Introduction

Good afternoon everyone and welcome to the CGS Administrators, LLC DME MAC Jurisdiction B New Oxygen Modifiers “Ask-the-Contractor Teleconference.” My name is Stacie McMichel and I am a provider outreach and education consultant and I will be facilitating today’s ACT call. These ACT calls are hosted by the DME Provider Outreach and Education team for Jurisdiction B and that includes me, Terri Shoup, and Ashley DeCoteau.

For this ACT call, we ask that you keep your questions related to the aspects of the new oxygen modifiers topic. We do have general ACT calls in which you can ask questions regarding any topic but this call is specifically about the new oxygen modifiers and want to limit the questions to this topic so that everyone will have an opportunity to ask their questions.

On the next slide you will see a disclaimer and all it says is that we have put our best effort in to ensuring that we have provided the most current and up to date information available. We have used a couple of references from CMS that we will talk about and the joint publications from the DME MAC medical directors

Please keep in mind that for ACT calls, your questions must be asked verbally and that is to be done by raising your hand. We will not answer questions that are submitted through the question feature of your Go-To-Webinar dashboard. The reason for that is our ACT calls are recorded, transcribed and uploaded to our website. We have disabled the chat feature in Go-To-Webinar. When we get to the question portion of today’s call, I will go through the directions on how to raise your hand.

Once you are connected to the audio portion of our webinar today, be sure that you enter the pin number that displays on your screen into your telephone keypad. In order to un-mute your line so you can ask a question during the Q&A portion, you will need to have entered your pin number.

MLN Matters MM10158

Lets start with MLN Matters MM10158 titled, Revised and New Modifiers for Oxygen Flow Rate (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10158.pdf), and was published in our CMS newsletter on April 10, 2018. This MLN provides an introduction to the new pricing modifiers for oxygen flow rate. Effective April 1, 2018 the QE, QF, and QG modifiers were all revised to clarify that the prescribed flow rate at rest is used in accordance with the federal regulations indicated in 42 Code of Federal Regulation 414.226€(3). This section of the CFR states that if the prescribed flow rate is different for the patient at rest, than for the patient at exercise, the flow rate for the patient at rest is used. As a result of this regulation, the QE, QF and QG modifiers were revised to add the words “at rest.” So now, the QE modifier describes when the prescribed amount of stationary oxygen at rest is less than 1 liter per minute (LPM). QF is used when the amount of stationary oxygen while at rest exceeds 4 LPM and portable oxygen is prescribed. Lastly, the QG means that the prescribed amount of stationary oxygen at rest is greater than 4 LPM.

In addition to revising the existing oxygen modifiers, three new modifiers were added to assist in identifying prescribed flow rate on the claim form and to ensure appropriate use of modifiers in all cases based on the prescribed flow rate at rest, at night, or based on the average of the rate at rest and at night if applicable, in accordance with the code federal regulations I mentioned earlier. For all dates of service on or after April 1, 2018, suppliers are required to use the QA modifier which indicates when prescribed amounts of stationary oxygen for daytime use at rest and nighttime use differ, and the average of the 2 amounts is less than 1 LPM. The QB modifier indicates that the liter flow for stationary oxygen for daytime use while at rest and nighttime use differ and the average exceeds 4 lpm, and portables are prescribed. Lastly, the QR modifier is used when the prescribed amount of stationary oxygen for daytime use while at rest and nighttime use differ and the average is greater than 4 LPM.

This chart can be used to help suppliers determine if and when a liter flow modifier is required. When the liter flow prescribed for day and night for the stationary vary, the liter flows are average to determine if service is eligible for payment as greater than 4 LPM. Effective April 1, 2017, when portable is prescribed and a liter flow modifier is needed, both the stationary and portable are billed, and the appropriate modifier is appended to both codes.

All of these instructions are included in the DME MAC medical director’s joint publication titled, Billing Instruction – Oxygen CMN Question 5 (https://www.cgsmedicare.com/jb/pubs/news/2018/04/cope7420.html).

This article was originally published on February 15, 2018 with supplier guidance on use of new oxygen “Q” modifiers and the Certificate of Medical Necessity (CMN) (CMS-484/DME 484.3) form. On April 26, 2018, the joint publication was revised, rescinding the instruction to submit a revised CMN. For dates of service on or after April 1, 2018, providers must report the highest prescribed flow rate for Question 5 on the CMN form. We encourage you to utilize all of the resources we have discussed today.
to educate providers on the completion of the oxygen CMN to follow the instructions included on page 2 of the CMN. As a reminder, the instructions on the Oxygen CMN for Question 5 states, “5. Enter the highest oxygen flow rate ordered for this patient in liter per minute. If less than 1 LPM, enter an “X”.”

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

Lastly, as an added effort to assist supplier with billing for oxygen with the beneficiary does not meet Medicare’s “Reasonable and Necessary” requirements for oxygen as specified in the Oxygen and Oxygen Equipment Local Coverage Determination, the KX, GA, GY, and GZ mandatory coverage and coding language will be added to the medical policy. The DME MAC medical directors released a joint publication on May 10th titled, *Correct Coding – Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ*. Effective for DOS on or after August 1, 2018, the KX, GA, GY, and GZ modifiers will be added as a requirement in the oxygen policy. As a reminder, the KX modifier indicates that all of the requirements in the policy have been met. GA is used when suppliers expect a not reasonable and necessary denial and have obtained a properly executed ABN. GY indicates that an item is statutorily excluded or does not meet the definition of any Medicare benefit [[for oxygen this would include items listed in the policy article as statutorily noncovered, for example accessories, repairs, or ACA denials]]. The GZ modifier indicates expectation of a not reasonable and necessary denial and no ABN on file. Beginning with DOS August 1 or after, oxygen claims submitted without the KX, GA, GY, or GZ modifier will be rejected as missing information.

**ForeSee Satisfaction Website Survey**

The last item I want to mention before I open up the phone lines for questions is the CMS ForeSee Satisfaction Website Survey. This survey pops up when you navigate through the CGS website or the myCGS Web portal. We ask that you take a few moments to take this survey whenever it is presented to you. Your input is vital and allows us to make changes to our website that will affect all suppliers. Virtually all the changes we’ve implemented to [https://www.cgsmedicare.com](https://www.cgsmedicare.com) have come from supplier input. Please use the survey to tell us what you like about the website, what you would like to see changed, and what you would like to see regarding future enhancements. It will only take a few moments of your time and we do value your opinion.

**Conclusion**

As I prepare to take your questions, I do want to remind you that we will only take questions via the phone. This call is being recorded for transcription purposes so we will not take any questions through the Go-To-Webinar chat feature. To raise your hand, click on the icon with the hand. Then we will un-mute your individual line so that you may ask your question. Also remember that no claim specific information or Medicare private health care information should be verbalized. We will pause for just a moment so that you can prepare to ask your questions.

**Question and Answer Section**

**Christine:** I have two questions. The first one is when you say the claims will be rejected for missing information, does that mean it is going to be a front end rejection during the transmission of the claim or is it a denial?

**Stacie:** Oxygen claims submitted without the appropriate KX, GA, GY or GZ modifier will not be rejected by the Common Electronic Data Interchange (CEDI)’s front end edits. The claims will be denied with an ANSI CO-16 for invalid/incomplete HCPCS/Modifier combination. Claims denied for invalid coding combinations will need to be resubmitted.

**Christine:** If we submit a claim that is prior to date of service August 1, 2018, will that deny or will that be accepted.

**Stacie:** The KX, GA, GZ or GY modifiers are not required prior to August 1, 2018. We will not accept the KX modifier on Oxygen claims prior to the August 1, 2018 implementation date.

**Jennifer:** I have two questions follow up questions from the previous question. So after August 1, 2018, if we are going to rebill a previous date of service is prior to August 1, 2018, will those claims have to follow the new the KX modifier rule or because the date of service is prior to August 1, 2018, it does not?

**Stacie:** For any services provided on or after August 1, 2018, the KX, GA, GY or GZ modifier must be appended to your oxygen claims. For services provided prior to August 1, 2018, the KX, GA, GY or GZ modifier is not required.

**Jennifer:** My second question was on the CMS 484 on question number 5 when it asks for the liter flow we always enter the highest even if we are just appending a modifier for the average?

**Stacie:** That is correct when the prescribed daytime and nighttime use of oxygen is the same. When there are differing daytime and nighttime prescribed flow rates, the provider must report the highest prescribed flow rate for Question 5 on the CMN.

**Ann:** For the E1390 and all of the other codes within the Oxygen LCD, the KX modifier required correct?

**Stacie:** Correct, suppliers must add a KX modifier only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have been met.

**Ann:** Ok and the additional modifiers QF, QG and QB are just additional modifiers if it meets are only required if they meet that particular guideline?

**Stacie:** Correct the new modifiers QA, QB, QE, QF, and QR are directly related to payment for greater than 4 LPM or less than 1 LPM.
Mike: If a physician is ordering oxygen for a patient for exercise only at 3 LPM, obviously meeting coverage criteria and testing, we are appending the modifiers RR KX to the claim.

If the physician is ordering 5 LPM for exercise only, according to the April 26th billing instructions, we can not use the Q modifiers, it would still be an RR KX. Would we still report the 5LPM as the highest liter flow in question 5?

Ashley: Per the instructions published in the April 26th article, in no case can the prescribed flowrate for exercise be used, either alone or in conjunction with a prescribed flow rate for nighttime use. In the case described above the oxygen flow rate for exercise use only would not be considered. Since there is not a single flow rate prescribed for day or night time use, the average flow rate would be zero and none of the Q modifiers would not be appropriate. The physician would enter the highest prescribed liter flow prescribed on question 5 of the CMN and the claim must be coded with modifiers RR and KX.

Cindy: When we have a patient who has been prescribed oxygen at rest and sleep and the patient qualifies at rest, but they do not qualify for oxygen during sleep, do we still average those to determine the Q modifier?

Ashley: If the qualifying blood gas study was performed at rest, and as long as the oxygen is not prescribed for nocturnal use only, the patient qualifies for both night and day time use. In this case, if the flow rate for daytime use differs from the night time use, the average must be calculated.

Bailey: Are the QG and QR modifiers limited to greater than 4 lpm for stationary use only?

Stacie: That is correct the QG and QR modifier are only required when the liter flow is greater than 4 LPMs for stationary equipment. If both the stationary and portable is provided, the high liter flow modifiers must be reported on both the stationary and portable systems.

Bailey: Prior to the new instructions, we had been billing the E1390 (stationary concentrator) with the QF modifier and we did not attach the QF modifier to the E0431 (portable E0431). Under the new instruction are we required to append the QF modifier to both the E1390 and E0431?

Stacie: For claims with dates of service on or after 04/01/2018 the modifier “QB or QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 LPM (LPM).

Sharon: In cases where there is a prescribed flow rate for nighttime use and none for daytime use, or vice versa are we still required to calculate the average?

Stacie: Yes, per the April 26th article, for beneficiaries with a single prescribed flow rate that doesn’t encompass a full 24 hours, an average calculation is still required with the unaccounted for portion of the 24 hour period set equal to “0.”

Anna Maria: Please clarify oxygen coverage for a beneficiary has a diagnosis of OSA, the oximetry testing if performed during the day while at rest, and the physician has ordered oxygen for day and night time use. Would we still be required to use the average of both the day and night time use?

Ashley: Yes home oxygen can be covered as long as the beneficiary meets the Oxygen LCD Group I or II coverage criteria. Oximetry testing while the beneficiary is awake may be used for qualification of home oxygen. While awake OSA does not affect blood oxygen levels. However, keep in mind that if the oxygen is prescribed at night for the treatment of OSA and if it indicates that in the medical record, that may bring up questions in the case of an audit. Nocturnal oxygen is not covered for the treatment of OSA. Oxygen coverage is limited to the treatment of an underlying lung condition. If the prescribed flow rate for daytime use differs from the night the average between the two must be calculated to determine the appropriate Q modifier. In addition if the stationary equipment is being used for nocturnal use to treat the OSA, the appropriate modifier for the stationary would be GA or GZ.

You may view all of our FAQs related to Oxygen Use in Beneficiary with Obstructive Sleep Apnea FAQs on our the https://www.cgsmedicare.com.

Janene: If there is only a prescribed flow rate for nighttime use, would any of the Q modifiers be applicable?

Stacie: For beneficiaries with a single prescribed flow rate that doesn’t encompass a full 24 hours, an average calculation is still required with the unaccounted for portion of the 24 hour period set equal to “0”. Depending upon the night time flow rate prescribed one of the Q modifiers may be applicable. For example, if the only available prescribed flow rate is nocturnal at 10 LPM, a “0” is reported for the prescribed daytime flow rate. Calculating the average of the night and day use yields an average reportable prescribed flow rate value of 5 LPM. In order to properly calculate the average flow rate used to determine the appropriate “Q” modifier, the following example is provided:

\[
\frac{(\text{day flow rate} + \text{night flow rate})}{2} = \text{average flow rate}
\]

\[
0 \text{ LPM} + 10 \text{ LPM} / 2 = 5
\]

Lisa: What is the effective date of the new Q modifiers for oxygen?

Stacie: The revised and newly added modifiers for oxygen flow rate became effective April 1, 2018 and effective for DOS on or after August 1, 2018, the KX, GA, GY, and GZ modifiers will be added as a requirement in the oxygen policy

Lisa: When oxygen claims are submitted with these new modifiers, does it matter which position the modifiers are reported in?

Stacie: Primary pricing modifiers should always be submitted in the first field on your claim.

Example: E1390RRKXQB
Lisa: Are revised Oxygen Certificates of Medical Necessity (CMNs) required due to the new flow rate modifiers?

Stacie: No, the instruction to submit revised CMNs was rescinded via the revised article Billing Instruction – Oxygen CMN Question 5 (https://www.cgsmedicare.com/jb/pubs/news/2018/04/cope7420.html) on April 26th.

Brian: When nocturnal oxygen is the only prescribed liter flow and the average is 1, what value to you report on the CMN?

Stacie: Clarification: The physician must report the highest flow rate order for their patient in LPM in question number 5 on the CMN. The average must be calculated when the flow rates differ for day and night use OR there a single prescribed flow rate does not encompass a full 24 hours. This average is calculated solely for the purpose of determining the appropriate “Q” modifier. The average must not be reported on the CMN; however prescribed liters must be documented in the beneficiary’s medical records.

Lori: If a patient refuses portable equipment at set up, but later request to have the portable equipment delivered, is there time frame?

Stacie: Clarification: Medicare program rules require the item to be delivered within 3 months of the initial date of the CMN or the physician’s signature.


To ensure that an item is still medically necessary, the delivery date/date of service must be within 3 months from the “Initial Date” of the CMN or DIF or 3 months from the date of the physician’s signature.

Alesa: If a patient is prescribed 6 LPM during exercise, 2 LPM at rest and during night time, would it be appropriate to enter the 6 LPM on the CMN since that is the highest liter flow and then not add a Q modifier on the claim? Would there be a higher payment since the patient is on 6LPM or is that no longer the case?

Stacie: The highest liter flow of 6 LPM would be reported on the CMN, however per the instructions provided in revised article dated April 26th, the prescribed flow rate for exercise can not be used alone or in conjunction with a prescribed flow rate for nighttime use, to determine whether or not a low, high or other prescribed flow rate applies for Medicare payment purposes.

Alexis: If a patient is on oxygen and prescribed 2 LPM for nighttime use only and nothing during the day, we are going to calculate the average for the appropriate Q modifiers to append to the claim. Is this correct?

Stacie: Yes that is correct.

Alexis: As of August 1, our claims have to have one of the additional modifiers?

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

Allison: When ever you are averaging, that is only to determine the appropriate use of the liter flow modifiers and the physicians are still required to report the highest liter flow prescribed in question 5 on the CMN. Is that correct

Stacie: Yes that is correct.

Allison: For claim submission does the order of the modifier placement on the claim matter

Stacie: Suppliers should always submit their claim for oxygen with the primary pricing modifier (example RR or NU) in the first field and then follow up with additional informational/policy specific modifier.

Allison: In a previous question some one mention there was a different liter flow rate for exertion, daytime and nighttime use. In this scenario would you take the average of all 3?

Stacie: No, per the billing instruction, in no case can a prescribe 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, high, or other prescribed flow rate applies for Medicare payment purposes.

Allison: If the beneficiary is prescribed oxygen for nighttime use only, why are we required to calculate the average if there is no day time use prescribed?

Stacie: Clarification: Medicare pays a monthly fee schedule amount for oxygen and oxygen equipment per beneficiary. For stationary oxygen equipment, this monthly fee schedule amount covers the oxygen equipment, contents and supplies and is subject to adjustment depending on the amount of oxygen prescribed (LPM (LPM)) and whether or not portable oxygen is also prescribed. The regulations at 42 CFR 414.226(e), and the Medicare Claims Processing Manual, of Chapter 20, Section 30.6.1 include the following payment rules regarding adjustments to the monthly payment amounts for oxygen and oxygen equipment based on the patient’s prescribed oxygen flow rate. Based upon the instructions provided in the regulations and the CMS claims processing manual the average must be calculated when the day and nighttime liter flow prescribed differ.

Ashley: So I guess you are saying if they are using different day and nighttime liter flows we are supposed to calculate the average. What if at rest they are using two, at exertion they are four and at night they are using three, do we average the three of those?

Stacie: The average must be calculated using the daytime and nighttime liter flow. At no time can the liter flow for exercise be used to calculate the average.

Tammy: if I have nighttime only and the calculated average is 1. Would it be appropriate for me to use the modifiers RR QE and KX?
Stacie: No, in this scenario, the QE modifier would not be appropriate. The QE modifier must only be applied when the calculated average is less than 1 liter per minute. Based on the scenario provided, you should only append the RR and KX modifier.

Noel: Can the different liter flows for night versus day time be documented on the order? As we know not all of our doctors document different liter flows in their progress notes. So in determining which liter flows to use in the calculation of the average, can this information be taken from the order?

Stacie: Per the Program Integrity Manual, the order is not considered to be part of the medical record and therefore information documented on an order would not be considered to establish medical necessity.

Noel: From a documentation standpoint, if the medical records document a single prescribed rate for day or nighttime use, will 0 be assumed for the unaccounted for portion of the 24 hour period? Does the medical record have to clearly indicate a liter flow value for daytime, nighttime and/or exertion?

Stacie: Per the billing instruction article, with respect to documentation in the beneficiary’s record:

…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 beneficiary’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.

Note: This question has been submitted for additional consideration and we will update the transcript once a response has been received.

Noel: For patients who are established on oxygen prior to the new payment rules, what is the expectation for the existing documentation to meet the new liter flow requirements?

Stacie: Per the published billing instructions for oxygen CMN question 5, the patient’s medical records must be in compliance with the regulatory policy. This guidance does not provide any exclusion for established patients.

Note: This question has been submitted for additional consideration and we will update the transcript once a response has been received.

Kelsey: If the prescribed liter flow is 10 LPM for exertion only, would the physician still be required to complete question number 6 on the CMN?

Stacie: Yes, per the instructions for question 6 on the CMN, if the prescribed liter flow is greater than 4LPM, the physician must enter the results of a recent test (ABG or O2 saturation test) taken on 4LPM while the patient is in a chronic stable state. The new oxygen “Q” modifiers do not change the CMN requirements for completion.

Paula: Our doctors often order 2LPM for 24 hours per day. What do we do in situations where the doctor has not specified a difference in the daytime or nighttime liter flow? Does that make a difference?

Stacie: Suppliers are required to calculate the average flow rate when there are differing daytime and nighttime prescribed flow rates. In cases where the physician as order a single flow rate for a continuous 24 hour period, the calculating the average would not be necessary.

Paula: When the physician is ordering oxygen for nocturnal use only, please explain why we are required to calculate the average for the unaccounted for portion of the 24 hours?

Stacie: Clarification: Medicare pays a monthly fee schedule amount for oxygen and oxygen equipment per beneficiary. For stationary oxygen equipment, this monthly fee schedule amount covers the oxygen equipment, contents and supplies and is subject to adjustment depending on the amount of oxygen prescribed (LPM (LPM)) and whether or not portable oxygen is also prescribed. The regulations at 42 CFR 414.226(e), and the Medicare Claims Processing Manual, of Chapter 20, Section 30.6.1 include the following payment rules regarding adjustments to the monthly payment amounts for oxygen and oxygen equipment based on the patient’s prescribed oxygen flow rate. Based upon the instructions provided in the regulations and the CMS claims processing manual the average must be calculated when the day and nighttime liter flow prescribed differ.

Sharon: On a previous question the caller indicated that the patient was prescribed 10 LPM during exercise and a different liter flow at night. What calculation is the supplier required to do since the flow rate during exercise can not be considered?

Stacie: The average flow rate in this scenario would be calculated using 2 LPM for the prescribed nighttime flow rate and 0LPM for the daytime flow rate. The exercise flow rate would not be considered to determine the appropriate Q modifier for Medicare payment purposes.

Jamie: Will the Medicare program pay for oxygen if it’s ordered for exertion only?

Stacie: Yes, Medicare will continue to coverage for oxygen for exertion only as long as the beneficiary meets the coverage criteria under exercise testing. The implementation of the new Q oxygen modifiers does not impact the current coverage criteria for oxygen.

Anne: If we have a patient tested for nocturnal use only, does the ordering physician have to indicate in the medical record that the oxygen is being prescribed for nocturnal use only? This information is normally captured on the order.

Stacie: Per the Program Integrity Manual, the order by itself is not sufficient enough to support medical necessity. The patient’s records must include a clear indication of the liter flows prescribed in order to be complaint with the new payment policy for oxygen.
Anne: If the patient is prescribed oxygen for continuous use, can that be indicated on the order and should continuous use be indicated in the patient’s record?

Stacie: The frequency of use is a requirement on the detailed written order for items provided on a periodic basis. If the physician has ordered oxygen for continuous use, that frequency must be indicated on the detailed written order.

Closing Remarks

Stacie: We do not have any more questions in the queue. I would like to thank everyone for joining us this afternoon. We appreciate you taking time out of your busy day. We will have a transcript of our call today published on the CGS website within the next few weeks. We will also have a ListServ message sent once the transcript is available.

Thank you to everyone for joining us. Have a good day.

Note: Some responses were edited for clarity.