

Understanding Durable Medical Equipment

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Justice in Aging

Justice in Aging is a national organization that uses the power of law to fight senior poverty by securing access to affordable health care, economic security, and the courts for older adults with limited resources. Since 1972, Justice in Aging has focused primarily on populations that have traditionally lacked legal protection, such as women, people of color, LGBT individuals, and people with limited English proficiency.

Introduction

Health programs like Medicare and Medicaid are often associated with essential health services, like primary care, specialty care, and prescription drug coverage. People may not realize that they also provide critical coverage for medical equipment and related medical supplies that allow older adults and people with disabilities to remain healthy and in their communities. These equipment and supplies can be as important as, if not more than, other covered services, but older adults may experience difficulty and confusion around accessing these benefits. The difficulty and confusion is sometimes exacerbated by changes to the Medicare and Medicaid delivery system, the increasing prevalence of managed care, and if an older adult is eligible for both Medicare and Medicaid.

Key Lessons

1. Doctors and other providers are the initial starting point to accessing durable medical equipment (DME). Providers need to be enrolled in Medicare. Medicaid is required to allow providers to enroll as an ordering or prescribing provider. The type of DME requested determines whether a prescription alone will be sufficient to establish medical necessity.
2. Finding a supplier will depend on the beneficiary's health coverage. Original Medicare may require that the beneficiary use a supplier through the competitive bidding process, and managed care plans, for either Medicare or Medicaid, will have their own networks.
3. For dual eligibles, Medicaid is the payer of last resort when DME is covered by both Medicare and Medicaid. This can create complications when Original Medicare reviews claims after DME is delivered, while Medicaid will require a denial from Medicare before paying.
4. Appeals for DME in Medicare and Medicaid are the same as any other covered service. Appeals in Original Medicare begin with the Medicare Administrative Contractor (MAC), and managed care appeals begin with the MA plan or MCO. State Medicaid appeal rules apply to Medicaid DME denials.

CASE EXAMPLE

Mary is 70 years old and qualifies for both Medicare and Medicaid. She has had diabetes for years. Medicare has been covering both her glucose monitoring equipment and her test strips. Recently, Mary had a serious fall. She suffered a spinal injury affecting both her ability to walk and her bladder function. She can get around her house with a walker but needs a manual wheelchair to go any distance. Mary also needs adult diapers to handle incontinence resulting from her accident. She can turn to Medicare and Medicaid for help. Medicare will cover a walker to help her get around the house. Medicaid will cover a manual wheelchair that allows her to go to a nearby grocery and her neighborhood senior center. Medicaid will also cover her incontinence supplies.

Glossary

Durable Medical Equipment (DME)

As defined by Medicare, Durable Medical Equipment must have a usable life of at least three years, must be used for a medical reason, not useful to someone who is not sick or injured, and be needed for use in the home. The limitation for use in the home does not apply in Medicaid. DME can be covered if needed for an individual to function in the community.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

The Medicare program uses this term to encompass all items subject to DME rules in Medicare. In addition to DME, it covers prosthetics (artificial limbs or items that replace all or part of a body organ or the function of an inoperative organ) and orthotics (e.g., external braces) and non-durable items that are used in conjunction with DME, for example, diabetic test strips used with glucose monitoring equipment.

Supplies

Medicaid coverage includes disposable medical supplies like incontinence supplies. As noted above, in Medicare, covered supplies are generally limited to disposable items used in connection with durable equipment.

Dual Eligible

An individual who is eligible for both Medicaid and Medicare.

Prior authorization (PA)

With prior authorization, or preauthorization, coverage for DME is approved before it is provided. Original Medicare generally does not use PAs. This means that DME must be delivered first before the Medicare program reviews the claim and decides whether to approve the item. In the Medicaid benefit, most DME requires a PA before it is delivered. If the beneficiary is enrolled in either a MA plan or a MCO, each plan may have their own PA process or requirement.

Original Medicare

The Medicare Part A and B benefit, also referred to as Traditional Medicare or fee-for-service Medicare.

MA Plan

Medicare Advantage Plans are managed care plans that combine the Part A and B benefits (and also frequently the Part D drug benefit). About 35% of Medicare beneficiaries are enrolled in MA Plans, and almost 30% of dual eligibles are enrolled in Medicare Advantage.

Medicaid Managed Care Organization (MCO)

Medicaid Managed Care Organizations are managed care plans that deliver Medicaid benefits. Increasingly, states are requiring that Medicaid beneficiaries enroll in MCOs for their Medicaid coverage.

Getting DME in Medicare

Getting started

DME falls under the Part B benefit, and the physician or another provider is the gatekeeper. **DME must be prescribed by a provider enrolled in Medicare.** The provider must sign the order. In many cases, the physician's prescription is adequate to demonstrate medical necessity; in other cases, specific criteria must be met. Those can be found in the [Medicare National Coverage Determinations Manual, Chapter 1, Part 4, starting at Sec. 280.](#)

Finding a supplier

Supplier requirements depend on how someone gets the Medicare benefit.

- **In Original Medicare:** The Medicare program is increasingly requiring that beneficiaries use Medicare competitive bidding suppliers for their DME needs. Competitive bidding requirements depend on both the DME in question and the geographic area where the beneficiary lives. [A searchable CMS site](#) allows beneficiaries and advocates to search for particular products in specific geographic regions to determine what items are covered by the competitive bidding regime and which suppliers have competitive bidding contracts in their region.
- **In Medicare Advantage:** Medicare Advantage plans have their own in-network suppliers. These suppliers might not be the same as suppliers who offer competitively bid products in Original Medicare. Beneficiaries should use the plan's provider list or call the plan to find out which suppliers are in the plan's network.

Getting approval

Approval procedures also depend on whether someone is in Original Medicare or in a MA Plan.

- **In Original Medicare:** The supplier provides the equipment and then bills Medicare. There are a few exceptions for certain expensive wheelchairs and mobility devices. For those items, the request must have a PA before delivery.
- **In Medicare Advantage:** Many items require a PA by the MA Plan before being delivered.

Paying for DME

In Original Medicare, the beneficiary pays 20 percent of the Medicare approved amount. In Medicare Advantage, the MA Plan establishes the co-insurance amount. Some DME items are provided on a rental basis. If a beneficiary is a Qualified Medicare Beneficiary (QMB), improper billing protections apply, and the QMB-eligible beneficiary has no payment liability. Additional state-specific billing protections may also apply.

Getting DME in Medicaid

Getting started

The prescribing physician or other provider must be enrolled in Medicaid. This can be a hurdle for dual eligible beneficiaries who use Medicare providers who are not enrolled in Medicaid. To address this concern, states are required to allow prescribers to enroll in Medicaid solely as a prescribing or ordering providers.

Finding a supplier

Suppliers must be enrolled in the state Medicaid program. If a beneficiary is in a MCO, the supplier must also be in the MCO's network.

Getting approval

Medicaid programs usually issue a PA before DME is delivered. The PA process can have different names depending on the state. In California, for example, it is called a TAR (Treatment Authorization Request).

Paying for DME

In most cases, the beneficiary pays nothing for Medicaid-supplied DME. In some states, there may be a small co-insurance amount due.

Intersection of Medicare and Medicaid

Medicaid is always the payer of last resort when DME is covered by both Medicare and Medicaid. This means that Medicaid will only pay for DME for a dual eligible if: 1) the DME is never covered by Medicare or 2) if Medicare denied coverage for the particular individual. Medicaid's payer of last resort status creates a challenge because Medicare does not review claims until *after DME has been delivered*. Sometimes suppliers are reluctant to deliver DME without assurance that someone will pay. Most states have created procedures, like preliminary PA approvals, to address the problem, but sometimes they do not work well. Advocates may need to work with Medicaid programs to untangle stalled DME requests.

Most areas of intersection relate to the difference between the Medicare "use in the home" requirement and the broader Medicaid standard. Mobility devices (e.g., wheelchairs suitable for outdoor use or power scooters) and items like portable oxygen tanks are devices that can prove to be challenging due to these different definitions.

PRACTICE TIPS

Understanding DME requirements

Mario's doctor isn't sure what information he needs to supply to get DME for Mario.

DME suppliers are usually very familiar with both Medicare and Medicaid requirements for specific items of DME. Working with knowledgeable staff at a DME supplier often is the most direct route to understanding what needs to be done.

Finding a willing supplier

Elena is having trouble finding a DME supplier in her area who is willing to provide the DME she needs.

Advocates report that finding suppliers is increasingly difficult. The number of suppliers has shrunk in recent years and pricing incentives have also changed. An individual in Original Medicare looking for a supplier can contact 1-800-Medicare for assistance in finding a supplier. In Medicare Advantage, the individual should contact the MA Plan. The MA Plan has an obligation to ensure that an in-network provider is available. Similarly, MCOs must help their members connect with an in-network supplier.

Getting repairs

Roger needs repairs for his wheelchair and his supplier is not being helpful.

For a Medicare-covered item, the supplier that provided the DME must provide repair and maintenance services. A beneficiary also can use any other Medicare supplier for repairs and adjustments, not just the original supplier. A helpful list of these and other beneficiary protections in DME is found [on the CMS Outreach and Education webpage](#).

It is always important to clearly communicate to a supplier when repairs are urgently needed. It also is appropriate to ask for a loaner while repairs are completed.

Filing a complaint

Sonja's Medicare DME supplier is not assisting her with adjustments to her DME. She urgently needs assistance and has hit a brick wall. She also wants to complain about rudeness of the supplier's staff and their constant failure to return her calls.

Sonja can call 1-800-MEDICARE. For her urgent needs, she should specifically ask that her complaint be forwarded to the Competitive Acquisitions Ombudsman. For her complaints about quality of service, she should say specifically that she wants to file a complaint. If she is in a MA Plan, she should first contact the plan and tell them she needs their assistance in getting the matter resolved. She should also make sure they

understand that she wants to file a formal complaint. In Medicaid, complaint routes may vary depending on the state, and if she is enrolled in a MCO, she can also call the plan and file a formal complaint that way too. In all cases, it is important to be specific and persistent.

Appealing a coverage denial

Eduardo was denied coverage for DME that his doctor ordered.

Appeals processes in both Medicare and Medicaid for DME are the same as for any other covered service. The denial letter should provide information on deadlines and processes. In Original Medicare, the appeal starts with the Medicare Administrative Contractor (MAC); in Medicare Advantage, the first level of appeal is with the MA Plan. State Medicaid appeal rules apply for Medicaid denials, including those issued by an MCO.

Conclusion

DME and related supplies are important services covered by Medicare and Medicaid that enable older adults and people with disabilities to remain healthy and in their communities, but problems accessing and maintaining them can arise and pose real barriers to older adults. The routes to accessing DME and advocating around DME-related issues may depend on whether the individual is enrolled in Original Medicare, Medicare Advantage, and/or a MCO, and whether the older adult is dually eligible, and when assisting an older adult with a DME-related problem, advocates should leverage the standard Medicare and Medicaid complaint and appeals mechanisms.

Additional Resources

- 42 CFR 414.200 et seq.
- [Medicare DME Manual](#)

Case consultation assistance is available for attorneys and professionals seeking more information to help older adults. Contact NCLER at ConsultNCLER@acl.hhs.gov.

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