DURABLE MEDICAL EQUIPMENT: What Sleep Lab & Sleep DME Providers Should Know

by Duane Johnson PhD

Are you aware of the new competitive bidding program which impacts sleep DME providers? The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173), requires the Secretary of the Department of Health and Human Services to replace the current DME payment methodology for certain items, with a competitive acquisition process. The MMA authorizes DHHS to freeze payment rates and require DME suppliers who provide services under Medicare Part B, to competitively bid for the provision of such services to patients. The new bidding process will establish payment for DME. The MMA also requires the DHHS to establish and administer a Program Advisory and Oversight Committee that will provide advice on the development and implementation of the competitive acquisition program. The new program is intended to provide an incentive for DME suppliers to provide quality items and services in an efficient manner and at a reasonable cost.

I interviewed Jayme Matchinski, JD, a legal education advisor and partner at Harris, Kessler & Goldstein, LLC, who has specific expertise in sleep lab and DME legal issues. Here are her answers to questions I am frequently asked as well as key information about the new competitive bidding program affecting sleep DME.

Which suppliers does the competitive bidding program affect?

Durable Medical Equipment (DME), Prosthetics, and Orthotics suppliers are affected by the new program.

When does this program begin?

The MMA established the competitive bidding program as a nationwide, permanent part of Medicare, beginning with 10 of the largest metropolitan statistical areas in 2007; 80 of the largest metropolitan statistical areas in 2009; and additional areas after 2009. In areas where competitive bidding is not conducted after 2009, DHHS may either apply competitive bidding payment amounts or may set payment amounts through inherent reasonableness (IR) authority.

What is the effect of the competitive acquisition program on DME providers?

The DME MAC (Durable Medical Equipment Medicare Administrative Contractor) will serve as a single point of contact for supplier for all claims-related business. The DME MAC will process all claims and assist suppliers with obtaining information on behalf of patients about items or services received from another provider or supplier that could affect claims payments.

What are the five objectives of the bidding program?

1. To operationalize competitive bidding for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and to use this to determine appropriate prices for categories of DMEPOS covered by Medicare Part B;
2. To protect beneficiary access to quality DMEPOS throughout the program;
3. To reduce the amount Medicare pays for DMEPOS and bring the reimbursement amount more in line with that of a competitive market;
4. To limit the burden on beneficiaries by reducing their out-of-pocket expenses; and
5. To mitigate proliferation of use of certain items of DMEPOS by contracting with suppliers who engage in a business model beneficial for the program and for beneficiaries.

What are the responsibilities of the Program Advisory and Oversight Committee?

Pursuant to the MMA, the Program Advisory and Oversight Committee (PAOC) is responsible for providing advise on the implementation of the competitive acquisition program; the establishment of financial standards that take into account the needs of small providers; the establishment of requirements for collection of data for the efficient management of the program; the development of proposals for efficient interaction among manufacturers, providers of services, suppliers, and individuals; and the establishment of quality standards.

What are the contractual differences between new DME MACs and current DMERCs?

The DME MACs workload has been awarded through a full and open competition that is conducted in accordance with the Federal Acquisition Regulations. The proposals with the best values for the government that are based upon structured evaluation

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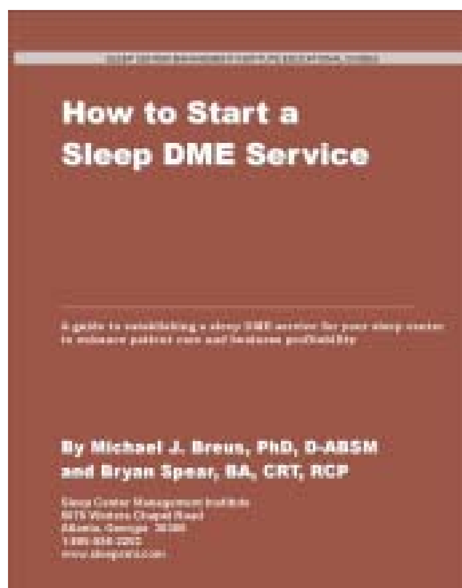

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***Durable Medical Equipment**... Continued from page 36*

criteria have been selected under this procurement. No DME MACs will perform pre-pay or post-pay medical review or benefit integrity work. As a result of this reduction in the business functions to be performed by the DME MACs, the costs of the MAC contracts for the DME workload are reduced from those of the current DME Regional Carriers.

Does the proposed bid evaluation process set forth any criteria whereby DHHS may not award a contract to a DME provider?

Yes, DHHS may not award a contract to any DME provider unless the entity meets applicable quality and financial standards. The total amounts paid to contractors within a competitive acquisition area must also be less than the total amounts that would otherwise be paid; and access to multiple suppliers is maintained.

What types of contracts have been awarded to the DME MACs?

The DME MACs were awarded under 'cost plus award fee' contracts. The period of performance for each of the four contracts is one base year with four 1-year options. The contracts have a potential value of $524 million over the 5-year period.

Which companies have been awarded contracts for DME?

On January 6, 2006, CMS announced the four Medicare Administrative Contractors who are designated as specialty contractors to handle the administration of Medicare claims for suppliers of DME. The four DME MAC companies are:

• National Heritage Insurance AdminaStar Federal, Inc. has been awarded the DME MAC contract for Jurisdiction A, which includes CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT.

• AdminaStar Federal, Inc. has been awarded the DME MAC contract for Jurisdiction B, which includes the states of IL, IN, KY, MI, MN, OH, and WI.

• Palmetto GBA, LLC has been awarded the DME MAC contract for Jurisdiction C, which includes the states of AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, Puerto Rico, SC, TN, TX, U.S. Virgin Islands, VA, and WV.

• Noridian Administrative Services Company has been awarded the DME MAC contract for Jurisdiction D, which includes the states and territories of AK, American Samoa, AZ, CA, Guam, HI, ID, IA, KS, MO, MT, NE, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, and WY.

How will the competitive bidding program impact your Sleep Lab and DME Provider?

DME suppliers who provide DME, including CPAP, to Medicare patients will be required to participate in the competitive bidding program. DME providers will also have to comply with certain quality standards and become accredited by a CMS designated organization.

What is the overall volume of DME claims and benefit payout?

The four current DME Regional Carriers processed over 68 million claims in fiscal year 2004 from suppliers of DME, orthotics and prosthetics that amounted to Medicare program benefit payouts in excess of $9.1 billion.

For more information readers can reference the Centers for Medicare and Medicaid's DME Center website section at http://www.cms.hhs.gov/center/dme.asp.

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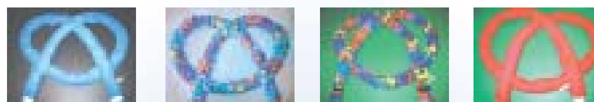

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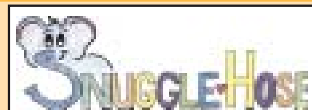

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***The "Sometimes Safety"**... Continued from page 54*

ing comfort to correcting derangements of metabolic and fluid balance. When other measures fail, deep sedation and even pharmacologic paralysis may be initiated.

Two other characteristics of PCV that may have an adverse bearing on the problem of VILI are the rapidity with which alveolar pressure rises (the so-called dP/dt) which accentuates shearing stresses at the boundary of closed and open tissue at the very onset of inspiration and a plateau pressure that is sustained by an inappropriately long inspiratory time. In theory, pressure support ventilation with the same targeted airway pressure could obviate the latter. Adjustment of the "attack" rate would help to moderate the proto-inspiratory shearing stresses. Even during passive controlled mechanical ventilation, a pressure that gently rises under the influence of flow controlled VCV applied with constant flow may paradoxically present a lower VILI risk when compared to either of the pressure targeted modes.

In the daily care of patients with complex critical illness we often learn that simple rules must bend. In today's practice, the development of management protocols for the bedside demands that rules be set and apply to all conditions. I quite understand this. However although it is appealing to simplify, there is inherent danger in making the same choices for everyone, ignoring the underlying physiology and requirements of the situation at hand. Such is the case with PCV. The respiratory care practitioner must carefully assess the vigor of breathing as well as the characteristics of the individual tidal cycle that relate to plateau pressure, attack rate, and end inspiratory flow before endorsing the initiation or continued use of this mode in the critically ill patient with acute lung injury or ARDS. Depending on the specific circumstances, PCV may prove safer or more hazardous than its traditional VCV alternative.