The Proposed Medicare Physician Fee Schedule for 2018

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) for 2018. Physician compensation for services to Medicare beneficiaries is based on national relative values (RVUs) that have been established by combining values for physician work, practice expense, and malpractice insurance expense. On average, physician work represents about 50.9 percent of payment for a service under the fee schedule, practice expense about 44.8 percent, and malpractice insurance about 4.3 percent. The RVU for each physician service is adjusted for geographic cost variations and multiplied by a conversion factor (CF) to convert the RVUs into dollar payment rates.

Prior to the passage of The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) the conversion factor was determined annually by applying the sustainable growth rate formula to determine a percentage increase or decrease in the conversion factor from the previous year. MACRA repealed the SGR and implemented what appeared to be a fixed annual percentage increase in the conversion factor. While the 2018 conversion factor was set at an increase of 0.5% by MACRA, two adjustments are being applied by CMS; a budget neutrality factor and a target recapture amount.

The Conversion Factor in effect for 2017 is $35.8887 per RVU. CMS estimates the 2018 PFS Conversion Factor to be $35.9903 per RVU, which reflects the 0.5 percent update reduced by the budget neutrality adjustment and the target recapture amount.

Budget Neutrality Factor

CMS is required to review the relative value of each CPT code no less often than every 5 years. CMS selects groups of codes
to be reviewed each year and makes adjustments, either up or down, to the component values. Current statute requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS makes an adjustment to the Conversion Factor to preserve budget neutrality. The CMS estimate of changes in Medicare expenditures for physician medical services for 2018 compared payment rates for 2017 with proposed payment rates for 2018 multiplied by 2016 Medicare utilization data. The 2017 total allowed physician charges were $89,467,000,000, and the 2018 total allowed physician charges are estimated to be $92,628,000,000. This calculation results in a 0.03 reduction to the expected 0.5 per cent increase in the Conversion Factor.

The Target Recapture Amount

Prior to passage of The Affordable Care Act (ACA), CMS relied on specialty society input to maintain the physician work values of each CPT code. Some societies were much more aggressive than others in promoting the value of their members work. Based on input from the Medicare Payment Advisory Commission the ACA required the agency to identify, review and adjust values for potentially misvalued codes. Subsequently, the Protecting Access to Medicare Act of 2014 established an annual target for reductions in PFS expenditures resulting from adjustments to relative values of misvalued codes. For calendar years 2017 through 2020 the target is 0.5 percent of the estimated expenditures under the PFS for each of those 4 years. If the target is not met, the conversion factor must be reduced by the difference between the target for the year and the estimated net reduction in expenditures, known as the target recapture amount. In this proposed rule, CMS has identified misvalued code changes that would achieve 0.31 percent in net expenditure reductions. If finalized, these changes would not meet the misvalued code target of 0.5 percent, therefore requiring an additional 0.19 reduction to the anticipated increase of the Conversion Factor.

Adjustments to pulmonary related RVUs

Several pulmonary related codes were selected to be examined as part of the misvalued code initiative and revised work values have been proposed. CPT code 31600 was identified as part of a screen of high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT codes 31601, 31603, 31605, and 31610 were added and reviewed as part of the code family.

31600 Tracheostomy, planned; current work RVU 7.17, proposed work RVU 5.56
31603 Tracheostomy, emergency procedure, transtracheal; current work RVU 4.14 proposed work RVU 6.00
31605 Tracheostomy, emergency procedure; cricothyroid membrane; current work RVU 3.57 proposed work RVU 6.45

CPT code 31645 was identified as potentially misvalued on a screen of Harvard-valued codes with utilization over 30,000 in CY 2014. CPT code 31646 was added for review as part of the family of codes, and both were revised to reflect recent changes in how the services are typically performed.

31645 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with therapeutic aspiration of tracheobronchial tree, initial; current work RVU 2.91 proposed work RVU 2.88
31646 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay; current work RVU 2.47 proposed work RVU 2.78
36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous; current work RVU 1.15 proposed work RVU 1.00

93503 Insertion and placement of flow directed catheter (eg, Swan-Ganz) for monitoring purposes; current work RVU 2.91 proposed work RVU 2.00

New Codes:

CPT code 94620 was identified as part of a screen of high expenditure services with Medicare allowed charges of $10 million or more that had not been recently reviewed. CPT code 94621 was added to the family for review. The CPT Editorial Panel deleted CPT code 94620 and split it into two new codes, CPT codes 946X2 and 946X3.

94621 Cardiopulmonary exercise testing, including measurements of minute ventilation, CO2 production, O2 uptake, and electrocardiographic recordings; current work RVU 1.42 proposed work RVU 1.42

946X2 Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; proposed work RVU 0.70

946X3 Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed; proposed work RVU 0.48

993X2 Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab International Normalized Ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s) when performed; proposed work RVU 0.18

710X2 Radiologic examination, chest; 2 views; proposed work RVU 0.22

Physician Quality Reporting System Criteria for Satisfactory Reporting

We may have the new administration to thank for significant changes to the PQRS and the penalties under the Value Based Payment Method for 2018. On review of data from the 2015 reporting period CMS estimates that there were roughly 525,000 eligible professionals who failed the PQRS reporting requirements for the 2015 reporting period and are receiving a downward payment adjustment in 2017. CMS has decided to ease the reporting restrictions and reduce the Value Based Payment penalties for the last year of the program. CMS has proposed to lower the requirement for the 2016 reporting period (2018 payment adjustment) from 9 measures across 3 domains to only 6 measures with no domain or cross-cutting measure requirement.
CMS also proposes to reduce the amount of payment at risk from -4% for groups with ten or more eligible professionals to -2.0%, and from -2.0% for groups with between 1 and 9 eligible professionals to -1.0%.

**Patient Relationship Categories and Codes**

We have previously discussed the efforts of CMS to establish an episode based cost measure to be used in conjunction with other cost measures to compose the cost category for determining physician compensation under the MIPS program taking effect in 2019. CMS has been working to define categories of physician responsibility and assign codes that would be required on fee-for-service claims submitted by physicians on or after January 1, 2018. CMS envisions that clinicians would first report a CPT Code and then add a Level II HCPCS modifier to identify their relationship to the patient. CMS appears to have finalized the physician relationship categories:

- Continuous/Broad Services.
- Continuous/Focused Services.
- Episodic/Broad services.
- Episodic/Focused Services.
- Only as Ordered by Another Clinician.

CMS submitted an application to the American Medical Association CPT Editorial Panel for a set of CPT modifiers for reporting the patient relationship codes. The CPT Editorial Panel declined to include patient relationship modifiers in the CPT code set at this time. They suggested that CMS publish the modifiers as Level II HCPCS Modifiers. CMS has proposed the following Level II HCPCS Modifiers:

<table>
<thead>
<tr>
<th>No.</th>
<th>Proposed HCPCS Modifier</th>
<th>Patient Relationship Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>1x</td>
<td>X1</td>
<td>Continuous/broad services</td>
</tr>
<tr>
<td>2x</td>
<td>X2</td>
<td>Continuous/focused services</td>
</tr>
<tr>
<td>3x</td>
<td>X3</td>
<td>Episodic/broad services</td>
</tr>
<tr>
<td>4x</td>
<td>X4</td>
<td>Episodic/focused services</td>
</tr>
<tr>
<td>5x</td>
<td>X5</td>
<td>Only as ordered by another clinician</td>
</tr>
</tbody>
</table>

CMS is proposing that Medicare claims submitted for items and services furnished by a physician on or after January 1, 2018, should include the patient relationship HCPCS modifiers as well as the NPI of the ordering physician. For 2018, CMS is proposing that the HCPCS modifiers may be voluntarily reported on Medicare claims, and the use and selection of the modifiers would not be a condition of payment. The Secretary of Health and Human Services, Dr. Tom Price, has the authority to modify this program as he sees fit with the first review due in November of 2018.

**Medicare Appropriate Use Criteria Program for Advanced Diagnostic Imaging**

Additional issues addressed in the 2018 proposed Physicians Fee Schedule include revisions to the Medicare Diabetes Prevention Program, payment for biosimilar products, adjustments to the Clinical Laboratory Fee Schedule, payment within fee-for-service Medicare for chronic care management, the addition of several codes to the list of telehealth services and the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging. While the latter has been on the radar for the last two years, it seemed to be of low priority for our membership. As more details emerge its importance is increasing and we will discuss it in the September Watchline.
Medtronic, a NAMDRC Industry Advisory Committee member, has submitted an article to share with you and follows on the next several pages. It is entitled: “Simplifying Respiratory Monitoring Using the Integrated Pulmonary Index™ algorithm” and is written by Greg Spratt, BS, RRT, CPFT and David Giarracco.
Simplifying Respiratory Monitoring Using the Integrated Pulmonary Index™ algorithm

Greg Spratt BS, RRT, CPFT and David Giarracco

Introduction

Respiratory Compromise (RC), defined as respiratory decompensation through insufficiency, failure and/or arrest (Figure 1), may be preventable through earlier identification and intervention. Respiratory conditions are the leading cause of ICU admissions, rescue calls, and ‘code blues’, and occur in nearly 1 of 8 elective surgery patients and 1 in 14 of all Medicare patients. It is projected that RC costs will reach $37 billion annually by 2019 and it ranks among the AHRQ Top 5 Most Rapidly Increasing Hospital Costs. Patients that develop RC while on the General Care Floor (GCF) have a mortality rate 29 times that of GCF patients that do not develop RC. In light of these sobering statistics, the potential for prevention offers a ray of hope. In a review of primary respiratory arrests, 64% were classified as potentially avoidable and of these, all had inadequate treatment prior to the event, while 67% demonstrated clinicians failed to respond to abnormal laboratory findings.

<table>
<thead>
<tr>
<th>Common</th>
<th>Costly</th>
<th>Deadly</th>
<th>Preventable</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Leading cause of ICU admissions, rescue calls, and ‘codes’</td>
<td>• RC costs will reach $37 billion annually by 2019</td>
<td>• Mortality rate 29 times that of GCF patients that do not develop RC</td>
<td>• Nearly 2 of every 3 cases of respiratory arrest found to be potentially avoidable</td>
</tr>
<tr>
<td>• 1 of 8 elective surgery patients</td>
<td>• AHRQ Top 5 Most Rapidly Increasing Hospital Costs</td>
<td></td>
<td></td>
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<tr>
<td>• 1 in 14 of all Medicare patients</td>
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Many disease processes may lead to RC including impaired control of breathing, impaired airway protection, parenchymal lung disease, increased airway resistance, hydrostatic pulmonary edema, and right-ventricular failure. These processes account for some of the most prevalent and expensive conditions treated in the hospital including sepsis, heart failure, pneumonia, ARDS, exacerbations of COPD/asthma, postoperative respiratory failure, many others.

Currently, a standardized and validated method of RC risk assessment with subsequent monitoring of those at increased risk does not exist leading some to suggest risk stratification is not an acceptable alternative and that all patients should be monitored (aka, surveillance

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1Greg Spratt is a respiratory therapist and pulmonary function technologist and David Giarracco is a biomedical engineer. Both are employees of Medtronic engaged in projects and activities to improve technology solutions for early recognition and intervention in Respiratory Compromise.
A survey of physicians and nurses revealed that 92% believe that continuous monitoring of patients who are at high risk or in early stages of RC can lead to earlier interventions, preventing further deterioration and 84% agree that RC monitoring can save money by preventing the need for more complex, more costly levels of care (e.g., ICU admissions, intubation, ventilation, etc.). Evidence suggests that the costs of continuous electronic monitoring are more than offset by cost reductions from event prevention.

The Challenge

Nurses and other clinicians often face tremendous challenges in monitoring multiple patients simultaneously. Many hospitals continue to use intermittent, manual methods of monitoring, visually counting a respiratory rate (RR) and performing oximetry spot checks. Manual monitoring is labor intensive requiring more staff, which is a difficult proposition in today’s healthcare environment. In reality, hospitals face increasing patient to nurse ratios and staff reductions due to declining reimbursement and budget cuts. The duties of health-care providers have steadily expanded, and the amount of time actually spent per patient has declined. A study of medical-surgical nurses in 36 hospitals showed that on average, they spend only 7 percent of their time on patient assessment and reading vital signs.

Even if staffing ratios were not an issue, simple observation may not be sensitive enough to detect early signs of respiratory decline. Using capnography and impedance monitoring, a study of patients undergoing monitored anesthesia care (MAC) found that 26% of subjects experienced apnea of at least 20 seconds that went unidentified by visual observation from the anesthesia providers. Lightdale found that endoscopy staff using observation only documented poor ventilation in 3% of all procedures and no apnea while simultaneous capnography (blinded to observing staff) indicated alveolar hypoventilation during 56% of these procedures and apnea during 24%. This demonstrates that even in an ideal one-on-one care setting, with direct and constant visualization, experienced providers cannot reliably detect a significant respiratory event such as hypoventilation and apnea.

Exploring Better Solutions

The Integrated Pulmonary Index™ algorithm (IPI) is a proprietary algorithm available on a variety of manufacturers’ monitoring platforms, developed to help clinicians more easily monitor a patient’s complete respiratory status by incorporating four real-time respiratory measurements: end-tidal CO$_2$, RR, SpO$_2$ and pulse rate (PR), into a single number (Figure 3). IPI uses mathematical modeling, mimicking a human’s logical thinking pattern to derive a respiratory status on a scale from 1 to 10, with 10 being a normal status (Figure 4). To further assist clinicians in monitoring patients with evolving respiratory compromise, IPI trending is displayed (Figure 5) providing early indication that may not be indicated by the current value of any of these four parameters individually.
More than 40 papers have explored IPI’s validity and potential value across multiple hospital environments and even outside the hospital. IPI has consistently been found to correspond closely with the clinicians’ evaluation of the patient’s respiratory status. Hospitals have now begun to incorporate IPI into their protocols for providing an earlier alert to evolving respiratory compromise. 

The validity of the index was demonstrated in a retrospective analysis of continuous SpO$_2$, RR, PR, and etCO$_2$ readings obtained from 523 patients in a variety of clinical settings. IPI correlated well with expert interpretation of the continuous respiratory data (R = 0.83, p < 0.001), with agreement of −0.5 ± 1.4. Receiver operating curves analysis resulted in high levels of sensitivity (ranging from 0.83 to 1.00), and corresponding specificity (ranging from 0.96 to 0.74), based on IPI thresholds 3−6. The IPI reliably reflected the respiratory status of patients in multiple areas of care.

In a separate analysis, data sets were scored by 18 medical experts (nurses, respiratory therapists, physiologists and anesthesiologists) using data sets from 85 patient cases. The IPI results agreed with the experts’ average (mean absolute differences =0.64±0.5). Comparing to all experts and cases, the average absolute difference between experts and model is 1±0.35 indicating that IPI closely mirrored clinician assessment of respiratory status.

Postoperative Monitoring

IPI has particular appeal on the postoperative GCF and in the post-anesthesia care unit (PACU). It provides a single number indicating respiratory status, helping to save busy nurse time when caring for multiple patients. It also offers a simplistic method of respiratory status monitoring for clinicians who may not be as familiar with more advanced monitoring such as capnography, which may not traditionally be used on the GCF.

When examining the use of IPI in post-operative applications, one hospital monitored capnography and oximetry using an interventional protocol guided by the IPI algorithm on three surgical care floors for patients with higher risk of Obstructive Sleep Apnea. The protocol resulted in a 65% reduction in code blue events in the 24 months following implementation compared to a 20 month baseline. None of the high-risk patients who were monitored with IPI experienced a code blue event since implementing the program.

In an analysis of 293 patients in the PACU, 18 patients (6.1%) suffered RC. The RC group had a significantly lower admission IPI than that of non-RC group (p<0.0001), demonstrating that IPI on admission to PACU can predict onset of respiratory adverse events better than SpO$_2$ alone. Other papers have shown that IPI has been shown to correlate with the respiratory status of adult patients after surgery under general anesthesia. Since it is displayed as a single value, it may simplify the monitoring of patients in a busy PACU.

IPI also shows promise as a ‘smart alarm’, where in one study, IPI alarms were found to be more effective than those of the individual parameters. The number of total alarms was reduced by two-thirds (66%) without losing sensitivity to clinically-significant events. Hence it can be used safely and may reduce alarms fatigue.

Procedural Sedation

Patients receiving moderate to deep sedation during minimally invasive procedures may also be at risk for developing respiratory depression which undetected may result in patient injury or even deaths. The American Society of Anesthesiologists requires capnography for moderate to deep sedation and recently the European Board of Anaesthesia strengthened their recommendations stating capnography – by facilitating early detection of ventilation problems – should be used in all patients undergoing procedural sedation. It is not uncommon for non-anesthetists to provide and monitor sedation for cases under the direction of the interventional physician. IPI may provide a valuable tool to assist clinicians in the early identification of evolving RC during procedural sedation.

Hirofumi et al demonstrated that IPI was able to detect all respiratory depression events in patients receiving sedation while pulse oximetry detected only 12.9% of the clinical respiratory depression events. Garah et al found that IPI alerted all apnea episodes and hypoxia episodes, whereas pulse oximetry captured only the hypoxia episodes (IPI sensitivity = 1, specificity 0.98, positive predictive value 0.95). Yamanishi et al state that IPI was more sensitive in detecting respiratory depression events during sedation than individual parameters of etCO$_2$, RR, or SpO$_2$, and contributes to increasing sedation safety for pancreatobiliary endoscopy.

Beyond the adult patient, IPI is also designed to work with children over the age of one year and has been shown to correlate well with the respiratory status of pediatric patients for procedures under sedation.
Invasive and Non-Invasive Ventilation

Several studies have also shown that IPI may be useful for patients being ventilated, either invasively or non-invasively. In non-invasively ventilated subjects, Waugh et al found that IPI appears to allow detection of abnormal breathing events caused by over-ventilation, rapid shallow breathing, and bradypnea and indicate that the integration of the capnography and oximetry values into one parameter in the form of IPI appears to allow non-invasive detection of hyperventilation and hypoventilation.\textsuperscript{xli}

For invasively ventilated patients, studies have shown that:

- IPI may predict the duration of postoperative mechanical ventilation and may be a valuable adjunct to the bundle of postoperative monitoring after Off Pump Coronary Artery Bypass.\textsuperscript{xlii}
- IPI was consistent with the interpretation of the respiratory status reflected by the ABG values.\textsuperscript{xliii}
- The IPI may be a useful tool in establishing and maintaining optimal MV settings and may be useful to decrease time on a MV or reduce ABG.\textsuperscript{xliv}

For evaluating weaning/extubation success:

- IPI values are higher in successful spontaneous breathing trials (SBTs) than in failing SBTs in obese patients undergoing evaluation for weaning. Further studies and larger sample size are needed to more clearly define the value of IPI during weaning from mechanical ventilation.\textsuperscript{xlv}
- IPI demonstrates reasonable agreement with clinical evaluation of Spontaneous Breathing Tests by Respiratory Therapy staff and may be useful in predicting readiness to discontinue mechanical ventilation.\textsuperscript{xlvi}
- In post-operative CABG patients, IPI demonstrates reasonable agreement with clinical evaluation of SBTs by Respiratory Therapy staff and may be useful in predicting readiness to discontinue mechanical ventilation.\textsuperscript{xlvii, xlviii}
- During early postoperative period after CABG, IPI can predict the success of tracheal extubation and reflects the changes in respiratory function. Thus, IPI may be a valuable adjunct to the routine perioperative monitoring, facilitating early detection of respiratory problems.\textsuperscript{xlix}
- Using IPI in patients post extubation may provide an indication of impending extubation failure.\textsuperscript{l}
- IPI value ≤ 9 at 6 hours after extubation demonstrated moderate predictive ability for early postoperative complications after Off-Pump Coronary Artery Bypass.\textsuperscript{l}
- Cumulative IPI data may be able to differentiate between patients who will eventually require intubations for critical deterioration and those who will improve without intubation.\textsuperscript{li}

Summary

Clinicians are increasing challenged by healthcare dynamics to effectively monitor patients for evolving RC. Early identification and subsequent intervention may help prevent many cases of RC from developing into respiratory failure requiring rapid response calls, ‘codes’, intubation, ventilation, and high costs.\textsuperscript{lii, liii} IPI is an algorithm developed to help clinicians continuously monitor complete respiratory status in a single number.
References


3. Respiratory Compromise Institute [https://www.respiratorycompromise.org](https://www.respiratorycompromise.org)

4. Society for Critical Care Medicine – Critical Care Statistics. [http://www.sccm.org/Communications/Pages/CriticalCareStats.aspx](http://www.sccm.org/Communications/Pages/CriticalCareStats.aspx)


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NAMDRCTM—WASHINGTON WATCHLINE

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NAMDRCTM 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 NAMDRCTM is an advocate for you and your profession.

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

One of NAMDRCTM’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 NAMDRCTM’s key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRCTM 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 NAMDRCTM:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRCTM) 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.

NAMDRCTM 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.
TWO EASY WAYS TO BECOME A NAMDRC MEMBER

1. Go to www.namdrc.org and register for membership online.

2. Mail this application to:

NAMDRC
8618 Westwood Center Drive, Suite 210
Vienna, VA  22182-2273

Please print clearly or type:

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DEGREE
____________________________________________________
ADDRESS
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CITY  STATE  ZIP CODE
____________________________________________________
TELEPHONE  FAX
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E-MAIL
____________________________________________________
FACILITIES WITH WHICH YOU ARE AFFILIATED

MEMBERSHIP DUES SCHEDULE
(Dues for first year include $75.00 Initiation Fee)

Individual and Small Group Dues………………$370.00
Includes groups of up to 6. Please include contact information for all members.

GROUP MEMBERSHIP DUES
(For larger groups, please attach a list of names. If a group member wishes to receive mailings at an address other than that indicated above, please attach appropriate information.)

Groups of 7-10………………………………..$1,175.00
Groups of 11-20……………………………….$1,560.00
Groups of 21-30……………………………….$1,930.00

TOTAL PAYMENT DUE……………………$___________

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☐ Change my credit card for total payment due
  ☐ American Express  ☐ VISA  ☐ MASTER CARD

____________________________________________________
CREDIT CARD NUMBER
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NAME AS IT APPEARS ON CREDIT CARD
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