LINCARE
3150 SOUTH ENERGY LANE
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CASPER, WYOMING 82604

TEL: 307-237-1004
800-359-0240
FAX: 307-577-1521

LINCARE®

April 15, 2014

Medicare Appeal Number: 1-2051312300

HHS OMHA Centralized Docketing
200 Public Square, Suite 1260
Cleveland, OH 44114-2316

RE: Mary Parvin (HIC#: 566627161A)

To Whom It May Concern:

I'm writing to request a telephone hearing with an Administrative Law Judge (ALJ) for the E1390 (oxygen concentrator) and E0431 (portable gaseous O2) provided to Mary Parvin for dates of service 2/12/12-5/12/12. The attached Medicare Reconsideration Decision dated 2/18/14 indicates we did not provide a copy of the SAT test results listed on the CMN (referencing a physician's order dated 8/29/12).

Lincare, Inc. provided the previous reviewer with a copy of the discharge orders from Carson Tahoe Regional Healthcare dated 8/29/11 that document the patient had a SAT of 81% at rest on room air, and 93% on oxygen at 2 lpm. We also provided medical chart notes throughout the patient's hospital stay that document the patient was on oxygen. The oxygen was removed on the day of discharge, the patient quickly desaturated to 81%, so the oxygen was placed back on at the rate of 2 lpm and the patient's SAT came back to 93%.

Lincare, Inc. previously provided all of the information (listed below) that supports the medical necessity for the equipment delivered to the beneficiary. If any of this information is not available, or is difficult to view from the previous appeal records, please feel free to contact me for a copy of anything you may need.

1. Medicare Appeal Decision letter from C2C Solutions, Inc.
2. Prescription for equipment
3. Verbal Order requesting Lincare to provide equipment
4. Lincare, Inc.'s CMN(s)
5. Evidence of qualifying test results
6. Chart notes
7. Lincare, Inc.'s Proof of Delivery
8. Lincare, Inc.'s Patient Agreement and Consent

Lincare, Inc. maintains that all coverage criteria contained in the Medicare policy have been met for this Beneficiary. Lincare, Inc. thanks you in advance for your review of the attached information. If you have any questions, or need additional information, please feel free to contact me.

Respectfully,

Steven Urhammer
Lincare, Inc.
307-237-1004 x149

Cc: Mary Parvin (beneficiary)

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Dear Lincare, Inc. Customer,

As you may be aware, Medicare is conducting an audit on the durable medical equipment you received from Lincare, Inc., as part of a widespread random audit. Medicare denied payment to Lincare, Inc., and we are in the process of appealing the decision to an Administrative Law Judge (ALJ).

Lincare, Inc. is providing you with the attached copy of our final appeal request for a telephone hearing before an ALJ.

There is no action required on your part. In fact, Lincare cannot charge a beneficiary in this situation unless we had notified you prior to delivery that you would be liable. Medicare allows for us to bill only for deductibles and co-insurance. If a beneficiary has a supplemental policy, then co-insurance and deductibles would be forwarded to your secondary insurance instead.

As part of Lincare, Inc.'s commitment to providing excellent customer service to our patients, Lincare, Inc. will conduct and follow through with this appeal request on your behalf. Once the hearing has been conducted, the judge will issue a decision to Lincare, Inc. A carbon copy of the judge's decision may be sent to you.

In the unlikely event that Medicare continues to deny your claims, you will be notified so that we can resolve any specific concerns pertaining to your medical record.

Thank you,

Audit Team

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICARE HEARINGS AND APPEALS

REQUEST FOR MEDICARE HEARING BY AN ADMINISTRATIVE LAW JUDGE

☐ Part A
☑ Part B

Effective July 1, 2005. For use by party to a reconsideration determination issued by a Qualified Independent Contractor (QIC)
(Amount in controversy must be $100 or more.)

Send copies of this completed form to:
Original *— Office of Medicare Hearings and Appeals Field Office specified in the QIC Reconsideration Notice*
Copy *— Appellant* ***Copy*** *— All other parties*
Failure to send a copy of this completed request to the other parties to the appeal will delay the start date of your appeal.
Did you send all required copies? ☑ Yes ☐ No

Appellant *(The party appealing the reconsideration determination)*
LINCARE, INC.

Beneficiary *(Leave blank if same as the appellant.)*			Provider or Supplier *(Leave blank if same as the appellant.)*		
MARY PARVIN					
Address 2 NORTH AVENA AVE			Address 3150 S ENERGY LANE		
City LODI	State CA	Zip Code 95240	City CASPER	State WY	Zip Code 82604
Area Code/Telephone Number (209) 333-8121	E-mail Address		Area Code/Telephone Number (307) 237-1004	E-mail Address	
Health Insurance (Medicare) Claim Number 566627161A			Document control number assigned by the QIC 1-2051312300		
QIC that made the reconsideration determination C2C SOLUTIONS, INC			Dates of Service From 02/12/2012	To 05/12/2012	

I DISAGREE WITH THE DETERMINATION MADE ON MY APPEAL BECAUSE:

(Please see attached.)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Office of Medicare Hearings and Appeals Field Office will give you a list of legal referral and service organizations. *(If you are represented and have not already done so, complete form CMS-1696.)*

Check **Only One** Statement:
- ☑ I **wish** to have a hearing. via telephone
- ☐ I **do not wish** to have a hearing and I request that a decision be made on the basis of the evidence in my case. *(Complete form HHS-723, "Waiver of Right to an ALJ Hearing.")*

Check **Only One** Statement:
- ☐ I **have** additional evidence to submit.
- ☑ I **have no** additional evidence to submit.

If you have additional evidence to submit, please attach the evidence or attach a statement explaining what you intend to submit and when you intend to submit it. If you are a provider, supplier, or beneficiary represented by a provider or supplier, the evidence must be accompanied by a good cause statement explaining why the evidence is being submitted for the first time at the ALJ level.

The appellant should complete No. 1 and the representative, if any, should complete No. 2. If a representative is not present to sign, print his or her name in No. 2. Where applicable, check to indicate if appellant will accompany the representative at the hearing. ☐ Yes ☐ No

1. (Appellant's Signature)		Date 04/16/2014	**2.** (Representative's Signature/Name)		Date
Address 3150 S ENERGY LANE			Address		☐ Attorney ☐ Non-Attorney
City CASPER	State WY	Zip Code 82604	City	State	Zip Code
Area Code/Telephone Number (307) 237-1004 ext 149	E-mail Address		Area Code/Telephone Number	E-mail Address	

Answer the following questions that apply:
- A) Does request involve multiple claims? (If yes, a list of all the claims must be attached.) ☑ Yes ☐ No
- B) Does request involve multiple beneficiaries? (If yes, a list of beneficiaries, their HICNs and the dates of service.) ☐ Yes ☑ No
- C) Did the beneficiary assign his or her appeal rights to you as the provider/supplier? ☐ Yes ☑ No
  (If yes, you must complete and attach form CMS-20031. Failure to do so will prevent approval of the assignment.)

Must be completed by the provider/supplier if representing the beneficiary:

I waive my rights to charge and collect a fee for representing _____ (Beneficiary name) before the Office of Medicare Hearings and Appeals.

Signature of provider/supplier representing beneficiary	Date

ATTACH A COPY OF THE RECONSIDERATION DETERMINATION (IF AVAILABLE) TO THIS COPY.

Must be completed by the provider/supplier if representing the beneficiary, they furnished the item(s) or services(s) at issue, and the appeal involves a question of liability under section 1879(a)(2) of the Social Security Act:

I waive my right to collect payment from the beneficiary for the furnished items or services at issue involving 1879(a)(2) of the Social Security Act.

Signature of provider/supplier representing beneficiary	Date

TO BE COMPLETED BY THE OFFICE OF MEDICARE HEARINGS AND APPEALS

Is this request filed timely? ☐ Yes ☐ No

If no, attach appellant's explanation for delay. If there is no explanation, send a Notice of Late Filing of Request for ALJ Hearing to the appellant and representative, if applicable, to request such an explanation.

Request received on	Field Office	Employee
Assigned on	Assigned by	Assigned to

Special response case? ☐ Yes ☐ No

If yes, explain why and state the targeted adjudication deadline.

Is the prehearing translator needed (including sign language)? ☐ Yes ☐ No

If yes, type needed.

If appellant not represented, has a list of legal referral and service organizations been provided? ☐ Yes ☐ No

PRIVACY ACT STATEMENT

The legal authority for the collection of information on this form is authorized by the Social Security Act (section 1155 of Title XI and sections 1852(g)(5), 1860D-4(h)(1), 1869(b)(1), and 1876 of Title XVIII). The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form may be disclosed by the Office of Medicare Hearings and Appeals to another person or governmental agency only with respect to the Medicare Program and to comply with Federal laws requiring the disclosure of information or the exchange of information between the Department of Health and Human Services and other agencies.