A. Guide to Medicare Coverage

Who qualifies for Medicare benefits?

- Individuals 65 years of age or older
- Individuals under 65 with permanent kidney failure (beginning three months after dialysis begins), or
- Individuals under 65, permanently disabled and entitled to Social Security benefits (beginning 24 months after the start of disability benefits)

The Different Benefits of Traditional Medicare

- Medicare Part A benefits cover hospital stays, home health care and hospice services
- Medicare Part B benefits cover physician visits, laboratory tests, ambulance services and home medical equipment
- While oftentimes you do not have to pay a monthly fee to have Part A benefits, the Part B program requires a monthly premium to stay enrolled. Typically, this amount will be taken from your Social Security check.

What Can You Expect to Pay?

- Every year, in addition to your monthly premium, you will have to pay the annual deductable of covered expenses out of pocket and then 20 percent of all approved charges if the provider agrees to accept Medicare payments.
- Unfortunately, your medical equipment provider cannot automatically waive this 20 percent or your deductible without suffering penalties from Medicare. They must attempt to collect the coinsurance and deductible if they are not covered by another insurance plan; however, certain exceptions can be made if you suffer from qualifying financial hardships.
- If you have a supplemental insurance policy, that plan may pick up this portion of your responsibility after your supplemental plan's deductible has been satisfied.
- If your medical equipment provider does not accept assignment with Medicare you may be asked to pay the full price up front, but they will file a claim on your behalf to Medicare. In turn, Medicare will process the claim and mail you a check to cover a portion of your expenses if the charges are approved.

Other possible costs:

- Medicare will pay only for items that meet your basic needs as prescribed by a physician. Oftentimes you will find that your provider offers a wide selection of products that vary slightly in appearance or features. You may decide that you prefer the products that offer these additional features. Your provider should give you the option to pay a little extra money to get a product that you really want.
- To take advantage of this opportunity, a new form has been approved by the Centers for Medicare and Medicaid Services (CMS) that allows patients to upgrade to a piece of equipment that they like better than other standard options prescribed by their physician.
- The Advance Beneficiary Notice, or ABN, must detail how the products differ, and requires a signature to indicate that you agree to pay the difference in the retail costs between two similar items. Your provider will typically accept assignment on the standard product and apply that cost toward the purchase of the fancier item, thus requiring less money out of your pocket.

Purpose of ABN

- The Advance Beneficiary Notice also will be used to notify you ahead of time that Medicare will probably not pay for a certain item or service in a specific situation, even if Medicare might pay under different circumstances. The form should be detailed enough that you understand why Medicare will not pay for the item you are requesting.
- The purpose of the form is to allow you to make an informed decision about whether or not to receive the item or service knowing that you may have additional out-of-pocket expenses.

Durable Medical Equipment (DME) Defined

- In order for any item to be covered under Medicare, it typically has to meet the test of durability. Medicare will pay for medical equipment when the item:
    - Withstands repeated use (excludes many disposable items such as underpads)
    - Is used for a medical purpose (meaning there is a condition which the item will improve)
    - Is useless in the absence of illness or injury (thus excluding any item preventive in nature such as bathroom safety items used to prevent injuries)
    - Used in the home (which excludes all items that are needed only when leaving the confines of the home setting)

Understanding Assignment (a claim-by-claim contract)

- When a provider accepts assignment, they are agreeing to accept Medicare's approved amount as payment in full.
- You will be responsible for 20 percent of that approved amount. This is called your coinsurance.
- You also will be responsible for the annual deductible.
- If a provider does not accept assignment with Medicare, you will be responsible for paying the full amount upfront. The provider will still file a claim on your behalf and any reimbursement made by Medicare will be paid to you directly. (Providers must still notify you in advance, using the Advance Beneficiary Notice, if they do not believe Medicare will pay for your claim.)

Mandatory Submission of Claims

- Every provider is required to submit a claim for covered services within one year from the date of service

The role of the physician with respect to home medical equipment:

- Every item billed to Medicare requires a physician's order or a special form called a Certificate of Medical Necessity (CMN), and sometimes additional documentation will be required.
- Nurse Practitioners, Physician Assistants, Interns, Residents and Clinical Nurse Specialists can also order medical equipment and sign CMNs when they are treating a patient.
- All physicians' have the right to refuse to complete documentation for equipment they did not order, so make sure you consult with your physician before requesting an item.

Prescriptions Before Delivery:

- For some items, Medicare requires your provider to have completed documentation (which is more than just a call-in order or a prescription from your doctor) before they can deliver these items to you:
    - Decubitus care (wheelchair cushions and pressure-relieving surfaces placed on a hospital bed)
    - Seat lift mechanisms
    - TENS Units (for pain management)
    - Power Operated Vehicles/Scooters
    - Electric Wheelchairs
    - Negative Pressure Wound Therapy

How does Medicare pay for and allow you to use the equipment?

1. Typically there are three ways Medicare will pay for a covered item:
    - They will purchase it outright, then the equipment belongs to you,
    - They will rent it continuously until it is no longer needed, or
    - They will consider it a "capped" rental in which Medicare will rent the item for a total of 13 months and consider the item purchased after having made 13 payments.
        - Medicare will not allow you to purchase these items outright (even if you think you will need it for a long period of time).
        - This is to allow you to spread out your coinsurance instead of paying in one lump sum.

- It also protects the Medicare program from paying too much should your needs change earlier than expected.

2. After an item has been purchased for you (either outright or after 13 payments), you will be responsible for calling your provider anytime that item needs to be serviced or repaired. When necessary, Medicare will pay for a portion of repairs, labor, replacement parts and for temporary loaner equipment to use during the time your product is in for servicing. All of this is contingent on the fact that you still need the item at the time of repair and continue to meet Medicare's coverage criteria for the item being repaired.

B. Medicare Coverage for specific types of home medical equipment

BiPaps/Respiratory Assist Devices

- For a respiratory assist device to be covered, the treating physician must fully document in your medical record symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, dyspnea, etc.
- A respiratory assist device is covered for those patients with clinical disorder groups characterized as (I) restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), (III) central sleep apnea (CSA), or (IV) obstructive sleep apnea (OSA).
- Various tests may need to be performed to establish one of the above diagnosis groups.
- Three months after starting your therapy, both your physician and you will be required to respond in writing to questions regarding your continued use along with how well the machine is treating your condition.

Cervical Traction

- Cervical traction devices are covered only if both of the criteria below are met:
    1. The patient has a musculoskeletal or neurologic impairment requiring traction equipment.
    2. The appropriate use of a home cervical traction device has been demonstrated to the patient and the patient tolerated the selected device.

Commodes

- A commode is only covered when the patient is physically incapable of utilizing regular toilet facilities. For example:
    1. The patient is confined to a single room, or
    2. The patient is confined to one level of the home environment and there is no toilet on that level, or
    3. The patient is confined to the home and there are no toilet facilities in the home.
- Heavy-duty commodes are covered for patients weighing over 300 pounds.

CPAPs

- Continuous Positive Airway Pressure (CPAP) Devices are covered only for patients with obstructive sleep apnea (OSA).
- You must have an overnight sleep study performed in a sleep laboratory to establish a qualifying diagnosis. Home and mobile sleep labs/studies are not accepted for diagnosing this condition.
- Medicare will also pay for replacement masks, cannulas, tubing and other necessary supplies.
- After your first three months of use, you will be required to verify if you are benefiting from using the device and how many hours a day you are using the machine.

Hospital Beds

- A hospital bed is covered if one or more of the following criteria (1-4) are met:
    1. The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, or

2. The patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been considered and ruled out, or
4. The patient requires traction equipment which can only be attached to a hospital bed.

- Specialty beds that allow the height of the bed to vary are covered for patients that require this feature to permit transfers to a chair, wheelchair or standing position.
- A semi-electric bed is covered for a patient that requires frequent changes in body position and/or has an immediate need for a change in body position.
- Heavy-duty/extra-wide beds can be covered for patients that weigh over 350 pounds.
- The total electric bed is not covered because it is considered a convenience feature. If you prefer to have the total electric feature, your provider usually can apply the cost of the semi-electric bed toward the monthly rental price of the total electric model by using an Advance Beneficiary Notice (ABN). You would be responsible to pay the difference in the retail charges between the two items every month.

Mobility Products: Canes, Walkers, Wheelchairs, and Scooters

- Essentially the new Mobility Assistive Equipment regulations will ensure that Medicare funds are used to pay for:
  - Mobility needs for daily activities within the home
  - Least costly alternative/lowest level of equipment to accomplish these tasks.
  - Most medically appropriate equipment (to meet the needs, not the wants)
- Medicare requires that your physician and provider evaluate your needs and expected use of the mobility product you will qualify for.
- They must determine which is the least level of equipment needed to help you be mobile within your home to accomplish daily activities by asking the following questions:
  - Will a cane or crutches allow you to perform these activities in the home?
  - If not, will a walker allow you to accomplish these activities in the home?
  - If not, is there any type of manual wheelchair that will allow you to accomplish these activities in the home?
  - If not, will a scooter allow you to accomplish these activities in the home?
  - If not, will a power chair allow you to accomplish these activities in the home?
- Keep in mind if you have another higher level product in mind that will allow you to do more beyond the confines of the home setting, you can discuss with your provider the option to upgrade to a higher level or more comfortable product by paying an additional out of pocket fee using the Advance Beneficiary Notice (ABN) to select the product you like best.
- A face-to-face examination with your physician is required prior to the initial setup of a power chair or scooter.
- Your home must be evaluated to ensure it will accommodate the use of any mobility product.

Nebulizers

- Nebulizer machines, medications and related accessories are usually covered for patients with obstructive pulmonary disease, but can also be covered to deliver specific medications to patients with HIV, CF, brochiectasis, pneumocystosis, complications of organ transplants, or for persistent thick or tenacious pulmonary secretions.
- Patients can obtain up to a three month's supply of nebulizer medications and accessories at a time.

Non-covered items (partial listing):

- Adult diapers
- Bathroom safety equipment
- Hearing aides
- Syringes/needles
- Van lifts or ramps
- Exercise equipment
- Humidifiers/Air Purifiers
- Raised toilet seats
- Massage devices
- Stair lifts
- Emergency communicators
- Low Vision Aides
- Grab bars

Oxygen

- Covered for patients with significant hypoxemia in the chronic stable state when:
  - patient has a chronic lung condition or disease or hypoxemia that might be expected to improve with oxygen therapy, and
  - patient's blood gas levels or oxygen saturation levels indicate the need for oxygen therapy, and
  - alternative treatments have been tried or deemed clinically ineffective.
- Categories/Groups are based on the test results to measure your oxygen:
  - I 55≤ mmHg, or 88%≤ saturation
    - For these results you must return to your physician 12 months after the initial visit to continue therapy for lifetime or until the need is expected to end. Typically, you will not have to be retested when you return to your physician for the follow-up visit.
  - II 56-59 mmHg, or 89% saturation
    - For these results, you must be retested within 3 months of the first test to continue therapy for lifetime or until the need is expected to end.
  - III ≥60 or ≥90% not medically necessary.

Patient Lifts

- A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined.
- An electric lift mechanism is not covered; because it is considered a convenience feature. If you prefer to have the electric mechanism, your provider can usually apply the cost of the manual lift toward the purchase price of the electric model by using an Advance Beneficiary Notice (ABN). You would be responsible to pay the difference in the retail charges between the two items.