Bard Intermittent Catheter FAQ

Q. How many intermittent catheters do Medicare allow?
A. Medicare will reimburse for up to 200 intermittent catheters per month, according to April 1, 2008 guidelines. Intermittent catheters are designed to be used only once and then discarded.

Q. Should I expect to get 200 of each supply every month? Medicare's policy shows a table listing a "usual maximum" of 200 for number of supplies allowed.
A. No, you probably won't need that many. Medicare's "usual maximum" number is for patients with extreme utilization requirements. Most people will not require 200. Your doctor will make a determination, based on your medical condition, about how many supplies you'll need. Medicare requires sufficient information in your medical record to justify the amount ordered. You or your caregiver must request refills of urological supplies before they are dispensed. Suppliers cannot automatically dispense a predetermined amount of supplies on a monthly basis. Instead they should check with you or your caregiver to find out how many you've used to date and adjust the number of supplies accordingly.

Q. What if I need more supplies than the usual maximum listed in the Medicare guidelines?
A. Your doctor will need to provide a written explanation for why you need more. This letter will be kept on file by your supplier. If you have a history of symptomatic recurrent urinary tract infections while using intermittent catheterization, you're eligible for a higher quantity of catheters or catheter kits with insertion supplies.

Q. What can I do about recurrent urinary tract infections? I've started using straight intermittent catheters, but they don't seem to help.
A. Talk with your doctor and see if a closed system intermittent catheter might help. It's a "touchless" catheter, meaning your hands do not have to touch it,

reducing the risk of infection. Medicare covers these under an A4353 HCPCS code. They do require additional documentation.

Q. My medical costs are covered by my private insurance policy, not Medicare. Will Medicare's policies affect me?

A. Check with your insurance company to be sure. Most insurance providers do follow Centers for Medicare and Medicaid Services (CMS) guidelines.

Q. My doctor says I require a coude tip catheter, since I've been unable to catheterize using a straight tip. Do I need to provide additional documentation to be covered?

A. Yes, Medicare requires that your medical history file be documented to show need for a coude tip. Your doctor will need to document that you're unable to pass a straight tip catheter, or that you suffer from urethral strictures that make catheterization more difficult. According to Medicare guidelines, a coude tip is not usually medically necessary in female patients, but women who are unable to pass a straight tip catheter are usually covered for use of a coude tip catheter. For women who are just learning to use intermittent self-catheterization, some healthcare providers have found that an olive tip coude may be easier to use.

Q. What information does Medicare require in an audit to cover payment for the type and quantity of urological supplies ordered by my doctor?

A. Your medical record must contain documentation of your medical condition that proves the type and quantity of items ordered are needed at the frequency of use or replacement ordered by your doctor. For intermittent catheterization, the information should include:

- Prescription
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Your medical record must include all clinical information necessary to support the medical necessity for the item. It should be further substantiated by a supplier-prepared statement or physician attestation. But neither your doctor's

order or attestation, nor a supplier-prepared statement alone is sufficient documentation of medical necessity.

In addition to your doctor's office records, your medical record may include hospital, nursing home, or home health agency (HHA) records, and records from other professionals including, but not limited to, nurses, physical or occupational therapists, prosthetists, and orthotists.

Q. If my supplier bills Medicare directly, do they also take my co-pay?

A. Yes. If your supplier accepts assignment for Medicare, you will need to pay the supplier 20% coinsurance of Medicare's allowable amount for your product. If your supplier doesn't accept assignment, they are still required to file your claim. Upon receipt of the claim, Medicare will pay its portion of the cost directly to you. The supplier may require you to pay most of the entire bill when you receive your supplies.

Q. What can I do if my supplier tells me my catheters are not covered? They're saying I have to pay for them.

A. Intermittent catheters are covered under Medicare and there are many suppliers who can help you get coverage and reduce your out-of-pocket expenses.

Q. Where is the best place to get my product if I don't have insurance?

A. You may be able to find lower prices on your product through a cash-based supplier. Since these suppliers avoid the administrative expenses of filing insurance claims, they can usually provide the same product for less money.