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From: sam giordano [<mailto:giordanosam@icloud.com>]

Sent: Friday, June 12, 2020 11:50 AM

To: CMS MCD Feedback <MCDFeedback@cms.hhs.gov>

Subject: MCD User Feedback

To: MEDCAC;

Re: NIPPV

I would answer "low confidence" to all questions.

Not because of the guidelines per se; but rather the fact that the only health care professionals (respiratory therapists) who are educated, trained, and licensed to perform these assessments and are familiar with the technical aspects of NIPPV devices are not accessible in physician practices. This creates an information gap since the average physician as well as other NPPs employed in practices, are not conversant in the technical aspects of NIPPV devices. They do vary in capability, cost, and effectiveness.

Respiratory Therapists offer a bridge between the medical and technical aspects of NIPPV and other clinical interventions requiring technology.

If they were allowed to be employed by physician practices to provide these assessments, in lieu of, but as Part B employees of attending physicians; they could recommend assess according to the criteria, and select the most appropriate device, if and as necessary.

The average physician, or NPP available under Part B in physician practices are not trained in the technical nuances of these and other respiratory related devices including modern portable oxygen devices. Currently there is an over reliance on DME providers, to literally dictate to physicians, and others regarding what devices they should prescribe. This creates conflict of interest.

Beneficiaries and their physicians should have an advocate knowledgeable about both medical and technical aspects of this clinical intervention, who does not have a financial interest in the decision to prescribe NIPPV, and assure follow up service visits post prescription.

Respiratory therapists can be employed in physician practices, but only under "Incident to".

This has worked as a barrier to hiring respiratory therapists as practice employees. They can work as respiratory physician extenders, and can provide assessment and equipment selection services, in lieu of physicians performing this function, and not in addition to such a service. This could be done at the option of employing physicians. It would add a needed resource to physicians' practices.

Technology has advanced in terms of respiratory related equipment. It is impractical to expect the majority of physicians to be expert in the technical nuances of these devices. Non invasive ventilators is but one example.

Our common prescription for supplemental oxygen has not changed in over 100yrs. It is codified in Medicare statute.

Many supplemental oxygen prescriptions; which are needed by many requiring NIPPV, are improperly written due to the technical performance issue not currently recognized by CMS (i.e. oxygen prescribed based on device outputs in liters/minute even though most newer portables are not capable of such outputs.) A respiratory therapist knows this and would recommend targeting oxygen saturation instead of liter flow. The absence of these professionals in physician practices leaves device selection and continued usage virtual up to the entities that stand to gain by placement and continued use, DME providers.

In a perfect world a professional with expertise in both the clinical and technical side of the healthcare equation would be employed in physician practices and act as an extender resource to attending physicians, within the limits of their licenses, and at the option of physicians.

There should be no direct billing, for services rendered in lieu of physicians and other NPPs.

You may want to drill into this issue with a survey of attending physicians regarding their knowledge and understanding of a variety of respiratory equipment devices.

I am happy to assist if I can.

Thank you.

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Chair US COPD Coalition

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