



Medicare & OHP Members

Refer to the [Authorization Overview](#) document for information about CareOregon's relationship to Coordinated Care Organizations.

Durable Medical Equipment (DME) and Supplies

FREQUENTLY ASKED QUESTIONS (FAQS) – Revised 1/1/14

This information is to be used in conjunction with the Medicare and OHP Plus benefit rules. The FAQ is not intended to replace the benefit rules or to cover the benefit details listed in the rules. Rather, the intent is to provide additional information in order to assist the reader with those issues that we repeatedly receive questions about.

Q.1. For diabetic supplies where the amount needed is more than the usual benefit, what documentation is needed and why?

A.1. The medical record needs to indicate the specific reason for the additional supplies and the member needs to provide documentation that they are testing as frequently as their provider has recommended. Member documentation of testing can be a copy of their diabetic log or if that is not readily available, they can take their glucose monitor to their provider's office and request a computer record from their glucose monitor. The diabetic log of testing must be current (within the past 30 days) and must include at least 14 days of testing.

The reason why documentation is needed is because Medicare and the Oregon Health Plan (OHP) has benefit limits and any additional supplies beyond the benefit limits need to meet Medicare or OHP medical necessity criteria before an authorization can be issued.

Q.2. What other supplies have benefit limits and is the same type of documentation needed for supplies that are over the benefit limit?

A.2. Examples of other supplies that have benefit limits are ostomy supplies, urological supplies (catheters) and incontinence supplies and other supplies listed in the Medicare or DMAP (OHP) DME Provider Guide. Both Medicare and OHP benefit "rules" state what the benefit limits are and what services are excluded. The rules also state the type documentation that is needed in order to qualify for additional supplies beyond the usual benefit limits. In these instances, medical record documentation must accompany the authorization request and must include specific details about the medical need for the additional supplies. For example, members who are receiving immunosuppressive drugs post-transplant, or on cancer chemotherapy, or have AIDS may qualify for additional supplies based on their medical condition. This information would need to be submitted with the authorization request in order for it to be processed accurately.

Q.3. If a member moves or due to other circumstances, needs or wants to change vendors and authorizations have already been processed for future delivery dates, what does the member or provider need to do?

A.3. First, the member needs to select a new CareOregon vendor. They can do that by either talking with their provider or by calling CareOregon and talking with a Customer Service Representative. A list of vendors is available based on geographic location and by type of equipment or supplies needed.

Next - once the member knows which vendor they want to use, they need to notify their provider to fax a new order to the new vendor. A "Change of Vendor Request Form" needs to be completed and faxed to CareOregon DME at 503-416-3637 or 1-800-862-4831 either by their ordering provider or by their new vendor.

Then - the member needs to notify their former vendor that they are changing vendors so that future shipments or deliveries are not made.

A CareOregon DME Specialist will end the authorization for the former vendor and will set-up a new authorization for the new vendor. Both vendors are notified by the DME Specialist of the effective date of the change.

Q.4 Medicare and OHP have "rules" about when they will pay for repairs and replacement of equipment that the member currently has. My questions are:

Q.4.a. Will Medicare and OHP pay for repairs to a piece of equipment that was obtained prior to the member being covered by Medicare or OHP?

A.4.a. The member must meet current Medicare or OHP reimbursement criteria for the equipment in order to be repaired if Medicare or OHP did not purchase the item. If it was obtained prior to Medicare or OHP coverage or if another payor purchased the equipment, the supplier/vendor must obtain the required documentation to verify coverage and to determine if the item is covered by a warranty.

Q.4.b. How is a product replaced prior to the 5-year life expectancy?

A.4.b. The replacement of a product before the 5-year life expectancy can only be done if the item is irreparably damaged, for example by a natural disaster such as fire, flood, etc. Replacement due to wear and tear before the 5-year lifetime is not covered.

Q.4.c. For repairs, may travel time be charged using the A9900 procedure code for DME supply or A9270 non-covered service?

A.4.c. Travel time is included in the reimbursement of parts and labor and MAY NOT be paid separately. If a supplier chooses to bill separately, code A9901 (DME delivery, set-up, and/or dispensing service component of another HCPCS code) must be used. This code is not reimbursed and will be denied. HCPCS code A9270 must not be used.

Q.4.d. Is a re-manufactured part with a warranty from the manufacture considered new or used equipment?

A.4.d. A re-manufactured part with a warranty is considered used.

Q.4.e A member is prescribed a new power wheelchair or replacement of an existing chair, which is eight years old. It is possible to repair the old unit for less than 50% of the replacement allowable for a new chair. Assuming the repairs carry a limited warranty, would the member ONLY qualify for repairs or would the 5-year useful lifetime apply?

A.4.e If a chair has reached its 5-year life expectancy, the chair can be replaced. However, if a chair reaches its 5-year life expectancy, is in good working order, and meets the member's medical needs, it should not be automatically replaced.

Reference for Repair/Replacement: NAS Q & A posted 10/18/07

Q.5 The oxygen and oxygen equipment payment “rules” have changed for Medicare. My questions are:

Q.5.a. What was the major change?

A.5.a. Historically oxygen and oxygen equipment used on a continuous basis was paid as a continuous rental for the entire time the member needed to use it. The Deficit Reduction Act (DRA) of 2005 changed the payment rules by limiting monthly rental payments for oxygen and oxygen equipment to 36-months of continuous use for equipment that was provided on or after January 1, 2006; after which the equipment title transferred to the member. However, this rule was modified in July 2008 by the Medicare Improvements for Patients and Providers Act (MIPPA) to allow the supplier (vendor) to retain the title for the equipment following the 36-month rental cap. The supplier who furnished the oxygen and oxygen equipment is required to continue to furnish it for any period of medical need for the remainder of the equipment's reasonable useful lifetime.

Q.5.b. What may the supplier/vendor charge for after the 36-month capped rental period has been reached?

A.5.b. Although the supplier/vendor can no longer charge for a rental fee payment after the 36th month, the payment rules allow for the following charges:

- In-home visits to inspect certain oxygen equipment and provide general maintenance and servicing every 6 months
- Oxygen contents used with liquid or gaseous oxygen equipment

Q.5.c. What is allowed for repair and replacement of oxygen and oxygen related equipment after the 36th month capped rental period?

A.5.c. NO payment is allowed to the supplier/vendor on or after January 1, 2009. This includes:

- Replacement parts furnished as part of any repair or maintenance of the oxygen or oxygen related equipment

- Repair costs (e.g. labor)
- Loaner equipment furnished during periods when repairs or maintenance are performed to supplier owned equipment
- Pick-up and disposal of liquid or gaseous oxygen content

The supplier is responsible for performing any repairs or maintenance and servicing of the equipment that is necessary to ensure that the equipment is in good working order for the remainder of the reasonable useful lifetime of the equipment.

Q.5.d. What is considered to be the “useful” lifetime of the oxygen and oxygen related equipment?

A.5.d. The reasonable “useful” lifetime for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the member and continues until the point at which the stationary or portable oxygen equipment has been used by the member on a continuous basis for five (5) years.

Q.5.e. I still have questions about oxygen and oxygen related equipment reimbursement, how can I get more information?

A.5.e. The Centers for Medicare and Medicaid Services (CMS) and Noridian Administrative Services have several questions and answer papers which address the reimbursement changes. They can be accessed at the following website addresses:

- <http://www.cms.hhs.gov/MLN MattersArticles/downloads/mm6297.pdf>
- <http://www.cms.hhs.gov/Transmittals/downloads/R421OTN.pdf>
- <http://www.cms.hhs.gov/Transmittals/downloads/R1177CP.pdf>
- <http://www.cms.hhs.gov/MLN MattersArticles/downloads/mm5461.pdf>
- <http://www.cms.hhs.gov/Transmittals/downloads/R443OTN.pdf>
- https://www.noridianmedicare.com/dme/news/oxygen_equipment_changes.html