

US COPD Coalition Webinar: Fee for Service Medicare and Oxygen Coverage

Q & A Follow up

November 22, 2019

- 1) If a beneficiary is currently using liquid oxygen, how can Medicare beneficiaries retain liquid oxygen?
 - a. Response: Under competitive bidding, scheduled to resume in 130 metropolitan areas on January 1, 2021, access to liquid oxygen is ensured. In non-bid areas, if the beneficiary is currently using liquid oxygen, the supplier must continue to furnish liquid oxygen and oxygen equipment to the beneficiary for the entire 5-year lifetime of the equipment. This is a requirement of the regulations and the protections put in place as a result of the payment cap mandated by the Deficit Reduction Act of 2005. Once the beneficiary reaches the end of the 5-year lifetime of the equipment, the supplier's obligation to furnish oxygen and oxygen equipment to the beneficiary in a non-competitive bidding situation ends, and there is no guarantee that the beneficiary will be able to get the supplier or another supplier to replace their equipment with a new liquid oxygen system versus another modality. Medicare recognizes this as an issue in areas where beneficiaries have not been protected with competitive bidding and noted in the preamble of the 2019 rule that it can consider additional increases in payment for liquid oxygen and oxygen equipment to address the situation.

- 2) If liquid is not being considered for separate treatment, what is being considered to be sure suppliers are paid what it's worth? Can they be paid for every delivery?

Suppliers are trying to stop handling liquid because Medicare does not reimburse properly. Some of us NEED liquid. This is a sad situation Medicare is creating.

 - a. Response: CMS separated portable liquid oxygen equipment from portable gaseous oxygen equipment and increased payments (more than doubled payments) for portable liquid oxygen in 2019. CMS also increased payments for delivery of portable liquid oxygen contents for high flow patients in 2019 by 50 percent. Therefore, CMS has considered, and in fact went through notice and comment rulemaking to treat portable liquid oxygen separately. As CMS states in the preamble for the 2019 rule (83 FR 57041, November 18, 2018), CMS may consider increasing the payments for liquid oxygen even further in subsequent rulemaking if necessary (see comment on the proposed rule and response below). CMS is monitoring the situation very closely.

Comment: Some commenters simply stated that the payments for portable liquid oxygen equipment and high flow liquid contents are too low given the high cost of furnishing these items.

Response: CMS agrees that the cost of furnishing liquid oxygen and oxygen equipment is higher than the cost of furnishing other oxygen modalities. The proposals, which are being finalized, will increase payment for portable liquid oxygen and oxygen equipment and portable oxygen contents for patients with high flow needs and

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therefore, will help to address the higher costs of these modalities. Although CMS could increase the rates by more than the amount proposed, any increase to payment amounts would require a higher budget neutrality off-set. It is believed that the best course of action is to see what effect finalizing the proposed changes will have on access to liquid oxygen and oxygen equipment before deciding to increase the rates further and requiring a larger off-set to be applied to other items.

- 3) When the prescription is for 6 liters per minute at night and 10 during the day, we feel that liquid is the only form that makes sense. Can you confirm that gas is acceptable? That is a lot of green tanks.
 - a. Response: It is the responsibility of the physician treating the beneficiary to determine the appropriate therapy needs and to prescribe according to those needs. The medical record must reflect what is required for the beneficiary and why. It should be noted that many stationary concentrators are able to deliver higher flow rates, and, in 2019 CMS established a separate payment class and increased the fee schedule amounts for portable liquid oxygen contents for patients with high flow needs by 50 percent. In addition, if the patient is using a transfilling machine, they can fill small gaseous tanks in their home and reuse these same tanks without having numerous small tanks of gaseous oxygen delivered to their home. CMS established a separate payment class and higher fee schedule amounts for transfilling equipment in 2007.
- 4) If a physician orders liquid oxygen needed over 4 LPM for the beneficiary's lifestyle can the DME supplier refuse if they are a liquid provider?
 - a. Response: During the gap period in competitive bid, any willing supplier may provide any DMEPOS services the supplier wishes. DMEPOS suppliers do have the right to refuse service, however they may not discriminate among Medicare beneficiaries.
- 5) How can Medicare beneficiaries make sure that a portable oxygen concentrator (POC) meets their needs including when sleeping as well as active?
 - a. Response: It is the responsibility of the treating clinician to determine the appropriate therapy and to work with the beneficiary and oxygen supplier to ensure that the desired therapeutic goals are met.
- 6) Can oxygen equipment be purchased under the Medicare program?
 - a. Response: No. Oxygen may only be rented under the Medicare program. DME suppliers are reimbursed for 36 months of rental and then must supply all oxygen required for months 37-60 when the equipment meets the reasonable useful lifetime and may be replaced.
- 7) Does the beneficiary have a co-pay in months 37 – 60?
 - a. Response: No. There is no additional payment in months 37 – 60 for rental of oxygen equipment. If the beneficiary uses a stationary and/or portable gaseous or liquid oxygen system, additional payments in months 37 – 60 are made for the delivery of oxygen contents for these systems. In addition, for concentrators and transfilling equipment, the supplier can charge for a maintenance and servicing visit once every six months as long as they come to the patient's home and service the oxygen concentrator and/or

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transfilling equipment. These services will result in co-insurance amounts due the supplier.

- 8) I moved from one state to another during month 24 of oxygen rental. The DME claimed that my contract started over simply because I had a new Medicare provider, yet it was the same company! The only one to benefit from this was the DME. I had to pay my portion for another three years.
 - a. Response: A new 36-month rental period does not begin in a case where relocation occurs, and the existing supplier has the ability to continue providing service as it was within their service area.

- 9) When a beneficiary moves out of a supplier's service area after the 36-month cap, is the original supplier responsible to continue providing service?
 - a. Response: Yes. The supplier who receives payment for month 36 of oxygen is required to either provide or arrange for provision of service for months 37 – 60. See Local Coverage Determination (LCD) Oxygen and Oxygen Equipment (L33797)

- 10) What options do beneficiaries have when a supplier refuses to deliver more oxygen tanks and the beneficiary is running out.
 - a. Response: If portable oxygen is covered, DME suppliers are required to provide whatever quantity of oxygen the beneficiary uses.

- 11) Why would suppliers be required to provide as many cylinders as a beneficiary wants?
 - a. Response: This was addressed during the webinar quoting the requirements for provision of portable oxygen.
 - i. LCD L33797 specifies "If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the beneficiary uses; Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed."

- 12) Can testing for Medicare be done by pulse oximetry or must it always be an ABG?
 - a. Response: Either pulse oximetry or ABG testing will be accepted, however if both have been performed on the same day under the same condition, the ABG should be the value reported on the oxygen CMN.

- 13) Do those needing nocturnal supplemental oxygen due to desaturation while sleeping also require an arterial blood gas opposed to simply overnight oximetry testing?
 - a. Response: There is not a requirement for both an ABG and overnight oximetry. Overnight oximetry will be accepted for those beneficiaries who are in their chronic stable state with no additional therapy during sleep. For beneficiaries having sleep disordered breathing that may require treatment with a PAP or RAD device, the sleep oximetry testing must occur in a polysomnography with the beneficiary at their optimal PAP or RAD settings.

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- 14) What is my quarterly statement from Medicare? I have never received one and I have been on Medicare since June 2014.
- a. Response: Medicare provides quarterly statements for beneficiaries who have received medical services billed to the Medicare fee-for-service program. See your “Medicare and You” benefit booklet.
- 15) Airlines have a list of approved portable oxygen concentrators, but the airlines do not actually provide the POCS. What is the DME supplier’s responsibility?
- a. Response: The oxygen policy addresses oxygen furnished by an airline and notes that it is not the responsibility of the supplier. Additionally, DME suppliers are not required to arrange for oxygen outside the United States and its territories.
- 16) If a beneficiary is hospitalized and upon discharge a portable oxygen tank is needed can the DME supplier refuse to deliver one to the hospital for that beneficiary?
- a. Response: DME suppliers are required to deliver either to the home or to the hospital. The beneficiary cannot be required to pick up oxygen.
- 17) Where can I find out who has the competitive bid contracts?
- a. Response: There are currently no competitive bid contracts. Information on competitive bid can be found here:
<https://www.dmecompetitivebid.com/cbic/cbic.nsf/DocsCat/Home>
- 18) During a competitive bid round, if we are in a contracted area and the DME supplier will not supply liquid can we go outside to use a supplier that is not contracted?
- a. Response: During the previous rounds of competitive bid, contracted suppliers were required to furnish exactly what was prescribed by the physician. The competitive bid implementation contractor would be able to assist with the requirements under the next round of contracts.