



CENTERS FOR MEDICARE & MEDICAID SERVICES



Medicare Coverage of Durable Medical Equipment and Other Devices

**This official government
booklet explains the following:**

- ★ What durable medical equipment is
- ★ Which durable medical equipment, prosthetic, and orthotic items are covered in the Original Medicare Plan
- ★ Where to get help with your questions



Do you need durable medical equipment or other types of medical equipment?

Medicare can help.

This booklet explains Medicare coverage for durable medical equipment, prosthetic devices, orthotic items, prostheses and therapeutic shoes in the Original Medicare Plan (sometimes called fee-for-service) and what you might need to pay. Durable medical equipment includes things like the following:

- 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 for you to know what Medicare covers and what you may need to pay. Talk to your doctor if you think you need some type of durable medical equipment.

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

Words in red are defined on pages 11–12.

Note: The information in this booklet was correct when it was printed. Changes may occur after printing. For the most up-to-date information, visit www.medicare.gov on the web, or call 1-800-MEDICARE (1-800-633-4227). A customer service representative can tell you if the information has been updated. TTY users should call 1-877-486-2048.

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“Medicare Coverage of Durable Medical Equipment and Other Devices” isn’t a legal document. Official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

What is durable medical equipment?

Durable medical equipment is reusable medical equipment such as walkers, wheelchairs, or hospital beds.

Does Medicare cover durable medical equipment?

Anyone who has Medicare Part B can get durable medical equipment as long as the equipment is **medically necessary**.

When does the Original Medicare Plan cover durable medical equipment?

If you have Part B, the **Original Medicare Plan** covers durable medical equipment when your doctor or treating practitioner (such as a nurse practitioner, physician assistant, or clinical nurse specialist) prescribes it for you to use in your home. A hospital or nursing home that is 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 are in a skilled nursing facility and the facility provides you with durable medical equipment, the facility is responsible for this equipment.

What if I need durable medical equipment and I am in a Medicare Advantage Plan?

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

Words in **red**
are defined
on pages
11–12.

What if I need durable medical equipment and I am in a Medicare Advantage Plan? (continued)

If you are 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 if your equipment is covered and how much it will cost. If you return to the **Original Medicare Plan**, you should tell your supplier to bill Medicare directly after the date your coverage in the Medicare Advantage Plan ends.

Note: If your plan leaves the Medicare Program and you are using medical equipment such as oxygen or a wheelchair, call the telephone number on your Medicare Advantage Plan card. Ask for Utilization Management. They will tell you how you can get care under the Original Medicare Plan or under a new Medicare Advantage Plan.

If I am in the Original Medicare Plan, how do I get the durable medical equipment I need?

If you need **durable medical equipment** in your home, your doctor or treating practitioner (such as a nurse practitioner, physician assistant, or clinical nurse specialist) must prescribe the type of equipment you need. For some equipment, Medicare also requires your doctor or one of the doctor's office staff to fill out a special form and send it to Medicare to get approval for the equipment. This is called a **Certificate of Medical Necessity**. Your supplier will work with your doctor to see that all required information is submitted to Medicare. If your prescription and/or condition changes, your doctor must complete and submit a new, updated certificate.

The chart on page 6 shows which items require a Certificate of Medical Necessity.

Words in red are defined on pages 11–12.

If I am in the Original Medicare Plan, how do I get the durable medical equipment I need? (continued)

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

To find a supplier that is enrolled in the Medicare Program, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Suppliers of Medical Equipment in Your Area.” You can also call 1-800-MEDICARE (1-800-633-4227) to get this information. TTY users should call 1-877-486-2048.

A supplier enrolled in the Medicare Program 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 durable medical equipment.

Power wheelchairs and 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 is only needed and used outside of the home.

Most suppliers who work with Medicare are honest. There are a few who aren't honest. Medicare is working with other government agencies to protect you and the Medicare Program from dishonest suppliers of power wheelchairs and scooters.

For more information about Medicare's coverage of power wheelchairs or scooters, view the publication “Protecting Medicare's Power Wheelchair and Scooter Benefit.” Visit www.medicare.gov on the web. Under “Search Tool,” select “Find a Medicare Publication.” You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What is covered, and how much does it cost?

The chart below and on page 7 shows 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**. For questions about whether Medicare covers a particular item, 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 below and on page 7.

Durable Medical Equipment	
What Medicare Covers	What You Pay
<ul style="list-style-type: none"> • Air fluidized beds • Blood glucose monitors • Bone growth (or osteogenesis) stimulators* • Canes (except white canes for the blind) • Commode chairs • Crutches • Home oxygen equipment and supplies* • Hospital beds • Infusion pumps and some medicines used in them • Lymphedema pumps/pneumatic compression devices* • Nebulizers and some medicines used in them (if reasonable and necessary) • Patient lifts* • Scooters • Suction pumps • Traction equipment • Transcutaneous electronic nerve stimulators (TENS)* • Ventilators or respiratory assist devices • Walkers • Wheelchairs (manual and power) 	<p>Generally, you pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year (\$135 in 2008). 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 durable medical equipment in different ways. You may be able to rent or buy the equipment.</p>

* You must get a **Certificate of Medical Necessity** before you can get this equipment. See page 4.

What is covered, and how much does it cost? (continued)

Prosthetic and Orthotic Items	
What Medicare Covers	What You Pay
<ul style="list-style-type: none"> • Arm, leg, back, and neck braces • Artificial limbs and eyes • Breast prostheses (including a surgical brassiere) after a mastectomy • Ostomy supplies for people who have had a colostomy, ileostomy, or urinary ostomy. Medicare covers the amount of supplies your doctor says you need based on your condition. • Prosthetic devices needed to replace an internal body part or function • Therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease <p>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 helps pay for one pair of therapeutic shoes and inserts per calendar year. Shoe modifications may be substituted for inserts.</p>	<p>You pay 20% of the Medicare-approved amount after you pay your Medicare Part B deductible for the year (\$135 in 2008). Medicare pays the other 80%. These amounts may be different if the supplier doesn't accept assignment. See page 8.</p>

Corrective Lenses	
What Medicare Covers	What You Pay
<ul style="list-style-type: none"> • Prosthetic Lenses <ul style="list-style-type: none"> —Cataract glasses —Conventional glasses and contact lenses after surgery with an intraocular lens —Intraocular lenses <p>An ophthalmologist or an optometrist must prescribe these items.</p> <p>Important: Only standard frames are covered. Eyeglasses and cataract lenses are covered even if you had the surgery before you had Medicare. Payment may be made for lenses for both eyes even if cataract surgery involved only one eye.</p>	<p>You are 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 (\$135 in 2008). Medicare pays the other 80%. Costs may be different if the supplier doesn't accept assignment. See page 8. If you want to upgrade the frames, you pay any additional cost.</p>

What is “assignment” in the Original Medicare Plan 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 durable medical equipment 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 (\$135 in 2008), 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 **durable medical equipment** and other devices are called “participating suppliers.” If a durable medical equipment supplier doesn’t accept assignment, **there is 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 durable medical equipment. The supplier will send the bill to Medicare for you, but you will have to wait for Medicare to reimburse you later for its share of the charge.

Important Note: Before you get durable medical equipment, ask if the supplier is enrolled in Medicare. If the supplier is not enrolled in Medicare, Medicare **won’t** pay your claim at all. Then, ask if the supplier is a participating supplier in the Medicare Program. A participating supplier **must** accept assignment. A supplier that is enrolled in Medicare, but isn’t “participating,” has the option whether to accept assignment. You will have to ask if the supplier will accept assignment for your claim.

To find suppliers who accept assignment, visit www.medicare.gov on the web. Under “Search Tools,” select “Find Suppliers of Medical Equipment in Your Area.” You can also call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

If your supplier is a Medicare-enrolled supplier, they will know whether Medicare allows you to buy a particular kind of **durable medical equipment**, or just pays for you to rent it. Medicare pays for most durable medical equipment on a rental basis. Medicare only purchases inexpensive or routinely purchased items, such as canes, power wheelchairs, and, in rare cases, items that must be made specifically for you.

Words in **red** are defined on pages 11–12.

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

Buying equipment

If you **own** Medicare-covered **durable medical equipment** 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** durable medical equipment 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 purchased items are limited to the fee Medicare sets to purchase the item. If you will need these items for more than a few months, you may decide to purchase these items rather than rent them. Monthly payments for frequently serviced items, such as ventilators, are made as long as the equipment is **medically necessary**. The payment rules for these types of rented equipment, called "**capped rental items**," are on page 10. Medicare will pay 80% of the Medicare-approved amount each month for use of these items. You pay the other 20% after you pay the Medicare Part B deductible (\$135 in 2008).

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.

Words in red
are defined
on pages
11–12.

Capped rental items and oxygen equipment

For certain kinds of **durable medical equipment**, like wheelchairs or hospital beds, Medicare will pay for the rental of the item for up to 13 months. After 13 months rental, you will own that equipment. Once you own the item, Medicare will make reasonable and necessary maintenance and servicing payments, as needed, on your equipment. If your doctor prescribes a **capped rental item** (like a nebulizer or manual wheelchair) and you decide to buy it without first renting for 13 months, Medicare won't pay for any portion of it. The only exception is power wheelchairs, which you can buy as soon as you start using the equipment. Medicare will pay 80% of the costs.

If you rent oxygen equipment, Medicare will pay for up to 36 months of rental payments. After 36 months, your supplier is required to continue furnishing the equipment as long as it is medically necessary. After 36 months, Medicare will also pay for oxygen contents for any gaseous or liquid oxygen equipment you rent.

Words to know

Assignment—An agreement between a person with Medicare, a doctor or supplier, and Medicare. Doctors or suppliers who accept assignment from Medicare agree to accept the Medicare-approved amount as full payment.

Capped rental item—Durable medical equipment (like oxygen, nebulizers, and manual wheelchairs) that costs more than \$150, and is rented to people with Medicare more than 25% of the time.

Certificate of Medical Necessity—A form required by Medicare that your physician must complete to get Medicare coverage for certain medical equipment.

Coinsurance—An amount you may be required to pay for services after you pay any plan deductibles. In the Original Medicare Plan, this is a percentage (like 20%) of the Medicare-approved amount. You have to pay this amount after you pay the Part A and/or Part B deductible.

Deductible—The amount you must pay for health care or prescriptions, before the Original Medicare Plan or other insurance begins to pay. For example, in the Original Medicare Plan, you pay a new deductible for each benefit period for Part A, and each year for Part B. These amounts can change every year.

Durable Medical Equipment—Medical equipment that is ordered by a doctor (or, if Medicare allows, a nurse practitioner, physician assistant, or clinical nurse specialist) for use in the home. A hospital or nursing home that mostly provides skilled care can't qualify as a "home" in this situation. These medical items must be reusable, such as walkers, wheelchairs, or hospital beds.

Medically Necessary—Services or supplies that are needed for the diagnosis or treatment of your medical condition.

Medicare Advantage Plan (Part C)—A type of Medicare plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Also called Part C, Medicare Advantage Plans are HMOs, PPOs, Private Fee-for-Service Plans, or Medicare Medical Savings Account Plans. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under the Original Medicare Plan.

Words to know

Medicare-Approved Amount—In the Original Medicare Plan, this is the amount a doctor or supplier that accepts assignment can be paid. It includes what Medicare pays and any deductible, coinsurance, or copayment that you pay. It may be less than the amount a doctor or supplier charges for the item.

Medigap Policy—Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare Plan coverage. Except in Massachusetts, Minnesota, and Wisconsin, all Medigap policies must be one of 12 standardized Medigap policies labeled Medigap Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Nebulizers—Equipment that delivers medicine in a mist form to your lungs.

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

Orthotics—Devices that correct or support the function of body parts. Examples include leg, arm, and neck braces.

Patient Lifts—Equipment designed to move a patient from a bed or wheelchair.

Prostheses—Devices that substitute for a missing body part. Examples include artificial legs, arms, and eyes.

Prosthetic Devices—Medical equipment (other than dental) that replaces all or part of an internal body organ.

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services

7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business

Penalty for Private Use, \$300

CMS Publication No. 11045

Revised July 2008



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(1-800-633-4227). Los usuarios de TTY
deben llamar al 1-877-486-2048.