March 30, 2026

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-6098-NC: Request for Information: Comprehensive Regulations to Uncover Suspicious Healthcare

Dear Dr. Oz,

On behalf of the Council for Quality Respiratory Care (CQRC), I want to thank you for providing the opportunity to offer recommendations to eliminate waste, fraud, and abuse in Medicare, Medicaid, and the State Children's Health Insurance Plan (S-CHIP). As legitimate, U.S. businesses who operate in all 50 States and U.S. Territories, our members employ more than nearly 29,000 people and provide health care services to more than 3.128 million individuals living with respiratory diseases and conditions. Our members make it possible for these individuals to remain active in their communities and live with their families.

CQRC has championed policy to root out waste, fraud, and abuse since our founding more than 20 years ago. We appreciate the Administration's effort to crush fraud in Medicare and stand ready to partner with you in this effort. To that end we make the following recommendations.

- Leverage existing technology-based solutions to prevent fraud and abuse in supplemental oxygen by adopting standardized data elements that can be collected from electronic medical records to establish medical necessity for supplemental oxygen. By having prescribers submit the standardized data elements electronically, which could be part of an ePrescribing platform, CMS and its contractors would receive the information necessary to establish medical necessity in an electronic format that would increase their ability to promote payment accuracy and efficiency. The concept of a template/standardize data elements for prescribers could then be extended to other product lines, including but not limited to CPAPs, RADs, and ventilators.

- Stop unscrupulous entities from being able to participate in the Medicare competitive bidding program (CBP) by reinstating the comprehensive supplier financial documentation qualification requirements.

- Hold DMEPOS suppliers to the amounts they bid as part of the Medicare CBP.

- Empower beneficiaries by adopting strong patient protections, which include having CMS provide up-to-date information about each beneficiary's own cost-sharing responsibilities.

- Establish transparency in the audit and appeals process by releasing annual reports with data including the number of appeals filed by provider or supplier type; descriptions by provider and supplier type of the top three reasons for the denials at the lower review levels; the number of denials overturned in favor of the provider and supplier by provider or supplier type, as well as the number of denials upheld in favor of the government; and descriptions by provider and supplier type of the top three reasons for the overturning denials in favor of the providers and suppliers, as well as the top three reasons for denials being upheld in favor of the government.

I. Adopting electronic templates in lieu of requiring medical record notes would address the most significant error related to improper payments.

During the past ten years, the estimated improper payment rate has fallen by more than 35.5 percentage points for oxygen equipment and supplies and nearly 30 percentage points for CPAP. Yet despite this important progress for reducing improper payments, the vast majority of the errors driving such improper payments remains "insufficient documentation." This error is caused by a prescriber's medical record notes, over which the supplier has no control, not meeting a Medicare contractor's view of what is required to meet medical necessity. The prescriber is completely separated from the supplier and does not engage with the contractors. To address the problem of improper payments in the area of supplemental oxygen therapy, we strongly urge CMS to require Medicare contractors to establish beneficiary medical necessity. This one step would create a comprehensive set of information for meaningful audit review and would address the problems created by contractors relying solely on physician notes. Moreover, the concept of a template/standardize data elements for prescribers could then be extended to other product lines, including but not limited to CPAPs, RADs, and ventilators.

We applaud CMS's *"The Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule*" as an important step towards achieving the agencies goals including waste, fraud, and abuse reduction. The next appropriate action already at CMS' disposal is to implement the clinical data elements template in prescribing supplemental oxygen. The Consolidated Appropriations Act of 2026, now public law, demonstrates strong bicameral, bipartisan support for the template and requires CMS to report back to Congress on the agency's progress in adopting it.[1]

[1] Accompanying Public Law No: 119-75 is report language: **The Consolidated Appropriations Act of 2026 Conference Report.**

This electronic template would significantly advance CMS' key objective to prevent fraudulent or abusive claims by requiring Medicare contractors to adopt electronic data elements (*i.e.,* a template) that CMS already has created. To date, contractors have refused to adopt these common-sense reforms. Adopting an electronic process in lieu of using physician's chart notes would provide for much needed clarity and accuracy in the review process. The data elements CMS developed require a physician to report the following information, among other things:

- Patient's qualifying diagnosis;
- Start date, length of need, flow rate, and oxygen saturation results
- The supplemental oxygen modality being ordered and means of oxygen delivery;
- The type of order (*e.g.,* initial, re-evaluation, etc.);
- Testing information; and
- The prescriber's signature, name, National Provider Identified, and date signed.

The problem of improper payments has been a critical concern for a decade. In the case of supplemental oxygen, the problem of improper payments is directly linked to the Medicare contractors' sole reliance on physician medical record notes. Since 2016, the CERT has reported that less than one percent of the improper payment rate was due to patients not meeting Medicare's medical necessity requirements.[2] During the same period, the CERT has also reported that 72 to 99 percent of the oxygen improper payment rate was

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"Unless otherwise noted, the language set forth in House Report 119-271 and Senate Report 119-55 carry the same weight as language included in this explanatory statement and should be complied with unless specifically addressed to the contrary in this explanatory statement. While some language is repeated for emphasis, it is not intended to negate the language referred to above unless expressly provided herein."
House Report Language: *Medicare "e-Prescribing" Template* (begin at the bottom of p. 161). The Committee is aware that CMS developed a set of clinical data elements in 2018 to identify the data necessary to support medical necessity of supplemental oxygen claims and allow for electronic prescribing of supplemental oxygen. However, CMS has not yet approved contractors to use this electronic template to establish medical necessity and support all audit documentation requirements. The Committee requests that CMS provide an update on such efforts in its fiscal year 2027 congressional justification.
Senate Report Language: *Supplemental Oxygen* (p. 206). The Committee notes that in 2018, CMS developed a set of clinical data elements to identify the data necessary to support medical necessity of supplemental oxygen claims and allow for electronic prescribing of supplemental oxygen. CMS has not approved of the use of this electronic template, and the clinical data elements template and electronic prescribing has yet to be implemented. Within 60 days of enactment of this act, the Committee directs CMS to provide a briefing on updates to the eprescribing of supplemental oxygen, including a process and timeline for provider adoption. The briefing should also include information on CMS's efforts to work with community stakeholders to improve access to supplemental oxygen."
[2]Centers for Medicare and Medicaid Services. Comprehensive Error Rate Testing (CERT), *2017-2021 Medicare-for-Service Supplemental Improper Payment Data. Tables D2 and J2.* Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports

due to problems with the ordering clinicians' documentation.[3] These reports indicate that there is no evidence of fraud or abuse in terms of beneficiaries receiving supplemental oxygen who do not medically require the equipment, supplies, and services. However, contractors reject millions of claims because physicians' chart notes — written for patient care, not bureaucracy — often lack the specific "magic words" Medicare contractors expect before reimbursing suppliers for prescribed supplemental oxygen. While the initial number of denied claims remains high year-over-year, a survey of national and regional suppliers found that Administrative Law Judges overturned the vast majority of such denials finding sufficient documentation of medical necessity.

The heart of this problem is that physicians write their medical record notes to support ongoing treatment of their patients and not to meet contractor review criteria, which remain unclear. With the support of physicians, patient advocates, suppliers, and manufacturers, CMS developed a set of clinical data elements that could be incorporated into electronic health records or similar systems to clearly identify the data CMS believes are necessary to support medical necessity of supplemental oxygen claims.[4] These data elements would not only provide clear direction to physicians who prescribe supplemental oxygen, but they also would make the medical review process efficient, accurate, and less costly. For example, if a submission did not include a required data element the system could alert the physician to the missing element, which he/she could then easily provide without undue burden to the patient in need of supplemental oxygen therapy. This approach would eliminate missing information and incomplete records, which in turn would reduce improper payments due to these errors. In addition to ensuring the proper payment for supplemental oxygen claims, this approach would reduce spending on audits and appeals that have historically resulted in nearly all of such claims being paid.

Despite the clear improvement these data elements would provide, Medicare contractors without explanation have refused to adopt them, and CMS has not required the contractors to do so. As a result, the clinical data elements defined in 2018 have yet to be implemented, resulting in more than five years of additional improper payments for supplemental oxygen due to medical record errors. This situation has reduced patient access to access medically necessary supplemental oxygen. Some patients have had to pay out of pocket for their life-sustaining supplemental oxygen, while others have been forced to leave their homes, families, and communities to enter nursing homes or long-term care facilities in order to access their Medicare benefit for supplemental oxygen. This situation particularly impacts our nation's seniors, who deserve better.

We encourage CMS to take this common-sense step and require the contractors to use the clinical data element template in lieu of medical records. Taking this approach

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[3] *Id.;* Centers for Medicare and Medicaid Services. Comprehensive Error Rate Testing (CERT), *Medicare Fee-for-Service 2016 Improper Payment Rate Report*. Retrieved from: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports.
[4] CMS. Home Oxygen Therapy Order Template. (2018). CMS also created templates for the face-to-face encounters and lab results.

would then allow the contractors and CMS to target their resources on actual fraud and abuse to protect taxpayer dollars.

II. Reinstating the comprehensive supplier financial documentation qualification requirements would stop unscrupulous entities from being able to participate in the Medicare competitive bidding program (CBP).

The CQRC was disappointed that the final rule for revising the competitive bidding program (CBP) adopted a set of streamlined financial document requirements that we believe will make it easier for bad actors and unscrupulous foreign entities to commit fraud and abuse against the Medicare program. In light of the CRUSH fraud and abuse initiative, we urge the agency to reconsider this policy and reinstate the previous financial requirements. This step would be aligned with CMS' rationale for adopting the moratorium.

As we noted in our previous comment letter, the CBP succeeds only if the winning bidders are legitimate organizations that have the capacity to provide the appropriate prescribed devices and services to Medicare beneficiaries. By reducing the financial documentation requirements to a business credit report with a numerical credit score or rating (or a business credit report showing no data or insufficient information to generate a credit score and a personal credit report with a numerical credit score or rating from the bidding entity's Authorized Official or Delegated Official listed in CMS' PECOS), CMS is eliminating its best opportunity to eliminate fraudulent suppliers from the program. Truncating the process both in terms of documentation and the review period will make it much easier for foreign entities, which public reports demonstrate have targeted the Medicare DMEPOS program, to gain a strong foothold into the program.

While not perfect, the previous financial documentation requirements and careful review process help to weed out illegitimate suppliers prior to contracts being awarded. As noted elsewhere in this letter, additional steps, including paying bidders at their bid amount, could strengthen this process.

Moreover, these financial documents are critically important to assessing a bidding entity's capacity. While CMS may not have acted on its concerns about self-reported capacity by removing bidders from the Round 2021 competition, the financial documentation appears to have allowed it to assess the veracity of the self-reported capacity based on the comments included in the preamble to the Proposed Rule. As we have noted elsewhere in this letter, considering a bidder's capacity is essential to ensuring beneficiary access to the devices in each product category. As a corollary, it is also important that CMS maintain the current detailed documentation requirements and review process to assess capacity as well.

CMS also seeks to allow for an attestation-only process for determining the small supplier threshold. Given the discussion about CMS' concerns regarding self-reporting of capacity, it is surprising that CMS proposes self-reporting for gross revenues. We urge CMS

to retain the financial documentation requirements currently in place to assess suppliers' gross revenues.

Therefore, the CQRC requests that CMS reinstate the previous financial documentation requirements and not finalize the proposed modifications.

III. Hold DMEPOS suppliers to the amounts they bid as part of the Medicare CBP.

One of the most glaring misaligned policies in the CBP is the fact that entities that submit low-ball bids are rewarded with contracts at rates higher than their bids. If CMS were to hold bidders to their bids and paid them based upon their bid amount, it would create an incentive for bidders to submit only reasonable bids and remove any incentive to attempt to game the bid process through low-ball bidding. It would also address fraud concerns since bidders would be held accountable for their submitted bid amounts and could not gain access to CBAs on the basis of implausibly low bid amounts. CMS could address low bidders in other ways, but the simplest solution of holding all bidders accountable may be the most elegant and generalizable way to achieve this goal with a rule that can apply equally well in large and small markets where there are many or few bidders. Other outlier-based methods may fail depending upon the exact number of total bids and number of strategic low bidders in each category and CBA.

IV. Empower beneficiaries by adopting strong patient protections, which include having CMS provide up-to-date information about each beneficiary's own cost-sharing responsibilities.

The CQRC strongly supports the Supplemental Oxygen Access Reform Act (S.1406/H.R.2902). We encourage CMS to review three provisions of the SOAR Act that would strengthen current laws to prevent fraud and abuse, promote Medicare program integrity, and protect beneficiaries if the legislation were enacted.

In addition to establishing the supplemental oxygen template, the SOAR Act would require the Medicare program to provide beneficiaries receiving supplemental oxygen with an annual notice of cost-sharing obligation and a notice when their cost-sharing obligations end after the capped rental period. Moreover, the SOAR Act would establish specific supplier responsibilities to support and protect patients. These expand on existing regulatory protections by enhancing the educational requirements, strengthening access to the prescribed equipment requirements, and building upon in-home monitoring obligations. It would also strength these safeguards by codifying them in statute.

V. Establish transparency in the audit and appeals process by releasing more detailed annual reports.

To align with its commitment to transparency, we recommend that CMS improve the transparency of the audit and appeal process. Providing more detail about audits,

denials, and appeals would help target and stop actual fraud. While the annual improper payment report provides useful information, it is only a small part of the process. It is important to include information that would provide a more complete understanding of the true error rate by incorporating appeal results data in the statistics that are shared by CMS. To improve transparency, we recommend that CMS release the following data points:

- The number of appeals filed by provider or supplier type. It would be extremely helpful to distinguish among the different types of suppliers rather than aggregate them into a single number.

- A description by provider and supplier type of the top three reasons for the denials at the lower review levels. This information would help clarify if the problem is primarily a technical error or behavior that amounts to actual fraud and abuse.

- The number of denials overturned in favor of the provider and supplier by provider or supplier type, as well as the number of denials upheld in favor of the government.

- A description by provider and supplier type of the top three reasons for the overturning denials in favor of the providers and suppliers, as well as the top three reasons for denials being upheld in favor of the government.

We understand that CMS may not currently track this information. This information would not only provide transparency, but would also create the basis for educating CMS, contract reviewers, providers, and suppliers about how to improve the appeals process at each level. Without this information, providers and suppliers may continue to describe their experiences to CMS and contractors, but if the past is any indication these experiences will not be used to create meaningful change.

VI. Conclusion

On behalf of the CQRC and its members, I want to thank you for seeking suggestions about how to better stop fraud and abuse in the Medicare program. We are committed to eliminating fraud and abuse so that legitimate suppliers can provide medically necessary services to beneficiaries in the care setting that is the most appropriate for them – their home. We would welcome the opportunity to discuss these recommendations or other ideas with you. Please do not hesitate to reach out to us if you have any questions.

Sincerely,

Robin Menchan
Chair, Council for Quality Respiratory Care