Recorded Webinar:
Oxygen and Oxygen Equipment

Contract	DME MAC Jurisdictions B & C
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Welcome to the Oxygen and Oxygen Equipment webinar, we have disclaimers in all of our presentations and that the information is current as of this moment and we strongly suggest that you go to our website for the most current information. This presentation cannot be recorded for any reason however CGS may record webinars for suture presentation purposes.

We have a very comprehensive agenda including:

Coverage Criteria for Oxygen, Testing Requirements, Documentation Requirements, Documentation for Continued Coverage, Coverage Considerations Beyond Testing Results, Coding and Billing Guidelines, Public Health Emergency (PHE), and helpful Resources.

The first topic on our agenda today is Coverage Criteria.

Due to changes to the oxygen NCD that occurred in September of 2021 and the revisions to the LCD and PA that occurred in January of 2023 there have been many changes to the oxygen coverage criteria.

When I provide this presentation, I like to say forget everything you know about oxygen as this is a fresh start.

CMS has determined when used in the home, oxygen and oxygen equipment can make meaningful contributions to the treatment of patients with both acute and chronic conditions who require the medical gas on either a short or long-term basis.

Home oxygen and oxygen equipment is covered only when both the reasonable and necessary criteria and the statutory documentation and payment rules discussed ion the LCD and the PA are met, always refer to the LCD and PA for additional information on statutory policy payment requirements.

We did receive a lot of questions when the policy was revised and we added a bunch of frequently asked questions to our website to address those concerns from the supplier community. If you have not yet reviewed those frequently asked questions on our homepage in the left-hand navigation, go to frequently ask questions and then under medical review is a whole section of oxygen questions.

So, moving into the coverage criteria. Initial coverage of home oxygen therapy and equipment is reasonable and necessary for group I and II if the conditions on the slide are met.

The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need and I'll talk about at the time of need and in just a few

moments, the beneficiaries blood gas study meets the coverage criteria, the qualifying blood gas study was performed by a treating practitioner or a qualified provider or supplier of laboratory services, and that provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.

Time of need is defined as during the patient's illness. When the presumption is that the provision of oxygen will improve the patient's condition.

Time of need determines that the beneficiary needs oxygen at that time, there is no technical timeframe for oxygen testing.

However, because oxygen is usually life sustaining equipment, we would expect that that testing, and the items would be provided at the time the beneficiary needs them.

Now for an inpatient hospital, patient anticipated to require oxygen upon going home, that time of need is within 2 days of discharge. So, it's important for the supplier to work with the referring, treating practitioner to obtain the information.

The required qualifying arterial blood gas or oximetry studies again, do need to be provided at the time of need and this refers to either an oximetry test or an ABG or arterial blood gas test.

Again, inpatient hospital, the time of need is within 2 days prior to discharge and for other patients, the time of need is during the period when the treating practitioner documents those signs and symptoms of an illness that will be relieved with oxygen within the home.

It's important to keep in mind that the beneficiaries medical record must have documentation that describes any concerns for variations in their oxygen measurement, that can result from factors such as age, skin pigmentation, altitude, or a decrease in oxygen carrying capacity.

Moving into group I, the arterial PO2 is 55 mm of mercury or less or saturation is 88% or less, taken at rest awake, while breathing room air or during sleep the arterial PO2 is at or below 55 mm of mercury or an arterial oxygen saturation at or below 88% taken during sleep for a patient who demonstrates that arterial PO2 at or above 56 or an arterial oxygen saturation at or above 89% while awake, or a decrease in the PO2 of more than 10 or a decrease in our material oxygen saturation of more than 5% from that baseline saturation taken during sleep, that's associated with their symptoms of hypoxemia. Such as impairment of their cognitive processes, nocturnal restlessness, or insomnia, and that is not an all-inclusive list.

In either of these instances during sleep, coverage is provided. Only during sleep. Only one type of unit would be covered of course, if the beneficiary only needs oxygen during sleep, we would not cover a portable in this situation.

During exercise. When oxygen equipment is provided during exercise the arterial PO2 at or below 55 MM of mercury or an arterial saturation at or below 88%, taken during exercise for a beneficiary who demonstrates that PO2 at or above 56 or saturation at or above 89% during the day while at rest.

In this situation. Portable oxygen and oxygen equipment is only necessary while the beneficiary is awake and during exercise. When it is covered during exercise, there must be documentation of the 3 oximetry studies in the Beneficiaries medical record, which we will review under the testing part of today's webinar.

Moving into group II. So, group II is an arterial PO2 of 56 through 59 of MM of mercury or a saturation of 89% and the beneficiary has any of the conditions listed on the slide.

Then we have group and group III has changed from what group III was in the past again forget everything you knew about oxygen.

Group III

Initial coverage of oxygen therapy is reasonably reasonable and necessary for group III if the beneficiary has an absence of hypoxemia as evidenced by a blood gas study, so they are not hypoxemic and there's also a medical condition that has distinct physiologic, cognitive, and/or functional symptoms that are documented in high quality peer reviewed literature that are improved by oxygen therapy. A good example is cluster headaches.

Keep in mind that the DME MaC use the same principles of evidentiary review that are those that were used for the national coverage determination. If you would like details, you can refer to

Appendix A of the NCA, excuse me, or national coverage analysis decision memo and I included a link on the slide.

If all of the coverage criteria for initial claims for beneficiaries in group I, group II, and group III or the documentation requirements for continued payment of subsequent claims are not met. The oxygen therapy and equipment will be denied as not reasonable and necessary and in those scenarios, you would not append the N modifiers or the KX modifier depending on the data service.

We'll talk about that in just a moment. Then group IV, which was kind of previously group III. Oxygen therapy and equipment is also denied if it's not reasonable and necessary if the beneficiary has any of the conditions on this slide Angina pectoris in the absence of hypoxemia, dyspnea without cor pumonale or evidence of hypoxemia, severe peripheral vascular disease in absence of systemic hypoxemia as there is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation, or terminal illnesses that do not affect the respiratory system. So again, in all of those scenarios, you would not append the N modifiers or the KX modifier, again, dependent on the date of service.

Moving on into oxygen and OSA or obstructive sleep apnea. Some beneficiaries with OSA may require the simultaneous use of home oxygen therapy with a PAP device or positive airway pressure device.

Keep in mind that their OSA must be sufficiently treated, such as their underlying condition resulting in the hypoxemia is unmasked.

A qualifying oxygen saturation test may only occur during a titration polysomnogram study and that can either be split night or alone.

The test that's obtained during the titration polysomnogram

will be accepted to qualify oxygen assuming that all of the other criteria that we just review is also met. So, the titration PSG is one in which all of the following criteria are met. The titration is conducted over a minimum of 2 hours and during titration, the AHI/RDI is reduced to less than or equal of an average of 10 events per hour or if the initial AHI/RDI was less than an average of 10 events per hour, the titration demonstrates further reduction in the AHI/RDI and nocturnal oximetry conducted for the purpose of oxygen therapy reimbursement, the qualification may only be performed after optimal PAP settings have been determined and the beneficiaries using that PAP device at those settings.

The nocturnal oximetry conducted through the PSG demonstrates an Oxygen saturation of less than 88%.

Now we get a lot of questions about Beneficiaries entering Medicare and oxygen testing. So, beneficiaries that are covered under another insurance such as the Medicare Advantage plan, a private insurance, or Medicaid prior to the eligibility or enrollment in Medicare, fee for service. Again, that time of need for oxygen is established on or after their Medicare fee for service enrollment date. In this circumstance, there does not have to be a new blood gas study. But the initial test must meet the recent qualifying study for the beneficiary that they previously obtained and under the guidelines specified in the policy.

We have allowed an exception to utilize a previously qualifying test. However, we would expect the treating practitioner would evaluate the results of that qualifying test and provide a new SWO or standard written order upon enrollment in Fee for service Medicare.

If they were on oxygen with traditional Medicare and then went to a Medicare Advantage plan, then back to traditional fee for service Medicare they would just continue to pick up where they left off with traditional fee for service Medicare.

All right, moving into testing as I promised earlier.

For initial claims for oxygen therapy for hypoxemic patients, they must be based on the results of a clinical test that has been ordered and evaluated by the treating practitioner, as I mentioned earlier, that could be an ABG or blood gas study or pulse oximetry, overnight oximetry, standalone pulse oximetry continuously recorded overnight. When both the ABG and pulse oximetry tests have been performed on the same day under the same conditions the ABG result will be used to determine if the coverage criteria is met. If the ABG test that's done at rest and awake is non qualifying but either an exercise or sleep oximetry test was done on the same day as qualifying, then that exercise or oximetry test would be used to determine coverage.

All oxygen testing must be performed in person by the treating practitioner or other medical professionals that is qualified to conduct oximetry testing and that's with the exception of the overnight oximetry testing. Keep in mind that a DME supplier is not considered a qualified provider or a supplier of laboratory services this may not qualify the beneficiary for home oxygen. This prohibition does not extend to the results of blood gas tests that are conducted by a hospital that is certified to do those tests.

The qualifying testing at rest is when the beneficiary is awake while sitting or lying and breathing room air, during sleep. The overnight sleep oximetry can be performed in the hospital or at home and the beneficiary can self-administer home-based overnight oximetry tests under the direction of a Medicare enrolled independent diagnostic testing facility or IDTF.

The titration polysomnogram, which is facility based, used for beneficiaries with concurrent OSA for beneficiaries who qualify for oxygen during the sleep test only or during sleep only are only eligible for stationary as I mentioned earlier of course portable would not be covered.

Moving into exercise testing, exercise testing must be performed in person by a treating practitioner or other medical professional that is qualified to conduct that exercise testing, there must be documentation of 3 studies in the beneficiary's record. Testing at rest without oxygen and testing during exercise without oxygen and testing during exercise with oxygen applied to demonstrate the improvement of their hypoxemia. Only the testing during exercise without oxygen is used for the qualification.

Oximetry tests that are obtained after exercise or any recovery testing is not valid for determining coverage.

All 3 tests must be performed during that same testing session and as I stated earlier, in an audit scenario all 3 tests must be available upon request.

Moving into oxygen documentation requirements. So, as I said, earlier, forget everything you know about oxygen. Because The Certificate of Medical Necessity, which has been a part of the oxygen policy for many, many years has been removed for any dates of service on or after January 1st of 2023. For any claims with dates of service on or after January 1st you must not submit a CMN with the claim, if a CMN is included or was included, the claim was rejected and returned by CEDI which is the front end of the Medicare claims processing system.

CMS had also provided a determination that CMNs would not be required for oxygen claims during the COVID-19 public health emergency and one of the reasons for that was because the coverage criteria was not enforced during the public health emergency. So, the beneficiary wouldn't meet the coverage criteria on the certificate of medical necessity and also due to the changes in the NCD regarding acute conditions.

Documentation for the initial coverage requires information in the medical record that of course shows evidence of the qualifying test results at that time of need as we talked about earlier and evidence of an evaluation of the qualifying test result by a treating practitioner.

In order to provide initial coverage for Beneficiaries in group I, II or III, there must be evidence in the documentation, the medical record documenting one of the following A through C criteria. Asymptomatic hypoxemic patient who meets group one or group II or asymptomatic normoxemic patient with medical condition that improves the oxygen therapy. That's for your non hypoxemic beneficiaries or for beneficiaries with concurrent obstructive sleep apnea, OSA. The qualifying oxygen test was prescribed during optimal treatment of the OSA as described in the local coverage limitation or medical necessity that we just reviewed and their OSA is sufficiently treated.

Moving into some of our standard documentation requirements. A Standard written order, proof of delivery, evidence of that qualifying test and medical records that support all the Medicare coverage criteria are met. We do have a documentation checklist for group I and group II Oxygen patients. So, if you're not familiar with documentation requirements or you want to do a periodic review of your medical records, those documentation checklists are very, very helpful.

For oxygen, we have the standard written order, and this is for all items that are provided to Medicare beneficiaries. The standard written order can be obtained prior to claim submission. Of course, that's dependent upon your state laws, because of course some states, most states you do have to have an order for oxygen prior to dispensing.

For other items, the standard written order is required prior to claim submission, and it must include all of the elements on the slide, the beneficiaries name or their Medicare beneficiary identifier, the date of the order, a general description of the item and that can either be a general

description, it could be the HCPCS code, it could be the HCPCS code narrative or a brand name or a model number.

It's important to include any separately billed options, accessories, or additional features, the quantity to be dispensed if applicable, under most circumstances, quantity is not required for oxygen because you're only providing one concentrator or one portable unit. The leader flow can be listed on the order, but it is not required we would expect that information to be in the medical record if it's not on the order.

The treating practitioners name or NPI and that treating practitioner signature.

Then moving into proof of delivery. Proof of delivery is required by supplier standard Number 12, and it does protect the supplier from liability if the beneficiary says, I never receive this item. Proof of delivery is a requirement, and it also protects the supplier.

It must include the beneficiaries name, the delivery address, and when the item is either delivered to the beneficiaries home or picked up at the retail location, it that would be the address delivered to the beneficiaries home by the supplier, beneficiaries address picked up at the retail location, suppliers address. The quantity delivered is required regardless of if you only provide one or not.

On proof of delivery, the quantity delivered is a required element. Again, it could be the narrative, it could be the HCPCS code, the long description of the HCPCS code, the long description of the HCPCS code or brand name a model number.

The date delivered and the beneficiary or their designee's signature. In this scenario, your date of service is the date the beneficiary actually receives that item and that's the date of service billed on your claim.

There are proof of delivery requirements even if the beneficiary is just coming from another payer or another insurer. If the beneficiary is receiving an item from another payer such as the Medicare Advantage plan and then they become eligible for fee for service, the first Medicare claim for that item is considered a new Medicare claim. It does not automatically continue coverage for any item from any other payer if the beneficiary when the beneficiary transfers to traditional fee for service Medicare.

For Medicare to provide payment, the beneficiary must meet all coverage, coding, and documentation requirements in effect for that date of service of that initial Medicare claim.

As I stated, proof of delivery is required for all items, even those that are already in the beneficiary's possession provided by another insurer. Prior to their Medicare fee for service eligibility. So, in this circumstance, the supplier record must document a statement signed and dated by the beneficiary or their designee that supplier has examined the item or a notation in the suppliers record that staff member has examined the item in the beneficiary's possession and confirmed it is in good working order. You have to have that statement signed and dated by the beneficiary or the designee that the supplier has examines the item and the supplier attestation that the item meets Medicare's coverage requirements.

Moving into documentation of continued oxygen coverage. So, for group I there is no requirement for reevaluation or retesting. The supplier should ensure oxygen therapy and equipment remain reasonable and necessary. For group II there must be a repeat qualifying blood gas test and evaluation of those test results by the treating practitioner between that 61st and 90th day after the initiation of therapy and there must also be a new standard written order by the treating practitioner or physician.

Now for group 3. That's for your non hypoxemic patients that also meet the coverage criteria outlined in the LCD. A repeat qualifying blood gas study and evaluation of those results by the treating practitioner, again, between that 61st and 90th day after initiation of therapy. Identifying that they're not hypoxemic and a new standard written order by the treating physician or practitioner.

Now that was for continued coverage. Now we're going to talk about continued need. Once all that initial and continued coverage criteria are met then every 12 months you must get continued need documentation.

For ongoing supplies and any rental DME items, there must be information in the medical record to support items continue to remain reasonable and necessary. For oxygen, a new order can be used to document continued need. In addition, a recent change in the order or prescription by the treating practitioner for refills or repairs. A recent change in the order or prescription a properly

completed CMN obtained prior to January 1st, 2023, when the appropriate length of need is specified or timely documentation in the medical record that shows the usage of those items.

Again, information used to justify continued medical need must be timely for the data service under review and that's within 12 months preceding the date of service. Unless it is specified in a particular medical policy.

A few reminders for continued oxygen coverage, reimbursement ends unless these continued payment and documentation requirements are met.

When the continued payment and documentation requirements are met. Payment will resume at the month in which the rental cycle where it was stopped, and a new initial rental cycle does not begin when the continued payment documentation requirements are met. It would just be a continuation.

Some additional coverage considerations coverage for a flow rate that is greater than 4 liters per minute, higher leader flow for a stationary system that's used for a flow rate of greater than 4 liters per minute will be paid. The initial oxygen criteria, groups I, II or III have been met a higher allowance for the stationary system for a flow rate of greater than 4 liters per minute will be paid.

Group I or group II, coverage criteria greater than 4 liters per minute does require a qualifying blood gas study that was performed while the beneficiary is on 4 or more leaders per minute.

If a flow rate greater than 4 liters per minute and the coverage criteria for the higher allowance is not met, then in that scenario, the payment would be based limited to the standard fee schedule allowance.

There is some information available regarding the payment amount and if you're billing for a portable as well as stationary unit. For more than 4 liters per minute and that is Medicare Learning Network Matters article 10158. You could just search this on a browser 10158 there are some additional details there.

Now, moving into Medicare coverage for portable oxygen. The beneficiary must be mobile within the home. The group I and group II, the qualifying blood gas study was performed at rest while awake or during exercise as we stated earlier, if the blood gas studies were only performed during sleep, portable oxygen will not be covered and will deny as not reasonable and necessary. If that coverage criteria are met, a portable oxygen system is usually separately payable in addition to your stationary system.

The supplier is obligated to provide whatever quantity of oxygen the beneficiary uses, and Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed.

Moving into oxygen contents the cost of oxygen contents are considered included in the stationary rental. Payment for contents is separately payable for gaseous or liquid when the stationary rental period ends.

If the beneficiary is only using a portable gaseous or liquid equipment during rental months 1 through 36 payment for the portable contents begins when the rental period for the portable equipment begins, if the beneficiary enters fee for service Medicare and they have a beneficiary owned gaseous or liquid system, those contents are separately payable and again, the supplier must provide whatever quantity of oxygen contents the beneficiary needs.

And our next topic is coding and billing guidelines, I had mentioned I would talk about this a little later and here we are. So, modifiers KX or N1, N2, and N3 for initial oxygen claims or new 36 months oxygen rental period with a date of service on or after April 1st.

This is new setups on or after April 1st of this year. Either the N1 to identify group I and N2 to identify group II or N3 to identify group III modifiers must be used.

For oxygen claims that are covered by Medicare prior to April first of this year the supplier may continue to use the KX or could use the N modifiers for dates of service on or after April 1st and all of these modifiers identify that the coverage criteria or the medical policy criteria have been met.

Moving into additional oxygen modifiers, the GA means that you have an advance beneficiary notice of non-coverage on file that you believe the item will be denied as non-covered for that particular patient and you would obtain an ABN. The GY identifies an item or service that is statutory excluded or does not meet the definition of a Medicare benefit.

The GZ identifies that that item or service is not reasonable and necessary, but you did not obtain an ABN.

So, depending on the claim date of service. The claim line that is billed without either a GA, GY, GZ, KX, N1, N2 or N3 modifiers will be rejected as missing information.

Just some oxygen modifier scenarios to try and make it a little easier to understand, for a rental period that began February of 2023 there are 2 options. The KX modifier is appended for the entirety of the rental period if the beneficiary meets the coverage criteria or report the KX modifier for February and March, dates of service. Then switch to the N1 N2, or N3 dependent upon the beneficiaries group.

After April 1st of 2023 scenario number 2. The oxygen rental period began April and you would want to use either the N1, N2, or N3 based on the coverage category or the group number. Additional modifiers for oxygen are the RR which identifies the rental, RA is when the oxygen is replaced and we will talk about replacement in just a few moments or MS, which identifies maintenance and service.

Then there are oxygen modifiers for leader flow. These are pricing modifiers. The QA identifies the oxygen is for daytime use while at rest and nighttime use differs the average of the 2 amounts is less than one liter per minute, the QB, the prescribed amount of oxygen for daytime use while at rest and nighttime use differ and the average of those 2 amounts exceeded to 4 liters per minute and portable oxygen is also prescribed, the QR, the prescribed amounts of stationary for daytime use while at rest and again nighttime use differ and the average of those two amounts is greater than 4 liters per minute without oxygen, the QE, prescribed amounts of oxygen while at rest is less than one liter per minute, QF prescribed amount of oxygen while it rests exceeds 4 liters per minute and again portable is prescribed, QG, prescribed amount of oxygen while at rest is greater than 4 liters per minute, no portable, and QH, which is also an informational modifier that states the oxygen conserving device is being used with the oxygen delivery system.

And moving into interruptions of continued use, break in billing versus break in need. So, we do receive a lot of questions about this.

Now there is comprehensive information available in chapter 5 of our supplier manual under news and publications, you would go to our supplier manual and chapter 5 Again, it's an excellent reference as to when Medicare will cover your break in need versus break in billing.

So, break in service. For the purpose of what we're discussing today is defined as a break in billing.

Now, if there's a change in medical condition, this means the beneficiary has a break in medical need.

Just to be clear, break in billing, the beneficiary goes to a skilled nursing facility, or they went to a Medicare Advantage plan or Medicare HMO, breaking billing. A Break in need means the beneficiaries medical condition has changed and the oxygen is no longer medically necessary.

So, your break in service is again a break in billing, but the beneficiary still needs that same equipment and there's been no change in their medical condition. For example, the beneficiary was in a skilled nursing facility and the DME MACs were not being billed, claims were not being billed to the DME MACs at this time. The payment would resume where it left off, this would not start a new 36-month rental period.

Change in medical condition or break in medical need, means again, that beneficiaries condition changed to the point that they no longer needed that original device.

Their condition then changed again, and the patient needed to resume using the original oxygen, it could be for same or different diagnosis.

This is when the beneficiary didn't need the item for more than 60 days plus the days remaining in the last rental month, then new medical necessity for oxygen is established. In this scenario, there must be new testing, a new standard written order and when submitting the claim, include a narrative for the new rental, explaining why the previous medical necessity ended. In this scenario, Medicare will allow for a new 36 month capped rental. Again, chapter 5 of our supplier manual has excellent resources.

It's important to remember that new rental periods do not begin when the need or use for oxygen ends for less than 60 days and then resumes. In that scenario, payment would resume where it left off, it would not be a new capped rental.

A new rental period does not begin during months, 37 to 60 when the need or use oxygen ends for more than 60 days and new medical necessity is established.

Because the supplier must provide all necessary items and services during the 5-year reasonable useful lifetime.

Moving into some additional information on oxygen contents. This handy chart is an outline of when we pay for contents.

As we talked about the payment of contents being included in the fee schedule allowance during the 36-month rental. However, depending on the circumstance, you can begin billing contents for liquid gas systems after the end of that 36-month cap.

It's important to note that the contents must match the type of system that the beneficiary has.

Keep in mind that if you use the incorrect contents code, the claim will deny because there's no record of that particular base equipment or portable unit. Feel free to print off this slide or the slide is also available in chapter 5 of our supplier manual.

Maintenance and service applies to concentrators and transfilling equipment. There is no maintenance and service payment for Gaseous or liquid equipment.

There is no separate payment of maintenance and service during that 36-month rental but for those concentrators and transfilling equipment. After the 36-month rental it can be billed every 6 months, starting 6 months after the end of that rental period or r end of warranty, whichever is later.

To be able to bill for maintenance and service, the supplier must make a physical visit to bill for that service and only one maintenance and service payment is made regardless of the number of visits that are made during that 6-month period.

If you would like additional information on maintenance and service, we have 2 excellent Medicare Learning Network Matters articles, and those links are on the slide.

As mentioned earlier, the reasonable useful lifetime for oxygen is 5 years. The supplier is responsible for furnishing all accessories, contents, and repairs during the RUL.

There are a few options once that reasonable useful lifetime is reached. Upon beneficiary request, the oxygen can be replaced and begin a new 36-month rental period and new reasonable useful lifetime or continue servicing the beneficiary billing only for contents and, or maintenance and service.

Keep in mind that the stationary equipment governs those RUL based rules for your portable systems. There's also a very helpful resource on the slide.

As I mentioned earlier, we're going to talk about replacement. Replacement payment is allowed when the original equipment is lost, this also includes replacement due to bankruptcy or a supplier going out of business or exiting the Medicare program, stolen or irreparably damaged due to a specific incident such as a fire, flood, hurricane. Irreparable damage does not refer to wear and tear over time.

If oxygen equipment is replaced because that equipment has been lost, stolen, or irreparably damaged. The beneficiary may elect to obtain a new piece of equipment, in these situations a new 36-month rental and new reasonable useful lifetime is started on the date that the replacement items are furnished.

Again, just to clarify or repairable damage, the equipment falls down the stairs. It does not apply to an item that is worn out.

When you are billing the first month of rental for replacement oxygen equipment the RA modifier would be appended to the HCPCS code for the replacement equipment also, you must include a narrative in your NTE or notes field of the claim as to the reason why this equipment is being replaced and maintain supporting documentation in the beneficiary's file.

An example and we get this question a lot.

If the equipment is stolen there should be a copy of the police report in the file. If the item is lost or irreparably damaged, you would want to maintain documentation that supports the narrative account of the incident.

For reasonable useful lifetime replacements. That narrative explanation should include the date the beneficiary received the equipment being replaced.

Keep in mind that the RA modifier is only for the first month of rental and would not be used on the second or subsequent months of rental.

So here the beneficiary reached the 5-year reasonable lifetime, again new 36-month rental RA modifier, first claim narrative that includes the date the equipment was being received and for any replacement item and you do need a new standard written order.

Some scenarios where a new reasonable useful lifetime or 36-month period does not start is, replacing the equipment, do a malfunction, as I mentioned, wear and tear, routine maintenance, or repair, when their equipment modality is changed, If the equipment needs to be replaced because it's not functioning, if the beneficiary switches to a new supplier and or new equipment during months, 37 through 60, if the need or use of oxygen ends for more than 60 days the supplier who provided the oxygen equipment during the 36 months must provide all necessary items or services for the remainder of that 5-year reasonable use the lifetime.

And as I promised, we'll talk a little bit about the COVID-19 public health emergency. We do have an entire page on CGS website. It's in that left hand navigation dedicated to COVID-19 and the public health emergency.

So, the PHE ended formally on May 11th, Since the CR modifier should only be reported during a waiver period or when a formal waiver is in place. The suppliers should discontinue using the CR modifier and COVID-19 narrative for any initial claims with dates of service on or after May 12 because that waiver ended on May 11th.

So, no new initial setups should be submitted with the CR modifier or the COVID-19 narrative.

Because of the change from the KX to the N modifiers and the CR modifiers and all the different dates. We just included this slide to assist with some of that date of service and modifier stuff. So, oxygen was provided under waiver the beneficiary did not qualify for oxygen perhaps at the time it wasn't acute condition before acute conditions were considered for coverage because the LCD coverage requirements were not being enforced. So, oxygen provided under non-enforcement with initial dates prior to April 1st the supplier would continue to append the KX and CR modifier with the COVID-19 narrative for a continuation of the rental.

For continued dates of service, again, could continue to use that KX as we talked about before or use the N modifier but would continue to append the CR modifier with that COVID-19 narrative. So again, that was for oxygen provided under waiver prior to April 1st of this year.

Now for oxygen that was provided under waiver with initial dates of service on or after April 1st initially provided on or after April 1st through May 11th would append the applicable N1 through N3 modifier and the CR modifier as well as that COVID narrative.

If none of the N modifiers apply due to the non-enforcement of the coverage criteria, the supplier would continue to use the CR modifier and COVID-19 narrative without an N modifier.

Again, this is specific to those dates of service and for beneficiaries who met the waiver requirements under non enforcement.

For oxygen that's provided after the end of the PHE on or after May 12th of this year, follow the current coverage criteria and billing guidelines. The waivers are no longer applicable.

You now have your N modifiers and would just follow all of the current coverage criteria and billing guidelines.

Moving into some resources.

There is an upcoming change to electronic funds transfer form submission. Effective earlier this week, CMS 588, EFT authorization agreement must be sent to the NPE or national provider enrollment contractors.

We'll remind you who those are in just a moment and that's for the supplier's physical location.

The bank information does have to be applicable for all 4 jurisdictions.

The forms that are received by the DME MACs from now until November 19th of this year will be forwarded to the NPE contractor.

However, if the form is received on or after November 20th, by the DME MAC, it will be rejected and returned.

So, you may want to start sending any CMS 5 88 EFT agreements to the NPE contractors starting today.

The supplier must contact the appropriate NPE contractor for any inquiries related to their EFT questions about EFT correspondence, the status of their EFT request or any changes in the EFT information.

This slide does include a helpful link to the CMS 588.

This ties directly into the transition from paper checks, supported by CFR or code of federal regulations, 42 requirements for enrolling in the Medicare program. A supplier must agree to receive Medicare payments through EFT at the time of enrollment, revalidation, change in Medicare contractors, or submission of an enrollment change request.

It is actually much quicker to receive your checks through electronic funds transfer versus receiving paper checks. Be sure to submit that 588 form to receive Medicare payment through EFT and the enrollment contractors will notify you when you must transition from paper to electronic funds transfer.

You have NPE East and NPE West contractors, which I'll show you a slide in just a moment.

I mentioned those oxygen FAQs, they were really created to complement the revised LCD and policy article when it came out. If you have not reviewed them, please be sure to do so because they are frequently asked questions that we received from the supplier community.

We do have a new physician letter, there is also a Medicare minute Oxygen and oxygen equipment video and as I mentioned earlier, there is currently an oxygen group I and group II Documentation checklist.

Also, if you have not yet used CGS Connect, you will see that for oxygen for the E1390 for initial claims, you can submit all of your medical records to CGS Connect for their review.

This is not prior authorization but our medical review staff, our nurses, will let you know if you're documentation meets the coverage criteria for any items on the slide.

I will particularly mention oxygen because we're doing an oxygen webinar. Another item is respiratory assist devices. These were recently added. I'm not going to talk about them today because it's an oxygen webinar but EO470 and the EO471 if you provide those items or any of the other items listed on the slide.

Just some additional quick resources. This is jurisdiction B and includes our customer service, our IVR, reopenings for those of you that submit paper claims where to send those, EFT form submission, which really should be to NPE, we will currently transfer them, but EFT form submission, written inquiries, appeals and your PWK segment submission.

This is jurisdiction C keep in mind that these are 2 separate jurisdictions and should be treated as such, if jurisdiction B sent you, for example an overpayment request please be sure to respond to jurisdiction B. If you need to send in a re-determination, please be sure to send it to the jurisdiction that processed your claim initially, we just don't want to delay your correspondence.

Hopefully everyone on the call today is signed up to the electronic mailing list, you'll receive updates when they occur. It's very easy and very quick to sign up and you'll always be aware of upcoming Medicare events, you will also be aware of changes to the policies when they occur. You'll get all of that information tight through our electronic mailing lists.

And as I promised, I'll talk a little bit about NPE, this is where your 588 applications will be sent to. For supplier locations that are east of the Mississippi River, the national provider enrollment contractor is Novitas Solutions. For supplier locations west of the Mississippi River it is the national provider enrollment contractor of Palmetto GBA.

Some additional resources include the PDAC or pricing data analysis and coding contractor, I don't see a lot of confusion with coding when it comes to oxygen, however, for any item that you're not quite sure about which code to bill, if you need clarification, if a code fits into a particular description, all that is handled by the PDAC.

Then I mentioned CEDI earlier because they will reject your claims with dates of service on or after January 1st , if you submit a CMN for oxygen. So, CEDI is the front end of the Medicare electronic claims processing system, when you submit an electric electronic claim through whatever billing software you use, it goes right through CEDI, it checks for edits, and then it comes to the appropriate DME MAC and if any of you are still submitting paper claims, CEDI does offer a free electronic billing software.

Thank you very much.

