Making Sense of Medical Equipment

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Disposable vs. Durable

- Disposable, meaning you use it once (or very minimally) and throw it away
- Is appropriate for use in all healthcare settings
- Can be kept and used in sterile fields without additional prep
- Reduces the risk of cross contamination between uses
- Fills up the ocean, landfills, and garbage bins

- 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
- Is likely to last for three years or more
- Can be adaptable for patient
- Reduces waste
- Requires cleaning and disinfection

What for When?

DISPOSABLE

- Sterile procedures
- Short-term use
- Short-term stay
- Infection control safe practices

DURABLE

- Made for wear and tear
- Long-term treatment
- Can be a training tool and/or assistive device
- Often portable (though sometimes clunky)

How Do You Get It? & Who Pays For it? **MED A**

Medicare part A does **NOT** cover DME. SNFs are responsible for providing any DME required while under Med A.

It's worth the time and investment to **take inventory** of your wheelchairs, walkers, nebulizer machines, Hoyer lift pads, shower chairs, etc. and **factor in maintenance and upkeep into your annual budget**. These are heavily used items and in terms of day-to-day wear, **safety is irreplaceable.**

How Do You Get It? & Who Pays For it?

MEDICARE ADVANTAGE PLANS

Medicare Advantage Plans **must cover the same medically necessary categories of DME items as Original Medicare (Part A and Part B).** However, suppliers and your specific costs will depend on which Medicare Advantage Plan you belong to.

Contact the plan the resident belongs to see if Cath it will cover the DME. If it *won't cover* a DME item or service, appeal the plan's denial of coverage and get an independent review of your request for coverage. Find a description of the Medicare Advantage Plan cost-sharing for all Medicare covered services, including supplemental benefits offered by the Medicare Advantage Plan, in its "Evidence of Coverage" document, or simply give them a call.

Medicare Advantage Plans DME Coverage Items

United Health–

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medadv-coverage-sum/dme-prosthetics-appliances-nutritional-supplies-grid.pdf

Aetna

https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/florida/provider/pdf/ABHFL_LTC_DME-Durable_Medical_Supply_Services_Fee_Schedule_03.2021.pdf

Humana—

https://docushare-web.apps.external.pioneer.humana.com/Marketing/docushare-app?file=4281927

How Do You Get It? & Who Pays For it? **MED B**

Anyone who has Medicare Part B (Medical Insurance) can get DME as long as the equipment is ***medically necessary.***

1. **Must have a physician order.** (Sometimes you need 2 or 3…or just a lot more detail!)
2. **Medicare only covers DME if you get it from a supplier enrolled in Medicare.** This means that the supplier has been approved by Medicare and has a Medicare supplier number. When you contact a supplier, be sure to ask whether they agree to accept the Medicare-approved amount as full payment (so the resident will pay less out of pocket). Visit https://www.medicare.gov/medical-equipment-suppliers/ to find a supplier in your area. *If your supplier doesn't have a supplier number, Medicare won't pay the claim.*
3. Maintenance/repairs—if you **own** the equipment, Medicare will not pay to fix it. If you're renting it, the supplier is obligated to keep it in working condition.

MED B…WHAT'S COVERED

Canes (however, Medicare doesn't cover white canes for the blind)

- Commode chairs
- Continuous passive motion (CPM) machines
- Crutches
- Glucose monitors and supplies
- Hospital beds
- Infusion pumps and supplies (when necessary to administer certain drugs)
- Manual wheelchairs and power mobility devices (power wheelchairs or scooters

needed for use inside the home)

- Nebulizers and some nebulizer medications (if reasonable and necessary)
- Oxygen equipment and accessories
- Patient lifts to lift you from a bed or wheelchair
- Pressure-reducing beds, mattresses, and mattress overlays used to prevent bed

sores

MED B…WHAT'S COVERED

- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers
- Arm, leg, back, and neck braces (orthotics)
- Artificial limbs and eyes
- Breast prostheses (including a mastectomy bra) after a mastectomy
- Ostomy bags and certain related supplies
- Urological supplies
- Therapeutic shoes or inserts for people with diabetes who have severe diabetes-related foot disease several *conditions along with this (read the fine print!)*
- Cataract glasses (for aphakia or absence of the lens of the eye)
- One pair of conventional glasses or contact lenses after each surgery with insertion of an intraocular lens
- Intraocular lenses

Important: Only standard frames are covered.

MED B…WHAT'S COVERED

About power wheelchairs and scooters…

For Medicare to cover a power wheelchair or scooter, the doctor must state that it's needed because of the resident's medical condition. Medicare won't cover a power wheelchair or scooter only for preference or use outside the facility or home.

For more information about Medicare's coverage of power wheelchairs or scooters, visit Medicare.gov/coverage/wheelchairs-scooters or read or download the fact sheet "Medicare's Wheelchair & Scooter Benefit" at Medicare.gov/publications. You can also call 1-800-MEDICARE (1-800-633-4227).

Resident $$ Responsibility

Resident pays 20% of the Medicare-approved amount after they've paid their Medicare Part B deductible for the year. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item. The amount the resident pays may vary depending on the DME item.

They also may be able to rent or buy the equipment.

Medicare only buys inexpensive or routinely bought items, like canes, walkers, and blood sugar monitors, or complex rehabilitative power wheelchairs. For some more expensive equipment, like wheelchairs and hospital beds, **Medicare pays to rent the item** for 13 months of continuous use. Once the 13th month of rental ends, the supplier must transfer ownership of the equipment to the resident.

Medicare and Oxygen

Supplier-resident contract.

1. Must have a doctor's order.
2. You pay 20% of Medicare-approved amount after you pay the Part B deductible for the year.
3. Order is good for 5 years—but reach out to the provider you're using to verify—some say 1 year, others say 6 months. Orders must include:
    1. Type (nocturnal only, continuous)
    2. Amount (liters per minute)
    3. Route (nasal cannula, mask, high-flow)
    4. **If they have lots of appointments or places where they'd need an e-tank or m-tank, make sure you include that too!!
    5. Make monthly rental payments for 3 years.. After 36 months, the supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. The supplier must provide equipment and supplies for up to a total of 5 years, as long as there is a medical need for oxygen.
    6. This covers *monthly*: concentrator, tubing, maintenance and repairs.

Medicare and Oxygen

- Portable oxygen equipment, often requires a separate monthly payment made in addition to the general monthly payment, which also ends after 36 months.

- Medicare will continue to pay each month for the delivery of portable tanks after the 36-month rental period. The supplier owns the equipment during the entire 5-year period.

Air Isn't Cheap!

- Average cost per e-tank is $35!
- E-tanks can last approximately 4 hours on 2L/NC or 2 hours at 4L/NC

Tell your staff—turn them off and put them on the concentrator whenever possible!

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DME and Medicaid

- **DME is not covered for those participants residing in a nursing home** (place of service 31 or 99 with level of care 1 or 2). **DME is included in the nursing home per diem rate and not paid for separately with the exception of the following items**:
- ACDs and Accessories
- Custom Wheelchairs
- Power Wheelchairs
- Orthotic and Prosthetic Devices
- Total Parenteral Nutrition
- Volume ventilators

DME and Medicaid—Custom Wheelchairs

MHD will reimburse for medically necessary custom wheelchairs for participants residing in a nursing facility. A custom wheelchair is defined as a chair that is tailor made for one participant and cannot be used by anyone else. Prior authorization is required.

https://mydss.mo.gov/media/pdf/durable-medical-equipment-manual

DME and Medicaid

The Centers for Medicare and Medicaid Services (CMS) revised federal regulation at 42 CFR 440.70 to require that **no Medicaid payment for certain items of DME for which Medicare requires a face-to-face encounter shall be made unless there is documentation of a face-to -face encounter** that meets all of the following criteria:

- **Related to the primary reason the beneficiary requires medical equipment**
- **Occurs no more than six (6) months prior to the written order**
- **Occurs prior to the date of service delivery**
- **Conducted by a physician** (M.D. or D.O.) or one of the following non-physician practitioners (NPP):
  - A nurse practitioner working in collaboration with a physician
  - A clinical nurse specialist working in collaboration with a physician
  - A physician assistant, under the supervision of a physician. If an allowed NPP performs the face-to-face encounter, the clinical findings of that face-to-face encounter must be communicated to the enrolled ordering physician and be incorporated into the ordering physician's medical record for the participant.

DME and Medicaid Face-to-Face Documentation Requirements

- The documentation must, at a minimum, include all of the following:
  - Clinical findings of the face-to- face encounter substantiating the need for the DME
  - Primary reason that the DME is required
  - Name, signature and credentials of the practitioner who conducted the face-to- face encounter; electronic signatures must meet requirements of electronic signatures for MHD Program, in accordance with 13 CSR 65-3.050•
  - Date of the face-to- face encounter
-

DME and Medicaid

- If two (2) different items each meet the need of the participant, the less expensive item must be employed, all other conditions being equal. Equipment features of an aesthetic or medical nature, which are not medically necessary, are not reimbursable.

Medicaid—Running Out of/ Low on Supplies

- For DME items supplied as refills to the original order (e.g. nebulizers supplies, Continuous Positive Airway Pressure (CPAP) supplies, diapers, etc.), the DME provider must contact the participant or caregiver prior to dispensing the refill and **not automatically ship on a pre-determined basis**, even if authorized by the participant.

This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion and to confirm any changes/modification to the order. **Contact with the participant or designee regarding refills must take place no sooner than 14 days prior to the delivery/shipping date**. For all items provided on a recurring basis, DME providers are required to have contact with the participant or caregiver/designee prior to dispensing a new supply of items. DME providers must not deliver refills without a specific refill request from a participant.

Setting Up DME on Discharge

- **Medicaid**—A DME provider may deliver a DME item to a participant in a hospital or nursing facility for the purpose of fitting or training the participant in the proper use of them. **This may be done up to two (2) days prior to the participant's anticipated discharge to their home.** The DME provider shall bill the date of discharge as the date of service on the claim and use the place of service as home *(SNF should NOT be billed for these items!)*
- Doctors use something called Cyber Access through the Medicaid department to put in their order and go through the authorization process so the sooner you can notify them of discharge, the more likely the resident will have oxygen set up when they are ready to leave!

DME and Medicaid—What's Covered

- Canes, crutches, walkers, wheelchairs
- Manual and semi-electric hospital beds, trapeze (mattress and side rails may be separate or excluded)
- Commodes
- Patient lifts (Hoyer-type, etc.)
- Pressure reducing mattresses, cushions
- Osteogenesis stimulators
- Underpads, diapers, briefs and protective underwear/pull-ons
- Respiratory equipment
- Orthotics, prosthetics

DME and Medicaid—What's Covered

- Urological supplies
  - See example on ostomy supplies
- Oxygen supplies

Most of these are covered to some extent; however, most require pre-certification, or additional agreement and information.

Example 1: Ostomy Supplies

Noncovered Ostomy Supplies

The following ostomy supplies are not reimbursable under the DME Program:

Absorption Flakes	Absorption Pad	Aerszoin Spray	Allucotton Dressing	Benzoin Tincture
Carrying Case	Catheter Shields	Cellucotton	Chux	Cleansers
Covers	Cutting Tools	Deodorizers	Dilating Glove	Disposable Liners
Drain Eez	Drying Hanger	Drying Rack	Dusting Powder	Enema Bags
Fiberall	Filters	Finger Cots	Flanellets	Foxy Covers
Fresh Tales	Gauze Pads	Gauze Sponges	Germicide	Gloves
Hexon	Incontinent Pads	Lemon Hexon	Nitrazine Paper	Ostomy Skin Bond or Cement Remover
Oxy-Chinol Tablets	Ozium	Spray	Perma-Type	Post-Op Bags
Post-Op Pouches	Post-Op Sets	Skin Barrier	Skin Conditioners	Soaking Tray

Example 2: Diabetic Shoes

- A5500: The physician who is managing he patient's systemic diabetes condition is an MD or DO and has certified the diagnosis and medical condition, and is treating the patient under a comprehensive plan of care; and
- Patient has Diagnosis in Appendix A; and
- one of the following medical conditions:
  - Previous amputation of the other foot, or part of either foot; or
  - History of previous ulceration of either foot; or
  - History of pre-ulcerative calluses of either foot; or
  - Peripheral neuropathy with evidence of callus formation of either foot; or
  - Foot deformity of either foot; or
  - Poor circulation in either foot;

Allowance= 1 pair of shoes/year

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Conclusion

DME isn't hard—it's just a process!

- Get to know your providers on a first-name basis.
- Have their #s posted at the nurse's stations so if things go crazy on off-times, your nurses are searching for contact.
- Take the time to explain to family members how the DME process works.
- Consider doing a clinic on DME for your clinical staff so they understand the various types of equipment and how to properly use things they might not be used to (such as high-flow oxygen!)

Resources

1. Medicare Coverage of Durable Medical Equipment & Other Devices

https://www.medicare.gov/media/publication/11045-medicare-coverage-of-dme-and-other-devices.pdf

2. MO Health Net https://mydss.mo.gov/media/pdf/durable-medical-equipment-resources
3. MO Health Net Benefit Tables for LTC https://mydss.mo.gov/media/pdf/nursing-facilities
4. MO Health Net Pre-certification Criteria Documents https://mydss.mo.gov/mhd/dme/pre-cert

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