



American Optometric Association

1505 Prince Street, Alexandria, VA 22314 • (703) 739-9200  
FAX: (703) 739-9497

TESTIMONY OF:

**The American Optometric Association**

**Presented by:**

**Rebecca H. Wartman OD**

Owner, Doctors Vision Center of Asheville  
Asheville, NC

**House Committee on Small Business**

**Subcommittee on Rural and Urban Entrepreneurship**

**Hearing on “Competitive Bidding for Durable Medical Equipment”**

**Wednesday, May 21, 2008**

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Mr. Chairman and Members of the Committee:

The American Optometric Association (AOA), representing over 34,000 doctors of optometry, would like to thank the Committee for holding this important hearing. My name is Dr. Rebecca Wartman and I am the owner of Doctors Vision Center in Asheville, NC. As an optometrist and small business owner, I am pleased to have the opportunity to provide witness testimony regarding burdensome requirements established by the Medicare Modernization Act (MMA) in the *Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)* and the chilling effect on providing patient care.

The AOA appreciates that the Centers for Medicare and Medicaid Services (CMS) exempted physicians and “treating practitioners” from having to participate in the competitive bidding program when they provide certain specified DMEPOS to their own patients as part of their professional services, and when the items are billed using a billing number assigned to these clinicians.

Optometrists and other physicians and health care professionals are concerned with two requirements of the program which, if implemented, could have an adverse impact on Medicare patients. First, we believe that requiring physicians and licensed health care professionals (hereafter referred to as health care professionals) to be accredited in order to continue supplying DMEPOS when treating patients is both financially and administratively burdensome.

Second, we believe that CMS is inconsistent in its application of competitive bidding requirements for health care professionals for such items as eyeglasses/lenses following cataract surgery, off-the-shelf orthotics (OTS), crutches, canes, walkers, and folding manual wheelchairs. The clinical judgment and expertise of health care professionals is critical for selecting, sizing, and fitting DMEPOS, as well as educating patients on their use. Many patients require immediate access to such items for immobilization, injury support, facilitation of safe mobility, or post-surgical recovery. It is unsafe and clinically inappropriate to delay or deny a patient's access to items or to send a patient out of a practitioner's office without the necessary DMEPOS.

In the MMA, it appears there is no recognition that health care professionals who supply DMEPOS integral to patient care are wholly dissimilar from suppliers who furnish DMEPOS products to the public as a primary part of their businesses. There is also a lack of recognition that health care professionals not only prescribe appropriate items of DMEPOS, but must frequently and expertly dispense and educate patients on their use at point of treatment.

As a result, CMS has made relatively few accommodations for the more than 38,000 physicians who currently have DMEPOS supplier numbers, as required by CMS, in promulgating supplier accreditation standards. Health care professionals are not providing DMEPOS to the public as a business alone but for the good of their patients, and it is unwarranted and inefficient for further accreditation to be required of them to perform the patient services for which they have been educated, trained, and licensed.

The DMEPOS products provided to Medicare beneficiaries by the roughly 14,000 optometrists with DMEPOS supplier numbers are lenses (Single vision or multifocal) and frames provided to individuals following cataract surgery, and these items are clearly an integral part of what the practice of optometry is all about. As of March 1, 2008, Medicare required health care professionals who are either new to the program or are existing suppliers opening a new practice location to become accredited prior to obtaining a national supplier clearinghouse (NSC) number. This requirement is unduly burdensome and unjust to optometrists who are just beginning to practice or are looking to expand the quality of the integral services they provide to their patients. The deadline for existing suppliers not changing their practice is September 30, 2009.

Optometrists and other health care professionals who provide DMEPOS products to their Medicare patients are licensed by the state in which they practice and are thus subject to a wide range of state regulatory and other requirements. DMEPOS suppliers who are not health care professionals obviously do not, and cannot, satisfy these requirements.

CMS' claims data indicates that DMEPOS products furnished by health care professionals make up a small portion of the Medicare-covered DMEPOS charges – slightly more than 3 percent according to 2004 claims data. It is unclear, therefore, what, if any, program improvement or cost savings would be realized by imposing these requirements on health professionals who only dispense DMEPOS when providing patient treatment.

Accreditation costs as much as \$3,000 per office for up to a three-year period. The accreditation process is time-consuming, expensive, and heavy on paperwork – precisely the type of barrier that large companies are equipped to surmount, but which pose special difficulties for optometrists and other health professionals' small businesses that do not, or cannot afford, to hire additional full-time regulatory compliance staff. Out of 10 accrediting organizations, only 4, possibly 5, accredit for post cataract eyewear.

A supplier manual from one of the CMS-sanctioned accrediting organizations is 128 pages, and represents the administrative red tape for meeting the CMS requirements. It is not difficult, therefore, to understand why health care professionals find it impractical to seek accreditation just to continue dispensing these items in their offices. It would essentially be impossible to recoup these costs given the amount Medicare pays for the small quantities of DMEPOS products furnished to their patients.

Additionally, many of the DMEPOS supplier quality standards and proposed enrollment safeguards do not make sense in the context of a health care professional's practice. For example, it would not be practical, nor would it appear to serve any useful purpose, to require all the health care professionals in a large professional building to each have a sign visible at the main entrance of the building with their business hours (as recently proposed).

Similarly, optometrists and other health care professionals are concerned that the proposed enrollment safeguard precluding a DMEPOS supplier from sharing a practice location with another Medicare supplier, "including a physician/physician group or another DMEPOS supplier," would inappropriately prevent a health care professional from providing both DMEPOS products and professional services to patients in the same practice location.

Ultimately, requiring additional, unnecessary, and redundant accreditation requirements of health care professionals may keep them from dispensing necessary DMEPOS items at point of treatment. Unfortunately, this could inconvenience or endanger Medicare beneficiaries, and compromise the health care professional's objective of providing the most appropriate quality care and of doing patients no harm. The American Optometric Association has received numerous complaints from optometrists indicating that they will no longer provide this service if they have to become accredited.

With burdensome new supplier regulations, optometrists – as well as a range of other health providers – could be faced with being unable to provide Medicare-covered DMEPOS products to their patients at the point of care. The only other available alternative would be to refer the beneficiary to a DMEPOS retail supplier, which may be unsafe for the beneficiary, prolong access to appropriate treatment, or, even worse, prevent the beneficiary from receiving the proper item because there is no DMEPOS retailer in close proximity. The cost of transportation, the need for at least two trips in most cases – one to select and one to have dispensed, the burden of finding a provider will all be serious hurdles for many Medicare beneficiaries. Likewise, for patients in nursing facilities or assisted living, many of whom I serve, will be faced with having to coordinate transportation and appointments, etc. Another example would be for aphakic patients who require contact lenses to be fitted following cataract surgery; they will face an increased health risk if this service is not performed with care and skill by an optometrist or other licensed qualified eye care provider.

As such an outcome would prove to be harmful to physicians and patients; it must be avoided through revised regulations. A “one size fits all” approach by CMS fails to recognize that DMEPOS suppliers today comprise a very diverse set of individuals and organizations, including licensed health professionals such as optometrists. The AOA believes that the accreditation and quality standards developed by CMS should recognize this diversity and be structured accordingly, and we believe the MMA gives the agency sufficient flexibility to do so.

We look forward to working with the House Small Business Committee and CMS to find a way to address these accreditation concerns and to avoid access issues for patients who rely on health care professionals to provide DMEPOS as part of their care.