THE MEDICARE PART B
DURABLE MEDICAL EQUIPMENT (DME) BENEFIT

Medicare’s Durable Medical Equipment benefit (DME) is available under Medicare Part B (Supplemental Medical Insurance). DME comprises a host of equipment that is used in the home and capable of repeated use. DME includes hospital beds, iron lungs, walkers, canes, wheelchairs, seat lifts, and portable oxygen and supplies. It also includes diabetes management equipment and supplies. In addition, some assistive technology devices can be covered under this benefit provided the device fits the Medicare definition and coverage criteria for durable medical equipment. For purposes of the DME benefit, Medicare law excludes institutions such as a hospital, a Community Access Hospital (CAH), or a skilled nursing facility from the definition of a home.

DME is often essential for people with short-term and/or chronic conditions. To be covered by Medicare, DME must be prescribed by a licensed physician and must be necessary to address a medical or physical need, and the item of DME must not ordinarily be used in the absence of a medical or physical condition. With the enactment of the Affordable Care Act of 2010, a face-to-face encounter with a physician is required before DME can be prescribed. As an additional fraud and abuse protection, the Affordable Care Act (ACA) states that only Medicare-enrolled physicians or other “eligible professionals” can prescribe DME. The Affordable Care Act

1 Payment for DME: §1834(a) of the Social Security Act, 42 U.S.C. §1395x(m); Definition of DME: §1861(n) of the Social Security Act, 42 U.S.C §1395x(n); 42 C.F.R. §410.38; Medicare National Coverage Determinations Manual: www.cms.hhs.gov/manuals/downloads/ncd103c1_Part4.pdf (includes the DME coverage issues reference lists).

2 See the Medicare Agency’s brochure on DME: www.medicare.gov/Publications/Pubs/pdf/11045.pdf.

3 Medicare does not make a specific distinction for assistive devices apart from its coverage rules for DME. The task for advocates is to show that a particular assistive device is or should be recognized as a Medicare-covered item of DME. See, for example, efforts of the Assistive Technology Network (AT Network Assistance), http://www.atnet.org/index.php?page=obtaining-durable-medical-equipment; law school programs, http://tatp.edb.utexas.edu/medicare.html; or the Amputee Coalition, http://www.amputee-coalition.org/fact_sheets/assist_orgs.html.


5 §1861(n) of the Social Security Act, 42 U.S.C §1395x(n).

6 See the Affordable Care Act of 2010, §6407(b), Pub. L. 111-148, enacted March 23, 2010, effective for DME ordered after January 1, 2010. Note, a physician face-to-face encounter is also required for prescribing home health care. Id. §6407(a). Further, the Secretary of Health and Human Services, (the Secretary), has been given the authority to apply the face-to-face requirement to other areas of Medicare to reduce waste, fraud, and abuse as she deems appropriate. Id. §6407(c). Moreover, she has been given the authority to apply the face-to-face requirement to Medicaid services if she deems it would reduce waste, fraud, and abuse. Id. §6407(d).

7 See the Affordable Care Act of 2010, §6405(a)-(c). Interim final regulations, with a comment period, to implement this provision are at 75 Fed. Reg. 24437 (May 5, 2010). See 42 C.F.R. §424.506 et seq., (May 5, 2010), effective July 6, 2010. The Centers for Medicare & Medicaid Services (CMS) is using its Provider, Enrollment, Chain, and Ownership System (PECOS), described in the above interim final regulations, as the vehicle through which it is

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defines an “enrolled physician” as one who has registered with Medicare in accordance with rules established by the Secretary.

An eligible professional is defined in ACA as one who has enrolled under Medicare's Quality Care Reporting System for providers.

The Centers for Medicare & Medicaid Services (CMS) is currently completing efforts to implement its system of Medicare Administrative Contractors (MACs), whose jurisdiction includes DME. Through 2011, CMS intends to award contracts to fifteen MACs that will serve the majority of all providers under both Parts A and B.

Discussion

DME is defined in §1861(n) of the Social Security Act, 42 U.S.C. §1395x(n), and includes items that are capable of repeated use, such as iron lungs, oxygen tents, hospital beds, and wheelchairs (including a power-operated vehicle (POV) used as a wheelchair). A POV must meet a physical need of the beneficiary as determined by a physician or other authorized and licensed professional. In addition, the POV must meet certain safety requirements and must be appropriate for use in the patient's home. The definition of DME also includes such items as blood-testing strips and blood glucose monitors for individuals with diabetes (without regard to Type I or Type II diabetes or use of insulin).

Note that coverage for a seat-lift chair is for the seat-lift mechanism, but not the chair itself. A more complete list of items of DME can be found in the Medicare National Coverage Determinations Manual, Section 280 (Medical and Surgical Supplies).

In general, Medicare expects a piece of equipment to last five (5) years. Thus, in most instances the program will not pay for the same or similar equipment within a five year time frame.

implementing §6405. Note, the limitation applies to home health care as well. However, CMS issued a press release on June 30, 2010, stating that it would not implement §6405 in a way that would deny necessary care and services during the period in which physicians have to enroll (through January 1, 2011). See: http://www.cms.gov/apps/media/press/release.asp?Counter=3774&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDvys=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

8 See §6405a, and its reference to §1866(j) of the Social Security Act, 42 U.S. C. §1395cc(j) (Enrollment Process for Providers of Services and Suppliers).
9 See §6505(a) and its reference to §1848(k)(3)(B) of the Social Security Act, 42 U.S.C. §1395w-4 (Payment Based on Fee Schedule). 42 U.S.C. §1395w-4(k)(3)(B) (Covered Professional Services and Eligible Professionals Defined) describes an “eligible professional” as a physician, a practitioner (including a certified nurse anesthetist, a certified midwife, a clinical social worker, and a clinical psychologist (see 42 U.S.C. §1395u)), and a physical or occupational therapist or a qualified speech-language pathologist.
10 A list of the DME MAC jurisdictions is included in the fact sheet available at: https://www.cms.gov/MedicareContractingReform/Downloads/MACJurisdictionFactSheet.pdf. In addition, a map of all A/B MAC jurisdictions is available at: https://www.cms.gov/MedicareContractingReform/Downloads/Primary_AB_MAC_Jurisdictions_MAP.pdf
12 §1861(n) of the Social Security Act, 42 U.S.C. §1395x(n) (Definition of Durable Medical Equipment).
13 Ibid.
16 Ibid.
Clinical Conditions for Coverage

The Secretary has established standards for clinical conditions for coverage of DME as provided by statute.\(^\text{17}\) In addition, there must be a "face-to-face examination of the individual by a physician (as defined in section §1861(r) of the Social Security Act), a physician assistant, a nurse practitioner, or a clinical nurse specialist and a prescription for the item," including a motorized or power wheelchair.\(^\text{18}\) Likewise, a motorized or power wheelchair must meet certain standards (durability, function, etc) as mandated by the Secretary.\(^\text{19}\)

Payment for Durable Medical Equipment

Rules for payment for DME are found in Section 1834 of the Social Security Act, 42 U.S.C. 1395m. Medicare pays 80% of the approved charge for DME.\(^\text{20}\) The beneficiary is responsible for a 20% co-payment on the amount recognized by the Secretary when the beneficiary uses a Medicare-participating supplier.\(^\text{21}\) With respect to a seat-lift chair or transcutaneous electrical nerve stimulator, the Medicare-recognized payment amount is reduced by 15 percent and, in the case of a transcutaneous electrical nerve stimulator furnished on or after January 1, 1991, the recognized amount is further reduced by 45 percent.\(^\text{22}\) In addition, Medicare provides that beneficiaries are not responsible for the cost of DME (and payments must be refunded) when a supplier of medical equipment or supplies provides an item of DME for which no payment may be made because the provider does not meet certain standards set by the Secretary, furnishes an item or service to a beneficiary for which payment is denied in advance under the Advance Determination Provisions (see below), or when payment is not reasonable and necessary.\(^\text{23}\)

- Payment for Inexpensive and Other Routinely Purchased Durable Medical Equipment

Inexpensive items of DME include items for which the cost does not exceed $150 at least 75 percent of the time (as determined by the Secretary), and such items which are used in conjunction with a nebulizer, aspirator, or a ventilator.\(^\text{24}\) For these items, payment is on a rental

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\(^{18}\) See the coverage rules of the DME MAC for your jurisdiction. An example is at the following link: [http://www.aetna.com/cpb/medical/data/200_299/0271.html](http://www.aetna.com/cpb/medical/data/200_299/0271.html).
\(^{19}\) Ibid.
\(^{20}\) See §1834 of the Social Security Act, 42 U.S.C. §1395m. Note, for persons dually eligible for Medicare and Medicaid, it is important to look at whether a state Medicaid program is more or less generous with respect to DME coverage and payment. In some instances, the state may cover more things and at higher or lower rates. See [Charpentier v. Belshe](https://example.com), 1994 WL 792591 (E.D. Cal. Dec. 21, 1994), Medicare & Medicaid Guide (CCH) at ¶43, 123, involving categorically needy individuals who were also eligible for Medicare; see also [Charpentier v. Coye](https://example.com), 1992 WL 48978 (E.D. Cal. Jan. 9, 1992), Medicare & Medicaid Guide (CCH) at ¶39,791; but see [Ralabate v. Wing](https://example.com), 1996 WL 377204, Medicare & Medicaid Guide (CCH) at ¶44, 550 (W.D.N.Y. 1996). Under Charpentier, the state must assure that services comparable to those available to non-dually eligible Medicaid beneficiaries are available to those who are dually eligible. See also, 2010 Medicare Handbook, Aspen Publishers, Stein and Chiplin, editors, §10.06(E).
\(^{23}\) See §1834(a)(4)(j) of the Social Security Act, 42 U.S.C §139m(j)(4)(Limitation on Patient Liability).
basis or in a lump-sum purchase amount in accordance with a formula established in the statute.\(^{25}\)

- **Payment for Certain Customized Items**

Items that are uniquely constructed or that have been substantially modified to meet the specific needs of an individual patient are to be paid in a lump-sum amount: "(A) for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item and (B) for the reasonable and necessary maintenance and servicing for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and servicing shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item."\(^{26}\)

A wheelchair furnished on or after January 1, 1992, is treated as a customized item if the wheelchair has been "measured, fitted, or adapted in consideration of the patient's body size, disability, period of need, or intended use, and has been assembled by a supplier or ordered from a manufacturer who makes available customized features, modifications, or components for wheelchairs that are intended for an individual patient's use in accordance with instructions from the patient's physician."\(^{27}\)

- **Payment for Oxygen and Oxygen Equipment**

Medicare provides for coverage of home oxygen therapy under the Part B DME benefit. This coverage includes the rental of the oxygen delivery system and the cost of oxygen itself, including portable units. In 1985, CMS, then the Health Care Financing Administration (HCFA), established rigid coverage criteria requiring patients to demonstrate medical necessity through specific laboratory evidence, generally through arterial blood gas (ABG) studies. When ABG studies are not available or are medically contraindicated, oxygen saturation levels may be determined by ear oximetry readings.\(^{28}\)

The coverage criteria create three categories:

1. An ABG-PO2 at or below 55 or oxygen saturation at or below 88%, is presumed to establish coverage,
2. An ABG-PO2 at 56-59 or oxygen saturation at 89% will establish coverage if one of three specified conditions are also shown:
   - Dependent edema suggesting congestive heart failure, or
   - Pulmonary hypertension, or cor pulmonale, or
   - Erythrocythemia with a hematocrit > 56%
3. An ABG-PO2 at 60 or above, or oxygen saturation at or above 90%, creates a presumption that oxygen is not medically necessary. Although it is stated that

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\(^{25}\) Ibid.

\(^{26}\) See 42 U.S.C. §1395m(a)(4)(a)-(B).

\(^{27}\) Ibid.

\(^{28}\) See, for example, Local Coverage Decision (LCD), [https://www.virtuox.net/dyndocs/Documents/LCDforOximetry.PDF](https://www.virtuox.net/dyndocs/Documents/LCDforOximetry.PDF) (7/9/2009). Advocates should check LCDs in their areas with their respective DME MACs.
the presumption is rebuttable, in practice CMS automatically denies coverage for anyone who does not meet the ABG or oximetry standards.

The oxygen coverage criteria have been established as a national coverage determination which is codified in the Medicare Coverage Issues Manual (see above). This means that the restrictive coverage criteria are binding on all coverage determinations from the initial decision through an ALJ hearing.29

Payment for oxygen and oxygen equipment is made on a monthly basis, including an amount for recognized add-ons to portable oxygen equipment. Items under the rental cap, including payment for oxygen equipment (including portable oxygen equipment) are not to extend over a period of continuous use of longer than 36 months. After the 36th continuous month, the supplier is to "continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary."30 Reasonable and necessary maintenance and servicing payments (for parts and labor not covered by the supplier's or manufacturer's warranty) are covered, as determined by the Secretary.31

- Payment for Other Items of Durable Medical Equipment

**Purchase:** Payment for items is to be made on a monthly basis, during a period of medical need, and is to extend no longer than a period of continuous use of 13 months. After the initial ten-month rental, Medicare pays for three or more months of rental payment (total of 13) followed by 80% of the purchase price and any subsequent maintenance.32 The equipment then belongs to the beneficiary. For power-driven wheelchairs, at the time the supplier furnishes the item, he or she must offer the beneficiary the option of purchasing the item, with payment on a lump-sum basis.33

**Rental:** After the initial ten-month rental, Medicare pays five or more months of rental payments (total of 15) then pays for lifetime use of the equipment with only a maintenance/service assessment every six months thereafter. The equipment remains the property of the supplier. Payment may also be made for repairs, maintenance, and delivery as well as for expendable and non-reusable items essential to the effective use of the equipment. However, routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered.34 More extensive maintenance, as recommended by the manufacturer and performed by authorized technicians, is covered as repairs. These services include breaking down sealed components and performing tests that require specialized testing equipment not available to the beneficiary.35

In making a decision to rent or purchase the equipment, beneficiaries should know that, for purchased equipment, they are responsible for 20% of the service charge each time the equipment is actually serviced and, for unassigned claims, the balance between the Medicare

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31 Ibid.
32 See §1834(a)(7) of the Social Security Act, 42 U.S.C. §1395m(a)(7) (Payment for Other Items of Durable Medical Equipment).
34 See §1834(a)(7) of the Social Security Act, 42 U.S.C. §1395m(a)(7).
35 Ibid.
allowed amount and the supplier's charge. However, for equipment that is rented for 15 months, the beneficiary's responsibility for such service is limited to 20% coinsurance on maintenance and servicing fee payments twice per year, whether or not the equipment is actually serviced.

**Competitive Acquisition of DME (DMEPOS Program)**

It is important to understand the competitive bidding program because over time it will redefine how DME is obtained and how the Medicare pays for it. Advocates will need to prepare locally tailored materials and conduct educational programs to ensure that beneficiaries understand the program and use it to their advantage.

Many items of DME furnished on or after January 1, 2011, are to be based on Medicare's competitive acquisition program. Under this program, the Secretary has established a supplier certification and bidding methodology, identified certain items of DME that are subject to the program, and identified the competitive bidding geographic areas in which the program is being applied on a phased-in basis. This controversial program has been the subject of debate, postponement, and reinstatement, but is now largely in place and on track for full implementation. A major element of the current controversy is whether the program will decrease beneficiary access to suppliers. At this point, our anecdotal experience is that suppliers are applying for certification and complying with the other DMEPOS requirements that are described below. Provider associations and beneficiary advocates remain watchful as the program unfolds.

Advocates should advise clients to check whether their geographic area is a competitive bidding location, assure that beneficiaries use certified suppliers, and assure that, when clients go outside of their geographic areas, they have arranged with their home area DME suppliers for the maintenance and repair of their DME in the area(s) to which they are traveling for vacations or

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36 See 42 U.S.C. §1395m(a)(1)(B)(i)-(ii). Note, however, if supplier participates in the Medicare assignment program, he or she agrees to accept Medicare’s payment amount with the beneficiary being responsible for a 20% co-payment amount; see also §1848(g) of the Social Security Act, 42 U.S.C §1395w-4(g).

37 See §1834(a)(7) of the Social Security Act, 42 U.S.C. §1395m(a)(7)

38 See 1834a(1)(g) of the Social Security Act (Use of Information on Competitive Bid Rates) , 42 U.S.C. §1395m(a)(1)(g) and §1847B of the Social Security Act, 42 U.S.C. §1395w-3b (Competitive Acquisition Program); see also 1871(a)(1) of the Social Security Act, 42 U.S.C. §1395w-3(a)(1); 72 Fed. Reg. 17,992 et seq. (April 10, 2007), 42 C.F.R. §414.400 et seq.

39 Note, Congressman Henry Waxman (D-CA), Chair of the House Committee on Energy and Commerce, has announced a September 2010 hearing on issues and problems associated with DMEPOS implementation and access. For a detailed discussion of the DMEPOS program, see the Center’s series of Weekly Alerts describing the program, the latest of which is at the following link, including identified items of DME subject to the program’s process and the competitive bidding geographic areas:

http://medicareadvocacy.org/InfoByTopic/PartB/PartB_09_07.02.CompetitiveBiddingUpdate.htm. The latest information on competitive bidding geographic areas is at:

http://www.cms.gov/DMEPOSCompetitiveBid/01a_MSAs_and_CBAs.asp#TopOfPage. Round 2 additional categories of DME have not yet been announced. Check at the following link from time to time for the latest information: http://www.cms.gov/DMEPOSCompetitiveBid/01b_Product_Categories_and_Items.asp#TopOfPage. The DMEPOS Competitive Bidding Implementation Contractor (CBIC) is Palmetto GBA:

www.dmecompetitivebid.com. The CBIC website should be checked periodically for updates on implementation. CMS plans to require DMEPOS suppliers to be enrolled in the PECOS program later in 2010. See 75 Fed. Reg. 24440 (May 5, 2010). The PECOS program is discussed in Footnote 7.
otherwise. In addition, CMS has sent notification letters to beneficiaries who may need to change suppliers in order for Medicare to pay for their equipment and supplies. The letter encourages each beneficiary to check with his/her supplier to make sure that the supplier meets the new requirements and provides instructions for the beneficiary to find another supplier, if necessary.  

- **Competitive Bidding Requirements**

Section 154 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided that upon its enactment, contracts awarded in Round 1 of the DMEPOS program would be terminated and no payment would be made on the basis of such contracts. Instead, payment for DMEPOS would be made under previously existing schedules and payment conditions. Suppliers, including those who were awarded competitively-bid contracts previously, must rebid under the Round 1 rebid. In addition, under MIPPA, DME furnished by a hospital to its patients during an admission or on the date of discharge is excluded from competitive bidding. The Round 2 competitive bidding competition is to occur in 2011.

- **Competitive Bidding Areas**

Competitive bidding is to occur in the nine largest Metropolitan Statistical Areas (MSAs): Cincinnati-Middletown (OH, KY and IN); Cleveland-Elyria-Mentor (OH); Charlotte-Gastonia-Concord (NC and SC); Dallas-Fort Worth-Arlington (TX); Kansas City (MO and KS); Miami-Fort Lauderdale-Miami Beach (FL); Orlando (FL); Pittsburgh (PA); Riverside-San Bernardino-Ontario (CA).

**Categories of Items and Services for Rebid**

The Round 1 rebid will include the following categories of items and services: Oxygen Supplies and Equipment; Standard Power Wheelchairs, Scooters, and Related Accessories; Complex Rehabilitative Power Wheelchairs and Related Accessories (Group 2); Mail-Order Diabetic Supplies; Enteral Nutrient, Equipment and Supplies; Continuous Positive Airway Pressure (CPAP); Respiratory Assist Devices (RADs), and Related Supplies and Accessories; Hospital Beds and Related Accessories: Walkers and Related Accessories; Support Surfaces (Group 2 mattresses) and overlays in Miami.

- **Certain Providers Exempted**

The competitive bidding process also allows for the "grandfathering" of certain special physician/practitioners (nurses, physician assistants, clinical nurse specialists, and physical therapists and occupational therapists in private practice) to receive payment for certain competitively-bid items furnished to their own patients as part of their professional services even though they have not submitted a bid and have not been selected as a contract supplier. Beneficiaries who are renting an item of DME, or oxygen and oxygen equipment, that meets the

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40 A copy of the notification letter along with additional information on Medicare’s new accreditation and surety bond requirements for DMEPOS suppliers may be found at [http://www.cms.gov/Partnerships/03_DMEPOS_Toolkit.asp#TopOfPage](http://www.cms.gov/Partnerships/03_DMEPOS_Toolkit.asp#TopOfPage).

definition of a grandfathered item may elect to obtain the item from a grandfathered supplier. The rules also contain special provisions for small suppliers, including forming networks of small suppliers.

- **Program Advisory and Oversight Committee (PAOC)**

CMS has convened a Program Advisory and Oversight Committee (PAOC) to advise CMS as it implements the DMEPOS competitive bidding program.42

- **Repair and Replacement of Beneficiary-Owned Items**

**Repair Only:** A beneficiary who owns a competitively-bid item that needs to be repaired may have the repairs performed by either a contract supplier or a non-contract supplier. Medicare will pay for reasonable and necessary labor that is not otherwise covered under a manufacturer's or supplier's warranty.

**Repair and Replacement:** If a part needs to be replaced to make the beneficiary-owned equipment serviceable and the replacement part is also a competitively bid item for the CBA in which the beneficiary maintains a permanent residence, the part may be obtained from either a contract supplier or a non-contract supplier. In these situations, Medicare pays the single payment amount provided under the Competitive Bidding Program for the part to be replaced.

**Replacement Only:** Beneficiaries who are permanent residents within a CBA are required to obtain replacement of all items subject to competitive bidding from a contract supplier - including replacement of base equipment and replacement of parts or accessories for base equipment that are being replaced for reasons other than servicing of the base equipment. Beneficiaries who are not permanent residents of a CBA, but require a replacement of a competitively bid item while visiting in a different CBA, must obtain the replacement item from a contract supplier. The supplier will be paid the fee schedule amount for the state in which the beneficiary is a permanent resident.

- **Mail Order Diabetic Supplies under the Program**

Medicare beneficiaries who are permanent residents in a Competitive Bidding Area (CBA) may purchase their diabetic testing supplies from a mail order contract supplier for the area in which the beneficiary is a permanent resident or from a non-contract supplier in cases where the supplies are not furnished on a mail order basis. These supplies will be reimbursed at the single payment amount for the CBA where the beneficiary maintains a permanent residence. For diabetic supplies that are not furnished through mail order, suppliers will be paid the fee schedule amount.

- **Competitive Bidding and Advance Beneficiary Notice Information**

In general, if a non-contract supplier in a CBA furnishes a competitively-bid item to any Medicare beneficiary, Medicare will not make payment unless there is an applicable exception, regardless of whether the beneficiary maintains a permanent residence in the CBA or another

area. In these circumstances, the beneficiary is not liable for payment unless the non-contract supplier in a CBA obtains an Advanced Beneficiary Notice (ABN) signed by the beneficiary.

A signed ABN indicates that the beneficiary was informed in writing prior to receiving the item that there would be no Medicare coverage due to the supplier's contract status and that the beneficiary understands that he or she will be liable for all costs that the non-contract supplier may charge for the item. CMS has stated on some of its training phone calls that waiver of liability provisions apply when beneficiaries are not provided an ABN.

- **Medicare Assignment**

Physicians must accept assignment if they provide competitively-bid equipment to Medicare patients who reside in a CBA. Under the Medicare assignment program, participating physicians and suppliers agree to accept the Medicare reasonable charge amount, with the beneficiary being responsible for a 20% co-payment. Physicians and other treating practitioners can determine if a Medicare beneficiary resides permanently in a CBA by comparing the beneficiary's Zip Code to the list of Zip Codes for the CBAs referred to earlier.

**Appeals of Medicare Denials of DME**

Appeals go through the DME MAC. The rules applicable to the Medicare A/B appeals process apply. A review of the Medicare appeals process is helpful. As a starting point, in determining whether to appeal a denial of DME, beneficiaries should review their Medicare Summary Notices (MSNs). The MSN will indicate whether and to what extent the DME MAC has covered an item, service, or procedure, and the amount of payment, including explanatory notes about denials of coverage or reductions in the amount paid. This information will be helpful in formulating one's appeal strategy. In addition, a printable Medicare inquiry/request for reconsideration form can be obtained from the DME MAC's webpage.

In many instances, a Request for Reconsideration accompanied by additional medical documentation (a strong physician's statement is often key), corrected DME coding, or clarifying responses to specific DME MAC information requests will lead to coverage. It is also important to review Medicare's National Coverage Decisions Manual (see Footnote 1, above) to ascertain additional coverage policy guidance. The Center for Medicare Advocacy's *Quick Screen*, included at the end of this Issue Brief, provides practical tips to help focus on coverable DME claims and appeal strategies.

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43 Check to see if your DME MAC has a form for requesting a reopening of an initial denial of DME, for example, see Noridian Administrative Services, [https://www.noridianmedicare.com/dme/forms/docs/nas_reopen_dme.pdf](https://www.noridianmedicare.com/dme/forms/docs/nas_reopen_dme.pdf). Valuable CMS appeals forms include the form for requesting a Redetermination, [http://www.cms.gov/cmsforms/downloads/cms20027.pdf](http://www.cms.gov/cmsforms/downloads/cms20027.pdf); the form for requesting a Reconsideration, [http://www.cms.gov/cmsforms/downloads/cms20033.pdf](http://www.cms.gov/cmsforms/downloads/cms20033.pdf); and the form for requesting an Administrative Law Judge (ALJ) hearing, [http://www.cms.gov/cmsforms/downloads/cms20034ab.pdf](http://www.cms.gov/cmsforms/downloads/cms20034ab.pdf). Also note that the several DME MACs may have their own (customized) forms for requesting various levels of review. For reconsideration review (second level review), CMS is using one Qualified Independent Contractor (QIC) for the nation, RiverTrust Solutions, Inc., P.O. Box 180208, Chattanooga, TN 37411-7208, or 1 Cameron Hill Circle, Ste 0011, Chattanooga, TN 37402-0011. Phone: 423-535-4386. For filing a request for ALJ review, please see the map of regional locations of the Office Medicare Hearings and Appeals (OMHA) and the accompanying address information: [http://www.hhs.gov/omha/contacts/offices.html](http://www.hhs.gov/omha/contacts/offices.html).

44 On assigned claims, the MSN is mailed on a 90-day cycle; for non-assigned claims, they are mailed to beneficiaries as they are processed.
Advance Determination of Medicare Coverage (ADMC)

The ADMC is an optional process\textsuperscript{45} that takes the place of the old "prior approval" process, but is only for certain wheelchairs (manual or power-driven), related options and accessories.\textsuperscript{46} It is used to obtain a coverage decision from a DME MAC, prior to delivery and payment for DME that is subject to the ADMC process. Requests for an ADMC are submitted to the relevant DME MAC, which will have on its web page, or will otherwise make available, a statement of the information that is required for review of an ADMC request. A negative ADMC determination is not subject to an appeal because it does not meet the definition of an initial determination, as no request for payment is being made. ADMC requests may only be resubmitted once during the six-month period following a negative determination. Likewise, if the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories.

Conclusion

The physician remains a critical alley in obtaining medically necessary items of DME. Advocates will need to strengthen such relationships and forge alliances as appropriate. In addition, advocates and beneficiaries face new access challenges as CMS implements the new requirement of a face-to-face physician encounter for all home health care and DME prescribing and as CMS implements the new requirement for physicians to be enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS). Similarly, the continuing roll-out of the DMEPOS program raises access concerns.

On the beneficiary education front, advocates will need to provide a variety of educational materials, seminars, and workshops to ensure that beneficiaries are fully informed of their rights and obligations. Likewise, advocates will need to engage with the DME MACs serving their geographic areas to assure that implementation rules and educational materials are beneficiary-friendly and readily available.

Waste, fraud, and abuse at the hand of DME suppliers will likely remain the driver for changes in DME coverage and payment rules going forward. Advocates and beneficiaries will need to assure that such changes do not have a negative impact on access to DME or on the scope of services available under the DME benefit.


\textsuperscript{46} See CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.16. Relevant Wheelchair HCPCS codes are E1161, E1231-E1234, K0005, K0009, K0835-K0843 K0848-K0855 (only if an alternative drive control interface will be provided at the time of initial issue), K0856-K0864, K0868-K0871 (only if an alternative drive control interface will be provided at the time of initial issue), and K0877-K0891. When the base code is eligible, all options and accessories ordered by the physician for the chair are eligible for an ADMC. A link to DME MACs is provided above.
A QUICK SCREEN TO AID IN IDENTIFYING COVERABLE CASES

A Medicare claim for Durable Medical Equipment (DME) is suitable for coverage, and appeal if it has been denied, if it meets the following criteria:

1. The equipment has been prescribed as medically necessary by a physician. Most items require a Certificate of Medical Necessity (CMN) filled out by a physician; and

2. The DME must be able to withstand repeated use. Medicare expects a piece of equipment to last 5 years and will not usually pay for like or similar equipment within that time frame; and

3. It must be primarily and customarily used for a medical purpose; and

4. It must generally not be useful to a person in the absence of illness or injury; and

5. It must be appropriate for use at home. Under a provision of federal law, a skilled nursing facility is not considered home; and

6. The DME supplier must be a Medicare-certified provider.

PRACTICE TIPS

1. The attending physician is always the key to obtaining Medicare benefits; obtain a statement from the beneficiary's physician stating why the prescribed DME is medically necessary as part of the physician's course of treatment, and explaining its therapeutic value to the beneficiary.

2. The equipment must not only be medically necessary for the beneficiary, it must also generally be used for medical purposes. Thus, an air conditioner, while perhaps medically necessary for an individual patient, is not generally considered to be for medical purposes and is, therefore, not covered. (Water mattresses, now used for non-medical purposes but originally created for patients, can be coverable if medically necessary.)

3. Iron lungs, oxygen tents, hospital beds, and wheelchairs are included in Medicare's definition of DME.

4. Some prosthetic devices, braces, artificial limbs and eyes are covered by Medicare Part B as "medical and other health services," not as DME.
5. A seat lift chair mechanism will be covered by Medicare as DME if:
   a. It is prescribed by a physician; and
   b. It is included in the physician's course of treatment; and
   c. It is likely to effect improvement OR arrest or retard deterioration of the patient's condition; and
   d. The alternative would be chair or bed confinement; and
   e. The seat lift is the type which can be controlled by the patient and effectively assist him in standing up and sitting down without other assistance. (Seat lifts which operate by a spring release mechanism with a sudden, catapult-like motion will not be covered.)

6. Durable medical equipment costs are payable under Medicare Part B and Medicare payment is subject to the Part B deductible and co-insurance requirements. The beneficiary must therefore be enrolled in Part B.