PULMONARY MEDICINE HEALTH POLICY SUMMIT

For 35 years NAMDR, the National Association for Medical Direction of Respiratory Care has been engaging Federal health policymakers on a wide range of issues affecting the practice of pulmonary medicine in physician offices, hospitals, and the home. To broaden the dialogue between the pulmonary medicine community and these policymakers, in cooperation with the American College of Chest Physicians, the American Thoracic Society, the American Association of Respiratory Care, the National Home Oxygen Patients Association and the COPD Foundation we are hosting a unique policy forum to provide for thoughtful, engaging discussions on a wide range of policies affecting the delivery of health care in pulmonary medicine.

On April 8-9, 2013 all the key pulmonary related societies and others interested in pulmonary related health policy will convene for the Pulmonary Medicine Health Policy Summit in Washington, DC. The goal of the Summit is to address a limited number of specific issues facing the pulmonary medicine community that lend themselves to regulatory and/or legislative solutions. A detailed strategic roadmap will be developed immediately after the two day conference and shared broadly within the pulmonary medicine community. The issues to be addressed have been vetted by the respective societies and will involve several hours of discussion from experts, including members of Congress and their staffs, representatives of regulatory agencies and nationally recognized experts in the respective specific issues.

The participating societies and additional experts will discuss the identified issues in an open forum, coordinated by a professional facilitator. The participating societies and additional experts intimately familiar with the legislative and regulatory processes necessary to implement recommendations will convene for a third day to outline specific regulatory and legislative strategic approaches to address the issues identified during the previous two days. Once the respective societies have had the opportunity to review the strategic roadmap, it will be released to the general pulmonary medicine community.

"NAMDRC will directly affect your practice more than any other organization to which you belong."
Several variables were taken into consideration regarding identification of issues. First, issues needed to be unique to pulmonary medicine. Secondly, there needs to be a reasonable expectation that these issues can be resolved through regulatory and/or legislative changes to national health policy. The issues to be addressed include:

**NHLBI funding of COPD research**

When comparisons are made to the impact of COPD on the economy compared to other chronic diseases such as diabetes, AIDS, etc., most would agree that research to address the 3rd leading cause of death in the United States is woefully inadequate. Management of COPD is a public health issue that does not lend itself to easily recognized or implemented solutions by the private sectors. Despite being the nation’s third leading cause of death, with nearly 140,000 lives lost annually, COPD funding from the National Institutes of Health (NIH) is only $108 million per year. By contrast, Diabetes which, like COPD, is a chronic disease, claims fewer than 70,000 lives annually, yet NIH funding for that disease is more than $1 billion per year.

**Performance measures for pulmonary medicine, their impact on health policy and the physician’s ability to practice state of the art, patient focused care**

The societies agree that pulmonary medicine is not moving as swiftly as other segments of the medical community, and that this can lead to the development of performance measures without direct, coordinated input from the pulmonary medicine community. As the health care delivery system shifts away from the traditional fee-for-service model to one significantly more focused on quality measures and payment tied to identifiable outcomes, it is critical that the pulmonary medicine community immerse itself in these issues. During its discussion in May 2012, the NQF Pulmonary and Critical Care Steering Committee identified important gap areas for further measure development. These included:

- measures focused on in-hospital, severity adjusted, high mortality conditions such as 30-day mortality rates, readmissions, sepsis and acute respiratory distress syndrome (ARDS);
- measures for earlier identification of sepsis at the compensated stage before it becomes decompensated septic shock and appropriate resuscitative measures;
- measures of efficiency and over utilization;
- measures that focus on palliative care for patients with end-stage pulmonary conditions;
- better measures of comprehensive asthma education;
- measures of unplanned pediatric extubations;
- measures for effectiveness and outcomes of post-acute care for COPD patients;
- measures of functional status;
- measures for quality of spirometries in relation to meeting the American Thoracic Society (ATS) standards for pediatric and adult patients.

With the imposition of quality measures it is important to remove any barriers to physician compliance that may exist. For example, reducing the complications of deep vein thrombosis and pulmonary embolism following hospitalization have been high priorities for CMS. CMS includes Deep Vein Thrombosis and Pulmonary Embolism Following Total Knee Replacement and Hip Replacement in the list of preventable Hospital Acquired Conditions. For 2013, DVT prophylaxis following knee surgery has been added to the individual quality measures for the physicians quality reporting system. In June of 2012, the American College of Chest Physicians released an updated version of their comprehensive antithrombotic guidelines. The updated guidelines included specific recommendations regarding the use of intermittent mechanical compression devices in the post hip and knee surgery patient. Medicare recognizes the benefit and covers the cost of pneumatic compression pumps for the treatment of lymphedema and the treatment of venous insufficiency however, at this time, despite the application of the quality indicators and the demonstrated need, intermittent pneumatic compression devices are not a Medicare covered benefit for DVT prophylaxis in the outpatient setting.
Telemedicine for pulmonary related diseases

Many health policy experts are increasingly citing advances in information technology as part of a menu of broad solutions to rising health care costs as well as access to health care services producing a vigorous debate over cost effectiveness. Despite the debate, both the federal government and the private sector have been moving forward with the adoption of telemedicine technology. The Department of Defense and the Veterans Administration, the two largest government IT customers, are engaged in intertwined modernization programs and have been enlisting a growing number of telemedicine technologies to help service members discharged from the armed forces to manage diabetes, high blood pressure and other physical and mental health issues from their homes. The Health Resources and Services Administration (HRSA) has been working to increase and improve the use of telehealth to meet the needs of underserved people, including those living in rural and remote areas, those who are low-income and uninsured or enrolled in Medicaid. The U.S. Department of Agriculture plans to award 45 telehealth grants through its Distance Learning and Telemedicine Program in 2013. The Institute of Medicine has recently released a workshop summary on the role of telehealth in the evolving healthcare environment. In recent years there has been a steady increase in the number of telemedicine services reimbursed by Medicare and Medicaid. On Jan. 1, 2012, Medicare initiated coverage of smoking cessation services provided by video conferencing. Also, in 2012, CMS established a final rule to streamline credentialing processes for physicians and other practitioners providing telemedicine services.

The American Telemedicine Association projects an exponential growth in the adoption of telemedicine and mHealth technologies as a record number of consumers are entering fee-capped managed care insurance plans. Some insurers are making networks of providers available to their consumers online, extending care into homes and workplaces. These include Blue Cross Blue Shield of Hawaii, Blue Cross and Blue Shield of Minnesota, OptumHealth (a division of United Healthcare) and HealthNow New York among others. Managed Care, which pays a flat fee to treat health conditions, creates a powerful incentive for providers to leverage the power of remote healthcare technologies to maintain or improve quality and lower costs.

Recognizing the inevitable growth in the use of telemedicine, the AMA has actively encouraged all national specialty societies to develop appropriate practice parameters to address the various applications of telemedicine and guide quality assessment and to work with state societies to develop comprehensive practice standards and guidelines and has offered to assist societies in these efforts.

The issue of hospital readmissions puts significant pressure on home monitoring of pulmonary related health issues, and patient compliance with a treatment action plan is integral to this discussion. It is the view of NAMDR that the pulmonary medicine community needs to explore telemedicine applications unique to pulmonary medicine. This issue crosses a wide spectrum of settings including the critical care unit, the nursing home, the outpatient clinic and the home setting. It is critical that the community move this facet of pulmonary medicine forward with an aggressive and direct strategy.

Oxygen payment reform

Medicare expenditures for long term oxygen therapy account for the largest single item under the durable medical equipment benefit. The current payment methodology is more than 25 years old and has not kept up with the advent of newer technologies, some of which are now more than a decade old. The current payment system results in the greatest payment for the cheapest devices (stationary concentrators) and the lowest payment amount for newer, standard of care portable devices. This can lead to access issues as providers find it difficult to shift their inventories of large cylinders to more clinically appropriate systems. Improving this situation is complicated by the realities of competitive bidding and its structure that requires providers to bid on payment for specific codes. Any change to payment formulas would unquestionably be chaotic to that program, but serious questions surrounding access and clinical appropriateness of device selection are driven by the current payment dichotomy.
Audits, Documentation and the Electronic Health Record

While all providers are understandably subject to scrutiny of their bills merely because of the size of the Medicare program, numerous issues appear unique to pulmonary medicine. For example, physicians who focus their practice on sleep may find it difficult to order CPAP and related devices and comply with requirements for e-prescribing because the supplier community has not embraced (nor are they required to) the costly, steep learning curve technology. Because pulmonary physicians prescribe oxygen, CPAP, ventilators, and Part B drugs/nebulizers, the landscape is not friendly.

Identifying all the documentation requirements that CMS payers impose for proper claims processing can be a notable challenge, and those requirements are often subject to subjective interpretation, invariably leading to payment denials. For example, two Medicare Administrative Contractors (MACs) were denying payment for pulmonary rehabilitation services because each individual claim did not identify the supervising physician even though the statute explicitly indicates that such supervision is presumed to be met when the service is provided in a hospital.

This two day program is open to everyone who is interested in the pulmonary medicine policy issues that are going to be addressed by national experts. The registration fee includes admission to all sessions during the two days of the open conference, breakfasts, coffee breaks, and lunches. There is no continuing medical education credit offered at this conference. A block of rooms has been reserved at the Hyatt Regency Capitol Hill for those wishing to attend. It is expected that physicians, allied health professionals, patients, policy experts and representatives of industry will compose the vast majority of attendees. For more information, contact the NAMDRC Executive Office at 703-752-4359 or visit the website at www.namdrc.org

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REMINDER — US GRANT HOTEL RESERVATIONS MUST BE MADE BY FEBRUARY 19TH!!!!

Don’t forget to make your hotel reservations before Tuesday, February, 19, 2013 for the NAMDRC 36TH Annual Meeting and Educational Conference to be held in San Diego, CA in order to receive the special guaranteed rate of $234 per night plus tax. These special rates cannot be guaranteed after that date.

To make reservations and to receive the special room rate for the period of March 20–23, 2012, contact the Hotel Reservations Department at 1-866-837-4270. You must identify yourself as a participant in the NAMDRC Group when you make your reservations. OR, go to our direct reservation link on-line at:

https://www.starwoodmeeting.com/Book/NAMDRC2013

NOTE: The only rooms available at the US Grant are in our NAMDRC room block. This means that the US Grant is almost sold out. So….don’t delay in booking your room!!
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.
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 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.

http://www.namdrc.org/coding.html

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.
Two Easy Ways to become a NAMDRC member
1. Go to www.namdr.org and register for membership online.
2. Mail this application to:
   NAMDRC
   8618 Westwood Center Drive, Suite 210
   Vienna, VA 22182-2222

Please print clearly or type:

Name (Last)   (First)   (MI)
Degree
Address
City   State   Zip
Telephone   Fax
E-mail

Facilities with which you are affiliated

Please indicate ALL the areas that apply to your practice:

☐ Respiratory Care Management
☐ Anesthesiology
☐ Sleep Disorders
☐ Pulmonary Rehabilitation
☐ Skilled Nursing Facility
☐ Hyperbaric Oxygen Therapy
☐ Critical Care
☐ Home Health Services
☐ Physiology Assessments

In accordance with IRS Regulations, 95% of your 2013 Annual Dues are tax deductible. NAMDRC’s Federal Tax ID # is 74-2020908.

For More Information, Contact NAMDRC
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Web Site: www.namdr.org

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.