Lessons on the New Oxygen Policy

Implementation: January 1, 2023

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April 18, 2023

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CMS CMN and DIF updates MLN SE22002

Effective January 1, 2023 DO NOT SUBMIT CMS CMNs/DIFS for <u>Traditional Medicare</u>

- If a CMS CMN/DIF is submitted for DOS on or after January 1, 2023, the CMN will reject
  - Front end rejection means the claim has not been entered into the system for processing.
  - Monitor Front end edit reports!

- DO NOT submit any CMS CMNs/DIFS for DOS on or after January 1, 2023, for traditional Medicare
- DOS prior to January 1 should be fine
- For dates after January 1, 2023, CMNs are valid for 12 months (unless LON specifies a shorter time)
- **Other payers may still require a CMS CMN- must follow their policy requirements**
- Do not use CMS CMNs as a SWO with DOS on or after January 1, 2023
- Do not use CMS CMNs for medical necessity information

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Oxygen Defined in 4 Groups

- Group I
- Group II
- Group III
- Group IV (Non-Covered)
- **The test results are the driving factor when determining which group patient qualifies under.**
- Testing done during sleep no longer needs to have 5 minutes of qualifying results. Recording time must be minimum of 2 hours.

Blood Gas Study

Oxygen Grouping	ABG (mm Hg)	Oximetry (SAT %)	Billing Modifier
Group I	≤55	≤88	N1
Group II	56-59	89	N2
Group III	≥60	≥90	N3

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Initial Coverage for BOTH Groups I and II ALL of the following Conditions Must Be Met

1. The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; **and**,
2. The beneficiary's blood gas study meets the criteria stated below; **and**,
3. The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; **and**,
4. The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.

- **NOTE:** Group I allows for acute/short term and chronic/long term
- Time of need is defined as during the patient's illness when the presumption is that the provision of oxygen will improve the patient's condition in the home setting.
- For an inpatient hospital patient anticipated to require oxygen upon going home, the time of need would be within 2 days of discharge.

***30-day testing and 30 –day visit requirement removed!**

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Oxygen FAQ - Medical Record # 1 & 14

- **Q1. Is an initial F2F evaluation required?**
- A1. While there's no formal requirement in the NCD or LCD, good medical practice would dictate some type of F2F or telehealth evaluation prior to ordering oxygen.

- **Q14. The LCD states that testing needs to be reviewed in the treating practitioner visit. If the patient has a visit 1/2/23 and the 6-minute walk test (6MWT) is booked for 1/25/23 does the patient need another visit to have these results discussed after?**
- A14. The time of need would be based on the 6MWT and the treating practitioner's interpretation and evaluation of that test. The treating practitioner is not required to have an in-person/telehealth visit following the 6MWT and may communicate with the beneficiary, at their discretion, the results of that test.

- *FAQ on DME MACs website

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Obstructive Sleep Apnea (OSA), Polysomnography and Home Sleep Tests

It is required that the OSA be appropriately and sufficiently treated before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy and oxygen equipment (see PAP LCD for additional information).

For beneficiaries with OSA, this means that the OSA must be sufficiently treated such that the underlying condition resulting in hypoxemia is unmasked. This must be demonstrated before oxygen saturation results obtained during polysomnography are considered qualifying for oxygen therapy.

For beneficiaries with OSA, a qualifying oxygen saturation test may only occur during a titration polysomnographic study (either split night or stand-alone).

The titration PSG is one in which all of the following criteria are met:

1. The titration is conducted over a minimum of two (2) hours; and,
2. During titration:
    1. The AHI/RDI is reduced to less than or equal to an average of ten (10) events per hour; or,
    2. If the initial AHI/RDI was less than an average of ten (10) events per hour, the titration demonstrates further reduction in the AHI/RDI; and,
3. Nocturnal oximetry conducted for the purpose of oxygen therapy and oxygen equipment 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,
4. The nocturnal oximetry conducted during the PSG demonstrates an oxygen saturation ≤ 88%.

*** Testing criteria remains the same except 5 minutes not required.**
*** Removed Chronic stable state language.**
*** Remember diagnosis is NOT OSA when oxygen is prescribed!**

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Does this mean patients with Dx of Hypoxia is acceptable?

- Yes! More than likely Group 1 coverage criteria applicable
- Short term condition
- Monitor these patients - need documentation to show medical need is ongoing OR get a valid medical condition documented
- Maintain the medical records in your patient file in preparation for an audit

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Group II criteria Include All of the Following:

A. An arterial PO_2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent; and,

B. Any of the following:

A. Dependent edema suggesting congestive heart failure; or,

B. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF); or,

C. Erythrocythemia with a hematocrit greater than 56 percent.

***Same testing criteria from previous policy**

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Group III criteria:

Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for Group III if all of the following conditions are met:

1. Absence of hypoxemia (normal test results) defined in Group I and Group II above; and,
2. A medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as *cluster headaches* (not all inclusive).

***New Group – Still learning about this group**

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Group III criteria:

Q11: Overall, what will audit contractors be looking for in the medical record for those patients in Group III? Is an initial F2F evaluation required? (LCD only references evaluation of test results)

- Evidence of an evaluation of the qualifying test results. What type of documentation are you looking for? The lab values are often a separate document in a record and ordering MD doesn't document they evaluated the lab result in as many words.
- Provision in the LCD that provision of oxygen will improve patient's condition, how will audit contractors evaluate this?

A11: A blood gas study is necessary to show the absence of hypoxemia. Additionally, the DME MACs would look for documentation to see if oxygen provided will improve the beneficiary condition. There must be a documented medical condition with distinct physiologic, cognitive, and/or functional symptoms published in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all inclusive). The DME MACs cannot speak for other auditing contractors.

FAQ on DME MAC website

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Group IV criteria – Non-Covered Group:

Oxygen therapy and oxygen equipment will be denied as not reasonable and necessary if any of the following conditions are present:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments; or,
2. Dyspnea without cor pulmonale or evidence of hypoxemia; or,
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation; or,
4. **Terminal illnesses that do not affect the ability to breathe.**

***Same Non-Covered Group as previous policy, just revised #4 language.**

***Consider an ABN. If option 1 chosen, then GA modifier.**

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DOCUMENTATION FOR CONTINUED PAYMENT OF OXYGEN AFTER INITIAL COVERAGE

In order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the medical record documenting:

Group I (short/long term)

While there is no formal requirement for re-evaluation and retesting, providers should ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary pursuant to Social Security Act §1862 (a)(1)(A)

Group II (original)

1. An evaluation and documentation of a repeat qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy pursuant to Social Security Act §1834(a)(5)(E); and,
2. A new SWO by the treating practitioner.

Group III (cluster headache)

1. An evaluation and documentation of a normoxemic qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy, pursuant to National Coverage Determination (NCD) 240.2 and Social Security Act §1834(a)(5)(E); and,
2. A new SWO by the treating practitioner.

NO CMNs!!!

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Continued Medical Need

- For ongoing supplies and rented DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to remain reasonable and necessary.
- Information used to justify continued medical need must be timely for the DOS under review.

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What Can Be Used as Continued Medical Need Documentation?

Any of the following may serve justifying continued medical need for oxygen therapy:

- **A recent order/prescription by the treating practitioner for refills of supplies;**
- A recent order/prescription by the treating practitioner for repairs;
- **A recent change in an order/prescription;**
- A properly completed CMN or DIF obtained prior to DOS 01/01/2023, with an appropriate length of need specified;
- Timely documentation in the beneficiary's medical record showing usage of the item.

- **Timely documentation is a record in the preceding 12 months**
- **Most States require an annual order for oxygen therapy – know your State law requirements**

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Continued Use

- Describes ongoing utilization of supplies or rented equipment
- Suppliers are responsible for monitoring use of rented equipment and utilization of supplies
- Suppliers must discontinue billing when rented equipment or ongoing supply is not being used by patient
- Examples of proving continued use:
  - Requests for refill of supplies
  - Proof of delivery showing supplies
  - Documentation in patient file discussing use
  - Compliance data/hour meter use
  - Maintenance performed on equipment
  - Medical record from treating practitioner that discusses usage

Timely documentation is within the preceding 12 months

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DOCUMENTATION FOR CONTINUED PAYMENT OF OXYGEN AFTER INITIAL COVERAGE

In order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the medical record documenting:

Group I (short/long term)

While there is no formal requirement for re-evaluation and retesting, providers should ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary pursuant to Social Security Act §1862 (a)(1)(A).

NO CMNs!

Be Cautious With This One:

- **Best Practice to make sure medical need is justified in medical record.**
- **Treating practitioner & physicians need to include oxygen under medication list to ensure it's addressed during an office visit.**
- **Your sales reps and clinicians need to educate referrals making sure oxygen is added to the medication list.**

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Initial Coverage for Group I

Documentation for initial coverage requires information in the medical record showing:

- The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; **and**,
- The beneficiary's blood gas study meets the criteria for Group 1; **and**,
- The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; **and**,
- The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.
- A symptomatic, hypoxemic patient who meets criteria for Group I

Example:

Patient Joe being discharged from inpatient hospital stay due to pneumonia.

- Hospitalist ordered oximetry testing in preparation for discharge to home on 01/25/2023
- Oximetry results done 01/25/2023 on RA at rest at 87%
- Oximetry testing done by the RT in the hospital.
- Hospital medical records indicate Patient Joe has had severe pneumonia with hypoxemia. Antibiotics, steroids, oxygen therapy, and pulmonary hygiene treatments have improved condition to discharge to home.
- 01/26/2023 Patient Joe discharged home antibiotics and steroids prescribed. Also, with an order to use oxygen at 2lpm via NC continuously.
- Follow up with treating practitioner.

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DOCUMENTATION FOR CONTINUED

- In order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the medical record documenting:
- **Group I (short/long term)**
- While there is no formal requirement for re-evaluation and retesting, **providers should ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary** pursuant to Social Security Act §1862 (a)(1)(A).

Example:

Patient Joe is at follow up appt with treating practitioner.

Follow up visit on 03/03/2023 is to review medical condition from hospital stay where Patient Joe had pneumonia.

What should the treating practitioner do now?

Few options:

- Recommend oximetry testing to see if Patient Joe still hypoxic and would still need oxygen therapy to treat pneumonia, or
- Pneumonia may be resolved, however another condition warrants continued use of oxygen, or
- Patient no longer needs the oxygen therapy, time to discontinue.

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Patients Transferring to Medicare FFS

- For Medicare to provide payment, the beneficiary must meet all Medicare coverage, coding, and documentation requirements for the DMEPOS items in effect on the DOS of the initial Medicare claim.
- No new oxygen testing required; however, the most recent qualifying test study obtained previously under the prior payer is required.
- A new proof of delivery **OR** a statement signed and dated by the beneficiary verifying the supplier has examined the equipment **AND** a supplier attestation that the equipment meets the Medicare requirements.

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Switching from ANY Plan to Medicare FFS

If testing is to be considered when it is done at time of need, how does that impact beneficiaries coming from another insurance into Medicare? Would all previous testing be accepted (not just from Advantage plans), or is new testing still required upon entry into Medicare?

Response: *"Time of need," from a Medicare-centric standpoint, is based upon eligibility for Medicare. There is a long-standing policy in Medicare that to get an item under Medicare, you must meet Medicare's requirements at the time of the first claim when under Medicare eligibility. The beneficiary does not have to obtain a new blood gas study, but the test must be the most recent qualifying study the beneficiary obtained previously and under the guidelines specified in DME MAC policy.*

Applies to Commercial, Medicaid, MCO, and MAP (HMO)

Important:

- New in-person office visit required
- Most recent visit before Traditional Medicare FFS is primary is acceptable
- Office visit must justify why oxygen is reasonable and necessary
- Must meet coverage criteria for the applicable Group (I, II, III)

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Example: Patient Transitioning into Traditional Medicare from Another Payer

- Patient Lee started on oxygen therapy 3 years ago while on BCBS insurance
- On January 1, 2023 Patient Lee is transitioning into traditional Medicare FFS as primary insurance with BCBS as secondary.
- Patient Lee informed ABC Home Medical of new insurance starting 1-1-2023. ABC Home Medical has been suppling the oxygen for him since the beginning.
- Patient Lee had an in-person office visiting in July 2022, and the medical records from that office discuss the use of oxygen to treating Patient Lee's COPD condition.

What does ABC Home Medical need to meet Medicare FFS coverage criteria:

- ABC Home Medical can use the original test results they have on file.
- ABC Home Medical can use the office visit from July 2022.
- ABC Home Medical needs a new SWO
- ABC Home Medical needs either a new POD or documentation meeting "Equipment From Previous Payor".

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Break in Medical Need

Patient has pneumonia with a 2-month medical need then oxygen is returned but 7 months later develops another acute condition and needs oxygen for 3 months. How do we communicate the new initial need? Do we add narratives for every "new need" and does a new 36-month count start over each time?

Standard oxygen payment rules apply. In this example, a new 36-month period would start for the new episode of need.

- Unless there is a break in medical necessity that lasts longer than 60 consecutive days plus the days remaining in the rental month in which use ceases, medical necessity is presumed to continue.
- If an interruption in the use of equipment continues for more than 60 consecutive days plus the days remaining in the rental month in which use ceases, a new rental period begins if the supplier submits all of the following information:
  - A new prescription.
  - New medical necessity documentation.
  - A statement describing the reason for the interruption and demonstrating that medical necessity in the prior episode ended.
- **Make sure the documentation shows a change in medical condition.**
- **Claim narrative for break in medical need requires: BIN**

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Oxygen Modifiers

- Oxygen Equipment Payment Category Still Exists
- Includes Q modifiers depending on high liter (above 4lpm) or low liter flow (below 1 lpm)

KX versus N Modifiers:

- Recurring rentals and through 60 month RUL **REQUIRES KX**

  EXAMPLE:

  - Patient Joe setup with oxygen equipment Jan 10, 2023: E1390RRKX
  - Patient Joe still on oxygen April 10, 2023: E1390RRKX
- Effective for DOS April 1, 2023 & Beyond: NEW INITIAL Claims (new oxygen patients) and RUL (Restart) Claims/Patients
  - N1 for Group 1 (RRN1)
  - N2 for Group 2 (RRN2)
  - N3 for Group 3 (RRN3)

  Example:

  - Patient Eleanor setup with oxygen April 3, 2023, qualified for Group 1 coverage: E1390RRN1
- Language exits in Oxygen policy article

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Oxygen "N" Billing Modifiers

	Blood Gas Study		
Oxygen Grouping	ABG (mm Hg)	Oximetry (SAT %)	Billing Modifier
Group I	≤55	≤88	**N1**
Group II	56-59	89	**N2**
Group III	≥60	≥90	**N3**

N modifiers for NEW initial claims with DOS April 1, 2023 & Beyond

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SWO/DWO Required Elements

- ❑ Beneficiary's name **OR** MBI
- ❑ Order date
- ❑ General Description of each item being ordered (itemized for each item being billed)
- ❑ Quantity to be dispensed (for supplies)
- ❑ Method of administration: NC or Mask
- ❑ Frequency of use: 2lpm cont. or 3lpm H.S.
- ❑ Length of need, optional*
- ❑ Treating practitioner's name **OR** NPI
- ❑ Treating practitioner's signature

- Supplier can still complete SWO, have practitioner review and sign order
- Best practice to get this before dispensing the items. A MUST prior to submitting claim for payment.
- The medical record trumps any discrepancies between an order or the medical record
- Length of need – option on the SWO, if in the medical record that trumps the order

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What is Supporting Documentation

In ADDITION to treating practitioners' notes ---Use Supporting Documentation as part of the patient's medical record.

- Who else is involved in the care of the patient:
  - PT/OT evaluations,
  - Prosthetist/Orthotist,
  - Nursing notes
  - Home health notes
  - Hospital discharge notes
  - SNF notes
  - Any other clinical notes, lab tests, dietician
- These DO NOT need to be co-signed by the treating practitioner

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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
- Certificates of Medical Necessity not mandated by CMS
- An order – more on next slide!
- And an order that has a statement like this: "Patient meets medical necessity for the item being order"

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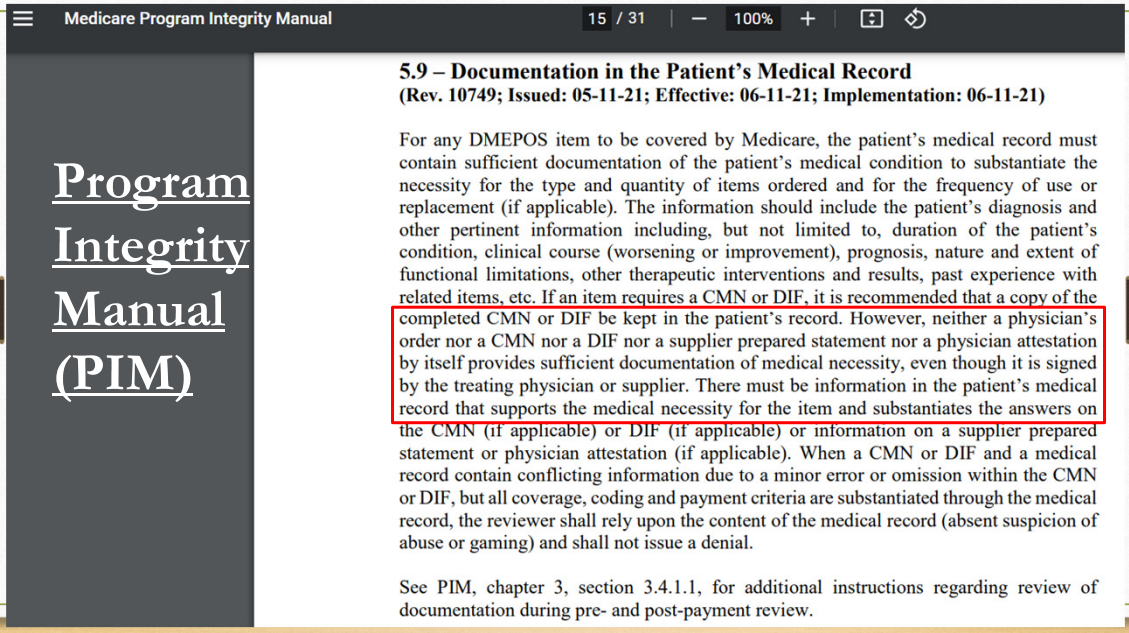
Program Integrity Manual (PIM)



5.9 – Documentation in the Patient's Medical Record
(Rev. 10749; Issued: 05-11-21; Effective: 06-11-21; Implementation: 06-11-21)

For any DMEPOS item to be covered by Medicare, the patient's medical record must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable). The information should include the patient's diagnosis and other pertinent information including, but not limited to, duration of the patient's condition, clinical course (worsening or improvement), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc. If an item requires a CMN or DIF, it is recommended that a copy of the completed CMN or DIF be kept in the patient's record. However, neither a physician's order nor a CMN nor a DIF nor a supplier prepared statement nor a physician attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating physician or supplier. There must be information in the patient's medical record that supports the medical necessity for the item and substantiates the answers on the CMN (if applicable) or DIF (if applicable) or information on a supplier prepared statement or physician attestation (if applicable). When a CMN or DIF and a medical record contain conflicting information due to a minor error or omission within the CMN or DIF, but all coverage, coding and payment criteria are substantiated through the medical record, the reviewer shall rely upon the content of the medical record (absent suspicion of abuse or gaming) and shall not issue a denial.

See PIM, chapter 3, section 3.4.1.1, for additional instructions regarding review of documentation during pre- and post-payment review.

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In Preparation for Post PHE –Ending May 11, 2023

- Still awaiting on instruction from CMS for Post PHE claims
- Run reports with CR modifier
  - Separate by equipment
  - Why is the CR modifier still on the claim?
  - Consider if the patient can get qualified according to the LCD
  - With NEW Oxygen LCD look at claims that may no longer need CR modifier (COVID-19 NTE)
  - Still waiting on instruction for post PHE claims – recurring rentals using the CR modifier
- Know when patient eligible for RUL
- Is continued medical need met – most items can be done with a valid order
- Are there any common referrals that need to be educated on life without the waivers?

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Oxygen Group I & II Coverage Criteria

Reasonable and necessity when <u>all</u> the below are met.

- ❑ Treating practitioner orders & evaluates results of a qualifying blood gas study at the time of need*.
- ❑ Qualifying blood gas study was performed by treating practitioner or a qualified provider or a laboratory services
- ❑ Copy of qualifying blood gas study is on file performed at "time of need".
- ❑ Patient may have either have acute or chronic condition.
- ❑ Medical record documentation showing O2 will improve the patient's condition in the home setting.
- ❑ For portable system, records must verify patient being mobile in the home.
- ❑ Prescribed liter flow should be documented in the medical records and or order.
- ❑ Length of need should be supported in the medical records (for acute conditions, the need may be short term).

Documentation in the medical record is key for proving medical need of home oxygen therapy.

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In Summary – What is Required For Coverage with New Oxygen LCD

- Prescription/Order/SWO
- Medical Records including any supporting documentation
- Qualified blood gas testing
- Proof of Delivery
- Follow initial coverage criteria for specified Group I, II, or III
- Follow continued coverage criteria for specified Group I, II, or III
- Know State Law requirements for oxygen therapy

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Webinar: **Post PHE - What Stays, What Goes**
May 4, 2023 @1pm CST (2pm EST, 12pm MST)

Join me @ **Heartland**
June 12-14, 2023

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