



Medicare Coverage for Home Medical Equipment

BiLevel Devices/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 headaches, cognitive dysfunction, dyspnea, etc.
- A respiratory assist device is covered if you have a clinical disorder characterized as (I) restrictive thoracic disorders (i.e., progressive neuromuscular diseases or severe thoracic cage abnormalities), (II) severe chronic obstructive pulmonary disease (COPD), or (III) central sleep apnea (CSA) or Complex Sleep Apnea (CompSA). If you are diagnosed with Obstructive Sleep Apnea, see the coverage criteria for Positive Airway Pressure Devices below.
- Various tests may need to be performed to establish one of the above diagnosis groups.
- Three months after starting your therapy, both you and your physician will be required to respond in writing to questions regarding your continued use along with how well the machine is treating your condition.

Breast Prostheses

- Breast Prostheses are covered after a radical mastectomy. Medicare will cover:
 - One silicone prosthesis every two years or a mastectomy form every six months.
 - As an alternative, Medicare can cover a nipple prosthesis every three months.
 - Mastectomy bras are covered as needed.
- There is no coverage for replacement prostheses due to wear and tear before the specified time frames. However, Medicare will cover replacement of these items due to:
 - Loss
 - Irreparable damage, or
 - Change in medical condition (e.g. significant weight gain/loss)
- You are allowed only one prosthesis per affected side, others will be denied as not medically necessary even if attempting asymmetry (an ABN should be provided in this circumstance).
- Mastectomy sleeves which are used to control swelling are not covered in the home setting because they do not meet Medicare's definition of a prosthesis; however, it is possible that they may be covered under the hospital per diem if you request one during your hospital stay.
- A mastectomy bra is covered if the pocket of the bra is used to hold a covered prosthesis or mastectomy form.

Cervical Traction

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

Commodes

- A commode is only covered when you are physically incapable of utilizing regular toilet facilities. For example:
 1. You are confined to a single room, or
 2. You are confined to one level of the home environment and there is no toilet on that level, or
 3. You are confined to the home and there are no toilet facilities in the home.
- Heavy-duty commodes are covered if you weigh over 300 pounds. Commodes with detachable arms are covered if your body configuration requires extra width, or if the arms are needed to transfer in and out of the chair.



Compression Stockings

- Gradient compression stockings worn below the knee are covered only when used for the treatment of open venous stasis ulcers. They are not covered for the prevention of ulcers, prevention of the reoccurrence of ulcers, or treatment of lymphedema or swelling without ulcers.

Positive Airway Pressure Devices (CPAPs and Bi-Level Devices for Obstructive Sleep Apnea)

- Continuous Positive Airway Pressure (CPAP) Devices are covered only if you have obstructive sleep apnea (OSA).
- You must have an overnight sleep study performed in a sleep laboratory or through a special, in-home sleep test to establish a qualifying diagnosis of Obstructive Sleep Apnea.
- Medicare will also pay for replacement masks, tubing and other necessary supplies.
- After the 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. Per Medicare, a face-to-face visit with your physician that documents an improvement of your symptoms is required no sooner than 31 days and no later than 91 days from the set-up date. A data report from your sleep equipment which documents that the PAP has been used for at least 4 hours per night on 70% of nights during a 30-day consecutive period is required.
- If the CPAP device is not working, or if you cannot tolerate the CPAP machine, your doctor may also try to use a different device called a Bi-Level or a Respiratory Assist device, and Medicare can consider this for coverage as well.
- Talk with your provider if you are having problems adjusting to the therapy. There are a lot of variations that can make the therapy more comfortable for you.

Diabetic Supplies

- For diabetics, Medicare covers the glucose monitor, lancets, spring-powered lancing devices, test strips, control solution and replacement batteries for the meter.
- Medicare does not cover insulin injections or diabetic pills unless covered through a Medicare Part D benefit plan.
- Diabetics can obtain up to a three month supply of testing materials at a time.
- Medicare will approve up to one test per day for non-insulin dependent diabetics and three tests per day for insulin-dependent diabetics without additional verification of need.
 - If you test above these guidelines, you are required to be seen and evaluated by your physician within six months prior to receiving your initial supplies from your provider.
 - In addition, you must send your provider evidence of compliant testing (e.g. a testing log) every six months to continue getting refills at the higher levels.
- If at any time your testing frequency changes, your physician will need to give your provider a new prescription.

Glasses

- Medicare covers one complete pair of glasses after the last cataract surgery. These can include:
 - frames
 - two lenses
 - tint, anti-reflective coating, and/or UV (when the doctor specifically orders these services for a medical need)

Hospital Beds

- A hospital bed is covered if one or more of the following criteria (1-4) are met:



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1. You have 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. You require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, or
 3. You require 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. You require traction equipment which can only be attached to a hospital bed.
- Specialty beds that allow the height of the bed to vary are covered if you require this feature to permit transfers to a chair, wheelchair or standing position.
 - A semi-electric bed is covered if you require frequent changes in body position and/or have an immediate need for a change in body position.
 - Heavy-duty/extra-wide beds can be covered if you 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. You will need to sign an Advance Beneficiary Notice (ABN) and will be responsible to pay the difference in the retail charges between the two items every month.

Lymphedema Pumps

- Lymphedema Pumps are covered for treatment of true lymphedema as a result of a:
 - Primary Lymphedema resulting from a congenital abnormality of lymphatic drainage or Milroy's disease, or
 - Secondary lymphedema resulting from the destruction of or damage to formerly functioning lymphatic channels such as:
 - radical surgical procedures with removal of regional groups of lymph nodes (for example, after radical mastectomy),
 - post-radiation fibrosis,
 - spread of malignant tumors to regional lymph nodes with lymphatic obstruction,
 - or other causes
 - Before you can be prescribed a pump, your physician must monitor you during a four-week trial period where other treatment options are tried such as medication, limb elevation and compression garments. If, at the end of the trial, there is little or no improvement, a lymphedema pump can be considered.
 - The doctor must then document an initial treatment with a pump and establish that the treatment can be tolerated.
- Lymphedema pumps also are covered for the treatment of chronic venous insufficiency (CVI).
 - Before you can be prescribed a pump for this condition, your physician must monitor you during a six month trial period where other treatment options are tried such as medication, limb elevation and compression garments. If at the end of the trial the stasis ulcers are still present, a lymphedema pump can be considered.
 - The doctor must then document an initial treatment with a pump and establish that the treatment can be tolerated, that there is a caregiver available to assist with the treatment in the home, and then the doctor must prescribe the pressures, frequency, and duration of prescribed use.

Medicare-Covered Drugs (Other than Medicare Part D Coverage)



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- As of February 2001, all providers of Medicare-covered drugs are required to accept assignment on these items.
- Traditional Medicare Part B insurance will cover some nebulizer drugs, some infused drugs that require the use of a pump, specific immunosuppressive drugs, select oral anti-cancer medications and most parenteral nutrition.
- The Medicare Part D plans may provide additional coverage of other oral medications, inhalers and similar drugs.

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
 - The lowest level of equipment required to accomplish these tasks.
 - The most medically appropriate equipment (that meets your needs, not your 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).
- A face-to-face examination with your physician to specifically discuss your mobility limitations and need for powered mobility 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.
- You may also be asked to see a physical therapist or occupational therapist to determine the best fit and equipment selection.

Nebulizers

- Nebulizer machines, medications and related accessories are usually covered if you have obstructive pulmonary disease, but can also be covered to deliver specific medications if you have HIV, Cystic Fibrosis, bronchiectasis, pneumocystosis, complications of organ transplants, or for persistent thick or tenacious pulmonary secretions.
- You may obtain up to a three month's supply of nebulizer medications and accessories at a time as long as you continue to regularly use the medications through your machine.
- If at any time you stop using your medications, please notify your provider.

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
- Elastic Garments

Orthopedic Shoes

- Orthopedic shoes are covered when it is necessary to attach the shoe(s) to a leg brace.
- Medicare will only pay for the shoe(s) attached to leg brace(s).
- Medicare will not pay for matching shoes or for shoes that are needed for purposes other than for diabetes or leg braces.

Ostomy Supplies

- Ostomy supplies are covered for people with a:
 - colostomy,
 - ileostomy, or
 - urostomy
- You may obtain up to a three month's supply of wafers, pouches, paste and other necessary items at a time.

Oxygen

- Oxygen is covered if you have significant hypoxemia in a chronic stable state when:
 - You have a severe lung disease or hypoxemia that might be expected to improve with oxygen therapy, and
 - Your blood gas levels or oxygen saturation levels indicate the need for oxygen therapy, and
 - Your oxygen study was performed by a qualifying physician or sleep lab, and
 - Alternative treatments have been tried or deemed clinically ineffective.
- Categories/Groups are based on the test results to measure your oxygen:
 - Group I Criteria: mmHG = 55, or saturation = 88%
 - For these results you must return to your physician between 9-12 months after the initial visit to discuss whether your oxygen therapy should continue for lifetime or for a shorter period if 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.
 - Group II Criteria: 56-59 mmHg, or 89% saturation
 - For these results, you must return for another office visit with your physician to discuss your oxygen therapy and you will also have to be retested within 3 months of the first test to continue therapy for lifetime or until the need is expected to end.
 - Group III Criteria: mmHg = 60 or saturation = 90% is considered to be not medically necessary.

Oxygen will be paid as a rental for the first 36 months. After that time, if you still need the equipment, Medicare will no longer make rental payments on the equipment. However, if equipment is still necessary, your provider will continue to provide the equipment to you for an additional 24 months. During this two year service period, Medicare will pay your provider for refilling your oxygen cylinders and for a semi-annual maintenance fee.



After 60 months of service through Medicare you may choose to receive new equipment.

Parenteral and Enteral Therapy

- Parenteral therapy requires all or part of the gastrointestinal tract to be missing. Nutritional formulas are delivered through a vein.
- Enteral therapy is covered if you cannot swallow or take food orally. Nutrition must be delivered through a tube directly into the gastrointestinal tract.
- Medicare will not pay for nutritional formulas that are taken orally.
- Specialty nutrients/formulations can be covered if you have unique nutrient needs or specific disease conditions which are well documented in your physician's records. In some cases you may have to try standard formulas and document that they are unsuccessful before you can receive the specialty nutrients.

Patient Lifts

- A lift is covered if transfer between a bed and a chair, wheelchair, or commode requires the assistance of more than one person and, if without the use of a lift, you 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. You will need to sign an Advance Beneficiary Notice (ABN) and would be responsible to pay the difference in the retail charges between the two items on a monthly basis.
- Patient lifts are a capped rental item, and that means they cannot be purchased outright. You will own the equipment after Medicare makes 13 payments toward the purchase of the equipment.

Seat Lift Mechanisms

- In order for Medicare to pay for a seat lift mechanism, you must be suffering from severe arthritis of the hip or knee, or have a severe neuromuscular disease. In addition you must be completely incapable of standing up from any chair, but once standing can walk either independently or with the aid of a walker or cane. The physician must believe that the mechanism will improve, slow down or stop the deterioration of your condition.
- Transferring directly into a wheelchair will prevent Medicare from paying for the device.
- Medicare will only pay for the lift mechanism portion. The chair portion of the package is not covered, and you will be responsible for paying the full amount for the furniture component of the chair.
- Your provider cannot deliver this product to you without a written order or certificate of medical necessity from your doctor, nor can they get the documentation at a later date because if they do, Medicare can never make payment for those products to you or your provider. So please be patient with your provider while they collect the required documentation from your physician.

Support Surfaces

- Group 1 products are designed to be placed on top of a standard hospital bed or home mattresses. They can utilize gel, foam, water or air, and are covered if you are:
 - Completely immobile OR
 - Have limited mobility or any stage ulcer on the trunk or pelvis (and one of the following):
 - impaired nutritional status
 - fecal or urinary incontinence
 - altered sensory perception
 - compromised circulatory status
- Group 2 products take many forms, but are typically powered pressure reducing mattresses or overlays. They are covered if you have one of three conditions:



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- Multiple stage II ulcers on the pelvis or trunk while on a comprehensive treatment program for at least a month using a Group 1 product, and at the close of that month, the ulcers worsened or remained the same. (Monthly follow-up is required by a clinician to ensure that the treatment program is modified and followed. This product is only covered while ulcers are still present.) OR
- Large or multiple Stage III or IV ulcers on the trunk or pelvis (Monthly follow-up is required by a clinician to ensure that the treatment program is modified and followed. This product is only covered while ulcers are still present.) OR
- A recent myocutaneous flap or skin graft for an ulcer on the trunk or pelvis within the last 60 days where you were immediately placed on Group 2 or 3 support surface prior to discharge from the hospital and you have been discharged within the last 30 days.
- A physician or healthcare professional must make monthly assessments as to whether continued use of the equipment is required. Sometimes your physician may order a home healthcare nurse to come visit you to make these assessments.
- Group 3 products are air-fluidized beds and are only covered if you meet ALL of the following conditions:
 - A stage III or stage IV pressure ulcer, and
 - Are bedridden or chair bound as the result of limited mobility, and
 - In the absence of an air-fluidized bed would require institutionalization, and
 - An alternate course of conservative treatment has been tried for at least one month without improvement of the wound, and
 - All other alternative equipment has been considered and ruled out.
- A physician or healthcare professional must assess and evaluate you after completion of a course of conservative therapy within one month prior to ordering the Group 3 support surface.
- A trained adult caregiver must be available to assist you. Medicare does not cover the cost of hiring a caregiver, or for structural modifications to your home to accommodate this equipment.
- Your provider cannot deliver these products to you without a written order from your doctor, nor can they get the documentation at a later date because if they do, Medicare can never make payment for those products to you or your provider. So please be patient with your provider while they collect the required documentation from your physician.

TENS Units

- TENS units are covered for the treatment of chronic intractable pain that has been present for at least three months or more, and in some cases for acute post-operative pain.
- Not all types of pain can be treated with a TENS unit. TENS units have been proven ineffective in treating headaches, visceral abdominal pain, pelvic pain, and TMJ pain, and therefore Medicare will not pay for the device when used to treat these conditions.
- For chronic pain sufferers that have had persistent pain for three or more months in duration, Medicare will pay for a one or two month trial rental to determine if this device will help or alleviate the chronic pain. You must return to your physician exactly 30-60 days after initial evaluation to discuss how the therapy is working and to authorize the purchase of this equipment.
- For acute, post-operative pain sufferers, Medicare will consider rental payment for a maximum of 30 days. Any duration longer than that will require individual consideration.
- Your provider cannot deliver this product to you without a written order or certificate of medical necessity from your doctor, nor can they get the documentation at a later date because if they do, Medicare can never make payment for those products to you or your provider. So please be patient with your provider while they collect the required documentation from your physician.

Therapeutic Shoes

- Special therapeutic shoes, inserts and modifications can be covered for diabetic patients with the following foot conditions:



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- previous amputation of a foot or partial foot
- history of foot ulceration
- peripheral neuropathy with callus formation
- foot deformity
- poor circulation in either foot
- You must have an office visit with your physician within six months of receiving new shoes to discuss and document your diabetes management and why you need these special shoes. This office visit must be repeated each time you wish to obtain replacement shoes.
- When providing you with shoes, your provider must perform an in-person evaluation of your foot/feet, and must verify that your shoes fit properly.
- Your provider cannot deliver this product to you without a written order or certificate of medical necessity from your doctor, nor can they get the documentation at a later date because if they do, Medicare can never make payment for those products to you or your provider. So please be patient with your provider while they collect the required documentation from your physician.

Urological Supplies

- Urinary catheters and external urinary collection devices are covered to drain or collect urine if you have permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected within 3 months.
- A maximum of six catheters may be used per day (up to 200 per month), unless it is determined that a higher number is medically necessary by your physician, and these unique circumstances are specifically documented in your medical records.
- When at home, you may receive up to a 3-month supply at one time.