



Talking Points Re: Oxygen Regulations

Sample talking points about CMS' October 30, 2008 oxygen rule for a telephone call, email or fax to the U.S. Representative for your congressional district and the Senators for your state.

As a provider of home oxygen therapy to Medicare beneficiaries, I am contacting you to express grave concerns about a rule issued by the Centers for Medicare and Medicaid Services (CMS) on October 30, 2008 in the 2009 physician fee schedule. About one-third of all patients who rely on the home oxygen benefit in Medicare will be affected by the new rules beginning on January 1, 2009.

The new CMS regulation for home oxygen therapy will cause confusion, disrupt service, and harm access to care for oxygen therapy, which is a life-sustaining benefit for more than one million seniors in Medicare with COPD and other lung diseases. The CMS regulation establishes coverage and payment policy for the treatment of oxygen therapy services to Medicare beneficiaries after the 36-month rental/service payment cap goes into effect. In short, Medicare's oxygen guidance indicates that it will make virtually no payment for maintenance, service or necessary supplies for a period of two years after the 36-month rental/service cap is reached.

The following are key concerns that must be immediately addressed:

- The unmanageable and unreasonable requirement that an oxygen provider must arrange continued care for a patient on oxygen therapy who moves out of the oxygen provider's service area, including moves to a distant region of the country, after monthly payments cap beginning on January 1, 2009;
- Inadequate reimbursement for routine maintenance and service of the oxygen system, which ensures that the system is working at an optimal level. The CMS rule allows for only two thirty (30) minute maintenance checks per year allowing only between \$15-\$30 per visit;
- CMS does not recognize any costs associated with visiting patients who require episodes of unscheduled emergency services. CMS indicates that equipment is reliable during its reasonable useful lifetime (five years) and that any unscheduled visits to the patient's home between months 37 to 60 are covered by the monthly rental/service rate paid to the provider between months 1 to 36.

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- CMS will not pay for supplies such as oxygen tubing, face masks, or cannulas required for oxygen patients between months 37 and 60. CMS states that any medically necessary supplies provided between months 37 and 60 are covered by the monthly rental/service rate paid to the provider between months 1 and 36.

These onerous regulations are in addition to the 9.5 percent reduction to reimbursement for oxygen therapy that will take effect on January 1, 2009 and a long series of additional cuts to oxygen dating back more than 10 years.

A second but related issue caused by the imposition of the 36th month cap is that beneficiaries who are approaching the 36th month cap and who are moving or want to select a different oxygen provider are having difficulty finding a new home oxygen provider. This is because the new oxygen provider will only be paid the remaining months of the 36-month cap window or nothing at all if the patient has been on oxygen therapy for more than three years.

Medicare's oxygen policy is seriously flawed and changes are necessary in order to make the oxygen benefit more focused on patients and the services they require. Please convey these concerns to your colleagues and CMS officials so that access to quality of care for oxygen patients is maintained.

Sincerely,

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