



Medicare

Funding Assistive Technology in Delaware

Medicare, often confused with Medicaid, is a health insurance program administered by the federal government. One of the things that distinguishes Medicare from Medicaid is that Medicare's rules are the same for each state. Medicare also requires program participants to make their own co-payments and pay an annual deductible.

Medicare Eligibility

Those eligible for Medicare are:

- Individuals age 65 and over
- Individuals of all ages who are permanently and totally disabled¹
- Individuals with end stage renal disease.

To be eligible for Medicare, an individual must have received Social Security Disability Insurance (SSDI) benefits for at least 24 months. An exception to this rule exists for those individuals under age 65 with Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's disease). These persons can receive Medicare during the first month in which they receive SSDI.

Coverage

Medicare offers two coverage types, Parts A and B.

Part A: This is essentially hospitalization insurance and it is automatically provided to all beneficiaries. Part A of Medicare covers some assistive technolo-

gy/durable medical equipment (AT or DME) as home health care. Examples of equipment covered by Medicare include wheelchairs, oxygen, and walkers. There is no premium for most beneficiaries.

Part B: This is optional medical insurance that pays for 80 percent of the allowable cost of most DME, as well as physical and occupational therapy. Part B has the following costs:

- A monthly premium (\$78.20 in 2005)
- An annual deductible (\$110 in 2005)
- 20 percent co-insurance (20 percent of the Medicare-approved amount for a device or service after the deductible has been paid).

Some persons may have dual coverage, qualifying for both Medicare and Medicaid. Medicare is always the primary payer and should be billed before Medicaid. In such cases, Medicaid may pay for Medicare premiums, deductibles, and co-payments. Medicaid may also pay Medicare premiums for certain low-income individuals even when that individual does not receive any other Medicaid benefits.

Obtaining AT and/or Related Services

Medicare refers to AT as durable medical equipment (DME). DME is defined as that which:

- Can withstand repeated use
- Is customarily used for a medical purpose
- Is generally not useful to a person in the absence of an illness, injury, or disability
- Is necessary for use in the home.

Medicare will pay for DME if a Medicare-approved provider supplies it, and the item(s) are considered "medically necessary." Medically necessary supplies and services must be:

- Prescribed by a physician
- Directly related to a diagnosed medical condition
- Expected to provide therapeutic benefit
- Not mainly for the convenience of a beneficiary or physician.

Equipment Prescription and Claim Submission

The process of obtaining DME typically involves a case manager (if the beneficiary has one), a physician, the service provider (e.g., speech therapist), and the equipment provider/vendor. The usual procedure for obtaining DME through Medicare is as follows:

1. A beneficiary is evaluated by a clinician (doctor or therapist) who identifies that person's need for DME.
2. The doctor writes a prescription for the DME² and a Letter of Medical Necessity

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justifying the need for the DME.

3. The beneficiary takes the prescription to a DME provider who determines the most appropriate device based on needs and cost.
4. The DME provider prepares a Certificate of Medical Necessity, which is completed in conjunction with the clinician.
5. The DME provider submits all the paperwork as well as a claim to Medicare and contacts the beneficiary, case manager, and service provider about delivery of the DME.

Payment/Reimbursement

Medicare pays for the "least costly alternative." Therefore, if a device has additional features that might be more convenient for the user, but are not related to the user's medical condition, Medicare will likely only pay for the standard, less expensive item. Medicare assigns an allowable charge to DME based on the lower of the fee schedule amount or the actual charge.

If the DME provider accepts "assignment," the provider will supply the equipment to the beneficiary upon receipt of the 20 percent co-payment and will bill Medicare for the 80 percent balance. However, if the provider refuses "assignment," the beneficiary must pay 100 percent of the

allowable charge up front before the provider will deliver the equipment. In the latter case, the provider will submit a claim to Medicare, which will reimburse the beneficiary for the 80 percent balance.

Appeals For Part B Claims

A Medicare beneficiary may appeal a decision if s/he does not agree with the decision to deny an equipment claim or with the amount of reimbursement for equipment purchased. Typically, the DME provider will attempt an appeal. Otherwise, the beneficiary may wish to contact the prescribing physician, DATI, or other agencies.

Contact Information

Medicare DME claims are administered by DME Regional Carriers (DMERCs). Delaware is in DMERC Region A. To contact Delaware's DMERC, call:

(800) 842-2052
(800) 444-4606 (voice)
(800) 842-9519 (TDD)

Questions about Medicare eligibility may be directed to the Social Security Administration office in the consumer's county of residence.

New Castle
92 Read's Way
New Castle, DE
(302) 323-0304

Kent
300 South New Street
Dover, DE 19901
(302) 674-5162

Sussex
600 N. DuPont Highway
Georgetown, DE 19947
(302) 856-9620

Information about Medicare can also be found at <http://www.medicare.gov>.

¹Medicare defines disability as the inability to engage in any substantial gainful activity by reason of any medically determined physical or mental impairment which can be expected to result in death, blindness, or has lasted or can be expected to last for a continuous period of not less than 12 months. ²Certain equipment may require a specialist's prescription. For example, only a neurologist, physiatrist, orthopedist, or cardiac specialist may prescribe a motorized wheelchair.