

## IS THE NEW MEDICARE PAYMENT METHODOLOGY A SHOT IN THE ARM? *Vernon Pertelle RRT MBA*



Recall conversations leading up to the Sixth Oxygen Consensus Conference held August 2005 in Denver, CO as well as disagreements that occurred at the conference amongst my former colleagues regarding oxygen classes. We also had similar conversations with industry leaders at the American Association for Homecare (AAHomecare) leadership conference in 2004 held in San Diego, CA in which the executive director of a prominent physician group presented the concept of length of use by patients and oxygen classes with regards to portable (or ambulatory) systems. Apparently the disagreements on length of time patients actually use equipment and if separating portable oxygen systems into different classes made any sense - don't matter now.

Gone are the sleepless nights and fear of the unknown as the new payment methodology for oxygen are now here and become effective January '07. The Centers for Medicare & Medicaid Services (CMS) released amounts to be reimbursed for beneficiaries who receive oxygen equipment. The system requires that payment stop and HME providers transfer ownership of equipment to beneficiaries after 36 months and payment for rental items caps after 13 continuous months of rental from the current 15 months and providers must transfer ownership of the item to the beneficiary. We now know that efforts to prevent this from occurring were unsuccessful. The next step is to determine how to structure their operations to

support provision of equipment and services under the new system while preserving or improving their bottom line.

### *Payment Methodology Described*

The new payment system outlined by CMS includes a new class description for oxygen and obviously developed from informed sources. The question of course on many of your minds is who was the source? Despite our disagreement with their decision we need to understand the details in order to establish a new process for equipment purchases, operational changes and more importantly planning for future defense against additional cuts. CMS under their statutory authority established the new class described as oxygen generating portable equipment or "OGPE", which includes oxygen transfilling equipment and portable oxygen concentrators. OGPE are new technologies that eliminate the need for refilling and delivery of oxygen contents. For the final rule, the OGPE add-on rate for 2007 will be \$51.63 per month. CMS also used the authority to increase the payment amount from \$20.77 to \$77.45 per month for delivery of portable oxygen contents for beneficiary-owned tanks and cylinders.

CMS stated that the new payment method and development of the new oxygen class was to discourage or prevent favoring use of specific types of equipment and assure access of the beneficiary to all types of oxygen systems. Whether or not this approach is successful remains to be seen however at the very least providers can structure their future purchase strategies around transferring ownership to patients and anticipating the need to provide maintenance and service for oxygen equipment. Providers will get paid for portable contents associated with gas or liquid systems at an additional \$56.68 per month more than they do in 2006. Providers must apply scrutiny to determine if the additional dollars support a return on investment (ROI) with using drivers and trucks for delivery of contents while fuel prices fluctuate and driver's salaries continue to increase; not to mention the onerous and expensive process of ensuring FDA and other regulatory compliance. The new OGPE class allows providers to utilize oxygen systems that are single solutions [such as portable oxygen concentrators] for stationary and portable use and receive an add on amount of \$51.63 with no need for expensive refill deliveries, maintaining a fleet of trucks to support liquid deliveries, deal with high gas prices - oh and I don't dare forget to mention the FDA audits and compliance associated with liquid and gaseous oxygen in addition to the associated expense. The goals of their policies according to CMS are to ensure that payments for oxygen and equipment are accurate, that beneficiaries who use portable oxygen systems have sufficient access to oxygen contents, and that Medicare payments do not create inappropriate incentives to provide particular types of oxygen technology. Well, once again they seem to be wrong in their assumption as the new payment system appears to encourage the use of a very specific type of technology and shift towards single delivery oxygen systems also known as non delivery oxygen systems [or nods]. From a clinical and business standpoint nods gets the "nod" (as I've stated in my previous columns) to reduce operational costs, overhead, regulatory nightmares and labor costs.

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### Stationary Reimbursement

Since the law requires that these changes be budget-neutral, CMS will redistribute the current payment amounts each year to insure annual budget neutrality of the new classes.

As such stationary oxygen concentrators for 2007 and 2008 will be reimbursed at \$198.40 and then changes to 193.21 for 2009 and is further reduced to 189.39 in 2010. CMS requires that HME providers not switch out equipment during the 36 or 13 month rental period unless (a) the item was lost, stolen, damaged beyond repair, or no longer functions, (b) physician orders a different type of oxygen system and (c) beneficiary chooses to obtain a newer technology or upgrade and must sign an advanced beneficiary notice acknowledging responsibility for payment (not covered by Medicare). Regardless of your opinion providers must make the best of the new payment system and maximize their opportunities with the new class system to improve their bottom line.

Single oxygen solutions may allow HME providers to eliminate certain operational costs "all together". Warranties provided by manufacturers for these single solutions become more important than they have been in the past as the warranty period will determine when a provider will get reimbursed for maintenance, repair or replacement. Medicare has traditionally paid for maintenance and servicing for beneficiary owned items and will continue this for beneficiaries when ownership is transferred. Payments for general maintenance and servicing will be reimbursed every six months, beginning six months after ownership for beneficiary-owned oxygen concentrators and OGPE. Payment will be based on the same method currently used for other beneficiary owned DME. CMS will also reimburse the HME provider for loaner equipment when repairs are made. There will be no payments for maintenance on beneficiary-owned liquid and gas equipment; however, there will be one payment for pick-up and storage or disposal in the case when oxygen is discontinued. CMS will allow for separate payment for replacement of supplies and accessories (e.g. cannula, tubing) after ownership of the equipment transfers to the beneficiary which is also a "plus" since they currently do not reimburse separately for supplies.

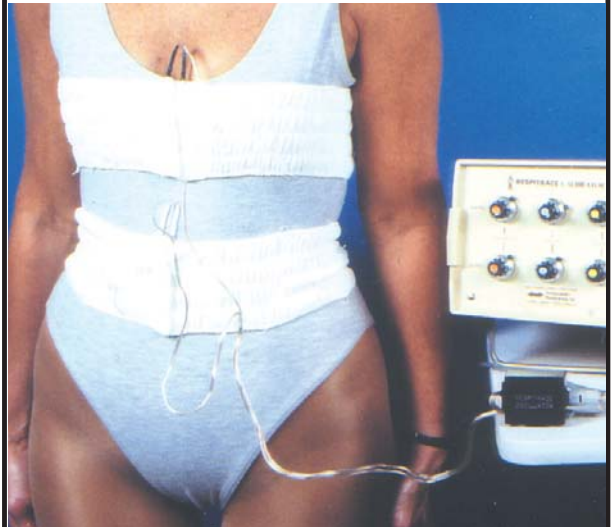
### Next Steps

Hopefully many of you remember the previous articles written by me on activity based costing (ABC) and activity based management (ABM) since these approaches are more important now that these changes are fait accompli (already occurred for those who are not well versed in Latin) and don't forget - competitive bidding is next! So, your survival will be based on understanding your operations and the opportunities to change the way you run your business, equipment purchases and how you structure your systems to document health and economic outcomes to gain proof to prevent further reductions in reimbursement. It's safe to "assume" that there will be no more reductions now that the myriad of reforms have been identified and will be effective the beginning of next year but the caveat of course is not splitting the word that appears early in this sentence [you know....the one in quotes] to a point where we do not prepare ourselves to prevent additional changes from occurring.

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