Learning Objectives

- Review the oxygen medical policy and related article for Medicare
- Identify the grey areas within the policy requirements
- Discuss the key qualifiers for home oxygen therapy to meet documentation and coverage requirements
- Attendee participation that will discuss amongst the group some common scenarios that occur on a regular basis

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Reason for Heavy Audits With DME Suppliers

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Improper Payment Rate</th>
<th>Improper Payment Amount ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>8.13%</td>
<td>$51.82 B</td>
</tr>
<tr>
<td>Part A Providers (excluding Hospital Inpatient)</td>
<td>0.57%</td>
<td>$10.00 B</td>
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<tr>
<td>Users</td>
<td>10.08%</td>
<td>$10.47 B</td>
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<tr>
<td>Hospital BPSI</td>
<td>0.28%</td>
<td>$4.05 B</td>
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<tr>
<td>Durable Medical Equipment, Prosthetics, Orthotics, and Supplies</td>
<td>3.54%</td>
<td>$2.54 B</td>
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</table>

Oxygen, CPAP, and Glucose Monitors always high error rates
Table 2: Top 20 Service Types with Highest Improper Payments, DMEPOS

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Improperly Paid Amount</th>
<th>Percent Improperly Paid</th>
<th>Frequency</th>
<th>Improper Payments Per 10,000 Claims</th>
<th>Improper (%)</th>
<th>Payment Amount</th>
<th>Total Improper Payments</th>
<th>Total Improper Payments Per 10,000 Claims</th>
<th>Percentage of Total Improper Payments</th>
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</thead>
<tbody>
<tr>
<td>Oxygen Supply</td>
<td>$30,652,595</td>
<td>10.0%</td>
<td>100,000</td>
<td>100</td>
<td>10.0%</td>
<td>$30,652,595</td>
<td>$30,652,595</td>
<td>100</td>
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<tr>
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<td>6.6%</td>
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<tr>
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<td>100</td>
<td>3.3%</td>
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<td>3.3%</td>
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<tr>
<td>Oxygen Supply</td>
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<td>100,000</td>
<td>100</td>
<td>1.8%</td>
<td>$5,652,595</td>
<td>$5,652,595</td>
<td>100</td>
<td>1.8%</td>
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<td>1.2%</td>
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</tr>
<tr>
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<td>100,000</td>
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<td>0.3%</td>
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<td>0.1%</td>
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<td>100</td>
<td>0.0%</td>
<td>$125,259</td>
<td>$125,259</td>
<td>100</td>
<td>0.0%</td>
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HCPCS code | Description                                                                 | Jan-19 | Aug-18 | Aug-12 |
-----------|-----------------------------------------------------------------------------|--------|--------|--------|
E1390      | OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE | $79.80 | $79.78 | $137.06 |
E431       | PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL, INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING | $17.50 | $17.50 | $29.43  |
K0738      | PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL, HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING | $37.46 | $37.46 | $51.63  |
E1392      | PORTABLE OXYGEN CONCENTRATOR, RENTAL | $37.46 | $37.46 | $51.63  |
O2 Payment Process

- Oxygen payment occurs for 36 months.
- Supplier that gets paid for month 36 must continue to provide oxygen services through month 60.
- Between months 37-60, supplier does not get paid for rental on stationary equipment.
- Supplier may get paid for oxygen content—OK? If patient has portable gas tank system, but payment is very little ($44.01/month regardless of number of tanks).
- Supplier is responsible for oxygen equipment during the entire 60 months including the 24 months of no payment for the rental.
- All the codes on previous slide—only get paid for 36 months.

2018 DURABLE MEDICAL EQUIPMENT DELIVERY COST

Great Lakes Region
IN, IL, MI, OH, WI

2018 Nonremuneration Rates - 100% Adjusted to本领 - National Average Per Month

- C1000 - Oxygen Concentrator - $30.00
- H2500 - Hospital Bed - $45.40
- H2000 - Standard Wheelchair - $20.00
- H1990 - Oxygen Mask - $5.25

28.87 Min
Time of Visit or Set Up

$111.40
Average Total Delivery Cost

47.16 miles
Round Trip to Home/Institution

Documentation is Key!

Being Proactive = Faster delivery + Patient Compliance / Satisfaction

Being Reactive = Costs time + $$$
Initial Coverage Criteria

All of the following must be met:
1. Severe lung disease or hypoxia related symptoms; and
2. Blood gas or oxygen saturation results meeting specific criteria; and
3. Oxygenation studies performed physician or a qualified provider or supplier of laboratory services; and
4. Oxygenation studies performed in a chronic stable state or within 2 days prior to discharge from an inpatient facility, and
   - Cannot be done in an ER –not in a chronic stable state & not inpatient
5. Alternative treatments found ineffective considered/ried and ruled out

Physician Visit

A physician visit must document the diagnosis, prognosis, history, and medical need for the items being ordered.

The specific technical elements required for the 30 day in-person visit are as follows:
- The visit must be dated and within 30 days of the initial date of service
- It must contain the beneficiary’s name
- Must contain the medical necessity information per the policy
- The document must signed and date by the treating physician or qualified entity, this must meet Medicare signature requirements

An order is not enough, must be documented in progress notes. The Order is not part of the medical records.

What is NOT a Medical Record

- Supplier created forms (even if completed by the physician and included in chart)
- Attestation statements signed by physician
- After-the-fact letters from physician to supplier - please do not use!
- Certificates of Medical Necessity not mandated by CMS
The Diagnosis: Severe Lung Disease or Hypoxia Related Symptoms

The treating physician examined the patient and determined that he or she has one of these conditions that might be expected to improve with oxygen therapy:

• **A severe lung disease**
  - Some examples: chronic obstructive pulmonary disease, diffuse interstitial lung disease (known or unknown etiology), cystic fibrosis, bronchiectasis, and widespread pulmonary neoplasm

• **Hypoxia-related symptoms or findings**
  - Some examples: pulmonary hypertension, recurring congestive heart failure due to cor pulmonale, erythrocytosis, impairment of cognitive process, nocturnal restlessness, and morning headache

Hypoxemia—Is It a Covered DX?

• Hypoxemia alone is not enough—it’s a symptom
• Documentation needs to be detailed to show alternative treatments have been tried/considered and ruled out
• What is causing the hypoxemia, underlying cause?
• **Question to Physician: Why is oxygen the appropriate treatment?**
  - Examples: Pulmonary HTN, recurring CHF, morning headaches
  - Paint the picture – tell the story of the patient’s condition

Home O2 Not Covered

• Angina pectoris in the absence of hypoxemia
• Dyspnea without cor pulmonale or evidence of hypoxemia
• Severe peripheral vascular disease in absence of systemic hypoxemia
• Terminal illnesses that do not affect respiratory system
• Medicare does not provide reimbursement for home oxygen as a treatment of OSA
Pneumonia and O2

There have been several recent discussions of denials for oxygen prescribed for patients coming out of the hospital with a diagnosis of pneumonia. The reasoning is that pneumonia is an acute condition, so the patient is not in a chronic stable state (CSS). It is our understanding that the in-patient discharge from the hospital is the exception to the CSS rule. If a patient has a diagnosis of pneumonia and the physician has ordered discharge from the hospital with oxygen, will this qualify the patient under the oxygen policy?

Response: The foundation of Medicare coverage for home oxygen is that the beneficiary must have a chronic lung condition. Therefore, we would not cover home oxygen for someone who needed short-term support strictly due to an acute illness such as pneumonia. However, coverage is available for a beneficiary with an acute exacerbation of a chronic condition if the qualifying test is done on an inpatient basis within two days of discharge and is the last test prior to discharge. In this situation, coverage is not dependent on the medical records indicating that the acute component has been resolved.

Medicare does not pay for home oxygen with diagnosis of pneumonia!

The Qualifying Blood Gas Study Was Obtained Under The Following Conditions

- During an inpatient hospital stay – Closest to, but no earlier than, 2 days prior to the hospital discharge date, with home oxygen therapy beginning immediately following discharge,

OR

- During an outpatient encounter – Chronic Stable State – Within 30 days of the date of Initial Certification while the patient is in a chronic stable state, which is when the patient is not in a period of acute illness or an exacerbation of his or her underlying disease

Chronic Stable State Requires All of the Following Be Met:

- Other forms of treatment have been tried, have not been successful, and O2 is still required
- Each patient must receive optimal therapy before long-term O2 therapy is ordered
- Cannot be during a period of acute illness or exacerbation of underlying disease
According to Medicare, can a patient be tested for O2 under observation stay in the hospital (not inpatient)?

Answer = NO
- When a patient is at a hospital under "observation", it's not considered an admission to the hospital so it's outpatient.
- It's an observation not an inpatient stay.
- This is considered outpatient, not inpatient which means these patients are not in a CSS. So the patient needs to pay privately or see physician for getting qualified.

Will Medicare accept oxygen testing when performed in the ER setting?

Answer = NO
- It's an ER Visit, not an inpatient stay.
- Need to make sure the patient is in chronic stable state and not performed in an acute state such as in an ER visit.
- So the patient needs to pay privately or see physician for getting qualified.

During an Inpatient Hospital Stay - This Will Be the Challenge

The medical record needs to clearly indicate the medical need for home oxygen and why home oxygen is the best form of therapy for the patient.

A diagnosis (COPD) and qualifying blood gas results are NOT enough.

For example:
- Patient admitted to hospital with pneumonia
- Diagnosis history lists COPD
- Testing is 88% on RA at rest
- Upon discharge, oxygen being ordered

If the documentation is not clear (thorough) to justify the oxygen is for COPD, the claim will deny.

The oxygen cannot ordered to treat pneumonia - claim will deny.
Testing for Home O2

Must be performed within 30 days of date of service or 2 days prior to discharge from hospital while patient is in a chronic stable state

• Arterial Blood Gas (ABG) – at or below 55mmHG on room air
• Blood oxygen saturation (SAT) – at or below 88%
• Study can be performed:
  – At rest
  – During sleep
  – During exercise

  If doesn’t qualify at rest, then document result, then
  Walk patient, document result (if below 88%), then
  Use oxygen walk patient again and document result (to show oxygen does help)

• Must have all 3 results during same session if qualifying with exercise

• Make sure that tests results indicate how test was performed:
  ex: 87% on room air at rest or 80% during sleep on room air

If patient has OSA and needs O2 bled in with PAP, how can the patient get qualified for home oxygen?

In The Sleep Lab – No Exceptions

• Tested in a “chronic stable state”
• Severe lung disease expected to improve with oxygen therapy
• OSA demonstrated to be sufficiently treated
• Qualifying oxygen saturation test may only occur during a titration polysomnographic study if all of the criteria are met
• The titration is conducted over a minimum of two hours; and
• During titration:
  • Nocturnal oximetry conducted for the purpose for oxygen reimbursement qualification may only be performed after optimal PAP settings have been determined and the beneficiary is using the PAP device at those settings; and
  • The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation ≤ 88 percent for 5 minutes total (which need not be continuous)
Alternative Treatments – What Are These?

- Policy states “tried or considered and ruled out” – deemed “clinically ineffective”
- Depends on diagnosis – right!
- Examples:
  - Medications, inhalers, nebulizer tx
  - Pulmonary rehab or Cardiac rehab
  - Pulmonary hygiene – proper coughing techniques, breathing techniques
  - Chest percussion or vest
  - Physical or Occupational Therapy

Portable Oxygen

- Additional requirements for portable oxygen
  - Medical records support the beneficiary is mobile within the home; and
  - Oxygen testing must be performed at rest (awake) or during exercise
    - Testing performed during sleep will not be accepted for portable oxygen
The Certificate of Medical Necessity (CMN)

- The physician (office) is required to complete sections B & D of a CMN.
- Sections A and C must be completed by the supplier prior to physician signing the CMN.
- Specific questions the physician is required to answer.
- Copy of test results or reports you have received.
- Any information from the Medicare policy (LCD).
- NO STAMPED SIGNATURES (Electronic Signatures OK).
- Suppliers cannot complete nor tell the ordering practitioner how to answer the questions on the CMN.
- The physicians have a legal responsibility to complete CMNs.
- Once the CMN is signed in by physician (NP, PA), the only person that can make changes or additions is the physician.

Physicians! Are You Ordering Oxygen For Your Patient?

Your medical record documentation determines whether your patient can receive the oxygen equipment and supplies you have prescribed and the amount of the patient’s out of pocket expenses.

Your medical record documentation must show that other alternative treatments (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried or considered and deemed clinically ineffective. The documentation must show the patient was seen within 30 days prior to the start of oxygen therapy. The medical record must show the medical condition necessitating the home use of oxygen therapy. The medical record and/or prescription would indicate the oxygen flow rate (e.g., two liters per minute), and the estimation of the frequency (10 minutes per hour), duration of use (12 hours per day) and duration of need (six months). You must specify the type of oxygen delivery system to be used (i.e., portable/stationary concentrator, compressed gas portable/stationary, liquid portable/stationary).

Medicare can make payment for home oxygen supplies and equipment when the patient’s medical record shows the patient has significant hypoxemia and meets medical documentation, test results, and health conditions as specified in the CMS Internet-Only Manual (IOM) Publication 100-03, Section 240.2. This link will take you to an external website.
Continued Need Letter – ADD oxygen to med list so it gets addressed during visits to prove continued need

Dear Physician,

DEL does not pay for equipment that you’ve ordered for your Medicare patient if it is not needed. Unfortunately, medical suppliers do offer riders that, if purchased, will allow the suppliers to make a profit. This should be the exception and not the norm. All oxygen equipment must be used at home as a hospice and/or LUPP equipment or at night. This is under standby to ensure compliance. (The patient can be using the equipment for several months or years.) However, it is necessary to document that the equipment is only used at home as an alternative to hospitalization or home health care. This may be accomplished by using a supplier medical form or a supplier’s medical form.

ADD oxygen to med list so it gets addressed during visits to prove continued need.

Details (details) from various clinical organizations overemphasize the importance of a medication list that includes the medication’s strength, dosage schedule, and route of administration. A medication list includes the patient’s current medications, both the patient’s general medications (DMO) and also the medications that the patient is currently using at home. The medication list will be used to track the patient’s current medications. Some of the main medication errors (ADE) can also be measured with this list.

Hospitalized patients, including patients in the hospital, will have a medication list (DMO) of the medications that they are currently using. The medication list will be used to track the patient’s current medications. Some of the main medication errors (ADE) can also be measured with this list.

ADD oxygen to med list so it gets addressed during visits to prove continued need.

If portable ordered, documentation in notes that state patient is mobile in the home; AND make sure qualifying blood gas study performed at rest while awake or during exercise. During sleep testing does not qualify for a portable unit.

Has a severe lung disease or hypoventilation related symptom with underlying cause

All 4 of the above coverage criteria must be met, and make sure:

1. Seen and evaluated by treating practitioner within 30 days prior to initial date of service
2. Documentation in the patient’s medical record. A CMN or DWO alone will not stand in an audit—information must be in the medical record.

Please sign your signature and your care of Medicare beneficiaries.
Summary

- NO Supplier created forms – will not stand alone for documentation purposes
- Use SOAP note format or H&P format
- A good progress notes relates to the need for the home medical equipment being ordered and should discuss the individual's functional limitations and medical condition as related to the specific equipment being ordered.
- Medical equipment is covered for in home use and there are specific requirements of documentation for payment to be received.

Note: If it is not documented it is not covered!

Thank you for your time an support!

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