REFORM OF MEDICARE INTRADIALYTIC PARENTERAL NUTRITION [IDPN] BENEFIT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. STARK. Mr. Speaker, when a group pays too much for a product and thereby provides windfall profits for the provider of that product, there is an overwhelming temptation by that provider to oversell and overuse the product.

That's what has happened in Medicare, where we pay grossly too much for a product called intradialytic parenteral nutrition [IDPN]. As a result, kidney dialysis providers are sorely tempted to overprescribe and overuse this product. To stop the questionable use of this product, I am today introducing legislation to reform how Medicare pays for this nutritional treatment needed by a very small number of end stage renal disease patients.

The current Medicare coverage of intradialytic parenteral nutrition [IDPN] has raised concerns involving the efficacy of this procedure as well as the possibility of gross overutilization. IDPN is the provision of parenteral nutrition that is administered during dialysis for end stage renal disease [ESRD] patients. IDPN is used to deliver nutrition, including amino acids, carbohydrates, and at times vitamins, trace elements, and lipids during dialysis. Although IDPN is provided in conjunction with dialysis, the coverage and reimbursement for IDPN are separate from the ESRD benefit. Specifically, coverage of IDPN is included under the prosthetic device benefit and reimbursed under the durable medical equipment benefit.

Parenteral nutrition is covered for those patients who have a functional impairment of the gastrointestinal tract, which prevents sufficient absorption of nutrients to maintain an appropriate level of strength and weight. Enteral feeding, additional nutrition administered orally or through a tube and absorbed through a functioning gastrointestinal tract, must first be proven ineffective before parenteral nutrition will be reimbursed. Parenteral nutrition is prohibited when it merely serves to supplement regular feeding.

There is concern within the medical field that IDPN is being unnecessarily utilized. Admittedly, there exist patients for whom IDPN is appropriate. According to a May 1993 Health and Human Service Office of Inspector General [OIG] report, an average of 2.4 percent of patients in dialysis facilities receive IDPN, in all cases only three times a week through their dialysis shunt. For-profit dialysis facilities had 2.9 percent of their ESRD patients using IDPN whereas only 1.5 percent of not-for-profit ESRD patients were on IDPN. This discrepancy between for- and not-for-profit hospitals should alert us to the possibility of abuse on the part of for-profit dialysis centers.

Current billing practices for IDPN have resulted in enormous overcharging for IDPN supplies. Some claim that Medicare is paying nearly 800 to 1,000 percent more than the provider's acquisition cost for IDPN supplies. Medicare allows $250 for one combination of total parenteral nutrition solution, but the actual price of these supplies is no more than a couple of dollars. With such inflated prices, it is no surprise that this specific Medicare part B benefit has been overutilized.

According to the U.S. Renal Data System's 1996 report, Medicare outlays for IDPN use rose from $51.6 million in 1991, $68.7 million in 1992, and to $78.1 million in 1993, but dropped off to $46.4 million in 1994. This treatment is considered by many in the medical field to be only appropriate for a very limited, constant number of end stage renal disease patients. It is no coincidence that the DMERC's new guidelines requiring more stringent documentation of the need for IDPN occurred just before this most recent decline in Medicare IDPN expenditures.

Since ESRD patients are on a dialysis machine three times each week for a limited time, the total amount of intradialytic nutrition delivered is rather limited. It is estimated that only 10 to 20 percent of the recommended weekly calories for an ESRD patient are supplied using the IDPN delivery method. However, on average it cost $60,000 per year to administer these few calories. Only 70 percent of the amino acids administered through IDPN are retained within the body. This method of amino acid supplementation provides roughly 108 to 114 grams of protein per week. For comparison, an oral supplement given three times per day would provide 189 grams of protein per week. The cost of such enteral amino acid feeding is roughly $6.30 a week at the Portland VA Medical Center. With these kinds of gross windfall profits, there will be constant pressure to overutilize and abuse IDPN. It is up to us to legislate reimbursement reform.

If the utilization rate and Medicare outlay increases were for a procedure that enjoyed definitive support from the medical community, I would not only justify but encourage widespread use of such treatment for our seniors and disabled. However, in the opinion of the HHS's own Office of Inspector General, ''the benefits of parenteral nutrition for ESRD patients are unproven, its use is associated with a high rate of complication, and the cost of care is disproportionate to the resources expended.''

Clinicians disagree as to the efficacy of this treatment method. Some cite increasing nutritional parameters as evidence that IDPN is indeed nourishing the patient, while others feel that the relatively few studies showing a positive correlation between IDPN use and increasing nutritional parameters contains shortcomings in the design of the study leading to unreliable conclusions. Still others claim that these studies simply fail to demonstrate a link between decreasing morbidity and increasing nutritional parameters.

We must address the IDPN pricing issue immediately to prevent the incentives for overutilization and the further plundering of our already endangered Medicare. I propose that we begin by first changing the reimbursement of IDPN from a rate within the durable medical equipment benefit to an incremental add-on payment within the ESRD benefit that would reflect the marginal costs of providing the individual components of an IDPN solution. This new ESRD benefit would cover only the arms length acquisition costs of the IDPN supplies plus an appropriate administrative service fee. The Secretary must conduct a survey of the IDPN market to determine the estimated true acquisition cost. To eliminate the benefit altogether would deny those few patients the right to a treatment that is indeed warranted. However, by altering the reimbursement of this treatment we will reduce the financial incentive for overutilization. In addition, specific HCPCS codes for IDPN will be created so as to be able to accurately identify the content of the solutions that are being administered.

IDPN coverage has created a complex, confusing system with tremendous opportunity for abuse. I urge my colleagues to support this measure designed to create a simpler, more cost-effective means of covering intradialytic parenteral nutrition in end stage renal disease patients.

TRIBUTE TO MRS. PATRICIA DAVIS OF NASHVILLE, TN

HON. BOB CLEMENT

OF TENNESSEE

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. CLEMENT. Mr. Speaker, I rise today to offer my enthusiastic congratulations to Mrs. Patricia E. Davis for her years of service to the Nashville community. As director of Citizens for Affordable Housing, an agency designed to fulfill the necessary fundamentals of housing and location needs for all families of the Metropolitan Nashville area, she works to enable residents of low-rent housing to become both physically and mentally self-sustaining. In addition to providing refinancing assistance, she also hosts workshops regarding credit, housing, and mortgage issues. This agency serves all perspective homeowners with a financial system which shows these individuals how to live by a budget as well as making them aware of their new responsibilities.

Mr. Speaker, I believe we could all do well to follow Patricia Davis' example, to pay attention to our communities, and give ourselves to them.

TRIBUTE TO DOMINICK RIVETTI

HON. HOWARD L. BERMAN

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Wednesday, September 25, 1996

Mr. BERMAN. Mr. Speaker, I am honored to pay tribute to my good friend Dominick Rivetti, who has been police chief of the city of San Fernando since May 1986. This year Chief Rivetti is celebrating 25 years as a member of the San Fernando Police Department. I am proud to be among those congratulating him on achieving this milestone.

Before becoming chief, he moved up the ranks, from patrol officer to senior training officer to watch commander to division commander. Chief Rivetti is passionately dedicated to law enforcement and San Fernando: He and I have had many conversations about finding funds to expand the size of the San Fernando Police Department. Indeed, the chief is constantly on the look out for government programs designed to help law enforcement.

The chief is currently vice president of the Los Angeles Police Chiefs' Association, and is affiliated with the International Association of Police Chiefs, the California Police Chiefs Association, the San Fernando Police Advisory