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 (you only have to pay money when you use the services), the Part B program requires a monthly premium to stay enrolled (even if you do not use the services). In 2016 that premium will be between $121.80-389.80 per month (but could be less) depending on your income. Typically, this amount will be taken from your Social Security check.
- Medicare Part C is coverage offered through various insurance companies that offer Medicare Advantage Plans. These plans are offered as an alternative to Medicare Part B. Medicare Advantage Plans cover the same benefits as your Part B plan but often have limited provider networks and may require authorization for services prior to making payment. Premiums and deductibles vary by plan. Some plans offer perks like gym memberships as a participation benefit.
- Medicare Part D offers optional program benefits that cover prescription drugs.
- For more information about your benefits or making coverage decisions, you can visit the official website for Medicare benefits at www.medicare.gov.

What Can You Expect to Pay for Medicare Part B Services?

- In 2016, in addition to your monthly premium, you will have to pay the first $166 of covered expenses out-of-pocket for Part B services, and then 20 percent of all approved charges if the supplier agrees to accept Medicare payments.
- Unfortunately, your medical equipment supplier cannot automatically waive this 20 percent or your deductible without suffering penalties from Medicare. They must attempt to collect the coinsurance and deductible if those charges are not covered by another insurance plan; however, certain exceptions can be made if you meet qualifying financial hardships established by your supplier.

- 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 supplier 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. Oftentimes you will find that your supplier 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 supplier should give you the option to allow you to privately pay a little extra money to get the 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 you to upgrade to a piece of equipment that you like better than the other standard option you may otherwise qualify for. This form is known as the Advance Beneficiary Notice or ABN.
- The ABN form that your supplier completes for you 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 supplier 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 of Non Coverage will also 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 probably 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 (which excludes many disposable items such as underpads)
    - Is used for a medical purpose (meaning there is an underlying condition which the item should improve)

- Is useless in the absence of illness or injury (which excludes any item that is 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 supplier 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, which is $166.00 for 2016.
- If you have chosen to receive an upgraded, fancier product than what Medicare typically covers, you will also be responsible for any additional amounts disclosed on the Advance Beneficiary Notice that identifies the additional features and fees that you have approved.
- If a supplier does not accept assignment with Medicare, you will be responsible for paying the full amount upfront. The supplier will still file a claim on your behalf and any reimbursement made by Medicare will be paid to you directly. (Suppliers must still notify you in advance, using the Advance Beneficiary Notice, when they do not believe Medicare will pay for your claim.)

Mandatory Submission of Claims

- Every supplier is required to submit a claim for covered services within one year from the date of service. However if the item is never covered by Medicare, your supplier is not obligated to submit a claim.

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 such as copies of office visit notes from prior visits with your physician or healthcare provider or copies of test results relevant to the prescription of your medical equipment.
- Nurse Practitioners, Physician Assistants, Interns, Residents and Clinical Nurse Specialists can also order medical equipment and sign CMNs when they are treating you.
- All physicians and healthcare providers have the right to refuse to complete documentation for equipment they did not order, so make sure you consult with your physician or healthcare provider about your need for medical equipment or supplies before requesting an item from a supplier.

- For every new item prescribed by your physician or healthcare provider, you should have a recent office visit that documents the reasons for ordering the equipment and products. Most items require you to have an in-person office visit with your doctor or healthcare provider to discuss the need and justification for the prescription of medical equipment (and even replacement equipment) before a supplier can fill those orders.

Prescriptions before Delivery:

- For some items, Medicare requires your supplier to have completed documentation (which is more than just a call-in order or a prescription from your doctor or healthcare provider) before they can deliver these items to you:
    - Decubitus care (wheelchair cushions, pressure-relieving surfaces placed on a hospital bed and air-fluidized beds)
    - Seat lift mechanisms
    - TENS Units (for pain management)
    - Power Operated Vehicles/Scooters
    - Electric or Power Wheelchairs and related options and accessories
    - Negative Pressure Wound Therapy (wound vacs)
- The list of items that require an office visit and written order before delivery has been expanded due to new provisions of the Affordable Care Act to include all items that cost more than $1000, and commonly prescribed items such as oxygen, hospital beds, wheelchairs and more. There are over 150 products across multiple product categories that are affected. Your supplier will be able to tell you if the item ordered by your doctor or healthcare provider is subject to these additional requirements.
- Your supplier cannot deliver these products to you without a compliant written order from your doctor or healthcare provider. They cannot provide services and get the documentation at a later date because if they do, Medicare can never make payment for those products to you or your supplier when a compliant order is not secured before delivery. So please be patient with your supplier while they collect the required documentation from your physician or healthcare provider.

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

- Typically there are four ways Medicare will pay for a covered item:
    - Purchase it outright, then the equipment belongs to you,
    - Rent it continuously until it is no longer needed, or
    - 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.
    - If you have oxygen therapy, Medicare will make rental payments for a total of 36 months during which time this fee covers all service and accessories.
        - Beyond the 36 months (for a period of two additional years), Medicare will limit payments to a small fee for monthly gas or liquid contents, where applicable, and a limited service fee to check the equipment every six months.
- After an item has been purchased for you, you will be responsible for calling your supplier 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.

What is competitive bidding?

In many parts of the country, a new program called Competitive Bidding will require you to obtain certain medical equipment from specific, Medicare-contracted suppliers in order for Medicare to pay. Not all products are subject to competitive bidding in the same area. If you are located in a city where the program is in effect, you will need to obtain some or all of the following items from a contracted supplier:

- Oxygen, oxygen equipment, and supplies
- Standard power wheelchairs, scooters, and related accessories
- Enteral nutrition, equipment, and supplies
- Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs), and related supplies and accessories
- Hospital beds and related accessories
- Walkers and related accessories
- Support surfaces (Group 1 and Group 2 mattresses and overlays)
- Manual Wheelchairs and accessories
- Mail-order and local home delivery of diabetic supplies
- Nebulizers

- Home infusion therapy including insulin pumps and supplies
- TENS Units and supplies
- Patient Lifts
- Commodes
- Seat Lift Chairs
- Negative Pressure Wound Therapy Devices and related supplies and accessories

Competitive Bidding areas are designated based on the zip code of your permanent residence on file with Social Security. To find out if your zip code is affected by Competitive Bidding, call 1-800-MEDICARE (1-800-4227). You may also visit Medicare.gov and lookup suppliers in your area by zip code (a notice will appear if your area is subject to Competitive Bidding). If medical equipment is marked with a yellow/orange star, it will need to be provided by a contracted supplier (also marked with an orange star). Throughout this guide, products that are potentially impacted by the competitive bidding program will be designated with a double asterisk **. Your provider can assist you with answering your questions about competitive bidding and can address whether or not they have been contracted to provide the services you need if subject to competitive bid.