Medicare Part B Payment Systems for DMEPOS

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DMEPOS

- Durable Medical Equipment
  - Provides therapeutic benefits or enables the beneficiary to function with certain medical conditions and/or illness
- Prosthetic and Orthotic Devices
  - Replaces all or part of an internal organ or replaces the function of an internal organ
- Supplies
  - Surgical dressings and casts
  - Supplies used with DME

DME Reimbursement Problems

- Eligibility in the “home”
- HCPCS Coding
  - Implications for Competitive Bidding
- Payment structure
  - Capped rental payments
  - Gap filling
- Coverage
  - Artificial criteria based on payment structure

Eligibility of DME in the Home

- Available only in the “home” – not institutional homes
- Based on “routine” DME available in 1970s
  - Bed frames, walkers, wheel chairs
  - No need for physician prescription
  - Owned and reused by facilities
- Does not take into account development of “ancillary” technology
  - Prescribed for specific conditions
  - Equipment not generally purchased by facilities

Problem #1: Patients who “live” in nursing facilities are denied access to “ancillary” DME

Solution: Demonstration project leading to legislation expanding the benefit

HCPCS Coding

- DME is classified with Level II HCPCS codes
  - Permanent codes assigned by national panel
  - Temporary codes may assigned by Medicare contractors, Medicaids, private plans (BCBS)
  - No customization of codes or modifiers allowed after HIPAA implementation 10/03
- HCPCS codes are the basis for payment
  - Fee schedules today
  - Competitive bidding beginning in 2007

Problems with HCPCS

Problem #2: Coding system is biased against addition of codes. New, advanced technologies are often assigned to existing codes creating significant technology gaps between products meeting minimum specs within the code and those which significantly exceed them.

Problem #3: If codes with technology gaps are competitively bid, winning bids are likely to be based only on the less expensive products meeting minimum specifications and the payment will be so low that advanced technologies previously included in the code will no longer be available to patients and caregivers.

Solutions:

a) Plan for expanded code set

b) Better definition of coding review criteria

c) Only bid tightly defined codes

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DME Payment

"Six Point Plan" adopted in 1987

1. Inexpensive or routinely purchased
2. Items requiring frequent and substantial service
3. General prosthetic an orthotic devices and miscellaneous supplies
4. Capped rental items
5. Oxygen (rental) and oxygen equipment
6. Customized equipment (including prosthetic and orthotic devices)

Capped Rental Equipment

- Definition
  - Not routinely purchased
  - Not service intensive
  - Not customized
  - Not oxygen
- Paid monthly rate, never prorated for shorter use
  - Amount which is “approximately” I/10th of the purchase price
    - Calculated through “gap filling” from 1987 to present
  - Up to 13 months then title transfers to patient (Deficit Reduction Act of 2006)
  - After transfer Medicare pays 80% of “reasonable and necessary” service costs

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Problems with Capped Rental

Problem #4: Sampling errors used to calculate baseline for gap filling can skew payment either high or low.

Solution(s): a) Eliminate technology gaps

b) Better define sampling methodology

Problem #5: Payment for capped rental is based on purchase price and does not account for caregiver/customer education, administrative costs with complicated claims requirements or product maintenance necessary to ensure safe, appropriate use

Solution: Develop a new payment mechanism for "ancillary" technologies

Payment Vs. Coverage

Problem #6: *Because only one payment can be made for a single month:*

a) Some medical policies require that a product be used for the full month before an alternate product could be used, even if there is evidence that the first product did not meet the patient's needs.

b) If a second supplier provided a replacement product during a month that has already been paid, the second supplier's claim will be denied as "not covered" and the first supplier will be paid for the full month regardless of how long the patient used the first product.

Solutions: *a) Don't require a failed product to be used for an entire month and;*

b) Adjust payment for that month to reflect the fee schedule of the higher of the two used products.

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SUMMARY

Many of the significant problems with DME reimbursement systems could be resolved with the following two changes:

- Create an “ancillary” DME category
  - Expand the benefit to nursing facilities
  - Create a new payment system
- Redefine the HCPCS coding process to increase predictability and transparence

Thank you!

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