Competitive Bidding for Negative Pressure Wound Therapy: What Will It Mean to You?

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The Centers for Medicare and Medicaid (CMS) are about to begin Phase 2 of a competitive bidding process that will affect how Medicare will acquire durable medical equipment (DME) for its more than 46 million beneficiaries. DME competitive bidding previously has included crutches, wheel chairs, and powered scooters; now, incongruously, negative pressure wound therapy (NPWT) devices are included in Phase 2. Unlike devices intended to support chronic and relatively uncomplicated conditions, NPWT is an active treatment for both acute and complex wounds. The impact on wound care patients and practitioners could be catastrophic.

Most clinicians would agree there are few differences among crutches or manual wheel chairs, but there are vast differences among different NPWT devices. Some NPWT devices are powered, others are manual. Some have foam, others use gauze. Some but not all have alarms. There are even differences among suppliers, including important distinctions with regard to home delivery, clinician education, patient hotlines, and insurance authorization assistance.

The competitive bidding process involves suppliers placing bids for geographic areas, such as the Dallas metropolitan area or Ohio. All prescribers in a covered area will be required to use the device of the winning bidder for home care of Medicare patients, regardless of their preference. Hence, a low-tech, no-service device supplier could bid and win an area, and providers won’t have a choice. This may be particularly problematic when care is initiated in the hospital with one NPWT device and then the patient is transferred to home care and therapy is interrupted because the mandated low-bidder device is substituted.

Some auction experts have condemned the program as not an auction at all, but rather an arbitrary pricing mechanism. That fact alone speaks volumes about certain bidders’ motivation. Additionally, no penalty will be assessed if a supplier low bids and then turns down the contract after finding it is not feasible to provide the service. This practice could disrupt service to an entire geographic area. During a similar past CMS pilot program, this disruption lasted for several months.

Knowledgeable clinicians are fearful that patient outcomes will worsen with use of inferior, low-tech, no-service devices, leading to increased complications, healing times, and cost of care. In some instances, hospital length of stays could increase because surgeons may insist on using a device that is available in the hospital but not in the home environment. In cases where patient hotlines are not available for troubleshooting, an increase in ER visits to manage device problems, which are common, is predicted.

Overall, clinicians support market competition to lower costs. But there must be standards to ensure equivalent devices and equivalent services. Whenever medical evidence is available, it should be used to inform the bidding process. However, the current initiative does not ensure equivalency, leaving patients to potentially suffer with unhealed wounds.

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