



Supporting Quality Health Care Services at Home

Via Electronic Mail

December 23, 2008

Kerry N. Weems
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 309-G
Hubert Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (73 Fed. Reg. 69726, November 19, 2008). (CMS-1403-FC)

Dear Acting Administrator Weems:

The American Association for Homecare (AAHomecare) submits the following comments on the above captioned interim final rule. AAHomecare is the only national association representing every line of service within the homecare community. AAHomecare members include providers of oxygen equipment and therapy, providers and manufacturers of durable medical equipment (DME), prosthetics, orthotics, and supplies (collectively “DMEPOS”) including rehab and assistive technologies, home health agencies, and pharmacies that provide home infusion and inhalation drug therapies to patients in their homes. Our membership reflects a cross-section of the homecare community, including national, regional, and local providers and suppliers. With approximately 800 member companies at 3,000 locations nationwide, AAHomecare and its members are committed to advancing the value of quality health care services at home.

The final rule implements §144 (b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Section 144 (b) “caps” payment for oxygen equipment after 36 months, and repeals the transfer of ownership of oxygen equipment mandated under the Deficit Reduction Act of 2005 (DRA). The rule imposes new obligations on suppliers that, under any measure, exceed what the Medicare program demands from any other provider. Among the extraordinary new obligations facing suppliers are requirements to provide emergency services and disposable supplies without compensation for as long as 24 months after Medicare payments cap and a requirement to continue serving beneficiaries who move or travel outside the supplier’s service area.

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Despite the unprecedented nature of this rule, suppliers have not had an opportunity to submit meaningful comments before the rule's January 1, 2009, effective date. The Centers for Medicare and Medicaid Services (CMS) determined that because the MIPPA *payment* provisions are self implementing, it had "good cause" to waive notice and comment. While we agree that effective January 1, 2009, the law and regulations require CMS to: 1) cap payment for oxygen equipment after 36 months; 2) pay for contents for as long as they are medically necessary; and 3) allow beneficiaries to elect new equipment at the end of the equipment's five (5) year useful life; suppliers could never have anticipated the rule's more onerous requirements simply by reading the statute. Further, because its effective date is only 60 days from the date it was published, suppliers have not been able to modify their operations to conform to the new rule. A complicating factor is that CMS has promised suppliers additional guidance on many important operational issues, but just five business days before the January 1 effective date this additional guidance had not been published.

We are aware that Representatives Tom Price and Heath Shuler and Senators Pat Roberts and George Voinovich have, along with a number of their colleagues in Congress, written CMS requesting that it delay implementing the rule. We agree. There are aspects of this rule including but not limited to the requirement that suppliers continue to serve beneficiaries who move, that were not addressed by Congress under §144(b) and are simply unworkable. Our comments below will highlight our concerns about each of these problematic issues and provide you with our recommendations for addressing them. For your convenience we have also included a list of the questions we have submitted to CMS over the last several months and that remain unanswered. It is our hope that responses to these questions can be expedited. We discuss these issues in greater detail below.

I. BACKGROUND

A. The Medicare Oxygen Benefit Is in Need of Reform

1. Payment for Home Oxygen Must Recognize the Services That Providers Furnish to Beneficiaries on Oxygen Beyond the Actual Equipment

We must begin by emphasizing that the policies underlying this rule are flawed and in serious need of reform. The oxygen benefit as it is currently structured does not accurately account for the full range of support functions and services that suppliers furnish to beneficiaries. This flaw is evident in CMS' longstanding position that the oxygen benefit is an equipment benefit only. As a result of this "equipment only" stance, Medicare has never fully acknowledged the support services and functions, including delivery, education, oversight, and monitoring that are necessary to ensure that that oxygen therapy is administered safely in the home. Basing payment on equipment costs only results in inaccurate reimbursement and ignores the needs of beneficiaries who require more extensive service.

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This flaw is evident in the conclusions drawn by the OIG in its October 2006 report,¹ *i.e.*, that suppliers are over paid because Medicare (and by extension beneficiaries) pay many times over the supplier's acquisition costs for the equipment. This reasoning incorrectly assumes that equipment acquisition cost is the only cost inherent in serving these beneficiaries. Morrison Informatics examined the costs of a broad range of providers who collectively serve more than 600,000 beneficiaries who use oxygen.² Morrison concluded that equipment acquisition costs represent only 28 percent of the total cost of servicing Medicare beneficiaries using home oxygen. Other operating and support functions necessary to safely deliver oxygen to beneficiaries in their home account for the remaining 72 percent of providers' costs.

These support functions and services include beneficiary education, scheduled and unscheduled maintenance and repair, ongoing patient support, training, and education, as well as other necessary operating and overhead costs. However, the OIG excluded from its analysis costs that are distinct from product acquisition costs. The report states only that these "other" costs are bundled into the fee schedule payments for oxygen.³ By ignoring supplier's service and operating costs, the OIG underestimates the true cost of serving a Medicare beneficiary on oxygen. CMS compounds this error by relying on the OIG study to conclude that suppliers are fully compensated for all of their costs to provide home oxygen (with the possible exception of performing routine maintenance in 2009) during the 36 month rental period. As a result, the payment policy does not address the needs of beneficiaries who may require more extensive services depending on their activity level and the stage of their disease.

2. Medicare Beneficiaries Rely on the Support Services Furnished by Their Oxygen Provider

All beneficiaries on oxygen need the support services identified by Morrison for as long as their medical necessity for oxygen lasts. These beneficiaries typically suffer from Chronic Obstructive Pulmonary Disease (COPD), often with significant co-morbidities, and require oxygen therapy for their long-term survival and well-being. The sickest beneficiaries on oxygen are part of what has been called the "frail elderly" and are the most at risk under the final rule. AAHomecare members who serve oxygen patients report that these beneficiaries are likely to live alone and are highly circumscribed in their activities of daily living (ADLs). Recent clinical studies have confirmed the correlation between the ADLs and patients with severe COPD who are on long-term oxygen therapy.

¹ Department of Health and Human Services, Office of Inspector General, Medicare Home Oxygen Equipment: Cost and Servicing, OEI-09-04-00420, September 2006

² Morrison Informatics, Inc., A Comprehensive Cost Analysis of Medicare Home Oxygen Therapy, June 27, 2006

³ "The monthly allowance for stationary oxygen equipment covers the oxygen equipment; oxygen contents including all refills for stationary and portable systems; equipment delivery, setup, and maintenance; accessories and supplies; patient education; and other services associated with furnishing home oxygen." OIG; p. 2.

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A study last year in *Chest* examined the impact on the ADLs for individuals suffering from one of three long-term chronic conditions, including COPD.⁴ The study concluded that, for all the patients in the sample, COPD was associated with a distinctive pattern of disability expressed by loss of selected ADLs. Other studies have shown that of individuals with COPD, those who required long-term oxygen therapy were less independent in their ADLs than those who did not require oxygen therapy.⁵ Earlier studies also confirm that individuals with COPD decline in their cognitive function as their disease progresses. These studies find that: “cognitive decline is faster in the presence of severe bronchial obstruction and parallels the worsening of the affective status in COPD patients on oxygen therapy.”^{6 7}

Home oxygen therapy is by far a more cost effective alternative to institutional care for patients with COPD. Yet the Medicare home oxygen benefit has been subject to numerous payment reductions since 1997. The largest reduction occurred under the Balanced Budget Act of 1997 (BBA). The BBA cut Medicare reimbursement for oxygen by 25 percent in 1998 and an additional 5 percent for 1999. The BBA also permanently froze all CPI updates for home oxygen. With the exception of modest, temporary updates that occurred in 2000 and 2001, the BBA statutory provisions for oxygen preclude any further CPI updates to oxygen payments unless Congress expressly approves them. Congress applied further reductions to oxygen payments under the Medicare Modernization Act of 2003 (MMA). The MMA reduced oxygen payments by an amount equal to the percentage difference in the median reimbursement for oxygen between the Federal Employee Health Benefit (FEHB) program plans and Medicare. The FEHB reductions, which averaged 10 percent across each DMEMAC jurisdiction, went into effect in 2005.

MIPPA will reduce payment for stationary oxygen equipment by 9.5 percent starting January 1, 2009. Avalere Health estimates that reimbursement will decline by as much as 27 percent in 2009 as a result of the cap and 9.5 percent payment cut. The cap and cut will reduce payments for oxygen by \$845,748,000 in 2009 alone.⁸

These aggressive payment reductions have been driven in large measure by the mistaken assumption that Medicare pays too much for equipment without accounting for the support services that are bundled into the monthly fee schedule amount. To the extent that CMS wants to meet beneficiaries’ needs cost effectively, its view of this benefit runs counter to that goal. Recent data published by the Medicare Payment Advisory Commission (MedPAC) shows that

⁴ Incalzi RA, et al. Construct Validity of Activities of Daily Living Scale: A Clue to Distinguish the Disabling Effects of COPD and Congestive Heart Failure. *Chest* 2005; 127:830-838

⁵ Okubadejo AA, et al. Home assessment of activities of daily living in patients with severe chronic obstructive pulmonary disease on long-term oxygen therapy. *Eur Respir J* 1997;10:1572-1595

⁶ Incalzi RA, et al. Predicting cognitive decline in patients with hypoxemic chronic obstructive pulmonary disease. *Respir Med* 198; 92:527-533.

⁷ Incalzi RA, et al. Verbal memory impairment in COPD: Its mechanisms and clinical relevance. *Chest* 1997; 112:1506-1513.

⁸ Avalere Health LLC, Home Oxygen Therapy: An Analysis of Recent Medicare Payment Policy, December 2008

the cost of a single hospital stay for a COPD patient far exceeds the cost of his home oxygen therapy in a year (\$5.86 per day or \$2,138.90) . Total costs for a *single* episode of hospitalization for a COPD patient, including costs both during and 30 days after the stay, range from a low of \$6,372.00 to a high of \$9,748.00.⁹ To ensure that all beneficiaries on oxygen can optimize their full functional capacity and remain in a cost effective home setting, Medicare payment policy must recognize that suppliers incur costs other than equipment acquisition costs in meeting the service needs of beneficiaries.

3. Medicare Home Oxygen Payments Must Be Tied to Beneficiaries' Need – Not the Equipment

Congress understood that providing oxygen in the home is fundamentally different from merely delivering a piece of equipment. When it established the fee schedules, Congress placed oxygen in a payment category that distinguished it from other medical equipment such as hospital beds. Congress also demonstrated its concern that oxygen providers furnish an appropriate level of service to beneficiaries when it required CMS to establish oxygen service standards under the BBA. To date, however, CMS has not done so, possibly because it is reluctant to acknowledge the specific service needs of beneficiaries and suppliers' costs related to those services.

The solution is to reform payment policy so that reimbursement rates match the support and attention that a beneficiary needs based on his activity level and the acuity of his disease. Current Medicare payment rates do not distinguish among beneficiaries according to their need for service, placing those with more intensive service needs at risk when payment levels decline. While we agree that the delivery of equipment and oxygen contents are indispensable components of the oxygen benefit, it is also important for beneficiaries to receive services appropriate to their specific needs and for Medicare to compensate providers accurately for *all* of the costs they incur serving beneficiaries..

II. COMMENTS on “J. Section 144(b): Repeal of Transfer of Title for Oxygen Equipment”

A. CMS Should Reimburse Providers for the Cost of Furnishing Non-Routine Service

We were surprised to see that CMS will not pay suppliers for non-routine services after the 36 month payment cap. Ironically, when Congress created the capped rental payment methodology it recognized that even hospital beds require *some* level of ongoing service. Consequently, Congress provided maintenance and service payments for capped rental equipment.¹⁰ Yet even

⁹ MedPAC, Report to Congress: Reforming the Delivery System; June 2008, p. 93

¹⁰ The DRA revised the capped rental payment methodology to require suppliers to transfer ownership of “capped rental” equipment to beneficiaries after 13 months. However the DRA instructs CMS to pay for service to beneficiary owned equipment, including repairs and replacement parts not covered under warranty, because Congress understood that medical equipment continues to require servicing after rental payments cap. Congress demonstrated a similar concern for beneficiaries on oxygen because it gave CMS the authority to pay for

though furnishing home oxygen is more resource intensive than delivering a hospital bed, CMS did not exercise its authority to establish non-routine maintenance payments for oxygen after the cap. CMS determined that it would be unreasonable to pay for non-routine maintenance because the supplier owns the equipment and therefore must maintain it in good working order.

The overarching rationale for this policy is that suppliers will have been fully compensated for the equipment, supplies and necessary non-routine services at the conclusion of the 36 month rental period. Again, this reasoning disregards the service needs of beneficiaries and incorrectly assumes that Medicare pays only for equipment under the oxygen benefit. CMS has not considered that in order to furnish *emergency* services and make *unscheduled* service calls, a supplier must have the capacity to furnish those services *whenever the beneficiary needs them*. In other words, non-routine services must be available *whether or not* a beneficiary requests them. It is impossible for a viable business to provide emergency services, which by definition must be rendered *on demand* without incurring overhead and other operating costs in ensuring that the services are available. This seems so obvious to us that we cannot understand how it is that CMS expects oxygen providers to furnish these services without any compensation. To our knowledge, CMS does not expect other health care providers in the Medicare program to work without reimbursement.

As we have recommended to CMS in the past, providers should be compensated for the direct labor and other costs of providing an episode of emergency service as well as the costs they incur in making those services continuously available. We also recommend that CMS pay providers for repairs and parts not covered by a manufacturers' warranty.

B. CMS Should Reimburse Providers for Providing Supplies That Are Necessary to Ensure the Therapeutic Effectiveness of Oxygen Equipment

After the 36 month payment cap, CMS expects suppliers to replenish, at no additional cost to Medicare or the beneficiary, the disposable supplies beneficiaries use with their oxygen equipment. In adopting this new rule, CMS appears to have abandoned its longstanding policy of reimbursing for supplies necessary to ensure the effective use of medical equipment even when the supply item is not explicitly covered under Medicare.¹¹ Historically, this policy permitted CMS to pay for items such as certain prescription drugs, which were not covered under the Social Security Act, but which were essential to ensure the therapeutic effectiveness of the DME. Thus, although there was no Medicare prescription drug benefit *per se* prior to the Medicare Modernization Act of 2003, CMS nonetheless covered and paid for respiratory medications, such as albuterol that were necessary for the effective use of nebulizers, a DME covered item. Prior to

maintenance and service after oxygen equipment caps. The statutory language does not distinguish between routine and non-routine maintenance and service, indicating Congress' intent that beneficiaries receive all necessary maintenance and service after rental payments end.

¹¹ Medicare Benefit Policy Manual, IOM 100-2, § 110.3.

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the MMA, Medicare also covered and paid for antibiotics and other drugs when they were administered through infusions pumps that were covered as DME.

In establishing this policy, CMS exercised the discretion inherent in its authority to administer the Medicare program. CMS appropriately considered beneficiaries' need to benefit from their DME equipment as well as Congress' intent when it created the DMEPOS benefit. There is no question that CMS correctly exercised its authority to cover the otherwise non-covered supplies because without it, the DME item would be ineffective and coverage for the item would be meaningless. Similarly, CMS has a longstanding policy to pay for supplies that are used in conjunction with beneficiary-owned equipment. These policies show that CMS understands that access to supplies is necessary for the beneficiary to benefit from certain items of DME because some DME simply will not work properly without the supply. In the case of oxygen equipment, lack of access to supplies of an appropriate quality and quantity can lead to complications such as respiratory infections.

In contrast to these longstanding policies, CMS is requiring providers to furnish beneficiaries with disposable supplies without reimbursement for the cost of the supply, the cost of delivering it, or the operating costs associated with maintaining an appropriate inventory of supplies. Importantly, we cannot find this new requirement anywhere in the final rule or in the preamble, yet CMS has stated in its press releases and various supplier education forums that, after equipment caps, suppliers are required to furnish -- at no cost to Medicare or the beneficiary -- disposable supplies used with oxygen equipment. CMS also has not offered any data or other support for its conclusion that it is reasonable for the Medicare program to not compensate providers for disposable supplies used with oxygen equipment. Given that this new and unprecedented obligation is not required by the final rule or under any provision §144 (b), appears to have no factual basis, and is apparently in conflict with longstanding Medicare policy in favor of paying for the supplies necessary for DME to work effectively, we question CMS' basis for this rule.

We recommend that CMS establish a payment amount to reimburse suppliers for the cost of furnishing disposable supplies used with oxygen equipment, including the cost of delivery and other related operating expenses. We also request that CMS publish the data it used in making the decision to not pay for disposable supplies.

C. CMS Must Establish a Realistic Payment Amount for Routine Maintenance and Service Visits

We were encouraged to see that CMS intends to pay for routine maintenance and service in 2009. We agree with the determination that payment for these services is reasonable and necessary to ensure that oxygen equipment functions effectively. However, we believe that the payment amount established for these services is unrealistic and does not account for the full costs of furnishing ongoing routine maintenance and service. For example, routine maintenance and service may require a number of activities that CMS has stated it will not pay for such as

replacing parts not covered under warranty. The payment amount is also inadequate to compensate suppliers for their costs of sending a technician to the home to perform these services. Earlier this year, we recommended that CMS establish a routine maintenance and service fee equal to one month's rental payment every six months. We strongly encourage CMS to adopt our recommendation. We also strongly recommend that CMS continue to make payments for routine maintenance and service in years subsequent to 2009.

D. CMS Should Reset the Payment Cap for Beneficiaries Who Relocate Outside Their Supplier's Service Area

The policy requiring suppliers to continue servicing beneficiaries who move or travel for extended periods outside their service area is extraordinary for the way in which it redefines the patient-provider relationship. We are not aware of any precedent under Medicare or state law that requires providers of a medical service such as home oxygen to continue servicing a patient without regard to any changes in the circumstances surrounding that relationship and with no compensation. Likewise we are unaware of any other policy or precedent that binds a patient to a service provider regardless of his reason for requesting a change. By requiring suppliers to service beneficiaries who move away from their service area, CMS eliminates the beneficiary's right to choose a new provider and places the provider in an untenable position financially because it is highly unlikely that another provider will be willing to assume care for a beneficiary once Medicare payments have capped.

Importantly, the policy is completely unworkable because suppliers may be unable to operate in the beneficiary's new location as a result of licensing or other regulatory requirements. Many states require DMEPOS suppliers to be licensed, and some states, such as California and Florida, require suppliers to have a physical facility in the state in order to obtain a license. Clearly it is not feasible for suppliers, with the possible exception of national chain providers, to be licensed in every state in case a beneficiary chooses to move there. Assuming that state law does not prohibit subcontracting for DMEPOS services, requiring providers to make arrangements with a provider to furnish services in the new location might be sufficient to cause the provider to be "doing business" in the state in violation of state licensing laws.

Further, to the extent that the final rule requires unlicensed suppliers to subcontract in order to meet licensing requirements at the new location, it would conflict with a proposed new supplier standard that CMS published earlier this year. The proposed rule would require suppliers to furnish directly any services that require a license under state law. Consequently, an unlicensed supplier could not subcontract for any services that require licensure in a state. For several years now the National Supplier Clearinghouse (NSC) has also maintained a policy against subcontracting for certain DMEPOS services, and a significant number of suppliers have had enrollment or reenrollment applications denied because they engaged in subcontracting. Compliance with state licensing laws and regulations has always been a threshold requirement for suppliers enrolling in the Medicare program. Given what can be a complex interplay between state licensing laws and Medicare supplier standards and enrollment requirements, it is unclear to

us how suppliers will be able to care for beneficiaries who are outside of their regular service area.

Aside from the program integrity concerns that subcontracting arrangements can present, there are also important quality and liability issues that speak against adopting the policy in the final rule. It is doubtful that suppliers, especially smaller suppliers with more limited staffing resources, can manage the subcontracting arrangement from a remote location. Patient quality and safety could be at risk as a result of the contractors' inability to effectively supervise the subcontractor. Further, because subcontractors will not be bound by the Medicare payment structure for oxygen, they will be free to charge contracting suppliers retail market rates for their services. Contractors, in turn, will be forced to make-up the difference between the contract rate and the Medicare rate out-of-pocket. This financial dynamic between the contractor and the subcontractor may have serious repercussions for the quality of the care a beneficiary receives. The loser in this arrangement is the beneficiary who is literally "stuck" unwillingly in the middle of an untenable situation.

For the reasons stated above, and because the decision to move away from the supplier's service area is entirely up to the beneficiary, we recommend that CMS allow a new 36-month rental period to begin again for these beneficiaries. In addition, for the so-called "snow birds," we recommend that CMS pay for their oxygen at the current fee schedule amount for as long as they are away from their usual residence.

Similarly, CMS' position on the ability for beneficiaries and suppliers to make changes in the care relationship after the cap appears to be inflexible in light of the many circumstances that compromise the ability of a supplier to continue caring for a beneficiary. CMS has not addressed what happens when the beneficiary is non-compliant or poses a physical threat to the supplier's staff. We recommend that CMS incorporate a process that would allow for a smooth transition of care in situations where a reasonably prudent person would agree that a change in provider is necessary.

E. CMS Must Provide More Details on How It Will Administer Rules Pertaining to the Equipment's Useful Life

The useful life of oxygen equipment is an important factor that determines suppliers' obligations and beneficiaries' rights under the final rule. The definition CMS applies to this concept and the billing and documentation rules to which suppliers must comply are extremely important. Although CMS has promised further guidance on these issues, it is still forthcoming. We strongly urge CMS to publish this guidance and may provide CMS with more comments once it is available.

F. CMS Has Not Given Suppliers Adequate Guidance on Their New Obligations under the Proposed Rule

The rule creates numerous questions that suppliers need clear and unambiguous guidance. The Association has submitted to CMS a number of these questions over the past year and has made additions as homecare providers have thought through the practical application of these rules. We, therefore, urge CMS to provide written responses to the following questions.

1. The oxygen rule binds the Medicare beneficiary on oxygen therapy to the original oxygen provider regardless of status of the relationship between the provider and patient. Yet, there are circumstances where a separation is warranted. How does CMS intend to address circumstances when either the oxygen provider or the Medicare beneficiary wants to terminate the patient/provider relationship? The current framework may penalize the beneficiary in that he/she may not easily find another provider based on the number of months the beneficiary has been on oxygen therapy. AAHomecare seeks CMS' views and guidance on the following examples and asks CMS to create a policy to address circumstance when these types of examples occur:
 - a. Patient is abusive
 - b. Patient is non-compliant
 - c. Patient abuses equipment
 - d. Patient is delinquent on co-pays and/or deductible
 - e. Patient's residence is unsafe
2. AAHomecare would appreciate CMS' written guidance on policies related to a break in continuous need of oxygen therapy. We would also like CMS to elaborate on CMS' payment policy when a patient is prescribed different technology during the 36 month period. In this latter example, if a patient is initially prescribed an oxygen concentrator but 18 months into therapy, the physician prescribes transfilling equipment, how will the provider bill for this change?
3. As we have noted previously in our comments, the Association does not agree with CMS' proposed policies regarding the compensation amount related to routine maintenance and service. We would appreciate if the Agency would provide its calculations quantifying how the Agency determined that 30 minutes of labor is adequate and that there is no need to bill for replacement parts. Under this question we would like CMS to elaborate on how travel costs are covered by this payment rate. Additionally, we would appreciate CMS sharing with the supplier community the warranty information from commonly prescribed oxygen systems illustrating that manufacturers commonly provide warranties of five years on oxygen equipment.

4. If one oxygen company purchases another oxygen company in an asset purchase (i.e., not a stock purchase), how are the patients of the purchased company treated?
5. If a company files for bankruptcy or its executives decide to close the practice, what is the company's responsibility for the Medicare beneficiaries currently receiving oxygen therapy? If the company plans to continue to provide other home medical equipment but would like to stop providing oxygen therapy, what is a company's responsibility to its oxygen patients?
6. The Association would appreciate written guidance addressing whether a signed proof of delivery is required for all oxygen content refills. Please explain the proof of delivery policy in which contents may not be delivered each month.
7. CMS currently pays one month's rental payment for loaner equipment when beneficiary-owned equipment is being repaired. Will CMS apply this policy to oxygen equipment after payment for the equipment has capped?
8. A beneficiary who has been furnished oxygen equipment requests a different technology (in a different payment class) for non-medical reasons under the following scenarios: 1) The patient would like to purchase a portable concentrator; and/or 2) The patient wants to travel and rent a portable concentrator. In each scenario the supplier may bill the patient directly and obtain an ABN from the patient acknowledging his understanding that Medicare will not pay for two like items. Please confirm that this is an accurate description of Medicare policy.
9. How will CMS reimburse oxygen contents for beneficiaries who had combination systems (stationary oxygen concentrators, stationary liquid and liquid portable equipment) during the 36 month rental period as opposed to beneficiaries who use only stationary and portable liquid oxygen? In this situation, the supplier will have billed Medicare only for a stationary concentrator and liquid portable during the rental period. After the rental payments for the concentrator cap, is the supplier able to bill for both portable and stationary liquid oxygen contents even though the DME provider did not bill for liquid stationary during the rental period? In this case, the beneficiary cannot use the portable unit without the benefit of the stationary unit and stationary contents.
10. How will CMS apply the payment rules for oxygen equipment furnished with an upgrade ABN? For example, if the beneficiary requests upgraded equipment during the 30th rental month, the provider must be able to recover its costs for the equipment. In this scenario, the provider should be able to furnish the beneficiary with an upgrade ABN and charge the beneficiary for the provider's full charges, minus any Medicare rental payments through month 36.

11. Does CMS intend to revise its upgrade ABN instructions to address the previous question?
12. CMS has explicitly stated that backup oxygen equipment is not covered. However, most accrediting bodies require suppliers to provide backup oxygen for beneficiaries using rental equipment. Inasmuch as backup equipment is a non-covered item, we request that CMS state explicitly beneficiaries may agree to pay for backup equipment out-of-pocket after rental payments for oxygen equipment cap.
13. A number of patients are asking oxygen providers for backup oxygen cylinders as the 36 month cap approaches. There are various reasons for these requests—one being that a hurricane is approaching and patients are concerned the electricity will go out. The prospect of no immediate access to electricity and/or emergency services is very concerning to these beneficiaries. Generally these beneficiaries have a concentrator for their system. Inasmuch as Medicare does not cover back-up equipment, and the backup equipment is furnished for the beneficiary's convenience, suppliers should be able to give the beneficiary an ABN to document the beneficiary's desire and agreement to obtain the backup using his own out-of-pocket funds or other applicable health insurance. Please confirm that our understanding is correct. Alternatively, in the event of a natural disaster, will CMS approve payment for back-up oxygen equipment for beneficiaries who use concentrators?
14. If a provider is billing non-assigned after month 36, can the provider create a usual and customary charge for the 6-month maintenance fee to bill the patient?
15. What is permissible when billing non-assigned for oxygen contents? Can providers bill different usual and customary charges based on individual patient usage?
16. What is CMS' strategy on educating referral sources?
17. How will CMS treat patients using transfilling oxygen generating portable equipment (K0738)? The code for transfilling portable oxygen equipment was not established until October 1, 2006, and a higher reimbursement to allow for the new technology did not go into effect until 2007. For patients on these systems since January 1, 2006, will the 36-month rental period start at January 1, 2007, in accordance with the updated fee schedule to reach full reimbursement for that technology?
18. The Association would like CMS to provide clear direction to Medicare suppliers regarding servicing oxygen patients after the 60th month. Suppliers would like CMS to explain how a supplier can terminate the patient/provider relationship after month 60 and pick up the oxygen equipment if the patient does not want to elect new equipment. Also, can suppliers enter into a private agreement with the patient and bill the patient for

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supplies, service calls, on call services, oxygen refills, etc., after month 60 if the patient does not elect new equipment.

III. CONCLUSION

For all of the forgoing reasons, the Association firmly maintains that the Medicare home oxygen benefit needs to be reformed to better accommodate both beneficiary and home oxygen provider concerns. Until that time, we request that CMS immediately revise the final rule in the manner we recommended above and that CMS promptly respond to the questions we submitted under Section "F."

Thank you for the opportunity to submit these comments. We are available to discuss these issues with you at your convenience. Please contact AAHomecare's Walter Gorski at (703) 535-1894 if we can be of further assistance.

Sincerely,



Tyler J. Wilson
President

CC: Herb Kuhn
Laurence Wilson
Martha Kuespert
Joel Kaiser