NAMDRC

WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY, CRITICAL CARE AND SLEEP MEDICINE

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Durable Medical Equipment 2020

The Centers for Medicare and Medicaid Services (CMS) published an update to the Durable Medical Equipment (DME) program in early November. This update marks a noticeable departure from the policies the Agency had been implementing in recent years. The impact of the federal DME policy on patient care is often underestimated. The increasing documentation requirements have been a burden on physician time, competitive bidding has reduced patient services and the complex coding and payment policy, focused on cost savings, has erected a barrier to the introduction of new technology. The agency has finalized the regulations for 2020 with the expressed goal of simplifying the required documentation, improving patient access and improving the pathway for introduction of new technology.

The Burden on Physicians

A number of reports from the Office of Inspector General of Health and Human Services as well as from the Government Accountability Office have focused on waste, fraud, and abuse within the Durable Medical Equipment sector. Analysis of 2018 Medicare Payment Data for DME claims suggested an improper payment rate of 35.5 percent, accounting for approximately 8.2 percent of the overall Medicare fee for service improper payment rate. Although there have been several high profile cases of fraud in the system, much of this was due to documentation issues rather than outright fraud. In a 2017 effort to reduce improper payments, CMS tightened up the documentation requirements and had even designed detailed templates to be used with prescriptions for oxygen and non-invasive ventilation as well as other items of medical equipment. The Agency has reversed course in the recently released regulations. The finalized rule creates one standardized set of required elements for all DME orders. There is no mention of the pre-existing Provider Documentation Manual or the documentation templates. The current rule simply states that a written order or prescription should include:

- The beneficiary name or Medicare Beneficiary Identifier.
- A general description of the item.

The ***WASHINGTON WATCHLINE*** *is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.*

NAMDRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

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NAMDRC 43rd Annual Meeting and Educational Conference will be held:
March 12– 14, 2020
The Scottsdale Resort at McCormick Ranch
Scottsdale, AZ

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"NAMDRC will directly affect your practice more than any other organization to which you belong."

- The quantity to be dispensed, if applicable.
- The order date.
- The treating practitioner name or national provider identifier.
- The treating practitioner signature.
- A date and time on the written order or prescription.

The final rule also creates a master list of DME items that require a documented face-to-face encounter and written order prior to delivery.

Included in the Master List are:

A7025 High Frequency Chest Wall Oscillation System Vest
E0424 Stationary Oxygen System
E0431 Portable Oxygen System
E0433 Portable Liquid Oxygen System
E0439 Stationary Oxygen System
E0465 Home Ventilator with Invasive Interface
E0466 Home Ventilator with Non-invasive Interface
E0470 Respiratory Assist Device, Bi-level Without Backup Rate
E0471 Respiratory Assist Device, Bi-level With Backup Rate, Non-invasive
E0472 Respiratory Assist Device With Backup Rate, Invasive
E0483 High Frequency Chest Wall Oscillation Air Pulse Generator
E0550 Humidifier for IPPB or O2
E0575 Ultrasonic Nebulizer
E0600 Respiratory Suction Pump
E0601 CPAP
E1390 Oxygen Concentrator, Single Delivery
E1391 Oxygen Concentrator, Dual Delivery
E1392 Portable Oxygen Concentrator
E1405 Oxygen and Water Vapor Enriching System with Heat
E1406 Oxygen and Water Vapor Enriching System without Heat
K0730 Controlled Dose Drug Inhalation System
K0738 Portable Gaseous Oxygen System

CMS has indicated the prescriber must document and communicate to the DME supplier that they had a face-to-face encounter with the beneficiary within the 6 months preceding the date of the written order or prescription. The face-to-face encounter must be documented in the pertinent portion of the medical record and should include information about the clinical condition for which the durable medical equipment is prescribed.

The Impact of Competitive Bidding

Most readers will be aware that NAMDRC has highlighted the decline in availability of liquid oxygen under the competitive billing program. Interestingly, in this finalized rule, CMS recognizes that delivery costs, including employee wages, affect a suppliers' overall costs more than equipment acquisition costs. The Agency references a study for the American Association for Homecare titled "A Comprehensive Cost Analysis of Medicare Home Oxygen Therapy", which used a survey of 74 oxygen suppliers to determine which factors are more important in influencing oxygen suppliers' cost of furnishing oxygen and oxygen equipment. The study found that equipment acquisition only accounted for 28 percent of the cost of providing medically necessary oxygen to Medicare beneficiaries. This study concluded that services such as preparing and delivering equipment, driving to the home to repair and maintain equipment, training and educating patients, obtaining

required medical necessity documentation, customer service, and operating and overhead costs accounted for 72 percent of overall costs. Importantly, they recognized that as a supplier increased their volume, the costs associated with labor, delivery, and overhead also increase proportionally.

In the 2019 finalized DME rule, CMS made a slight increase in the compensation for liquid oxygen equipment and contents with the commitment that they would track availability. There was no discussion of this issue in the current document. A number of patient and physician groups, including NAMDRC, have submitted a joint letter to CMS calling for the agency to use its authority to "carve out" portable liquid oxygen from the competitive bidding program. It has also been suggested that Congress eliminate the budget neutrality requirement related to CMS payment for medical oxygen and the required equipment.

Realistic Compensation for New Technology

One of NAMDRC's main goals is to make cutting edge medical care available to our patients. For patients with respiratory disease this often involves new and improved respiratory support devices. Obtaining a Healthcare Common Procedure Coding System (HCPCS) code and a realistic payment is a major gateway to the marketplace for new or improved medical devices. Decisions by CMS staff and the Medicare Durable Medical Equipment Administrative Contractors play a critical role in this pathway. Typically, more than 100 applications for new or revised codes are submitted to the CMS HCPCS Workgroup each year. Approximately one-third of these applications are for new codes. The assignment of new codes and payment amounts has become increasingly complex, opaque and subjective. There have been two major issues. The first has been decisions by CMS staff on whether a device is unique to the marketplace or simply a modification of an existing device. The second is the decision of how much to pay for a device determined to be unique. Adverse decisions by CMS staff or by medical directors employed by Medicare Administrative Contractors have had an impact on the availability of some new devices as well as funding for research and development of new designs.

Conflict has arisen between manufacturers and CMS over the determination of uniqueness. CMS has publicly expressed skepticism about the integrity of the data and information submitted by manufacturers on their applications. On their part, the CMS process for making a determination of uniqueness has been opaque and often poorly informed. This conflict led to a proposal by CMS, in a previous rule, that uniqueness of a device would be established by a Technology Assessment Panel comprised of CMS staff and outside experts. Those experts would, of course, be selected by CMS.

In the October 2019 ***Washington Watchline*** we noted that, in response to Congressional pressure, CMS was prepared to accept the Food and Drug Administration decisions on new medical devices for the hospital setting. In the 2020 DME rule CMS has taken some small steps toward improving the pathway for new medical devices for the outpatient setting. It appears that CMS will abandon the laborious policy of technology assessments to establish the uniqueness of a new DME application. CMS has clarified that the determination of uniqueness vs duplication will be based on a comparison of:

-Physical components
-mechanical components
-electrical components
-function and intended use
-additional attributes and features.

It appears that the responsibility for the determination will remain with the HCPCS Workgroup but hopefully there will be increased transparency.

Establishing an appropriate level of reimbursement for a device described by new HCPCS codes has also been a challenge. CMS has employed a methodology that has been adjusted over the last several years but is still dependent on comparison with existing compensation for technologies already approved for coverage and payment. Recently, CMS proposed that fee schedule amounts for new devices should also be established by their Technology Assessment Panel. In the 2020 DME rule, CMS has now taken the position that a payment may be established using supplier price lists, including catalogs and other retail price lists that provide information on commercial pricing for the item. They have also indicated that they are willing to include payments made by Medicare Advantage plans and non-Medicare payer data.

Looking Forward

While the 2020 Durable Medical Equipment rules seem to be a step forward the program still retains a significant amount of subjective decision making that will be influenced by cost containment policies. The steps noted above, combined with the loosening of the New Technology Payment Policy in the 2020 Inpatient Prospective Payment rule, suggest that the agency is preparing to take a long term view of patient care. These changes have been, to a great extent, influenced by grass roots patient advocacy and Congressional pressure. If you are aware of examples of barriers to clinically appropriate medical care, as defined by our medical organizations, the NAMDRC office would like to be informed.

PRODUCT AND TECHNOLOGY NEWS!

NAMDRC is providing this space to our benefactors and patrons who provide us with information about new products and innovations related to pulmonary medicine. NAMDRC reserves the right to edit this copy as appropriate.

NAMDRC Membership Benefits AT *A GLANCE...*

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

https://www.namdrc.org/content/issue-advocacy

One of NAMDRC's primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC's key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

NAMDRC

MEMBERSHIP OPPORTUNITIES WITH NAMDRC

INSTITUTIONAL MEMBERSHIPS

NAMDRC has restructured its membership opportunities to more accurately reflect how physicians practice medicine, acknowledging that genuine "private practice" is nowhere near as prevalent today as it was even five years ago. Physicians are now employees of hospitals and medical systems.

To improve our communication with you and hospital based colleagues, we have revamped our dues structure, with individual/small practice remaining basically the same as it is today. We are renaming our group practice options into two specific categories:

Institutional Membership/Gold for institutions that identify at least seven physicians, but no more than 20 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive two half price registrations for our Annual Conference at the standard member rate.

Institutional Membership/Platinum for institutions that identify at least 21, but no more than 50 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive four half price registrations for our Annual Conference at the standard member rate.

Small Group Practice (1-6 physicians)	$295 for renewal
	$395 for new member (includes one-time $100 initiation fee.)
Gold Institutional Membership (7-20 physicians)	$1750
Platinum Institutional Membership (21 – 50 physicians)	$2500

If you are based at a particular institution, we believe this is an excellent way to bring NAMDRC and its benefits to the attention of many of your colleagues. And the aggregate cost, per membership, drops dramatically under these new membership categories.

RENEW NOW!

JOIN NOW!

Go to www.namdrc.org and join and/or renew your membership online.

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NAMDRC INSTITUTIONAL MEMBERSHIP APPLICATION

Please select the category you are applying for:

☐ Small Group Practice (1-6 physicians)	$295/year for renewal
☐ NEW Small Group Practice (1-6 Physicians) *(includes one-time $100 initiation fee)*	$395 for new member/year
☐ Gold Institutional Membership (7-20 physicians) *Includes two half price registrations for NAMDRC Annual Conference at the standard member rate.*	$1750/year
☐ Platinum Institutional Membership (21-50 physicians) *Includes two half price registrations for NAMDRC* Annual Conference at the standard member rate.	$2500/year

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person:_____

Email address: _____

Address: _____

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City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION *(Make check payable to "NAMDRC")*

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

Name as it Appears on Credit Card _____

Billing Address (If Different From Above) _____

Printed Name_____ Signature _____

Email _____ Phone_____

USE THE ATTACHED MEMBERSHIP FORM TO LIST ALL MEMBERS OF YOUR GROUP

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NAMDRC INSTITUTIONAL MEMBERSHIP FORM

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