

CHANGES IN HOME OXYGEN REIMBURSEMENT FOR 2007

by Jim Stegmaier, RRT-NPS, RPFT, CCM



Oxygen therapy has been provided to patients in their private residence for over a quarter century. Home oxygen is reimbursed based upon the Social Security Act which authorizes Medicare to provide compensation to the durable medical equipment (DME) provider under the patient's Medicare Part B DME benefit. DME is defined by Medicare as equipment that can withstand repeated use, is primarily to serve a medical purpose and is appropriate for use in the patient's home.

Oxygen therapy has been reimbursed by Medicare on a rental only basis since 1989. Medicare provides separate payment for stationary and portable oxygen systems. Most patients require *both* stationary and portable systems. Patients who are prescribed oxygen only nocturnally do not receive portable systems. Patients with an oxygen concentrator additionally have some form of compressed gas or liquid oxygen separate from their portable system in case of a power or equipment failure.

In 1989 when Medicare developed the DME fee schedule, oxygen therapy began being reimbursed modality neutral. This meant that regardless of the method in which the oxygen therapy was provided, reimbursement would be the same. Prior to the DME fee schedule, Medicare was paying for liquid oxygen by the amount consumed by the patient and a different fee for an oxygen concentrator. This reimbursement structure provided

an incentive to potentially provide a system to the patient based upon reimbursement rather than clinical needs.

The reimbursement for home oxygen therapy has been reduced by Medicare three times since the initial fee structure in 1989. The Balanced Budget Act of 1997 reduced the compensation for oxygen therapy by twenty five percent on January 1, 1998 and an additional five percent on January 1, 1999. In 2005 the Centers for Medicare and Medicaid Services (CMS) reduced payment again by an average of eight percent for both stationary and portable oxygen systems.

In February 2006, the Deficit Reduction Act ended the policy of rental only for home oxygen therapy. Under the new regulations oxygen therapy would be reimbursed for up to thirty six months of rental and then the patient would own the oxygen therapy equipment. Once the equipment becomes the property of the patient, Medicare provides, as a covered service, reasonable and necessary maintenance every six months plus loaner equipment and any necessary disposable supplies (tubing, cannulas, etc.). However, CMS will *not* cover any general maintenance or service for liquid or compressed oxygen systems. Medicare will reimburse for a one time disposal fee for liquid and compressed oxygen systems when a patient no longer has a medical need for these items. Equipment can be replaced every five years and the durable medical equipment providers are responsible during this period to provide repairs or replacement.

Effective January 1, 2007 oxygen therapy will no longer be reimbursed modality neutral. With the advent of new technology, portable oxygen concentrators and oxygen systems which will transfill compressed gas cylinders in the patient's residence will have a separate HCPC code and reimbursement fee. The fee will be approximately \$51.63 per month. Historically, when a durable medical equipment organization provided these types of oxygen equipment, the reimbursement was identical to the portable oxygen reimbursement for compressed gas cylinders and liquid oxygen. The costs of providing portable concentrators or transfill systems require a much larger cost to the durable medical equipment provider initially but have reduced costs of operation by not having to provide routine compressed gas or liquid oxygen deliveries to a patient's residence. CMS has also recognized that the cost of providing compressed gas cylinders and/or liquid oxygen has increased and is raising the reimbursement for portable oxygen from approximately \$20.77 to \$77.45. Costs in providing routine gas delivery exceed just the delivery costs. Other costs include the actual cost of the oxygen, the cost involved in the tracking of the oxygen lot number and, the cost involved in processing the patient's order to begin with.

Medicare's position is to remain budget neutral on the services and benefits it provides to its patients. Reduction in compensation for the stationary oxygen system will occur January 1, 2007 and again in 2009 and 2010 to keep the total cost of providing home oxygen therapy at an identical level to 2006. The exact level of compensation reduction will be calculated on an

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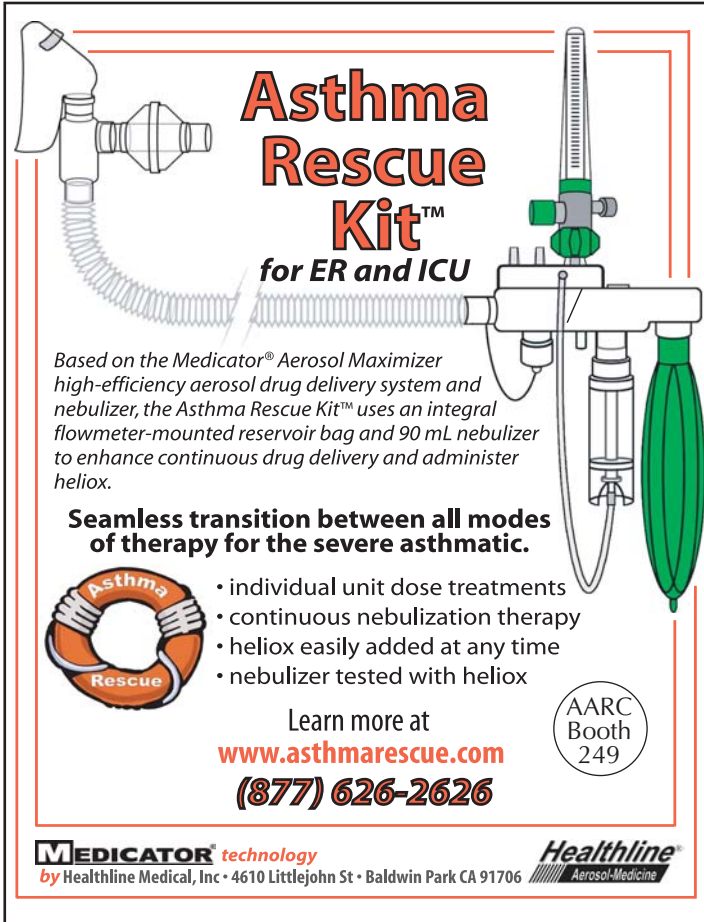
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annual basis. The current reductions are based upon the assumption that 5% of all home oxygen patients will be utilizing either a portable oxygen concentrator or a home tranfill system.

CMS has established a number of safe guards into the new regulations to protect the interests of the patient. Durable medical equipment providers will not be allowed to switch out a patient's oxygen unless one of the following conditions applies:

- Equipment is lost, stolen or cannot be repaired
- A Physician orders a different oxygen system
- A Patient wishes to upgrade their system signing beneficiary notices acknowledging their financial responsibilities
- Patient who moves out of a service area is allowing a new provider either on a temporary or permanent basis

As of 2004, home oxygen therapy accounted for \$2.7 billion of the \$11.1 billion (24%) CMS paid to provide durable medical equipment, prosthetics, orthotics and supplies for a patient in their private residence. The goal of CMS is to allow new cost effective technology to be made available to their patients while at the same time providing an avenue for the traditional methods of providing portable oxygen therapy. There are pro's and con's to the different types of oxygen systems available and based upon clinical and lifestyle needs of a patient different types of oxygen systems can be more advantages than others.

As the durable medical equipment industry moves into 2007 these changes will provide a challenge to each organization as the costs to provide services (wages, benefits, vehicles, fuel, etc.) continue to rise. Providing quality patient services under with reimbursement which will be the same and declining in the future is a hurdle that every home care provider faces on a regular basis. Now that CMS has put into writing their reimbursement plan along with their updated Quality Standards, the home oxygen therapy provider has the opportunity to strategize on how to provide appropriate quality services to their patients, physicians and referral sources.

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viding home ventilator services and other types of high tech care offer challenging employment for the RT seeking a rewarding career in respiratory care. It's not just oxygen, compressor/nebulizer or CPAP set-ups anymore.

So where do we go with the shortage of RTs in the home? The answer to this problem lies with all of us. Not just with the schools or the AARC or the government (state or federal levels). We need to address the larger picture of RT shortage in the profession as a whole, and then perhaps, more qualified practitioners will decide on home care careers and take the positions that are available. Reimbursement for RT home visits will not hurt. This is still being debated in Congress and hopefully, in the near future, there will be a reimbursement mechanism for respiratory therapist home care visits. Remember, COPD is on the rise, and so will the need for home care RTs to conduct patient assessments and deliver the highest level of care possible.