

**CIGNA**

**Moderator: Ronja Roland  
December 8, 2008  
1:00 p.m. CT**

Operator: Good day everyone and welcome to today's CIGNA "Oxygen: Ask the Contractor" teleconference. Today's call is being recorded.

At this time, I would like to turn the call over to Ronja Roland. Please go ahead, ma'am.

Ronja Roland: Thank you, Operator. Good afternoon everyone and welcome to the CIGNA Government Services "Ask the Contractor" teleconference regarding oxygen.

I am Ronja Roland with Provider Outreach and Education. I would like to thank everyone for participating in today's call. Again, your participation helps us to identify issues or concerns that are important to you so that we can better meet your needs as a supplier.

CIGNA Government Services is pleased to be the first to provide education regarding oxygen payment changes. And our oxygen – excuse me – our education efforts include today's call as well as Webinars in the coming weeks.

Today's call is dedicated to suppliers that bill oxygen claims to Medicare. Because today's call is specialized for oxygen suppliers, we ask that all questions be limited to those concerning oxygen coverage and payment.

For those suppliers on today's call that may not be oxygen suppliers or have general inquiries, we will host a general Ask the contractor teleconference on Wednesday, December 10, at 1 pm, and that is Central Time.

During today's call, we will discuss the latest changes affecting oxygen suppliers such as changes in Medicare payment or oxygen and oxygen equipment.

Joining us today are additional representatives from our Provider Outreach and Education department and our operations department. In anticipation of questions that cannot be addressed by CIGNA Government Services as a contractor, we do have representatives from CMS present on today's call to address those questions.

Please keep in mind that we are not able to answer questions about individual claims issues. If you have any individual claims issues, please contact our provider contact center at 866-270-4909. To check claims status, you may call the interactive voice response or IVR system at 866-238-9650.

We do want to let you know today's call is being recorded, and playback of today's call will be available on the Jurisdiction C Web site. The minutes from today's call will also be posted to the Jurisdiction C Web site no later than December 22. A listserv message will be sent to notify providers of the recording as well as the minutes. Please be sure to sign up for the CIGNA Government Services listserv if you are not currently signed up, to ensure that you are receiving recent Medicare information that may affect you as a provider.

Let's begin with some key points regarding oxygen payment and billing issues.

Oxygen and oxygen equipment are currently paid on a fee schedule basis. The beneficiary is responsible for coinsurance and deductibles. The rental payment covers the equipment, content, maintenance and supply and accessories such as tubing or mouthpiece and other services necessary for furnishing oxygen and oxygen equipment.

Based on the Deficit Reduction Act of 2005, monthly payments for oxygen and oxygen equipment are limited to 36 months of continuous use, after which the equipment title transfers – transfer to the beneficiary. As now required by the Medicare Improvement for Patients and Providers Act of 2008, or often known as MIPPA, there are new oxygen payment rules and supplier responsibilities regarding oxygen.

Section 144b of MIPPA repeal the provision mandated by the Deficit Reduction Act which require a supplier of oxygen equipment to transfer titles of the equipment to the beneficiary at the end of a 36-month rental period. The new provision repeals the transfer ownership and permits suppliers to retain ownership of the oxygen equipment following the 36-month rental path.

Section 414.226 of the CMS regulations require the supplier who furnished the oxygen equipment in the first month to continue furnishing the oxygen equipment for the entire 36-month period, with certain exceptions such as when the beneficiary relocates out of service area, when the beneficiary elects to obtain oxygen equipment from another supplier, or in certain emergency situations granted by the DME MAC or CMS.

Section 414.226 also prevents suppliers from switching oxygen modalities during the 36-month period, in cases such as from liquid oxygen to a concentrator. There are sections to this regulation in the event the physician orders different equipment or the beneficiary chooses newer technology and an ABN has been signed.

The following provisions apply after the 36-month cap has been reached.

The supplier is required to continue furnishing the equipment, supplies, accessories and content and for ensuring the equipment as in good working order for any period of medical need for the remainder of the five-year reasonable useful lifetime of the equipment.

The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen content used with the supplier-owned oxygen equipment for any period of medical need for the remainder of the useful lifetime of the equipment.

Medicare will pay for oxygen contents for any gaseous or liquid oxygen equipment. Suppliers should continue to use codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen content.

Medicare can pay for a general maintenance and servicing visit for concentrators or transfilling equipment in 2009 which must take place six months after the end of a 36-month rental period. This payment will be made if the supplier visits the beneficiary home, performs any necessary maintenance and servicing, and inspects the equipment to ensure that it will function safely for the next six months. Other than this general maintenance and service payment, no other payment will be allowed for any repair or maintenance and servicing of supplier-owned equipment, including any replacement part furnished as part of any repair maintenance and service of oxygen.

The supplier is responsible for furnishing all of the same items and services after the 36-month rental period as furnished during the rental period with no additional charge to the beneficiary. Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

In discussing beneficiary relocations, if the beneficiary relocates before the end of the 36-month rental period, they should work with their supplier to make arrangements to continue receiving oxygen from a new supplier at his or her new place of residence. If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing the oxygen and oxygen equipment and therefore must make arrangements for the beneficiary to continue receiving oxygen services at their new place of residence.

Please note, effective January 1, 2009, a fee schedule reduction of 9.5% applies to oxygen rental payment.

Now we'll look at the useful lifetime of the equipment.

In accordance with Section 414.210, the reasonable useful lifetime of durable medical equipment including oxygen equipment begins on the date that the equipment was first delivered to the beneficiary. The reasonable useful lifetime of oxygen equipment furnished to beneficiaries on December 31, 2005 was not adjusted to begin anew on January 1, 2006 to correspond with the start date of the 36-month rental period. Therefore, in these situations, the equipment reasonable useful lifetime may end at any point during or after the 36-month rental period.

The information provided during today's call can be found in Medlearn Matters article SE 0840. You may also reference the Federal Register on – located on the CMS Web site, and that is [www.cms.hhs.gov](http://www.cms.hhs.gov).

This concludes the update portion of today's call. As a reminder, the recording and minutes from this call will be posted to the CIGNA Government Services Web site. And that Web site address is [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com), and you may select the DME MAC Jurisdiction C homepage.

We will – in just a moment we will open the lines for your questions. Please keep in mind, again, that we will not be able to answer questions about individual claims or general inquiries. If you have a question regarding a specific claim, you may contact the provider contact center at 866-270-4909.

And again, we'd like to take this opportunity to thank you for participating in today's call. And we will now take your questions.

Operator: Thank you and if you would like to ask a question, please press star 1 on your touch-tone phone. Also please deactivate any mute function to be sure your signal can reach our equipment. A voice prompt on your phone line will indicate your line is open. And we do ask that you please state your name before posing your question. Once again, that is star 1 for a question. We'll pause a moment to assemble our roster.

And we'll take our – now take our question from our first questioner. Your line is open.

(Pattie): Hi, yes. My name is (Pattie) with Health Services of Miami and my question was, so you had mentioned that we are responsible after the 36-month cap, if the patient moves outside of our area, we're responsible to continue servicing them with oxygen, so in other words, we might have to set them up with another company wherever they're at. But how would it work as far as reimbursement to that other company?

Ronja Roland: OK. I'm sorry. And your name is (Pattie)?

(Pattie): (Pattie), yes.

Ronja Roland: Hi, (Pattie), this is ...

(Pattie): Hi.

Ronja Roland: ... Ronja.

in regards to the beneficiary relocation ...

(Pattie): Right.

Ronja Roland: ... with that, you can contact with the provider in that area, if it's outside – or in a new place of residence, you can contact with the supplier in that area. Only one provider will be paid for either – for the maintenance and servicing or the contents refill. So at that point, like I said, you may want to contract with a provider in that area.

(Pattie): So if you're worried that there might be providers that will be unwilling to do it for a maintenance fee because they'd have to provide the concentrator on a monthly basis, let's say the patient moved and they're not going back to our area, so it will be two years that they'll only be able to bill a maintenance fee. So that might be hard for us as a supplier to find somebody to willing to do that in another region where we're not even familiar with the companies in the area.

Ronja Roland: Yes, and that may be a concern that we would hear from the supplier community.

(Pattie): Right. Are they going to address that? Are they looking into ...

Ronja Roland: If CMS would like to – if there are any additional thoughts they would like to add, (they're free to do so).

(Pattie): OK. Because that's the one thing that when I saw that that was part of the rule, I found that that would be probably next to impossible to find a company willing to do that for a maintenance fee, which was – my other question, do you know what the maintenance fee will be?

Ronja Roland: The reimbursement ...

(Pattie): The reimbursement, right, for the maintenance every six months.

Ronja Roland: Yes. Just a moment, let me locate that.

(Pattie): Thank you.

Ronja Roland: OK, (Pattie), the reimbursement, it would be two units of the E1340, and of course depending on the state that you're in, and I'm not sure what state you said you were.

(Pattie): In Florida.

Ronja Roland: It will be 17.46.

(Pattie): For two units – two units at 17.46 each unit?

Ronja Roland: I'm sorry – I missed the last part of your question.

(Pattie): You mentioned two units, it's two units at 17.46 a unit?

Ronja Roland: Per unit, yes.

(Pattie): And then, does that include the – are we supposed to charge separately for the cannulas or that's included in that maintenance fee? The cannulas and the humidifiers, filters, whatnot?

Ronja Roland: That information we do not know currently.

(Pattie): Oh, they don't – OK, they haven't decided that.

All right. Well, thank you very much. That was it.

(Joel Kaiser): Hi, this is (Joel Kaiser) from CMS. I can respond to the question about the furnishing the oxygen after the 36-month cap for a beneficiary who's located outside the normal service area of the supplier.

We discussed that scenario in the interim final rule and in preamble, and we also discussed payment for maintenance and servicing after the cap for certain equipment and the rationale for the determination as far as what was reasonable and necessary and what was not reasonable and necessary.

But getting back to the furnishing you know responsibilities for furnishing equipment after the 36-month cap, the law very clearly mandates that the supplier furnishing the equipment for the 36-month period must continue to furnish the equipment for any period of medical need for the remainder of the reasonable useful lifetime of the equipment. And there are no exceptions to that mandate, to that provision in the statute.

So if a beneficiary does move to another part of the country, the supplier is still responsible for continuing to furnish the equipment. And obviously that might be a little hard if you know it's from one side of the country to the other.

So there are different things that the supplier could do. They could you know if it's an oxygen concentrator, particularly a portable oxygen concentrator or even a stationary one, that's something that can be transported with the beneficiary. They could let them take the concentrator with them and then they could send them through the mail the tubing and cannulas. And if there's any servicing that needs to be done, they can contract with a supplier in the new area to do the servicing.

Or they could have the – set the, you know, work with another supplier in the other area to accept the beneficiary up once they get to the new area with their stationary oxygen equipment. And the new supplier would provide the equipment and would provide the replacement supplies, et cetera. And since it's the responsibility of the supplier who received the 36th payment, they would have to reimburse that supplier for furnishing the services.

That is what this new payment rule essentially is. It's three years of payment for a beneficiary to use oxygen equipment for three years or more. The supplier is paid up front for the first three years, but the responsibility continues after the 36th payment has been made, until the end of the reasonable useful lifetime. So the way you need to look at it is the supplier is paid up front in advance three years worth of payment for a five-year responsibility.

So that is you know the law of the land now. That is the new payment law. You know the main part of this was repealing the transfer of ownership so that suppliers did not have to lose title to equipment at the end of the three-year period, but going with that are the responsibilities that the supplier who keeps the equipment to continue furnishing the equipment for the rest of the reasonable useful lifetime. And there are no exceptions, like I said, for beneficiaries who relocate.

The maintenance and servicing issue was something we discussed in detail in the interim final rule, so I would invite you to read that. And I would also let you know that you know the comment period for that rule continues until 5:00 pm on December 29. Thank you.

Ronja Roland: Thank you, (Joel).

Operator: OK. And we'll take our next question.

(Joey Graham): Hi. My name is (Joey Graham). And I have a question about the reasonable useful lifetime. Many oxygen suppliers frequently swap out the equipment in lieu of doing the service at the patient's residence. And so throughout the 36-month payment period, the concentrator might be swapped out multiple times. I was wondering, does that useful lifetime restart every time the concentrator swapped out, or is it still based on the initial date of service?

(Joel Kaiser): Yes, hi, this is (Joel Kaiser) again. That's something that has not been specifically addressed in our guidelines yet. I would point out that we'll be issuing revisions to the Internet-only manual, specifically Chapter 20 of the claims processing manual, that also includes all the payment rules and instructions related to those rules and policies. This is a question that we're well aware of related to reasonable useful lifetime.

The regulation currently states that – the reasonable useful lifetime actually can be longer than five years if the carrier determined that the reasonable useful lifetime should be longer than five years, but in no case can't be less than five years, that the only way it can be less than five years is if CMS issues program instructions indicating reasonable useful lifetime of less than five years. So, generally, the default is five years.

And what it says in the regulation is that the reasonable useful lifetime is based not on the age of the equipment but the date that the equipment is initially furnished. So now the question comes,

what does that mean when the equipment as initially furnished? Does that mean the exact piece of equipment or does it mean the type of equipment in general, such as oxygen equipment?

And all I could say at this point is that we'll be providing additional clarification on that in the very near future either through one of our Medlearn Matters articles or through Web posting. So there will be guidance on that coming in the near future. We know it's a very important issue for suppliers, and we're going to get that out. We have to you know go through the channels of clearing the final policy.

But we know that reasonable useful lifetime now has you know another meaning with this legislation. Before it was just a means of determining when it's reasonable to replace equipment based on lifetime – useful lifetime of equipment. Now it has a meaning in that the supplier is bound to continue furnishing the equipment until the end of that lifetime.

So we know it's a matter of utmost importance to suppliers, and we will be providing clarification in the very near future. Thank you.

(Joey Graham): Thank you, (Joel).

Ronja Roland: Thank you ...

Operator: And we'll take our next question.

Jerry Francisco: Good afternoon. This is Jerry Francisco of Apria Healthcare and I have a couple of questions.

The – my first question is a continuation of the reasonable useful lifetime. And for our patients wherein we had delivered – first delivered the equipment prior to 1/1 of '03, our understanding is

that we can supply the patient with a new piece of rental equipment and we can start a brand new cap rental episode. If our understanding is correct, what type of documentation would we need to submit to the DME MAC? And is a new CMN required in such situation?

(Joel Kaiser): Yes. Another – I'm glad you brought that up. That's another really important issue we're dealing with right now and also one that we'll be providing guidance on in the very near future.

That is one that clearly is laid out in the rule; however, we're still processing through exactly how suppliers will be billing in those situations, how the claims will be processed in those situations. We're getting close to having the final answers that we need in order to provide guidance to the suppliers on how to bill in these situations. And you know hopefully we'll be getting that out in the very near future.

Jerry Francisco: Thank you. And my second question is in reference to billing for monthly fills. It is our understanding that we can bill one unit of fills and that we will be paid a flat monthly fee. Prior to the DRA for oxygen, there was a mechanism to bill Medicare for high or low liter flow patients in which reimbursement would either be upped or reduced depending on certain modifiers, but they were modifiers appended to rental HCPCS code. With the billing of monthly fills, will there be a similar mechanism?

(Joel Kaiser): Yes. Hi. Yes, the adjustment for patients that use more than 4 liters a minute and the reduction in payment that applies to patients who use less than 1 liter per minute, those apply to the single – I'm sorry – to the monthly payment amount for oxygen and oxygen equipment. They don't apply to the oxygen content fee. The oxygen content fee is a monthly payment for furnishing oxygen content and it's not a, you know, one payment per delivery. It is the payment for the patient's monthly oxygen contents need.

So there is just one payment amount. It doesn't adjust based on you know liters per minute of oxygen use. It is one payment amount. We have been paying this payment amount in limited circumstances in the past when the beneficiaries own their own oxygen equipment. But of course, now it's going to you know there's going to be many more payments for oxygen contents now that we have these new rules for payment after the cap.

But again, there is no similar adjustment for, you know, a volume adjustment for the oxygen content. That only was mandated in the law for the oxygen and oxygen equipment payment that's made during the 36-month period.

Jerry Francisco: Thank you very much.

Ronja Roland: Thank you and Operator?

Operator: Yes?

Ronja Roland: If you don't mind, just remind them, if their question has been asked, to remove themselves from queue. And we're going to limit each question – each participant to one question, so that we allow enough opportunity for the attendees to ask a question.

Operator: OK and if you would like to remove yourself from the queue if your question has been answered, it is star 1 to ask question and star 2 to remove yourself.

And we'll take our next question.

(Louis): Yes, this is (Louis) from Fort Lauderdale. My question, I'd been hearing a lot on provider responsibilities; I have a question on beneficiary responsibilities with respect to their coinsurances

and deductibles. If we have a beneficiary who absolutely refuses to pay their coinsurance and deductibles, are you saying we're obligated to continue to do business with them?

Ronja Roland: This is CIGNA Government Services. Unfortunately, we don't have any additional information. I'm not sure if CMS has any to add in.

(Louis): Then, when are we going to get it?

(Joel Kaiser): Well, I can tell you what the law requires. This is (Joel Kaiser) again. The law thus speak in terms of the supplier being responsible to continue to furnish the equipment after the 36-month period ...

(Louis): I'm talking about from the first month on.

(Joel Kaiser): Yes, I know. And what I was going to say was that we had the same issue that was brought up during the rule-making process for the Deficit Reduction Act. And we consulted with our general counsel, and our general counsel advised us that you know the payment rules are the payment rules. They're you know the plain reading of the statute; this had to do with the title transfer. Someone during the rule-making asked, maybe several people commented on, "Do we need to transfer title after the 36-month if the payment still owes us copayments – coinsurance payments?" And the answer is that – yes. The law requires you to transfer title on the first day following the 36th payment.

Now, obviously collecting copayments is something that you need to deal directly with the beneficiary about you know through what your normal means of doing that or through collection agencies or however you do that. But the law you know under the DRA did require transfer of title after 36 months.

Now that's been changed. The new law for MIPPA is that there's no transfer of title, but the supplier must continue to furnish the equipment.

So I would guess that (GC) would give us the same answer they gave us on the title transfer, that this is a requirement in the law and that you know there's no exception provided in the case where beneficiary has outstanding coinsurance payment.

So that would be my answer to that question.

Operator: And we'll take our next question.

(Julie): Hi, my name is (Julie); I'm calling from Medical Billing Solutions. I have several questions.

I was under the impression that there had to be a 90-day required O2 concentrator check for the accreditation companies. And now I hear that there's a six months check. Has that changed?

Ronja Roland: (Julie), yes – this is Ronja. The accreditation companies may require something different as your states may require something different. The thing to remember is that you must be in compliance with any state, local or federal guidelines that must be in place. So if that is a requirement based on accreditation, to meet your accreditation guideline, then my thought would be that yes, you would have to maintain that as well.

(Julie): So there would be no way for us to charge you guys or ...

Ronja Roland: Yes.

(Julie): ... be able to send then a claim.

Ronja Roland: No.

(Julie): That would be something that would be ...

Ronja Roland: No, not in the ...

(Julie): ... an additional loss to the supplier ...

Ronja Roland: No ...

(Julie): ... along with all the laws that we have now?

Ronja Roland: As it stated, like I said, the only maintenance would be the every six months. That would be the only maintenance payment that would be made.

(Julie): OK.

Ronja Roland: Thank you.

(Julie): Thank you.

Operator: Once again,that is star 1 to ask a question. And we do ask that you pose one question due to time constraints.

Caller, your line is open.

(Bob): Hi, my name is (Bob) from Crystal River, Florida. Are we there?

Ronja Roland: Yes, go ahead, (Bob).

(Bob): Oh OK. I have a question concerning the break of service. It states in the MLN Matters SE0840 that temporary breaks due to hospital stays and facility stays aren't going to impact the 36-month rental cap. However, in Florida in particular, and I'm sure elsewhere, we have all of these wonderful people with HMOs running around and taking these patients from traditional Medicare to the HMO, and then after six or eight months they get fed up with it and they want to come back to traditional Medicare. What happens in those situations? And how do we tell if the patient's been on oxygen for, say, for example, 30 months prior to going to an HMO?

Ronja Roland: OK. We're, if you don't mind, we're going to ask that if CMS could address this and in regards to the – you said break-in service patient going from HMO or ...

(Bob): Primarily from an HMO back to traditional Medicare.

Ronja Roland: To traditional Medicare.

(Joel Kaiser): Yes, hi, this is (Joel Kaiser) again.

(Bob): Hi, (Joel).

(Joel Kaiser): Hi. With the issue of – the definition of continuous use first came up in – when we were implementing the Omnibus Budget Reconciliation Act of 1987 when the first cap rental DME payment rules were established. It said pay no more than 15 months of continuous use. And so we had to define through regulations what we meant by continuous use.

And in the regulations back way back when, we determined that you know continuous use meant uninterrupted use of the equipment, including temporary interruptions that were defined by us as

interruptions of less than 60 days plus the days remaining and the last months that we paid for.

So that's the key, if the break has been less than 60 days plus the last – plus the days of the last month we paid for, then it's a temporary interruption. And so you know we don't start the counting over, we don't stop the counting of the continuous month.

However, if it is an interruption of more than 60 days plus the days remaining in the last rental month that we paid for, then that is a, you know, that is not a temporary interruption. That is a break in continuous use. And just like for cap rental items we've been paying for since 1989 you know that would be a break in continuous use for oxygen as well.

When we did the DRA rule-making and you know subsequently the MIPPA rule-making, we adopted the same definition of continuous use for oxygen purposes. And so if it's a break in use of more than 60 days plus the days remaining in the last rental payment, we start a new 36-month rental period.

(Bob): Thank you very much.

Operator: And we'll take our next question.

(Brian): Hi, this is (Brian) from Texas. I had a question on the contents, the liquid versus gaseous contents. There had been some back and forth that CMS had decided that the contents for liquid was going to be exactly the same for the gaseous contents and yet the cost of providing the liquid contents was so much more and the original contents on the fee schedule was approximately \$154, depending on what state you're at. And I was curious to know if they had made a final ruling that the contents for liquid was going to be in that neighborhood of the \$154 and then the gaseous contents was going to be around the \$77.

(Joel Kaiser): Yes, hi. (Joel Kaiser) here again. One-fifty-four, that would be the quote for both the stationary contents and the portable contents.

To give you a little bit of the history, we used to have one monthly payment for both stationary and portable. It included – included both. And that was around \$154. What we did as part of implementing the Deficit Reduction Act through the rule-making was we used an authority in the statute that was first added to the statute by the Balanced Budget Act of 1997 – to establish separate payment classes for oxygen and oxygen equipment. That authority came with a stipulation that any change in the payment classes had to be done in a way so that it was annually budget-neutral.

And so what we saw when we were in implementing the Deficit Reduction Act, we saw a need to refine the payment classes for oxygen. Namely, we added a new portable oxygen class for oxygen-generating portable equipment: stationary concentrators, transfilling equipment. That new class has a higher add-on payment for that newer technology.

The other thing we did was we took that combined stationary and portable contents fee and we split it into two new fees, one for just the stationary and one for just the portable, so that suppliers will get paid. You know if they only provided stationary contents or if they only provided portable contents, they would get that one amount. If they provided both, then of course – 77, I think, 45 is the fee – 77.45 plus 77.45 would be the combined \$154 or whatever it comes out to.

So if you deliver both stationary and portable contents, that is, the beneficiary using both stationary liquid or gaseous and portable liquid or gaseous, then you can bill for both content fee and you will get paid both. However, if you only provide one or the other, either stationary, they're using liquid or gaseous stationary and they don't use portable, or they use you know some other technology, or if you – if they use a concentrator and they use portable gaseous or liquid,

then you would only bill and receive payment for one contents payment. So it's one payment for stationary, one payment for portable.

As far as the fee, at the same time you know before this change, we were – we had a fee of \$21 a month for portable contents. If the beneficiary only needed portable contents, we only pay \$21. And so that was something that we saw as a problem.

So using that authority, we increased the payment for that class, the \$77. So now you know before it was a combined payment if you were furnishing stationary content. We paid you for the stationary and the portable at the same time. If, however, you provided only portable content, it was only a \$21 fee. So we saw a problem there. We increased the payment to \$77.

So now combined, it's you know it's pretty much the same that was paid before for the combined, but now if you only provide the portable, it's a much higher reimbursement.

So that was something that was addressed through authority. That authority, again, does require that it be annually budget-neutral. So each year we have to apply an offset to the monthly oxygen and oxygen equipment payment to pay for those new payment classes and the increase in the payment for the portable contents. And I believe the adjustment this year was about \$3 – or 3%, something like that.

And again, it's to pay for the higher portable contents fee and it's also to pay for the higher payment for the newer technology portable equipment.

The law did allow us to establish the payment classes, but it did say that we had to do it so that we're going to budget annually budget-neutral fashion.

So to make a long story short, it's 77.45 for stationary content, it's 77.45 for portable content. If you're providing both, then you bill both and you get both payments.

(Brian): So, even if a – the patient is liquid and they're filling their portable from their stationary, because they are using portability, you're going to bill both the stationary and the portable?

(Joel Kaiser): Absolutely not. If they're not using stationary liquid, then you shouldn't be billing for stationary liquid. If they're using a concentrator and they're only using liquid for their portable oxygen needs, you should only be billing for the portable oxygen content.

(Brian): But if they had their base that they use when they're at home and their HELIOS portable liquid content has to be filled from their base when they have to leave the house, then they're basically filling their portable from their base that they use when they're not leaving the house.

(Joel Kaiser): Yes. If they're using liquid oxygen as both their stationary and their portable, then you can bill for both contents apiece.

(Brian): OK. And on the – the payment though does not necessitate us actually having to deliver to the patient's house. When we accept contents, we're accepting that we will supply them, whether the patient comes to get their tanks or their liquid or whether we go to the house. Is that correct?

(Joel Kaiser): No. No, I'm sorry. The supplier standards do require delivery, so you would have to deliver the oxygen to the patient. And that's basically what the service is, that's what the 77.45 is for, it's for delivering content to the patient to their home.

So it doesn't mean, again, it doesn't mean that you go out every month. It just means that you get paid once a month for continuing to provide their contents. You may go out once every two months or however often you go out, but you do get paid monthly.

(Brian): So we're going to get that 77.45 every month whether we deliver contents or not?

(Joel Kaiser): As long as they have the content that they need for that month. If they're on liquid or gaseous stationary and/or liquid or gaseous portable, as long as they have the tanks, the canisters in their home, they've been delivered, then you can bill for it. If you deliver them, you can bill for them monthly.

(Brian): Because my – I guess that was – the clarification was that if we provide tanks to them in February, then we're going to be able to bill 77.45 in January as well as February and get paid for both? So this is going to be a recurring fee that we're going to be able to bill monthly after January 1?

(Joel Kaiser): Right. After the 36-month period you can bill for the monthly content delivery – the monthly content. So it doesn't mean, again, it doesn't mean you have to drive out at least once a month, it just means that they have the content.

(Brian): We're agreeing to continue to provide them content.

(Joel Kaiser): Well, yes, not only are you agreeing, but you actually – you must provide the content. If you receive payment for the liquid or gaseous equipment in month 36, you must continue to provide the "equipment" and also deliver the content.

(Brian): OK. Because I think most suppliers were thinking we were only going to get the 77.45 only if you made one delivery. And if you didn't make a delivery every month, you didn't get to charge that fee.

(Joel Kaiser): No, that's not true. The way to look at it is it's paying for the monthly content needs of the beneficiary. It doesn't mean you have to go out every month. It just means that you know if you go out and deliver a bunch of tanks one month and it's you know enough tanks for two months, then you only have to go out every two months. But you need to go out as often as you need to go out for – to get the Medicare beneficiary the tanks that they need.

(Brian): OK.

Ronja Roland: Thank you, (Brian).

(Brian): Thank you.

Operator: And we'll now take our next question.

(Debbie): Hello?

Ronja Roland: Yes, go ahead with your question.

(Debbie): Yes, ma'am. My name is (Debbie) and I'm calling from Texas and my question is, if we take on an O2 patient from another service area that has had oxygen equipment for, say, 20 months, and there is 16 months left payable, will we be able to bill that last remaining 16 months or will that payment go to the previous provider?

(Joel Kaiser): Yes, that – that will be a situation where that – the previous supplier for our regulation as they're currently written, the beneficiary moves out of their normal service area, they are no longer obligated to continue furnishing equipment. The new supplier that you know if a new supplier furnishes the equipment, the new supplier would start going for the monthly payment.

They would be able to receive the first payment you know on the first day, that is, the day after the last month that Medicare paid for.

(Debbie): All right. Thank you so much.

Operator: And we'll take our next question.

(Lorraine Foria): Yes. This is (Lorraine Foria). I just wanted to follow up on a comment in regards to the maintenance and service. Is the intent that the billing will be done at the sixth month but the provider could provide that maintenance and service at any point in time during that six months? It will be difficult to be at the home exactly on the same day every six-month period. Is that the intent of that?

(Joel Kaiser): Yes, hi, this (Joel), (Lorraine).

The intent is that you know the oxygen supplier provides the equipment for 36 months, concentrator or transfilling equipment, which is what this maintenance and servicing fee applied to. Then, six months later, we're paying for a supplier to go out and just to make sure the equipment is OK and in good working order and to provide any general maintenance as needed. It's mostly a service of checking the equipment, to make sure it's going to continue for another six months.

We discussed this during the DRA rule-making and we discussed it in the MIPPA rule-making. So it is a definitive timeframe, the checking of equipment every six months. So it's not anytime during the six months. It's six months following the 36 months the supplier goes back or a supplier goes into the beneficiary's home. "OK, it's been six months since the 36th payment has been made, since the 36th rental month, we've got to check the equipment, we're going to make sure it's in good working order and there's no major problems, it's going to be OK for the next six

months," and then that payment is made. Then, if we continue this policy beyond 2009, then it would be exactly six months later that the supplier could go out and do the same service. And again, we would pay for that six-month anniversary.

It's not – it's not like the old cap rental maintenance and servicing where you paid for a six-month period and they could provide any and all servicing during that six-month period. This is really a point in time payment to go out every six months and check on the equipment.

(Lorraine Foria): So that means that the date would vary, I mean, because obviously you wouldn't be there on the exact same date. So, it was June, you could be out January 5th or 10th or 12th, whatever it may be, of the next year, and – six months later. And that's the date you would bill, the actual date you went to the patient's home.

(Joel Kaiser): Yes, suppliers are going to have you know obviously have their scheduling issues as far as when they can get to the beneficiary's home. But as long as it's within a reasonable time you know then OK. I mean, it doesn't have to be the exact anniversary date, but it should be approximately six months as of the last time it was done. And we are – we have solicited for comments on this policy and whether or not it's reasonable to ((inaudible)).

So, for 2009, we're going to be making one payment for beneficiary, that is that first maintenance and servicing payment six months after the 36 months. The earliest that you know the next six-month period could start for any beneficiary would be January 1, 2010.

And you know at this point, whether we're going to continue this policy as a permanent policy beyond 2009, that decision has not been made yet. We're going to consider the comments that are received on the interim final rule. And then at some point in 2009, we'll issue our final rule and it will address whether these payments will continue permanently beyond 2009.

(Lorraine Foria): And there was on that E1340, there's a modifier that is used, or not?

Ronja Roland: Yes, there is no modifier.

(Lorraine Foria): OK. So, how – I guess the question is, how do you know what that's for? But the provider just bills one or two units of service E1340.

(Joel Kaiser): No. We're going to be providing the billing guidance on that in the very near future. Just to give you an advance notice you know what the billing instructions are going to say is use the code for the equipment, the concentrator or the transfilling equipment, use the HCPCS code for the equipment plus the MS HCPCS modifier. If you use those combined equipment and the MS modifier, the payment would be automatically at the two units, the 30 minutes.

(Lorraine Foria): And one other clarification on the interruption or break-in service that you mentioned ...

Ronja Roland: I do apologize, (Lorraine), but we will have to move on. We do have quite a few questions in queue.

Operator: As a reminder if your question has been answered, please press star 2. Also we do ask that you limit yourself to one question due to time constraints and to allow others to pose their questions. We appreciate your cooperation.

And caller, your line is open.

(Jane): I have a question about portable concentrator, the E1392 – this is (Jane) from Texas.

Ronja Roland: OK, (Jane), go ahead with your question.

(Jane): Does that piece of equipment cap out?

Ronja Roland: And I'm sorry, it was code – what was the code again?

(Jane): E1392, the portable concentrator.

Ronja Roland: Yes, it does. I'm sorry. Yes.

(Jane): OK, it does cap out.

Ronja Roland: Yes.

(Jane): OK.

Ronja Roland: Thank you.

Operator: And we'll take our next question.

(Susan Gore): This (Susan Gore) in Savannah.

Ronja Roland: I'm sorry; say your name again for me?

(Susan Gore): (Susan) in Savannah.

Ronja Roland: Thank you, (Susan). Go ahead with your question.

(Susan Gore): This may be a dumb question. Does maintenance and service apply only to the  
concentrator?

Ronja Roland: Yes, that it correct.

(Susan Gore): So we will still be able to bill for portable systems? We'll still get a monthly fee for portable systems?

Ronja Roland: You will get – you will only get contents for that portable.

(Susan Gore): OK, and the code for those contents?

Ronja Roland: It could be – let me see. I think I referenced them early ...

(Susan Gore): Is that the E0441 ...

Ronja Roland: Through E0444.

(Susan Gore): OK. And will that be – is that in the oxygen chapter now?

Ronja Roland: Yes. You can actually – yes, as far as codes, and just current billing and coverage guidelines, yes, you can go to the oxygen LCD to find that.

(Susan Gore): OK, thank you very much.

Ronja Roland: Thank you.

Operator: And we'll take our next question.

Female: Hi, I have a question about the DME benefit for in the home. It's my understanding, that equipment is covered for use within the home. How about the patients who have portability that are taking their portable tanks to the doctor's office, to the casinos, to church, to bingo? Since they're not using it within the home, is there a point where we do not have to provide it to them for outside the home?

(Joel Kaiser): Yes, hi, this is (Joel Kaiser). Yes, regardless of change in payment rules, the responsibility for providing portable equipment is the same as it always has been. Yes, durable medical equipment is a benefit for equipment use in the home. But the idea behind portable oxygen is its therapeutic benefit, it gets the person who would otherwise be better chair-confined up and out of their bed, up and out of their chair.

There really aren't any limits on how far away from the chair or beds they can ambulate. It's been understood that this is a benefit for portable oxygen, for it to allow the beneficiary to be portable. And that doesn't mean they can't leave their home.

Just like we've always said for power wheelchairs, you don't you know we pay for power wheelchairs that are used in the home, that doesn't mean that you can't take the power wheelchair out of the home. Obviously we you know we'll pay for repairs of patient-owned power wheelchairs. They are mainly due to wear and tear of use of the equipment outside the home.

So with the oxygen benefit you know how you know how DME payments worked, it was based on supplier charges for many, many years until a fee schedule was enacted and implemented in 1989. That fee schedule amount is updated every year on an annual basis. So suppliers' charges for portable oxygen have been accounted for all these years and there's nothing that has changed.

The supplier should continue furnishing the same quantities of portable oxygen that they've been furnishing in the past. Just because there have been recent changes in payment law doesn't mean that the benefit has changed. It doesn't mean that you have the right to you know start withholding contents from beneficiaries you know different from how you have in the past, because the payment amount in effect today are based on those historic payments.

We never heard any access issues, any problems with beneficiaries in terms of you know oxygen and going outside their homes. So that shouldn't change today. Suppliers should be providing the same services, the same quantity of content that they provided in the past. If they're not, then they're not providing what our payments are based on.

Our payments are based on monthly portable content used by the beneficiary. There is no "you can't leave the home" requirement. So you know nothing has changed in that regard. And supplier practices in terms of you know furnishing content should not change.

Operator: And we'll now take our next question.

(Anthony): Yes, this is (Anthony) in Virginia. My question is a licensure issue. You're saying if these patients move after 36-month cap, if I can't find the supplier to take care of them, then it's my responsibility to do this. Pharmacies can't dispense across state lines. Some of the states are so restrictive with their DME license that, especially Tennessee, you have to have a facility located inside the boundaries of the State of Tennessee. So how am I supposed to supply oxygen to other patients in other states when they move if you know there's (licensure laws) and then there's Board of Pharmacy. That means I have to have a license in every state somebody move to.

(Joel Kaiser): Yes, again, the – what the law mandates is that the supplier who receives the three-year upfront payment, the 36 months payment over the 36-month payment must continue to furnish the equipment for the remainder of the reasonable useful lifetime.

(Anthony): And I can't you know I can't go against state statutes in other states. I mean you're forcing me to provide something to another state that I will be held accountable for. State law tells me that I've got to have that license in that state, and if I'm not licensed in that state to practice then, how am I supposed to do that?

(Joel Kaiser): One thing is for sure, that you know again, there are no exceptions to this requirement that the supplier is responsible for continuing to furnish the equipment. That doesn't mean that, again, I addressed this earlier in the call, that doesn't mean they have to physically provide the concentrator or the liquid or gaseous equipment ...

(Anthony): But if I've got a company that doesn't support that says, "OK you know we're going to charge you \$400 a month to take care of that patient." You're expecting me to pull \$400 out of my pocket to pay another provider in another state. That's well above and beyond you know what I got reimbursed monthly from you know Medicare.

(Joel Kaiser): I would write to your local congress person, because that's you know that's – you can't in any way be you know released from this statutory requirement. It's a statutory requirement. So you know I'd write to your local congress person to express your concerns. But that is the current law.

(Anthony): And what about – well, (it goes with my) – with oxygen requirements, what happens if they go from 5 liters to 7 liters? I was paid at a 5-liter rate. Now after 36-month cap, their condition got worse, different machine. One concentrator produces – some produce 3 liters, some produce 5, then you got 10-liter concentrators. So, what are we supposed to do for that?

(Joel Kaiser): Yes. Well, you're probably talking about there is the change in the patient's condition. As with DME in general, if there's a change in the patient's condition and may need different equipment, we would make – we would pay for that. So if you need to replace their concentrator with a concentrator that now meets their new medical condition, then Medicare would pay for that. We'd start a new 36-month period.

Ronja Roland: Thank you, (Anthony).

(Anthony): Thank you.

Ronja Roland: We're going to go ahead and take our next question.

(Martha): Yes, hello. My name is (Martha) from Orlando, Florida and I did not understand the question that was brought up by the gentleman from Apria as had made reference to oxygen concentrators that were initiated prior to 2003. Did that or do those also meet the cap rental? Did I understand that correctly?

Ronja Roland: And I'm sorry, you're referring to the question in regards to – if it was provided prior to 2003?

(Martha): Right. I thought that was the date that he spoke to (Joel) about. Concentrators that were initiated in place prior to 2003. Did I pick up the wrong date? That did not meet the cap rental – the cap rental policy?

(Joel Kaiser): I'm sorry. Can you repeat the question once more?

(Martha): OK. The gentleman from Apria was speaking about the oxygen concentrators or any of the oxygen equipment that was initiated, placed prior to 2003, some policy that would omit these concentrators, these beneficiaries from the cap rental policy of 2006. Did I misunderstand that? Prior to 2003? Maybe he said prior to 2004.

(Joel Kaiser): You're talking about the reasonable useful lifetime?

(Martha): Yes.

(Joel Kaiser): Yes, the reasonable useful lifetime is – the regulation is that it's five years. That's – the default reasonable useful lifetime is five years from the date that the equipment is initially furnished.

What the DRA, the 36-month cap, which doesn't go away with MIPPA, is that it was implemented in a way that it applied – the cap didn't start until January 1, 2006. If you were using oxygen equipment before 2001 – I'm sorry – before January 1, 2006, then you know we may have paid for past rental payments, but the 36-month cap, that is, rental payments don't apply towards that cap. The rental cap starts – the earliest it can start for anyone was January 1, 2006.

However, reasonable useful lifetime is not affected by that cap, and that you know starting of the cap in January 2006. So if you were using equipment prior to January 1, 2006 you know the five-year useful lifetime could have ended prior to the end of that 36-month cap.

And again, we're going to be issuing guidance in the near future on how you bill in those situations for the replacement equipment.

Operator: And we'll take our next question.

(Sylvia): Hi, my name is (Sylvia). I'm calling from Professional Medical. I have a question regarding the break-in service guidelines since oxygen has never been a cap rental item. The – your guidance states that if there's a break-in service of greater than 60 days due to an in-patient status in the HMO, hospice, et cetera, the provider will receive a new cap rental period. Guidance from the DME MAC state that if the need for oxygen was there during the break-in service, a new cap rental period will not be granted. This is a really important issue for providers and I was wondering if you could clarify break-in service versus break-in need.

(Joel Kaiser): Yes, hi, it's (Joel Kaiser). It's the same as it always has been for other cap rental DME. It's really a break in Medicare Part B payment. If you go into an in-patient setting, for example, you may still need oxygen, and I'm sure you will. But we're not making any Part B payments. The DME benefit, in other words, is not an effect.

When you come out of the in-patients there, you come out of a SNF or you come back from an HMO, then the Part B payment starts again and if (it were) to break up more than 60 days plus the days in the last rental payment period, then it would start a new 36-month period. But if you still need oxygen during the break, it is still a break. And if it's more than 60 days plus those days in the last rental month, then it starts a new 36-month period.

That – same rules as have been in place for years for other cap rental DME.

Operator: And we'll take our next question.

(Lisa): Hi, this is (Lisa) for (Mercy). And the question I have is about the portable monthly content fee. Let's say for example we only deliver one E tank refill and our usual and customary charge for that refill is \$15. Do we have to charge that \$15 or can we charge a new fee of a – or a monthly portable content fee of like \$90?

(Joel Kaiser): What – I'm not sure I understand the question. What's the difference between the 15 and the 90?

(Lisa): The 15 would be our usual and customary charge per tank.

(Joel Kaiser): Oh.

(Lisa): And you know with that – you said the monthly content is a \$77.45 monthly fee ...

(Joel Kaiser): Right ...

(Lisa): ... regardless of when you deliver them, as long as it's a usage.

(Joel Kaiser): Right. Your charge in this case is going to be – your charge for providing oxygen content for the beneficiary for one month. And it includes the delivery of the content to the patient's home. It doesn't have to be a delivery every month, but you – what you're basically doing is you're you know you're basically charging your average – your average you know monthly charge, your average monthly cost for furnishing the portable equipment to the – I'm sorry, content or the stationary content, to the patient for that one month.

It is not a per you know quantity of oxygen charge, it is a monthly charge. And so it you know whatever your charge is for furnishing content for patients for a month, that's what you would bill as your charge.

Operator: And we'll take our next question.

(Russ Varner): Yes. This – thank you. This is (Russ Varner) Med-Equip in Dalhart, Texas. Is there any consideration for high-use patients on the portable oxygen after the 36 months? Some patients,

we have used as much as five tanks per week. And they'll no doubt continue to use that after the 36 months. So, what's your situation with that?

(Joel Kaiser): Well, Medicare's payment for durable medical equipment are basically you know the long-standing history is, if you're talking about you know a HCPCS code, it has a variety of different you know ranges of products within it, they basically do the same thing. Or if you're talking about a monthly payment for oxygen content or if you're talking about you know an arm cast, what you're talking about is (Medicare's allow) payment amount.

And you could have situations where your costs for a beneficiary are higher. In some cases they normally are. Or you could also have situations where your costs for a beneficiary are lower than they normally are. Some patients may need a lot of contents and you get paid 77.45 for that patient. Some patients may need not very many contents and you still get paid 77.45 for that patient.

So you know there's going to be some situations where your cost for a particular patient are higher than they normally are. Likewise, there's going to be situations where your costs are lower than they normally are.

So, Medicare's payment is always you know a payment for a service. It's not based on specific quantities of items or specific quantities or supplies, or particular products. It is a payment for that service. And you know like I said, sometimes like with an arm cast, we have one payment for a cast, it's basically the average cost of physicians' casting supplies. Some patients may need a lot you know a large patient with a large arm may you know may need a lot of casting material, and you – but you're still going to get paid that one payment that we make for that cast. And you may have a very small patient who needs very small amount of casting materials, then you know you're going to probably get paid more than your cost.

So you know it – the way you know it works is we don't pay for particular, specific products, we don't pay for particular specific quantities. In the case of oxygen contents, ((inaudible)) amount, sometimes your costs are going to be a little higher than they normally are, sometimes they're going to be lower than they normally are. So it's supposed to all average out, and that's the way Medicare payment for – pretty much all DME pay for and identified by HCPCS code works. And that's been the same since the reasonable charge days and it continues today under the fee schedule.

Operator: And we'll take our next question.

(Tammy Johnson): Yes. This is (Tammy Johnson) in (Maniles) and I know we're running this portable in the ground, but I do have a question about it. How long can we bill for a portable O2 content after the 36 rental month? What if they O2 for ten more years, can we bill ten years once a month for their portable content, one unit of 77.45?

(Joel Kaiser): Yes. Yes, I mean, you can – you can bill the content for as long as you're furnishing the content service. There's no – there's no limit on that.

If, however, the beneficiary elects to get new equipment at the end of the reasonable useful lifetime period, they could switch to a concentrator if they wanted to. Or if they continue using liquid or gaseous systems, then we would start the 36-month payment, which includes payment for content. At the end of the 36-month payment for that next generation of equipment, then the content payments could start again after the 36 months cap.

Operator: And we'll take our next question.

(Tammy): Hello?

Operator: Yes, caller, your line is open.

(Tammy): Yes, I have a question. This is in regard to – this is more intricate question, not just a general, on the portable backups that have been billed along with the concentrators, the concentrators cap out, we are now billing the content as opposed to the backup system. Do we have to get a new CMN to be put on file since it will be a new code?

Ronja Roland: OK. I'm sorry, I'm not sure that I understand your question. Could you repeat it for us just to make sure I guess we're on the same line.

(Tammy): OK. Concentrators are the E1390, the backup systems that have been built along with them is the E0431. But as of January 1, the cap concentrators, after that, we can only bill content for the portable systems, which would be EO441 through the EO444. Do we need a new CMN on file with the new content code in order to be able to bill and receive this \$77.45 fee?

Ronja Roland: (Tammy), does the patient already have the portable – are we paying you currently for the portable equipment for the ...

(Tammy): Yes, for the backup, for the E0431.

Ronja Roland: No, we don't pay for backup equipment. We would pay for portable for those patients who are – who are mobile within the home and require that portable system. If they have the portable, and we – the portable has capped out, yes, we will continue to pay the contents for the portable ...

(Tammy): So we just switch the code to transmit? We don't have to get a separate CMN with the new content code on it?

Ronja Roland: That is correct. As long as the portable equipment is already on file, there's not – there's no need to change it for the contents.

(Tammy): That is great. That saves a lot of wear and tear and a lot of barraging the physicians.

(Joel Kaiser): (Joel Kaiser) here. Just to clarify, you're asking when you stop billing for the portable add-on payment E0431 and with the 37th month you start billing for the contents code, do you need a new CMN? Is that what you're asking?

(Tammy): Yes.

(Joel Kaiser): OK. Then, yes, I agree.

(Tammy): That we will not need one?

(Joel Kaiser): You do not need one. The patient – the medical need for the portable oxygen has already been established. You're just now billing for the contents which the payment rules allow you to do for furnishing the contents after the 36-month cap. The patient still receiving the same equipment, they always have, but it's just that you know the 36th month is when the equipment payment stop and the content payments ...

(Tammy): Begins.

(Joel Kaiser): Yes.

(Tammy): OK. I just wanted to make sure you know that that was clarified, so if we did need a new CMN, that you know we could get a head start to get them into the physician.

Ronja Roland: Thank you so much for your question.

Operator: And we'll now take our next question.

(Christine): Hi, this is (Christine) from Tennessee. My question is regarding supplies. Will we be able to bill for any tubing, cannula, humidifiers, or is that going to just go with our monthly service fee?

Ronja Roland: There will be no additional payment for the supplier; it's all included.

(Christine): OK. Thank you very much.

Ronja Roland: Thank you.

Operator: And we'll take our next question.

(Judy): Yes, this is (Judy) in Oklahoma. I had a question on the concentrators. Whenever – we have a patient that was set up prior to 2003, and you know at least two years. Well, in – at the end of 2008 it's five years. Do we start – set them up with a new concentrator and start again or how do we go about taking care of that question?

(Joel Kaiser): Are you referring to the reasonable useful lifetime ...

(Judy): Yes.

(Joel Kaiser): Yes. Again, that's the third time we've been asked about that. And it is addressed in the interim final rule, in the preamble discussion of that rule. And as far as implementing that, as you know we're in the implementation phase. We were in the rule-making phase, now we're in the

implementation phase. We're going to be providing instructions in the near future for suppliers to tell them how to bill in those situations.

The instructions – the guidance is not out there yet, but it will be in the near future.

Operator: And we'll take our next question. Caller, your line is open.

Caller, your line is open.

(Judy): Can you hear me?

Operator: Yes.

(Judy): Hi, my name is (Judy) and I'm also from Oklahoma and I've been taking notes for billing the contents, and I think I understand that, but if I have a patient that has that E1390, the gaseous concentrator, and the E0431 which is the gaseous portable unit, and say they've had it for seven years. Is there any reimbursement after 1/1 of '09 for the E1390?

Ronja Roland: No, that would be maintenance and service.

(Judy): OK. So this 77.45 is a reimbursement for contents only?

Ronja Roland: Correct.

(Judy): Whether it's liquid or gaseous?

Ronja Roland: Yes, that is correct.

(Judy): OK.

Ronja Roland: OK, thank you.

(Joel Kaiser): Yes. And just a reminder, it doesn't apply for concentrators or transfilling equipment. It applies to liquid or gaseous equipment, that is you know oxygen tanks, oxygen canisters, oxygen modalities that require delivery of content.

(Heather): Hello?

Ronja Roland: Yes, go ahead with your question.

(Heather): This is (Heather) in Alabama. Again we were going to ask, who is responsible for establishing the provider if the beneficiary moved during the 36-month rental period? Are we responsible or is the patient responsible?

Ronja Roland: Both would be responsible.

(Heather): OK. And if they are accepted in, say, again the question has come but I don't – I didn't get it clarified – they're accepted after 20 months, are they going to just pick up at the 16th month and only be paid for the 16-month?

Ronja Roland: Yes, that will be it. You will be paid the remainder.

(Heather): OK.

Ronja Roland: Thank you.

Operator: And we'll take our next question.

(Laurie): Hi, this is (Laurie), and I've got a question. And this question is, prior to the cap you know if you start out in your billing portability, the E0431, and a lot of times you know we'll get a patient who wants to convert to us because we do a home fill system, for example, and that goes – the billing out of K0738. And when I start billing a K0738 after, let's say, like 12 months where the oxygen renewal has already occurred, is that month number 1 for the K0738, or does it start out at month 13 if I've already done you know 12 months of billing or another company has?

Ronja Roland: OK, let me make sure I understand your question. The patient initially started out on the E0431 ...

(Laurie): Right.

Ronja Roland: ... and just during the 36-month rental, and then at some point you switch to the home bill system, the K0738?

(Laurie): Right. And when I switched from you know tanks over to ((inaudible)) and then I switched the code, does my billing on the K0738 then start out after the 12 months as you know month 13, or does that restart at – for the portability at month number 1?

(Joel Kaiser): Hi, it's (Joel Kaiser) again. I would like to remind folks that as part of the DRA rule-making, we do have a regulation that prevents switching equipment for existing patients. You obviously have the right to you know provide any of the modalities for new patients. But what the DRA, when we implemented the DRA, the regulations were established that there can be no switching of equipment.

So you can't switch from one modality to another, for example, from portable gaseous equipment to a transfilling system, unless the physician orders that switch or the beneficiary chooses to upgrade to that newer technology and signed an advance beneficiary notice as a record that they choose to upgrade to that newer technology. Those are two situations where you can change equipment.

There's also you know a miscellaneous clause where CMS or a carrier can grant an exception to the rule in particular circumstances as you know the circumstances merit the switch. But generally, you should not be switching equipment for existing patients.

Now, to respond to your specific question, it is a 36-month cap on portable equipment regardless of the number of times the patient switches from one modality to another. It's also a 36-month cap – separate 36-month cap for the stationary equipment regardless, again, of how many times the patient switches from one modality to another. We don't restart the 36-month payment every time the patient switches from one modality to another.

So if a patient does elect to upgrade and signs an ABN and they upgrade from portable gaseous to a home fill system, or if the physician provides a new order that says, "I want my patient to now use the home fill system," that 36th month payment you know period does not start anew. It continues – the supplier would just bill for the new you know the different equipment, the different HCPCS code the next month. And that next month would be the next of the 36 months you know in the sequence of the 36 months.

Operator: And we'll move on to our next questioner.

Male: Yes. We saw some literature about doing ABNs after the 36th month on tanks. We've kind of talked about this question already about the multiple use tanks, and I think, (Joel), you already

answered this, but I want to just clarify. Is there any legalities to doing ABNs on people who use high cylinder volumes after the cap?

(Joel Kaiser): No and that literature would not have been anything that CMS produced. The law you know provides for payment of contents after the cap. It says to make the payment in accordance with the standard payment rules of 183489, the standard payment rules are the 77.45. It's a monthly payment for oxygen content. It's not dependent on the quantity of oxygen that's provided. So it's absolutely no option for a supplier to have a beneficiary sign an ABN and charge them you know for extra quantity when Medicare's payment already includes payment for the content that the patient needs for that month.

So that literature is erroneous and should be disregarded.

Operator: And we'll take our next question.

(Vee): Hi, this (Vee) from Texas. Can you hear me?

Ronja Roland: Yes, go ahead with your question.

(Vee): I'm sorry. I do have a question. No one's really mentioned much about accepting assignment and ABNs, and I mean, we hear here – I mean, we already have suppliers trying to get rid of per se your patients that are capping. And we keep hearing, well, as long as you, you know, do not bill that 36th month or receive payment, that you can pretty much get rid of these patients. I mean, is that – is that true? Or is it based on you accepting assignment the first month of the 36 months?

(Joel Kaiser): Yes, hi, it's (Joel Kaiser) here.

(Vee): Hi.

(Joel Kaiser): Hello. Just to be clear you know the DRA rule-making addressed you know the laws at the time that the DRA Act was in effect you know those amendments were in effect. And with those amendments, we established the regulation for it to safeguard the beneficiary, that the supplier who furnishes the oxygen equipment in the first months of rental must continue to furnish the oxygen equipment as long as it's medically necessary, up to and you know including the 36th month. So if you furnish it to a patient in month 1, you must continue to furnish it.

What this new law does is it allows suppliers to you know keep the equipment. They don't have to transfer it after the 36 months, but they must continue to furnish it for the remainder of (the reasonable useful) lifetime.

So now if you're an oxygen supplier and you provide the equipment in the first month, you're not only you know bound to continue providing it for the whole 36 months, but you're bound to continue to provide it for the whole reasonable useful lifetime period. And that applies to you know to all your patients.

You can turn new patients away, but you cannot abandon the patients that you already are serving and have been serving. The law and the regulation binds you to continue furnishing the item till the end of the reasonable useful lifetime. So now it's not just 1 through 36 that you're bound to furnish the equipment, it's month 1 through the end of the reasonable useful lifetime.

And I just want to make clear that you know some folks have said, "Well, what if a supplier just elects to get out of the oxygen business?" That's fine. A supplier can do that for any new patient. For any existing patient, the laws and the regulations require ((inaudible)) your responsibility to continue furnishing it until the end of the reasonable useful lifetime period. So, absolutely that's the case. If you provided it in month 35 and month 36 comes along and the patient still needs it,

you must furnish. You must bill – submit a claim on behalf of the beneficiary. The law and regulation requires.

If after the 36 months the beneficiary continues to need the oxygen equipment, the law and regulations require that you continue to furnish that equipment after the 36-month period for any period of medical need for the remainder of the reasonable useful lifetime.

Operator: This concludes our question-and-answer session. At this time, I'd like to turn the conference back over to Ronja Roland for any additional or closing comments.

Ronja Roland: We do want to thank everyone for attending today's Oxygen: Ask the Contractor teleconference. Again, the minutes from today's call as well as a recording of today's session will be available on the CIGNA Government Services Web site no later than December 22. Again, we encourage you to go out and reference Medlearn Matters article SE0840, as well as you can research the Federal Register as well.

We thank you again for your attendance, and you have a great day.

Operator: This concludes today's conference. We thank you for your participation. You have a good day. Thank you.

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