CENTERS for MEDICARE & MEDICAID SERVICES

Medicare Coverage of Durable Medical Equipment and Other Devices

This official government booklet explains:

- **What durable medical equipment is**
- **Which durable medical equipment, prosthetic, and orthotic items are covered by Original Medicare**
- **Where to get help with your questions**

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Do you need durable medical equipment (DME) or other types of medical equipment? Medicare can help.

Definitions of blue words are on pages 18 – 19.

This booklet explains Original Medicare coverage of DME and what you might need to pay. DME includes things like:

- Home oxygen equipment
- Hospital beds
- Walkers
- Wheelchairs

This booklet also explains coverage for prosthetic equipment (like cardiac pacemakers, enteral nutrition pumps, and prosthetic lenses), orthotic items (like leg, neck, and back braces) and prostheses (like artificial legs, arms, and eyes). It's important to know what Medicare covers and what you may need to pay. Talk to your doctor if you think you need some type of DME.

If you have questions about the cost of DME or coverage after reading this booklet, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Note: The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users should call 1-877-486-2048.

"Medicare Coverage of Durable Medical Equipment & Other Devices" isn't a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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       Baltimore, MD 21244-1850
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- Writing:

  Office for Civil Rights
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

Definitions of blue words are on pages 18 – 19.

What's durable medical equipment (DME)?

DME is reusable medical equipment like walkers, wheelchairs, or hospital beds.

If I have Medicare, can I get DME?

Anyone who has Medicare Part B (Medical Insurance) can get DME as long as the equipment is medically necessary.

When does Original Medicare cover DME?

Original Medicare covers DME under Part B when your doctor or treating practitioner (like a nurse practitioner, physician assistant, or clinical nurse specialist) prescribes it for you to use in your home. A hospital or nursing home that's providing you with Medicare-covered care can't qualify as your "home" in this situation. However, a long-term care facility can qualify as your home.

Note: If you're in a skilled nursing facility and the facility provides you with DME, the facility is responsible for this equipment.

What if I need DME and I'm in a Medicare Advantage Plan?

Medicare Advantage Plans (like an HMO or PPO) must cover the same items and services as Original Medicare. Your costs will depend on which plan you choose. If you're in a Medicare Advantage Plan and you need DME, call your plan to find out if the equipment is covered and how much you'll have to pay.

If you're getting home care or using medical equipment and you choose to join a new Medicare Advantage Plan, you should call the new plan as soon as possible and ask for "Utilization Management." They can tell you if your equipment is covered and how much it will cost. If you return to Original Medicare, you should tell your supplier to bill Medicare directly after the date your coverage in the Medicare Advantage Plan ends.

Definitions of blue words are on pages 18 – 19.

Note: If your plan leaves Medicare and you're using medical equipment like oxygen or a wheelchair, call the phone number on your Medicare Advantage Plan card. Ask for "Utilization Management." They can tell you how you can get care under Original Medicare or a new Medicare Advantage Plan.

If I have Original Medicare, how do I get the durable medical equipment (DME) I need?

If you need DME in your home, your doctor or treating practitioner (like a nurse practitioner, physician assistant, or clinical nurse specialist) must prescribe the type of equipment you need by filling out a detailed written order. For some equipment, Medicare may also require your doctor to provide additional information documenting your medical need for the equipment. Your supplier will work to make sure your doctor submits all required information to Medicare. If your prescription and/or condition changes, your doctor must complete and submit a new, updated prescription.

Medicare only covers DME if you get it from a supplier enrolled in Medicare. This means that the supplier has been approved by Medicare and has a Medicare supplier number.

To find a supplier that's enrolled in Medicare, visit Medicare.gov, and select "Find suppliers of medical equipment & supplies." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

A supplier enrolled in Medicare must meet strict standards to qualify for a Medicare supplier number. **If your supplier doesn't have a supplier number, Medicare won't pay your claim**, even if your supplier is a large chain or department store that sells more than just DME.

Definitions of blue words are on pages 18 – 19.

Does Medicare cover power wheelchairs & scooters?

For Medicare to cover a power wheelchair or scooter, your doctor must state that you need it because of your medical condition. Medicare won't cover a power wheelchair or scooter that's only needed and used outside of the home.

Most suppliers who work with Medicare are honest. However, there are a few who aren't. For example, some suppliers of medical equipment try to cheat Medicare by offering expensive power wheelchairs and scooters to people who don't qualify for these items.

For more information about Medicare's coverage of power wheelchairs or scooters, view the publication "Medicare's Wheelchair and Scooter Benefit." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What if my equipment or supplies are lost or damaged in a disaster or emergency?

If Original Medicare already paid for durable medical equipment (DME) or supplies damaged or lost due to an emergency or disaster:

- In certain cases, Medicare will cover the cost to repair or replace your equipment or supplies.
- Generally, Medicare will also cover the cost of rentals for items (like wheelchairs) during the time your equipment is being repaired.

If you're in a Medicare Advantage Plan or other Medicare health plan, contact your plan directly to find out how it replaces DME or supplies damaged or lost in an emergency or disaster.

You can also call 1-800-MEDICARE to get more information about how to replace your equipment or supplies.

What's covered, and how much does it cost?

The charts on pages 9–11 show some of the items Medicare covers and how much you have to pay for these items. This list doesn't include all covered durable medical equipment (DME). For questions about whether Medicare covers a particular item, visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you have a Medigap policy, it may help cover some of the costs listed on pages 9–11.

Definitions of blue words are on pages 18 – 19.

Durable Medical Equipment (DME)	
What Medicare covers	**What you pay**
▪ Air-fluidized beds and other support surfaces ▪ Blood sugar monitors ▪ Blood sugar (glucose) test strips ▪ Canes (however, white canes for the blind aren't covered) ▪ Commode chairs ▪ Continuous passive motion (CPM) machine ▪ Crutches ▪ Hospital beds ▪ Infusion pumps and supplies (when necessary to administer certain drugs) ▪ Manual wheelchairs and power mobility devices ▪ Nebulizers and nebulizer medications ▪ Oxygen equipment and accessories ▪ Patient lifts ▪ Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories ▪ Suction pumps ▪ Traction equipment ▪ Walkers	Generally, you pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year. Medicare pays the other 80%. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item. However, the amount you pay may vary because Medicare pays for different kinds of DME in different ways. You may be able to rent or buy the equipment.

Prosthetic and Orthotic Items

What Medicare covers	What you pay
▪ Orthotics, as long as you go to a supplier that's enrolled in Medicare ▪ Orthopedic shoes only when they're a necessary part of a leg brace ▪ Arm, leg, back, and neck braces ▪ Artificial limbs and eyes ▪ Breast prostheses (including a surgical bra) after a mastectomy ▪ Ostomy bags and certain related supplies ▪ Urological supplies ▪ Cochlear implants and certain other surgically implanted prosthetic devices ▪ Prosthetic devices needed to replace a body part or function ▪ Therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease. The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. A podiatrist or other qualified doctor must prescribe the shoes and inserts. A doctor or other qualified individual like a pedorthist, orthotist, or prosthetist must fit and provide the shoes. Medicare Part B (Medical Insurance) covers the furnishing and fitting of either one pair of custom-molded shoes and inserts or one pair of extra-depth shoes each calendar year. Medicare also covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. Medicare will cover shoe modifications instead of inserts.	You pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year. Medicare pays the other 80%. These amounts may be different if the supplier doesn't accept assignment. See page 12.

Corrective Lenses	
What Medicare covers	**What you pay**
Prosthetic Lenses ▪ Cataract glasses ▪ Conventional glasses and contact lenses after surgery with an intraocular lens ▪ Intraocular lenses An ophthalmologist or an optometrist must prescribe these items. **Important:** Only standard frames are covered. Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).	You're covered for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. You pay 20% of the Medicare-approved amount after you pay the Medicare Part B deductible for the year. Medicare pays the other 80%. Costs may be different if the supplier doesn't accept assignment. See page 12. If you want to upgrade the frames, you pay any additional cost.

Definitions of blue words are on pages 18 – 19.

What's "assignment" in Original Medicare, and why is it important?

Assignment is an agreement between you (the person with Medicare), Medicare, and doctors or other health care providers, and suppliers of health care equipment and supplies (like DME and prosthetic or orthotic devices). Doctors, providers, and suppliers who agree to accept assignment accept the Medicare-approved amount as full payment. After you have paid the Part B deductible, you pay the doctor or supplier the coinsurance (usually 20% of the approved amount). Medicare pays the other 80%.

Suppliers who agree to accept assignment on all claims for DME and other devices are called "participating suppliers." If a DME supplier doesn't accept assignment, **there's no limit to what they can charge you**. In addition, you may have to pay the entire bill (Medicare's share as well as your coinsurance and any deductible) at the time you get the DME. The supplier will send the bill to Medicare for you, but you'll have to wait for Medicare to reimburse you later for its share of the charge.

Note: Before you get DME, ask if the supplier is enrolled in Medicare. If the supplier isn't enrolled in Medicare, Medicare **won't** pay your claim at all. Then, ask if the supplier is a participating supplier in Medicare. A participating supplier **must** accept assignment. A supplier that's enrolled in Medicare, but isn't "participating," has the option whether to accept assignment. You'll have to ask if the supplier will accept assignment for your claim.

To find suppliers who always accept assignment, see the Supplier Directory on Medicare.gov. Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Definitions of blue words are on pages 18 – 19.

How will I know if I can buy durable medical equipment (DME) or whether Medicare will only pay for me to rent it?

If your supplier is a Medicare-enrolled supplier, they'll know if Medicare allows you to buy a particular kind of DME, or just pays for you to rent it. Medicare pays for most DME on a rental basis. Medicare only buys inexpensive or routinely bought items, like canes; scooters; and, in rare cases, items that must be made specifically for you.

Buying equipment

If you **own** Medicare-covered DME and other devices, Medicare may also cover repairs and replacement parts. Medicare will pay 80% of the Medicare-approved amount for purchase of the item. Medicare will also pay 80% of the Medicare-approved amount (up to the cost of replacing the item) for repairs. You pay the other 20%. Your costs may be higher if the supplier doesn't accept assignment.

Note: The equipment you buy may be replaced if it's lost, stolen, damaged beyond repair, or used for more than the reasonable useful lifetime of the equipment.

Renting equipment

If you **rent** DME and other devices, Medicare makes monthly payments for use of the equipment. The rules for how long monthly payments continue vary based on the type of equipment. Total rental payments for inexpensive or routinely bought items are limited to the fee Medicare sets to buy the item. If you'll need these items for more than a few months, you may decide to buy these items rather than rent them. Monthly payments for frequently serviced items, like ventilators, are made as long as the equipment is medically necessary. The payment rules for other types of rented equipment, including "capped rental items," are on page 9. You pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year. Medicare pays the other 80%.

The supplier will pick up the equipment when you no longer need it. Any costs for repairs or replacement parts for the rented equipment are the supplier's responsibility. The supplier will also pick up the rented equipment if it needs repairs. You don't have to bring the rented equipment back to the supplier.

How does Medicare pay the supplier for oxygen equipment and related supplies?

If you have Medicare and use oxygen, you can rent oxygen equipment from a supplier for as long as you have a medical need, up to 36 months of continuous use. After 36 months, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. Your supplier must provide equipment and supplies for up to a total of 5 years, as long as you have a medical need for oxygen.

What do I pay the supplier? What does the rental payment cover?

The monthly rental payments to the supplier cover not only your oxygen equipment, but also any supplies and accessories like tubing or a mouthpiece, oxygen contents, maintenance, servicing, and repairs. You pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year. Medicare pays the other 80%.

What happens with my oxygen equipment and related services after the 36 months of rental payments?

Your supplier must continue to maintain the oxygen equipment (in good working order) and furnish the equipment and any necessary supplies and accessories, as long as you need it until the 5-year period ends. The supplier can't charge you for performing these services.
If you use oxygen tanks or cylinders that need delivery of gaseous or liquid oxygen contents, Medicare will continue to pay each month for the delivery of contents after the 36-month rental period. The supplier that delivers this equipment to you in the last month of the 36-month rental period must provide these items, as long as you medically need them, up to 5 years. The supplier owns the equipment during the entire 5-year period.

Definitions of blue words are on pages 18 – 19.

My oxygen equipment doesn't allow me to move around like I want to inside and/or outside my home. What should I do?

If your doctor determines that your oxygen equipment doesn't meet your needs, he or she may notify the oxygen supplier with a new letter of medical necessity. It should address your mobility needs both inside and outside your home.

What happens if the equipment I have is no longer effective for me?

If your doctor decides that your oxygen equipment is no longer effective for you, he or she may notify the oxygen supplier with a new letter of medical necessity for different equipment. The oxygen supplier must provide you with equipment that fits your needs.

What if my oxygen supplier tells me they'll no longer provide liquid oxygen?

If your supplier tells you they'll no longer provide your prescribed therapy, and you haven't completed your 5-year contract, you should:

- Get the oxygen supplier to put their intentions in writing
- Call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users should call 1-877-486-2048.

Can my oxygen supplier decide to change the terms of my contract for my equipment or the number of tanks I get each month?

Your supplier can't change the type of equipment or number of tank refills you get unless your doctor orders a change. If you find you need more tank refills, ask your doctor to submit an updated letter of medical necessity to your supplier.

What happens if my oxygen supplier goes out of business or leaves the program during my rental period?

Suppliers leaving the program must give you a 90-day notice in writing, telling you that they can no longer provide oxygen therapy services. This notice must be one of these 2 letters:

- A letter notifying you of their intent to stop oxygen therapy services, including the date when they'll stop services
- A letter to a new supplier you've chosen, transferring responsibility for oxygen therapy services to the new supplier on a specific date

Work with your supplier to find a new oxygen supplier in your area and request that they send a letter to the new supplier on your behalf. This will ensure you'll have continuous service and your medical records will be transferred to the new supplier within 90 days.

What happens to my oxygen equipment after 5 years?

If your medical need continues past the 5-year period, your supplier no longer has to continue providing your oxygen and oxygen equipment, and you may choose to get replacement equipment from any supplier. A new 36-month payment period and 5-year supplier obligation period starts once the old 5-year period ends for your new oxygen and oxygen equipment.

If I decide to travel by plane, is my oxygen supplier required to provide a portable oxygen concentrator?

Your oxygen supplier isn't required to give you an airline-approved portable oxygen concentrator, and Medicare won't pay for any oxygen related to air travel. You may be able to rent a portable oxygen concentrator from your supplier. Also, rentals are available through online companies that work with most airlines. These companies can give the documentation needed for your travel.

What if I'm away from home for an extended period of time or I move to another area *during* the 36-month period?

If you travel away from home for an extended period of time (several weeks or months) or permanently move to another area during the 36-month rental period, ask your current supplier if they can help you find a supplier in the new area. If your supplier can't help you locate an oxygen supplier in the area where you're visiting or moving to, visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What if I'm away from home for an extended period of time or I move to another area *after* the 36-month period?

If you travel or move after the 36-month rental period ends, your supplier is generally responsible for ensuring that you have oxygen and oxygen equipment in the new area. Your supplier may arrange for you to get oxygen and oxygen equipment from a different supplier in your new area. For more information visit Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What if my supplier refuses to continue providing my oxygen equipment and related services as required by law?

If your supplier isn't following Medicare laws and rules, call 1-800-MEDICARE. A customer service representative will refer your case to the appropriate area.

Definitions

Assignment — An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance — An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Deductible — The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Durable medical equipment (DME) — Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Medically necessary — Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C) — A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount — In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medigap policy — Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in Original Medicare coverage.

Original Medicare — Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Patient lift — A medical device used to lift you from a bed or wheelchair.

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