**Ask-the-Contractor Teleconferences (ACT)**

**Provider Outreach & Education**

**Date: December 13, 2017**

**Moderator: Ashley DeCoteau**

**Time: 10:30 a.m. ET**

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**Introduction**

Good morning and welcome to the CGS Administrators, LLC DME MAC Jurisdiction B Oxygen “Ask the Contractor Teleconference (ACT).” My name is Ashley DeCoteau and I am a Provider Outreach and Education Sr. Analyst with CGS and I will be facilitating today’s call. Also on the call this morning, are Jurisdiction B subject matter experts from various operational departments. For this ACT call you may ask questions pertaining to today’s topic, which is oxygen. Before I open up the line for questions, I will give you a brief update on a few of the most common denials we see for oxygen as well as some oxygen resources. At the close of the update we will open the line for questions.

**Common Oxygen Denials**

I’m going to talk first about the most common errors that we see for oxygen. The first error that we consistently see is “the medical record documentation does not support 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.” This is based on the first criteria outlined in the local coverage determination (LCD) and we often see claims come in for oxygen where the beneficiary does not have a severe lung disease, or that they have an acute condition such as pneumonia. Oxygen would not be payable for acute conditions such as pneumonia, but only severe lung conditions or chronic conditions expected to improve with home oxygen.

The next error is “medical records do not verify that the standard treatment regimen associated with the disease condition producing the hypoxia-related symptoms was tried or considered and deemed clinically ineffective.” Again, this is outlined in the LCD as one of the five basic criteria for oxygen to be considered for coverage. Alternative treatments must have been tried or considered and deemed clinically ineffective. We often get asked what treatments we are looking for. This would depend on the beneficiary and their condition, and that particular physician’s plan of care. While there is not an all inclusive list as each patient’s medical history and situation are different, often we see for patients with chronic obstructive pulmonary disease (COPD) that inhalation medications and nebulizer treatments have been tried, and oxygen is still required. The medical records must clearly indicate those treatments that were tried and failed before oxygen is considered.

Another error is “the medical record documentation does not support the blood gas study was obtained while the beneficiary was in a chronic stable state.” The LCD and national coverage determination (NCD) both require that if the testing is not done during an inpatient hospital stay, the testing must be done while the patient is in a chronic stable state. This means not during a period of acute illness, or an exacerbation of their underlying disease.

The next most common error we see is that “the medical record documentation does not support the treating physician was seen and evaluated by the treating physician within 30 days prior to the date of initial certification.” The LCD requirement is that both the qualifying test and evaluation by the treating physician be within 30 days prior to the initial date on the certificate of medical necessity (CMN).

**Oxygen Resources**

Next, I would like to discuss a few oxygen resources available at our [https://www.cgsmedicare.com](https://www.cgsmedicare.com) website. First is the Medical Review Oxygen Resources page. This page is available when you visit our Jurisdiction B DME website, and click on “Medical Review” in the left hand navigation panel. Once you select “Medical Review Resources,” then “Oxygen Resources,” there are a number of resources specific to oxygen. The remaining resources you see here may be found in this section of our website.

The next resource is the Oxygen Documentation Checklists ([https://www.cgsmedicare.com/jb/mr/documentation_checklists.html](https://www.cgsmedicare.com/jb/mr/documentation_checklists.html)). These are available on the Medical Review Resources page, and have been found to help ensure suppliers have gathered all of the supporting documentation prior to claim submission, and to help educate physicians on what is needed when ordering oxygen. There are two checklists for oxygen, one for beneficiaries meeting group I criteria and one for those meeting group II coverage criteria.

Next, is the Oxygen Use in Beneficiaries with Obstructive Sleep Apnea (OSA) Frequently Asked Questions (FAQs) ([https://www.cgsmedicare.com/jb/help/faqs/current/oxygen_apnea.html](https://www.cgsmedicare.com/jb/help/faqs/current/oxygen_apnea.html)) which are available in the FAQ section of our website, or again on the Medical Review Resources webpage. These FAQs include some common scenarios related to oxygen coverage for those beneficiaries with obstructive sleep apnea, and provide clarification on required testing while the beneficiary is in the chronic stable state. Also on this FAQ page, you will find a flow chart which will help suppliers understand testing requirements for beneficiaries with OSA to qualify for home oxygen.

The last resource listed here is an article titled “Background on Medicare’s Oxygen Coverage” ([https://www.cgsmedicare.com/jb/mr/pdf/oxygen_coverage.pdf](https://www.cgsmedicare.com/jb/mr/pdf/oxygen_coverage.pdf)). This article reviews how Medicare’s coverage criteria for oxygen were developed, based on the Nocturnal Oxygen Therapy Trial (NOTT) study. It also outlines testing criteria for group I and group II, and reviews the chronic stable state requirement. Again, a link to this article may be found on the Medical Review Resources page within Oxygen Resources.

I also wanted to mention our video education. The medical directors have a series of Medicare Minute MD videos ([https://www.cgsmedicare.com/jb/education/video/index.html](https://www.cgsmedicare.com/jb/education/video/index.html)). These videos are available in the education section of our website under video education, or on our YouTube page, which is titled CGS DME MAC Jurisdiction B. There are many policy specific videos as well as more general videos focusing on documentation requirements. The Jurisdiction B Medical Director has a video titled “Oxygen Policy Pearls” which explains the NOTT study, testing, and Medicare’s oxygen policy.
The last resource I wanted to mention is our CGS Wizard (https://www.cgsmedicare.com/medicare_dynamic/job/mrwizard/denials.aspx), formerly known as the MR Wizard. This tool provides suppliers with detailed claim determinations on all claims submitted to Jurisdiction B and C as well as additional documentation request (ADR) status, CGS Medical Review decisions, and related education and resources. All suppliers need to access this information is the 14-digit claim control number. I encourage suppliers to utilize this tool before contacting customer service as this is the same information that customer service would provide.

Before we open the call up for questions, I’d like to mention the Centers for Medicare & Medicaid Services (CMS) ForeSee Website Satisfaction survey. From October 4 to November 30, CGS conducted a pilot program with CMS that permitted us to provide you with a direct link to the survey. CGS offered the direct link as part of our nightly ListServ distributions. The results of the pilot have been shared with CMS who will determine whether contractors will be permitted to offer direct survey links in the future. With completion of the pilot, all direct links have been removed so it is very important that you, once again, complete the survey that comes up when you navigate to the CGS website or the myCGS web portal. Your input is vital in making changes to our website that will positively affect all suppliers. Virtually all of the major changes and additions to https://www.cgsmedicare.com have come about from supplier input. Use the survey to tell us what you like about the website, what you would change and what you would like to see for future enhancements. It only takes a few minutes of your time and your contribution is very important to us.

Conclusion

As we prepare to queue your questions, please be reminded that we will only take verbal questions over the telephone as this call is being recorded for transcription purposes. In order to ask a verbal question you must enter your audio PIN into your telephone keypad. This is available in the audio section of your GoToWebinar control panel. To raise your hand, simply click on the icon of the hand. If the arrow is red, your hand is raised. If it is green, your hand is lowered. I will unmute individual lines so that you can ask your question. No specific claim information or Medicare beneficiary’s private health information should be mentioned. No specific claim information or Medicare beneficiary’s private health information should be mentioned. We will now take just a moment to prepare our question roster.

Question and Answer Section

Eraca: I have a client who qualified for oxygen in his sleep study. He is on BiPap. They were able to set the pressures and they got really high in order to correct the oxygen. The doctors sent him home with the pressure change since he had been on BiPap for a long time. He is unable to tolerate the high pressures so the doctors lowered his pressures back to where he was before and then ordered the home oxygen to supplement because the lower pressure did not take care of the oxygen level.

We are trying to figure out if Medicare will pay for that. The pressure will take care of that but the client is unable to tolerate it so then will Medicare pay for the oxygen or not?

Ashley: So, just to clarify, you are saying the beneficiary is on BiPap. The beneficiary has obstructive sleep apnea and is unable to tolerate that BiPap during the titration. Is that correct?

Erica: He had been on BiPap for the sleep study to get titrated for oxygen. Since he had oxygen for the BiPap and we had done it incorrectly because we didn’t know if he could be qualified for the sleep study. We redid the sleep study. He qualified at the lower pressure. We raised the pressure up to correct the oxygen. The doctor wrote us a prescription; we changed it to the higher pressure and he tried it for about two weeks and could not tolerate the higher pressure. The doctor lowered the pressure back to what it was and put him back on the supplement oxygen.

Because it could be corrected but he can’t tolerate it, we are trying to figure out if he is going to be covered or not?

Ashley: I think I need some clarification on the question. Are you saying the beneficiary was unable to tolerate the BiPap in order to get that OA optimally treated to obtain that qualifying test for oxygen purposes? Or, are you saying that following the titration, they were unable to continue to wear the BiPap?

Erica: He had been at that pressure for years and years. In the sleep study, it showed at that pressure, he needed oxygen with that. So they titrated him in the sleep study to a higher pressure and it corrected the oxygen. After it corrected the oxygen and titrated him in the sleep study for higher pressure, he was sent home and they changed his BiPap oxygen to the higher level. When he tried that at home for a couple of weeks, he could not tolerate the higher level and could not wear his machine. The doctor put him back on the lower pressure with the oxygen supplement. That’s where we are.

Ashley: Is there anybody on the line from Medical Review that might be able to address that question?

Heather: The point of the LCD is that once the OSA is treated appropriately there is still the underlying lung condition causing the oxygenation and therefore needs the oxygen treatment for that. What it sounds like without seeing the information is OSA (when it is optimally treated) will treat oxygenation issues so if that is the actual lung condition causing the problem. It would be hard to go strictly by the LCD to say that we would cover oxygen. It would have to be something documented clearly in the notes from the clinician that did the sleep interpretation and lowered the BiPap settings and then we would probably have to take something like that to our Medical Directors to get feedback because it is not a normal situation.

Again, the point of the LCD is to see if it is not the OSA that is causing the oxygen to be low - it is actually the underlying lung condition. From what I hear, that is not the case in this particular situation. It is kind of an outlier that we would need input from the Medical Directors.

Erica: How can I send this in for review?

Heather: Since we don’t actually look at BiPap in the CGS Connect program, let me check with our manager on that for you. We can follow-up after the call.

We are looking at the oxygen part and not the BiPap in the CGS Connect program. That is a perfect example of when you could send in the information for review. A nurse from Medical Review could look that over, provide some feedback, and give you a call to explain what you would need. Sending it to CGS Connect would be the best way to handle this.
Erica: Is that on the CGS website? I don’t know what the CGS Connect program is.

Heather: Yes. It is listed on our website and it tells you how to submit a claim. Before you have actually submitted a claim, you can send information and get feedback from a nurse reviewer on whether or not it would go through.

Ashley: The CGS Connect program can be found in the Medical Review section of our website.

Wendy: I have a question about an inpatient discharge. The patient went in with an acute diagnosis.

It has actually exacerbated upon discharge. The patient was in the hospital for five or six days and upon discharge, they are still giving the exacerbated diagnosis. We can follow the trail to see that the patient had been treated but with that exacerbated diagnosis, would oxygen be covered at that point or would the patient need to be re-tested after discharge?

Ashley: You said they were in the hospital for an acute condition, correct?

Wendy: Correct.

Ashley: Do they also have a severe underlying lung disease or is the oxygen being ordered to treat the acute condition?

Wendy: The patient has numerous conditions. It states if the patient has COPD (or non-specific or stable) or following the COPD exacerbated, then possibly having the patient having a CA tap on the side.

Ashley: OK. So if they have COPD or a chronic lung condition and they are in an inpatient stay, what would we expect to see, while the chronic stable state is only applied to testing done outpatient, we would expect to see that exacerbation of acute conditions have been treated and that alternative treatment methods have been tried and clinically ineffective would come into play.

As long as those conditions have been treated and that testing was done within two days prior to that inpatient stay, that testing would be appropriate.

Wendy: So it would not matter if they changed the admit discharge to a different discharge or an admit diagnosis to a different discharge diagnosis? If they went in with exacerbated COPD and are discharged with it that will not have any bearing on being listed in the notes that it has been treated. Right?

Ashley: Yes. Keep in mind, we will be looking at those alternative treatment methods that have been tried and deemed clinically ineffective. You said they have an exacerbation and what has been done to treat it. Does that help?

Wendy: That helps immensely. Thank you.

Kayla: I have a couple of patients that started off with entering Group I. They were 88% or lower.

Upon their one-year recertification, they tested at 89% which would put them in Group II.

It was my understanding that you don’t usually change from one group to another. Would the 89% have to be reported on the recertification CMN? Would that put them into Group II where they would need another recert down the line or would we just use the initial testing?

Ashley: There is not a retesting requirement for Group I. A beneficiary who originally qualified under Group I could be re-tested. The requirement for recertification CMN is the most recent qualifying test, which would have been the 88%. They would not change from Group I to Group II. There is not that requirement for the new test.

Kayla: That brings up another question. If a patient initially qualifies during an exercise test… complete test at 86% on rest. On recert, they are then tested at 93% at rest, does that disqualify a patient or not?

Ashley: The only requirement for the recertification CMN is the most recent qualifying test. We are not looking for additional testing unless there was something in the medical record to indicate that the oxygen is no longer medically necessary.

Keep in mind from an audit perspective, if they are looking at those records and do see a test, they might look to see if there is supporting information to support that oxygen continues to be medically necessary.

Kayla: We have different doctors that don’t like to do the complete 3-part test. They will do two portions of it but then it is not complete and we are not really sure what that means. They still need it. That is still their diagnosis. Thank you very much, that answers my question.

Lisa: My question has to do with the detailed written order prior to delivery of portable oxygen. I noticed recently since November 20, there was a publication that did not indicate that we had date stamped received on the detailed written order any longer. I just wanted to make sure that we don’t have to date stamp received face-to-face documentation.

Ashley: Are you referring to items subject to ACA 6407, such as portable gaseous tanks?

Lisa: Correct.

Ashley: For the 5-element order, or 5E0, there is not currently a date stamp requirement. It was removed for the date stamp or equivalent on that 5E0. It is encouraged but we would want is that the order date is prior to delivery. The date stamp for the 5E0 is not a requirement.

Lisa: What about the documentation for the patient’s visit with the physician? The previous language said it was not going to be reinforced. Has that been removed?

Ashley: The face-to-face is included in the ACA 6407 requirement. That is still not enforced by the DME-MACs but other auditing contractors may look for that. I believe CERT is one that does look for that face-to-face for ACA 6407. Keep that in mind. The oxygen policy has that 30-day requirement with the physician, so that should meet the 6-month requirement.

Lisa: So other contractors are not going to be looking for the received stamp on the 5-element order but they could still be looking for it on the face-to-face visit for the portable.

Ashley: Correct.

Kara: You were talking about denials. I have several patients that are at their recent stage and I have my recent CMN signed and transmitted it. Every single one of them was denied for CO176. I am not sure what I’m doing wrong and this has just happened recently.

Ashley: This might be something we have to take offline after this call. The recent is due and you are still getting 176 denials?
Don: Along the same line about billing, we have a new customer with a new capped rental that was eligible. They were under billing maintenance. Let’s say we billed starting on the 3rd. Do we start the new capped rental after the 30 days for the last month of maintenance?

Ashley: It would be the next month that the homefill would be payable. It would deny with the portable already being billed.

Bambi: My first question is about setup for oxygen. They set up the portable and 2 days later, the patient was set up on a homefill. How do we bill that? We can’t bill for both. Do you just bill for the portable for one month and then start the homefill the following month?

Don: Along the same line about billing, we have a new customer with a new capped rental that was eligible. They were under billing maintenance. Let’s say we billed starting on the 3rd. Do we start the new capped rental after the 30 days for the last month of maintenance?

Ashley: If you are going to bill for the portable first, let’s say the 5th of the month, and then the homefill comes on the 8th, it would be payable the following month.

Ashley: Does the date they signed for the homefill not matter? We have to start the billing the following month.

Ashley: It would be the next month that the homefill would be payable. It would deny with the portable already being billed.

Bambi: Does the date they signed for the homefill not matter? We have to start the billing the following month.

Ashley: Yes, thanks.

Don: So the signed date on the paperwork on the capped rental with the homefill, it is ok to start the billing after the first of the month.

Ashley: You would want to coordinate the delivery of the new equipment with when you are going to start that new period.

Don: So would it have to be delivered on the day after the last month of maintenance or the last month of the portable?

Ashley: Let me get some additional perspective from someone else. Denise, are you on the call?

Denise: I am not sure if they would hit against each other. So, they got their maintenance and service and directly after that the beneficiary elected new service and got a new 5-year reasonable lifetime, correct?
Maria: He would need to have a PSG with the oral device to show that he is being optimally treated then?

Heather: We would need to see that the OSA has been optimally treated before the AH1 has been reduced in order to know that it is not the OSA causing the problem, but that it is the underlying lung condition. Unless we know the AH1 has been reduced and the OSA is not the issue, we can't prove that they are in a chronic stable state.

Maria: Thank you.

Michelle: We are seeing a lot of C0-176 denials with that prescription.

Ashley: To where the recent CMN is due and you submitted it and it was denied?

Michelle: Yes.

CGS: Have you contacted Customer Service and they have been unable to help?

Michelle: They have been able to help and they said the same thing that Kara brought up.

Ashley: If you want to do the same thing, I would be happy to take a look at it. Just reply to the email that was sent to you confirming your registration for today and make that to my attention.

Michelle: OK. Thanks.

Beverly: My question is about qualifying during titration. That policy has not always been in effect. It is fairly new as far as Medicare rules go. When did Medicare say that in order to qualify for oxygen with OSA, you had to desat during titration?

Ashley: Does anyone on the call remember the date?

Michael: You could go to our website and look under LCDs that are retired and see when it was added based on the history of that LCD.

Beverly: OK, I'll look at it. The second part of my question is the customer did desat prior to that rule and they are due for a 60-month switch out. Maybe they have already had a prior switch-out. Would that be considered 'grandfathered'?

Ashley: We would look for the most recent qualifying test. By qualifying, it would have to meet Medicare’s current coverage criteria. If they did qualify maybe 10 years ago with an overnight oximetry, that would not be able to be used for that replacement even if it might have been their second replacement.

Michael: Since it is replacement and they have already been certified for life, no new test is necessary.

Ashley: Correct. So that new initial CMN would be looking for the most recent qualifying test (meeting Medicare’s current coverage criteria).

Beverly: But they would have to get a new test if they had oxygen previously on a desaturation that was done without a titration for OSA?

Ashley: Right, if they did not have a test that met Medicare’s current coverage criteria for testing.

Heather: I just want to clarify that it has always been that they have to qualify during titration to qualify in a chronic, stable state. The changes to the LCD weren’t actual changes when they added that verbiage; it was just clarifying the chronic state for OSA patients. Technically, that is not a new rule. It was just clarifying further a few years ago. It has always been how you determine a chronic stable state for an OSA patient.

Beverly: Thanks for that answer.

Crystal: I have a question about a patient we set up with oxygen and we later received denials if they did not qualify.

Are we able to have that patient get requalified and then start billing or do we have to get a new provider?

Ashley: It would depend on the situation. What kind of oxygen is this? Is it something that is under ACA 6407 such as the portable gaseous oxygen? If the denial was related to the ACA 6407 requirements, a new provider with a different provider transaction access number (PTAN) would be able to bill for that but not the same provider. For example, if you didn’t have a valid 5-element order and it denied for that, then a new provider could provide oxygen.

Crystal: Thank you.

Amanda: I have a question about getting a patient qualified. Let’s say we have a patient that is discharged from the hospital and they no longer meet inpatient criteria and we have to dispense oxygen but we don’t have the face-to-face qualifying documentation yet. How are we supposed to dispense oxygen for that patient that needs it?

Ashley: Is this portables or something related ACA 6407?

Amanda: Correct.

Ashley: If you don’t have what is necessary the ACA 6407 requirements, I would say an advance beneficiary notice (ABN) would be appropriate.

Amanda: The problem is when we have asked about that previous on different calls, they said we can’t get a blanket ABN. Just because you don’t have the documentation, doesn’t mean the patient will not qualify. I understand but the patient hasn’t had a chance to get a face-to-face. They literally are getting discharged from the hospital. They no longer meet the inpatient criteria. If we can do an ABN, then we will do it but it just seems more often than not that we will be doing more ABNs.

Ashley: You are saying they are being discharged from the hospital on oxygen that is subject to ACH6407 being ordered and you do not have a copy of the face-to-face prior to delivery. The question is can an ABN be issued?

Amanda: Correct.

Ashley: If you have attempted to obtain that documentation of the face-to-face, document that in your records. As long as we see you have tried to get that, then you can issue the ABN.

Amanda: OK. Let’s be honest, physicians are not that great at putting their documentation in a timely manner.

Ashley: We have heard that before. If you can, have the beneficiary contact the doctor and you can document you tried to get it through them as well.

Amanda: OK. Another piece to that...so we bill for the first month rental utilizing the ABN because we don’t have the documentation. If we get it within the first 30 days, do we change our rental date to the second month to go to insurance to cover it, or is it always going to be with that ABN now.

Ashley: You received the 5-element order; you just didn’t get the face-to-face?
Amanda: Correct.

Ashley: In that case, I do believe you can bill Medicare because you did receive the face-to-face documentation but not prior to delivering the item.

Amanda: Thank you.

Kayla: I have two questions. The first is where we have the prescribing order for four liters. In order to bill for a concentrator and a half, we have to add a QF Modifier to that? Does a test have to be taken on four liters or four liters or more? Say for instance if a patient has been prescribed six liters, can that be reported with a QF Modifier or does it have to be a four liter test?

Ashley: More would be acceptable. At least four liters.

Kayla: One more question. If a patient is on three liters and they are still at 86%, is that considered a qualifying test because they are on oxygen but the desat is still below 88%?

Ashley: Yes, that is acceptable. We don’t expect them to remove it during the test; we are just looking for the qualifying sat.

Kayla: Does the doctor have to document that they can’t remove the oxygen or not?

Ashley: No.

Kayla: A patient’s one-year certification has been done. The patient went into a nursing home for three months but now they are out and they want the oxygen back and we are still looking at 36 months of billing, do we do a new delivery ticket for it or do they have to requalify? Do we do a revised CMN? I am never quite sure how that works.

Ashley: You said they went to a skilled nursing facility and then they came back home and continued to use the oxygen provided by your company?

Kayla: Or perhaps they didn’t need it but the doctor continued it but two months later, went back in and still were within that 36-month billing.

Ashley: That would be two different situations. In the first situation, if they did go into a facility say for three months and then come home and continue to use the oxygen there, the need for oxygen was there all along. That would be considered a break in billing and payment could resume where it left off. I would include that information in the narrative of the claim.

In a situation where you said they went to a nursing facility and no longer needed the oxygen or the doctor issued orders to stop oxygen. That would be considered a break in medical need and eligible for a new 36-month rental period but only if they it was a true break. Maybe they are now being treated for a new medical need.

Kayla: If it doesn’t change, do we deliver it back to them with the same information that has been on file with Medicare and change date of service for billing or do they have to requalify?

Ashley: If there is not a true break in medical need but just a break in billing, payment would just pick up where it left off. You would still have to keep in mind medical records that say they need to keep and use that equipment, as well as a recert if that is coming due. If you have a specific situation that you want to run by me offline or are you just hypothetically thinking?

Kayla: Sometimes if we have certain patients where they don’t feel have the need for oxygen or they are borderline, the doctor will order to discontinue the oxygen. Then they will go to a different doctor 3 months later and get an order for oxygen again. I never know how we proceed. The initial has been done; the research has been done but we haven’t completed the 36 months. But the diagnosis and what he is prescribing is the same as what they had prescribed a year-and-a-half earlier. It wouldn’t really be a break in need because, technically, they did need it but the doctor said otherwise.

Ashley: The requirement isn’t necessarily a different diagnosis, it is just for oxygen. We are talking about a chronic condition. It is not likely that the condition or the medical need will completely go away. We would want to see proof that the medical need ended and a new period of medical need began.

Kayla: So with where the billing begins, let’s say we picked up the medical equipment and we re-deliver it when they come back out, the date of service would change. Would that change anything or not?

Ashley: It would pick up where it left off as far as which rental month it is in. The anniversary date would change. If they went into a nursing facility and came out on the 15th, the new anniversary date would be the 15th. Do include that information in your claim narrative…that they were in an inpatient stay for these dates. That way there is a notice to extend the CMN to pay for the 36 months.

Cindy: I wanted to touch back on the CO-176 denials. For the recert, we have been putting in the additional notes to go over the records. The patient didn’t see the doctor until this date for recertification. We are asking them to change the recert date. Would you still need to ask for an extension on that? Could you just bill out another 24 months and be done?

Ashley: If it is moving it back so many months that the recert for Group I patient just got pushed out because they didn’t have that evaluation with the physician until say two months later?

Cindy: Some go out a year because the doctor is not documenting the oxygen correctly. We are telling the doctors that Medicare requires this documentation and sometimes it is a year before we see it. I put down that this is when they were seen and please extend the date or put the new date down for recert. Do we really need to ask for an extension for that?

Ashley: Yes, if it has been pushed back that will change when the 36th month payment is up. When an initial CMN comes in, the system is going process as if 36 months later, 36 payments have been made. However, if there is a little bit of a delay because the recert is delayed, that means the 36-month payment is going to be pushed to a later date. That’s when that narrative comes into play that you would have to indicate to please extend CMN as recert was delayed or something to that effect.

Cindy: Even though they put 36 months as of this date? They are always going by the initial date for the 36 months.

Ashley: It would need to be corrected once. Are you saying you have to do it on every claim that it is still looking for it?

Cindy: Not necessarily. I thought they would just look at the last date billed. I think I answered my own question because they look at the initial date.

Ashley: You should be able to get that changed to re-open that date, but you should only have to do that once and not on every claim.

Cindy: Ok, thank you.
Dawn: Maria: is transpiring. Medicare contractor to get that issue resolved. We would then 1-800-Medicare and they can work with the beneficiary and the liaison would work with that supplier to make sure they are compliant. Otherwise, the beneficiary would have to contact their oxygen is not doing so. What would be the next step? Ashley: Whether they deliver the equipment or supplies or they make arrangements with another local supplier where the beneficiary moved to.

Maria: Would that be like paying us if we needed to put in a new concentrator or going out and doing the concentrator checks? Ashley: Right. That could be an arrangement with the local supplier and the supplier that received the 36-month payment.

Maria: How would you get them to comply with those guidelines? If a client has called their durable medical equipment (DME) company several times because something needs to be done because they out of the (supplier) area and they are not getting anywhere with the situation, what would be the alternative?

Ashley: Stacie, are you on the call? We have a situation where the supplier that received the 36-month payment is obligated to take of that beneficiary and their oxygen. Whether they deliver the equipment or supplies or they make arrangements with another local supplier where the beneficiary moved to.

Maria: Would that be like paying us if we needed to put in a new concentrator or going out and doing the concentrator checks? Ashley: Right. That could be an arrangement with the local supplier and the supplier that received the 36-month payment.

Maria: How would you get them to comply with those guidelines? If a client has called their durable medical equipment (DME) company several times because something needs to be done because they out of the (supplier) area and they are not getting anywhere with the situation, what would be the alternative?

Ashley: Stacie, are you on the call? We have a situation where the supplier that received the 36-month payment is obligated to continue to provide the equipment and supplies needed for the oxygen is not doing so. What would be the next step?

Stacie: If they are in a comp bid area, they could contact the Competitive Bidding Implementation Contractor (CBIC) and their liaison would work with that supplier to make sure they are compliant. Otherwise, the beneficiary would have to contact 1-800-Medicare and they can work with the beneficiary and the Medicare contractor to get that issue resolved. We would then also reach out to that other supplier to get the full picture of what is transpiring.

Maria: Thanks.

Dawn: I wanted to jump on a previous question that was asked in regard to the 484. In a situation where we discharge a patient with an EO431 and we have a written order prior to delivery (WOPD), the patient is discharged and we set him up with a portable and a stationary. A week later, we get an order for a portable concentrator, E1392.

On the initial 484, is there an issue with our loading on there the concentrator and the EO431, which was initially delivered and then also put on the E1392 to be billed for month two? Would you consider that to be a blanket prescription because it has two modes of portability on it? Even though we delivered two different ones in the course of the same month, but we are only billing for the EO431 for the first month and the E1392 for the second month.

Ashley: You would want to obtain a revised CMN. You said they were on the 0431 and then switched to the 1392. You would want to do a revised CMN to add the 1392.

Dawn: So to make it easy, the initial is 12/1/17 and the revised one…would we revise that with the anniversary date or the date the doctor ordered the portable concentrator?

Ashley: You would use the date the doctor ordered. Your date of service might not be until the anniversary date but it is ok on that CMN to have the date the doctor ordered or switched from the 0431 to the 1392.

Dawn: So let’s pretend that date is 12/10/17. If we do our recert a year later, that date will be 12/1/18, correct?

Ashley: Correct. Based on the initial and not the revised.

Dawn: Great. One more question. I have a patient that we are reviewing. Medicare has been paying 484s. We have the initial; we have a recert. Everything was golden. When we started doing a post-payment audit, we could not find the exact testing for the hall walk? All we have is the 484. In my opinion, we have a huge problem because we don’t have evidence of the test and how the test was completed. In that situation, would you consider this a ‘fail’ and should we refund all the money and get the patient retested and send them to a new provider?

Ashley: You are saying that it is already paid, you have recert and now you cannot find a copy of the test or it does not appear that they qualified?

Dawn: I can’t find a copy of the test. From the information the doctor provided to us, the patient qualified with the saturation and the diagnosis, etc. But I can’t find the physical piece of paper that substantiates how that hall walk was done or when the testing was done. My concern is if there was ever an ADR or post-payment audit, you would request me to provide that evidence, correct?

Ashley: Yes, that was going to be my next question. Has this capped?

Dawn: No, I am still in the middle of the rental cycle. I have already received 12 payments, actually more than 12 because I have the recert. Everything is golden but I started doing some poking around and this is what I have identified.

Ashley: You are right. If there was an audit on your claims or even post-pay, that could be requested and you would have to have access to that testing. I am not sure on course of action to do a voluntary refund on that because you are not necessarily saying it did not occur. Have you contacted the referring physician to see if they have a copy? Have you exhausted all avenues to find that test?
Dawn: Yes, I have gone through all avenues to try and have a physical piece of paper that shows me something other than a sentence that doesn’t give me enough information.

Ashley: This might be something we would have to take offline. Send me an email at the email address that was sent to you to confirm you registration.

Dawn: Yes, thanks.

Crystal: I asked a previous question about if we had submitted and been denied if we had to go a new provider. I know we touched on if it related to the 5EO; we would have to go to a different provider with a different PTAN. If it was something where we had submitted a stationary to Medicare and it was denied and then we realized that there was an issue with the testing being written wrong on the CMN. Are we able to correct that and still get them requalified and submit with our PTAN? Or do we have to send them on to a new provider as well?

Ashley: The new provider would only be new cases that the denial was related to the ACA 6407 provision, so something like this you would be able to correct on your end.

Cindy: If you have a patient that is on oxygen with a Medicare HMO and then they returned to traditional Medicare. We have to get new testing, correct?

Ashley: It needs to be treated like a new, initial oxygen patient with the exception of what is outlined in the LCD. If they are enrolled in an HMO Advantage plan and then returned to traditional Medicare, the most recent qualifying test while they were enrolled in the HMO is acceptable. It does not have to be new testing. If they had a qualifying test six months ago while enrolled in the HMO that is OK.

Cindy: Would I just put it in the record why the test is so old because of the transition? We would put in the narrative with the initial claim to the traditional Medicare that the test was done while enrolled in the HMO.

Ashley: Yes.

Lisa: We have some competitors who are billing for oxygen concentrators but also for the portable the E1392. How is this possible or even acceptable?

Ashley: There is nothing in the policy to indicate that the stationary and portable concentrator could not be covered together at the same time.

Lisa: I thought it was one or the other that was billable.

Ashley: They can both be billed at the same time. There is language in the policy that whether they are using a stationary concentrator or the portable concentrator E1392. There are situations where a portable concentrator can function as both a stationary and a portable. In that case, both codes would be billed. You can find that in the LCD or the policy article. I can’t pull it up now for some reason.

Denise: It does indicate in the coding guidelines when to use the QG or QF. It does say the portable qualifies under the 1392, where the stationary would be the 1390. They are allowed together. It is in the policy article.

Lisa: Thanks.

Erica: We had a gentleman that was on oxygen with us about three years ago. He rented up until month 12 and then returned the oxygen. We did not do a recert for him since he returned the oxygen. It has been two years and now he needs to go back on oxygen. It has been two years and now he needs to go back on oxygen. Is there a 36-month rental period just keeps going. He is having new testing to requalify. When I input the information (it is technically going to be month 13), is that considered a recertification or a new initial?

Ashley: It sounds like it was a break in billing rather than a break in medical need. So if 12 months were paid for Group I beneficiary, then recert would be the next step.

Erica: So put that under recert with all the new testing.

Ashley: You would report the most recent qualifying test.

Randy: I want to clarify something that I heard earlier. That is regarding a diagnosis of pneumonia as not being covered. Is that what you said?

Ashley: Yes.

Randy: OK. My concern is that first oxygen is not a diagnosis-driven item and secondly, if they have saturations and ABG that still is qualifying, I would think pneumonia would be acceptable.

Ashley: While it is not a diagnosis-driven policy, oxygen is covered for treatment of a chronic condition, not for an acute condition. If they are going to be sent home with oxygen to treat the pneumonia, it is only for maybe three months. It is only payable for conditions that are considered chronic.

Randy: So what the policy is doing is saying that we have to use common sense when we qualify somebody even though they fit the guidelines. We have to look at the diagnosis and figure out whether or not it is acute or chronic. Is that what we are saying here? Several decades ago, pneumonia was a big topic of conversation that some people thought pneumonia was never covered. We were told pneumonia was covered. I just wanted to make sure we are all clear on that. Some of us old-timers had heard otherwise.

Ashley: One of the articles I mentioned in the Resources section of the presentation is the background on Medicare’s oxygen coverage. It mentions that oxygen will not be covered for treatment of an acute condition such as pneumonia. I believe it mentions in the NCD (National Coverage Determination) where language in there also addresses that topic.

Randy: Thanks.

Ending

Ashley: We are out of time. Thanks for all who called. You will see the transcript of the call on our website within a few weeks.