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February 7, 2011

NATIONAL DME MAC CERT EDUCATION TASK FORCE - OXYGEN ACT PRE -SUBMITTED QUESTIONS

The following questions were received prior to the DME MAC Comprehensive Error Rate Testing (CERT) Education Task Force Ask the Contractor Teleconference (ACT) on February 3, 2011.

Coverage Questions

Q1. I have heard that alternative treatment measures part of the required medical records will be going away. Is this true?

Answer: No, the requirement remains in the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) at this time.

Q2. Paying for contents while portable equipment is still being rented, is this allowed and under what circumstances?

Answer: Yes, if the stationary equipment has reached the 36 month cap and the portable system is still in the rental cycle, the portable gaseous or liquid contents are payable. Remember, the allowance for contents is based on the stationary equipment, not the portable.

Q3. When will the 6 month contemporaneous notes be part of the LCD and required to have on file?

Answer: There is no specific time frame to support continuous need/use. Reviewers will assess each patient separately to determine medical necessity based upon the records available. Realistically, oxygen is a serious drug that should be monitored by the physician periodically.

Q4. What is considered to be alternative treatment measures before the oxygen is ordered?

Answer: Many disease conditions have standard treatment regimens associated with them. This criterion, together with the requirement that testing be done while the patient is in their chronic, stable state means that the usual treatment modalities need to be optimized before oxygen becomes eligible for reimbursement.

Q5. What is the responsibility of the provider for patients who are traveling outside the US ?

Answer: The supplier is not responsible to furnish oxygen for a patient that travels or resides outside the US .

Q6. If pulse oximetry for Oxygen is more than 88%, what additional documentation do we need besides the Certificate of Medical Necessity?

Answer: For a patient with a blood gas saturation of 89%, the patient may qualify under the Group II benefit if they meet all the criteria stated in the LCD under the indications and limitations of coverage and/or medical necessity section. For Group II patients, in addition to the qualifying blood gas study, they must meet one of the following criteria: (1.) Dependent edema suggesting congestive heart failure, or (2.) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III , or AVF), or (3.) Erythrocythemia with a hematocrit greater than 56 percent. For beneficiaries with a blood gas saturation of 90% or above, they would fall under Group III and there is a rebuttable presumption of non-coverage.

Q7. When following up with an oxygen patient, is the provider required to do any kind of testing on the patient such as a pulse ox reading?

Answer: For Group I patients, Medicare requires a test within 30 days prior to the initial date on the CMN. Once the patient qualifies, further testing is not required by Medicare. For a Group II patient, Medicare requires a test within 30 days prior to the initial CMN. In addition, a test is required between the 61st and 90th day after the date of the Initial CMN. Additional testing should be performed according to what the primary care physician (PCP) determines appropriate. The supplier does not need to test the patient. Testing performed by the supplier is not considered as a qualifying test under Medicare guideline

Q8. A. Coverage Criteria Scenario 1- Patient begins oxygen therapy 6/7/06 . They are in the hospital for two months (7/7/08 and 8/7/08). We bill 36 months of rental and are paid. What day does the 5 year cap go into effect? Would it be 6/7/2011 or 8/7/2011 (since we either refunded two months of service or did not bill the patient's medical condition did not change and they remained on oxygen during the two months we could not bill Medicare)?

Answer: A . The equipment would meet the reasonable useful lifetime on 6/7/2011 in this scenario.

B. Scenario 2 Same as above but no hospital stay during months 1 – 36, However, a hospital stay on 1/7/11 and 2/7/11 . Would 5 year cap be 6/7/11 or 8/7/11 ?

Answer: B. The equipment would meet the reasonable useful lifetime on 6/7/2011 in this scenario as well. Hospital stays do not affect the reasonable useful lifetime calculation for the equipment.

Q11. A. If the patient is seen in the ER for one condition and they address a respiratory problem at the same time, can the ER doctor order oxygen if necessary?

Answer:A. The patient must be in a chronic stable state as an outpatient when tested for oxygen within 2 days prior to discharge from an inpatient facility to their home.

B - If not, should the patient then be referred by the ER doctor to their primary physician to be qualified?

Answer: B - Yes , if the patient was not in a chronic stable state to be tested while at the hospital.

Q12. Could you explain the process needed to switch out oxygen equipment due to RUL please? Including modifiers, claim notes, documentation, CMNs, etc.

Answer: At any time after the end of the 5-year reasonable useful lifetime for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period. An article titled, "Oxygen - Certificates of Medical Necessity - Replacement Equipment" was published in February 2009 by all DME MACs which outlines the criteria and billing for Oxygen Replacement after the reasonable useful lifetime has been reached. Be sure to include the RA modifier on the first month of rental for the new Oxygen system.

Q13. A patient who is currently on oxygen is moving into my area or, has disenrolled from home hospice but required oxygen during that hospice stay. In those situations, is the patient required to see a physician within the 30 days prior to the initial set up of the oxygen by my firm?

Answer: Yes. All of the existing coverage and documentation requirements must be met except that the original testing done while the patient was in hospice may be used as the qualifying test.

Q14. How much portable contents are suppliers required to provide to a patient for a month?

Answer: Suppliers must provide whatever quantity of oxygen contents are needed for a patient's activities both inside and outside the home. A maximum of 3 months of oxygen contents may be delivered at any one time.

Q15. We received a medical review letter and denial because we don't have documentation that the patient was seen 30 days prior to initial setup. We have tons of documentation, just not within 30 days. We had money taken back on this patient. Can we have them see their doctor and be retested to re-qualify? Would we start a new 36 months cap rental period or start with the next billing month that we would have billed?

Answer: Yes, they can see their doctor and be retested to re-qualify. A new cap rental period would not begin in this situation.

Q16. Please go over the group I qualification for 5% desat. Is the only qualifying sats 88 or below? And what documentation is needed?

Answer: The rule applies to sleep oximetry testing. The LCD says;

“A decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia”

Detailed information from the overnight sleep oximetry would be needed in the event of an audit.

Q17. Please emphasize what the physician needs to document in the patient's chart that supports the information on the CMN form that he/she signs for the oxygen company...it is more than just a signature on a form!

Answer: The CMN is not a complete summary of all requirements. There must be documentation in the patient's medical chart indicating the following information in which home oxygen therapy is covered only if all of the following conditions are met:

1. The treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, **and**
2. The patient's blood gas study meets the criteria stated below, **and**
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, **and**
4. The qualifying blood gas study was obtained under the following conditions:

If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or

If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

Q18. When Medicare is the secondary payer, does the patient still need to meet Medicare testing requirements for payment?

Answer: Yes

Q19. For patients who receive portable oxygen only, is the oxygen supplier able to receive reimbursement for the rental of the portable oxygen as well as cylinder contents?

Answer: If the patient is using only portable gaseous or liquid equipment and not stationary equipment during months 1 through 36 of the portable equipment rental, payment for portable contents begins when the rental period for the portable equipment begins. If stationary equipment is subsequently added, separate payment for portable contents ends because payment for contents is included in the payment for stationary equipment.

Q20. Is there an office visit required for a new initial CMN for replacement equipment?

Answer: There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

Q21. The current LMP states that there needs to be documentation from the MD's office visit or nursing home notes stating the patient is mobile within their home for portable oxygen to be covered. If the O2 saturation testing is done with ambulation would that suffice, or do we need to bother the doctors to create a specific note stating they are mobile in the home.

Answer: Medicare does not cover oxygen in the nursing facility. The physician should document the patient's mobility needs in the home that cannot be met with a stationary system. A convenience reason, such as not wanting a long piece of tubing, is not sufficient justification.

Testing Questions

Q22. Can you clarify criteria while beneficiary is tested "on oxygen"?

Answer: Per the TESTING SPECIFICATIONS section of the LCD,

The qualifying blood gas study may be performed while the patient is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

Q23. When oxygen is being bled into a CPAP or BIPAP what are the testing and documentation requirements? Do the sleep study saturations qualify the patient?

Answer: Reimbursement for oxygen is based upon meeting the blood gas testing criteria set out in the LCD. As discussed in the question above, testing must be performed while the patient is in the chronic, stable state. Since one of the consequences of untreated obstructive sleep apnea is hypoxia, oxygen testing performed during sleep testing would not qualify because the chronic, stable state criteria are not met. In order to qualify for oxygen, a patient with obstructive sleep apnea would need to be compliantly using a properly fitted and titrated PAP device. Once the OSA is adequately treated, oxygen may be reimbursed if a qualifying blood gas test result remains.

Q24. If a patient has private commercial insurance and then becomes eligible for Medicare but fails to inform the supplier of the change in insurance, when does the provider start billing Medicare for oxygen? Do suppliers need to wait until after a qualifying blood gas study or oxygen saturation test can be performed or does the supplier begin billing Medicare from the Medicare effective date with a Certificate of Medical Necessity (CMN) that indicates there is not a qualifying test?

Answer: The Oxygen and Oxygen Equipment LCD indicates an Initial CMN must be submitted with the first claim for home oxygen, (even if the patient was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO). The LCD also indicates the blood gas study reported on the CMN must be the most recent study obtained within 30 days prior to the Initial Date. The only exception to the 30-day test requirement is for those patients who were started on oxygen while enrolled in a Medicare HMO and then transition to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial date, but must be the most recent qualifying test obtained while in the Medicare HMO. Furthermore, the patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification. Therefore, suppliers may not begin billing Medicare for oxygen until they have a completed, signed and dated Initial CMN.

Q25. What defines exercise when a patient is being tested in the doctor's office?

Answer: Per the LCD

“When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the patient’s medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). All 3 tests must be performed within the same testing session. Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the CMN. The other results do not have to be routinely submitted but must be available on request.”

Instructions about what is acceptable testing protocols to be used to perform valid, reliable exercise oximetry is beyond the scope of this Q&A. Refer to the published clinical literature for information about oximetry testing and exercise testing protocols.

Q26. For an order over 4 liters, would a test done at above 4 LPM be accepted as long as the patient met the qualifying criteria of SaO₂ of 88% or below or PO₂ of 55 or below? For example, a patient tested at 5 liters but their saturation was 87%.

Answer: In order for a patient to qualify for 4 LPM, there must be testing on 4 LPM documenting that group 1 or 2 coverage criteria are met. If the coverage criteria are met but the testing was performed at a higher rate than 4 LPM the results would indicate that the patient would need to be on more than 4 LPM.

Q27. Why do claims deny if test is done under other circumstances ?

Answer: In order for testing to be accepted as valid evidence that the beneficiary qualifies for reimbursement the published testing standards must be met .

Q28. Does testing have to be conducted on room air only or can it be done on oxygen to qualify for oxygen equipment rental?

Answer: With the exception of the beneficiary qualifying during exercise, the beneficiary may be on oxygen during testing as long as the reported blood gas values meet the Group I or Group II criteria.

Q29. If a patient returns oxygen equipment against medical advice for a substantial period of time (6 month or more) and then the equipment is reordered, is this considered a break in medical need/service?

Answer: No, a "Break in service/medical need" is defined as a change in the patient's medical condition to the point that they no longer need the original equipment (i.e., the patient no longer met medical necessity requirements for the equipment) for a period of 60 days plus the days remaining in the last paid rental month. The patient's condition changed again and the need for the equipment resumed (the patient again met medical necessity requirements for the equipment). It could be for the same or a different diagnosis.

Q30. If a patient's condition changes after the 36 month cap, and the patient now requires >4 LPM, how can the supplier obtain the additional reimbursement for the higher liter flow?

Answer: There is no further payment for oxygen equipment during the 5-year reasonable useful lifetime (RUL) of the equipment after 36 rental payments have been made. The supplier who provided the equipment during the 36 th rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5 year reasonable useful lifetime of the equipment. If the patient was using portable gaseous or liquid equipment during the 36 th rental month of stationary equipment (gaseous, liquid, or concentrator), payment for portable contents are payable during months 37-60. There is no difference in payment for oxygen contents for beneficiaries receiving more than the 4 LPM or less than 1 LPM.

Q31. If a patient wants to switch suppliers due to poor service, but 36-rental payments have already been paid, can the patient switch suppliers?

Answer: Yes, the beneficiary has the option of switching suppliers; however, it may be difficult for the beneficiary to locate a new supplier willing to service them, given the new supplier will not receive any additional rental payments. However, if the beneficiary believes their supplier is not following supplier standards they have the option of reporting the supplier to 1-800-Medicare.

Q32. Why doesn't Medicare pay for a pulse oximeter if the patient's condition requires them to be on ventilator or to monitor their oxygen saturation levels?

Answer: Reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for all accessories is included in the rental allowance.

Q33. How much will suppliers receive reimbursement for oxygen contents after the 36-month cap is met?

Answer: Most payments of durable medical equipment (DME) including oxygen are based on a fee schedule. A standard fee is established for each DMEPOS item by state. Payment is calculated using either the fee schedule amount or the actual charge submitted on the claim, whichever is lower. The fee schedule allowances include the application of national floors and ceilings. Published fee schedule amount can be found on the CMS Web site at www.cms.gov .

Q34. How many portable contents are suppliers required to provide to a patient for a month?

Answer: Suppliers must provide whatever quantity of oxygen contents are needed for a patient's activities both inside and outside the home. A maximum of 3 months of oxygen contents may be delivered at any one time.

Q35. What is the supplier's responsibility to the oxygen patient if they travel or relocate? Is the supplier required to provide?

Answer: During months 1-36, if the beneficiary travels or relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), then for the remainder of the rental month for which it billed, the home supplier is required to provide the equipment and related items/service itself or make arrangements with a different supplier to provide the equipment, items and services. For subsequent rental months that the beneficiary is outside the service area, the home suppliers is encouraged to either provide the equipment and related items/services itself or assist the beneficiary in finding another supplier in the new location. The home supplier may not bill for or be reimbursed by Medicare if it not providing oxygen equipment or has not made arrangements with a different supplier to provide the equipment on the anniversary billing date. Medicare will pay only one supplier to provide oxygen during any one-rental month.

During months 37-60 if the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), the home supplier is required to either provide the equipment and related items/services itself or make arrangements with a different supplier to provide the equipment and related items/services. If the home supplier contracts with another supplier in the travel area, it is the home supplier's responsibility to bill for the oxygen and reimburse the temporary supplier.

Oxygen services furnished by an airline to a beneficiary are noncovered. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.

Medicare does not cover items or services provided/used outside the United States and its territories. The supplier is not required to provide or arrange for oxygen use in those situations.

Q36. If suppliers are billing for someone that has 6 LPM, billed at a higher rate with QF modifier and have now billed for 36 months and tried to bill for the portable contents and Medicare is denying, how can we bill for contents when

we did not bill for the portable during the 36 rental months because we billed the E1390 at the higher rate with the QF modifier?

Answer: If basic oxygen coverage criteria are met, a higher fee schedule allowance is paid for the stationary system, a separate allowance is not paid for portable oxygen equipment. However, after the 36-month cap portable liquid or gaseous contents are payable. When the beneficiary is using more than 4 liters per minute (LPM), and is using a portable oxygen system also, suppliers must submit narrative information (in the NTE segment of the electronic claim or item 19 of the paper claim,) stating the beneficiary is using the portable unit and include the HCPC of the item being used.

Q37. If a patient has a fire in their house and the oxygen equipment is destroyed, it's halfway through the billed month do we have to supply that patient with more equipment until the re-bill date?

Answer: Yes.

Q38. If a patient is with a supplier for 6 months then decides to go to another company, because they moved out of the area, do we have to take the patient back if he moves back to our area since we billed the first month?

Answer: If the patient moves away prior to month 36, another supplier may pick up the patient. However no new billing cycle is started. Payment resumes where it was discontinued. Whoever receives the month 36 payment is responsible for all oxygen needs for months 37-60.

Q39. If a patient qualified for oxygen under the state Medicaid guidelines and then became Medicare eligible, what testing must be completed in order to meet coverage criteria?

Answer: All Medicare requirements must be met.

Q40. Can a home health agency with an order for oxygen from the doctor complete the oxygen saturation to qualify patients for oxygen?

Answer: No. Home health agencies are not considered a qualified provider or a qualified laboratory for purposes of the Oxygen and Oxygen Equipment LCD . Testing must be done by a Medicare qualified provider (i.e., Part A provider, laboratory, independent diagnostic testing facility).

Q41. What tests need to be performed in order to qualify a patient for home oxygen?

Answer: The patient must have a qualifying blood gas study which includes both an oximetry test and an arterial blood gas test.

Q42. Does an overnight oximetry test need to be any certain length of time?

Answer: There is no specified minimum sleep time. The testing requirement requires a minimum of 5 minutes of qualifying values in order to meet the standard for coverage.

Q43. Is the Independent Diagnostic Testing Facility (IDTF) required to check oxygen saturation of the patient with oxygen after they have determined that the saturation is below 88% at room air?

Answer: No, this is not a requirement of the LCD.

Q44. The current LCD states that only those qualified to bill Medicare for the testing of oximetry levels may take the qualifying saturation levels. Would this statement exclude nursing home staff since they are billing part A for a per diem and therefore not able to bill individually for the test itself?

Answer: Yes. Nursing home staff is not considered a qualified provider or a qualified laboratory for purposes of the Oxygen and Oxygen Equipment LCD. Testing must be done by a Medicare qualified provider (i.e., Part A provider, laboratory, independent diagnostic testing facility).

Certificate of Medical Necessity Questions**Q45. Example: Initial CMN completed for stationary, 6 months later portable is ordered and a revised CMN is completed. 12 months from initial CMN, a recertification CMN is completed. Does a recertification CMN for portable need to be completed in 12 months from the date that the portable was started?**

Answer: No. Only a revised CMN would be used to add the portable, and there is no requirement to recertify a revised CMN.

Q46. If a patient is FFS then HMO and then back again to FFS, is a Break-In-Service or Break-In-Billing required on the CMN? Does the month count resume where it left off before the HMO period? Is a new CMN required?

Answer: Without a defined break in medical need, there is no new initial CMN or rental period. The month count would resume where it left off.

Q47. When a Doctor orders 4 LPM of oxygen per minute, does he have to list the patient's saturation level on 4 LPM on the CMN?

Answer: No. The oxygen LCD states that a higher allowance for a stationary system for a flow rate of GREATER than 4 liters per minute (LPM) will be paid only if a blood gas study is performed while the patient is on 4 LPM meets Group I or II criteria.

Q48. Why are the recertification CMN's not uploaded to the common working file? They always have to go through redeterminations. Software vendors state it's not them, Medicare states, it's not them... What is the issue?

Answer: There is no known issue with CMN's (initial or recert) incorrectly loading to the Medicare claims processing system. Specific examples should be discussed with the Customer Service department of the contractor in question.

Q49. How long does an Oxygen CMN last?

Answer : Most beneficiaries who require home oxygen therapy beyond a few months require it lifelong. Therefore, once a Form CMS -484 recertification establishes that the medical necessity continues. Subsequent recertifications are not routinely required.

Q50. Policy states no new CMN is required when a beneficiary switches from private insurance to Medicare coverage. However, if the only CMN on file with the private insurance is with testing from years back, Medicare denies.

Answer: When a beneficiary switches from non-Medicare insurance to Medicare a new initial CMN is needed. The initial date should be the date of Medicare eligibility if the patient has a Medicare qualifying test within 30 days before their eligibility. If they do not get the qualifying test until after they become Medicare eligible, then the initial date should be the date of the qualifying test.

Q51. When a patient switches to my company from another, do I need to get a CMN or just an order confirmation if I have a copy of the original CMN?

Answer: A revised CMN must be completed and kept in your files.

Q52. A patient receives oxygen for one month (Medicare pays rental) and then turns it in but needs it 6 months later. You have a new SAO2 but the same diagnosis. Do you get an initial CMN done and start billing with month 1 or a revised CMN and start billing with month 2 and ask for extended rental months in narrative explaining that O2 was picked up after 1st month?

Answer: This is a break in service greater than 60 days with no change in medical condition. Ask for the current CMN to be extended and start billing with month 2.

Q53. In an audit, is the CMN considered a detailed written order when section C is filled out properly?

Answer: Yes, the CMN can be considered a detailed written order, but the CMN is not a substitute for Medical records from the treating physician.

Q54 Will CMNs be a factor for pricing determination of claims for oxygen and oxygen equipment in the future? Will CMNs be required documentation for paper and electronic claim submissions for oxygen and oxygen equipment?

Answer: CMNs are currently required documentation for paper and electronic oxygen claims.

Documentation Questions

Q55. Is there a form provided that we can print out for the doctors to fill in that specifically addresses all the requirements? If so where can we find it?

Answer: There is no single form that can be used to meet all of the Medicare documentation requirements for an item. There is Oxygen and Oxygen Equipment Certificate of Medical Necessity attached to the LCD. However, the Certificate of Medical Necessity does not address all documentation and the CMNs answers must be backed up by a comprehensive medical record that supports the need for the item.

Q57. What documentation is required to start a new 36 month rental period after the patient has had the equipment for 5 years?

Answer: A new order, a new initial CMN, documentation supporting continued need for the oxygen equipment, and proof of delivery.

Q58. How extensive is the documentation needed, other than physician's notes, testing reports, hospital discharge reports, history and physical, etc? Would this be sufficient?

Answer: In the event of an audit there needs to be sufficient information in the medical record to demonstrate that all applicable reimbursement criteria are met. That information should be detailed and specific enough to clearly address the relevant issues.

Q59. Is something from the patient's medical record at the physician's office showing qualifying saturation levels sufficient to document medical necessity for oxygen, or is more required? Does it have to be signed by the doctor? We've been told that for any DME, the physician has to address the item being ordered, what other alternatives were considered and state why it is medically necessary. He/she must sign this entry in the medical record. Physicians simply do not and will not do this.

Answer: There are multiple requirements that must be documented in order to justify reimbursement. While many are listed in the LCD others come from NCD, CMS manuals, regulations and statutes. Suppliers must be knowledgeable about ALL applicable requirements and convey relevant information to their referral sources.

Q60. Clinical notes supporting medical need is basically CMN questions answered in narrative format on a physician progress note. Why are both

required if covered on the mandatory CMN? Supplier's beneficiary file must contain continued medical need documentation.

Answer: It is a common misperception that simply restating the CMN issues in the medical record will provide sufficient documentation to justify reimbursement. CMN questions sets often address only a few of the applicable coverage criteria related to a DMEPOS item. In the event of an audit, ALL applicable reimbursement criteria must be met and sufficient documentation demonstrating eligibility must be present in the record.

Q61. What is needed in the NTE segment field to report a pickup ticket from another supplier when replacing a patient's concentrator during the cap rental period?

Answer: Pickup ticket information does not need to be routinely reported in the NTE segment field during the cap rental period. If a new supplier is taking over for another supplier, having a pickup ticket available is recommended in the event of an appeal.

Q62. What is a provider to do if Medicare denies oxygen coverage due to lack of documentation but the doctor will not give them a discharge to pick up oxygen because he feels patient needs oxygen? We cannot just leave equipment there without coverage. Who is liable should anything happen to pt as a result of picking up oxygen without discharge?

Answer: Suppliers should have a thorough intake process to verify the patient meets Medicare coverage criteria before dispensing. Incorporating business practices to ask the ordering physician policy specific question and verifying coverage criteria are well documented in the patient's medical record, prior to dispensing the oxygen, is crucial. Liability issues should be discussed with a legal professional.

Q63. Most physicians do finger pulse testing which does not print out a report. Would documenting this result in the patient's medical record chart note be acceptable?

Answer: Yes. Finger pulse testing reported in the patient's medical record is acceptable.

Q64. When oxygen testing is obtained during exercise must there be documentation of additional testing?

Answer: Yes. In order for a beneficiary to qualify for oxygen based on exercise there must be documentation in the patient's medical record of three (3) tests taken during one session:

Testing at rest without oxygen

Testing during exercise without oxygen

Testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

Only the second qualifying test is reported on the Certificate of Medical Necessity.

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