Is it reasonable?** Are there proportional therapeutic benefits? Are there more appropriate alternatives?

TRADITIONALLY NON-COVERED DME EXAMPLES

- Equipment designed for **comfort/convenience**

  Examples: elevators, stairway elevators

- **Physical Fitness or self-help** equipment

  Examples: Exercise equipment, safety grab bars

- Devices and equipment used for **environmental control**

  Examples: Air conditioners, room heaters, dehumidifiers

- Some Medicare Advantage plans are offering some items.

Covered DME **Not Covered DME**

CRITERIA TO QUALIFY FOR MEDICARE DME COVERAGE

- A beneficiary **enrolled** in Medicare Part B; with
- DME **documented** by treating practitioner who certifies medical necessity (CMN); **and**
- **Ordered** by a treating practitioner; **and**
- After a **face-to-face meeting** with the treating practitioner (certifications via telehealth are permitted subject to certain limitations)
- Therapists may be involved in the process.

MEDICARE COVERED DME
REPAIRS

- If Beneficiary **owns** an item – Medicare covers costs to make it serviceable, unless item is under manufacturer or supplier warranty.
- If Beneficiary **rents** an item – supplier responsible for repairs, no additional coverage for repairs
- No new Certificate of Medical Necessity or Order
- Includes repair of items obtained before Medicare

MEDICARE COVERED DME REPAIRS (CONTINUED)

- While repairs are underway:
  - Medicare covers a temporary replacement
  - Supplier bills "Code K0462" for loaner item (any type)
  - Narrative section of the claim MUST include:
    - Description of item & why repair took more than one day
    - Manufacturer
    - Brand name
    - Brand or Serial number of **item being repaired** AND
    - Same information (as above) for **temporary replacement item**

MEDICARE COVERED DME
MAINTENANCE

- Routine testing, cleaning (per owner's manual) not covered
- Maintenance required by authorized technician is covered
- No new CMN or Order needed for maintenance
- Owned after a rental period ends, **maintenance will be covered after the later of**:
  - 6 months from the end of the final rental month, OR
  - No longer covered by a warranty

MEDICARE COVERED DME
REPLACEMENT

- Irreparable **damage** (e.g., fire, flood)?
  Beneficiary needs new Certificate of Medical Need/Order
- After a **reasonable useful lifetime** – minimum of 5 years

WARNING – "Reasonable useful lifetime" is defined by Medicare as based on the date the equipment is delivered to the beneficiary, not on the age of the equipment.

TIP – Always ask the supplier for a new item, or an item with the least wear and tear as possible. If you ask, they might make the effort to look at their inventory.

MEDICARE COVERED DME
DELIVERY, SET-UP, TRAINING

Delivery, set-up and training should be **included** in the payment Medicare allows for DME (whether purchased or rented) when item is obtained from a Medicare participating supplier.

Reference: Medicare Claims Processing Manual, Chapter 20, Section 60 Payment for Delivery and Service Charges for Durable Medical Equipment

DME COSTS TYPICAL FOR TRADITIONAL MEDICARE

- Annual **Part B Deductible**, if not already met; **and**
- **20%** of the Medicare-approved amount for Medicare-covered items, if participating supplier.

WARNING:

- If a supplier does not participate/accept assignment, there is **no limit** on amount they can charge.
- If a supplier is **not enrolled** in Medicare, **no payment** will be made by Medicare.

MEDICARE COVERED DME
TYPES OF SUPPLIERS

- Medicare **enrolled "participating"** suppliers
- Medicare **enrolled "non-participating"** suppliers
- Suppliers **not-enrolled** in Medicare

Reference: Example – Patient Lifts
https://www.medicare.gov/coverage/patient-lifts

MEDICARE COVERED DME
TYPES OF SUPPLIERS

Enrolled "participating" suppliers must accept Medicare "assignment"

- This type of supplier agrees to **accept the Medicare allowed charge,** for the medically required equipment or services, as the full payment for the item.
- The supplier cannot charge any differential amount attributable to the reasonable and necessary equipment furnished.

MEDICARE COVERED DME
TYPES OF SUPPLIERS

Medicare enrolled suppliers who do <u>not</u> "participate"/"accept assignment" may charge and collect the full price

- **No limit** on the amount they can charge
- Medicare will pay the Medicare "allowed amount" directly to the patient
- However,…Suppliers may agree to accept assignment on a case-by-case basis

MEDICARE COVERED DME
TYPES OF SUPPLIERS

Suppliers not enrolled in Medicare

- **No** Medicare payment will be made to supplier or patient

WILL MEDICARE RENT OR PURCHASE DME?

- A Medicare enrolled supplier should know when Medicare will purchase or rent for a beneficiary.
- Generally, **most items of DME needed longer-term are rented via a 13-month rental program** thereafter, after ownership transfers to beneficiary.
- Medicare typically purchases:
  - Inexpensive items, and
  - Customized items made specifically for a beneficiary.

MEDICARE DME RENTAL

- Medicare makes **monthly payments** (the length of time of the payments varies by type of equipment – most are 13 months).
- A supplier picks up the equipment when it requires repair or it is no longer needed.
- The cost of repairs or replacement parts are the supplier's responsibility during a rental period.

MEDICARE DME PURCHASE

- Medicare usually covers the cost of **repairs or replacement parts** for beneficiary-owned items.
- An item may be **replaced** if lost, stolen, damaged beyond repair, or used by the individual for more than the "reasonable useful lifetime" of the item.

MEDICARE COVERED DME
DELUXE FEATURES PAYMENT

- Generally, Medicare pays based on a "standard" item.
- However, if **added features** are "medically necessary", more Medicare payment may be considered "reasonable".
- A supplier "participating" in Medicare may not charge for features that are not medically required unless:
  - Beneficiary specifically requests excessive or deluxe item/services,
  - Beneficiary is informed of the amount she/he will be charged, and
  - Advanced beneficiary notice (ABN) is required as documentation that beneficiary has made such an informed request.

Reference: Medicare Claims Processing Manual, Chapter 20, Section 90 Payment for Additional Expenses for Deluxe Features

DME COSTS IN MEDICARE ADVANTAGE PLANS

- MA plans must cover at least the same items and services as traditional Medicare – some plans cover more.
- Beneficiary out-of-pocket DME costs will depend on the MA plan chosen, typically 20% - 50%.
- To determine if an item is covered, and the cost to the beneficiary, call the plan and ask for the **"Utilization Management Department**".
- **Concerns reported:** High co-pays, limited # of in-network suppliers/available items, and long authorization wait times

REQUIRED
PRIOR AUTHORIZATION

- Prior authorization is required for some items of durable medical equipment, **45 items (suspended for COVID):**
  - 40 code categories of **power wheelchairs**
  - 5 **"Support Services"** items (including pressure reducing mattresses, mattress overlays, powered air floatation beds)
- Claims for these items **must receive prior authorization** before the item is furnished, or a claim is submitted, **as a condition for payment** (supplier should know if an item needs prior authorization)
- May create access problems and delays

VOLUNTARY
PRIOR AUTHORIZATION

- Advance Determination of Medicare Coverage (ADMC) is **available for some customized DME** (to determine if medically necessary)
- For items generally with an average purchase of $1,000 or greater, or average rental fee of $100/month or greater
- **Caution: If prior authorization is denied, only one re-submission is allowed per six-month period, but the supplier may still submit a claim to Medicare without prior authorization**

*Medicare Program Integrity Manual Chapter 5 §5.1.6.5

PROCESS TO OBTAIN AN ITEM/SUPPLY - GENERALLY

- Ask prescriber to recommend suppliers they know
- At https://www.medicare.gov/medical-equipment-suppliers/ enter beneficiary zip code, then…
  - **Locate the covered item** or service on the list
  - **Review the list of suppliers** that accept Medicare assignment for that item or service
    - If no suppliers accept assignment, look for enrolled suppliers
  - **Contact several suppliers** for information. Have the prescription and doctor's notes ready to provide data
- **OR** call 1-800-MEDICARE for assistance

PROCESS TO OBTAIN AN OTS BACK BRACE OR KNEE BRACE

As of January 1, 2021, traditional Medicare patients who live in certain zip codes are limited to the suppliers to use for an **off-the-shelf (OTS) back brace or knee brace**.

At https://www.medicare.gov/medical-equipment-suppliers/ enter beneficiary zip code to find suppliers

OR call 1-800-MEDICARE for assistance

ALTERNATIVE PLACES TO OBTAIN SOME DME ITEMS

- In certain cases, a beneficiary can **obtain** walkers, folding manual wheelchairs & external infusion pumps:
  - **From a health care provider** while receiving other medical care, or
  - **From a hospital** while hospitalized or on discharge day
  - The prescriber provides required documents (Certificate of Medical Need/Order) directly to Medicare

PROCESS TO OBTAIN A SPECIFIC ITEM

- Practitioner should **prescribe a specific item.**
- Practitioner should **document the need** for that specific item/supply in the medical record.
- The supplier is **required** to do one of the following:
  - **Give the exact** brand/form of item/supply requested, **or**
  - Work with the practitioner to **find another brand**/form the prescriber agrees is **both safe and effective**.

NOTE: For suppliers accepting assignment, separate delivery charges are allowed only in "rare and unusual circumstances"

DME BENEFICIARY CHECKLIST: QUESTIONS FOR A SUPPLIER (PG 1)

- ✓ Do you sell & service "xyz" item? Is it in stock?
- ✓ Are you a Medicare enrolled supplier? For how long?
- ✓ Describe how you will work with my prescriber.
- ✓ Do you agree to accept Medicare assignment?
- ✓ If not, will you consider assignment in my case?
- ✓ If not, what is your non-assignment charge?
  - ✓ How is the charge imposed – outright payment or rental?
  - ✓ Is there extra charge for necessary delivery/set up/training?
- ✓ What is your process for delivery/set up/training?

DME BENEFICIARY CHECKLIST: QUESTIONS FOR A SUPPLIER (PG 2)

- ✓ Will you bill Medicare for me?
- ✓ Do you have a direct customer service rep I can call?
- ✓ What are your company policies about customer responsiveness and follow through?
- ✓ If you are not geographically convenient for me, do you have customer service representatives in my area?
- ✓ How will you perform maintenance or repairs if I rent? If I purchase/own?

(**Note**: Look for Big Red Flags – BBB, online reviews)

DISASTERS OR EMERGENCIES - GENERALLY

If items are damaged or lost due to a disaster or emergency:

- In most cases, Medicare will cover the cost of repair or replacement.
- In most cases, Medicare will cover the cost of a rental during repair or replacement.

DME QUERIES & COMPLAINTS (NOT APPEALS OF DENIALS)

- Contact supplier for required response:
  - Within 5 days, must confirm receipt and confirm investigating
  - Within 14 days, must respond with investigation result in writing
- Or, call 1-800-MEDICARE (1-800-633-4227)
  - TTY 1-877-486-2048
- Or by Mail: Medicare Contact Center Operations

  PO Box 1270, Lawrence, KS 06044
- For investigation, submit patient consent-English/Spanish
  - https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10106.pdf
  - https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS10106S.pdf

DME ADVOCACY CURRENT ISSUES

- **Advocating for individual item coverage** – E.g., tilt recline shower commode chair, seat elevator power wheelchair, standing feature on power wheelchair, electric Hoyer patient-lift, incontinence supplies
- **Advocating for fair access** to items, delivery, set-up, training, repairs, maintenance and replacement for effective use

DME ADVOCACY CURRENT ISSUES (CONTINUED)

- **Advocating for a fair and transparent reimbursement program** to ensure suppliers have appropriate incentives to be a "participating" supplier and provide necessary items.
- **Advocating for more accurate I.D. of true Medicare fraud**.
- **Advocating to modernize the DME laws**
  - Allow traditional Medicare to cover technological advances
  - Allow traditional Medicare to cover additional items Medicare Advantage is allowed to cover (e.g., grab bars)
  - Expand the definition of DME: for nursing home residents to obtain DME; for DME not to be primarily used at home; for "reasonable & necessary" to be for the individual patient.

THREE DME CASE STUDIES

#1 Comparing costs with different types of suppliers for a Rollator Walker

#2 Using the Compare Cost tool on Medicare.gov for a CPAP Machine

#3 Obtaining DME for Oxygen

CASE STUDY #1 OBTAINING A ROLLATOR WALKER

- Ms. K had several falls and needs ongoing support to ambulate. She has traditional Medicare.
- The doctor, who is enrolled in Medicare, prescribed a rollator walker for Ms. K to help her balance while walking.
- Ms. K. wants to know where she can get her rollator walker and how Medicare may help pay for it.

CASE STUDY #1 OBTAINING A ROLLATOR WALKER

CASE STUDY #1
OBTAINING A ROLLATOR WALKER

In this case, the walker costs **$150**, but Medicare's allowed amount for the medically necessary model is **$100**:

- If Ms. K buys from a **Medicare participating/assigned supplier**, she will pay **$20**, Medicare will pay $80, or
- If Ms. K buys from a Medicare enrolled, but **non-participating supplier**, Medicare will pay $80 for the item to Ms. K, but she could pay **$70** of her own money ($150 minus $80 she receives from Medicare) or
- If Ms. K buys from a **non-enrolled supplier**, she could pay **$150**.

CASE STUDY #2 CPAP

To help Mr. M. breathe more easily while he sleeps, a Pulmonary Specialist prescribed a Continuous Positive Airway Pressure machine (CPAP) for his Obstructive Sleep Apnea

Let's assist Mr. M to find a supplier for his CPAP (he has traditional Medicare).

CASE STUDY #2 CPAP

CASE STUDY #2 CPAP - FIND EQUIPMENT AND SUPPLIERS

- Follow this link: https://www.medicare.gov/medical-equipment-suppliers/

OR

- Call 1-800-MEDICARE for assistance

CASE STUDY #3
OXYGEN

- Most DME is either purchased or obtained under a 13-month "capped" rental agreement.
- The beneficiary usually owns the equipment following the capped rental period.

But…

- Medicare's oxygen benefit is set-up differently

CASE STUDY #3
OXYGEN

- Ms. Z. has traditional Medicare and she been diagnosed with Chronic Pulmonary Obstructive Disease (COPD).
- Her doctor prescribed a stationary oxygen concentrator for her home.
- Ms. Z. would also like to know about options for oxygen when she goes shopping, attends religious services and for other outings.

CASE STUDY #3 OXYGEN STATIONERY & PORTABLE

CASE STUDY #3
PORTABLE OXYGEN

- If coverage criteria are met, a person can get both portable and stationary oxygen equipment if both are prescribed.
- When a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the beneficiary uses (the supplier gets the same reimbursement regardless of the amount of oxygen supplied).

CASE STUDY # 3
MEDICARE PAYMENT FOR OXYGEN

- In the first 36 months, suppliers are paid for the entire 60-month covered period.

- During the 36th-60th rental months, the supplier is required to continue to provide the equipment, accessories, contents maintenance, and repair of the oxygen equipment

Questions and Discussion

CT SMP and CHOICES Contact Information

Contact SMP to report suspected Medicare fraud or errors.

Contact CHOICES for Medicare Counseling.

Call CHOICES and SMP at your local Area Agency on Aging (AAA):

Senior Resources, Eastern CT AAA: (860) 887-3561

North Central AAA:	(860) 724-6443
South Central AAA:	(203) 785-8533
Southwest AAA:	(203) 333-9288
Western CT AAA:	(203) 757-5449
Call Toll-free:	1-800-994-9422

WHO CAN HELP AT NO COST TO YOU?

- For Medicare Counseling (in every state): https://www.shiptacenter.org/
- To Report Suspected Medicare Errors or Fraud (in every state): https://www.smpresource.org/

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