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Portable Oxygen Woes

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Consider these four ways to make portable oxygen more profitable.

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To offset the losses that come from providing low- or no-profit items, many HME providers have worked hard to increase their share of the respiratory care HME market.

Some have even rejected the idea of one-stop shops, despite their historical appeal to referral sources, and become almost exclusively respiratory care specialists.

But, in my experience, even the respiratory specialists struggle to come out financial winners in one area of their respiratory equipment lineups: portable oxygen.

Is Portable O2 Reimbursement Unfair?
The Durable Medical Equipment Regional Carriers (DMERCs) pay a flat monthly fee that ranges from $30 to $36, depending on the state where the patient resides, for all equipment, oxygen content, and supplies associated with providing a portable oxygen system to a beneficiary. This fee is most likely based on the DMERCs' philosophy that coverage for portable oxygen should not extend beyond that which is absolutely medically necessary.

The qualifying criteria for portable oxygen are that a patient requires continuous oxygen therapy and is mobile in the home. Medicare neither promises nor provides benefits for portable oxygen beyond that required for greater mobility within the patient's residence and for occasional medically necessary trips to a physician. Most other payors have similar policies.

However, the reality is that countless patients use their portable systems to enable them to lead an active life outside the home, and that can result in costs to the provider that are much higher than the fee schedule amount for portable oxygen systems.

HME providers traditionally have hesitated to set limits on the amount of portable oxygen provided to the patient. Many compete for referrals by marketing a commitment to excellent customer service. Others are patient advocates who understand that active chronic lung patients have better outcomes than less active ones.

In addition, determining who decides when requests for portable oxygen refills become excessive is a problem because few payors with flat monthly reimbursement for portable oxygen provide guidance on utilization for patients or equipment providers.

What You Can Do
Whatever the reasoning, HME providers have a long history of shielding beneficiaries from the true limits of their portable oxygen coverage. So what can an HME provider do short of setting specific and perhaps arbitrary limits on a patient's portable oxygen use, and, as a result, looking like the bad guy in this equation? Here are a few suggestions:

1. Get help from patients. Ask high oxygen utilization patients to pick up extra tanks instead of having them delivered. Sure, cylinder fill costs and demurrage charges are high in some parts of the country due to a lack of competition among compressed gas dealers. But you will likely find that it is the cost of delivery that is primarily responsible for eroding the profitability of providing portable oxygen.

If a patient is requesting delivery of portable oxygen cylinders more than once every 7 to 10 days, then presumably they are active enough to drop by and pick up tanks as needed rather than having them delivered. Although Medicare requires that the HME provider be responsible for delivery, this sort of voluntary cooperation by the beneficiary should not pose a problem for the supplier when high utilization is in question.

2. Investigate reservoir-type conservation devices. If the patient resists the suggestion to pick up portables, or that practice seems averse to your organization's customer service policies, consider reservoir-type conservation devices. These are relatively inexpensive when compared to intermittent-flow oxygen conserving devices, and can result in oxygen savings of up to 75% when worn by the average patient using two liters per minute of continuous flow oxygen.

Reservoir conservation devices typically come in two styles—pendant and "moustache." The pendant style is generally considered more esthetically appealing to patients because it is less noticeable. Both accumulate

oxygen in a 20-mL reservoir when a patient is not actively inhaling, preserving it for the next breath, and thus allowing flow rates that are often less than half of the continuous flow oxygen equivalent.

Manufacturers of reservoir-type conservation devices provide guidance regarding equivalent liter flows. However, because the individual patient's tidal volume and respiratory rate can affect the actual percentage of oxygen delivered, it is a good idea to check oxygen saturation levels while the patient is engaging in the same sort of activities he or she normally would do when using portable oxygen. This assessment is key to determining the proper liter flow for the patient using a reservoir device, and, ultimately, how much oxygen the device will save.

Although reservoir cannulas are less expensive than other types of oxygen conserving devices, they are much more expensive than typical cannulas. Therefore, you will want to make sure that patients understand cleaning procedures in order to maximize the life expectancies of the devices.

3. Check out intermittent-flow devices. If reservoir-type conservation devices do not prove to be the solution for your patients, consider intermittent-flow oxygen conservation devices. These devices either incorporate a regulator or attach via tubing at the regulator, allowing the patient to use a standard cannula. Depending on the type of oxygen conserving device used and the patient's liter flow and respiratory rate, these devices can extend the life of a cylinder by a factor of between 2:1 to 6:1. However, because they can cost hundreds of dollars each, you may want to reserve them for outlying patients whose frequent delivery requests make these devices most cost-effective.

There are three basic varieties of intermittent-flow conservers: pulse, demand, and hybrid. Pulse systems deliver oxygen in a short burst at a flow rate slightly higher than the patient's equivalent continuous flow rate. They then shut off prior to the end of inspiration when inhaled gases typically no longer come in contact with gas-exchanging alveoli (air cells) in the lungs. Demand systems, on the other hand, deliver oxygen at an equivalent continuous flow rate during nearly the entire inspiratory cycle. Hybrid-type intermittent-flow devices use a combination of principles from demand and pulse systems. Typically, they provide a pulse at the beginning of inspiration followed by a declining continuous flow through the rest of the inspiratory cycle.

Pulse systems generally provide greater oxygen conservation because the flow of oxygen takes place only during the most effective gas exchange portion of the inspiratory cycle. However, the clinical effectiveness of such systems depends on the volume of oxygen provided in each pulse (set by the manufacturer), and the patient's respiratory rate and tidal volume.

Demand systems may be more forgiving of less typical tidal volumes and respiratory rates, but as with any oxygen conserving device, clinical effectiveness can still vary between patients.

No matter which type of oxygen conserving device you provide to a patient, you will want to slowly and analytically adjust (titrate) settings to achieve a satisfactory blood oxygen saturation level during the patient's typical ambulatory activities. And remember, all conserving devices require an order by the treating physician.

4. Use concentrators. HME providers may find that they can cut portable oxygen delivery costs by providing patients with concentrators that also fill portable oxygen tanks. The drawbacks to these devices are that they are still quite costly (two to three times more than that of a regular concentrator), and they may be too difficult for some patients to operate.

Whether profitable or unprofitable, portable oxygen comes with the territory for oxygen suppliers. However, by looking at all of the options and putting them to use in a sensible way, an HME supplier should be able to maximize the profitability of providing oxygen therapy to patients.

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