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OXYGEN COVERAGE MADE EASY

Denise M. Leard, Esq.

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OXYGEN COVERAGE BASICS

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- Home oxygen therapy is reasonable and necessary, only if the following conditions are met:
  - The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
  - There must be evidence in the medical record documenting:
    - A severe underlying lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy.
    - The beneficiary is not experiencing an exacerbation of their underlying lung disease or other acute condition(s) impacting the beneficiary's oxygen saturation.
    - For beneficiaries with concurrent PAP therapy, the qualifying oxygen saturation test is performed following optimal treatment of the OSA as described in the Coverage Indications, Limitations, and/or Medical Necessity.

OXYGEN COVERAGE BASICS

- Home oxygen therapy is reasonable and necessary only if the following conditions are met (cont'd):
  - The beneficiary's blood gas study meets the specific criteria (to be discussed).
  - The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services.
  - The qualifying blood gas study was obtained under the following conditions:
    - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date,

    OR

    - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the beneficiary is in a chronic stable state,

    AND

OXYGEN COVERAGE BASICS

- Home oxygen therapy is reasonable and necessary only if the following conditions are met (cont'd):
  - Alternative treatment measures have been tried or considered and deemed clinically ineffective
    - Per the NCD, the medical records must document that "other forms of treatment (e.g., medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required."

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THE DEVIL IS IN THE DETAILS

QUALIFYING BLOOD GAS

- Group I criteria includes any of the following:
  - An arterial PO_2, at or below 55 mm Hg, or an arterial oxygen saturation, at or below 88 percent, taken at rest (awake)

  OR

  - An arterial PO_2, at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least five minutes taken during sleep for a beneficiary who demonstrates an arterial PO_2, at or above 56 mm Hg, or an arterial oxygen saturation, at or above 89 percent, while awake

  OR

  - A decrease in arterial PO_2, more than 10 mm Hg, or a decrease in arterial oxygen saturation more than five percent from baseline saturation, for at least five minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia

  OR

QUALIFYING BLOOD GAS

- Group I criteria includes any of the following (cont'd):
  - An arterial PO_2, at or below 55 mm Hg, or an arterial oxygen saturation, at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial PO_2, at or above 56 mm Hg, or an arterial oxygen saturation, at or above 89 percent, during the day while at rest. In this case, oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the beneficiary was breathing room air.
- Initial coverage for beneficiaries meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter.

THE DEVIL IS IN THE DETAILS

- Group II criteria includes the presence of:
  - An arterial PO 2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake); during sleep for at least five minutes; or during exercise (as described under Group I criteria)
  - AND
  - Any of the following:
    - Dependent edema suggesting congestive heart failure
    - 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)
    - Erythrocythemia with a hematocrit greater than 56 percent.
  - Initial coverage for beneficiaries meeting Group II criteria is limited to three months or the physician specified length of need, whichever is shorter.

QUALIFYING BLOOD GAS

- Group III includes beneficiaries with arterial PO_2 levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these beneficiaries there is a rebuttable presumption of non-coverage.

QUALIFYING BLOOD GAS

- Qualifying Blood Gas Study:
  - Must comply with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B.
  - The test must be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician.
  - A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable.
  - The qualifying blood gas study may not be paid for by any supplier.
  - Exception to these prohibitions for blood gas studies performed by a hospital certified to do such tests.

QUALIFYING BLOOD GAS

- Exercise testing:
  - When oxygen is covered based on an oximetry study obtained during exercise, there must be documentation of three (3) oximetry studies in the beneficiary's medical record.
    - Testing at rest without oxygen
    - Testing during exercise without oxygen

    AND
    - Testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia) are required
  - All three tests must be performed within the same testing session

QUALIFYING BLOOD GAS

- Exercise testing (cont'd):
  - Exercise testing must be performed in-person by a physician or other medical professional qualified to conduct exercise oximetry testing.
  - Only the testing during exercise without oxygen is used for qualification and reported on the CMN. The other two results do not have to be routinely submitted but must be available on request.
  - Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the three required test elements and is not valid for determining eligibility for oxygen coverage.

OVERNIGHT OXIMETRY STUDIES

- Overnight sleep oximetry may be performed in a facility or at home.
- For home overnight oximetry studies, the oximeter provided to the beneficiary must be tamper-proof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.
- For all the overnight oximetry criteria, the five minutes does not have to be continuous.
- Baseline saturation is defined as the mean saturation level during the duration of the test.

OVERNIGHT OXIMETRY STUDIES

- For purposes of meeting Criterion 3 described in Group I above, there must be a minimum of two hours test time recorded for sleep oximetry,
  - A decrease in arterial PO_2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, for at least 5 minutes taken during sleep associated with symptoms,
- The result must reach a qualifying test value otherwise the Group III presumption of non-coverage applies,

OVERNIGHT OXIMETRY STUDIES

- Home overnight oximetry is limited solely to stand-alone overnight pulse oximetry performed in the beneficiary's home under the conditions specified below.
- Overnight oximetry performed as part of home sleep testing or as part of any other home testing is not considered to be eligible under this provision to be used for qualification for reimbursement of home oxygen and oxygen equipment even if the testing was performed in compliance with the requirements of this section.
- Beneficiaries may self-administer home based overnight oximetry tests under the direction of a Medicare-enrolled Independent Diagnostic Testing Facility (IDTF).

OVERNIGHT OXIMETRY STUDIES

- A DME supplier or another shipping entity may deliver a pulse oximetry test unit and related technology to a beneficiary's home under the following circumstances:
  - The beneficiary's treating physician has contacted the IDTF to order an overnight pulse oximetry test before the test is performed.
  - The test is performed under the direction and/or instruction of a Medicare-approved IDTF:
    - The IDTF must provide clear written instructions to the beneficiary on proper operation of the test equipment and must be available to address other questions.
    - The DME supplier may not create this written instruction, provide verbal instructions, answer questions from the beneficiary, apply or demonstrate the application of the testing equipment to the beneficiary, or otherwise participate in the conduct of the test.

OVERNIGHT OXIMETRY STUDIES

- The test unit is sealed and tamper-proof such that test results cannot be accessed by anyone other than the IDTF, which is responsible for transmitting a test report to the treating physician.
- The DME supplier may use related technology to download test results from the testing unit and transmit those results to the IDTF.
- In no case may the DME supplier access or manipulate the test results in any form.

OVERNIGHT OXIMETRY STUDIES

- The IDTF must send the test results to the physician.
- The IDTF may send the test results to the supplier if the supplier is currently providing or has an order to provide oxygen or other respiratory services to the beneficiary or if the beneficiary has signed a release permitting the supplier to receive the report.
- Oximetry test results obtained through a similar process as described for home overnight oximetry (see above) while the beneficiary is awake, either at rest or with exercise, may not be used for purposes of qualifying the beneficiary for home oxygen therapy.

OVERNIGHT OXIMETRY STUDIES

- Overnight oximetry does not include oximetry obtained during polysomnography or other sleep testing for sleep apnea, regardless of the location the testing was performed. See below for information on sleep testing that may be used to qualify for oxygen coverage.

CERTIFICATES OF MEDICAL NECESSITY

- Initial CMN is required:
  - With the first claim for home oxygen (even if the beneficiary was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO).
  - Break in Need During the first 36 months of the rental period.
  - When the equipment is replaced because the reasonable useful lifetime of prior equipment has been reached.
  - When the equipment is replaced because of irreparable damage, theft, or loss of the originally dispensed equipment.
    - Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood).
    - Irreparable damage does not refer to wear and tear over time.

CERTIFICATES OF MEDICAL NECESSITY

- Testing and Visit Requirements:
  - Initial CMN for first claim for home oxygen and if there is a break in need.
  - The blood gas study must be the most recent study obtained within 30 days prior to the Initial Date.
  - For situation the first claim for home oxygen, there is an exception to the 30-day test requirement for beneficiaries who were started on oxygen while enrolled in a Medicare HMO and transition to fee-for-service Medicare. For those beneficiaries, the blood gas study does not have to be obtained 30 days prior to the Initial Date but must be the most recent qualifying test obtained while in the HMO.
- The beneficiary must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.

CERTIFICATES OF MEDICAL NECESSITY

- Initial CMN for replacement equipment:
  - Repeat blood gas testing is not required.
    - Enter the most recent qualifying value and test date.
    - This test does not have to be within 30 days prior to the Initial Date.
    - It could be the test result reported on the most recent prior CMN.
  - There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

CERTIFICATES OF MEDICAL NECESSITY

- Recertification CMN is required:
  - For Group I patients a recertification CMN is required 12 months after Initial Certification (i.e., with the 13th month's claim).
  - For Group II patients a recertification CMN is three months after Initial Certification (i.e., with the fourth month's claim).

CERTIFICATES OF MEDICAL NECESSITY

- Revised CMN Requirements:
  - When the prescribed maximum flow rate changes from one of the following categories to another:
    - Less than 1 LPM
    - 1-4 LPM
    - Greater than 4 LPM
  - If the change is from category (a) or (b) to category (c), a repeat blood gas study with the beneficiary on 4 LPM must be performed.
  - When the length of need expires – if the physician specified less than lifetime length of need on the most recent CMN.

CERTIFICATES OF MEDICAL NECESSITY

- Revised CMN Requirements (cont'd):
  - When a portable oxygen system is added subsequent to Initial Certification of a stationary system.
  - When a stationary system is added subsequent to Initial Certification of a portable system.
  - When there is a new treating physician but the oxygen order is the same.
  - If there is a new supplier and that supplier does not have the prior CMN.

WRITTEN ORDERS PRIOR TO DELIVERY

- ACA 6407 Requirements:
  - Applicable to the following items: E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444.
  - These items require an in-person or face-to-face interaction between the beneficiary and their treating physician within 6 months prior to prescribing the item, specifically to document that the beneficiary was evaluated and/or treated for a condition that supports the need for the item(s) of DME ordered. A dispensing order or detailed written order is not sufficient to provide these items. A Written Order Prior to Delivery (WOPD) is required.
  - Note that WOPDs also require the prescriber's National Provider Identifier (NPI) to be included on the order.

WRITTEN ORDERS PRIOR TO DELIVERY

- ACA 6407 Requirements (cont'd):
  - A new face-to-face examination is required each time a new prescription for one of the specified items is ordered. A new prescription is required by Medicare:
    - For all claims for purchases or initial rentals.
    - When there is a change in the prescription for the accessory, supply, drug, etc.
    - If a local coverage determination (LCD) requires periodic prescription renewal (i.e., policy requires a new prescription on a scheduled or periodic basis).
    - When an item is replaced.
    - When there is a change in the supplier.
    - When required by state law.
  - The face-to-face examination must be within six months prior to the date of the WOPD.

CMS CHANGE REQUEST 9886

- The purpose of the change is to instruct contractors to accept timely orders and medical documentation, regardless of whether the supplier received the documentation directly from the beneficiary's eligible practitioner or from another, transferring supplier.
- This change allows the new supplier to obtain a copy of a valid written order from the old supplier, instead of having to obtain a new written order from the practitioner.

THE DEVIL IS IN THE DETAILS

- Medicare Program Integrity Manual, Chapter 5, §5.2.7 is amended to read:
    - A new order is required in the following situations:
        - There is a change in the order for the accessory, supply, drug, etc.
        - On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.
        - When an item is replaced.
        - When there is a change in the supplier, if the recipient supplier did not obtain a valid order for the DMEPOS item from the transferring supplier.

PORTABLE OXYGEN

- A portable oxygen system is covered if the beneficiary is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise.
- If the only qualifying blood gas study was performed during sleep, portable oxygen will be denied as not reasonable and necessary.
- If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system.
- If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the beneficiary uses; Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed.

INITIAL 36-MONTH RENTAL PERIOD

- Reimbursement for oxygen equipment is limited to 36 monthly rental payments and is all inclusive.
- Payment for stationary equipment is increased for beneficiaries requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for beneficiaries requiring less than 1 LPM.

INITIAL 36-MONTH RENTAL PERIOD

- The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month rental period, unless one of the following exceptions is met:
  - Beneficiary relocates temporarily or permanently outside of the supplier's service area
  - Beneficiary elects to obtain oxygen from a different supplier
  - Individual case exceptions made by CMS or DME MAC
  - Item becomes subject to competitive bidding

INITIAL 36-MONTH RENTAL PERIOD

- . . . Unless one of the following exceptions is met (cont'd):
  - Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, trans-filling equipment) is not permitted unless one of the following requirements is met:
    - Supplier replaces the equipment with the same or equivalent item
    - Physician orders different equipment
    - Beneficiary chooses to receive an upgrade and signs an Advance Beneficiary Notice of Non-coverage (ABN)
    - CMS or the DME MAC determines that a change in equipment is warranted

RESTARTING THE 36-MONTH RENTAL PERIOD

- Specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost
- Break-in-need for at least 60 days plus the days remaining in the month of discontinuation and new medical necessity is established (see "BREAK-IN-SERVICE" below)

RESTARTING THE 36-MONTH RENTAL PERIOD

- Lost, Stolen, or Incident Resulting in Damage Beyond Repair:
  - A specific incident of damage to equipment is required, such as equipment falling down a flight of stairs, as opposed to equipment that is worn out over time,
  - New 36-month cap rental period cannot be started if equipment is replaced due to malfunction, wear and tear, routine maintenance or repair needed.
  - A new 36-month rental period and new reasonable useful lifetime is started on the date that the replacement equipment is furnished to the beneficiary.

RESTARTING THE 36-MONTH RENTAL PERIOD

- Lost, Stolen, or Incident Resulting in Damage Beyond Repair (cont'd):
  - Claims for the replacement of oxygen equipment for the first month of use only are billed using the HCPCS code for the new equipment and the RA modifier.
    - You must include on the claim for the first month of use a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in your files. For example, if equipment was stolen, you should keep a copy of the police report in your files. For lost or irreparably damaged equipment, you should maintain any documentation that supports the narrative account of the incident.
    - AFTER expiration of the 36-month cap rental period, supplier of oxygen equipment must continue providing oxygen contents to the beneficiary during ANY period of medical need for the remainder of the 5-year reasonable useful lifetime of the equipment.

RESTARTING THE 36-MONTH RENTAL PERIOD

- Lost, Stolen, or Incident Resulting in Damage Beyond Repair (cont'd):
  - Initial CMN and claim for replacement equipment:
    - Initial Date should be the date of delivery of the replacement oxygen equipment.
    - Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss.
    - Claims for the initial rental month must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the supplier's files.

RESTARTING THE 36-MONTH RENTAL PERIOD

- Lost, Stolen, or Incident Resulting in Damage Beyond Repair (cont'd):
  - Recert CMN for replacement equipment:
    - Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
    - There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

RESTARTING THE 36-MONTH RENTAL PERIOD

- A new 36-month rental period does not start in the following situations:
  - Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
  - Providing different equipment based on a physician order or beneficiary request for an upgrade
  - Break-in-need less than 60 days plus the days remaining in the month of discontinuation
    - If need/use of oxygen ends for less than 60 days plus the remainder of the rental month of discontinuation and then resumes, payment resumes where it left off
    - During the 36-month rental period, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new 36-month rental period would begin

RESTARTING THE 36-MONTH RENTAL PERIOD

- A new 36-month rental period does not start in the following situations (cont'd):
  - Break-in-need less than 60 days plus the days remaining in the month of discontinuation (cont'd)
    - During months 37-60, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new rental period does not begin. The supplier who provided the oxygen equipment during the 36th rental month must provide all necessary items and services for the duration of the reasonable useful lifetime

THE DEVIL IS IN THE DETAILS

- A new 36-month rental period does not start in the following situations (cont'd):
  - Break-in-billing
    - Break-in-billing/Part B payment without break-in-medical necessity
    - If beneficiary enters hospital or SNF or joins Medicare HMO and continues to need/use oxygen, when beneficiary returns home or rejoins Medicare FFS, payment resumes where it left off
  - Changing suppliers

MONTHS 37-60

- There is no further payment for oxygen equipment during the five-year reasonable useful lifetime (RUL) of the equipment after 36 rental payments have been made.
- If use of portable equipment (E0431, E0433, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until 36 rental payments have been made for the portable equipment.
- The supplier who provided the equipment during the 36th rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5-year reasonable useful lifetime of the equipment.

AFTER THE 60-MONTH RENTAL PERIOD

- Months 61 and after:
  - At any time after the end of the 5-year reasonable useful lifetime for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.
  - If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months 37-60 remain in effect.
  - There is no separate payment for accessories or repairs.
  - If the beneficiary was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

AFTER THE 60-MONTH RENTAL PERIOD

- Months 61 and after (cont'd):
  - If the beneficiary elects not to receive new equipment after the end of the five-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily non-covered by Medicare.
  - Contents are separately payable for beneficiary-owned gaseous or liquid systems.
  - If a beneficiary enters Medicare FFS with beneficiary-owned equipment, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

RELOCATION AND TRAVEL

- Months 1 through 36:
  - If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), then for the remainder of the rental month for which it billed, the home supplier is required to provide the equipment and related items/service itself or make arrangements with a different supplier to provide the equipment, items, and services.
  - For subsequent rental months that the beneficiary is outside the service area, the home supplier is encouraged to either provide the equipment and related items/services itself or assist the beneficiary in finding another supplier in the new location.

RELOCATION AND TRAVEL

- Months 1 through 36 (cont'd):
  - The home supplier may not bill for or be reimbursed by Medicare if it is not providing oxygen equipment or has not made arrangements with a different supplier to provide the equipment on the anniversary billing date.
  - Medicare will pay only one supplier to provide oxygen during any one-rental month.

RELOCATION AND TRAVEL

- Months 37 through 60:
  - If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), the home supplier is required to either provide the equipment and related items/services itself or make arrangements with a different supplier to provide the equipment and related items/services.

ABANDONMENT OF OXYGEN PATIENTS

- In late August 2013, CMS published the following announcement regarding "abandonment" of patients:
  - MLN Connects Provider eNews 08/22/13.
  - Replacement of Home Oxygen Services in the Event that a Supplier Exits the Medicare Oxygen Business.
  - Effective immediately, CMS will allow for the replacement of oxygen equipment in cases where a supplier exits the Medicare oxygen business and is no longer able to continue furnishing oxygen and oxygen equipment. In these instances, the oxygen equipment will be considered lost and a new 36-month rental period and reasonable useful lifetime will begin for the new supplier furnishing replacement oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

ABANDONMENT OF OXYGEN PATIENTS

- In late August 2013, CMS published the following announcement regarding "abandonment" of patients (cont'd):
  - Suppliers exiting the Medicare oxygen business with patients that they were unable to transfer to new suppliers should be aware that they are in violation of the statutory and regulatory requirements for furnishing oxygen equipment both before and after the payment cap.
  - As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) supplier standards set forth at 42 CFR 424.57(c).

ABANDONMENT OF OXYGEN PATIENTS

- This is particularly relevant in the competitive bidding arena. A DME supplier may be motivated to walk away from its oxygen business after losing out on a competitive bid contract.
- Without the influx of new patients, the Medicare oxygen business can quickly become unprofitable.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following:
  - In the event the DME supplier voluntarily exits the Medicare oxygen business and is no longer able to continue furnishing oxygen and oxygen equipment, then the oxygen equipment will be deemed to be "lost" under the Medicare regulations.
  - CMS intends to protect oxygen patients in the event their supplier walks away from the business, leaving the patients "abandoned" with nowhere to go for equipment, contents, or repairs.
  - Allowing the 36-month rental period to restart by classifying the equipment as "lost" is an incentive for new suppliers to assume responsibility for the abandoned patients.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following (cont'd):
  - The regulations provide that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable and useful lifetime or has been lost, stolen or irreparably damaged. When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier beginning on the date that the replacement equipment is furnished to the beneficiary.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following (cont'd):
  - The article reminds suppliers (voluntarily exiting the Medicare program) that they are in violation of their regulatory obligations. The regulations state that (i) subject to a few exceptions, the supplier that furnishes oxygen equipment in the first month must continue to furnish the equipment for the entire 36 month period of continuous use, unless medical necessity ends and (ii) the supplier that received the 36th month rental payment must continue furnishing the oxygen equipment during any period of medical need for the remainder of the equipment's reasonable useful life.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following (cont'd):
  - The article then states that oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the supplier standards.
  - The article gives the following instructions to suppliers that are voluntarily exiting the Medicare oxygen market. These suppliers are strongly encouraged to provide a minimum of 30 days notice to the beneficiary of the supplier's intention to no longer provide oxygen therapy services.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following (cont'd):
  - The notice must be provided in writing and must take one of two forms:
    - a letter to the beneficiary notifying him/her of the supplier's intention to discontinue oxygen therapy services; the letter must specify a date upon which this will occur; or
    - working with the beneficiary, a letter to the new supplier selected by the beneficiary that transfers the provision of oxygen therapy services to the new supplier as of a specific date.

ABANDONMENT OF OXYGEN PATIENTS

- Joint DME MAC article originally posted on 12/19/13 and revised 6/19/14 entitled "Supplier Exit from Oxygen Equipment Business." The article provides the following (cont'd):
  - The article then gives the following instructions to the new supplier that assumes responsibility for beneficiaries of suppliers that have elected to voluntarily exit the Medicare oxygen business. The claims for replacement equipment must:
    - Include the RA modifier (replacement of a DME item) on the claim line for the replacement equipment,

    OR

    - Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.

ABANDONMENT OF OXYGEN PATIENTS

- When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
- When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.

ABANDONMENT OF OXYGEN PATIENTS

- In the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement include:
  - 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.

ABANDONMENT OF OXYGEN PATIENTS

- In the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement include (cont'd):
  - The article further states that if the new supplier is unable to obtain the required documentation, then the new supplier may not append the RA modifier to the claim and may not initiate a new 36 month capped rental period.
  - Lastly, the article reminds all suppliers (accepting transfers of beneficiaries) that all Medicare documentation rules apply.

ABANDONMENT OF OXYGEN PATIENTS

- These announcements are meant to deter DME suppliers, that provide DME products in addition to oxygen equipment, from voluntarily leaving the Medicare oxygen business without fulfilling their oxygen obligations to patients.
- The "deterrence" is CMS' statement that such abandonment is a violation of the DMEPOS supplier standards, which could lead to the revocation of the DME company's Medicare supplier number.

ABANDONMENT OF OXYGEN PATIENTS

- What if the exiting supplier sells its business (or oxygen assets) to another supplier?
  - In a bona fide asset sale, the asset sale allows for the continuation of patient support and service by the buyer; therefore there is no abandonment.
  - It is B&F's position that a supplier, that assumes responsibility for patients who transfer to the supplier pursuant to a bona fide asset sale, is not eligible to restart the 36-month rental for such patients.

ABANDONMENT OF OXYGEN PATIENTS

- If a physician charges an initial consultation fee that covers all necessary medications, and the physician nevertheless faxes a patient-specific prescription to the pharmacy , and the pharmacy mails the drug directly to the patient, then can the pharmacy technically bill the physician for those orders?
  - This scenario would be a problem because the drugs would not be considered "in office" use, if they are being mailed directly to the patient.

ABANDONMENT OF OXYGEN PATIENTS

- The "takeaway" for the DME supplier exiting the market is that if it can sell its business to another supplier, thereby insuring the orderly transition of oxygen patients, then that is the preferable course of action to take.
- If the exiting supplier cannot find a buyer for its business, then it needs to give the required advance notice to the beneficiary.
- The "take away" for the new supplier that intends to start a new 36-month cap period is that the supplier needs to properly submit the claim and obtain the necessary documentation to withstand an audit.

OXYGEN PATIENTS OF BANKRUPT SUPPLIER

- Competitive bidding is forcing a number of DME suppliers to close their doors. Some of these suppliers are filing bankruptcy.
- The guidance issued by CMS related to payment for replacement oxygen equipment in bankruptcy situations is contained in Section 50.4 of Chapter 20 in the Medicare Claims Processing Manual. It states that "when a supplier files for Chapter 7 or 11 bankruptcy … and cannot continue to furnish oxygen to its Medicare beneficiaries, the oxygen equipment is considered lost in these situations and payment may be made for replacement equipment. For replacement oxygen equipment, a new reasonable useful lifetime period and a new 36-month payment period begins on the date of delivery of the replacement oxygen equipment."

OXYGEN PATIENTS OF BANKRUPT SUPPLIER

- The supporting documentation that will be required to verify that the supplier declared bankruptcy depends on whether the bankruptcy is a Chapter 7 (liquidation) or a Chapter 11 (reorganization). For a Chapter 7, the "supporting documentation must include court records documenting that the previous supplier filed a petition for a Chapter 7 bankruptcy in a United States Bankruptcy Court …"

OXYGEN PATIENTS OF BANKRUPT SUPPLIER

- For a Chapter 11, the "supporting documentation must include Court records documenting that the previous supplier filed a petition for a Chapter 11 bankruptcy in a United States Bankruptcy Court; and documents filed in the bankruptcy case confirming that the equipment was sold or is scheduled to be sold as evidenced by one of the following:
  - The Court order authorizing and/or approving the sale; or
  - Supporting documentation that the sale is scheduled to occur or has occurred, e.g., a bill of sale, or an asset purchase agreement signed by the seller and the buyer; or
  - A Court order authorizing abandonment of the equipment."

OXYGEN PATIENTS OF BANKRUPT SUPPLIER

- Because this policy contemplates the establishment a new reasonable useful lifetime, it should allow for a new 36-month payment period regardless of whether a patient of the bankrupt supplier was still in the 36-month rental payment period or the non-rental payment period consisting of rental months 37-60.
- As with any other situation in which oxygen equipment is lost and replacement equipment is furnished, the RA modifier must be submitted on the claim and a narrative explanation should be included on the claim.
- In addition, the new supplier must obtain the necessary qualifying documentation, including the blood gas testing results, a new order and/or CMN, and proof of delivery.

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Denise M. Leard, Esq.
Brown & Fortunato, P.C.
905 S. Fillmore St., Ste. 400
Amarillo, Texas 79101
dleard@bf-law.com | 806-345-6318