3 MYTHS OF ORTHOTICS & DME AS ANCILLARY REVENUE:

WHY PHYSICIANS, HOSPITALS AND HEALTH SYSTEMS SHOULDN'T OVERLOOK THIS IMPORTANT SERVICE LINE

EXECUTIVE SUMMARY

The impact of declining reimbursements and rising overhead on physicians in clinics, hospitals and health systems is no myth. Providers must seek additional sources of revenue to remain relevant. Adding ancillary services – supplemental lines of business offered in-house, like orthotics & Durable Medical Equipment (DME) – can add sources of revenue and improve patient satisfaction.

Nearly everyone at some point in their lives will need a support or device, including DME, orthotics or home medical equipment (HME). According to the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics, $48.5 billion was spent on DME in the U.S. during 2015.[1]

Despite this date, why do only one-third of providers offer ancillary services,[2] with most still out-sourcing orthotics & DME?[3] Many providers are either not aware of the value created by offering these services in-house, or they believe in one or more of the following three myths that generally dissuade them from offering such services to their patients.

- **Myth #1: It is not compliant:**
  Health care fraud and abuse laws including the federal Anti-Kickback Statute and Stark Law, and related state laws prohibit such service lines.
- **Myth #2: It is not profitable:**
  Financial risk is too high; value is too low.
- **Myth #3: It is too complicated:**
  There are too many business considerations, staff burden and interoperability issues.

Providers should not overlook a well-run orthotics & DME program that can be an important factor in generating revenue, reducing cost and enhancing the patient experience across the hurt-to-healthy orthopedic episode. In this whitepaper, we explore these myths and the realities of providing orthotics & DME as an ancillary service given the current environment of value-based reimbursement, the importance of continuity of care, and compliance with numerous regulations. Establishing and maintaining a successful orthotics & DME program is dependent on matching provider needs to the right delivery platform, so we continue the discussion with a look at potential business models. This includes in-house ancillary orthotics & DME programs, outsourced inventory programs (sometimes referred to as a stock and bill), HME services and hybrid programs.

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[1] "National Health Expenditures 2014 Highlights," CMS.gov, https://www.cms.goviresearch-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/down-loads/highlights.pdf. Accessed June 13, 2016.
[2] "The Value of Ancillary Services," Medscape, http://www.medscape.com/viewarticle/828246. Accessed June 13, 2016.
[3] Bolesta, W.A., "The Physician-Owned Orthotic and Durable Medical Equipment Service," Orthop Clin N Am 39 (2008) 71-79.

Acronym soup: O&P, DME and DMEPOS

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) is an acronym established by the Centers for Medicare & Medicaid Services (CMS) DMEPOS is categorized into two sections: "orthotics & prosthetics" (O&P) and "durable medical equipment" (DME).

Separating O&P from DME and Supplies

O&P and DME are frequently lumped together and used interchangeably since both involve supplying devices; however, they are distinct categories of care, and laws may treat them differently. Care should be taken to distinguish between the two.

Orthotics (leg, arm, back and neck braces) and prosthetics (artificial legs, arms and eyes) often require specialized education and clinical skills to fit the device to the patient. There is a labor services component associated with O&P in addition to the cost of the product itself. DME refers mainly to mobility devices like wheelchairs, walkers, canes and crutches, and some home-use devices like oxygen therapy. Supplies are usually disposable and cannot withstand repeated use by more than one individual. Examples include diabetic supplies, bandages and test strips.

1 MYTH #1 – It is not compliant: Health care fraud and abuse laws including the federal Anti-Kickback Statute and Stark Law, and related state laws prohibit such service lines

Reality: The Exceptions and Safe Harbors

The federal Stark Law prohibits a physician from making a referral to a provider offering Stark designated health services (DHS) that would otherwise be covered by Medicare if the physician or an immediate family member has a financial relationship with the provider unless an exception applies. In addition, the Stark Law prohibits a provider from submitting a bill or claim for DHS referred by the physician, prohibits payment of such claims, and if payment is made, prohibits retention of such payments if the physician or an immediate family member has a financial relationship with the provider unless an exception applies.

Health care providers, including physician groups, hospitals and DMEPOS suppliers, are subject to the Stark Law if they furnish DHS. However, the Stark Law contains numerous exceptions, including the in-office ancillary services exception for physician groups, that may allow a provider to offer certain DME and/or O&P in compliance with the Stark Law.

The federal Anti-Kickback Statute makes it a crime for any person to knowingly and willfully offer or pay any remuneration, directly or indirectly, in cash or in kind, to induce a person to make referrals for services or items that may be covered by Medicare or another Federal health care program. The Anti-Kickback Statute also prohibits any person from soliciting or receiving any remuneration in return for making referrals for Federal health care program-covered services or items. Similar to the Stark Law, the Anti-Kickback Statute contains safe harbors that are not treated as offenses under the statute.

Many states have self-referral and anti-kickback laws similar to the federal laws described above. Each provider should consult legal counsel about their specific situation before developing an ancillary patient services line.

2 MYTH #2 – It is not a profitable venture: Financial risk is too high; value is too low

Reality: Ancillary services can enhance revenue, decrease costs and improve patient outcomes and satisfaction

In fact, ancillary services can reduce overhead between 10% and 30%,[4] and orthotics & DME can generate an average net profit of $46K per doctor, per year, for a mid-sized practice.[5] How much revenue a provider generates through an in-house orthotics & DME program will depend on the volume, type of products dispensed and the reimbursement for each product. Some orthotics & DME products are not reimbursed by payors, so the provider will need to determine patient pay amounts for these products.

From a financial risk standpoint, many providers continue to outsource orthotics & DME, usually for three primary reasons:

1) **Inventory cost:** Given rising overhead, there may be a low tolerance for the perceived financial risk of carrying inventory on the books.
2) **Staff costs:** There may be a perception that a licensed/certified fitter must be on staff, and program implementation will require more staff hours, offsetting any increase in revenue.
3) **Value per patient:** Providers may believe the revenue potential per patient is too low to warrant bringing orthotics & DME into practice management.

Implementation of an orthotics & DME service line can be adjusted to fit the provider's business mission and philosophy. Selecting the right business model (discussed later in the paper) can address the issues above. For example, to minimize risk, inventory may be carried on consignment or through an outsourced inventory model, in which inventory is located on-site, but owned and managed by the DMEPOS supplier. Providers can greatly reduce orthotics & DME spend while maintaining patient continuity of care, but this convenience must be weighed against lost billing revenue.

Staffing will depend on the level and scope of referrals. Some providers treat multiple patients per week who require custom fabricated or custom fit devices while other providers may treat very few. Some states require licensed or certified practitioners to provide custom orthotic services. In other states, orthotics can be fit by trained staff under the supervision of a physician or other health care practitioner. This responsibility typically falls to orthopedic technicians, athletic trainers and physician assistants in the office setting. The decision to hire a certified orthotist depends on the services provided and state regulations.

Value per patient may be largely driven by the most commonly dispensed DME items, including walker boots, slings, and ankle and wrist supports, all of which are lower cost when compared to custom fabricated items. Although these lower-cost items represent smaller gross revenue, the collective volume associated with dispensing these items may yield a larger return than highly reimbursed or more expensive custom-fabricated items.

The decision to implement an orthotics & DME service line must take into account not only the individual provider, but also the healthcare environment itself. Navigating the move to value-based care will be critical to success.

[4] Bert, J.M., MD, "Ancillary Services Available to the Orthopedic Surgeon," Sports Med Arthrosc Rev, Vol. 12, No. 4, December 2004.6 "History of Stark Law," USLegal.com. http://stark-laws.uslegal.com/history-of-stark-law/. Accessed June 13, 2016.

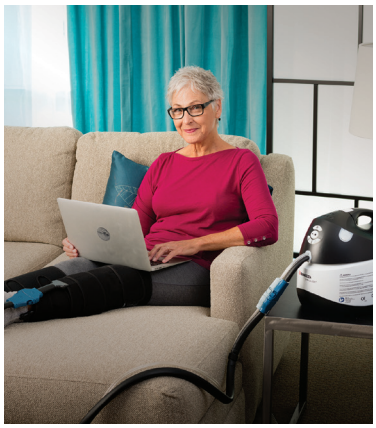
[5] Breg Impact aggregate client data as of June 2016.

How orthotics & DME ancillary programs can impact value-based programs

Bundled payments for total joint replacements

Starting April 1, 2016, certain hospitals became accountable for all costs associated with hip and knee replacements starting at hospital admission to 90 days post discharge. Under the CMS Comprehensive Care for Joint Replacement Model (CJR), if patients recover and go home quickly, hospitals are rewarded. If patients have complications or require lengthy stays in rehab, hospitals could end up owing Medicare instead.

As a result, providers are looking at the indicators of risk under bundled payments and are taking steps to address those risks. This includes lack of patient compliance with at-home physical therapy, DVT prevention, infection rates, proper fit of implants, techniques and conservative prescription protocols. Orthotics & DME, including DVT compression units, monitoring technology and other devices can help mitigate the risk of readmissions.



DMEPOS competitive bidding[6]

Competitive bidding changes the amount Medicare pays suppliers for certain DMEPOS, and changes who can supply these items. Any provider or supplier that supplies a Medicare beneficiary with a product subject to competitive bidding in a competitive bidding area (CBA) must submit a bid and be selected as a contract supplier or the patient will face disruption unless an exception applies.

Physicians and hospitals that are enrolled in Medicare as DMEPOS suppliers may furnish certain competitively bid items to their own patients in CBAs without submitting a bid and being selected as a contract supplier. In these situations, the provider and the patient will experience minimal disruption to the delivery of these items, outside of potentially reduced reimbursement rates. Physicians and hospitals that are not enrolled in Medicare as DMEPOS suppliers and refer patients to a supplier, or rely on outsourced inventory model services, could face disruption if the supplier is not selected as a contract supplier.

Value-Based Care: Financial implications

The core of practice and hospital management is shifting away from fee-for-service to paying for value delivered by providing better care more efficiently. The evolving system is intended to reward quality, outcomes and cost efficiency, not the volume of procedures. This requires more closely tracked value measures, including, but not limited to, complications, readmissions and patient satisfaction. Payors will reward providers that perform well on certain metrics and patient surveys. For those who can't achieve the required scores, the financial penalties and lower reimbursements will create a significant financial burden.

Providers of orthotics & DME services are well placed to have an impact on value-based care. These services are often a component of fulfilling conservative treatment requirements and providing at-home care for patients once they have left the care facility.

- Conservative treatment: Providers are required to document a patient's treatment path, including conservative, non-surgical elements of the patient's orthopedic episode, such as the use of bracing before surgical options are considered.
- At-home care: Hospitals now face financial penalties if readmission rates are too high, and must look for ways to extend care for patients at home, outside the hospital setting. This may include protocol compliance monitoring, DVT prevention management and at-home physical therapy regimens.
- Both conservative treatments through orthotics & DME, and DVT prophylaxis can be part of a healthy in-office ancillary program.

[6] The Centers for Medicare & Medicaid Services (CMS) has decided to temporarily delay moving forward with future rounds of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. Please continue to monitor the CMS.gov and Competitive Bidding Implementation Contractor (CBIC) websites for updates. "DMEPOS Competitive Bidding - Home," CMS.gov, https://www.cms.goviMedicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBidiindex.html. Accessed February 23, 2018.

3 | MYTH #3 – It is too difficult to implement: There are too many business considerations, staff burden and interoperability issues

Reality: The right partners can help structure an ancillary service line that is easy to set up and maintain, meets the needs of the provider and offers patient continuity of care

Instituting a healthy ancillary service line can seem daunting given complexities, potential disruption, and staffing and training needs. Such activities not directly associated with patient care can be difficult to focus on in a clinical setting. While challenges exist, it is possible to succeed by starting with an appropriate assessment of operational needs within the orthopedic environment, robust planning for implementation, and putting in place the right tracking, monitoring and feedback mechanisms.

Many providers that have successfully implemented ancillary programs have found that the right partners and tools can significantly reduce complexity and smooth the transition to patient continuity of care by providing systems to help navigate implementation and provide ongoing program support.

Health systems in particular may be concerned about implementing an orthotics & DME service line. For many large organizations, one size does not fit all. They should consider if a blend of services will best meet the different needs of diverse departments within the organization. For example, some systems have implemented an in-house bracing and supplies program within their clinics and an outsourced inventory program in their ERs, and use group purchasing agreements to manage pricing. The right partner can integrate all three solutions within the system to streamline workflow, cut costs and provide high quality products and services to patients.

Seamless continuity of care throughout the orthopedic episode can be a major concern for providers. For example, when a non-surgical orthopedic device is prescribed, there are a number of steps involved from evaluating and ordering of the appropriate device, fitting and educating the patient, billing for the device and following up with the patient.

For providers who don't offer these services onsite, they must send patients outside of the acute care, ambulatory or clinic setting to an outside equipment provider. This may increase the risk of insufficient knowledge transfer to a third-party of patient history, treatment plan, specific condition and care requirements. Additionally, patients may require assistance with ambulation, and may risk further injury by leaving a provider without any bracing support. This lack of coordinated care can add more obstacles to a patient's journey from hurt to healthy.

ORTHOTICS & DME BUSINESS MODELS

In the past, practitioners provided braces, splints and other DME to their patients in a variety of ways. Often, the provider kept a small stock of braces and splints on hand. It was part of ensuring patients received high quality care with the added convenience of having products immediately available and fit by the physician or credentialed office staff. For more complex, expensive or custom fabricated items, the physician wrote the patient a prescription which was filled at O&P shops or other equipment providers.

Today, providers have more options for dispensing orthotics & DME. Business models vary in terms of revenue yield vs. convenience, ranging from a completely independent in-house unit which requires the most investment of resources but yields the highest revenue, to a modified program which offers patient continuity of care, but yields less revenue. Providers need to weigh the various benefits and limitations based on needs. Two commonly used models include in-house ancillary services and outsourced inventory programs (sometimes referred to as a stock and bill).

Ancillary In-House Model

The ancillary in-house model provides the most control and therefore the best continuity of care and revenue advantage. In this model, the provider sets up and manages all aspects of its orthotics & DME program, including stocking product, inventory management, patient fitting and billing. The benefits from owned orthotics & DME can be significant: control over product quality and inventory; improved quality of care and convenience for the patient; and more revenue capture.

Providers must first assess internal requirements and be aware of legal issues associated with developing an in-house ancillary program. Providers who dispense and bill Medicare for orthotics & DME must typically have a separate Medicare DMEPOS supplier number. Providers must also comply with the current supplier standards published in 42 C.F.R. 424.57(c).[7] CMS also requires that such suppliers (except for exempted professionals) comply with the Medicare program's quality standards to become accredited. Regulations governing ancillary services are complex and depend upon the provider type; providers should consult legal counsel about their specific situation as it relates to billing, and fraud and abuse compliance.

Product selection

The provider must be prepared to make an upfront investment in product inventory based on utilization patterns. In order to select the right products for their program, the provider must become educated about product options, quality, pricing and service. Proper coding knowledge is imperative, not only for clean claims, but also to understand the impact prefabricated, prefabricated custom-fit, custom fabricated and higher quality products can have on quality of care and margins.

Providers need to consider quality, price and service for the products they offer to patients. Product failures and breakdowns that happen in lower quality products can put the service line at risk. When carefully considered, product selection can lead to more options for the provider and the patient, decreased inventory levels and higher quality of patient care. Some manufacturers also offer a custom logo service, in which the facility's logo can be applied to products, further tying the product to the provider's brand.

Inventory management

Managing multiple SKUs, finding shelf space, reducing "shrinkage," and ensuring proper stocking levels can seem a formidable task. Providers can help mitigate the complexity by stocking universal products, when appropriate, and by implementing workflow management systems and software.

[7] "DMEPOS Supplier Standards," CMS website. Accessed May 25, 2016 http://www.ecfrgoy/cgi-bin/text-idx?c=ecfr&SID=8faa91945881bf476ca44232fb4eb75e&rgn=div8&yiew-text&node=42:3.01.1.11.4.5.8&idno=42. Accessed May 25, 2016.

Charge control

Providers with an in-house model also set billing charges. This provides more flexibility when determining costs to patients which can be better managed on a case-by-case basis if needed.

Billing

Product billing complexities, including fee schedules, coding and documentation and patient billing, can be a perceived barrier for providers that want to implement an in-house program. Variances exist in charges for the same codes based on how the practice sets its fee schedules. Common charge bases include product cost, contracted allowable within each insurance contract, and on the percentage of the Medicare allowable fee schedule. Proper coding is critical for correct reimbursement and compliance.

Providers typically focus on the clinical engagement of patients, but not necessarily their financial engagement. Now, more than half of employer-covered Americans carry $2,000 deductibles, which means as much as 35 percent of provider revenue originates with patient payments.[8] Control of the billing process can have a significant impact on patient satisfaction, sometime negative. It is critical that transactions are straightforward, transparent and convenient:

- Unified billing that combines services and products across providers and facilities, with simple language patients understand.
- Upfront pricing with clear patient responsibility for out-of-pocket costs, and a discussion of how these costs will be handled before treatment begins builds patient trust and loyalty, and paves the way for prompt and full payment.

It takes time and resources to set up in-house billing, but the right technology can make it remarkably easy. Provider charge control engages the patient in the health care process and improves patient satisfaction in the delivery of quality care.

Custom services

Some states require licensed or certified practitioners to provide custom orthotic services. The decision to hire a certified orthotist or to permit trained staff to provide fitting services is largely dependent upon the services provided and state regulations.

Patient out-of-pocket costs

To the patient, cost is the amount payable out of pocket for healthcare services, medical equipment and supplies. For orthotics & DME, this includes deductibles, copayments, coinsurance and amounts payable for equipment not included in the patient's benefit package, or for services provided by out-of-network providers. The amount out-of-pocket a patient is willing to pay depends on individual preferences, financial situation, and priorities.

Additionally, the Internet makes it easy for patients to research the cost of orthotics & DME. Ordering bracing and other medical products (that don't require a prescription) online can offer significant savings. But, this may be considered "out-of-network," possibly subjecting patients to a hefty deductible. Explaining to patients the benefits of purchasing through their provider – getting the right product fitted correctly, better service, and recourse if there are problems with the device – can offset the sometimes added expense.

Patients may not understand that provider estimates are just that, estimates. Insurance companies set the reimbursement pricing, not the provider or supplier. Clear communication upfront means patients are able to make better-informed decisions about their care and can become more engaged with the provider.

[8] "What Retailers Have in Common with Healthcare Providers," Group Practice Journal, October 9, 2014. https://www.patientco.com/what-retailers-have-in-common-with-healthcare-providers/ Accessed April 28, 2016.

Outsourced Inventory Model

Sometimes referred to as a "stock and bill," the outsourced inventory model arose as a way to make it easy for providers to improve patient continuity of care while steering clear of any issues with direct-billing patients for orthotics & DME. In the outsourced inventory business model, manufacturers or other third party suppliers stock their products at the provider location. Because the manufacturer or supplier is not owned by the hospital or practice, it operates under its own Medicare provider number and tax ID. Inventory is not carried on the provider's books, and the arrangement can offer a larger breadth of high-quality products and improve patient continuity of care.

The third party supplier ensures product delivery, staff training, fitting, inventory management, stocking, carrying costs, billing and collections. In exchange for convenience and reducing spend on orthotics & DME, the provider gives up revenue from billing products to the patient and/or insurance. Each provider should consult legal counsel about their specific situation before developing an outsourced inventory program.

In the hospital setting, many ER services do not typically include orthotics and DME in the reimbursement.

Orthotics & DME are often sourced by materials management based primarily on cost and hospitals are looking for ways to reduce such costs. An outsourced inventory program can help meet that need.

Home Medical Equipment Model

Similar to an in-house ancillary service line, an HME entity is typically owned by a hospital or large health system. HMEs provide patient continuity of care for equipment used in the home. Because the HME controls all aspects of the orthotics & DME program, including stocking product, inventory management, patient fitting and billing, the same issues and complexities exist for HMEs as for in-house ancillary services. There is frequent confusion regarding laws that govern the referral of services. HMEs must also be aware of coding differences between orthotics & DME as discussed earlier.

Payoff vs. work

Providers need to weigh profit vs. amount of work. For example, a supply chain director for a health system spent six months negotiating a large capital deal that netted them $1 million in savings. In comparison, it took the director just three weeks to decide to outsource their DME which netted them $500,000.

ABOUT BREG

Breg provides remarkably easy products, services, technology and consulting to improve the quality and lower the cost of the orthopedic episode, from conservative treatment to pre- and post-surgery. The second largest U.S. provider of orthopedic bracing, Breg is a partner to 6,000 orthopedic surgeons and 90 percent of Integrated Delivery Networks who provide sports medicine and rehabilitation products to more than one million patients annually.

As part of the Breg Impact™ program, Breg offers consulting to help orthopedic practices implement and maintain a compliant in-office bracing and orthotics program to help drive ancillary revenue and provide patient continuity of care. Breg Vision® Patient Workflow Management software automates and optimizes an in-house bracing and supplies program. Launched more than eight years ago as a web application, Breg Vision services more than 5,600 providers and 1,400 locations at over 470 leading healthcare facilities, helping them manage patient workflow. For more information on Breg Vision, please view our animation: www.breg.com/vision. If you would like to learn more about Breg Impact, please contact your local Breg sales rep or call 800-321-0607.

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KEYS TO SUCCESS

Is an ancillary in-house model or outsourced inventory program right for you?

There are several considerations when determining if your practice or health system is a good candidate for an orthotics & DME service line. Here are key factors to assess that can greatly impact your success.

- **Current in-house programs:** do you already have an internal DME entity or fulfillment pathway? Seperate billing numbers and/or contracts may be required to bill orthotics & DME.
- **Third-party agreements:** does your practice/facility have an outsourced inventory program with a manufacturer that could limit the scope of products offered?
- **Payer mix:** if your practice/facility is owned by a health plan that has integrated providers with a closed panel, then your practice/facility may not be a good candidate for an ancillary service line or billing program.
- **Volume and patient mix:** potential business value is affected by the type of patient mix and volume. Look at the areas where products may be used: do you have sufficient demand to make a program viable?
- **Specialties:** starting with just one clinic location or a specialty area such as an ER or orthopedics department can be a great way to prove value. If the practice/facility has multiple locations or specialty areas with a patient mix that can drive sufficient demand, your practice/facility's value from the program can be much greater. This can include:

Area of Specialty	Products	Area of Specialty	Products
General Orthopedics	All lower extremity orthotics, walker, crutches	Podiatric	Crutches, pneumatic ankle splints, walker boots
Upper Extremity Orthopedics	Splints, fracture bracing, WHOs, clavicle straps, shoulder immobilizers	Sports Medicine	Tennis elbow, patellar straps, AFOs, knee sleeves and hinged knee bracing, clavicle and shoulder immobilizers
Foot and Ankle Orthopedics	Walker boots, AFO, crutches, walkers	Emergency	Walkers/crutches, knee sleeves/hinged wraps, clavicle straps, cervical collars, LSOs, pneumatic ankle splints, walker boots, slings and wrist splints
Total Joint Replacement	Post-operative orthotics and therapies. OA bracing for pre-operative	Rheumatology	OA bracing for upper and lower extremities, walkers
Spine Surgeons	LSOs, TLSOs, Collars	Pediatrics	Crutches, walker boots, slings, wrist splints, knee sleeves, pneumatic ankle splints, and clavicle straps

Also consider:

- Orthopedic practices or orthopedic specialty hospitals
- General hospitals with a high volume of orthopedic and spinal procedures
- Emergency rooms or emergency hospitals
- Hospitals within a larger system that could lead to additional dispensing locations such as urgent care locations or physician offices
- Occupational therapy
- Physical therapy
- Operating room
- Post-op recovery
- Pediatrics
- Neurology

- **Physician support and motivation:** administrators need to pay particular attention to this success factor. Physicians may be motivated by other positive impacts related to patient continuity of care and positive patient reviews.
- **Program coordination:** as practices and health systems continue on the expansion path, the ability to integrate facilities on a singular platform is critical. Recognize that communication to all stakeholders is key. Reach out to the various departments and groups where orthotics & DME products may be used to better understand the needs such programs can fulfill.
- **Ownership and accountability:** consider who the decision makers are from a purchasing and clinical perspective. In a health system, those most interested in revenue generation and cost-savings, and who have the ability to authorize a program, include the CEO, CFO, Medical Director and Department Heads (purchasing contracting and clinical specialty). In a clinical practice, it is typically the physician owners who have the authority and interest in ancillary programs.
- **Medicare compliance:** regardless of the business model, any orthotics & DME provider that is separately enrolled as a Medicare DMEPOS supplier must comply with the Medicare supplier standards and, unless exempted, quality standards.
- **Business reviews and chart audits:** you must be willing to conduct periodic reviews and documentation audits, both of which can be done in-house or with consultation with outside partners. This will ensure you are optimizing your business value and remaining compliant.
- **Inventory/DMEPOS management:** along with understanding how to implement an in-office orthotics & DME program is the management of products and workflow. Easy-to-use cloud-based applications can simplify inventory tracking, dispensing and reordering. Technology that also interfaces with electronic medical records (EMR) / electronic health records (EHR) and practice management (PM) systems can streamline workflow by reducing duplicate entry and ensuring compliant paperwork.
- **Continuing education with peer networking:** a final success factor is recognizing the value of learning from others who have implemented similar programs. Understanding the potential pitfalls, challenges and solutions can shorten the learning curve and greatly impact program effectiveness.

BEFORE YOU BUY: QUESTIONS TO ASK ANY DMEPOS WORKFLOW PROVIDER

Documentation

- What kind of compliance support do you offer?
- Is there a policy and procedure manual?
- Do you assist with coding, documentation and clinical justification of the products to minimize their risk of a pre-payment review denial?
- Do you offer a detailed written order (DWO)?
- Do you offer proof of delivery (POD)?
- Do you offer an advance beneficiary notice (ABN)?
- What is your warranty and return policy?
- Do you adhere to Medicare supplier standards?
- Do you have a capped rental form?

Consulting

- How many consultants/experts will I have access to?

Support Team

- What is the ongoing support like?
- How many people and resources will be assisting you?
- Reps (product expert) vs Consultants (coding)?
- Are they local?
- How many accounts do you currently have and do you support them with denials?
- Do you assist with Medicare updates?
- Do you assist with the 855s if needed?
- Will you help me with a Medicare site visit?
- Will you support me during an audit?

Billing

- Financial analysis for all orthotic devices?
- Will you assist me with understanding my fee schedules?
- Will you assist me with setting up DME as its own cost center?

Interface

- Do you connect to EMRs/EHRs outside of your outsourced inventory models?
- Is the flow of information bi-directional?
- Can you tell me about the process and timeline?
- What financial responsibilities do we have as a practice?
- What kind of technical support do you offer?
- How many PM/EMR connections do you have live and not in beta?
    - Who are they?
    - Are they practices that are doing their own billing?
- What type of messages are you exchanging?
- What data points are you pulling?
- What data points are you pushing?
- What about documentation?

Platform

- Is it Web based, App based or both?
- What platforms will this work on? (Apple, Android, Windows etc.)
- Is it vendor neutral?

Products

- Do I have to use all of one type of product?
- Will my product mix affect the cost of my product?

Ordering

- What kind of order tracking do you have?
- Do you have partial check-In?
- Do you offer access to inventory real time?
- Do you make it easy to identify par, reorder and critical levels?
- Do you offer transfers?

Reporting

- What kind of reporting features do you have?
- How many standard reports do you have?
- Do you have the ability to manage and schedule reports?

Implementation

- What does training look like?
- Whom do you talk to in our practice/health system?
- What does implementation look like?
- What are the steps to installing this?
- What are our roles and responsibilities vs. you and your team?
- Who is responsible for loading and updating the system?
- How will you help me be more efficient from a clinical workflow perspective?
- What timelines do you have to install this program?

Access

- What type of access will you have to my information?
- Is the system encrypted?
- How do you handle HIPAA information?
- What's your best practice recommendation to adding a new product?
- Do you offer user vs. admin access?
- Can you add/delete products?

Clinical Application

- Please walk me through an entire clinical / patient experience from start to finish.

Partnership

- Do you conduct business reviews?
- Do you conduct chart audits?

References

- Who, where and how long?
- How many accounts are doing 100% of their own billing?
- Do you have 3 references that are:
    - Doing their own billing that are the same size / demographics as us?
    - Doing an in-office DME program that use your system to pull and push information between our PM/EMR and your DMEPOS workflow system?
- Peer to peer feedback from AAOE?

Success Measures

- What are your top three benchmarks to measure success?

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