

CIGNA

**Moderator: Ronja Roland
March 11 2009
1:00 pm CT**

Operator: Good day and welcome to the CIGNA Ask the Contractor conference. Today's call is being recorded.

At this time, I would like to turn the conference over to Ms. Ronja Roland. Please go ahead.

Ronja Roland: Good afternoon and welcome to the CIGNA Government Services "Ask the Contractor" teleconference for our DME MAC Jurisdiction C suppliers. I am Ronja Roland with Provider Outreach and Education.

I would like to thank you for participating in today's call. Your participation helps us to identify issues that are important to you so we may very meet your educational needs and help you to reduce claim submission errors.

During today's call, we will discuss Medicare update and available resources to assist in the submission of accurate claims.

Joining us today are additional representatives from our Provider Outreach and Education Department along with members of our Claims Operations Department.

Please keep in mind that we are not able to answer questions about individual claim issues. For specific claim issues, please contact our provider contact center at 866-270-4909. If you wish to check claim status, you may use our interactive voice response system at 866-238-9650. Our Web site is www.cignagovernmentservices.com. The pages for our tools and resources is located under the Jurisdiction C DME MAC section.

We do have several upcoming Medicare changes we want to share with you today.

Effective January 2009, a reduction of 9.5% in the fee schedule payment for items that were included in round one of the DMEPOS Competitive Bidding Program began. This reduction in the fee schedule will be applied to these items nationwide even if the beneficiary or supplier is not located in a competitive bid area. A full list of the HCPCS code impacted by the 9.5% reduction may be viewed in the Med Learn Matters article MM6270. All other items including non-competitively-bid items will receive a 5% increase in the 2009 fee schedule.

To differentiate reimbursement for those items that may be paid at either the 9.5% reduction or the 5% increase, one of two modifiers would be required. The KL modifier must be appended only to claims for diabetic testing supplies delivered to patients by shipping or mail service. And that is effective January 1, 2009. The addition of the KL modifier applies the 9.5% reduction. Omit the KL modifier if the diabetic supplies are provided at the store front or direct-delivered. An omission of the KL modifier also applies to the 5% increase.

There are accessories that may be added to both competitively as well as non-competitively-bid equipment based HCPCS code. The KE modifier identified as accessories appended to basic equipment codes that are excluded from competitive bids and will apply the 5% fee schedule increase to those items. Use of the KE modifier indicates the item billed is not part of competitive bidding; therefore, no 9.5% reduction will occur.

Adam Hasty with our Provider Outreach and Education Department will continue to provide more Medicare updates.

Adam Hasty: Good afternoon everyone.

Effective for dates of service on or after April 1 of 2009, the Durable Medical Equipment Medicare Administrative Contractors or DME MACs are instituting a billing and payment policy for common repairs based on standardized labor times. This applies to non-rented and out-of-warranty items. This effective date coincides with the effective date of the new code for repairs for non-oxygen equipment.

This is the K0739 which means repair or non-routine service for durable medical equipment other than oxygen requiring the skill of a technician labor component per 15 minutes. One unit of service will be 15 minutes.

Code E1340 is no longer valid for repairs for dates of services on or after April 1 of 2009. Units of service include basic troubleshooting and problem diagnosis. There is no separate Medicare payment for travel time or equipment pickup and/or delivery. Suppliers may only bill the allowable units of service listed for each repair regardless of the actual repair time.

Claims for repairs must include a narrative information explaining each repair and the time taken to complete each repair. Remember that Medicare does not pay for repairs to capped rental items during the rental period, nor is repair reimbursement allowed for the items under warranty.

For more detailed information and the items commonly repaired chart, please refer to the article titled "Repair Labor Billing and Payment Policy" dated February 26, 2009 under the Archived News section on the Jurisdiction C DME MAC homepage.

Effective April 6, 2009, the provider authentication requirements will change for all telephone and written inquiries including the IVR. Three data elements are required and must be validated with each telephone and written inquiry to all Medicare contractors. The three required elements are the NPI, PTAN and the last five digits of the tax identification number. Previously the effective date for this change was March 1, 2009; however, that has been changed to April 1, 2009. Further information about this change may be viewed in MLN Matters article MM6139. You may access this article at www.cms.hhs.gov.

The Reopenings Department would like to remind you to be sure to verify that all documentation requirements for all claims are included on the initial claim submission. We are seeing an increase of reopening requests for the addition of the KX modifier. Please assist us in lowering these errors by reviewing the local coverage determination documentation requirement section for all items you commonly provide. This will prevent unnecessary delays in your reimbursement and also assist us with reducing this workload so that we may improve our processing rates.

We would also like to remind you to remain compliant with all the supplier standards, but we would like to highlight supplier standard number two. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.

Invalid addresses on file with the NSC are causing an increase in administrative cost and a delay in supplier reimbursements. We must put a hold on all checks when the correct address is not on file with the NSC, so please update your information as soon as possible if it has changed.

Now let's turn our attention to the upcoming implementation of Zone Program Integrity Contractors or ZPICs. CMS is in the process of moving to Program Safeguard Contracts, PSC, to Zone Program Integrity Contracts or ZPIC. The ZPICs will handle Medicare parts A and B, DMEPOS, home health, hospice, Medi/Medi and Medicare parts C and D.

Two ZPIC contracts have been awarded, the first to Health Integrity LLC for Zone 4 which includes Texas, New Mexico, Colorado and Oklahoma, and the second to safeguard services for Zone 7 which includes Florida, Puerto Rico and the U.S. Virgin Islands. Zone 5 which includes the remaining Jurisdiction C states which – are West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas and Louisiana had not been awarded. Now zones, excuse me, 4 and 7, they started processing work on February 1, 2009, Zone 7 is still pending.

It is time again for the annual Medicare Contract Provider Satisfaction Survey or the MCPSS administered by Westat on behalf of CMS. Westat randomly selects suppliers to participate in this important survey. Your honest participation is critical to the success for the MCPSS project. Each contractor will receive detailed analysis of your confidential responses so we know where to focus education and improve processes.

We also use this information to see if the actions we put in place based on the previous year's survey had been successful. The MCPSS also gives you the opportunity to provide verbal comments on our performance. If you are contacted to participate in this survey, please take the time to participate and let us know how we are doing.

Now since our last general (Ask) call, there have been several changes regarding payment of oxygen equipment and supplies. And I will turn it over to (Mark Loney) with Provider Outreach and Education for an overview of these changes.

(Mark Loney): Good afternoon, everybody. Let's start talking first about some of the changes that happened during the 36-month rental period.

The rental covers equipment, contents, maintenance and supplies and accessories such as tubing in our mouthpiece and other services necessary for furnishing oxygen and oxygen equipment. Suppliers are prevented from switching oxygen equipment modalities during the 36-month period with the following two exceptions: the physician orders different equipment based on medical necessity or the beneficiary chooses new technology and signs an Advanced Beneficiary Notice of Non-Coverage or an ABN, acknowledging the potential financial liability.

Suppliers retain ownership of the oxygen equipment following the 36-month rental cap. If the beneficiary relocates outside the service – I'm sorry, the supplier's service area before 36 rental months are paid, the beneficiary and the supplier should work together to find another oxygen supplier in the new area.

Let's move now to what changed after the 36-month cap is complete.

Supplier who furnished the oxygen equipment during the 36-month period is responsible for continuing to furnish equipment, supplies and accessories for any period of medical need for the remainder of the reasonable useful lifetime of the equipment which is five years. It includes the use of equipment following temporary breaks of in-home oxygen services, for example, a hospital or SNF stay of any duration.

Supplier who furnished the liquid or gaseous oxygen equipment during 36 months rental period is responsible for furnishing the oxygen contents used with the supplier-owned equipment for any period of medical necessity following a 36-month cap for the remainder of the useful lifetime of the equipment. In this situation, Medicare will pay for oxygen contents for the gaseous or liquid oxygen equipments.

Suppliers should continue to use HCPCS code EO441 through EO444 to bill oxygen contents.

Medicare can pay for a general maintenance and servicing visit for concentrators or transfilling equipment which must take place six months after the end of the 36-month rental period. Other than this general maintenance and servicing payment, payment is not allowed for any repair or maintenance and servicing of supplier-owned oxygen equipment including any replacement part furnished as part of any repair or maintenance and servicing of the equipment.

Supplier is responsible for furnishing all of the same items and services after the six-month rental period as they furnished during the rental period. With the exception of oxygen contents and general maintenance and servicing, the supplier must furnish these items and services without billing the beneficiary or Medicare.

Payment is not allowed for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

Let's move now to the replacement of oxygen equipment.

If oxygen equipment is replaced because the equipment has been in continuous use by the patient before the equipment's reasonable useful lifetime or is lost, stolen or irreparably damaged, the patient may elect to obtain a new piece of equipment. In these situations, a new 36-month rental period and new reasonable useful lifetime is started on the date that the new replacement item is furnished.

Claims for the replacement of oxygen equipment for the first month of use only are billed using the HCPCS code for the new equipment and the RA modifier. And that's valid for date of service on or after January 1, 2009.

Suppliers must include on the claim for the first month of use a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in

the supplier's file. A new certificate of medical necessity or CMN is required in these situations. New testing, however, is not required unless it is necessary in order to meet existing medical review guidelines for oxygen and oxygen equipment.

Contractors should continue to follow the existing guidelines for requiring recertification CMNs for all situations in which oxygen equipment is being replaced. The most recent qualifying value and testing date should be entered on the CMN and order is also required when replacing equipment.

A couple of points talking about a change in the oxygen equipment during the reasonable useful lifetime period – the reasonable useful lifetime for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the beneficiary and continues until the point at which the stationary or portable oxygen equipment has been used by the beneficiary on a continuous basis for five years. Computation of the reasonable useful lifetime is not based on the age of the equipment. If there was a change in oxygen equipment modalities prior to the end of the reasonable useful lifetime period, this does not result in the start of a new reasonable useful lifetime period or new 36-month payment period.

In addition, if oxygen equipment that is not functioning properly has to be replaced prior to the end of the reasonable useful lifetime period, this does not result in the start of a new reasonable useful lifetime period or a new 36-month payment period.

Some points now about what happens during the continuous use of the oxygen and equipment.

For breaks in medical need (when a beneficiary no longer needs or uses the equipment) of less than 60 days plus the days remaining in the last paid rental month, the period of continuous use does not start over; instead the count of continuous months picks up where it left off before the break. If there was a break in need more than 60 days plus the days remaining in the last paid rental month and the need for the equipment resumes at a later date, a new period of continuous

use, a new 36-month payment period and a new reasonable lifetime period would begin provided that the supplier submits new medical necessity documentation and a narrative explaining why there was a break in need for the equipment, and the contractor determines that there was a break in need of greater than 60 days plus the days remaining in the last paid rental month followed by a resumption in medical necessity for the oxygen equipment.

Contractors will require a new medical necessity documentation, a new CMN and retesting for oxygen and oxygen equipment and portable oxygen equipment whenever there's an interruption in medical need that is greater than 60 days plus the days remaining in the last paid months. In this situation, the supplier must submit a narrative explanation describing the reason for the interruption which shows that medical necessity in the prior episode ended.

And lastly, on oxygen, let's talk about the proof of delivery requirements.

Following the stationary oxygen equipment payment cap or 36 months, suppliers should bill for oxygen contents on the anniversary date of the oxygen equipment billing. For example, if the 36 months of continuous use of the stationary oxygen equipment begins on March 11 and ends on April 10, the supplier should begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11. For subsequent months, the supplier does not need to deliver the oxygen content every month in order to continue billing for the contents on a monthly basis.

A maximum of three months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the date of service, anniversary date on the claim; however, in order to bill for content for a specific month, the supplier must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim.

Suppliers should have proof of delivery for each actual delivery of oxygen, but as discussed above, this may be less than monthly. Additional resources for the oxygen payment rules are available on our Web site at www.cignagovernmentservices.com or the CMS Web site at www.cms.hhs.gov.

I'll turn it back to Ronja Roland now for the conclusion of the narrative.

Ronja Roland: Thank you, (Mark).

As a reminder, CIGNA Government Services Provider Contact Center is closed every Thursday from 8:30 to 10:30 am to provide additional training for our customer service representatives to ensure the most accurate and consistent service to our Jurisdiction C supplier community. We would like to remind suppliers to always utilize our IVR for claim and redetermination status as well as to check CMN status for equipment on file. Please do not refer beneficiaries to the Jurisdiction C Provider Contact Center for inquiries. Always refer beneficiaries to the 1800 Medicare beneficiary contact center for assistance.

The CIGNA Government Services Provider Outreach and Education Team has been busy scheduling our education and outreach activities for 2009. We are pleased to announce that the frequency and capacity of our education activities have increased significantly, so more of you will have access to contractor education in various cities throughout Jurisdiction C.

We are hearing from you that it is difficult to attend some of our workshops due to the economy. We would like to hear from you ways that we can make this easier for you. We welcome your comments today during our question-and-answer period or you may send your comments through our online inquiry form that is available on our Web site.

We would also like to remind you that there is a series of video instructions featuring our Jurisdiction C medical director, Dr. Robert Hoover. This video instruction called "Medicare Minute" is now available for PAP and blood glucose monitors. "Medicare Minute" is located under the Education section of our CIGNA Government Services Web site.

This concludes the update portion of today's call. We will now open the lines for your questions. Please keep in mind that we are not able to answer questions about individual claims issues. Again if you have specific issues, please contact our provider contact center at 866-270-4909. To check claim status, call the IVR system at 866-238-9650.

Operator, we will now take our first call.

Operator: Thank you. To ask a question, please press star 1 on your telephone keypad at this time. A voice prompt on your phone line will indicate when your line is open to ask a question. Please state your name before posing your question. Once again, press star 1 to ask a question. And we'll pause for just a moment.

We'll take our first question. Caller, your line is open. Please go ahead.

(Connie): Hi, this is Connie at General Hospital. I have a question with regards to how to bill or document the replacement of a non-oxygen useful lifetime item that is past the useful lifetime of the rental month such as I have someone that has CPAP equipment back from '01 and they chose to be on the maintenance schedule. They are on a maintenance schedule. I've been you know billing that biannually maintenance, but the useful life is well past the five years. Can I replace it and how do I bill that, if I can replace it and start a new rental period over?

Ronja Roland: OK. Thank you, (Connie), for your question on replacement.

You can, if the beneficiary elects new equipment, since the useful lifetime has passed, that equipment can be provided again if the beneficiary elects. And what you – of course you would have proof of delivery documentation if new equipment has been provided to that beneficiary. You also want to make sure they are still meeting Medicare coverage guidelines if that equipment is provided.

(Connie): That coverage though, the CPAPs have changed. Will they be grandfathered in at the coverage back in '01 or do I need to start the new style of documentation and do they need a new sleep study and stuff like the original?

Ronja Roland: There are actually instructions in the LCD for that that cover if the patient was previously on the equipment.

(Connie): Actually I couldn't find it and I called in and they said I had to write them to get the answer. I was hoping you would know more on that information.

Ronja Roland: OK. Bear with us just a moment; we'll have to locate the LCD very quickly. Hold on just a second.

(Connie): Yes.

Ronja Roland: OK. There is also – this question is also addressed in the – there are actually I believe three sets of FAQs for the PAP policy.

(Connie): OK.

Ronja Roland: (Flyer) FAQs, I believe it's question 13, and it talks about, if a patient comes or has had the equipment prior to the change in the policy.

(Connie): OK.

Ronja Roland: And you can also refer back to – it was effective or published in November of 2008. They would again need to make sure they meet the current coverage guidelines. However, the face to face would not have to be prior to providing that equipment.

(Connie): OK. Would I use that RA modifier like they do on the oxygen for the five years?

Ronja Roland: Yes, you would need to put the RA modifier on the first month claim only.

(Connie): OK. OK.

Ronja Roland: And just make sure you include the narrative that states that it is you know the continuous – the reasonable useful lifetime has been met.

(Connie): Thank you very much.

Ronja Roland: Thank you, (Connie).

Operator: We'll take our next question. Caller, your line is open.

(Paula): Hello?

Ronja Roland: Go ahead with your question.

(Paula): Hi, this is (Paula). My question is concerning portable oxygen after the 60 months. If the patient chooses to get new concentrator and new portable – the 60 months useful lifetime, we can then start over with the 36 months on the stationary and portable systems?

Ronja Roland: That is correct. If the beneficiary does elect to (pay a) new equipment, then, yes, you can begin to bill for both pieces of equipment and it will start a new 36 months cap period.

(Paula): OK.

Ronja Roland: OK.

(Paula): But if they only elect to get a new concentrator, then we no longer get paid for contents on the portable?

Male: Correct.

Ronja Roland: Correct.

(Paula): OK. So, but they can elect to get the new portable equipment, we get a whole new 36 months.

Ronja Roland: Yes.

(Paula): OK, that's what we wanted to know.

Ronja Roland: OK, thank you.

(Paula): All right.

Operator: We'll take our next question. Caller, your line is open.

(Dan): Hi, this is (Dan).

Ronja Roland: Hi, (Dan); go ahead with your question.

(Dan): Earlier, the gentleman speaking about oxygen mentioned the same items and services provided before the 36 months should be provided after the 36 months except contents which could be built on portable. And I missed the last part of what he said. Was it maintenance and service on the concentrator?

Ronja Roland: Yes, it is; maintenance and service on the concentrator.

Male: Transfilling ...

(Dan): OK. But everything else would be included with the service ...

Ronja Roland: Yes.

(Dan): ... as before, right?

Ronja Roland: That is correct, (Dan).

(Dan): OK, great. Thank you.

Ronja Roland: Thank you, (Dan).

Operator: Once again, you can press star 1 to ask a question. We'll move on to our next question.

Caller, please go ahead. Caller, your line is open. Please check your mute function.

(Selena): This is (Selena) in Texas and I have a question about the repair labor billing and payment policy.

Ronja Roland: Go ahead, (Selena).

(Selena): OK. In the documentation that was rolled out, it indicates that suppliers are also reminded that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty. So it appears as if this is only for out-of-warranty items that are repaired. But what it doesn't really explain, we bill for the labor for items under repair, we just don't bill for the part itself because it's the part that's under warranty, not the labor. So would we use the chart only for items that we're repairing out of warranty and still bill the full unit of labor for items that are in warranty?

Female: (It) actually indicates on there that the labor is not included in the warranty because some manufacturers do cover labor and warranty of those defective parts. So you would have in your narrative, indicate that particular item does not include warranty, that does not include labor under the warranty.

(Selena): OK. So that would be on the labor narrative that we'd include?

Female: Yes.

(Selena): OK. Thank you.

Ronja Roland: Thank you, (Selena).

Operator: There are no further questions at this time. However, I would like to remind the audience, if you would like to ask a question, you can press star 1.

And we do have another question. Caller, your line is open.

(Charlene): This is (Charlene). I just want to make sure I'm clear as to what you were saying about the repairs. Are you there?

Ronja Roland: Yes, we are, go ahead.

(Charlene): OK. If I guess the equipment is out of warranty, then you will – Medicare will cover for the – any labor or services?

Ronja Roland: That is correct. Once it is past warranty, the supplier may bill Medicare for either the items being repaired or – repair as well as the labor.

(Charlene): OK.

Ronja Roland: What the previous question was dealing with is the labor is not covered under warranty.

(Charlene): Oh. OK, OK. OK. And then I know we talked about the codes to you for the repairs ...

Ronja Roland: Yes.

(Charlene): ... the K0739 we don't – that's the new one, never going to use effective ...

Ronja Roland: That will be effective April 1. And also remember that that is only – we will only pay for the repairs on beneficiary-owned equipment.

(Charlene): OK, repairs on beneficiary – OK. And then the E1340, we won't use that one anymore.

Male: Right.

Ronja Roland: Correct.

(Charlene): OK, all right. And I was just ((inaudible)) I just jotted down some questions.

Ronja Roland: That's OK.

(Charlene): And then the oxygen, you said, OK, if a patient elects to get the new portable equipment, then it starts another 36 months?

Ronja Roland: I apologize, could you repeat that for me?

(Charlene): If a patient, they elect to get the new portable equipment ...

Ronja Roland: Yes, after the ...

(Charlene): ... then they start another 36 months?

Ronja Roland: After the either reasonable useful lifetime has been met or ...

(Charlene): OK.

Ronja Roland: ... lost, stolen or irreparably damaged.

(Charlene): OK, that's understandable. OK, I see what you're saying. And then on the reduction on the fee schedule, so a list of HCPCS codes that's going to be coming out, will that come to everyone or we'd be updated with that or ...

Ronja Roland: I just want to make a quick reminder and then I'm going to ask you to ask your question one more time.

(Charlene): OK.

Ronja Roland: With the five years, it has to be five years continuous years. That's the thing to remember. It has to be five years continuous years.

(Charlene): On the – on what?

Ronja Roland: The oxygen equipment.

(Charlene): OK.

Ronja Roland: And then your last question?

(Charlene): What the HCPCS codes.

Ronja Roland: For the oxygen?

(Charlene): Yes. Or, I mean, what you said at first, in the beginning of the call about the reduction in the fee schedule ...

Ronja Roland: Yes. Oh, the reduction in the fee schedule, either it will be a 9.5% reduction on some – it's going to apply to all codes. There are some oxygen codes excluded from the 9.5% reduction and these items (i.e., oxygen contents and transfilling equipment) have a 0% change in the 2009 fee schedule.

(Charlene): Just on some codes, OK.

Ronja Roland: ... but we do reference Med Learn Matters article 6270. And it details which codes will be affected by that.

(Charlene): OK, OK. OK, well, that's all I needed.

Ronja Roland: Thank you, (Charlene).

(Charlene): Thanks.

Operator: We'll move on to our next question. Caller, your line is open.

Female: OK, back to the oxygen equipment, whenever it goes to maintenance, then we can start billing maintenance after June of this year. For the stationary concentrator, we're going to bill an E1390 with the MS modifier?

Ronja Roland: That is correct.

Female: OK. And what are we going to be paid for that?

Ronja Roland: I don't have that handy. You can access that on the Web site, the fee schedule on the Web site. It will be located under the Coverage and Pricing link on the DME MAC homepage.

Female: OK. Is it going to be like a normal rental month like it is on the other items, the other cap rental items like when a ((inaudible)) and we bill maintenance on it every six months, we get one month of rental?

Ronja Roland: Just a moment. We are checking so just bear with us for just a moment. But we did limit – the reimbursement for the maintenance on that concentrator will be twice the labor fee and we're actually going to pull the actual pricing on that code.

We do want to remind you too that for the maintenance and service, it actually has to be performed. You have to go out and service that equipment before that is billed.

Female: Yes. Now we'll get to bill maintenance on the portable and the stationary?

Ronja Roland: No.

Female: No, just the stationary.

Ronja Roland: The – I mean, excuse me, the maintenance is only the concentrator and you can bill for content on the portable equipment.

Female: OK. What about the liquid stationary?

Ronja Roland: Just a second.

Female: The liquid stationary you can also bill contents on.

Female: OK.

Female: It's just your concentrator E1390, the K0738 ...

Female: E1392.

Female: ... and 1392 are the only ones that you can bill maintenance and service for.

Female: OK. And they can reimburse the labor rate.

Female: Right.

Ronja Roland: Yes.

Female: OK. Now, is it a one-time deal or is this going to continue every six months?

Ronja Roland: Right now we don't have any instructions past 2009.

Female: OK. All right, thank you.

Ronja Roland: Thank you.

Operator: We'll take our next question. Caller, your line is open.

(Selena): Hi, this is (Selena) in Texas.

Ronja Roland: Hi, (Selena).

(Selena): So I have another question. The anti-tipping device is there specifically listed under the manual wheelchairs for the repair labor billing and payment policy. It's not listed under the power wheelchairs, however. So do we not have a cap for the allowed unit for anti-tipping devices?

Ronja Roland: Are you – I'm sorry, were you referring to the repair charge that ...

(Selena): Yes.

Ronja Roland: ... the article ...

(Selena): Yes, the repair labor billing and payment policy.

Ronja Roland: OK. Give me just a moment.

(Selena): OK.

Male: Billing article.

Ronja Roland: (Selena), the article is just – it doesn't include all of the items; it was just kind of the top items that are repaired. But, yes, it can be done on a manual wheelchair, so that list is not necessarily all inclusive. It is just kind of an overview of the top items that are billed.

(Selena): I'm sorry, I don't understand that. So there's more items that we're going to have a cap on labor ...

Robert Hoover: No ...

(Selena): ... that aren't listed here?

Robert Hoover: ... this is Dr. Hoover. What we started with was kind of the top ten or 12, or they may actually be 14 in that list, of items that are common – that are common repairs that we set a flat labor rate on. If it's not included in that table, then you know your other labor rate – there's not a set labor rate for that.

(Selena): OK. So if ...

Robert Hoover: But if you had to repair an anti-tipper on, I think we had manual wheelchairs in that article, if I'm not mistaken.

(Selena): Yes. So if I'm replacing a power wheelchair anti-tipping device, I can bill the appropriate labor unit?

Robert Hoover: You would bill – you would bill whatever labor units that were necessary for the repair of that item.

(Selena): OK.

Robert Hoover: You know we may expand that list in the future as we do more research and get you know a larger list of things, but we started with that first group that is the most commonly submitted repairs.

(Selena): OK. So the allowed units of service – oh, I guess that's another question, I'm sorry. Should I ask it now or should I get back in line?

Robert Hoover: You can ask it.

Ronja Roland: Go ahead with your question.

(Selena): The allowed units of service, was that based on the average billing of the suppliers? Because, for example, the drive wheel motors for a single replacement motor, you're allowing two units of labor. But for two, you're allowing three units of labor. So the math kind of doesn't add up. You'd think that it would be two units of labor for one or four units of labor for two.

So in some instances, suppliers have the opportunity to really spend more time with the customer and get reimbursed less because we have that cap in place. So I'm curious how we got the allowed units of service.

Robert Hoover: The allowed units of service were developed – and there are multiple documents out there that have been developed by various groups in the industry, I know Med Group has a flat rate labor book that their members use, and also the experience of the medical directors looking at repairs, the types of repairs that are submitted to us.

As far as you know two for one motor versus three for the second motor, if you look at some of the work that goes into repairing a single motor, you have – you often have to remove the seeding system to get to that. Well, if you're going to remove the seeding system to get to the motors you know the bulk of the time is – will be spent doing that and then you get to the one motor just as easily as you get to the second motor. So the – adding only you know not doubling the units of services, taking into account some work that you would have already done, whether you're having to get the one motor or both motors.

(Selena): Thank you.

Ronja Roland: And I do want to go back very quickly and talk about the billing for maintenance on the oxygen concentrators, just want to follow up with that as far as the payment and reimbursement.

Just remember that payment will be made every six months beginning six months after the 36-month rental cap. And that can be as early as July 1, 2009 in some cases. The allowed payment for each visit is equal to the 2009 fee schedule amount for codes E1340, which we mentioned will change to K0739 multiplied times two, and that is based on the state in which the in-home visit takes place.

And also to let everyone know on today's call, the minutes from today's call will be posted to the Web site within the coming week.

Operator, we can go ahead with the next question if there is one.

Operator: Sure. We'll take our next question. Caller, your line is open.

(Tristan): Yes, my name is (Tristan). I just want to get some clarification on a couple of things. Hello?

Ronja Roland: Go ahead with your question.

(Tristan): Yes, my name is (Tristan). I just want to get a clarification on a couple of things.

First of all, you said that after the 60 months is over with the portable, if the patient elects, they can get new equipment. But my question is, is if they don't elect, are you saying that you can no longer get paid for the contents if the contents are still being delivered?

Ronja Roland: Yes. If the beneficiary chooses not to obtain the equipment, you can still get paid for the content.

(Tristan): OK, OK. And then my next question is, in reference to the maintenance of the concentrators, you're saying that you can begin payment six months after the cap out has been complete after 36 months and you have to go do it, I understand that as much too. But is it mandatory?

Ronja Roland: Yes, it is.

(Tristan): It is mandatory.

Ronja Roland: Yes.

(Tristan): OK, that is what I needed to know.

Ronja Roland: Thank you, (Tristan).

(Tristan): Thank you.

Operator: We'll move on to our next question. Caller, your line is open.

(Dan): Hi, this is (Dan).

Ronja Roland: Hi, (Dan).

(Dan): I have a question about content for portable. I wanted some clarification concerning the anniversary date and billing monthly after the 36 months cap. Does it occur on a monthly basis? Does it have to be recurring on the anniversary date on a monthly basis or can that fluctuate after the first month?

Ronja Roland: It should not – it should be on the anniversary billing.

(Dan): Yes.

Ronja Roland: The only exception would be in the event of say the patient went into a facility and then maybe once they're discharged, that may change your billing date.

(Dan): Yes.

Ronja Roland: But other than that, it should be the same billing date, the anniversary date.

(Dan): So we could have – we could set up the patient with the refills for the first month but come the second month, they may – their needs may change, they may require more than one delivery. Is it possible to bill that one unit and have several deliveries within a month?

Ronja Roland: Yes. And that could be the case. Like you said, at that point, that may affect your billing date. If there are no changes, then it should be the monthly date. But like I said, there are going to be circumstances where you may have to deliver at a later date, the beneficiary may be finding that need on that anniversary date and you have to deliver it at a later date. And at that point, that could change your billing date.

(Dan): So the anniversary date is kind of the target date, the (tickler) date, if you will ...

Ronja Roland: Yes.

(Dan): ... for resupplying that patient. That could be – that could move forward if they don't need the service at that time.

Ronja Roland: Yes, it could.

(Dan): I see. OK. All right. Thank you.

Ronja Roland: Thank you, (Dan).

Operator: We'll take our next question. Caller, your line is open.

(Selena): Hi, this is (Selena) in Texas and I once again have a question about the repair labor billing and payment policy. The units that are listed in there, is that a standard or is that a max? In other words, do we bill with the labor units up to the maximum or would we bill the specified amount even if it was less time spent on the repair?

Robert Hoover: That is the maximum that is allowed for those repairs.

(Selena): OK. Excellent. So we would, if we billed, for example, if it's one unit to replace batteries, we would bill the one unit, not the two.

Robert Hoover: You have the option of billing two. If you would like to bill one, you can one, but the most we will pay is two.

(Selena): So if we spent 12 minutes replacing batteries, it would – we could bill two?

Robert Hoover: Correct.

(Selena): OK. Thank you.

Ronja Roland: Thank you, (Selena).

Operator: It appears we have no further questions.

Ronja Roland: OK. Well, I think at that point, since we have no additional questions, we do thank everyone for participating again. The question and the – excuse me, the transcript and minutes from today's call will be posted on the Web site in the following weeks. We thank you again. And have a great day.

Operator: Once again that does conclude today's conference call. Thank you for joining us and have a wonderful day.

END