Medicare Minute Teaching Materials — May 2025
Medicare and Durable Medical Equipment

1. What is durable medical equipment?
Durable medical equipment (DME) is equipment that helps you complete your daily activities. It includes a variety of items, such as walkers, wheelchairs, and oxygen tanks. Medicare usually covers DME if the equipment:

- Is durable, meaning it is able to withstand repeated use
- Serves a medical purpose
- Is appropriate for use in the home, although you can also use it outside the home
- And is likely to last for three years or more

To be covered by Part B, DME must be prescribed by your primary care provider (PCP). If you are in a skilled nursing facility (SNF) or are a hospital inpatient, DME is covered by Part A.

Medicare also covers prosthetics (devices that replace all or part of a bodily organ), orthotics (certain supports for body parts), and supplies. This equipment falls under the broad category called durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Whether you have Original Medicare or a Medicare Advantage plan, the types of Medicare-covered equipment are the same.

Examples of DME include:

- Wheelchairs
- Walkers
- Hospital beds
- Power scooters
- Portable oxygen equipment
- Blood glucose monitors

Prosthetics can include prosthetic devices that replace all or part of an internal bodily organ–including catheters for permanent conditions artificial legs, arms, and eyes.

Orthotics include rigid or semi-rigid leg, arm, back, and neck braces.

Medical supplies include diabetes test strips and lancets used with glucose monitors. It also includes some prescription medications and supplies used with covered DME, like medications used with nebulizers.

To find out if Medicare covers the equipment or supplies you need, or to find a DME supplier in your area, call 1-800-MEDICARE or visit www.medicare.gov. You can also learn about Medicare coverage of DME by contacting your State Health Insurance Assistance Program (SHIP). Contact information for your local SHIP is on the last page of this document.

2. What kind of equipment and supplies does Medicare not cover?
There are certain kinds of DME and supplies that Medicare does not cover, including the following:

- Equipment mainly intended to help you outside the home. For example, if you can walk on your own for short distances–enough to get around your house–Medicare does not cover a motorized scooter that you only need outside the home.
- Most items intended only to make things more convenient or comfortable. This includes stairway elevators, grab bars, air conditioners, and bathtub and toilet seats.
- Items that get thrown away after use or that are not used with equipment. For example, Medicare does not cover incontinence pads, catheters (except they can be covered as a prosthetic if the need is permanent), surgical facemasks, or compression leggings. However, if you receive home health care, Medicare pays for some disposable supplies–including those that cannot be covered separately, like gauze–as part of your home health care benefit.
- Modifications to your home, such as ramps or widened doors for improving wheelchair access.
    - Note: Some Medicare Advantage Plans may cover minor home modifications or other items as a supplemental benefit.
- Equipment that is not suitable for use in the home. This includes some types of DME used in hospitals or skilled nursing facilities (SNFs), like paraffin bath units and oscillating beds.

Keep in mind that Medicaid may cover some equipment that Medicare will not cover or may have different standards for coverage.

3. How can I get DME covered by Medicare?
Whether you have Original Medicare or a Medicare Advantage Plan, Medicare covers your DME if you meet the following two conditions:

1. Your primary care provider (PCP) must sign an order, prescription, or certificate. In this document, your PCP must state that:
    a. You need the requested DME to help a medical condition or injury
    b. The equipment is for home use
    c. And, if applicable, a face-to-face visit occurred
        i. Your face-to-face visit, when required, must take place no more than six months before the prescription is written. Your provider should know if Medicare requires a face-to-face visit for the item you need.

2. Once you have your PCP's order or prescription, you must take it to the right supplier to get coverage. Be sure only to use suppliers with approval from Original Medicare or your Medicare Advantage Plan.

Note: There is a different process if you need coverage for a manual or power wheelchair or scooter (see question 7).

4. From which suppliers should I get my DME?
If you want Medicare to help cover your DME costs, it is important to use the right supplier.

Original Medicare DME suppliers
If you have Original Medicare, you should get your DME from a **Medicare-approved supplier** that takes assignment. You can call 1-800-MEDICARE or visit www.medicare.gov/medical-equipment-suppliers for a list of these suppliers in your area.

Be aware that many suppliers are Medicare-approved but do not take assignment (that is, accept Medicare's payment rate). These suppliers may charge you more than Medicare's approved amount for the cost of services. Medicare will still only pay 80% of its approved amount for services, so you will be responsible for any additional costs.

Avoid suppliers who have not signed up to bill Medicare for DME, who are not Medicare-approved. Medicare will not pay for items you receive from these suppliers. This means you are responsible for the entire cost. If you use a DME supplier that has not signed up with Medicare, the supplier should ask you to sign a private contract confirming that you understand you are responsible for the full cost of your care. If you do not sign a private contract, you do now owe the supplier for the cost of your DME.

Medicare Advantage DME suppliers
If you have a Medicare Advantage plan, you must follow the plan's rules for getting DME. Your plan may require that you:

- Receive approval from the plan before getting your DME.
- Use a supplier in the plan's network of suppliers.
    - You may get little or no coverage if you use an out-of-network supplier.
- Use a preferred brand.
    - You may pay a higher cost when using a non-preferred brand.

Contact your plan to learn more about its DME coverage rules before ordering your DME.

5. What are the costs associated with DME?

Renting/Buying: Depending on the type of durable medical equipment (DME) you need, Medicare may require that you either rent or buy it.

- Most equipment is initially rented, including many manual and power wheelchairs.
    - Original Medicare covers 80% of the cost of a monthly rental fee for 13 months. You pay a 20% coinsurance.
    - After 13 months, ownership is typically given to you automatically.
- In certain situations, you may have to buy your DME. For example, Medicare may require that you purchase an item that is made to fit you.
    - Original Medicare covers 80% of the Medicare-approved amount of the cost of the equipment. You pay a 20% coinsurance.
- Medicare allows you a choice as to rent or buy certain items, such as some power wheelchairs, items costing less than $150, and parenteral/enteral infusion pumps.
- Note: There are different rules for oxygen equipment (see question 8).

Repairs/Maintenance: Your DME may at some point require repairs and/or maintenance from your supplier.

- Repairs by a supplier involve fixing equipment that is worn or damaged.
- Maintenance means checking, cleaning, and servicing your equipment.

If possible, you are expected to do regular maintenance yourself using the owner's manual. However, a supplier should perform maintenance if the task is more complicated and requires a professional. Medicare's coverage of more specialized DME repairs and maintenance depends on whether you or the supplier owns the equipment.

- **Renting DME:** As long as you are paying a monthly rental fee for your equipment, your supplier must perform all needed repairs and maintenance when a professional is required. The supplier cannot charge you for this work.
- **Owning DME:** If you purchased your equipment or otherwise own it, Medicare covers needed repairs and maintenance when a professional is required and the services are not covered by a warranty.
    - Original Medicare covers 80% of the Medicare-approved amount when you use a DME supplier that takes assignment. You pay a 20% coinsurance.
- Note: There are separate rules for repairs and maintenance for oxygen equipment (see question 8).

Upgrades/Special Features: Medicare generally only covers the most basic level of durable medical equipment (DME) to meet your medical needs. If you want additional features or upgrades, you may have to pay for them out of pocket. For example, Medicare will cover a power wheelchair that you need for home use, but if you request a special backrest or tilt function that is not medically necessary, you may need to pay for those features yourself.

That said, Medicare may pay for special features or upgrades when your doctor includes them in your DME order or prescription. In this case, your doctor should explain why your health condition justifies the additional feature. For example, if your doctor states that you do not have the strength or balance to lift a standard walker without wheels, Medicare should pay for a model with wheels.

If your supplier thinks that Medicare may not pay for additional features or upgrades, the supplier should have you sign a waiver form called an Advance Beneficiary Notice (ABN) before you get the items. On the ABN, you must check the box stating that you want the upgrades and agree to pay their full cost if Medicare denies coverage for them. Even if Medicare refuses the upgrade, it should still pay the amount it would have paid for the basic model of the equipment. You will then receive a bill for remaining costs. If Medicare refuses to cover upgrades, and the supplier failed to provide you with an ABN, you do not owe the supplier for the added features.

6. What if I need to replace my DME?

Medicare will pay to replace equipment that you rent or own at any time if it is lost, stolen, or damaged beyond repair in an accident or a natural disaster, so long as you have proof of the damage or theft.

Replacing equipment means substituting one item for an identical or nearly identical item. For example, Medicare will pay for you to switch from one manual wheelchair to another, but it will not pay for you to replace a manual wheelchair with an electric wheelchair or a motorized scooter.

If your equipment is worn out, Medicare will only replace it if you have had the item in your possession for its whole lifetime. An item's lifetime depends on the type of equipment but, in the context of getting a replacement, it is **never less than five years** from the date that you began using the equipment. This five-year timeframe differs from the three-year minimum lifetime requirement that most medical equipment and items must meet in order to be considered DME by Medicare. The item must also be so worn from day-to-day use that it can no longer be fixed. Medicare covers repairs for worn DME if the equipment has not reached the end of its lifetime (see question 5). Medicare will pay for repairs up to the cost of replacement.

To be eligible for a DME replacement, your primary care provider must write you a new order or prescription that explains your medical need. It is most cost-effective to use a Medicare-approved supplier who takes assignment (see question 4).

7. What are the special rules for Medicare coverage of manual and power wheelchairs and scooters?
Keep in mind that you can only receive Medicare coverage for one piece of equipment that addresses at-home mobility issues. Your PCP will determine whether or not you need a manual wheelchair, a power wheelchair or scooter, or a different device based on your condition. Once you have your PCP's order or prescription, you must take it to the right supplier to get coverage (see number 4).

Manual wheelchairs
If you think you need a manual wheelchair, first speak to your doctor or primary care provider (PCP). If your PCP determines that it is medically necessary that you use a manual wheelchair, they should sign an order, prescription, or certificate after a face-to-face office visit. The order should say the following:

- Your health makes it very hard to move around in your home, even with the help of a walker or cane
- It is difficult for you to perform activities of daily living (such as bathing and dressing) in your home
- You can safely use the wheelchair yourself, or always have someone to help you use it
- The wheelchair will help with a specific medical condition and be used in the home
- And, you have a face-to-face meeting with the doctor
    - This meeting should take place no more than six months before the prescription is written.

Power wheelchairs and scooters
If you think you need a power wheelchair or scooter, first speak to your doctor or PCP. If your PCP determines that it is medically necessary that you use a power wheelchair or scooter, they should sign an order, prescription, or certificate after a face-to-face office visit. The order should say the following:

- Your health makes it very hard to move around in your home, even with the help of a walker or cane
- It is difficult for you to perform activities of daily living (such as bathing and dressing) in your home
- You cannot use a manual wheelchair but can safely use a power wheelchair or scooter
- The wheelchair or scooter will help with a specific medical condition and be used in the home
- And, you have a face-to-face meeting with the doctor
    - This meeting should take place no more than 45 days before the prescription is written.

If you have Original Medicare and need a power wheelchair or scooter, your provider or supplier should first contact Medicare and find out if you need to request prior authorization. Prior authorization means that Medicare must be asked for permission before you can get a certain service or item. This requirement only applies to certain power wheelchairs and scooters.

Note: If you need a power wheelchair or scooter that is not subject to prior authorization requirements, you may instead need a signed order from your PCP for Original Medicare to cover the device.
Your provider or supplier must send the prior authorization request to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC). The DME MAC will respond within 10 business days (sooner if your health would be harmed by going without equipment), either approving or denying your request.

If the DME MAC approves prior authorization for your equipment, your supplier will provide the equipment, and you will owe your normal Medicare cost-sharing amounts (deductibles and coinsurances). If the DME MAC denies prior authorization for your equipment, your provider or supplier can request such authorization one more time, giving more reasons for why you need the power wheelchair or scooter. If you are denied again, it is unlikely that Medicare will pay for your DME.

If you choose to get the DME after a denial of prior authorization, your provider should have you sign an Advance Beneficiary Notice (ABN). This notice states that you understand that Medicare will not cover the requested DME and that you will be responsible for the full cost. Make sure you select the option to ask the supplier to still submit a bill to Medicare. If Medicare denies payment, you have the right to appeal.

8. What are the special rules for Medicare coverage of oxygen equipment rental, repairs, and maintenance?
Medicare's coverage rules for oxygen equipment rental, repairs, and maintenance are different from its rules for other forms of durable medical equipment (DME). Keep in mind that you should still use the right kind of supplier to limit your costs (see question 4).

Rental: Unlike other types of DME, oxygen equipment is always rented in a five-year cycle, and you never have the option to buy it.

- Medicare will pay the supplier a monthly rental fee for the first 36 months. The fee includes all equipment, oxygen, supplies, and maintenance. You must pay 20% of each month's rental fee.
- After the 36-month rental period, you pay no more rental fees, although the supplier still owns the equipment. You keep the equipment for up to 24 additional months. If you use oxygen tanks or cylinders, you must continue to pay a 20% coinsurance for oxygen each month. You will also pay a coinsurance for any needed maintenance during these additional 24 months.
- At the end of five years, you will have the choice to either get new oxygen equipment from your supplier or to switch suppliers.

If you need oxygen equipment for less than five years, the supplier will take it back after you no longer need it.

Repairs and maintenance: Throughout your five-year rental period, the supplier must keep your oxygen equipment in good working condition. During the first 36 months of the rental period, the supplier must provide you with supplies and maintenance free of charge. During the last 24 months, providers are allowed to bill you for in-home maintenance visits every six months, and you must pay a 20% coinsurance.

9. How does Medicare cover insulin pumps?
If you use a non-disposable insulin pump, it can be covered by Part B under Medicare's DME benefit. And if you use a pump that's covered as DME, then the insulin you use with that pump will also be covered by Part B.

Remember that Part B covers 80% of the Medicare-approved amount for DME, and you owe the other 20%. Part B-covered insulin copays are limited to $35 per month, with no deductible.

Medical supplies that you use to inject insulin, though, are covered by Part D with a prescription, as long as they are on your plan's formulary. This includes syringes, fillable pens, gauzes, and alcohol swabs. This equipment is not subject to the $35 per month cap and a deductible may apply. The $35 cap applies to the insulin you put into these supplies.

One point of confusion is around how Medicare covers patch pumps, like the Omnipod. These patch pumps may also be called tubeless insulin pumps. They are small, wearable devices that deliver insulin directly into your skin, without pump tubing or injections. These pumps are disposable, though, meaning they are not considered durable medical equipment and are instead covered by Part D, the Medicare prescription drug benefit. If you need coverage for a patch pump like the Omnipod, it is recommended that you first find the best Part D plan for the medications you take. Because these patches are considered medical devices, you won't be able to look at a plan's formulary or on Medicare.gov for a plan's coverage of the patch. Once you have chosen a potential Part D plan, you should then contact the plan directly to ask if and how they cover the patch pump.

10. What is DME fraud, errors, and abuse?
Scammers often call and offer medical equipment or supplies that people don't want or need. They may even pretend to be a health care provider. They will charge your Medicare without showing medical need and sometimes without sending the equipment to you. It's important to protect your Medicare information and read your Medicare statements to check for suspicious charges.

Some red flags:

- You see charges for DME on your Medicare statements you didn't need or never asked for.
- You were offered "free" equipment or supplies.
    - For example, you might receive a phone call from a telemarketer who asks if you are experiencing any pain. If you say yes, the caller may ask for your personal information, like your Medicare number, so that they can send you a knee or back brace to help with the pain. This is likely a fraudulent call, and you should not provide the caller with any personal information. If you receive a call like this, contact your Senior Medicare Patrol (SMP) for assistance reporting it.
- You had a DME provider ask for your Medicare number at a presentation, during a sales pitch, or on a phone call.
- You were given a cheaper, lower quality item but Medicare was billed for a custom or fitted item.
- You see that a DME provider continued to bill Medicare for equipment that you already returned.

11. How can I protect myself from suspected DME fraud, abuse, or errors?
Medicare will not cover DME unless your doctor has certified that you need it. There must be documentation in your medical record supporting your medical need for the equipment or supplies. If you do need DME, ask your doctor about whether you meet coverage requirements to get it. If you do, get your DME from a provider that accepts Medicare assignment or, if you have a Medicare Advantage plan, from an in-network provider.

Be aware of aggressive marketing that tries to offer you "free" equipment or talk you into changing DME providers. Before making a decision, speak with your doctor and your current provider to see if there is a need for you to change.

Do not respond to ads that offer "free" equipment to Medicare beneficiaries, be skeptical of offers that seem too good to be true, and do not give any personal information to someone who calls offering DME that you do not need or want.

Protect your Medicare number. Only give your Medicare number to your doctors and other trusted providers. Be careful when others ask for your Medicare number or offer "free services" as long as you provide your Medicare number.

Check your Medicare Summary Notices (MSNs) if you have Original Medicare, or your Explanations of Benefits (EOBs) if you have a Medicare Advantage Plan, and billing statements regularly. Carefully look for any suspicious or unknown charges. Also, remember that providers are not permitted to routinely waive cost-sharing or offer gifts or financial incentives for you to receive services from them. If you see any suspicious charges or have any reason to believe your provider is inappropriately billing Medicare for DME, call your provider to see if they have made a billing error.

If you suspect a health care provider of DME fraud, contact your Senior Medicare Patrol (SMP). Contact information for your SMP is on the last page of this document.

12. What are the marketing rules that DME suppliers have to follow?
Medicare-approved DME suppliers must follow requirements set by the Centers for Medicare & Medicaid Services (CMS) related to how they can market their products. Some of these requirements include, but are not limited to:

- Suppliers cannot use Medicare's name or logos in a way that suggests that the items or services they provide are approved, endorsed, or authorized by Medicare.
    - Suppliers may be able to use Medicare's name or logo if they get express written permission from Medicare.
- Suppliers cannot call you directly without you asking them to. There are three exceptions in which a DME supplier can call you directly:
    1. If you have given them written permission to contact you by telephone about furnishing a DMEPOS item.
    2. If the DME supplier has already provided you with a Medicare-covered piece of DME and they are calling you only regarding providing that piece of DME.
    3. If the DME supplier has sold you a piece of Medicare-covered DME in the past 15 months, they may contact you about other items they are able to provide you if you need them.
- If a DME supplier's contact does not fit the above exceptions, neither you nor Medicare is obligated to pay for the items.

If you see marketing by a DME supplier that does not follow Medicare's rules, you should collect proof of the interaction, if possible.

- DME suppliers must have procedures in place to handle complaints from beneficiaries like you. If you file a complaint with your DME supplier, they must let you know within five days that they got your

complaint and are investigating it. Within 14 days, your supplier must send you the result of your complaints and their response in writing.
- You can also call your SMP for assistance reporting marketing concerns, if appropriate. Contact information for your SMP is on the last page of this document.

13. Who should I contact with questions?

Your doctor or other health care provider: If you believe you need a piece of DME, first speak with your doctor.

1-800-MEDICARE: Call if you have questions about Medicare's coverage of DME or would like a list of Medicare-approved suppliers who take assignment.

Your Medicare Advantage plan: If you have a Medicare Advantage plan, you should call the plan directly to learn about any additional DME coverage rules and which suppliers are in-network.

State Health Insurance Assistance Program (SHIP): Contact your SHIP if you have questions about how Medicare covers DME or if you need help finding a supplier or appealing a denial of coverage. Your SHIP can provide you with advice and counseling about Medicare's coverage rules. Contact information for your local SHIP is on the last page of this document.

Senior Medicare Patrol (SMP): If you believe you have experienced Medicare fraud, contact your SMP to report. SMPs can help you prevent, identify, and report Medicare fraud. Contact information for your local SMP is on the last page of this document.

SHIP case study
Dorian has Original Medicare. Recently, he has developed mobility issues and is having trouble getting around his home. He believes that he needs a power wheelchair but doesn't know how to get it covered by Medicare or what he will have to pay.

What should Dorian do?
- Dorian should call 1-800-MEDICARE or his State Health Insurance Assistance Program (SHIP).
    - If Dorian doesn't know how to contact his SHIP, he can call 877-839-2675 or www.shiphelp.org.
- The Medicare or SHIP counselor will tell Dorian that he should visit his primary care physician (PCP) to talk about his mobility issues and his options for addressing them.
    - If Dorian and his provider decide that a power wheelchair is the best mobility device for him, they can begin the process of getting him one.
        - The PCP should contact Medicare and find out if prior authorization is needed for the specific power wheelchair that Dorian needs.
        - If Dorian is not required to get prior authorization, his provider should write a prescription or order for the power wheelchair that details Dorian's need for a power wheelchair.

- The counselor can explain to Dorian that once he has prior authorization and/or a prescription for the power wheelchair, he will need to visit a Medicare-approved supplier who takes assignment. The counselors can assist Dorian in obtaining a list of these suppliers in his area.
- The Medicare or SHIP counselor can also explain to Dorian how the process of renting and/or buying the power wheelchair will work and will remind Dorian that he should visit the correct kind of supplier when he needs maintenance and repairs on his wheelchair.

SMP case study

Barbara has had mild back pain for some time and has spoken to her doctor about it. One day she received a box of back braces at her home that she was not expecting, but that she assumed were from her doctor. The next month, she reads her Medicare statement and sees that a company she's never heard of has billed her and her Medicare for the back braces as well as knee braces that she didn't even receive. She knows she's talked to her doctor about her back pain before, but she's now feeling unsure that her doctor would order these braces for her without talking to her about it.

What should Barbara do?

- Barbara should contact her SMP for information and assistance.
    - If Barbara doesn't know how to reach her SMP, she can call 877-808-2468 or visit www.smpresource.org.
- The SMP can let Barbara know that there are ways to report complaints about suppliers who receive Medicare payment. The SMP can assist Barbara and report her compliant to the proper authorities.
- The SMP will let Barbara know that if she wants to get a back brace or any other medically necessary equipment, she can go to her doctor to discuss this.
- The SMP can remind Barbara about the importance of keeping her Medicare number safe and continuing to check her Medicare statements so that she can identify and report any suspicious charges.

Local SHIP Contact Information	Local SMP Contact Information
SHIP toll-free: **SHIP email:** **SHIP website:** **To find a SHIP in another state:** Call 877-839-2675 and say "Medicare" when prompted or visit www.shiphelp.org.	**SMP toll-free:** **SMP email:** **SMP website:** **To find an SMP in another state:** Call 877-808-2468 or visit www.smpresource.org.

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SHIP Technical Assistance Center: 877-839-2675 | www.shiphelp.org | info@shiptacenter.org
SMP Resource Center: 877-808-2468 | www.smpresource.org | info@smpresource.org