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SENIOR BULLETIN: MEDICARE

Obtaining durable medical equipment through Medicare

A person eligible for Medicare may be able to obtain coverage for an item of durable medical equipment (DME), such as a wheelchair or hospital bed. Here are some points to keep in mind.

1. The person must be enrolled in Medicare Part B in order to obtain DME for home use. Part B pertains to physician services, outpatient services and therapy, ambulance services, as well as DME and other items and services. It is financed by monthly premiums paid by enrolled individuals and may be automatically deducted from an enrollee's Social Security check. Part B has an annual deductible requirement and is reimbursed at 80% of the "reasonable charge" for an item or service, with the enrollee being responsible for the other 20%.

2. Medicare claims for DME are suitable for coverage if they are:

- prescribed as medically necessary by the attending physician;
- able to withstand repeated use;
- primarily and customarily used for a medical purpose;
- generally not useful in the absence of illness or injury;
- appropriate for use in the home;
- obtained through a Medicare-certified provider.

3. The key to establishing medical necessity for the requested item of DME is the attending physician. The physician should provide a statement with the request prescribing the DME item as medically necessary and part of the course of treatment for the enrollee's condition, and explaining its therapeutic value. The DME item must be not only medically necessary for the patient, it must also generally be used for a medical purpose. Thus, an air conditioner might not be approved because it is not generally considered to be for a medical purpose, even though it may provide some medical benefit in an individual case.

4. Some prosthetic devices, braces, artificial limbs and eyes are covered by Medicare Part B as "medical and other health services," not as DME.

5. The denial of a DME request to Medicare may be appealed. The different appeal steps are:

- Review by the insurance carrier. Appeal deadline: 6 months after the initial decision denying the request.

- Insurance carrier hearing. Appeal deadline: 6 months after review decision. Monetary threshold: $100 or more.

- Administrative law judge hearing. Appeal deadline: 60 days after the carrier hearing decision. Monetary threshold: $500 or more.

- Review by Departmental Appeal Board. Appeal deadline: 60 days after the ALJ decision. Monetary threshold: $500 or more.

- Review by federal district court. Appeal deadline: 60 days after the DAB decision. Monetary threshold: $1,000 or more.

6. "Dually eligible": eligible for both Medicare and Medicaid. Medicare must be billed first, and problems arise when the Medicaid reimbursement amount for the requested DME is higher than the amount set by Medicare as the "reasonable charge" for that item. *Example*: Let's say Medicare sets the reasonable charge for a wheelchair at $500, even though it retails for $800. Meanwhile, the state sets the Medicaid reimbursement rate for that wheelchair at $650. If the person requesting the wheelchair were eligible for Medicaid only, the state would pay the vendor $650 as full payment and the Medicaid recipient would receive the wheelchair without any out-of-pocket expense. However, if the person is also enrolled in Medicare Part B, Medicare pays its 80% share of $400 and the state pays only the remaining 20% of Medicare's reasonable charge, which is $100. This leaves the enrollee $150 below the Medicaid rate and $300 below the retail cost of the wheelchair.

Advocates for dually eligible persons are working to address this problem, so that dually eligible persons are not worse off than Medicaid recipients who aren't Medicare eligible. Anyone experiencing difficulties obtaining DME because they are dually eligible should contact Northwest Justice Project's CLEAR (Coordinated Legal Education, Advice & Referral) unit if under age 60 (1-888-201-1014) or CLEAR*Sr if age 60 or older (1-800-387-7111).