The changes

In January 2006, the Centers for Medicare and Medicaid Services (CMS) ruled that bilevel ventilators (renamed respiratory assist devices or RADs by CMS) with backup rates would no longer be classified as durable medical equipment (DME) requiring frequent and substantial servicing (FSS).

This ruling, along with a provision of the Deficit Reduction Act of 2005, meant that Medicare payments would end after 13 months, with the initial ruling start date of April 1, 2006. Ownership of the device would be transferred from the DME provider to the user.

If you used a bilevel device with backup rate before April 1, 2006, the clock started ticking April 1, 2006. You will be sent documentation transferring the ownership of the device to you on your anniversary date in May 2007.

Medicare will pay for repairs, but routine periodic servicing of the equipment is the responsibility of the beneficiary, namely you. Replacement of the equipment is according to “the reasonable useful lifetime of durable medical equipment” determined through “program instructions.” In the absence of such instructions, the lifetime cannot be less than five years.

The changes in reimbursement may also result in a loss of accompanying respiratory care services from the DME company – such as regular visits to assess your condition, inspect the ventilator, and adjust the ventilator settings – because the DMEs will not be able to absorb the costs.

Depending on the results of the new competitive bidding program also recently proposed by CMS, several service issues may change and also result in wide regional variability.

Who is affected?

Medicare beneficiaries who use bilevel ventilatory equipment with backup rates, e.g. users of:
- BiPAP® S/T (Respironics, Inc.)
- BiPAP® Synchrony (Respironics, Inc.)
- VPAP® III ST (ResMed Corp.)
- VPAP® III ST-A (ResMed Corp.)
- KnightStar® 330 (Puritan Bennett)

Options for you

Pay privately for respiratory care services through your DME company. (The cost may range up to $100 for an hourly visit.)

If not an emergency situation, call or go to your physician’s office. However, some physicians may not be as familiar with adjusting the settings on the equipment as are the respiratory therapists from the DME companies.

If an emergency situation arises, go to an emergency room. However, you should always be prepared, through careful advance decision-making, to advise the ER personnel about your ventilatory wishes. Do you want to receive invasive ventilation through an endotracheal tube or a tracheostomy? Do you want to continue receiving noninvasive ventilation? You also need to be prepared with medical information to resist the provision of oxygen therapy instead of assisted ventilation, which may be harmful.
Medicare states, “The overall clinical care of a beneficiary who receives DME is the responsibility of the beneficiary’s treating physician.” Discuss with your physician changing the ventilator prescription to a volume or pressure support ventilator. Volume and pressure support ventilators are in a DME category that calls for frequent and substantial servicing (FSS). Medicare’s monthly reimbursement for this will enable the DME companies to provide the respiratory care services you need. CMS will no doubt keep a very close eye on sudden shifts to new equipment unless there is clear physician documentation and demonstration of a change in medical status and medical necessity.

What you can do NOW!

Contact your Senator or Congressman to explain the situation and ask them to initiate legislation to change this potentially harmful ruling.

Under the leadership of Peter Gay, MD, pulmonary physicians with the National Association for the Medical Direction of Respiratory Care (NAMDRC) have already begun to advocate for legislative action to change this seemingly capricious and arbitrary ruling by CMS.

For background ...
