

## **CIGNA**

**Moderator: Dante Thomas  
December 10, 2008  
1:00 p.m. CT**

Operator: Good day everyone and welcome to the CIGNA Government Services General Ask-the-Contractor teleconference. As a reminder, today's call is being recorded.

It is now my pleasure to turn the conference over to Dante Thomas for opening remarks and introduction. Please go ahead.

Dante Thomas: Thank you, Necole. Good afternoon and welcome again to the CIGNA Government Services Ask-The-Contractor teleconference for DME MAC Jurisdiction C. I am Dante Thomas with the Provider Outreach and Education team. 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 that we may better meet your educational needs and also help you to reduce claim submission errors.

During today's call, we will discuss Medicare updates and available resources to assist in the submission of accurate claims. Joining us today are Ronja Roland, Taveo Perry, James Herren and Max Garner from our provider outreach and education department, along with members of our claims operations department.

Please keep in mind that we're able to answer questions about individual claim issues. If you have specific claim issues, please contact our provider contact center at 1-866-270-4909. To

check claim status, you should use our interactive voice response or IVR system at 1-866-238-9650.

We have several upcoming Medicare changes that we would like to share with you today. Beginning March 1, 2009, the provider authentication requirements will change for all telephone and written inquiries including the IVR. Three data elements will be required and must be validated with each telephone and written inquiry to all Medicare contractors.

The three required elements will be the NPI or National Provider Identifiers, PTAN or Provider Telephone Access Number and the last five digits of the text identification number. Further information about this change may be viewed in MLN matters article MM6139.

In collaboration with all other DME MAC jurisdictions, CIGNA Government Services was pleased to be the first to host an Oxygen Ask-The-Contractor teleconference in coordination with the other DME MACs and CMS this past Monday, December 8. Our guest speaker on the call was Joel Kaiser, Deputy Director DMEPOS Division with the CMS Regional Office in Baltimore, Maryland.

If you were unable to join us for the live call, we will have a recording available on our Web site at [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com) on Monday, December 15. This was a very informative call and we thank Mr. Kaiser for answering questions related to oxygen changes.

CIGNA Government Services is still awaiting additional instructions from CMS regarding the processing of oxygen contents and maintenance claims for patients whose equipment has capped. We will publish the finalized instructions as well as oxygen frequently asked questions in our DME MAC insider publication on our Web site and via our listserv as soon as we receive them from CMS.

The positive airway pressure local coverage determination was recently updated to match the changes outlined in the National Coverage Determination or NCD. The NCD changes added the requirement of a pre-evaluation by the trading physician and approve the usage of home sleep studies to qualify patients for PAP and RAD devices for Obstructive Sleep Apnea.

The National Coverage Determination coverage was in effect from March 13, 2008 through October 31, 2008. The new PAP Local Coverage Determination or LCD changes went into effect as of November 1, 2008. Patients will be required to meet the criteria in effect at the time they receive the equipment.

For those patients who received equipment before Medicare coverage went into effect and only require accessories, they must meet the criteria in effect at the time that they became Medicare eligible.

For further details on the updated Local Coverage Determination, please access the PAP LCD through our Web site at [www.cignagovernmentservices.com](http://www.cignagovernmentservices.com).

The CIGNA Government Services Medical Review Department would like to remind that documentation checklist for many frequently prescribed items are now available in the Medical Review section of our Web site. These checklists guide you in obtaining all necessary documentation to ensure that the medical necessity criteria is meet and properly documented in the event of a CERT or Comprehensive Error Rate Testing or other audit.

Currently, checklists are available for the following policies; Enteral nutrition, groups one and two pressure services, large and small volume nebulizers and inhalation drugs, manual wheelchair bases, power-operated vehicles and glucose monitors and supplies. Additional checklists will be added monthly.

Medical Review is initiating a prepayment review of randomly selected claims for glucose test strips and lancets for non-insulin treated patients receiving quantities of supplies that exceed utilization guidelines as defined in the Glucose Monitors LCD. If you receive a development letter for this reason, please include all 6 of the following items:

- 1) A detailed written order, remember that PRN will result in claims denying as not medically necessary;
- 2) Medical documentation from the doctor supporting the need for the frequency of testing ordered;
- 3) Proof that the testing is being done;
- 4) Proof of patient's request for refill;
- 5) Itemized proof of delivery; and
- 6) Proof of patient/caregiver education and competence.

Please visit the Medical Review section of our Web site for information on Blood Glucose Monitors Prepayment Edit Resources and additional instruction; this is a new section on our Web site.

I will now turn the call over to James Herren with our provider outreach and education team who'll provide information concerning the upcoming 2009 C schedule changes.

James Herren: Hey, thank you, Dante. All right. In 2009, Medicare will apply a reduction of 9.5% in the fee schedule payments for items that were included in round one of the competitive bidding programs. This reduction in fee schedule will be applied to these items nationwide even if the beneficiary or supplier is not located in a competitive bid area or a CBA.

For a full list of HCPCS codes that will be impacted by the 9.5% reduction, you can view Medlearn matters article MM6270 all other items, those that were not known competitively bid items or – let me say that again. All other items, non-competitively-bid items that is, 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 will be required and that is either the KL modifier or the KE modifier.

The KL modifier must be appended to the claims for diabetic testing supplies delivered to patients through a shipping or mail service and this is effective January 1, 2009. Now addition of the KL modifier applies to the 9.5% reduction. Omit the KL modifier if the diabetic supplies are provided at the store front or are direct-delivered, that is not using a shipping services. Omission of the KL modifier applies the 5% increase.

The KE modifier identifies items (accessories-only) that are not included in the competitive bidding and those that apply to the 5% increase fee schedule. There are accessories that may be added to base codes that are competitively-bid as well as base equipment that is not competitively-bid. The KE modifier differentiates between the items that are included in the competitive bid and those items that are excluded from the competitive bid. So make sure you are aware of the use of the KE modifier.

Also moving on to something else: CMS is in the process of moving the PSCs or the program safeguard contractors to zone program integrity contracts or ZPIC, another acronym for you to learn. Two ZPIC contracts have been awarded. The first is awarded to Health Integrity LLC for zone four. Zone four includes jurisdiction C state Texas, New Mexico, Colorado and Oklahoma. Again, that's Zone four Texas, New Mexico, Colorado and Oklahoma.

The second of the awards went to Safeguard Services for Zone seven. Zone seven includes jurisdiction C state Florida as well as Puerto Rico and the U.S. Virgin Islands.

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

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

Now, I will turn this call over to Taveo Perry, also with provider outreach and education, and he's going to cover updates about upcoming education activities and important customer services updates. Taveo.

Taveo Perry: Thank you, James. 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 2009 education activities will increase significantly; so more of you will have access to contractor education in various cities throughout jurisdiction C.

Our 2009 offerings include expanding on audio and video training courses, webinars and our interactive online education modules. In November, we launched a new series of video instructions featuring our Jurisdiction C Medical Director, Dr. Robert Hoover. The new video instruction is called the Medicare Minute and it is exactly as titled, a short video instruction lasting only few minutes featuring guidance on a variety of subjects. The current instruction guides you to the recent positive airway pressure or PAP policy, Medicare Minute is located on the education section of our CIGNA government Web site.

As a reminder, the CIGNA Government Service Provider Contact Center is closed every Thursday from 8:30 am – 10:30 am to provide additional training for our CSRs to ensure the most accurate and consistent service to you.

We would like to remind you to always utilize our IVR for claim and redetermination status as well as 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 1-800-MEDICARE.

Beneficiaries should contact that center for assistance. Dante Thomas will provide instructions for the question and answer session at this point.

Dante Thomas: Thank you, Taveo and James. This actually concludes the update portion of today's call.

We will now prepare the lines for your questions. But please keep in mind that we are not able to answer questions about individual claim issues. If you have specific claim inquiries, please contact our provider contact center at 1-866-270-4909. And if you would like to check the status of a claim or (same or) similar equipment on file for beneficiary, you may call the interactive voice response or IVR system at 1-866-238-9650.

And Necole, we are now ready to take questions.

Operator: Certainly. The question and answer session will be conducted electronically. 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. If you find your questions have all ready been answered, you may remove yourself from queue by pressing star 2. Once again if you'd like to ask a question, please press star 1.

And we'll take our first question. Your line is now open.

(PJ): I'd like some clarification on the KE modifier. We have a business that does business outside of a competitive bid area but we also have some warehouses and stores in the competitive bid area.

Dante Thomas: OK, thank you for your question. And also let me mention this before I forget, when you come on the line to ask your question, if you could please also give us your name. I'm sorry what was your name, ma'am?

(PJ): I'm sorry. This is (PJ) from Asheville.

Dante Thomas: Thank you, (PJ). Actually with the KE modifier, the way that the fee schedule will be applied is actually applied across the nation. So, regardless of whether you're in a competitive bid area or not, if you are providing items that may be used with both competitive bid items and not competitive bid items. For instance some accessories for instance for power wheelchair, for instance, you may use that accessory on a power wheelchair or may also be used on a non-power wheelchair or regular manual wheelchair.

Well, regular manual wheelchairs are not competitive bid, but power wheelchairs are. So, if you're providing that item that can be used on both, to let us know what type of equipment you are applying that accessory to. The KE modifier lets us know whether or not it is being used with a competitively bid item. Does that help?

(PJ): So, it doesn't matter if you were not in that zone. It's just whether or not it was an item on the competitive bid list.

Dante Thomas: Exactly. That is correct.

(PJ): Thank you.

Dante Thomas: Thank you.

Operator: We'll take the next question.

Dante Thomas: Go ahead with your question and check to make sure that your phone is not on mute.

(Stephanie): Hello?

Dante Thomas: Hello?

(Stephanie): Hi, yes. This is (Stephanie) from Georgia. We have a question regarding C-PAP supplies.

Recently, we've been able to bill for the A7034 with the A7032 and the A7033. But recently we've been getting denials and recoupments on this. Can you explain why?

Dante Thomas: OK. So this is a patient who owns their PAP equipment or you're just providing supplies?

(Stephanie): We're billing for the initial setup with the C-PAP and we're billing for the A7034, the A7032 and A7033. And they're stating that you cannot bill for the A7034 with the A7032 and A7033.

Dante Thomas: And I'm sorry. Could you tell me – I don't have the definitions of those codes in front of me currently. Could you give me what each of these are? I know they're accessories but what is the 34, the 32 and the 33 again?

(Stephanie): It's for the – gee. I don't even remember ...

Female: The cushions and the pillows.

Dante Thomas: Cushions and pillows?

(Stephanie): Yes, and it's the replacement cushion and the interface. The replacement supplies.

Dante Thomas: OK. Actually we did have some claims that were previously denying for that purpose.

We're no longer doing that. So if you're still experiencing that or if you have claims that are unresolved that denied for that purpose, please contact our customer contact center with those examples and they will be able to research them and get them corrected for you.

(Stephanie): OK, we tried to do that and they told us that you cannot bill for replacement supplies with the actual supply itself. They're saying it has to be billed on a different day. You cannot bill them on the same day.

Dante Thomas: OK, I'm sorry, ma'am. Actually with this one, if you've all ready contact the customer service on it and for some reasons, the best thing to do at this point is to –bear with me just a moment.

Female: Dante?

Dante Thomas: Yes.

Female: I think she's trying to bill replacement supplies with the initial setup and you can't bill for replacement when you're initially setting something up because replacements replace things after they wear out.

Dante Thomas: OK. Is that what you're doing, (Stephanie)? Are you billing for replacement items with the initial setup? Is that what you're indicating?

(Stephanie): Yes. That's what we're doing and all of a sudden there are denying them. We used to do it before but now they are denying them.

Dante Thomas: OK, if this is something that is included with the initial issue, then the replacement is for after those items wear out. And then you would bill for the replacement at a later time. You wouldn't necessarily bill for – for instance an example that I could give. For instance, if you are billing with the commode – billing for a commode chair, there is a code for a replacement pot for that commode chair.

You cannot bill for the pot with the chair at the same time because the pot is actually a replacement item after the initial issue has worn out. So it sounds like what is occurring is that you are billing for items that are included with the initial issue and should not be billed separately until those items actually wear out.

Additional note: If you are billing replacement items with A7032, A7033, and A7034 they are allowed for submission at the same time. We have identified a system issue that caused these items to deny as duplicate in error; a mass adjustment will be made in mid-January, 2009. We apologize for any inconvenience.

(Stephanie): OK, thank you.

Dante Thomas: Thank you. OK, we'll take our next question.

Operator: Before we move to our next question, I would love to give another reminder. If you would like to ask a question, please press star 1 or if you feel your question has been answered, you can remove yourself by pressing star 2. And we'll move to the next question, please state your name.

(Jamie Ferret): Hi, my name is (Jamie Ferret) and I am calling from Palm City, Florida. My question is, I understand that conductive garments associated with TENS units are rarely medically-necessary and that the KX modifiers requires proper documentation. If patient have those over and they qualify and they received a garment and they have repetitive use of that item and it becomes ineffective, dirty, it's the cleanliness issue, it stretch out, what have you ruined, is that same patient who qualified the first time, do they qualify for a replacement or a secondary garment, say six months or a year – a year past the initial claim?

Dante Thomas: OK, so you're asking if they're replacing the original piece. There's not been a change in medical need. It's just a replacement of already covered equipment. Is that what you're asking?

(Jamie Ferret): Yes, ma'am. Like for instance, a diabetic neuropathy patient has a conductive sleeve maybe for her foot. And maybe because of repetitive use and the sleeve is in not real good shape because of how the patient's been utilizing it on a daily basis, does that patient qualify and are we able to bill for another garment, whether it be six months down the line or a year or are we able to do that?

Dante Thomas: OK. Actually I'm going to ask (Carol), are you able to speak to (Datlin) or Dr. Hoover?

(Carol): I think that that would – things that qualify, we would pay for replacement as long as you know probably need to make sure that they document why.

(Jamie Ferret): OK.

Dante Thomas: And that there still meet medical criteria. So you should be ...

(Carol): Yes. OK, so there is not – if somebody for instance – without getting too graphic, is the cleanliness issue and it's three months later? As long as the physician says that basically their conductive garment looks like a train wreck, then they qualify – they can qualify for another one.

Dante Thomas: It's actually going to have to be a situation where it is a medical need. It can't be for just looks per se. But if it's something that is causing issue with the item meeting that patient's medical need, then yes, we will consider coverage for replacement. But it would not be covered for cosmetic reasons ...

(Jamie Ferret): Right, right. OK.

Dante Thomas: OK.

(Jamie Ferret): Thank you.

Dante Thomas: Thank you for your question. We'll take our next question.

(Tammy Johnson): Yes, this is (Tammy Johnson), in Manila, Arkansas. And we're wondering on the KE modifier, does this start January the 1 of 2009 and if so, where do we find the competitive bid list to see what all we need to apply this modifier to?

Dante Thomas: OK. Actually, if you would access the MLN Matters 6270, that does provide details on what items are included for the 9.5% reduction. Those are the items that are included in the round one competitive bidding list.

(Tammy Johnson): OK and ...

Dante Thomas: It's broken down into each product category. But basically, as far as the KE is concerned, if the accessory provided is not competitively bid (and the accessory may also be used with items which are competitively bid), then the KE modifier would be necessary. For these same accessories (applicable to both competitive and non-competitive base codes) when applied to competitively-bid items you would omit the KE when submitting your claims.

(Tammy Johnson): OK, so if this going with something that is being on the competitive bids, we do add the KE?

Dante Thomas: You do not add the KE.

(Tammy Johnson): OK.

Dante Thomas: If it goes with competitive bid, no KE; if, however, it goes with a non-competitive bid item that is when you would use the KE.

(Tammy Johnson): OK, not competitive bid, use the KE.

Dante Thomas: Right.

(Tammy Johnson): And it's only on those competitive bids items that are listed.

Dante Thomas: That is correct.

(Tammy Johnson): OK. How do we know if we're in that area that we use the KE or not?

Dante Thomas: There's no particular area any longer – the competitive bid pricing is applied nationwide for the identified product categories.

(Tammy Johnson): OK. Thank you.

Dante Thomas: Thank you.

Operator: Before we move to our next question, I would like to give you a reminder. If you have a question, please press star 1. Or if you find your question has already been answered, you may remove yourself by pressing star 2.

We'll move to our next question. Caller, please state your name?

(Susan Dorr): Yes, this is (Susan Dorr) in Savannah, Georgia.

Dante Thomas: Hi, (Susan). I'm sorry we can barely hear you.

(Susan Dorr): I'm on a speaker phone. Is this any better?

Dante Thomas: That's better.

(Susan Dorr): OK. I have a question, starting January 1, the oxygen concentrator will be capped?

Dante Thomas: Yes; that is, for patients receiving the equipment on or before January 1, 2006.

(Susan Dorr): If we have a patient, who has been on – who has delivered a concentrator say, in January of '03 and technically that machine as of January 1, '09 has surpassed the five year – what's the term I want.

Dante Thomas: Useful lifetime?

(Susan Dorr): Useful lifetime.

Dante Thomas: Yes.

(Susan Dorr): How do we bill for a replacement concentrator, has that issue been addressed yet?

Dante Thomas: Actually, we are expecting further details and those are the instructions I was referring to during the introduction. We are awaiting further instruction from CMS. We will post those immediately upon receipt. They are planning to send this out in the very near future.

(Susan Dorr): OK

Dante Thomas: So, we expect those any day now.

(Susan Dorr): Right.

Dante Thomas: And as soon as they come out, we will definitely send that information via listserv and we will have the details on how that will be billed properly.

(Susan Dorr): Thank you, I appreciate it.

Dante Thomas: Thank you and we do encourage you again to go out and listen to the audio file of the oxygen call on December 15<sup>th</sup>.

Dante Thomas: Yes. Thank you. Thank you for your question.

(Susan Dorr): Thank you.

Operator: And we'll take our next question, caller please go ahead.

(Paula): This is (Paula) in Laurel, Mississippi. My question is in reference to – it's not really a question, it's a statement actually. The Medicare – 1-800-MEDICARE number that the beneficiary is calling, they tend to be getting incorrect information especially about diabetic supplies and (the fact that) the supplier needing their – I mean their log book ...

Dante Thomas: Yes.

(Paula): ... or a download of their meter.

Dante Thomas: Right.

(Paula): ... because – to be able to bill. You know we can't bill without some information, if they are over utilizing.

Dante Thomas: Right.

(Paula): And they're being told by (pugly) – now this is secondhand from the beneficiary ...

Dante Thomas: Right.

(Paula): ... that we don't need that information that the doctor would be the person that need hat information which she needs it as well, I understand that. But we do have – it is right, is it not to receive the information?

Dante Thomas: Actually, you are required to obtain that information. You can obtain that either directly from the beneficiary or from the physician but you would need proof that the patient is actually utilizing the supplies at that level.

And if the 1-800-MEDICARE staff is providing incorrect information at anytime, you can – what we would encourage you to do is to request either a Tier 2 CSR or perhaps a supervisor to report the incorrect information.

(Paula): OK, well actually I did do that this morning as well.

Dante Thomas: I'm sorry, Paula. Something else you could do also if you'd like to provide that information in writing to us to pass along, you certainly can but again, that is outside of our jurisdiction if you will because the beneficiary call center is separate. Or you could also contact CMS directly possibly and provide feedback there as well.

But we will pass – we do have some interaction with 1-800-MEDICARE and I'll be sure to just pass them on that that concern was raised. And we do thank you for your feedback.

(Paula): Well, I appreciate it.

Dante Thomas: Thank you. We'll take our next question.

Operator: Caller please go ahead, your line is open.

(Christie): This is (Christie) from Texas.

Dante Thomas: Hi, (Christie).

(Christie): Hi, is there ever an occasion that a DME company that is all ready accredited and has a Medicare number of course, uses another DME company that's not accredited and does not have Medicare supplier number, to ((inaudible)) claims through and the billing?

Dante Thomas: Oh, no. That shouldn't occur. That's actually a violation of the supplier standards.

(Christie): Yes.

Dante Thomas: Now, there are some – in the future, there will be – like for instance with the oxygen thing, there will be, but it's not a situation where you should funnel your claims through someone else. But there may be some other things but that is not something that is acceptable with Medicare.

So no, that would not be appropriate. And if you're aware someone that is doing that you can refer to that to the program safeguard contractor.

(Christie): It has been reported and it's been about six months. So how long does that process take?

Dante Thomas: There is not a set time for the process and it's not – you may not hear anything else back about it. They don't always provide feedback as to what is occurring with it.

(Christie): OK and there's no such thing called the, "sub-station provider"?

Dante Thomas: No. And another thing that you can also do, you can contact the National Supplier Clearing House, the SACU. You can also report it there as well because it is also a violation of the supplier standards. So between the two, it will definitely be addressed and corrected.

(Christie): OK.

Dante Thomas: OK, thank you. We'll take our next question.

Operator: Before we move to our next question, I would like to give another reminder. If you would like to ask a question, please press star 1 on your telephone keypad. Or if you find your question has all ready been answered, you may remove yourself from the queue by pressing star 2.

Once again, please make sure your mute function is turned off to allow your signal to reach our equipment. We'll take our next question.

(Pat): Hello?

Dante Thomas: Hello, go ahead with your question.

(Pat): My name is (Pat). And my question is, we've been given conflicting information from customer service concerning of adding a portable to an oxygen concentrator. The patient got first tested at sleeping did qualify for the concentrator but the doctor re-tested the patient and now qualifies for the portable. We've been told we had to do a new initial and then we've been told we had to do the revise.

And even though we have the LCD in front of us, we've been told both answers. Our revise has been being denied and our initials had been going through and then later on, being denied on the back end. So, could you help me?

Dante Thomas: OK. Actually, a revised CMN would be appropriate there if there's been a re-test that is done that moves them from just the concentrator or the stationary to also qualify for the portable (off of sleep).

A revised Certificate of Medical Necessity is what you would require and you would submit that information in to us and we should – make sure that you do include a narrative with the claim and stating that there has been a re-test done. And include the revised CMN with your first claim with the portable oxygen.

And if for some reason you may want to check your rejections, because sometimes there may be something wrong with the – something else wrong with the Certificate of Medical Necessity that causes it to reject when you submit it electronically. So you want to make sure that it did not reject for some other reason. Sometimes – and an example could be that the wrong form was utilized or something along those lines.

But check your CMN rejection and make sure that the Certificate of Medical Necessity – the revised CMN did not reject for another reason. If it did not reject for reason other than we already have the equipment on file, then you can contact our customer service department and they can take a look at it to verify it. So they should be able to get that corrected for you.

(Pat): Thank you. Can I ask one more?

Dante Thomas: OK, we'll take one final question and I do want to remind everyone if we could try to limit the questions to one just that that we could make sure that we get all – as many questions as possible. But we'll go ahead and take your second one.

(Pat): Thank you so much. If the patient goes from Medicare to a SNF or hospice and they've been to the SNF or the hospice for a long time for their oxygen, is there a break of service when they get discontinued?

Dante Thomas: I'm sorry. I'm not sure that I understand your question. If they were in a Skilled Nursing – so they had oxygen, then they went into a Skilled Nursing Facility for a long period of time and then they came out ...

(Pat): Correct.

Dante Thomas: So like if they were there for like 6 months, is that a break in service? Is that what you're asking?

(Pat): That is what I'm asking, yes ma'am.

Dante Thomas: So, the way that we view break in service is really a break in medical need. Unless there has been a break in medical need for greater than 60 days – in other words, the patient improved and did not require the equipment that would necessitate a break in medical need. Or if they went into a Medicare advantage plan for greater than 60 days, that also would necessitate a break in medical need. And only in those cases would we start a new capped rental for that purpose.

(Pat): Thank you so much and happy holidays.

Dante Thomas: Thank you, you too. We're ready for our next question.

Operator: Caller, your line is open, please go ahead.

(Marie): Yes, my name is (Marie) in Cleveland, Tennessee.

Dante Thomas: I'm sorry, (Marie) you said?

(Marie): Yes.

Dante Thomas: OK, go ahead.

(Marie): Yes my question is, in regards to the use of the KE modifier ...

Dante Thomas: Yes.

(Marie): Specifically the power wheelchairs and accessories, is that going to be used in addition to the modifiers that we're currently using for new equipment?

Dante Thomas: You mean like the NU pricing modifiers, is that what you mean?

(Marie): NUKX, actually, on the accessory.

Dante Thomas: That is correct. KE is in addition to the regular pricing modifiers.

(Marie): OK and what would be the placement on that, would it go after the KX?

Dante Thomas: Placing the KE at the end of the other modifiers would be preferred.

(Marie): OK, thank you.

Dante Thomas: Thank you.

Operator: Take the next question.

Dante Thomas: Hello?

(Michelle): Hi, this is (Michelle) from Oklahoma.

Dante Thomas: Hi (Michelle). Go ahead with your question.

(Michelle): I have a question for you about the oxygen in regards to portable concentrators. After the 36 months CAP whenever they're capped out on a portable concentrator, you don't really do fills but since – during the 36 months you're billing dual codes you know? Your A1390 and your A1392, are you allowed to bill for monthly fills on that even though you're not doing technically a fill? How does that work?

Dante Thomas: Actually that is the instruction that we are currently waiting for. But there will be specific instructions in the very near future hopefully in the coming days that will explain exactly how the maintenance and service fee for oxygen will work, but we do expect that to be covered within that instruction from CMS. So, keep an eye out on the listserv for those instructions.

(Michelle): And so the instructions will include whether or not we're allowed to do the fills on or you know bill for a fill technically not just the maintenance and service on that piece of equipment?

Dante Thomas: There are no contents for a concentrator; we will only allow maintenance and service charges in 2009 for patients with oxygen concentrators.

(Michelle): Right, but in the past these particular types of concentrators ...

Dante Thomas: Are you talking about a (transfilling) concentrator where they fill the portables from the concentrator?

(Michelle): No, I'm talking about a portable concentrator, the kind that you can ...

Dante Thomas: Oh, a portable concentrator, OK.

(Michelle): Yes.

Dante Thomas: We will only allow maintenance and servicing for any type of concentrator or transfilling equipment. We will only allow contents if the supplier is delivering gaseous or liquid fills to the beneficiary ...

(Michelle): Right.

Dante Thomas: ... contents would not be billable. The only time contents are billable is if the supplier is actually providing the content. So, it would be under the maintenance – the oxygen maintenance and service fee. But the instructions, the details on that are forthcoming.

(Michelle): Let me clarify something with you then, on Monday when we were on the oxygen call with Joel Kaiser ...

Dante Thomas: Yes.

(Michelle): ... we had – somebody had called in and asked about the fills and he stated basically that that was – you could bill for that each month even though you weren't technically delivering that month.

Dante Thomas: Right.

(Michelle): Is that true?

Dante Thomas: That is true. If you're delivering it – what he's saying is you could take – theoretically, you could take three months worth of oxygen to the patient ...

(Michelle): Yes.

Dante Thomas: ... will bill for each of those three months even though you only did one delivery ...

(Michelle): OK.

Dante Thomas: ... you're still providing oxygen for three months of service. So you would be able to bill for three months of service that you provide.

(Michelle): OK. All right that's what I need to know. Thank you.

Dante Thomas: Thank you.

Operator: And we'll move to the next question. Caller, please go ahead.

(Laura): Hello?

Dante Thomas: Hello, go ahead with your question.

(Laura): Yes. Excuse me, this is (Laura) in Augusta, I have a question regarding C-PAP patients. If a patient has a C-PAP machine that let's say they got in 2002 and the machine is now broke, would they have to have another sleep study to obtain another rental period?

Dante Thomas: Did Medicare pay for the equipment in 2002?

(Laura): They did. And the policy actually states that the date of the face-to-face is required. So is it the face – that the face-to-face prior to the sleep study, so is the face-to-face that was – the sleep study back in 2002?

Dante Thomas: ((Inaudible)).

(Laura): It doesn't give a date that the sleep study has to be repeated or the length of time for the sleep study.

Dante Thomas: Actually, for this one, if, as we mentioned, if the patient qualifies under whatever requirements were in place when they qualified for the equipment, as long as there's not been a change in medical need, they would still be grandfathered in under those requirements.

So if the patient received it back in 2002, they're grandfathered in under those requirements unless there's been a break in medical need or something along those lines.

(Laura): So if this is just a case of – they opted to purchase the equipment out previously ...

Dante Thomas: Yes.

(Laura): ... so it was purchased out and the machine is now broke, so it's obsolete, non-repairable and we started a new rental period, they do not have to have another sleep study, nor do they have to have a date of a face-to-face, is that my understanding?

Robert Hoover: Dante, this is Dr. Hoover, let me clarify that and we're getting ready to publish a set of FAQs probably next week. I think it's get loaded this Friday actually in the Medicare database, but we'll probably have something out in the listserv this week.

If you think about it, there's kind of two situations that you could have with C-PAP. One is the example that you're talking about where the patient received the C-PAP device that was paid for by the Fee-For-Service Medicare program at the previous time and now they either need to replace their device or replace supplies.

And in that situation you know they must have met the policy or requirements that were in effect at the time their C-PAP was dispensed, they need to continue to use the device, may have to have a new order from their treating physician. And that's been a fairly standard process and unchanged over the past numerous years.

The other situation is when you have a patient – and this probably the more common situation as the patient was diagnosed with their Obstructive Sleep Apnea and they have a PAP device that as paid for by a private insurance company or managed care company and now they enroll in fee-for service Medicare and they need a replacement PAP device for accessories.

And that's been part of the hold up in getting this FAQ out because the general rules for our Medicare are that, when you come in to Medicare, you have to meet all of the requirements that are in effect at the time that you come under Medicare enrolment if you want something replaced.

And you know in this particular case, we're doing something slightly different – although not greatly different, the requirements are, if you come into Medicare from another insurer and you now want to have your device replaced, for the sleep test – if you had a sleep test that was conducted prior to Medicare fee-for-service, it just has to meet the AHI and RDI criteria that are in effect now.

In other words, they have to – you know if the sleep test was five years ago but it shows that they had an apnea-hypopnea index of 5 to 14 with symptoms or 15 or greater without symptoms, that would be – meet that first requirement.

And then the second is, they need to have a clinical evaluation at this point following their enrollment – let me re-state that. For the clinical evaluation piece of it, the beneficiary has to have a face-to-face by their treating physician and that face-to-face needs to document that they have a diagnosis of Obstructive Sleep Apnea and that they're continuing to use their PAP device.

When we look at this and look at kind of that standard position that Medicare takes that you need to meet all of the coverage requirements, you'll notice in those statements that I made that you know we're not looking for that adherence metric that is there that's required for new patients.

This is – what we're looking for is some recognition – you know if the patient's been on the device for ten years, that they're continuing to use it –you know they're benefiting from it and that they have a diagnosis that meets our coverage criteria. But we're not going to make the medical equipment supplier go swap out their device for one that we'd be able to give them that you know 4 hours a night on 70% of the nights in 30 consecutive days.

So to restate, they need to have a sleep test that shows they meet today's requirements and that sleep test could have been conducted prior to their entering into fee-for-service Medicare and they need to have a clinical evaluation where the physician documents that they have a diagnosis of OSA and that they're continuing to use the device.

(Laura): So, if I can recheck my understanding of this, if they're coming from a private insurance to meet into the Medicare system, and they're just needing a replacement of their machine, as long as they have the sleep test that meets the criteria that is in place now, and so that would eliminate the face-to-face prior to the sleep test. They would just need to have a clinical evaluation of face-to-face now from the physician which states that they have had a machine, they had been compliant and they continue to need this – to use the machine and need another machine.

Robert Hoover: And you get an order. Yes, I mean I didn't give that last one but that's sort of a given.

There needs to be ...

(Laura): OK. Thank you, sir.

Robert Hoover: All right.

Dante Thomas: Thank you, Dr. Hoover. We are ready for our next question.

Operator: As a reminder, if you have a question, please press star 1. If you find your question has already been answered, you may remove yourself by pressing star 2. We'll take our next question. Caller, your line is now open.

(Carolyn): Can you hear me?

Dante Thomas: Yes. (Please go ahead) with your question.

(Carolyn): This is (Carolyn) from New Mexico. And I have a question reference to oxygen. I have a patient that on the initial certification, the patient qualifies for a regular reimbursement for the stationary and the portable. On the re-certification, the physician now wants the patient on a higher reimbursement. He's providing this with the higher liter flow, over 4 liters, but he's stating that we shouldn't have to get one at rest. That he can use the testing from the initial CMN at rest. Is that correct?

Dante Thomas: I'm sorry. So it was ((inaudible)) what is the liter flow that the physician is prescribing?

(Carolyn): I'm sorry?

Dante Thomas: What liter flow is the physician prescribing for the ...

(Carolyn): The initial it was 2 liters.

Dante Thomas: OK. ((Inaudible)) prescribed 2 liters and now they are trying to prescribe a higher liter flow and what's the new liter flow?

(Carolyn): And the new liter flow is 5 liters.

Dante Thomas: So, they wanted them to move from 2 liters to 5 liters per minute.

(Carolyn): Correct.

Dante Thomas: And what's your question about the testing, I'm not sure that ....

(Carolyn): Well, you have to have testing on 4 liters over. So, he's providing us with that but the information that's in section – in question one, he's still using that original testing information along with the testing date. Is that satisfactory?

Dante Thomas: Actually, if you're looking at the initial testing of the patient, if there's been a change then, there would have had been a test or something done to identify that is ...

(Carolyn): That ((inaudible)) that risk, correct?

Dante Thomas: There should be test – you know a new test at the regular and then at the higher liter flow so that we can see that there is you know improvement.

(Carolyn): OK and that's what I thought. Thank you very much.

Dante Thomas: Thank you.

Operator: And we'll move the next question. Caller, your line is now open.

(Pat): Hello?

Dante Thomas: Go ahead with your question.

(Pat): This is (Pat) in Georgia. And we're an O&P practice and my question is, is O&P part of the competitive bidding or is still exempt at this point in time.

Dante Thomas: I'm sorry, come again?

(Pat): Competitive bidding; right now my understanding if I'm correct is that the competitive bidding is affecting just the DME, it is not affecting any orthotics or prosthetics. Is this still the case?

Dante Thomas: That is correct.

(Pat): OK and then I have a general question at ((inaudible)) if it was (2.50) and instead of two, did you go over information in all six of these items or have you just been accepting questions on them like the medical review documentation checklist? Did you cover the tools that you can use or were these just items that we could ask questions about?

Dante Thomas: We actually went over the list of items and several things. We will actually post the transcription of the call to our Web site.

(Pat): Yes.

Dante Thomas: And so, if you did miss any portion of the call, you are welcome to go out to our Web site under the, "Ask-The-Contractor" teleconference page under "Education". And the transcription of the call will be available.

(Pat): And when will that be?

Dante Thomas: It will be within 12 days from today.

(Pat): Thank you.

Dante Thomas: And we're ready for our next question.

Operator: Caller, your line is open, please go ahead.

(Peg): Hello this is (Peg) calling from (Bluebell), Pennsylvania.

Dante Thomas: Hi, (Peg), go ahead with your question.

(Peg): I am an enteral-tube feeding biller and I'm wondering what they modifier code is for partial month pump and pull use?

Dante Thomas: I'm sorry. So, for partial month?

(Peg): Yes, when we're billing for the pumps and pulls we used – the from-and-to date is the same. We don't (stand) the date. Is there a code for say when the patient – if he passes away before the anniversary data on that month?

Dante Thomas: OK. As long as the patient was utilizing the pump and the pull on the first day of the month and the way that it's built, they were technically entitled to the full month of payment. But if for some reason let's say that they stopped using it the day before that anniversary date, then you would not be entitled to any payment for that month, but you are – if they utilize the item for any portion of the month, you are entitled for the full month for the pump and the pull.

But if you don't want to accept the full payment for the full month you are more than welcome to pro-rate your submitted charge for the month and that would reduce the amount that you're reimbursed.

(Peg): OK even if it's one day – I mean, the renewal date on the pump in one case is the 14th of the month and if the patient passes away on say the 15th of the month, so I only want to bill for one day pump and pull use.

Dante Thomas: What you can do is just pro-rate the amount that you submit on the charge because we would – we're never going to exceed the amount that we would reimburse as primary insurer. But if you submit an amount that's lower than that, then we would not exceed the amount that you submit.

So, if you don't feel comfortable accepting the full month or the one day, you could just bill us whatever amount that you would normally bill for one day of usage and that would be your submitted charge and that's how you would be reimbursed.

(Peg): OK, thank you very much.

Dante Thomas: OK, thank you.

(Peg): Bye-bye.

Operator: We'll move to the next question.

(Christine): Hello?

Dante Thomas: Go ahead with your question.

(Christine): Hello, this is (Christine) and I'm in Texas. I have a couple of questions. The first one is regarding the PAP policy. Can a nurse practitioner or a physician assistant do the face-to-face with the patient? Or does it have to actually be the prescribing doctor?

Robert Hoover: Yes, they can. This is Dr. Hoover. And that's a question that will be addressed in our frequently asked questions.

Medicare, when you look at treating physicians takes into consideration, M.D.s, D.O.s and in some cases – in limited amount chiropractors and podiatrists. They're limited by either statute or they're scope of practice for the state.

But it also includes nurse practitioners and physician assistants, clinical nurse specialists. So, they are allowed to do the face-to-face and follow up evaluation.

(Christine): OK. And just to get a clarification. We were in on the other call in for the oxygen with Joel Kaiser and we just want a clarification on break in service and break in need.

Dante Thomas: OK. So you want clarification on break in service and break in medical need ...

(Christine): Right. They're not the same thing, correct?

Dante Thomas: Not always. Sometimes they are used interchangeably, but sometimes they are the same and sometimes they are not, it depends on the situation. And actually the information as it relates to when a new rental will begin, that will be addressed in that document that we're currently awaiting those instructions that we're currently awaiting from CMS.

(Christine): OK.

Dante Thomas: And we do expect to receive those any day now.

(Christine): OK. So any day, you'll receive new documents ...

Dante Thomas: Yes and once we receive that document, we will send that information out via listserv.

(Christine): OK.

Dante Thomas: OK? Thank you for your questions, (Christine). We'll take our next question.

Operator: As a reminder, if you would like to ask a question, please press star 1. If you find your question has all ready been answered, you may remove yourself from queue by pressing the star 2 on your touch tone telephone. We'll move to our next question. Caller, please go ahead.

(Betty): Hello?

Dante Thomas: Hello.

(Betty): Hi, this is (Betty) from North Carolina. Going back to the C-PAP supply question – it's kind of back at the beginning. I understand for a new patient that after the C-PAP we're billing the mask,

the tubing you know things like that. And the lady was saying about the A7033, the pillows, nasal pillows or the cushion are replacement issues?

Dante Thomas: Yes.

(Betty): OK. Here's my question. If after three months the patient gets a new mask an A7034, at that time, can we also bill the replacement pillows?

Dante Thomas: As long it's not at the initial use and it is something that is separately payable and it medically-necessary for them to receive those items, we can consider coverage for it. The key is with the replacement items generally for those items that are identified as replacement items, they are truly just that, you are replacing items that were provided as initial issue.

(Betty): Right.

Dante Thomas: So, if it's something that is being replaced, they already have received that item and you're replacing it that is when it would be appropriate to bill as a replacement.

(Betty): OK. So, I would be billing replacement pillows and it's basically replacement mask, although it doesn't say, "replacement". It's just an A7034. Those codes could get paid on the same date if there's no – let's say later date issued item.

Dante Thomas: Bear with me just a moment. So, what you're doing is and let me just clarify to make sure that I'm understanding. Your mask ...

(Betty): Right.

Dante Thomas: ... or the PAP, does the mask come with the pillow – with the pillow all ready on it?

Because I think that the A7034 does include the pillows or cushions.

(Betty): OK.

Dante Thomas: So, if you are just replacing those pieces ...

(Betty): Yes.

Dante Thomas: ... then you would bill for the separate pieces. But if you are billing for a mask which includes those pieces, then you would just bill for the mask.

(Betty): I think I get it now. For the A7034, say they get one three months later if we give the whole mask, you're saying that would, that mask would still include the pillows or cushions?

Dante Thomas: Right.

(Betty): OK. It's only when say in – because I only see the pillows and cushions in every month are OK.

Dante Thomas: Right. So let's say that they're just – you're just replacing that component of the item that the patient all ready has.

(Betty): I see. So you're never really billing the A7033 and A7032 at the same time there's an A7034?

Dante Thomas: Right.

(Betty): Because those two are replacements. Got you. Well, OK, thank you.

Dante Thomas: Thank you.

Operator: We'll move to the next question. Caller, please go ahead.

Female: Yes. I have a couple of questions about oxygen. Like January 1 of 2009, if oxygen is under the competitive bid list and we bill it, will we add a KE modifier to that or we will not add a KE modifier to that?

Dante Thomas: OK. Actually the KE modifier would only be required for those items that fall both in and out of competitive bid. Oxygen is in competitive bid. Therefore, it would not be – I don't think it would be necessary to include the KE – bear with me just a moment.

Female: OK.

Dante Thomas: And the KE modifier is only for accessories. So, we don't separately pay accessories for oxygen, so the KE modifier will not be utilized with oxygen.

Female: OK. KE modifier is just for accessories. It's not for the oxygen or the power wheelchair itself.

Dante Thomas: Right. It's only for those accessories that can be used for base equipment that is competitively-bid as well as base equipment that is not competitively-bid; the KE differentiates between the types (competitive/non-competitive) of base equipment for which the accessory is provided with.

Female: OK. I understand that now. Thank you.

All right the portable O2; for instance the revised CMN, it's the portable O2 and that is lighter, say a patient has had a concentrator for – during their 35th month and then the doctor does a test in

the office and orders portable O2, we would get a revised CMN for the portable O2, (take it out).

Then would we be all – would that start for the portable alone, would it be 36 months rental, at that rate? Or would it ...

Dante Thomas: Or would it just be the content ...

Female: ... or would it just be the content?

Dante Thomas: If you're just now adding the equipment, it would b 36 months for the equipment.

Female: Itself.

Dante Thomas: Itself.

Female: OK and then the portable, is it also considered like five years reasonable and useful lifetime?

Dante Thomas: As it stands right now, yes. All the equipment with the exception of parenteral and nutrition pumps has an expected useful lifetime of five years.

Female: OK, thank you very much.

Dante Thomas: Thank you.

Operator: We'll take our next question. Caller, please state your name before posing your question.

(PJ): This is (PJ) from Asheville North Carolina again.

Dante Thomas: Hi, (PJ).

(PJ): All right. I just have one other question about the maintenance on portable oxygen. What if a patient has a separate concentrator in the home but he has a liquid self-fill unit that we don't go – I mean we're still providing it but he has his own tanks and everything else so we don't go out there. I mean we might go regularly once every 6 weeks or something just to fill his O2 cylinder – the portable cylinder, the liquid. Can we still bill for the portable at that point?

Dante Thomas: Bear with me just a moment.

(PJ): Sure.

Dante Thomas: OK. I'm going to punt this one to Ellen Edenfield.

Ellen Edenfield: Yes, this is Ellen. According to what Joel Kaiser said on Monday, is that as long as you are providing contents for oxygen system, then you can bill us monthly for that content. If you have a concentrator, you don't have contents for that but if you have a liquid portable, you will have content. If you only deliver it six months and it lasts six months, he's stated you say that you could bill every month for that content.

(PJ): So it's regardless of it, you're delivering it or if it's already and they're filling your own.

Ellen Edenfield: But you delivered it for them to fill from.

(PJ): Correct.

Ellen Edenfield: Yes, you are providing content to that beneficiary.

(PJ): OK, great. Thank you.

Dante Thomas: Thank you.

Operator: As a reminder, if you would like to ask a question, please press star 1. If you find your question has all ready been answered, you may remove yourself by pressing star 2. We'll move to our next question. Caller, your line is open.

(Jamie Ferret): Yes, this is (Jamie). And I have a couple of questions for you. I need some clarification on the C-PAP test again, I apologize. I'm a little un-clear because I've been hearing it a couple of different ways on these calls and I just want to make sure that I'm doing it right.

On a patient who had a sleep study through a commercial payer and is now Medicare effective, do you have to have the information that Medicare requires now or is it just CAHI? Is that what he said earlier, Dr. Hoover?

Robert Hoover: This is Dr. – yes, I said they needed to have – they have to have a sleep test.

(Jamie Ferret): Right.

Robert Hoover: And the sleep test has to meet the AHI or RDI criteria that are in effect today, which is 5 to 14 with symptoms or 15 or greater without symptoms.

(Jamie Ferret): OK. So, OK, I think that clarifies – and what about repairs? It doesn't matter who purchased the equipment basically in the beginning, it's just – or does it? If you're just looking at repair or replacement of the equipment

Dante Thomas: OK for the repairs or replacement of equipment ...

(Jamie Ferret): Yes.

Dante Thomas: It actually needs the same criteria as long as the patient – it depends on whether or not they – did Medicare purchase\ the items initially or is this – are you referring to those that were purchased via private insurers?

(Jamie Ferret): In this case it would be purchased by a private insurance.

Dante Thomas: If it something that was purchased by a private insurer and it requires repair or replacement, the patient would have to – let me make sure that I'm reading correctly. They would meet the Medicare criteria for the equipment at the time that you purchased it.

(Jamie Ferret): At the time when – I'm sorry, I didn't hear you.

Dante Thomas: At the time ...

Robert Hoover: At the time of the repair, want to make sure that met medical guidelines at the time that you're actually repairing something that Medicare does not pay for the item upfront.

Dante Thomas: OK.

(Jamie Ferret): See, I think that's why I'm lost at this because last week when we had talked about this before, it was stated basically if the patient had established medical necessity with Medicare at any point they were considered grandfathered. But if you'd never established medical necessity with Medicare, whether it be for supplies or repairs or new equipment, then you had to meet the coverage criteria on the day you did the delivery.

So, in other words, if I did the repairs or replacement today, I would have to meet every step of the Medicare LCD. But that's not the way Dr. Hoover said it earlier. So I'm confused.

Dante Thomas: Actually I'm going to punt this one back to Dr. Hoover if I may, Dr. Hoover because I think this is actually going to be addressed with the frequently asked questions that you plan to release this week. Because there are a few changes to what was initially planned with that. Is that correct?

Robert Hoover: Yes and in terms of – I mean really it's only in terms of meeting that adherence metric and having to document you know the adherence based on today's policy. I got a little confused with your question. Could you restate it for me?

(Jamie Ferret): Yes, I think – initially when I have spoken with you guys last week in Dallas, they way that it was explained to me was, if a patient has already previously met medical necessity or established medical necessity with Medicare, OK? Whether that means, Medicare has paid for a machine or if they've just been paying for supplies for the past several years. If I've all ready established medical necessity, then they're grandfathered.

However, if you've never billed Medicare for anything, equipment or supplies, then the policy – then you would have to meet today's criteria for a setup regardless of whether it's repair, supplies or new equipment. That's not the way that you had it explained it earlier. So I'm trying to make sure which you know which way is correct.

Robert Hoover: And that's then part of you know our discussions with CMS that is delayed the release of the FAQ is Medicare's kind of general rule is that when you come in to Medicare, you want something paid for by Medicare, you have to meet today's coverage requirements for Medicare.

(Jamie Ferret): Right:

Robert Hoover: And so, that would mean you know if you got to sleep test two days ago and you became Medicare eligible today, we would say, "Well, you need a new sleep test. You need a face-to-face evaluation. You need to meet the adherence criteria that we have the policy, the reevaluation and all of those requirements."

And so we have had a number of discussions with CMS about how to handle that because the bulk of the patients that are going to need a device replaced are probably going to have gotten their devices outside of the Medicare program.

(Jamie Ferret): Right.

Robert Hoover: What we said is that, when you become Medicare eligible and you now want something, we need to see a sleep test and that sleep test could have been done yesterday, it could have been done five years ago.

But it has to meet today's coverage criteria. So if it doesn't, yes they're going to have to get a new sleep test. If it does meet today's criteria from a test five years ago, that's criterion that you've met.

The second criterion that you need to meet is that, now that you are enrolled in Medicare and you want this, you need to go see the treating physician and have a face-to-face evaluation, that documents that indeed you have OSA because that's the diagnosis for which this device is covered. And the doctor has to document that you're continuing the use of the device. In other words, him saying, yes it's still medically-necessary.

(Jamie Ferret): Yes, I think what I'm referring to the coverage criteria though is the AHI and the RDI, I understand all of that sweet time, but the point that I'm trying to figure out is this face-to-face you

know? Like you said if they had a sleep study done two days ago through a commercial insurances that may come into effect now, do I have to have a face-to-face that was prior to? Are you saying that the face-to-face can actually be done after the sleep study in these cases?

Robert Hoover: Yes, they could have had a sleep study five – that's what I'm saying, the sleep study could have been five years ago.

(Jamie Ferret): Yes.

Robert Hoover: You're probably not going to be able to go back and retroactively you know resurrect a face-to-face that didn't occur ...

(Jamie Ferret): Right.

Robert Hoover: ... before that. So, I mean that's been part of the issues. We said you know now that you are enrolled in Medicare, you can have a sleep test that was conducted at anytime as long as it meets today's Medicare coverage criteria.

(Jamie Ferret): OK.

Robert Hoover: And you have a face-to-face now with your doctor. Not face-to-face from five years ago.

(Jamie Ferret): OK.

Robert Hoover: It's face-to-face now.

(Jamie Ferret): OK. That's what I needed to know. Thank you, Dr. Hoover.

Dante Thomas: Thank you, Dr. Hoover. Now I will like to mention that this is new information that is coming out. So this has – these will be posted this week and this information may not have been previously provided because we didn't have it before, we just receive the guidance from CMS.

But thank you so much for your question and thank you Dr. Hoover for clarifying. We're ready for the next question.

Operator: Caller, your line is open. Please go ahead.

(Linda): I have a question regarding oxygen. My name is (Linda). I'm from Arkansas. My question is, if we have patients that have previously been reimbursed through our Medicaid program and ...

Dante Thomas: I'm sorry you've – (Lina), are you still there? (Lina)?

(Linda): Can you hear me better now?

Dante Thomas: I can hear you now. All I heard was Medicaid.

(Linda): We have patients that when we initially bring them on as our patients have Arkansas Medicaid as their primary pay source.

Dante Thomas: Yes.

(Linda): And those – through Arkansas Medicaid, they require prior authorization for oxygen and sometimes it takes a long time to get that. They tell us six to eight weeks. So we're usually actually getting – we're behind in our billing sum on that.

But then they get Medicare and of course they don't always tell us that. And sometimes they have Medicare for three or four months before we realized that they do because we're waiting for our authorization to be approved, the billing to go through and things like that.

Dante Thomas: Yes.

(Linda): So, in those instances do the ABGs or the oxygen CMNs has to be within a certain timeframe? Or could we use older ones that we have on file that have been – is that they do meet the criteria but they may have been on oxygen for a year or two, maybe three or more through the Medicaid program.

Dante Thomas: OK, bear with me just a moment. OK, they would have to meet the Medicare criteria for the oxygen to be considered for coverage and Medicare criteria requires that the patient is tested and the oxygen is delivered within 30 days of the test.

So, are you saying that they're meeting the Medicare criteria or they are not?

(Linda): Well, they meet the ABG levels and/or the Sat levels. But some of them can't come off the oxygen to have a new test as they are dependent. They've been on it forever.

Dante Thomas: OK, but they are meeting the Medicare – because the criteria does not indicate specifically of whether if they're on or off of oxygen. The key is that they have to fall within the ranges of either group one or group two in order for Medicare to consider coverage. But they would have to meet the Medicare criteria in order for us to reimbursed for the oxygen

(Linda): I understand that. My question is, the test dates and things.

Dante Thomas: If the test date occurring within 30 days of the initial date/eligibility of Medicare.

(Linda): No, because they've been – we didn't know that they had Medicare and they've been being paid for by Medicaid.

Dante Thomas: Well then the Medicare coverage would begin once the qualifying testing is done and the patient – and you do have documentation indicating that the patient does meet Medicare's criteria.

So, if you were not aware then, once they have received it, it is at that point forward that we would be able to make the payment for the oxygen equipment

(Linda): Yes ma'am, we understand that but the thing is the test and they can't come off oxygen long enough to have a test off oxygen.

Dante Thomas: OK. So what you're saying is if they're being re-tested again to qualify for Medicare but they're not – they're being tested while using oxygen and then with the use of their oxygen, they're not qualifying for Medicare's guidelines, is that what you're indicating?

(Linda): My understanding is that, you can't have a test and qualify for Medicare while on oxygen.

Dante Thomas: Carol or Dr. Hoover do you have any thoughts on this one? Actually, OK what we do this then – bear with me just a moment.

(Linda): OK and I do have one question too on home fill, if I can ask that? Just on the people that have home fill systems where the contents are being filled from the concentrator itself, is a combination system.

Dante Thomas: Yes.

(Linda): How does that work with the cap and the billing and everything?

Dante Thomas: OK. With all of the oxygen equipment whether it's – regardless of the concentrator or the portable the 36 months cap applies to each piece of equipment once the 36 months has completed, the no more rentals will be allowed.

Once it has capped, at that point we are still awaiting the final instructions from CMS to advise how the maintenance and service payments will go. So that information is forthcoming hopefully within the next few days. We are expecting.

Robert Hoover: ((Inaudible)) I think more importantly and may be what she ask but didn't ask is with the home fill type system or I-fill where the patient is connecting their cylinder to a unit that is in their home and filling their own cylinders, will the supplier to be able to bill for content, is that your – is basically your question?

(Linda): Well, that was part of it, yes. But I think that I understood that but I wanted to get clarification and then I need to know how Jessica's going to get back with me.

Dante Thomas: OK, actually I have an answer to that question. We did pull up the policy and the policy does indicate that with the testing if the patient can't come off the oxygen to take a test, the patient can be tested while on oxygen. For patients who cannot be tested without the oxygen, they can be tested while using the oxygen but they still have to meet the Medicare group one or group two criteria; even though they're being tested while using the oxygen. The supplier is only allowed to bill for contents separately with capped oxygen if the supplier is actually delivering the contents to the patient's home. There is not a specific frequency of delivery required, but the contents are billable monthly.

(Linda): And those tests with results would have to be – they would have to meet the oxygen criteria while on oxygen.

Dante Thomas: Exactly. If they can't come off the oxygen and take the test, you can test them while they're on it but they still have to meet the same criteria as if they were tested without it.

(Linda): OK.

Dante Thomas: And that is directly from the local coverage determination for oxygen.

(Linda): OK.

Dante Thomas: OK? Thank you. We'll take our next question and thank you, Dr. Hoover for your clarification and Jessica also.

(Peggy): Hi, my name is (Peggy). I'm calling from New Bern, North Carolina. I have a question about insulin infusion sets. The LCD states that we are allowed to – we pay for one per week as a bundled item. I was wondering where the information is coming from that would decide what's going in into the LCD that would mean that it needs to be a bundled item?

Dante Thomas: OK. So, your question is where does it state that is a bundled item?

(Peggy): No, my question is more like, where are you guys getting the information from to base what's in the LCD?

Dante Thomas: As far as the code?

(Peggy): Right as far as how the item is bundled and how many they allowed per week?

Dante Thomas: Actually that information comes from several different areas, medical directors. It comes from the guidance that is outlined with Congress through the coverage. Some of it comes from the national coverage determination as well as the pricing and data analysis contractor. So there are a lot of different entities involved in identifying the coding and the guidelines that are listed within each local coverage determination and policy article. So, there are a quite a few different places from which that information is compiled.

But as far as the coding itself of the items, that is actually coordinated through the PDAC or Pricing and Data Analysis Contractor.

(Peggy): OK. So if there was something that we disagreed with and that's in the LCD, is there something that we can do to try and change that or what do we need to try and do?

Dante Thomas: It depends on what it is that you're trying to change. If you have questions – it sounds like you're having an issue or question with the coding. So for that, I would refer to the PDAC and their Web site is [www.dmepdac.com](http://www.dmepdac.com). Because it sounds like your issue is with the way that the item is coded because the way – the coverage is part of that code and that code is actually for one week of supply.

(Peggy): Right. OK and that would also – let me express about how the pricing is for it as well or is that a different area?

Dante Thomas: Actually, they do coordinate the fee schedule as well. So, yes they would be able to assist with any concerns that you may have with that or coordinate or at least provide that feedback to CMS.

(Peggy): OK.

Dante Thomas: OK?

(Peggy): Thank you.

Dante Thomas: Thank you.

Operator: As a reminder, if you have a question, please press star 1. If you find that your question has all ready been answered, you may remove yourself from the queue by pressing star 2. We'll move to the next question.

Dante Thomas: Go ahead with your question.

(Carol): Yes, this is (Carol) with New Mexico. And I still have a question on the C-PAP supplies. I think I'm a little confused then may be guys you can help. On the A7034 and then also billing the A7033 and A7032s, we've been billing the replacements, not on the initial setup but you know like three years, six months down the line, the patient's getting supplies.

So when we bill the A7034, which we're under the understanding when we give them the A7034s, the pillow, the A7033s and the cushions, A7032s are not included in the A7034s. That's why we billed them separately.

Dante Thomas: OK. Bear with me just a moment as we check for this but the code outline indicate that the maximum amount of replacement in the policy article is, for the A7034, there is one for three months. And then for the A7033 or the A7032, they have a maximum of two per month.

(Carol): Correct.

Dante Thomas: Bear with me just a moment as we pull up the policy article to check for a column one, column two code guidance for the A7034 along with the A7033 and A7032.

(Carol): OK, because we billed these all the way. I mean we've been doing it for a while this way. Like I said, not on the initial but then we've been billing them for the replacements and we were paid. And then as of November, we've gotten denied on every single one of our A7033 when we bill them with the A7034s.

Dante Thomas: OK. Bear with us just a moment as we get this pulled up online.

(Carol): OK.

Female: Dante?

Dante Thomas: Yes.

Female: I've got this policy article up.

Dante Thomas: OK.

Female: A7032, A7033, A7005 and A7006 include the lid jar, (baffles), tubing, (CTs) and mouth piece. In addition, code A7066 includes a filter. Code A7004, includes only the lid jar and (baffles). It's A7033 and A7032 that you're stating is included in the A7034?

Dante Thomas: Does it have anything –that's what we're trying to look for (Carol) is the mask, if there's any guidance of whether the pillows and/or cushions are separately billable from the mask because apparently they are now being denied.

Robert Hoover: This is Dr. Hoover. An initial issue the interface is – and either pillows or cushions, depends on how the interfaces is constructed. There is a set of cushions that come with the interface and are not billed separately at initial issue.

(Carol): Correct.

Robert Hoover: And for subsequent issue, you can bill a set of cushions or pillows. But with initial issue there's not any unbundling.

Dante Thomas: What about with the mask because ((inaudible)) billing for the mask to A7034 which is the actual interface, can they bill for the pillows and cushions along with that masks as well or ... is that correct, Dr. Hoover? Or are you saying with the initial issue of the mask?

Robert Hoover: In terms of at a replacement time?

Dante Thomas: That is correct.

Robert Hoover: Or the initial issue?

Dante Thomas: Let's say for instance, four months later they need a new mask, the A7034 which is the actual mask itself. Where do we pay for the pillows and accessories – I mean the pillows and the cushions separately with that mask, and that's what we're trying to find in the policy but we don't see it right now.

Robert Hoover: You know I'll have to look and see. I think they can. But I'll have to look and see. I'll get back to you, Dante.

Dante Thomas: OK. Thank you, Dr. Hoover. As Dr. Hoover looks for that information, hopefully we will get the information but it will be included – we'll be sure to include that answer to this question in the minutes.

If for some reasons we do not get the response to this question during the call, so if you are interested in the answer to this question concerning the PAP, for the purpose of the time, we're going to move on to our next question. But if you are interested in the answer to this question, because you provide these items, please refer to the minutes.

And as I mentioned earlier in the call, the minutes – the transcription of this call will be posted on our Web site under the "Ask-The-Contractor teleconference" portion. And that's under "Education" within 12 business days. Thank you so much and we'll take our next question, Necole.

Follow-up: If you are billing replacement items with A7032, A7033, and A7034 they are allowed for submission at the same time. We have identified a system issue that caused these items to deny as duplicate in error; a mass adjustment will be made in mid-January, 2009. We apologize for any inconvenience.

Operator: Caller your line is open. Please go ahead.

(Stephanie): Hello?

Dante Thomas: (Stephanie), your line is breaking up a bit.

(Stephanie): Is that better?

Dante Thomas: That is better. Go ahead with your question.

(Stephanie): This is in reference to the C-PAP supplies that we were all just talking about.

Dante Thomas: Yes.

(Stephanie): Whenever I call, I'm always being referred to the archives to the summer 2005 ((inaudible)) and it shows that the A7034 includes the items the 32 and the 33? And our items at the A7033 are being denied but I was still paying our A7032 guidance. And that's what we're trying to get clarification on ((inaudible)) we are being told these items are included with that and that's why they are being denied. So that's what ...

Dante Thomas: And you said, that was summer 200 ...

(Stephanie): And five.

Dante Thomas: OK. As we mentioned earlier, Dr. Hoover – they're researching this to ensure that this is correct information that they are being (dedicated) appropriately. And the response to this question will be included in the transcription of this call.

So those of you who are interested in the answer to the question and if you are in queue in currently to ask the question about these supplies, please refer to the transcription that will be posted within 12 business days on our Web site under the "Ask-The-Contractor teleconference". But thank you so much Stephanie for that reference of the summer 2005 article. We'll also take a look at that as we complete this information on our Web site. And we will now take our next call.

Follow-up: If you are billing replacement items with A7032, A7033, and A7034 they are allowed for submission at the same time. We have identified a system issue that caused these items to

deny as duplicate in error; a mass adjustment will be made in mid-January, 2009. We apologize for any inconvenience.

Operator: As a final reminder, if you have a question, please press star 1. Or if you found that your questions have all ready been answered, you may remove yourself by pressing star 2. Caller, your line is now open. Please go ahead.

(PJ): This is (PJ) from Asheville, again. I wanted some clarification on the C-PAP. (In my understand) that if a patient received the C-PAP like in 2002, and now needs a new C-PAP because this machine is obsolete and ((inaudible)), that he needs to get a new order and a new face-to-face with a physician, before we can supply him with a new C-PAP?

Robert Hoover: You know this is Dr. Hoover and I would suggest we do this. And this is about the fourth time I've gone over what's here and it's clearly creating some issues by me doing this verbally. If you will wait until early next week, we have a frequently asked questions document that comes out and then I'll have this information in writing. And I think it will be much clearer to you than it will be for us to review this again verbally.

(PJ): OK, thank you.

Dante Thomas: We'll take our next question. Go ahead with your question. OK, you may want to remind everyone, Necole that if their question has been addressed, how to remove themselves from the queue. And for those that are currently in queue, if you are next on the call, check your mute button to make sure that you can ask your question.

Operator: Certainly ma'am. If you find your question has all ready been answered, you may remove yourself by pressing star two. Caller your line is open, please go ahead.

(Ramona): Hello, this is (Ramona) in Texas. Do you hear me?

Dante Thomas: Yes, I can. Go ahead, Ramona.

(Ramona): I have a question on oxygen concerning 60-day break involving an HMO. If the patient starts out traditional Medicare and joins an HMO and is with the HMO 60 to 90 days and then goes back to traditional Medicare, am I understanding that they can begin a new 36 months CAP at that time?

Dante Thomas: OK. And this one is also one that is addressed in that document that we are awaiting from CMS that is going to explain the maintenance and service fee – appropriateness of maintenance and service. It will also address the break in service rules and guidance because it is going to be – I think the way that it was explained in the call. They're going to be some different requirements depending on whether the break in medical need occurs before or after the 36 months CAP.

So we are awaiting those items from CMS and we will provide that information as soon as we received it via our listserv. So that would be addressed through that document that we are waiting, but thank you for your question.

(Ramona): Thank you.

Dante Thomas: Thank you. We'll take our next question.

Operator: Caller, your line is open. Please go ahead.

(Susan Dorr): Hi, my name is (Susan). I was wondering if I do a non-assigned claim, can I charge a delivery fee?

Dante Thomas: Actually, no. Delivery charges are included in the Medicare allowed amount. The example that I used often times with – when Medicare will consider is separate charge for deliver and when the patient can be – when a delivery charge is appropriate for billing separately. And that will be an example where the patient is – it's a rare situation where – say for instance the patient lives on a deserted island and you have to obtain a boat or a helicopter to give the equipment to the patient. It's something that is really rare and that would be a rare example of when we may consider separate delivery charges. But no, you would not be able to bill separately for the patient for delivering the item.

(Susan Dorr): So can I bill the patient if it's a ((inaudible))?

Dante Thomas: Not for delivery. The delivery is included in the allowed amount for the item. I mean if you go a non-assigned claim, then your claim would be for the item that you're delivering and that item would still include the way that Medicare looks at it. It is included in the reimbursement for the item itself. So, no you would not be able to bill separately for delivery charges.

(Susan Dorr): Thank you.

Dante Thomas: Thank you.

Operator: We'll move to the next question. Caller, please go ahead.

(Susan Dorr): Thank you. This is (Susan) in Florida.

Dante Thomas: Go ahead with your question, (Susan).

(Susan Dorr): I have a question regarding the oxygen CAP and non-assigned claims. If we accept a new oxygen patient as a Medicare beneficiary after one month, and we are billing the claim as non-assigned, is there additional documentation – I mean do we have to have an ABN or is there any other additional documentations we have to have to be in compliance with the (status)?

Dante Thomas: Basically, what you would want to do is to – because there's a requirement in the Federal Register that does require you to indicate to the patient in advance what you're assignment status will be for the full rental period.

So you would want to have documentation that you did you know notify the patient of that information, but there's not like an ABN requirement as it relates to whether you will accept the assignment or not. No, that would not be something that is required.

(Susan Dorr): So, if we – and the patient agreed to accept services on a non-assigned basis, then the oxygen allowable would still be the same, is that correct?

Dante Thomas: The allowed amount does not change regardless of whether the claim is assigned or non-assigned. The differences with a non-assigned claim, the patient is reimbursed and then Medicare – 80% of the Medicare (proved amount) versus the supplier receiving that reimbursement.

(Susan Dorr): We have the patient signed you know really state they understand that it would be an non-assigned claim from the beginning of the first claims submission when we (step into the service) because that what's we choosing to do.

But I just want to make sure that I didn't have to have any other type of additional documentation in order to make the (status).

Dante Thomas: No. No additional documentation is required.

(Susan Dorr): OK, thank you.

Dante Thomas: Thank you.

Operator: At this time, we have no further questions. But as a final reminder, if you do have a question, please press star 1.

Dante Thomas: OK. Or if that's the case we have answered all of our calls, we would like to thank everyone for joining us for today's General Ask-The-Contractor teleconference and for all of your questions. We also like to give a special thanks to everyone who was present on the call to assist with the answering the question.

We do encourage you to stay tuned to the listserv and the CIGNA Government Services Web site for further educational outreach and opportunities. And thank you all for joining us and have a great day. Good-bye.

Operator: That does conclude today's call. You may now disconnect.

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