UNIVERSITY OF MICHIGAN HEALTH
MICHIGAN MEDICINE

Orthotics and Prosthetics Center Patient Information

What is the contact information for the Orthotics and Prosthetics Center?

There are multiple locations/clinics that are part of the Orthotics and Prosthetics Center. Hours of operation vary by location:

- South Industrial:
  - Monday – Friday, 7:30 a.m. – 5:00 p.m.
- Brighton Center for Specialty Care:
  - Monday – Friday, 8:00 a.m. – 5:00 p.m.
- Northville Health Center:
  - Monday – Friday, 8:00 a.m. – 5:00 p.m.
- University Hospital:
  - Monday – Friday, 8:00 a.m. – 5:00 p.m.

To contact any of the locations listed above during their hours of operation:

- Call: (734) 973-2400 (your call will be routed as appropriate)
- Fax: (734) 975-4726

Please note: If you have a medical emergency, please call 9-1-1.

For after-hours emergency services:

- Call: (734) 936-6267
- Ask for the Orthotist on call

How long will it take for me to receive my device?

After your evaluation, your provider will plan for the delivery of your device. They will consider the time needed to obtain or manufacture the orthosis or prosthesis.

Below are the approximate timeframes for delivery of some devices we commonly provide:

- Custom orthotic devices: 2-8 weeks after your initial evaluation
- Custom prosthetic devices: 4-12 weeks after your initial evaluation
- Prefabricated orthotic and prosthetic items: 2-10 days after your initial evaluation
- Over the counter: typically, dispensed within one day, though this may vary depending on inventory

What information should I know about rental versus purchased items?

Medicare has defined certain items as being "**capped rental items**," including suction pumps, external infusion pumps, hospital beds, wheelchairs, mattress overlays, nebulizers, and patient lifts. For these items, Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which ownership of the equipment, as well as responsibility for repair/servicing, is transferred to the Medicare beneficiary.

Medicare has defined certain items as "**inexpensive or routinely purchased items**," including home blood glucose monitors, external infusion pump suppliers, external infusion pump suppliers, canes/crutches, wound care items, and ostomy care items. A Medicare beneficiary may either rent or purchase these items, although Michigan Medicine does not offer rental of items in this category. If rented from another supplier, the total amount paid for an item obtained on a monthly rental basis may not exceed the fee schedule purchase amount.

What do I do if I need repairs to my device?

We will make any necessary repairs to your device free of charge during the 90-day warranty period. After 90 days, you will need to ask your doctor for a new prescription if the device needs repairs or replacement.

What should I know about the warranty on my device(s)?

Orthotics and Prosthetics Center honors all warranties expressed and implied under State Law. We will notify all Medicare beneficiaries regarding warranty coverage for any supplies sold.

Orthotics and Prosthetics Center will not charge the beneficiary or the Medicare program for the repair or replacement of items covered by Medicare or services covered under warranty. In addition, beneficiaries will receive an owner's manual with warranty information for all DMEPOS where this manual is available.

Can I return my device?

You may not return devices if they are:

- Custom-made
- Modified, damaged, or significantly worn

You can return **off the shelf items** (not specially made or custom-designed) within 14 days of purchase if returned:

- In the original packaging
- In an unused condition
- With the receipt

What do I do if I have concerns about my device?

If you feel your device is not meeting your needs:

- Please call us at (734) 973-2400 as soon as possible.
- We will do everything possible to accommodate your needs.

If we are not able to resolve your concerns:

- You may contact our Patient Relations & Clinical Risk (PRCR) office at (877) 285-7788.
- PRCR office hours of operation: Monday – Friday, 8:00 a.m. – 4:00 p.m.

If you are a Medicare patient, in addition to the above resources, you can also call 1-800-MEDICARE (1-800-633-4227) with questions.

Medicare DMEPOS Supplier Standards:

These standards, in their entirety, are listed in 42 C.F.R. 424.57(c) and went into effect December 11, 2000.

(1) Operates its business and furnishes Medicare-covered items in compliance with all applicable Federal and State licensure and regulatory requirements;
(2) Has not made, or caused to be made, any false statement or misrepresentation of a material fact on its application for billing privileges. (The supplier must provide complete and accurate information in response to questions on its application for billing privileges. The supplier must report to CMS any changes in information supplied on the application within 30 days of the change.);
(3) Must have the application for billing privileges signed by an individual whose signature binds a supplier;
(4) Fills orders, fabricates, or fits items from its own inventory or by contracting with other companies for the purchase of items necessary to fill the order. If it does, it must provide, upon request, copies of contracts or other documentation showing compliance with this standard. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal Government Executive Branch procurement or nonprocurement program or activity;
(5) Advises beneficiaries that they may either rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental durable medical equipment, as defined in §414.220(a) of this subchapter. (The supplier must provide, upon request, documentation that it has provided beneficiaries with this information, in the form of copies of letters, logs, or signed notices.);

(6) Honors all warranties expressed and implied under applicable State law. A supplier must not charge the beneficiary or the Medicare program for the repair or replacement of Medicare covered items or for services covered under warranty. This standard applies to all purchased and rented items, including capped rental items, as described in §414.229 of this subchapter. The supplier must provide, upon request, documentation that it has provided beneficiaries with information about Medicare covered items covered under warranty, in the form of copies of letters, logs, or signed notices;
(7) Maintains a physical facility on an appropriate site. The physical facility must contain space for storing business records including the supplier's delivery, maintenance, and beneficiary communication records. For purposes of this standard, a post office box or commercial mailbox is not considered a physical facility. In the case of a multi-site supplier, records may be maintained at a centralized location;
(8) Permits CMS, or its agents to conduct on-site inspections to ascertain supplier compliance with the requirements of this section. The supplier location must be accessible during reasonable business hours to beneficiaries and to CMS, and must maintain a visible sign and posted hours of operation;
(9) Maintains a primary business telephone listed under the name of the business locally or toll-free for beneficiaries. The supplier must furnish information to beneficiaries at the time of delivery of items on how the beneficiary can contact the supplier by telephone. The exclusive use of a beeper number, answering service, pager, facsimile machine, car phone, or an answering machine may not be used as the primary business telephone for purposes of this regulation;
(10) Has a comprehensive liability insurance policy in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. In the case of a supplier that manufactures its own items, this insurance must also cover product liability and completed operations. Failure to maintain required insurance at all times will result in

revocation of the supplier's billing privileges retroactive to the date the insurance lapsed;

(11) Must agree not to contact a beneficiary by telephone when supplying a Medicare-covered item unless one of the following applies:

(i) The individual has given written permission to the supplier to contact them by telephone concerning the furnishing of a Medicare-covered item that is to be rented or purchased.

(ii) The supplier has furnished a Medicare-covered item to the individual and the supplier is contacting the individual to coordinate the delivery of the item.

(iii) If the contact concerns the furnishing of a Medicare-covered item other than a covered item already furnished to the individual, the supplier has furnished at least one covered item to the individual during the 15-month period preceding the date on which the supplier makes such contact.

(12) Must be responsible for the delivery of Medicare covered items to beneficiaries and maintain proof of delivery. (The supplier must document that it or another qualified party has at an appropriate time, provided beneficiaries with necessary information and instructions on how to use Medicare-covered items safely and effectively);

(13) Must answer questions and respond to complaints a beneficiary has about the Medicare-covered item that was sold or rented. A supplier must refer beneficiaries with Medicare questions to the appropriate carrier. A supplier must maintain documentation of contacts with beneficiaries regarding complaints or questions;

(14) Must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. The item must function as required and intended after being repaired or replaced;

(15) Must accept returns from beneficiaries of substandard (less than full quality for the particular item or unsuitable items, inappropriate for the beneficiary at the time it was fitted and rented or sold);
(16) Must disclose these supplier standards to each beneficiary to whom it supplies a Medicare-covered item;
(17) Must comply with the disclosure provisions in §420.206 of this subchapter;
(18) Must not convey or reassign a supplier number;
(19) Must have a complaint resolution protocol to address beneficiary complaints that relate to supplier standards in paragraph (c) of this section and keep written complaints, related correspondence and any notes of actions taken in response to written and oral complaints. Failure to maintain such information may be considered evidence that supplier standards have not been met. (This information must be kept at its physical facility and made available to CMS, upon request.);
(20) Must maintain the following information on all written and oral beneficiary complaints, including telephone complaints, it receives:

(i) The name, address, telephone number, and health insurance claim number of the beneficiary.

(ii) A summary of the complaint; the date it was received; the name of the person receiving the complaint, and a summary of actions taken to resolve the complaint.

(iii) If an investigation was not conducted, the name of the person making the decision and the reason for the decision.

(21) Provides to CMS, upon request, any information required by the Medicare statute and implementing regulations.
(22) All suppliers of DMEPOS and other items and services must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment for those specific products and services.

(23) All DMEPOS suppliers must notify their accreditation organization when a new DMEPOS location is opened. The accreditation organization may accredit the new supplier location for three months after it is operational without requiring a new site visit.
(24) All DMEPOS supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. An accredited supplier may be denied enrollment or their enrollment may be revoked, if CMS determines that they are not in compliance with the DMEPOS quality standards.
(25) All DMEPOS suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation. If a new product line is added after enrollment, the DMEPOS supplier will be responsible for notifying the accrediting body of the new product so that the DMEPOS supplier can be re-surveyed and accredited for these new products.