Looking at Getting Into the Oxygen Services? Let's Discuss the Policy First!

Sept 2018

Oxygen Coverage - 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. Oxygenations studies performed in a chronic stable state or within 2 days prior to discharge from an inpatient facility, **and**
5. Alternative treatments found ineffective considered/tried and ruled out

Oxygen requires a TRUE CMN (CMS-484)

Oxygen - 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 DOS (no wiggle room)**
- ✓ 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

Home O2 Covered

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

  or
- **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
- Pneumonia is NOT a reason to get home oxygen covered
- 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**

Qualifying Blood Gas Study

Qualifying blood gas study value was obtained under these 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** – 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

2 Types of Groups For Oxygen

Group I Coverage: - Most Common

- Arterial Blood Gas (ABG) – at or below 55mmHG on room air
- Blood oxygen saturation (SAT) – at or below 88%
- Study can be performed in one of the following ways:
  - At rest on room air
  - During sleep on room air
    Must be for at minimum 2 hours at or below 88% for total of 5 minutes doesn't have to be continuous
  - During exercise
    If doesn't qualify at rest on room air, then document result, then
    Walk patient on room air, document result (if below 88%), then
    Use oxygen walk patient again and document result (to show oxygen does help)
    - **Must have all 3 results 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

Group II Coverage:

Must meet one of the three requirements below in addition to the testing requirements

1. Dependent edema suggesting congestive heart failure, **or**
2. 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**
3. Erythrocythemia with a hematocrit greater than 56 percent

Arterial PO2 of 56–59 mm Hg or arterial blood oxygen saturation of 89 percent at:

--Rest (awake)
--During sleep for at least 5 min, or
--During exercise, and
Follow same testing requirements as Group I

Home-based Overnight Testing

- Beneficiaries self-administer home-based overnight oximetry tests
  Under direction of Medicare-enrolled IDTF(Independent Diagnostic Testing Facility)
- Supplier or shipping entity may deliver pulse oximetry test unit and related technology if:
  1. Treating physician contacted IDTF to order test before it is performed
  2. Test performed under direction of Medicare-approved IDTF
  3. Test unit is sealed and tamper-proof
  4. The IDTF must send test results to physician
- Must be for at minimum 2 hours at or below 88% for total of 5 minutes doesn't have to be continuous
- Use the completed date of test on the CMN
- Use the lowest oxygen saturation on the CMN (not average)

OSA and Oxygen Bled Into CPAP Machine at Night

- 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 – NO exceptions**

- The titration is conducted over a minimum of two hours; **and**
- During titration:
  - -- The AHI/RDI is reduced to less than or equal to an average of ten events per hour; or
  - -- If the initial AHI/RDI was less than an average of ten events per hour, the titration demonstrates further reduction in the AHI/RDI; and
- 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 O2 saturation ≤ 88 percent for 5 minutes total (which does not need to be continuous)

According to Medicare, can a patient be tested for O2 under observation (not inpatient) stay in the hospital

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

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.
- Need to make sure the patient is in chronic stable state and not performed in an acute state or in an ER visit.
- Generally these patients are not in either state, so not in a CSS. So the patient needs to pay privately or see physician for getting qualified.

Portable Oxygen

- Additional requirements for portable oxygen
  - Medical records support the beneficiary is mobile within the home; and
  - BGS performed at rest (awake) or during exercise
    - BGS performed during sleep will not be accepted

Basically, in the case where beneficiary initially qualified at night only, new testing news to be obtained when oxygen is being ordered for use during awake hours (i.e., continuous)

Can a HHA or SNF qualify a patient for home oxygen?

Testing Requirements

- Qualifying test covered under Medicare Part A or B (see below)
- Test must be performed by provider qualified to bill Medicare: Part A provider, Laboratory, IDTF (independent diagnostic testing facility), Physician
- Most recent blood gas study obtained within 30 days prior to initial date of service
- If a **patient is under a Part A covered stay payment** such as hospital, nursing facility, home health, or hospice
  - Meets the qualified provider standard
  - Need to be sure that patient is under a Part A covered payment
  - If the patient is not under the Part A covered payment, then the requirements are not met and qualification would be invalid

For example, if a patient is under Part A in nursing facility, Medicare covers the first 100 days, if the patient is under that first 100 days, and qualifies for home oxygen, and then the testing performed in the nursing facility is acceptable. Home Health Part A coverage varies based on diagnosis and plan of care.

From article around released January 16, 2014, titled: Payment Rules Reminder – Home O2 initial Qualification Testing

Alternative Treatments – What Are These?

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

Dispensing Order:

- Can be either written or verbal
- If verbal make sure to include the name and title of the person giving the order and the name of the person at your office taking the order
- Dispensing order can be used to deliver stationary concentrator (E1390), portable concentrator (E1392), and Homefill system (K0738)

Detailed Written Order:

- Must include the following information:
  - ✓ Patient's name
  - ✓ Description of each item being ordered
  - ✓ Date of order
  - ✓ Liter flow
  - ✓ Frequency of use
  - ✓ Method of delivery
  - ✓ Ordering practitioner's printed name and NPI
  - ✓ Ordering practitioner's signature and signature date
- Required for all other oxygen HCPCS codes prior to delivery (portable gas system (E0431), portable gas content (E0443), all liquid codes

Initial CMN –CMS 484 Form

- When is an initial CMN required?
  - First claim for home oxygen
  - During the first 36 months of the rental period, when a break in medical necessity of at least 60 days
  - Equipment is replaced because reasonable useful lifetime (RUL) has been reached
  - Equipment is replaced because of irreparable damage, theft, or loss
  - Can also act as DWO but Section C must include method of delivery and frequency of use
  - New CMNs are out with MBI – can use new or current until Dec. 31, 2019

Dates on the CMN

- According to the Program Integrity Manual (PIM), chapter 5.3.1, titled *Completing a CMN or DIF*.
  - The initial date found in section A of the CMN should be either the specific date that the physician gives as the start date or the date of the order.
  - The signature date in section D of the CMN is the date the physician signs the CMN which means this date could be different the initial date.
  - The delivery date or date of service on the claim must not precede the initial date on the CMN or the start date of the written order. The delivery date or date of service must be within 3 months from the initial date of the CMN, or 3 months from the date of the physician's signature.
  - Be cautious with the dates on the CMN, and be sure to review the dates prior to submitting a claim.

What Information may I provide?

- Explain what sections of the CMN the physician is required to complete
- Supplier can not complete sections B & D of a CMN
- Section A and C are completed by the supplier prior to physician signing the CMN
- Copy of test results, medical records, order
- Any information from the Medicare policy (LCD)
- NO STAMPED SIGNATURES {Electronic Signatures OK}
- Suppliers should not complete nor tell the ordering practitioner how to answer the questions on the CMN
- The physicians have a legal responsibility to complete CMNs

Recertification CMN

- Beneficiary's meeting Group I Criteria
  - 12 months after initial CMN
  - Most recent **qualifying** BGS prior to the thirteenth month of therapy
  - Beneficiary was seen and reevaluated by the treating physician within 90 days prior to the recertification date
- Beneficiary's meeting Group II Criteria
  - 3 months after initial CMN
  - Most recent BGS performed between the 61st and 90th day following the initial certification
  - Beneficiary was seen and reevaluated by the treating physician within 90 days prior to the recertification date

Revised CMN – Change

- When the prescribed maximum flow rate changes from one of the following categories to another
  - a. Less than 1 LPM
  - b. 1-4 LPM
  - c. Greater than 4 LPM
    - If change is from category a or b to c, a repeat BGS with the beneficiary on 4 LPM must be performed BGS must be most recent study obtained within 30 days prior to initial date
- When length of need expires BGS must be most recent study obtained within 30 days prior to initial date
- When portable oxygen is added subsequent to the initial CMN for stationary oxygen
  - No requirement for a repeat BGS unless the initial qualifying study was performed during sleep, in which case a repeat BGS must be performed while the beneficiary is at rest (awake) or during exercise within 30 days prior to the revised date
- Note: IF a revised falls at same time of recert, the recert overrides revised

Revised CMN Continued

- When stationary oxygen is added subsequent to the initial CMN for portable oxygen
  - No BGS required
- When there is a new treating physician but the oxygen order is the same
  - No BGS required
  - Does not need to be submitted with the claim
- If there is a new supplier and that supplier does not have the prior CMN
  - No BGS required
  - Does not need to be submitted with the claim

Revised CMN/DIF will <u>NOT</u> be required because of issuance of new Medicare card

CMN Common Scenarios

#	ITEM	CERTIFICATION REQUIRED	COMMENTS
1	Break in service > 60 days (change in medical condition)	Initial	"BIN" (break in need)
2	Break in service > 60 days (no change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
3	Break in service < 60 days (change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
4	Break in service < 60 days (no change in medical condition) none "BIB" (break in billing)	None	"BIB" (break in billing)
5	Change in supplier (no break in service)	Revised	Change in supplier (no break in service) revised in supplier's files In an acquisition, the original may be used if it is available.
6	Initial CMN did not qualify, patient retested and now qualifies.	Initial	Initial CMN did not qualify, patient retested and now qualifies. The initial date should be the date of the qualifying test
7	Group II patient not retested within 61–90th day recertification	Recertification	The recertification date should be the date of the physician visit.
8	Group I patient with a length of need less than or equal to 12 months (but not lifetime) and not retested 30 days prior to revision.	Revised	The revised date should be the date of the physician visit.
9	Group I patient with lifetime length of need, not seen and evaluated by the physician within 90 days prior to the 12 month recert but subsequently seen.	Recertification	The recertification date should be the date of the physician visit.

#	ITEM	CERTIFICATION REQUIRED	COMMENTS
10	Portable was added after stationary	Revised	
11	Stationary was added after portable	Revised	
12	Change in modality	None	If the physician is requesting this change, a new order is required.
13	Changed billing assignment (non-assigned to assigned)	None	
14	Change in doctor	Revised in supplier's files	Supplier should maintain in their files.
15	Change in liter flow	Revised if change in payment category (e.g. 4 LPM to 5 LPM) None if payment category doesn't change (e.g. 2 LPM to 3 LPM)	Change in liter flow revised if change in payment category, e.g., from 4 LPM to 5 LPM. None if payment category does not change
16	Change from Medicare secondary to Medicare primary none	None	
17	Change from non-Medicare insurance to Medicare initial.	Initial	Change from non-Medicare insurance to Medicare initial. The initial date should be the date of Medicare eligibility if the patient has a Medicare qualifying test within 30 days before their eligibility. If they do not get the qualifying test until after they become Medicare eligible, then the initial date should be the date of the qualifying test.

Months 37-60- Get the Content

- Supplier who provided equipment during 36th rental month is required to continue to provide equipment, accessories, maintenance, and repair during the 5 year reasonable useful lifetime (RUL) -- "married to patient"
- If patient was using portable unit during initial 36 months, then oxygen content is reimbursable---as long as patient needs the content (or tanks) once rental ends:
  - 1 month's rental covers whatever the content quantity is for that month—if patient has enough to last the following month, then can bill –document
  - If the bene began using portable equipment after starting on stationary equipment, payment for the portable would continue until the end of the 36-month rental period for that equipment even though payment was also being made for the contents.
  - Can bill maximum of 3 months at one time, but patient must need content all 3 months
- Content (E0443) part of F2F ruling which means this must be on your DWO prior to delivery. If it is not on the initial order, then patient needs new F2F evaluation and new DWO both have to be obtain prior to delivery.

Oxygen Content Billing Chart

Equipment furnished in month 36	Monthly Contents After Capped Rental
O2 Concentrator Only (E1390, E1391, or E1392)	None
Portable Gas Transfill (K0738)	None
Portable Liquid Transfill (E1399)	None
Stationary Gas O2 System (E0424)	Yes- Gas Contents (E0441)
Stationary Liquid O2 System (E0439)	Yes- Liquid Contents (E0443)
Portable Gas System	Yes- Portable Gas Contents (E0443)
Portable Liquid System	Yes- Portable Liquid Contents (E0444)

You may not bill for stationary oxygen contents if the beneficiary uses a stationary concentrator and you may not bill for portable oxygen contents if the beneficiary uses a portable concentrator or transfilling equipment.

Months 37-60: Get the Maintenance

- If using stationary or portable concentrator or transfilling equipment during the first 36 months, maintenance and servicing (M&S) is payable unless still under warranty
  - No more than 1 visit every 6 months
  - Must actually make a visit to bill for the service
  - No M&S for gaseous or liquid equipment
  - First maintenance occurs 6 months after month 36
  - If the equipment is covered under a warranty that covers labor related to routine/general maintenance and servicing, payment for the first M&S visit can be no sooner than 6 months following the end of that warranty

For example, if maintenance and servicing is billed for a column I code, additional payment for the maintenance and servicing of any of the column II codes will not be made.

Column I	Column II
E1390 MS	E1391 MS, E1392 MS
E1391 MS	E1390 MS, E1392 MS
E1392 MS	E1390 MS, E1391 MS, K0738 MS
K0738 MS	E1392 MS

There is no M&S payment for gaseous or liquid equipment

Month 60 or after (RUL)

- If portable oxygen differs from RUL of stationary, the RUL of the stationary governs the when a new RUL can be initiated
- No repeat test required, but most recent test and date must be used
- Medicare will tell you no physician visit is required, but get one anyway to establish continued medical need. Would get a new order as well.
- New equipment (different) and new intake
- New CMN required, so a new rental period begins
- Narrative required on claim using RUL for reason with original date of service
- **Add RA modifier on first month claim only**
- If patient elects not to receive new equipment, can transfer ownership of the equipment to the patient—make sure patient is aware they will be responsible for accessories and maintenance, and possibly repairs

Switching from Advantage Plan to Medicare FFS

A beneficiary who was previously enrolled in a Medicare Advantage Plan, returning to traditional Medicare FFS, is subject to the same benefits, rules, requirements, and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare. Therefore, if a beneficiary received any items or services from their Medicare Advantage Plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a capped rental item (e.g., hospital bed) through a Medicare Advantage Plan must, under traditional FFS Medicare, obtain a Certificate of Medical Necessity (CMN), if applicable, and meet FFS Medicare criteria for the item before a new capped rental period would begin.

A partial exception to this rule involves home oxygen claims. If a beneficiary begins taking oxygen while under a Medicare Advantage Plan, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins. In this situation, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN, but the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in LCD.

It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS.

These instructions apply whether a beneficiary voluntarily returns to FFS or if he/she involuntarily returns to FFS because their Medicare Advantage Plan no longer participates in the Medicare+Choice program.

Revised Billing Instruction - Oxygen "Q" Modifiers and Medical Documentation

For beneficiaries with a single prescribed flow rate that doesn't encompass a full 24 hours, an average is NOT required using "0" for the unaccounted for portion of the 24 hour period.

Suppliers cannot bill for oxygen using the "Q" modifier until compliance with the regulations at 42 CFR Section 414.226(e) has been documented in the patient's record. That regulation stipulates that:

- If prescribed flow rate is different for stationary versus portable, the flow rate for stationary is used.
- If prescribed flow rate is different for the patient at rest versus the patient with exercise, the flow rate at rest is used.
- If prescribed flow rate is different for nighttime versus daytime use, the flow rates are averaged.

For all "Q" modifiers, in no case can a prescribed flow rate for exercise be used, either alone or in conjunction with a prescribed flow rate for nighttime use, to determine whether or not a low (less than 1 LPM), high (more than 4 LPM), or other (more than 1 LPM but less than 4 LPM) prescribed flow rate applies for Medicare payment purposes.

Since the "Q" modifiers submitted on the claim will be used in determining the applicability of the volume adjustment payment, suppliers cannot bill for oxygen until compliance with the regulations has been documented in the patient's record. Oxygen volume adjustment claims where the medical record is not in compliance with regulatory policy constitutes fraudulent billing and may be subject to penalties

Updated: Sept. 27th, 2018

The "Q" update

Modifier QE - PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS LESS THAN 1 LPM

- If prescribed flow rate is <1 LPM, examine the record for an "at rest" qualifying test value on room air.

Modifier QF - PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LPM AND PORTABLE OXYGEN IS PRESCRIBED

- If prescribed flow rate is >4 LPM, examine the record for an "at rest" qualifying test value on room air taken at 4 LPM.

Modifier QG - PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS GREATER THAN 4 LPM

- If prescribed flow rate is >4 LPM, examine the record for an "at rest" qualifying test value on room air taken at 4 LPM.
- DO NOT use a "with exercise" qualifying test and associated flow rate to determine the use of modifier QG.

Modifier QA - PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS IS LESS THAN 1 LPM

- If prescribed flow rate is <1 LPM, examine the record for a daytime "at rest" qualify test value on room air and a prescribed flow rate (if applicable) and a "nocturnal" qualifying test value and prescribed flow rate.
  - If both a flow rate for daytime rest use and flow rate for nocturnal use are documented, calculate the average of the two values (standard arithmetic rounding rules apply). If the result is an average flow rate <1LPM, use the QA modifier.

Modifier QB - PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LPM AND PORTABLE OXYGEN IS PRESCRIBED; and,

Modifier QR - PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS IS GREATER THAN 4 LITER LPM

- If prescribed flow rate is >4 LPM, examine the record for a daytime "at rest" qualify test value on room air and a prescribed flow rate (if applicable) and a "nocturnal" qualifying test value and prescribed flow rate.
  - If both a flow rate for daytime at rest use and flow rate for nocturnal use are documented, calculate the average of the two values (standard arithmetic rounding rules apply). If the result is an average flow rate >4LPM, use the QB modifier if both stationary and portable are prescribed.
  - If both a flow rate for daytime at rest use and flow rate for nocturnal use are documented, calculate the average of the two values (standard arithmetic rounding rules apply). If the result is an average flow rate >4LPM, use the QR modifier if only stationary is prescribed.
  - If there is a single flow rate for nocturnal use only, no average is required.
    - If the flow rate is >4LPM, use the QB modifier if both stationary and portable are prescribed.
    - If the flow rate is >4LPM, use the QR modifier if only stationary is prescribed.

Let's "Q" It Up:

Example 1

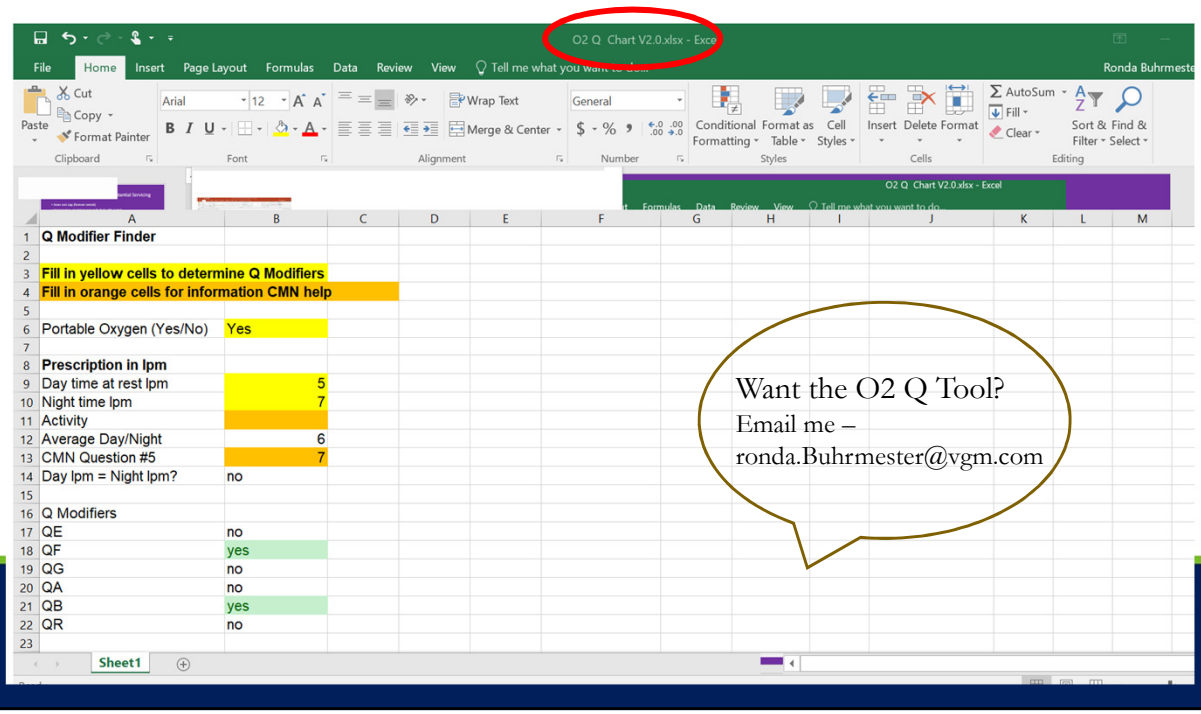
Stationary equipment ordered: Patient prescribed O2 @ **5 lpm at night only**
Average = 5lpm + 0 lpm daytime = 5/2 =2.5lpm (use rounding rules) = 3lpm
MD should be reporting **5LPM** in question 5

No additional Q modifiers

Example 2

Stationary equipment & portable equipment ordered
Patient prescribed O2 @ **5lpm at rest, 6lpm with activity, and 5lpm with sleep**
Daytime and Night time use the same liter flow
MD reports 6lpm on CMN question #5

Additional Q modifiers needed QF



Correct Coding – Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ

Joint DME MAC Article

It has recently come to the attention of the DME MACs that there are instances whereby a supplier possesses information that a beneficiary does not meet Medicare "Reasonable and Necessary" requirements for oxygen as specified in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD L33797).

In order to expedite the adjudication of oxygen claims, the DME MACs will be adding the following modifiers to the Policy Specific Documentation Requirements section of the LCD L33797 Policy-related Article (A52514). These modifiers will indicate whether the applicable payment criteria are met (KX modifier), and provide additional information related to the coverage and/or liability (GA, GY and GZ modifiers) when the policy criteria are not met.

Effective for claims with Dates of Service (DOS) on or after 08/01/2018, the use of these modifiers is mandatory. Claim lines billed without a KX, GA, GY or GZ modifier will be rejected as missing information.

KX - Requirements specified in the medical policy have been met
The KX modifier must be appended to an oxygen or oxygen equipment claim when all the statutory and reasonable and necessary (R&N) requirements have been met. Suppliers are not required to secure all the required documentation prior to claim submission, however, appending the KX modifier to each of the oxygen codes billed serves as an attestation by the supplier that the requirements for its use have been met.

Started AUGUST 1, 2018

All O2 HCPCS Codes

GA - Waiver of liability (expected to be denied as not reasonable and necessary, ABN on file)
When a Medicare claim denial is expected because an item or service does not meet the R&N criteria, the supplier must issue an ABN to the beneficiary before furnishing the item or service. When the beneficiary accepts financial responsibility, and signs a valid ABN, the supplier submits the claim to Medicare appending modifier GA to each corresponding HCPCS code. Modifier GA indicates that the supplier has a waiver of liability statement on file. Modifier GA must not be submitted if a valid ABN is not issued. Claims submitted with the GA modifier will receive a medical necessity denial holding the beneficiary liable.

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit
The GY modifier indicates that an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. Oxygen and oxygen equipment is covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). Claims for Oxygen equipment have additional statutory requirements pursuant to 42 CFR 410.38(g), and require a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS the beneficiary liable for the excluded services.

GZ - Item or service not reasonable and necessary (expected to be denied as not reasonable and necessary, no ABN on file)
When a Medicare claim denial is expected because an item or service does not meet the R&N criteria, the supplier is expected to issue an ABN to the beneficiary. If the supplier chooses to accept liability for the expected denial, the supplier must append the GZ modifier to each corresponding HCPCS code. Modifier GZ indicates that the supplier does not have a waiver of liability statement on file. Claims submitted with the GZ modifier will receive a medical necessity denial holding the supplier liable.

Proper selection of the correct G modifier requires an assessment of the possible cause for a denial. Some criteria are based upon statutory requirements. Failure to meet a statutory requirement justifies the use of the GY modifier. When Reasonable and Necessary (R&N) criteria are not met, either the GA or GZ modifier is appropriate based upon Advance Beneficiary Notice of Noncoverage (ABN) status.

Additional information on the coverage, coding and documentation requirements for oxygen may be found in the Oxygen and Oxygen Equipment Local Coverage Determination (L33797 EXT) and related Policy Article (A52514 EXT) on the DME MAC web sites and the CMS Medicare Coverage Database.

Publication History

Publication Date: May 10, 2018

Oxygen Replacement: Supplier "Abandonment" of Beneficiaries and Oxygen Equipment

CMS issued instructions to the DME MACs to process claims for replacement oxygen and oxygen equipment in the event that a supplier voluntarily exits the Medicare oxygen business (for example, goes out of business) and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

In these situations, CMS considers the equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a beneficiary may elect to obtain a new piece of equipment.

When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

Obligations of Supplier "Abandonment" of Beneficiary with O2 Equipment

Obligations of Existing Supplier -Exiting

Supplier voluntarily exiting the program must provide a 30 day notice to the beneficiary of their intention to no longer provide the O2 services.
This must be provided in writing and must in one of two ways:

1. A letter to beneficiary notifying them of supplier's intention to discontinue O2 services. The letter must specify a date upon which this will occur, **OR**

2. Working with the beneficiary, a letter to the new supplier selected by the beneficiary, transferring provision of O2 therapy services to the new supplier as of a specific date.

Obligations of Supplier "Abandonment" of Beneficiary with O2 Equipment:

Obligations of New Supplier –Taking on O2 Beneficiary

For supplier who receive beneficiaries from supplier who has elected to voluntarily exit the Medicare oxygen business, claims for replacement equipment must:

1. Include the RA modifier on the claim line for replacement equipment only on 1st month, **AND**
2. Document in narrative field of the claim that "beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement, **AND**
3. Documentation demonstrating the transfer from supplier that exited the business Examples are:
   - Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated, **or,**
   - Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program, **or,**
   - **Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.**

Obligations of Supplier "Abandonment" of Beneficiary with O2 Equipment:

Obligations of New Supplier -Do NOT Forget!

Suppliers accepting transfer of beneficiaries are reminded that **ALL Medicare rules apply, this includes:**

1. New Order
2. New initial CMN
   - ❖ Repeat blood gas study is not required. Use the most recent qualifying test results and date. DOES NOT have to be within 30 days prior to the initial date. It could be most recent test report on prior CMN.
   - ❖ There is not requirement for a physician visit related to completion of the CMN for replacement of equipment.
3. Medical necessity as outlined in the O2 medical policy.

- Team of expert consultants providing…
  - Prescreen Reviews
  - Forms and Documentation Reviews
  - Proactive Claim Audits
  - On-going compliance support packages
  - "Any willing provider" prep kit (1 hr product-specific webinar for staff and 1 hr documentation/form review = $399 for VGM Members)
  - TPE/RAC/UPIC Audit support and appeal preparation

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Oct 9th at 11am central
PMD Documentation Requirements
https://attendee.gotowebinar.com/register/2423198676217400067

Oct 24th at 10am central
Digging Into CPAP Policy Requirements
https://attendee.gotowebinar.com/register/4577193631967896321

Nov 9th at 11am central
Is the Hospital Bed and Group Support Surface a Good Market to Expand Into in 2019?
https://attendee.gotowebinar.com/register/4213146431610892034

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