The Patient Protection and Affordable Care Act (ACA) promises improved quality and access to healthcare at lower costs (Osborne, 2014). One provision of the ACA, though, risks the opposite effect on all three counts. Section 6407 of the ACA requires select licensed healthcare providers to secure a physician co-signature when prescribing common durable medical equipment (DME) such as glucometers and nebulizers (Osborne, 2014). Providers who diagnose, treat, and routinely prescribe delicate, even dangerous medications lose the authority to prescribe blood glucose monitors under the ACA. Glucometers, available for free and without a prescription through some pharmacies, can now only be prescribed to Medicare and Medicaid patients through the signature of a physician (FTM Real Savings, 2014). This policy brief examines the impact of ACA section 6407 highlighting the risk of harm to patients, loss of provider access among vulnerable populations, and increased costs to Medicare and Medicaid. This publication further recommends that stakeholders in congress, in healthcare, and in waiting rooms alike advocate for immediate passage of H.R.3833 which reverses Section 6407 of the ACA (Osborne, 2014).

**Strengths of the ACA**

The ACA implements a pay-for-performance reimbursement strategy that brings statisticians to every management dialogue in healthcare today (Evans, 2014). Hospitals and providers are now penalized both for readmissions and healthcare acquired injuries such as infections and pressure ulcers (McKinney, 2014). This increases quality while reducing costs. At the same time, millions of previously uninsured Americans now enjoy health coverage for the first time through ACA healthcare exchanges (Brandon & Carnes, 2014). The newly insured may now leave behind the expensive band aid approach of an emergency room in favor of more cost effective engagement and health promotion in the primary care office (Brandon & Carnes, 2014; Senft, 2013). Through these and many other measures, there is hope that the ACA will achieve its quality, cost and access goals.

**Section 6407 – Lack of Evidence**

Section 6407 was written into the ACA with an expressed goal of reducing fraudulent billing of DME to Medicare and Medicaid (Osborne, 2014). A review of ACA and fraud literature shows no evidence, however, that Nurse Practitioners (NP) or Physician’s Assistants (PA) commit a disproportionate share of DME fraud compared to physicians (Osborne, 2014; Rudman, Eberhardt,JS.,III, Pierce, & Hart-Hester, 2009; Zigmond, 2011). Further, there is no published evidence that a physician co-signature is likely to reduce Medicare or Medicaid fraud (Osborne, 2014; Senft, 2013). Neither data nor logic support a practice restriction against APNs and PAs in the name of fraud prevention.
Patient Harm & Cost

As written, the ACA requires a physician signature before a patient takes delivery of DME items specified in section 6407 (Schaum, 2013; Senft, 2013). This will delay care to patients in need of DME since advanced practice providers often work off-site from the physicians with whom they collaborate (Osborne, 2014). Patients suffering from chronic diseases such as diabetes, asthma and COPD will wait for oxygen, nebulizers and weight distribution mattress pads (Osborne, 2014; Schaum, 2013). In full practice states where advanced practice teams work independently of physicians, APNs will either establish a new, time consuming, and expensive relationship with an outside physician or turn patients away (Osborne, 2014). Section 6407 of the Affordable Care Act also creates billing code G0454 paying physicians an estimated $8.85 on average for cosigning face-to-face encounters between advanced providers and their patients (Schaum, 2013).

Risk of Readmissions: Asthma & COPD

A delay in care for prescriptive signatures holds potential consequences beyond the immediate disruption of care. When oxygen equipment, oxygen tanks, and nebulizers are delayed, the risk of injury to patients is real. Putting this in perspective is a study demonstrating that partially controlled asthma significantly increases the odds of readmission for asthma exacerbation (Visitsunthorn, Lilitwat, Jirapongsananuruk, & Vichyanond, 2013). Others demonstrated that improvements in Children’s Asthma Care (CAC-3) quality measures on discharge reduced asthma readmissions by 5 percentage points (Fassl et al., 2012). The CAC-3 quality measures require the facility discharging a child after an asthma exacerbation to document a home plan of care that details when to use a nebulizer (Fassl et al., 2012). These findings highlight the vulnerability of pediatric asthma patients and call into question the wisdom of measures that will delay access to the nebulizers required to care for and avoid hospitalization of asthma patients.

The historical readmission rate of COPD patients is 22.6% (Jencks, Williams, & Coleman, 2009; Messenger, 2012). Messenger (2012) indicated that reducing this costly readmission rate requires improved compliance with oxygen therapy. Section 6407 of the Affordable Care Act creates unnecessary red tape and the likelihood of delayed oxygen therapy for this vulnerable population (Osborne, 2014). This risks triggering the COPD and asthma exacerbations that often lead to hospitalization at great cost to Medicare and Medicaid.
**APN Cost and Quality Advantage**

A review of scientific literature regarding quality of care reveals that APNs provide comparable care to that provided by physicians (Arts, Landewe-Cleuren, Schaper, & Vrijhoef, 2012; Bauer, 2010; Newhouse et al., 2011; Osborne, 2014). Bauer (2010) found cumulative evidence that all studies published in peer-reviewed journals since 1981 indicate nurse practitioners fill the physician’s role with “at least comparable outcomes” in 90% of all primary care encounters (Bauer, 2010; Laurant et al., 2004). An Institute of Medicine / Robert Wood Johnson Foundation report synthesizes the breadth of such literature calling for nurses to “be full partners, with physicians and other healthcare professionals in redesigning health care in the United States” (The Institute of Medicine, 2011, p. S3). With respect to cost of care delivered, historical data published through Vanderbilt University documents APN-led practices yield 23% lower costs compared to other primary care settings (Bauer, 2010; Spitzer, 1997). The quality and cost effectiveness of the primary care APN are well established (Arts et al., 2012; Bauer, 2010; Fund & Swanson-Hill, 2014).

**Call for Passage of H.R.3833**

If section 6407 of the Affordable Care Act is a well-intentioned bid against fraud, it nonetheless transfers final prescriptive authority for durable medical equipment away from the exam room and away from the APN or PA. This defers the final signature on a wheelchair, for example, to an off-site physician who has likely never met much less walked with the patient in need. A distraction of this kind makes ownership of the prescriptive decision ambiguous at best. At worst, it risks injury through the delay of care and is a logistical burden to vulnerable patients who often lack independent transportation (Osborne, 2014). It also risks diverting newly insured and vulnerable patients away from advanced practice offices where long-term management of chronic disease is effectively and efficiently managed (Newhouse et al., 2011). Section 6407 negatively affects the three targets of healthcare reform. It simultaneously jeopardizes quality, access and cost without even a suggestion of evidence that the physician signature on an advanced practice prescription reduces DME fraud. H.R.3833 leaves in place the requirement for a face to face visit while eliminating the requirement for a physician co-signature on orders placed by an advanced practice provider.

The American Nurses Association provides details with convenient links for contacting congress to request passage of H.R.3833 (American Nurses Association, n.d.a). Available at http://www.rnaction.org/site/PageNavigator/nstat_take_action_dme.html H.R.3833 is in committee as of September 21, 2014. If passed, it will strengthen the Affordable Care Act by eliminating the requirement for a physician co-signature when nurse practitioners and physician assistants order common durable medical equipment like those listed below:

- Home blood glucose monitors
- Oxygen – home and portable versions
- Nebulizers and controlled dose inhalation drug delivery system
- Wheelchairs – all types including standard, pediatric, extra wide, lightweight, etc.
- Wheelchair accessories including commode seat, anti-tipping device
- Hospital beds – manual and electric
- Equipment needed to safely transfer patients
- Air mattresses and mattress pads that prevent pressure ulcers

(American Nurses Association, n.d.b)
References


Prevent Patient Harm: Pass H.R.3833

Schaukm, K., D. (2013). 2013 "heads-up": Detailed written orders and face-to-face encounters for certain durable medical equipment. Advances in Skin & Wound Care, 26(8), 350-351. doi:10.1097/01.ASW.0000422243.28718.58


