DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

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Implementation Date: April 3, 2017

Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

Note: This article was revised on March 6, 2017, to reflect the release of an updated Change Request (CR). That update added an instruction for the MACs. The transmittal number, CR release date and link to the transmittal also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting claims to Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for oxygen services provided to Medicare beneficiaries.

Provider Action Needed

CR 9848 updates Chapter 20, Section 130.6 of the "Medicare Claims Processing Manual" to provide additional instructions in processing claims for oxygen and oxygen equipment. Make sure that your billing staffs are aware of these changes.

Key Points of CR9848

The fee schedule amount for stationary oxygen equipment is increased under the following conditions. If both conditions apply, DME MACs use the higher of either of the following add-ons, but may not pay both add-ons:

Volume Adjustment

If the prescribed amount of oxygen for stationary equipment exceeds 4 liters per minute, the fee schedule amount for stationary oxygen rental is increased by 50 percent. If the prescribed liter flow for stationary oxygen is different than for portable or different for rest and exercise, DME MACs use the prescribed amount for stationary systems and for

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patients at rest. If the prescribed liter flow is different for day and night use, DME MACs use the average of the two rates.

Portable Add-on

If portable oxygen is prescribed, the fee schedule amount for portable equipment is added to the fee schedule amount for stationary oxygen rental.

The following HCPCS code modifiers should be used to denote when the oxygen flow exceeds 4 liters per minute:

- QF - Prescribed amount of oxygen is greater than 4 Liter Per Minute (LPM) and portable oxygen is prescribed
- QG - Prescribed amount of oxygen is greater than 4 Liters Per Minute (LPM)

The modifier “QF” should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 LPM.

Effective April 1, 2017, stationary and portable oxygen and oxygen equipment QF fee schedule amounts will be added to the DMEPOS fee schedule file. The stationary oxygen and oxygen equipment QF fee schedule amount on the file will represent 100 percent of the stationary oxygen and oxygen equipment allowed fee schedule amount. The portable oxygen equipment add-on QF fee schedule amount on the file by state will represent the higher of:

1) 50 percent of the monthly stationary oxygen payment amount (codes E0424, E0439, E1390, E1391) or
2) The fee schedule amount for the portable oxygen add-on (codes E0431, E0433, E0434, E1392 or K0738).

The following are possible claims processing scenarios:

Scenario 1 – A claim for stationary oxygen equipment is submitted with the QG modifier. Medicare reviews the history and discovers that portable oxygen equipment was billed AND paid within the last 30 days prior to the date of service for the stationary oxygen equipment. Since the portable oxygen equipment add-on payment has already been made for this month, the volume adjustment add-on payment shall not be made in accordance with the rules of the statute. Use of the QG modifier is inappropriate in this case, and the claim should be returned as unprocessable.

Scenario 2 – A claim for stationary oxygen equipment is submitted with the QG modifier, and within 30 days the beneficiary needs portable oxygen equipment. In this case, the volume add-on payment has already been made for this month, so the portable oxygen equipment add –on payment shall not be made in accordance with the rules of the statute. The claim for the portable oxygen equipment should be returned as unprocessable.

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Scenario 3 – A claim for stationary oxygen equipment is submitted with the QG modifier AND a claim for portable oxygen equipment is submitted with the same date of service. In this case EVERYTHING is returned as unprocessable due to the incorrect use of the modifier, and neither the claim for stationary oxygen equipment with the QG modifier nor the claim for portable oxygen equipment is valid.

NOTE: All these claims are being returned as unprocessable since there is no way for Medicare to know whether the first submitted claim was billed incorrectly or the subsequent claim was billed incorrectly.

Unprocessable claims will be returned with the following messages:

- Group Code: CO (Contractual Obligation)
- Claim Adjustment Reason Code (CARC) 4 - The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remarks Code (RARC) MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Additional Information

The official instruction, CR9848, issued to your MAC regarding this change is available at **https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3730CP.pdf.**

If you have any questions, please contact your MAC at their toll-free number. That number is available at **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/**.

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