



Medicare Coverage of Durable Medical Equipment and Other Devices

This official government booklet explains:

- What durable medical equipment is
- Which durable medical equipment, prosthetic, and orthotic items are covered by Original Medicare
- Where to get help with your questions



Do you need durable medical equipment (DME) or other types of medical equipment? Medicare can help.

Definitions of **blue** words are on pages 18 – 19.

This booklet explains **Original Medicare** coverage of **DME** and what you might need to pay. DME includes things like:

- Home oxygen equipment
- Hospital beds
- Walkers
- Wheelchairs

This booklet also explains coverage for prosthetic devices (like ostomy supplies, urinary catheters, enteral nutrition, and certain eyeglasses and contact lenses), leg, arm, neck, and back braces (“orthotics”), and artificial legs, arms, and eyes. It’s important to know what Medicare covers and what you may need to pay. Talk to your doctor if you think you need some type of DME.

If you have questions about the cost of DME or coverage after reading this booklet, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Note: The information in this booklet describes the Medicare Program at the time this booklet was printed. Changes may occur after printing. Visit Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227) to get the most current information. TTY users can call 1-877-486-2048.

“Medicare Coverage of Durable Medical Equipment & Other Devices” isn’t a legal document. Official Medicare Program legal guidance is contained in the relevant statutes, regulations, and rulings.

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Note: You can get the “Medicare & You” handbook electronically in standard print, large print, or as an eBook.

For general Medicare inquiries and Medicare publications, call us at 1-800-MEDICARE (1-800-633-4227). TTY: 1-877-486-2048.

For all other CMS publications and documents in accessible formats, you can contact our Customer Accessibility Resource Staff:

Call 1-844-ALT-FORM (1-844-258-3676). TTY: 1-844-716-3676.

- Send a fax to 1-844-530-3676.
- Send an email to altformatrequest@cms.hhs.gov.
- Send a letter to:

Centers for Medicare & Medicaid Services
Offices of Hearings and Inquiries (OHI)
7500 Security Boulevard, Mail Stop S1-13-25
Baltimore, MD 21244-1850
Attn: Customer Accessibility Resource Staff

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- To inquire about a request for accessible formats.
- To submit concerns and issues about accessible communications, including the quality and timeliness of your request.

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- Your name, phone number, and the mailing address where we should send the publications or documents.
- The publication title and CMS Product No., if known.
- The format you need, like Braille, large print, or data/audio CD.

Note: If you're enrolled in a Medicare Advantage or Medicare Prescription Drug Plan, you can contact your plan to request their documents in an accessible format.

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1. Online at hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html.
2. By phone: Call 1-800-368-1019. TDD user can call 1-800-537-7697.
3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

What's durable medical equipment (DME)?

DME is reusable medical equipment like walkers, wheelchairs, or hospital beds.

If I have Medicare, can I get DME?

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

When does Original Medicare cover DME?

Original Medicare covers DME under Part B when your doctor or other health care provider (like a nurse practitioner, physician assistant, or clinical nurse specialist) prescribes it for you to use in your home. A hospital or nursing home that's providing you with Medicare-covered care can't qualify as your "home" in this situation. However, a long-term care facility can qualify as your home.

Note: If you're in a **skilled nursing facility (SNF)** as part of a stay covered under Medicare Part A, the facility is responsible for providing any DME you need while you're in the facility for up to 100 days.

What if I need DME and I'm in a Medicare Advantage Plan?

Medicare Advantage Plans (like an HMO or PPO) must cover the same items and services as Original Medicare. Your costs will depend on which plan you choose. If you're in a Medicare Advantage Plan and you need DME, call your plan to find out if the equipment is covered and how much you'll have to pay.

If you're getting home care or using medical equipment and you choose to join a new Medicare Advantage Plan, you should call the new plan as soon as possible and ask for "utilization management." They can tell you if your equipment is covered and how much it will cost. If you return to Original Medicare, you should tell your supplier to bill Medicare directly after the date your coverage in the Medicare Advantage Plan ends.

Definitions of **blue** words are on pages 18–19.

Note: If your plan leaves Medicare and you're using medical equipment like oxygen or a wheelchair, call the phone number on your [Medicare Advantage Plan](#) card. Ask for "utilization management." They can tell you how you can get care under [Original Medicare](#) or a new Medicare Advantage Plan.

If I have Original Medicare, how do I get the DME I need?

If you need [DME](#) in your home, your doctor or treating practitioner (like a nurse practitioner, physician assistant, or clinical nurse specialist) must prescribe the type of equipment you need by filling out an order. For some equipment, Medicare may also require your doctor to provide additional information documenting your medical need for the equipment. Your supplier will work to make sure your doctor submits all required information to Medicare. If your needs and/or condition changes, your doctor must complete and submit a new, updated order.

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.

To find a supplier that's enrolled in Medicare, visit [Medicare.gov/supplierdirectory](https://www.medicare.gov/supplierdirectory). Or, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

A supplier enrolled in Medicare must meet strict standards to qualify for a Medicare supplier number. **If your supplier doesn't have a supplier number, Medicare won't pay your claim**, even if your supplier is a large chain or department store that sells more than just DME.

Definitions
of [blue](#)
words are
on pages
18–19.

Does Medicare cover power wheelchairs & scooters?

For Medicare to cover a power wheelchair or scooter, your doctor must state that you need it because of your medical condition. Medicare won't cover a power wheelchair or scooter that's only needed and used outside of the home.

Most suppliers who work with Medicare are honest. However, there are a few who aren't. For example, some suppliers of medical equipment try to cheat Medicare by offering expensive power wheelchairs and scooters to people who don't qualify for these items.

For more information about Medicare's coverage of power wheelchairs or scooters, visit [Medicare.gov/coverage/wheelchairs-scooters](https://www.medicare.gov/coverage/wheelchairs-scooters) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What if my equipment or supplies are lost or damaged in a disaster or emergency?

If [Original Medicare](#) already paid for [durable medical equipment \(DME\)](#) or supplies lost or damaged due to an emergency or disaster:

- In certain cases, Medicare will cover the cost to repair or replace your equipment or supplies.
- Generally, Medicare will also cover the cost of rentals for items (like wheelchairs) during the time your equipment is being repaired.

If you're in a [Medicare Advantage Plan \(like an HMO or PPO\)](#) or other [Medicare health plan](#), contact your plan directly to find out how it replaces DME or supplies lost or damaged in an emergency or disaster.

You can also call 1-800-MEDICARE to get more information about how to replace your equipment or supplies.

What's covered, and how much does it cost?

Pages 9–11 show some of the items Medicare covers and how much you have to pay for these items. This list doesn't include all covered [durable medical equipment \(DME\)](#). For questions about whether Medicare covers a particular item, visit [Medicare.gov](#), or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. If you have a [Medigap policy](#), it may help cover some of the costs listed on pages 9–11.



Definitions of [blue](#) words are on pages 18–19.

Durable Medical Equipment (DME)

What Medicare covers

- Pressure reducing beds, mattresses, and mattress overlays used to prevent bed sores
- Blood sugar monitors
- Blood sugar (glucose) test strips
- Canes (however, white canes for the blind aren't covered)
- Commode chairs
- Continuous passive motion (CPM) machines
- Crutches
- 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 (a medical device used to lift you from a bed or wheelchair)
- Sleep apnea and Continuous Positive Airway Pressure (CPAP) devices and accessories
- Suction pumps
- Traction equipment
- Walkers

What you pay

Generally, you pay 20% of the [Medicare-approved amount](#) after you pay your Medicare Part B [deductible](#) for the year. Medicare pays the other 80%. The Medicare-approved amount is the lower of the actual charge for the item or the fee Medicare sets for the item.

However, the amount you pay may vary because Medicare pays for different kinds of [DME](#) in different ways. You may be able to rent or buy the equipment.

Prosthetic and Orthotic Items

What Medicare covers

- Orthopedic shoes only when they're a necessary part of a leg brace
- Arm, leg, back, and neck braces (orthotics), as long as you go to a supplier that's enrolled in Medicare
- Artificial limbs and eyes
- Breast prostheses (including a surgical bra) after a mastectomy
- Ostomy bags and certain related supplies
- Urological supplies
- Therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease.

The doctor who treats your diabetes must certify your need for therapeutic shoes or inserts. A podiatrist or other qualified doctor must prescribe the shoes and inserts. A doctor or other qualified individual (like a pedorthist, orthotist, or prosthetist) must fit and provide the shoes. Medicare Part B (Medical Insurance) covers the furnishing and fitting of either one pair of custom-molded shoes and inserts or one pair of extra-depth shoes each calendar year. Medicare also covers 2 additional pairs of inserts each calendar year for custom-molded shoes and 3 pairs of inserts each calendar year for extra-depth shoes. Medicare may cover shoe modifications instead of inserts.

What you pay

You pay 20% of the [Medicare-approved amount](#) after you pay your Medicare Part B [deductible](#) for the year. Medicare pays the other 80%. These amounts may be different if the supplier doesn't accept [assignment](#). See page 12.

Corrective Lenses

What Medicare covers

Prosthetic Lenses

- Cataract glasses (for Aphakia or absence of the lens of the eye)
- Conventional glasses or contact lenses after surgery with insertion of an intraocular lens
- Intraocular lenses

Important: Only standard frames are covered. Medicare will only pay for contact lenses or eyeglasses provided by a supplier enrolled in Medicare, no matter who submits the claim (you or your supplier).

What you pay

You're covered for one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens. You pay 20% of the [Medicare-approved amount](#) after you pay the Medicare Part B [deductible](#) for the year. Medicare pays the other 80%. Costs may be different if the supplier doesn't accept [assignment](#). See page 12. If you want to upgrade the frames, you pay any additional cost.

Definitions
of [blue](#)
words are
on pages
18 – 19.

What's "assignment" in Original Medicare, and why is it important?

Assignment means that your doctor, provider, or supplier agrees (or is required by law) to accept the **Medicare-approved amount** as full payment for covered services.

Suppliers who agree to accept assignment on all claims for DME and other devices are called "participating suppliers." If a DME supplier doesn't accept assignment, **there's no limit to what they can charge you**. In addition, you may have to pay the entire bill (Medicare's share as well as your coinsurance and any deductible) at the time you get the DME. The supplier will send the bill to Medicare for you, but you'll have to wait for Medicare to reimburse you later for its share of the charge.

Note: Before you get DME, ask if the supplier is enrolled in Medicare. If the supplier isn't enrolled in Medicare, Medicare **won't** pay your claim at all. Then, ask if the supplier is a participating supplier in Medicare. A participating supplier **must** accept assignment. A supplier that's enrolled in Medicare, but isn't "participating," has the option whether to accept assignment. You'll have to ask if the supplier will accept assignment for your claim.

To find suppliers who always accept assignment, visit [Medicare.gov/supplierdirectory](https://www.Medicare.gov/supplierdirectory). Or, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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How will I know if I can buy DME or whether Medicare will only pay for me to rent it?

If your supplier is a Medicare-enrolled supplier, they'll know if Medicare allows you to buy a particular kind of [DME](#), or just pays for you to rent it. Medicare pays for most DME on a rental basis. Medicare only buys inexpensive or routinely bought items, like canes, walkers, and, in rare cases, items that must be made specifically for you, like complex rehabilitative power wheelchairs.

Buying equipment

If you **own** Medicare-covered DME and other devices, Medicare may also cover repairs and replacement parts. Medicare will pay 80% of the Medicare-approved amount (up to the cost of replacing the item) for repairs. You pay the other 20%. Your costs may be higher if the supplier doesn't accept [assignment](#).

Note: The equipment you buy may be replaced if it's lost, stolen, damaged beyond repair, or used for more than the reasonable useful lifetime of the equipment, which is generally five years from the date you start using the item.

Renting equipment

If you **rent** DME and other devices, Medicare makes monthly payments for use of the equipment. The rules for how long monthly payments continue vary based on the type of equipment. Total rental payments for inexpensive or routinely bought items are limited to the fee Medicare sets to buy the item. If you'll need these items for more than a few months, you may decide to buy these items rather than rent them. Monthly payments for frequently serviced items, like ventilators, are made as long as the equipment is [medically necessary](#). You pay 20% of the Medicare-approved amount after you pay your Medicare Part B [deductible](#) for the year. Medicare pays the other 80%.

The supplier will pick up the equipment when you no longer need it. Any costs for repairs or replacement parts for the rented equipment are the supplier's responsibility. The supplier will also pick up the rented equipment if it needs repairs. You don't have to bring the rented equipment back to the supplier.

How does Medicare pay the supplier for oxygen equipment and related supplies?

If you have Medicare and use oxygen, you can rent oxygen equipment from a supplier for as long as you have a medical need, but payments for the equipment stop after 36 months of continuous use. After 36 months, your supplier must continue to provide oxygen equipment and related supplies for an additional 24 months. Your supplier must provide equipment and supplies for up to a total of 5 years, as long as you have a medical need for oxygen.

What do I pay the supplier? What does the rental payment cover?

The monthly rental payments to the supplier cover your oxygen equipment, and any supplies and accessories, like tubing or a mouthpiece, oxygen contents, maintenance, servicing, and repairs. If you use portable oxygen equipment, there is a separate monthly payment made in addition to the general monthly payment, which also ends after 36 months. In both cases, you pay 20% of the [Medicare-approved amount](#) after you pay your Medicare Part B [deductible](#) for the year. Medicare pays the other 80%.

What happens with my oxygen equipment and related services after the 36 months of rental payments?

Your supplier must continue to maintain the oxygen equipment (in good working order) and furnish the equipment and any necessary supplies and accessories, as long as you need it until the 5-year period ends. The supplier can't charge you for performing these services.

If you use oxygen tanks or cylinders that need delivery of gaseous or liquid oxygen contents, Medicare will continue to pay each month for the delivery of contents after the 36-month rental period. The supplier that delivers this equipment to you in the last month of the 36-month rental period must provide these items, as long as you medically need them, up to 5 years. The supplier owns the equipment during the entire 5-year period.

If you use either an oxygen concentrator or equipment used to fill portable tanks in your home, you may have to pay a maintenance and servicing payment every 6 months if the supplier comes to your house to inspect and service the equipment. The supplier can't charge you for this service unless they come to your home to inspect and service the equipment.

Definitions of [blue](#) words are on pages 18–19.

What happens to my oxygen equipment after 5 years?

If your medical need continues past the 5-year period, your supplier no longer has to continue providing your oxygen and oxygen equipment, and you may choose to get replacement equipment from any supplier. A new 36-month payment period and 5-year supplier obligation period starts once the old 5-year period ends for your new oxygen and oxygen equipment.

My oxygen equipment doesn't allow me to move around like I want to inside and/or outside my home. What should I do?

If your doctor determines that your oxygen equipment doesn't meet your needs, he or she may notify the oxygen supplier with a new letter of medical necessity. The letter should explain your mobility needs both inside and outside your home. If you switch from using stationary oxygen to portable oxygen, a new 36-month payment period and a new 5-year supplier obligation period begins once the 5-year contract for the stationary oxygen expires.

What happens if the equipment I have is no longer effective for me?

If your doctor decides that your oxygen equipment is no longer effective for you, he or she may notify the oxygen supplier with a new letter of medical necessity for different equipment. The oxygen supplier must give you equipment that fits your needs.

What if my oxygen supplier tells me they'll no longer provide liquid oxygen?

If your supplier tells you they'll no longer provide your prescribed therapy, and you haven't completed your 5-year contract, you should:

- Get the oxygen supplier to put their intentions in writing.
- Call 1-800-MEDICARE (1-800-633-4227) to file a complaint. TTY users can call 1-877-486-2048.

Can my oxygen supplier decide to change the terms of my contract for my equipment or the number of tanks I get each month?

Your supplier can't change the type of equipment or number of tank refills you get unless your doctor orders a change. Your oxygen supplier must provide all your oxygen equipment and supplies, including all necessary tank refills.

If I travel by plane, is my oxygen supplier required to provide a portable oxygen concentrator?

Your oxygen supplier isn't required to give you an airline-approved portable oxygen concentrator, and Medicare won't pay for any oxygen related to air travel. You may be able to rent a portable oxygen concentrator from your supplier. Also, rentals are available through online companies that work with most airlines. These companies can give the documentation needed for your travel.

What if I'm away from home for an extended period or I move to another area during the 36-month period?

If you travel away from home for an extended period of time (several weeks or months) or permanently move to another area during the 36-month rental period, ask your current supplier if they can help you find a supplier in the new area. If your supplier can't help you find an oxygen supplier in the area where you're visiting or moving to, visit [Medicare.gov/supplierdirectory](https://www.Medicare.gov/supplierdirectory) or call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

What if I'm away from home for an extended period or I move to another area after the 36-month period?

If you travel or move after the 36-month rental period ends, your supplier is responsible for making sure that you have oxygen and oxygen equipment in the new area. You can't be charged for oxygen equipment after month 36 even in these situations.

If you use either an oxygen concentrator or equipment used to fill portable tanks in your home, you may have to pay a maintenance and servicing payment every 6 months if the supplier comes to your house to inspect and service the equipment. The supplier can't charge you for this service unless they come to your home to inspect and service the equipment.

Your supplier may arrange for you to get oxygen and oxygen equipment from a different supplier in your new area. For more information, visit [Medicare.gov/supplierdirectory](https://www.Medicare.gov/supplierdirectory) or call 1-800-MEDICARE.

What if my supplier refuses to continue providing my oxygen equipment and related services as required by law?

If your supplier isn't following Medicare laws and rules, call 1-800-MEDICARE. A customer service representative will refer your case to the appropriate area.

Definitions

Assignment — An agreement by your doctor, provider, or supplier to be paid directly by Medicare, to accept the payment amount Medicare approves for the service, and not to bill you for any more than the Medicare deductible and coinsurance.

Coinsurance — An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Deductible — The amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay.

Durable medical equipment (DME) — Certain medical equipment, like a walker, wheelchair, or hospital bed, that's ordered by your doctor for use in the home.

Medically necessary — Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Medicare Advantage Plan (Part C) — A type of Medicare health plan offered by a private company that contracts with Medicare. Medicare Advantage Plans provide all of your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.

Medicare-approved amount — In Original Medicare, this is the amount a doctor or supplier that accepts assignment can be paid. It may be less than the actual amount a doctor or supplier charges. Medicare pays part of this amount and you're responsible for the difference.

Medicare health plan — Generally, a plan offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. Medicare health plans include all Medicare Advantage Plans, Medicare Cost Plans, and Demonstration/ Pilot Programs. Programs of All-inclusive Care for the Elderly (PACE) organizations are special types of Medicare health plans. PACE plans can be offered by public or private companies and provide Part D and other benefits in addition to Part A and Part B benefits.

Medicare Part B (Medical Insurance) — Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medigap policy — Medicare Supplement Insurance sold by private insurance companies to fill “gaps” in Original Medicare coverage.

Original Medicare — Original Medicare is a fee-for-service health plan that has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance). After you pay a deductible, Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance and deductibles).

Skilled nursing facility (SNF) — A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.



**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**

Centers for Medicare & Medicaid Services
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Official Business
Penalty for Private Use, \$300

CMS Product No. 11045
Revised July 2019

Paid for by the Department of Health & Human Services.



This booklet is available in Spanish. To get your copy, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

Esta publicación está disponible en Español. Para obtener una copia, llame al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY pueden llamar al 1-877-486-2048.