Bard: Intermittent Catheters

A guide to

REIMBURSEMENT OF INTERMITTENT CATHETERS

BARD

Intermittent catheterization is a covered Medicare benefit when basic coverage criteria are met and the individual or caregiver can perform the procedure. Bard Medical provides this information to help answer questions about coding and reimbursement for intermittent catheters.

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Coverage Criteria

Medicare considers an intermittent catheter as a prosthetic benefit—it's purpose is to replace some part of the body that is permanently inoperative or malfunctioning. For this reason, the primary criteria for Medicare coverage of BARD® intermittent catheters is that the individual have permanent urinary incontinence or urinary retention.

Utilization Guidelines

Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure. For each episode of covered catheterization, Medicare will cover:

One catheter (A4351, A4352) and an individual packet of lubricant (A4332); or

One sterile intermittent catheter kit (A4353) if additional coverage criteria (see page 4) are met.

[1] Intermittent catheterization using a sterile intermittent catheter kit (A4353) is covered when the patient requires catheterization and the patient meets one of the following criteria (1-5):

1. The patient resides in a nursing facility.

2. The patient is immunosuppressed, for example (not all-inclusive):

    - on a regimen of immunosuppressive drugs post-transplant
    - on cancer chemotherapy
    - has AIDS
    - has a drug-induced state such as chronic oral corticosteroid use

3. The patient has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization,

4. The patient is a spinal cord injured female with neurogenic bladder who is pregnant (for duration of pregnancy only),

5. The patient has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization with A4351/A4352 and sterile lubricant A4332, twice within the 12-month prior to the initiation of sterile intermittent catheter kits.

A patient would be considered to have a urinary tract infection if they have a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of one or more of the following signs, symptoms or laboratory findings:

- Fever (oral temperature greater than 38º C [100.4º F])
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
- Physical signs of prostatitis, epididymitis, orchitis
- Increased muscle spasms
- Pyuria (greater than 5 white blood cells [WBCs] per high-powered field)

[2] Documentation Requirements

To begin the claims process and get your intermittent catheter supplies, you'll need a doctor's order or prescription. Be sure this documentation includes the following:

- The patient's name
- Description of the item, including product brand name
- Approximate quantity used each month
- Order start date
- Treating physician signature with date

In cases where quantity used each month exceeds that originally prescribed by your doctor, you may need additional documentation to ensure reimbursement. A pharmacy or medical supplies dealer should be able to help you get medical records that indicate this need due to permanent urinary incontinence or urinary retention.

Categories and Healthcare Common Procedure Coding System (HCPCS) Codes

Intermittent catheters are classified into generic descriptive categories and are assigned an alphanumeric code. These HCPCS codes are used when billing for your catheter supplies.

HCPCS Description

- A4351 Intermittent urinary catheter; straight tip, with or without coating, each
- A4352 Intermittent urinary catheter; coude (curved) tip, with or without coating, each
- A4353 Intermittent urinary catheter, with insertion supplies
- A4332 Lubricant, individual sterile packet, for insertion of urinary catheter with sterile technique

The following table represents the usual maximum number of supplies:

Code (#/mo)
A4332 (200)
A4351 (200)
A4352 (200)
A4353 (200)

Frequently Asked Questions

How many intermittent catheters does Medicare allow?[3]

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.

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.[3]

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.

What if I need more supplies than the usual maximum listed in the Medicare guidelines?[3]

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.

I understand the new criteria effective on April 1, 2008 for coverage of sterile kits is different from the previous criteria. If I qualified for the sterile kits under the pre-April 1, 2008 guidelines, am I grandfathered under the new policy?[3]

Most likely you are. If you were using sterile catheter kits (A4353) under the old guidelines and met the requirements necessary to be covered (based on Medicare's urological supplies local coverage decisions), you should still be covered. The previous guidelines required two infections while using "clean technique" (washing and reusing catheters). The newest criteria requires two infections while using sterile, single-use catheters (A4351, A4352). Your medical record must document the need and show that coverage criteria were met under the old guidelines for you to be grandfathered under the new criteria.

Has the Department of Veterans Affairs made any changes to their policies regarding and the use of sterile catheters?

An informational letter from the Under Secretary for Health of Department of Veterans Affairs, dated December 13, 2007, details new catheterization recommendations for VA clinicians, specifically, that they:

- Follow the manufacturer's instructions for catheter use
- Not re-use catheters identified as single-use devices in any setting
- Provide patients an adequate number of catheters to use a new sterile catheter each catheterization

What can I do about recurrent urinary tract infections? I've started using straight intermittent catheters, but they don't seem to help.

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.

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

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

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?[1]

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.

What information does Medicare require in an audit to cover payment for the type and quantity of urological supplies ordered by my doctor?[3]

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:

- Your diagnosis and prognosis
- Clinical course (worsening or improving)
- Duration of your condition
- Nature and extent of functional limitations
- Other therapeutic interventions and results
- Past experience with related items
- A statement from the physician specifying how often the patient (or caregiver) performs catheterizations

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.

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

Yes. If your supplier accepts assignment for Medicare, you will need to pay the supplier 20% co-insurance 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.

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

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

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

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.

I'm having trouble getting my Bard® brand of catheters. What can I do?

Contact the Bard helpline at 1-800-526-4455 or email us at bard.helpline@crbard.com if you're having difficulties. Also, keep in mind that all brands of intermittent catheters are reimbursed at the same dollar amount allowable under Medicare guidelines.

Who can I contact with further questions?

Please call the Bard helpline at 1-800-526-4455 or email us at bard.helpline@crbard.com

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