With commercials for "free" equipment and supplies running daily, you need to be ready to respond when a patient requests a prescription.

Direct-to-Consumer Marketing of Durable Medical Equipment

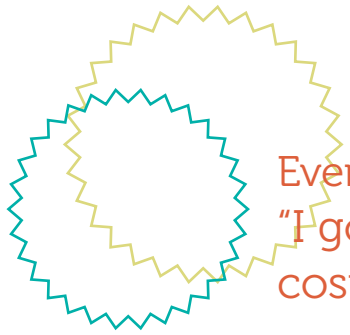
Stanley Borg, DO

STUART BRADFORD

The commercials are pervasive. Every time I hear the line, "I got a new scooter, and it didn't cost me a dime," I get an uneasy feeling, since the main message comes across as how to get "free stuff" from Medicare. It's not surprising that some of the companies that provide scooters, oxygen, diabetes supplies, and various durable medical equipment (DME) have been investigated for fraud and abuse. Certainly, there is something to be said for helping patients get medically necessary supplies and equipment. Still, aggressive tactics by some of these companies may also pose a risk for you. What's a physician to do?

Understand the law

It is against the law for suppliers to make unsolicited sales calls, or "cold calls," to Medicare beneficiaries. Section 1834(a)(17)(A) of the Social Security Act states that the beneficiary must give his or her written permission or the supplier must have furnished at least one covered item to the beneficiary during the preceding 15 months for the supplier to call the beneficiary legitimately. Even if the supplier is contacting the beneficiary to follow up on a physician order it has received, this contact would be considered unsolicited if the beneficiary was not aware that the physician would be contacting the supplier. ➤



Every time I hear the line, "I got a new scooter, and it didn't cost me a dime," I get an uneasy feeling.

Aggressive tactics of durable medical equipment (DME) suppliers may rise to the level of fraud.

Medicare regulations limit DME marketing efforts and put responsibility for appropriate prescribing on physicians' shoulders.

A power operated vehicle (POV) may be appropriate for someone with mobility limitation but enough upper extremity function to operate the scooter.

Understand Medicare's coverage requirements

Medicare has explicit coverage requirements for many DME items and medical supplies. Most private insurers use similar criteria. Knowing those requirements and following them can help keep you out of trouble – the kind of trouble that might come from signing a completed authorization form faxed by an aggressive DME vendor without conducting the required history and physical to validate the need. (In fact, on Sept. 1, CMS began a demonstration project requiring mandatory prior authorization for power mobility devices in California, Florida, Illinois, Michigan, New York, North Carolina, and Texas.) Here are the Medicare coverage criteria for some of the equipment and supplies most commonly prescribed by family physicians:

Power operated vehicles (motorized scooters). Medicare covers a power operated vehicle (POV) when all of the following criteria are met:

- The patient has a mobility limitation that significantly impairs his or her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home,
- The patient's mobility limitation cannot be resolved sufficiently and safely by the use of an appropriately fitted cane or walker,
- The patient does not have enough upper extremity function to propel an optimally-configured manual wheelchair in the home to perform MRADLs during a typical day,
- The patient has the mental and physical ability to transfer safely to and from the POV and maintain safety while using the vehicle,
- The patient's home can accommodate use of the vehicle.

Power wheelchairs. A power wheelchair is covered by Medicare when all of the following criteria are met:

- The patient's condition is such that without the use of a wheelchair the patient would be confined to a bed or chair,
- A wheelchair is medically necessary, and the patient is unable to operate a wheelchair manually,
- The patient is capable of safely operating the controls for the power wheelchair,
- A POV would not meet the patient's need, or the patient could not safely operate it,
- The patient needs a power wheelchair for at least six months.

A patient who requires a power wheelchair is usually totally nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease or condition. Medicare won't cover a POV or a power wheelchair when the patient needs it only for mobility outside the home or when the patient can carry out MRADLs with another assistive device such as a cane, walker, or manual wheelchair.

Physician exam and documentation of medical necessity are required for all power mobility devices. The ordering physician must examine the patient and provide the DME supplier with documentation of the exam and of medical necessity within 45 days of the exam or hospital discharge date.

The physician may refer the patient to a physical therapist or occupational therapist for evaluation of physical abilities and limitations. In such cases, a report from the

About the Author

Dr. Borg is a family physician and health care consultant in Chicago, specializing in market and technical strategy for heath information, pharmaceutical, medical device, and health insurance companies. He has 20 years of experience as a senior executive for some of the nation's most prominent health care organizations. He is a member of the American Academy of Family Physicians Commission on Quality and Practice. Author disclosure: no relevant financial affiliations disclosed.

therapist should be included in the physician's documentation. For more information, including a checklist for use in the physician's exam, see the Centers for Medicare & Medicaid Services (CMS) fact sheet "Power Mobility Devices: Complying With Documentation & Coverage Requirements" at http://go.cms.gov/Qn1g8P.

Payment for the history and physical exam will be made through the evaluation and management code appropriate to the encounter. You may also report code G0372, which indicates that all of the documentation necessary to support the POV or power wheelchair prescription is included in the medical record and that the prescription and supporting documentation will be delivered to the DME supplier within 30 days after the face-to-face exam. Not all commercial carriers pay for G0372, and the Medicare allowed charge averages only $9 and change, but it's a help.

The Medicare benefit for a POV or power wheelchair includes all labor charges involved in the assembly and all covered additions or modification. It also includes support services, such as emergency services, delivery, set-up, education, and ongoing assistance with use of the POV or wheelchair.

CMS provides a brochure that may assist you in conversations with patients who request a POV or power wheelchair but fail to meet the Medicare guidelines for coverage. Download "Medicare's Wheelchair and Scooter Benefit" at http://1.usa.gov/N8lUYf.

Oxygen. Before Medicare will pay for oxygen, a certificate of medical necessity (CMN) is generally required. (Download the form at http://go.cms.gov/LSc4hL.) It is important to refer to your Medicare Administrative Contractor's local coverage determination for "Oxygen and Oxygen Equipment," as there may be specific requirements for your Medicare region. (Look up the local coverage determination for your state at http://go.cms.gov/OTmyJQ.) In determining coverage, the dates of treatment and testing are critical. For example, you should not list an initial date of need for home oxygen coverage that precedes the date of the order or the date of the test used to determine whether the coverage criteria are met. Once coverage is established, the estimated length of need, the circumstances, and the results of the testing that established the medical necessity at the outset will determine when you will need to recertify the need.

Qualifying tests must be conducted by the treating physician or a provider certified to conduct such tests within 30 days before the date of initial certification unless oxygen is ordered when the patient is discharged from the hospital, in which case the qualifying test must have occurred within 48 hours before discharge. Because of the potential for conflict of interest, the results of oximetry tests conducted by a DME supplier cannot be accepted to establish the need for home oxygen therapy services, either in initial claims or when accompanying recertification CMNs. When both arterial blood gas (ABG) and oximetry tests have recently been performed, greater weight is given to the ABG result. For patients tested while at rest, if arterial PO2 levels exceed 59 mm Hg or the arterial blood oxygen saturation exceeds 89 percent, oxygen will not be covered unless one of the other criteria is met. For more information, see "Oxygen Therapy Supplies: Complying With Documentation & Coverage Requirements" at http://go.cms.gov/QmVowm.

Diabetes supplies. Medicare generally covers the following diabetes supplies:

- Blood glucose monitors,
- Blood glucose test strips and lancets (the number supplied may differ for Type 1 and Type 2 diabetes),
- Calibration solutions and test strips.

Your order for diabetes supplies must include the item(s) to be dispensed, the frequency of testing ("as needed" is not acceptable), the length of need, your signature, and the signature date.

Medicare will pay only for supplies the beneficiary requests, and vendors cannot "auto refill" supplies. Vendors may contact the beneficiary regarding refills no sooner than seven days before the delivery/shipping date and may deliver the items no sooner than about five days before the patient finishes the current products. Patients will need a new prescription every six months. For more information, see "Glucose Testing Supplies: Complying With Documentation & Coverage Requirements" at http://go.cms.gov/MbsWBJ.

Understand your options

As you probably know from experience, patients may be prompted by direct-to-con-

If the patient lacks upper extremity strength, a power wheelchair may be appropriate.

Neither a POV nor a power wheelchair is appropriate unless it is needed for mobility-related activities of daily living.

Medicare requires a certificate of medical necessity documenting test results before it will pay for oxygen.

Medicare won't cover a scooter or a power wheelchair when the patient needs it only for mobility outside the home.

Medicare will cover diabetes testing supplies for beneficiaries with documented need.

The physician's order must include a description of the items ordered, testing frequency, and length of need.

sumer marketing to request prescriptions for DME. Unsurprisingly, the DME may not be medically necessary. When you do receive such a request, be on the alert for possible fraud and abuse. Suspected fraud and abuse can be reported to the U.S. Department of Health & Human Services Office of the Inspector General (OIG). Additional information can be found at the OIG website at http://oig.hhs.gov/fraud/report-fraud/index.asp.

It is the policy of the American Academy of Family Physicians that when a family physician receives unsolicited requests from vendors for DME or supplies, the physician may disregard the request without need to respond to the vendor or notify the patient. However, the physician is encouraged to educate the patient at the next clinic visit regarding the proper indication for DME or supplies. Dealing with unsolicited or unsupportable requests for DME can be a hassle, but it does not have to be problematic. If you understand the law and Medicare requirements and remember that you have options in responding to such requests, you will be able to help your patients appropriately without putting yourself or your practice at risk. FPM

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