Audio Title: Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements
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Welcome to Medicare Learning Network Podcasts at the Centers for Medicare and Medicaid Services, or "CMS". These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information for Medicare Fee-For-Service providers.

This podcast gives you information on common Comprehensive Error Rate Testing, or CERT, Program errors. If you are a Medicare Fee-For-Service, or FFS, provider or supplier who submits claims to Medicare for oxygen therapy supplies, you will benefit from this podcast! In this podcast, you will learn more about the documentation and coverage requirements needed to submit Medicare claims for oxygen therapy supplies.

CERT is a review program that employs a small, random sample of Medicare FFS claims and medical records for compliance with Medicare coverage, coding, and billing rules. CMS developed the CERT Program to comply with the Improper Payments Elimination and Recovery Act of 2010.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare trust funds and protect patients. CMS calculates two error rates: (1) a national Medicare FFS paid claims error rate, and (2) a provider compliance error rate, which measures Medicare claims processing contractor performance and identify errors. CMS publishes the review results in an annual report with semi-annual updates.

Please note, the information discussed in this podcast was current as of December 2010. As of that time, the five (5) most common oxygen and oxygen equipment CERT errors were:

- One (1), no documentation of a physician visit or evaluation prior to the initial/recertification date;
- Two (2), no documentation of original blood gas or saturation test results;
- Three (3), no documentation of the patient's need or use of home oxygen;
- Four (4), no documentation that indicates the patient is mobile within the home (for portable oxygen); and
- Five (5), no documentation of continued need or use of equipment.

In addition, many providers and suppliers did not include the following four (4) policy requirements when submitting claims for payment:

- One (1), physicians must order home oxygen after evaluating a patient's medical need. The physician visit must occur two days before the patient is discharged from an inpatient stay or while he or she is in a chronic

stable state. The physician's notes must establish the need for oxygen based on Local Coverage Determination, or L-C-D, requirements. The visit and test should not exceed thirty (30) days from the initial date on the Certificate of Medical Necessity, or C-M-N;

- Two (2), a patient must have a continued need for oxygen in the home **and** must also be using the oxygen equipment;
- Three (3), a patient must be mobile within the home and tested under certain conditions to qualify for portable oxygen; and
- Four (4), physicians should first evaluate patients who use home oxygen either by arterial blood gas, or A-B-G, or oximetry test, or S-A-T. The physician's notes must document the test results for verification purposes.

Providers and suppliers should document the following three (3) items for Medicare oxygen therapy:

- First, a detailed written order,
- Second, **all** required coverage conditions; and
- Third, Medicare qualifying saturation test results.

The detailed written order should include:

- The patient name;
- A detailed description of the provided items. This includes the means of oxygen delivery, specific varying oxygen flow rates, and/or non-continuous use of oxygen, and the length of need; and
- The treating physician's signature and date order signed, including the start date of the order. **Note**, this is only required if the start date is different from the signature date.

Next, the required overage conditions should include **all of** the following coverage conditions:

The treating physician determination that the patient has a severe lung disease, or hypoxia-related symptoms, that may improve with oxygen therapy;

For an inpatient stay, the patient's blood gas study must be obtained closest to, but no earlier than, two (2) days before the hospital discharge date; **or**, in the absence of an inpatient stay, the study must be performed while the patient is in a chronic stable state;

The physician, or a qualified provider or supplier of laboratory service, must perform the qualifying blood gas study; and

Attempted or considered alternative treatment measures are deemed clinically ineffective.

- And finally, Medicare qualifying saturation test results must meet the following criteria:

    - Obtain test results within 48 hours of the date of delivery, **unless,** the arterial saturation tests were taken during an outpatient encounter or during the patient's sleep. This would require test results within 30 days of the date of delivery; and

- Classify test results into Group I or Group II with their respective C-M-N requirements. To view the criteria for both groups describing specific patient testing conditions, download the Medicare Learning Network, or M-L-N, fact sheet titled "Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements," on the M-L-N Product web page at www.cms.gov/MLNProducts.

Please note, Medicare covers a portable oxygen system if the patient is mobile within the home, and the qualifying blood gas study was taken in one of these three scenarios:
while the patient is at rest,
or while he or she is awake,
or during exercise.

The treating physician must sign, complete, and date the Certificate of Medical Necessity, or C-M-N, using the C-M-S Form 484, and the supplier must keep a copy and provide it upon request. Medicare will deny claims submitted without a valid C-M-N and determine they are not medically necessary. Tables 3, 4, and 5 describe specific C-M-N reporting requirements, including the type of C-M-N, testing, and visits by the treating physician. To view these tables, download the M-L-N fact sheet titled "Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements," on the M-L-N Product web page at www.cms.gov/MLNProducts.

Please note, if you meet the Revised C-M-N indications at the same time that a Recertification C-M-N is due, you should file the C-M-N as a Recertification C-M-N.

Medicare payment for oxygen delivery equipment in the patient's home is allowed under certain conditions. Medicare pays for oxygen on a capped rental basis for a 36-month period. The treating physician should regularly document the patient's need and use of oxygen delivery equipment.

The following four points will help you prevent common errors related to oxygen therapy and oxygen therapy supplies:

- First, verify that the physician noted the need for oxygen based upon policy requirements. The visit (and test) should not exceed 30 days from the Initial Date on the C-M-N or 90 days from the recertification date;
- Second, ensure your documentation shows a continued need for oxygen and continued use of the equipment by the patient;
- Third, ensure your portable oxygen documentation indicates that the patient is mobile within the home.
  In addition, make sure the patient's oxygen test occurs while he or she is either exercising or at rest. If the test occurs while the patient is asleep, the patient does not qualify for portable oxygen; and
- Fourth, it is important that you have the results of the qualifying test, whether A-B-G or S-A-T. Retain a copy of the test for your files in case of an audit. The test results can be printed or written in the physician's notes.

The following three common misconceptions will help you comply with oxygen and oxygen equipment policy.

- First, once you recertify a patient, a supplier does not need to obtain more documentation. **Please note**, Medicare pays for an item only when a patient uses it. **This includes**

oxygen. The physician must regularly document a patient's need and use of oxygen in their medical record.

- Second, suppliers do not need a copy of the A-B-G, or S-A-T score because it is listed on the C-M-N. An auditing agency, such as the CERT contractor, can ask for the physician's documentation to confirm the patient's test results and need for oxygen services, and

- Third, suppliers do not need to maintain documentation when the 36-month cap is met and when the patient is on maintenance and service. You should maintain documentation for continued use of oxygen therapy although the 36-month cap is met.

To learn more about documentation and coverage for oxygen therapy supplies, detailed education is available from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) serving Jurisdictions A, B, C, and D.

More questions? Contact your Medicare contractor or visit our website http://www.cms.gov/MLNGenInfo and follow the links to MLN Products and download the full fact sheet on this subject titled "Oxygen Therapy Supplies: Complying with Documentation & Coverage Requirements." Be on the lookout for information regarding future MLN podcasts.
