Medicare Updates: Home Health Care and Durable Medical Equipment

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The Center for Medicare Advocacy is a national non-profit law organization that works to advance access to comprehensive Medicare, health equity, and quality health care.

- 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
- Medicare/Medicaid Third Party Liability Projects
With Gratitude to
California Health Advocates
Senior Medicare Patrol
for Sponsoring this Program
Services Offered

• Presentations
• Fraud Alerts, e-Newsletter
• Billing Research
• Fraudulent billing referred for investigation

855-613-7080

This project was supported, in part by grant from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.
SMP
Message:

Protect
Detect
Report
CA-SMP complaints as of in 2022, as of 4/15/2022

- Billing Issues: 15
- Coronavirus Scams: 15
- Deceptive Hospice Enrollments: 5
- DME Brace Scams: 25
- Fraudulent Genetic Tests: 10
- Medicare Advantage Plans and Agents: 10
- Medicare Card Phone Scams: 10
- Medicare Prescription Drug: 20
- Medicare Supplement Scams: 5
- Phone Scams: 5
- Misc.: 5
• **Guard the Medicare Card:** A Medicare beneficiary accepts offers of free goods such as shoes or DME items and is unknowingly placed into home health care.

• **Review Medicare Summary Notices (MSN):** Charges on the Medicare Summary Notice (MSN) statement shows claims for services not rendered.

**Consequences:** Loss of access to legitimate services the beneficiary may already be receiving such as physical therapy.
• Cold calls offering braces covered by Medicare that can help alleviate pain.

• “My MSN shows charges for braces by a company out-of-state. I don’t know the referring physician listed.”
Visit our Website!
cahealthadvocates.org

Click on the Fraud & Abuse tab:
Spanish on the back!

Tagalog on the back!

MEDICARE FRAUD ALERT!

Beware!
You may have been tricked into signing up for a program that is medically unnecessarily for your condition is a benefit, covered by Medicare and it is avoidable Medicare beneficiary with a terminal illness.

Some hospice agencies may approach you outside of their usual practice or may show up at your home unannounced and deliver mail that appears to be from Medicare beneficiaries by offering you free forms or services.

If you or someone you know signed up for free services but now feel issues accessing medical care, please contact the Senior Medicare Patrol immediately at 855-613-7080.

For additional information on healthcare fraud, visit cahealthadvocates.org
SMP Materials

Contact Cassandra Ng at: cng@cahealthadvocates.org

Medicare Fraud Alert
Beware of Scams

Do not respond to offers for free medical equipment or services.

Check your medical statements routinely for services not provided.

Call us for a FREE fraud prevention presentation or for guidance if you suspect you may be the victim of fraud.

Share your Medicare number only with your trusted providers.

Report Medicare Fraud to California Senior Medicare Patrol 855-613-7080

California Senior Medicare Patrol
Empowering Seniors To Prevent Healthcare Fraud

Guard Your Card
Report Medicare Fraud 855-613-7080

California SMP
Senior Medicare Patrol
Empowering Seniors To Prevent Healthcare Fraud

This project was supported in part by grant number 25PRES20190003 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201.
New SMP Envelopes!

13 x 10 inches

Contact Cassandra Ng at: cng@cahealthadvocates.org
Join Us for Webinars!

- May 26: Weapons of Fraud
- June 23: California Advocates for Nursing Home Reform (CANHR)
- August 25: Centers for Medicare and Medicaid Services
- September 22: Understanding the Medicare Hospice benefit
- October 27: What's New with Medicare 2023
- October 28: What's New with Medicare 2023

For registration information, contact Jasmine G. Suo at:
jsuo@cahealthadvocates.org
Guard the Medicare Card:
A Medicare beneficiary accepts offers of free goods such as shoes or DME items and is unknowingly placed into home health care.

Review Medicare Summary Notices (MSN): Charges on the Medicare Summary Notice (MSN) statement shows claims for services not rendered.

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Medicare Home Health Care

- Review: Coverage Criteria & Covered Services
- Advocacy Tips
- Updates
— Review —

Medicare Home Health Coverage Criteria

Under the Care of Physician or Authorized Provider

- Certified Plan of Care every 60 days AND
- Face-to-Face certification

Confined to Home ("Homebound")

- Inability to leave without device or assistance and/or leaving is contraindicated, AND
- Requires a considerable and taxing effort to leave
- (Not stuck in house or bed bound)

In need of reasonable and necessary skilled services

- At Least One Required to Qualify For Coverage:
  - Skilled Nursing
  - Physical Therapy
  - Speech Language Pathology

42 C.F.R. § 409.40 et seq

- To Continue Coverage
  - Occupational Therapy
Confined To Home ("Homebound") Requirement

The patient must either:

• Because of illness or injury, need the aid of a supportive device; the use of special transportation; or the assistance of another person to leave their residence; OR
• Have a condition such that leaving home is medically contraindicated.

Two additional requirements:

• There must exist a normal inability to leave home; AND
• Leaving home must require a considerable and taxing effort.

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1
Homebound Requirement (Continued)

- Can leave home for:
  - Health care
    - Medical appointments, therapy not available at home, adult day care for the purpose of therapeutic, psychosocial, or medical treatment
  - Infrequent absences or absences of short duration
    - Religious services, occasional trip to barber, walk around the block, family reunion, funeral, graduation, etc.

Medicare Benefit Policy Manual, Ch. 7, Sec. 30.1.1
Skilled Care Requirement

- To trigger (start) home health coverage, a beneficiary must require a skilled service:
  - Intermittent skilled Nursing services; or
  - Skilled Physical Therapy (PT) or Speech Language Pathology (SLP/ST) services
- Occupational Therapy (OT) - Sufficient to continue, but not to trigger coverage

42 C.F.R. § 409.40 et seq
Standard for Skilled Services

- Skilled = inherent complexity of the service, can be performed **safely and effectively** only by or under general supervision of qualified professional.

- Must be **medically reasonable and necessary**, based on **individualized assessment** of patient’s clinical condition, to:
  - Treat patient’s illness or injury **OR**
  - Maintain patient’s current condition or prevent or slow further deterioration
  - Restore or maintain function affected by patient’s illness or injury
Skilled Care?

- **Restoration potential is not the deciding factor** for deciding whether Medicare coverage is available
  - “Even if full recovery is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities” 42 C.F.R. § 409.32
- **Improvement is not required** in order for a service to be considered skilled
- **Question:** Can care be safe and effective without skilled personnel?
  - *Jimmo v. Sebelius*, See: CMS.gov; MedicareAdvocacy.org
Medicare Covered
Home Health Services

- Must Need/Receive at Least One Skilled Service:
  - Intermittent Skilled Nursing
  - Physical Therapy
  - Speech Language Pathology
  - Occupational Therapy (To continue, not trigger coverage)

"Dependent" Services Can Be Covered

- IF a Skilled Service is Required and Received, Then Coverage is Available for:
  - Home Health Aides (Part-time or Intermittent personal care)
  - Medical Social Services
  - Medical Supplies

If Receiving Skilled Services
Home Health Aides

How much can be covered – under the law?

- Combined with skilled nursing, can be provided up to 28 hours per week and any number of days per week as long as they are provided less than 8 hours each day
  - Subject to review on case-by-case basis, they may be available up to 35 hours per week
- Separately if the skilled service is therapy

42 U.S.C. § 1395x(m)(7)(b); 42 CFR §409.45(b)
Home Health Aides (Continued)

How much is covered – in practice?

- Too often told:
  - Only 1-3 hours a week and only for a bath
  - Agency does not have staff to provide many (or any) aide hours/visits
  - Agency may suggest finding a “private pay” alternative
- This is not all that’s authorized by law
Home Health Aides (Continued)

What is *Hands-On Personal Care*?

- Bathing, dressing, grooming, caring for hair, nails, oral hygiene to facilitate treatment or prevent deterioration
- Changing bed linen of incontinent patient
- Feeding, assistance with elimination, routine catheter and colostomy care, skin, foot, ear care
- Help with bed mobility, transfers, ambulation
- Medication assistance & simple dressing changes that don’t require skills of licensed nurse
Impact of Caregivers At Home

- Patient is entitled to have the costs of reasonable and necessary services reimbursed by Medicare without regard to whether someone else is available to furnish the services. But, where someone is or will be providing services that adequately meet patient’s needs, it’s not reasonable & necessary for HHA to furnish.

- Presumption that there is no able and willing person at home to provide the services unless patient/family indicate otherwise or HHA has first-hand knowledge to the contrary.

Medicare Benefit Policy Manual, Ch. 7, Sec. 20.2
Medicare Home Health Coverage is Not Limited in Time or Visits

Medicare Home Health coverage continues to be available so long as skilled care is needed and other threshold criteria are met

Medicare Benefit Policy Manual (MBPM), Ch. 7, Sec. 40.1.1

Payment can be made for an unlimited number of covered visits, and there is no limit on continuous recertifications for beneficiaries who continue to be eligible.

42 C.F.R. § 409.48(a)-(b); MBPM, Chapter 7 Secs. 70.1 & 10.3
News & Updates

- Initial home health assessments can be completed by an occupational therapist when the patient does not need a home health nurse (OT and PT or OT and SLP or OT/PT/SLP)

- The home health value-based purchasing model (HHVBP) expansion from 9 states to 50 states will take place as of January 1, 2023.
2021 Home Health Survey: Medicare Beneficiaries Likely Misinformed and Underserved
Survey Overview

- April 28, 2021 – November 19, 2021
- 217 Medicare-certified home health agencies
- 20 states represented
- 10 calls to 1-800-Medicare
- Questions focused on home health services available for a hypothetical patient with an authorized practitioner’s order certifying one hour of physical therapy per week, one hour of skilled nursing per week, and 20 hours of home health aide services per week.
Survey Findings

- Home health aide services, in the amount or type defined in the Medicare benefit, are almost impossible to get.
- Misinformation about Medicare coverage and qualifications is widespread.
- Home health aides are considered “bath aides” throughout the industry.
- An improvement standard continues to be communicated and implemented.
- Medicare Advantage plans cover less, deny more, and are harder to work with.
- Calls to 1-800-Medicare yield inconsistent and inaccurate information.
- The quality measures used to rank home health agencies on the CMS website are unhelpful and misleading.
CONGRESSIONAL HISTORY OF MEDICARE HOME HEALTH (HH) COVERAGE

- Reviewed multiple times in Congress since Medicare enacted in 1965
- Originally limited to 100 days of HH care, after 3-day inpatient hospital stay, with a deductible and co-insurance.
- 1972: Added coverage for certain people with disabilities, repealed Part B co-insurance for HH
- 1980: Removed 100-day limit, prior hospital stay requirement, and the Part B deductible for HH
- 1997: Moved payment for HH after 100 visits to Part B if individual has Parts A & B, but did not reduce total # of coverable visits
- 2000: Clarified Homebound requirement still met if individual attends Adult Day Care or religious services
- 2015/18: Introduced new payment models, but did not scale back eligibility or scope of benefit
CMS JIMMO REMINDER
(DECEMBER 2, 2021)

“Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder

Medicare covers skilled nursing care and skilled therapy services under skilled nursing facility, home health, and outpatient therapy benefits when a beneficiary needs skilled care to maintain function or to prevent or slow decline, as long as:

- The beneficiary requires skilled care for the services to be provided safely and effectively
- An individualized assessment of the patient's condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist are needed for a safe and effective maintenance program

Visit the Jimmo Settlement Agreement webpage for more information.”

Link: Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder
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 of Equipment

- 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” (also known as “assigned”) suppliers
- Medicare enrolled “non-participating” (also known as “non-assigned”) suppliers
- Suppliers not-enrolled in Medicare

Reference: Example – Patient Lifts
https://www.medicare.gov/coverage/patient-lifts
Medicare Covered DME
Types Of Suppliers (continued)

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 enrolled suppliers who do not “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
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
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 §5.16.5*
DME Costs In Medicare Advantage (MA)

- 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
Process To **Obtain** An Item/Supply - 
**Generally**

- Ask prescriber to recommend suppliers they know
- At [https://www.medicare.gov/medical-equipment-suppliers/](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 OTS knee or back braces*, walkers, folding manual wheelchairs, or external infusion pumps:

- **From a health care provider** during an appointment as part of the clinical service, or
- **From a hospital** while hospitalized or on discharge day
- The provider/hospital needs to be an enrolled supplier in Medicare and must provide required documents (Certificate of Medical Need/Order).

*Health care provider or hospital does not have to be a contracted supplier in the competitive bid program.
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 Supplier

✓ 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 Supplier (Continued)

✓ 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
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.
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
No-Cost Help for Beneficiaries

- For Medicare Counseling (in every state): https://www.shiptacenter.org/

- To Report Suspected Medicare Errors or Fraud (in every state): https://www.smpresource.org/
For further information, to receive the Center’s free weekly electronic newsletter, *CMA Alert*, update emails and webinar announcements, contact:

Communications@MedicareAdvocacy.org

Visit

MedicareAdvocacy.org

860-456-7790

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