

# Oxygen and Oxygen Equipment

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification as applicable.

Oxygen requires precertification and certain codes require a physician face-to-face.

<b>National Coverage Determination Policy</b>	CMS Publication 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Sections 240.2, 240.2.1
<b>Local Coverage Determination Policy</b>	J- B/C
<b>Effective Date</b>	For services performed on or after 10/31/13
<b>Revision/Review Date</b>	12/18, 06/05/2018, 07/01/17, 07/01/16, 10/08/14
<b>The Health Plan</b>	Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents.  <b>West Virginia Medicaid</b> has updated oxygen requirements for MCO's- please follow those payment rules and contractual agreements when indicated.

## DESCRIPTION

Oxygen therapy is the administration of oxygen as a medical intervention.

**COVERAGE GUIDELINES**

Home oxygen therapy is covered only if all of the following conditions are met:

1. The treating physician has determined that there is a diagnosis of severe lung disease (COPD, CF, interstitial lung disease.) or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The blood gas study (arterial blood gas or oximetry testing) meets the criteria stated below, and
3. The qualifying blood gas study (arterial blood gas or oximetry testing) was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study (arterial blood gas or oximetry testing) was obtained under the following conditions:
  - If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than two days prior to the hospital discharge date, or
  - If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and
5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

**Group I** criteria include any of the following:

1. An arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or
2. An arterial PO<sub>2</sub> at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least five minutes taken during sleep for a member who demonstrates an arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or
3. A decrease in arterial PO<sub>2</sub> more than 10 mm Hg, or a decrease in arterial oxygen saturation more than five percent, for at least five minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and (nocturnal restlessness or insomnia) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia or
4. An arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a member who demonstrates an arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen would be authorized for use during exercise, if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the member was breathing room air.

Per Medicare initial coverage for individuals, meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. For Medicare and Commercial lines of business, The Health Plan will authorize the 36-month cap if lifetime need is established with a definitive respiratory diagnosis (e.g., COPD, OSA, CA, sarcoidosis, etc.) Diagnosis of hypoxemia and/or respiratory insufficiency does not meet that requirement. Medicaid reimbursement is subject to BMS rules and contractual agreement.

**Note:** Medicare and THP require a secondary diagnosis if using hypoxemia as the primary diagnosis.

**NOTE:** If the provider submits a request for coverage under the 5 percent rule (#3) above, they must include the information from the medical record documenting the signs and symptoms attributed to hypoxemia. If that information is not included, the request will be denied as not meeting coverage guidelines.

To meet under **Group II** coverage, submission of an arterial PO2 of 56 - 59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five minutes, or during exercise (as described under Group I criteria) and any of the following:

1. Dependent edema suggesting congestive heart failure, or
2. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, III, or AVF), or
3. Erythrocythemia with a hematocrit greater than 56 percent.

For Medicare initial coverage for members, meeting Group II criteria is limited to three months or the physician-specified length of need, whichever is shorter. The Health Plan will review on a case-by-case basis.

**NOTE:** Other than authorization for lifetime use, the duration of need may be limited based on the diagnosis (reason for requiring oxygen). Diagnoses that may qualify for limited oxygen use are:

Asthma	Croup	Pneumonia
Bronchitis	Hemoglobinopathies	CHF
Cluster Headaches (see below)	Infants w/BPD	

Requests for ongoing oxygen therapy in these circumstances will be subject to medical review and submission of qualifying lab results on a case-by-case basis. Initial authorization will be for one to three months and will require a new pulse oximetry or ABG if the physician wants to extend the authorization. The repeat blood gas or pulse ox study must be performed within 30 days prior to the date of the request and a new precertification must be obtained.

**COVERAGE IN CONJUNCTION WITH PAP**

In order to meet the use for a PAP device with oxygen, the criteria in both policies must be met.

Only testing from approved providers will be accepted.

Providers are to follow all of the requirements set forth by Medicare when qualifying The Health Plan members for coverage.

Providers are encouraged to review coverage guidelines outlined in Medicare’s Coverage Determination Policies on oxygen and PAP devices.

**Note:** It is expected that the OSA has been treated to a point that the patient is in a chronic stable state before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy.

To qualify for oxygen placed after Pap devices are in use the member will need to have a saturation study done while using the PAP device.

### **PORTABLE OXYGEN SYSTEMS**

A portable oxygen system is covered if the patient is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise.

If the coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. *(See exception in "Liter Flow Greater Than 4 LPM.")*

If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the patient uses. Reimbursement is the same, regardless of the quantity of oxygen dispensed. Portable fills are not separately payable during stationary system rental period.

### **LITER FLOW GREATER THAN 4 LPM**

A repeat blood gas study is required with liter flow change of greater than 4 liters per minute (LPM). A physician visit is not required.

A new blood gas study is not required if liter flow change is ordered when someone is authorized already at > 4 LPM and rate is increased from four liters.

If basic oxygen coverage criteria has been met, a higher allowance for a stationary system for a flow rate of greater than 4 LPM will be paid only if a blood gas study performed while the patient is on 4 LPM meets Group I or II criteria. The monthly payment for the stationary system will be reimbursed based on contractual agreement, or the The Health Plan Fee Schedule amount for the portable oxygen add-on.

If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, the higher allowance will not be paid.

### **COVERAGE OXIMETERS**

For Medicare Advantage plans, oximeters (E0445) and replacement probes (A4606) will be denied as not covered because they are monitoring devices that provide information to physicians to assist in managing the patient's treatment and are not covered by Medicare.

For Commercial plans, The Health Plan will allow rental of E0445 up to purchase price, per lifetime of the member. With respiratory diagnoses, such as RSV, apnea, poor lung development d/t prematurity, respiratory distress syndrome, GERD, patent ductus arteriosus (PDA), bronchopulmonary dysplasia (BPD), and cystic fibrosis, where symptoms require oxygen or apnea monitor. Probes (A4606) are not separately billable during rental period.

Mountain Health Trust allows one unit of E0445 per lifetime, ten-month capped rental item. A licensed respiratory specialist, nurse, or physician must be on staff. Code A4606 is not separately billable during capped rental period.

**OXYGEN ACCESSORIES**

Accessories, including but not limited to, transtracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with patient-owned oxygen equipment will be denied as not covered.

Water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for patients with rented home oxygen equipment.

**CLINICAL TRIALS**

Under Medicare, oxygen is covered for patients who are enrolled subjects in clinical trials approved by CMS and sponsored by the National Heart, Lung, and Blood Institute (NHLBI) and who have an arterial PO<sub>2</sub> from 56 to 65 mmHg or oxygen saturation at or above 89 percent. The additional Group 2 coverage criteria do not apply to these patients.

**COVERAGE CRITERIA FOR MEDICARE BENEFICIARIES WITH CLUSTER HEADACHES**

As of 01/04/2011, The Medicare Advantage Plans will cover oxygen for members with the diagnosis of cluster headaches when they are enrolled in a Medicare/Medicaid approved clinical trial for gaining further evidence. Must comply with the requirements at IOM 100-3 240.2.2.

Only a stationary gaseous oxygen system (**E0424**) and related contents (**E0441**) are covered for the treatment of cluster headaches (ICD-10 G44.009, G44.019, G44.029) for Medicare beneficiaries enrolled in a clinical trial approved by CMS. To see the compliance requirements, refer to the CMS National Coverage Determination Manual (Internet Only Manual 100-3) §240.2.2, for dates of service on or after 01/04/2011. Refer to the link below for information.

CMS adopted the diagnostic criteria used by the International Headache Society to form a definitive diagnosis of cluster headaches (CH). Therefore, once admitted into the clinical study, the home use of oxygen to treat CH is covered by Medicare, only when furnished to Medicare beneficiaries who have had at least five severe to very severe unilateral headache attacks lasting 15 - 180 minutes when untreated. (Intensity of pain: degree of pain usually expressed in terms of its functional consequence and scored on a verbal five-point scale: 0=no pain; 1=mild pain, does not interfere with usual activities; 2=moderate pain, inhibits but does not wholly prevent usual activities; 3=severe pain, prevents all activities; 4=very severe pain. It may also be expressed on a visual analogue scale.)

**The headaches must be accompanied by at least one of the following findings:**

1. Ipsilateral conjunctival injection and/or lacrimation; or
2. Ipsilateral nasal congestion and/or rhinorrhea; or
3. Ipsilateral eyelid edema; or
4. Ipsilateral forehead and facial sweating; or
5. Ipsilateral miosis and/or ptosis; or
6. A sense of restlessness or agitation.

To view the complete article, click on the link

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Requests for oxygen for cluster headaches, for all other product lines, will be reviewed on a case-by-case basis. For other lines of business please follow standard coding of oxygen stationary and portable systems.

### COVERAGE GUIDELINES: TESTING SPECIFICATIONS

Baseline saturation is defined by CMS as the mean saturation level during the duration of the test. For the purpose of meeting criterion 3 described in Group I above there must be a minimum of two hours test time recorded for sleep oximetry. The result must reach a qualifying test value otherwise the Group III presumption of non-coverage applies.

When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test at rest/awake is non-qualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage.

A provider who is qualified to bill Medicare for the test must do the qualifying blood gas study, for example, a Part A provider, a laboratory, an independent diagnostic testing facility (IDTF), or a physician. The DME supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, any supplier may not pay for the qualifying blood gas study. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests.

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

### EXERCISE OXIMETRY

Requires all three tests

1. Testing at rest w/o oxygen, and
2. Testing during exercise w/o oxygen, and
3. Testing during exercise w/ oxygen applied.

Recovery testing may be submitted, but it is not one of the required elements.

Unsupervised or remote exercise testing will not be accepted.

If a CMN is submitted, The Health Plan retains the right to request documentation from the medical record in order to determine if coverage criteria has been met.

#### OVERNIGHT OXIMETRY STUDY

May be done at home or in a facility.

**Home overnight oximetry** is acceptable for qualification; however, it is limited to stand alone overnight pulse oximetry. **It cannot be part of a home sleep testing for obstructive sleep apnea, or any other type of home testing.**

The oximeter provided must be tamper-proof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value

For all the overnight oximetry criteria described above, the five minutes does not have to be continuous. For coverage there must be a minimum of two hours test time recorded and the result must meet the coverage guidelines in Group I.

#### NONCOVERAGE STATEMENT

Oxygen accessories and supplies will not be separately billable/payable with multi functional home ventilator system ( E0467) – Please see ventilator policy for specific information.

Oxygen therapy will be denied as not reasonable and necessary if any of the following conditions are present:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
2. Members with an arterial PO<sub>2</sub> levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent.
3. Dyspnea without cor pulmonale or evidence of hypoxemia.
4. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO<sub>2</sub> will improve the oxygenation of tissues with impaired circulation.
5. Terminal illnesses that do not affect the respiratory system.
6. Emergency or stand-by oxygen systems, and oxygen PRN, as needed, will be denied as not reasonable and necessary, since they are precautionary and not therapeutic in nature and does not meet the frequency/duration requirement.
7. Oxygen services furnished by an airline to a member are non-covered. Payment for oxygen furnished by an airline is the responsibility of the member and not the responsibility of the supplier.
8. Medicare does not cover items or services provided/used outside the United States and its territories. The supplier is not required to provide or arrange for oxygen use in those situations. The Health Plan has adopted this policy.
9. **E1352 - Breathe NIOV** (noninvasive open ventilation system). Provides positive pressure inspiratory support for member's on oxygen. It is considered an oxygen accessory. It is all inclusive. It is not eligible for separate billing as it is a stand-alone DME. It is not considered a ventilator or any other type of positive airway pressure device. **Per MHT: Not covered as limited**

**research available. Device used by physiotherapist to improve lung function.** West Virginia Medicaid does not enroll physiotherapist as providers.

10. If the only qualifying blood gas study was performed during sleep, *portable* oxygen will be denied as not reasonable and necessary.
11. Only rental oxygen equipment is eligible for coverage. Purchased oxygen equipment is statutorily non-covered.
12. Respiratory therapist services are non-covered under the DME benefit.
13. **Topical hyperbaric oxygen chambers** (A4575) will be denied as not reasonable and necessary.
14. **Topical oxygen delivery systems** (E0446) are not covered.
15. **Preset Portable Oxygen Systems:** (flow rate deny - emergency, first aid, or not adjustable) precautionary equipment; essentially not therapeutic in nature.

**CODING INFORMATION**

**CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.**

**HCPCS MODIFIERS**

<b>EY</b>	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE
<b>Q0 (zero)</b>	INVESTIGATIONAL CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY
<b>QE</b>	PRESCRIBED AMOUNT OF OXYGEN IS LESS THAN 1 LITER PER MINUTE (LPM)
<b>QF</b>	PRESCRIBED AMOUNT OF OXYGEN IS GREATER THAN 4 LITER PER MINUTE (LPM) AND PORTABLE OXYGEN IS ALSO PRESCRIBED
<b>QG</b>	PRESCRIBED AMOUNT OF OXYGEN IS GREATER THAN 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS NOT PRESCRIBED
<b>QH</b>	OXYGEN CONSERVING DEVICE IS BEING USED WITH AN OXYGEN DELIVERY SYSTEM
<b>RA</b>	REPLACEMENT OF A DME ITEM

**HCPCS CODES  
EQUIPMENT**

<b>E0424</b>	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
<b>E0425</b>	STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING

<b>E0430</b>	PORTABLE GASEOUS OXYGEN SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING
<b>E0431</b>	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING
<b>E0433</b>	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUIFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, REGULATORS, FLOWMETER, HUMIDIFIER, CANNULA, OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESEVOIR AND CONTENTS GAUGE
<b>E0434</b>	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING
<b>E0435</b>	PORTABLE LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOWMETER, HUMIDIFIER, CONTENTS GAUGE, CANNULA OR MASK, TUBING AND REFILL ADAPTOR
<b>E0439</b>	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
<b>E0440</b>	STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
<b>E0441</b>	STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
<b>E0442</b>	STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
<b>E0443</b>	PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
<b>E0444</b>	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
<b>E0445</b>	OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NONINVASIVELY
<b>E0446</b>	TOPICAL OXYGEN DELIVERY SYSTEM, NOT OTHERWISE SPECIFIED, INCLUDES ALL SUPPLIES AND ACCESSORIES
<b>E0447</b>	PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH SUPPLY= 1 UNIT, PRESCRIBED AMOUNT AT REST OR NIGHTTIME EXCEEDS 4 LITERS PER MINUTE (LPM)
<b>E1390</b>	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE
<b>E1391</b>	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH
<b>E1392</b>	PORTABLE OXYGEN CONCENTRATOR, RENTAL
<b>E1405</b>	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY
<b>E1406</b>	OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY

<b>K0738</b>	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING
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### HCPCS CODES ACCESSORIES

<b>A4575</b>	TOPICAL HYPERBARIC OXYGEN CHAMBER, DISPOSABLE
<b>A4606</b>	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT
<b>A4608</b>	TRANSTRACHEAL OXYGEN CATHETER, EACH
<b>A4615</b>	CANNULA, NASAL
<b>A4616</b>	TUBING (OXYGEN), PER FOOT
<b>A4617</b>	MOUTH PIECE
<b>A4619</b>	FACE TENT
<b>A4620</b>	VARIABLE CONCENTRATION MASK
<b>A7525</b>	TRACHEOSTOMY MASK, EACH
<b>A9900</b>	MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE
<b>E0455</b>	OXYGEN TENT, EXCLUDING CROUP OR PEDIATRIC TENTS
<b>E0555</b>	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
<b>E0580</b>	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
<b>E1352</b>	OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE
<b>E1353</b>	REGULATOR
<b>E1354</b>	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
<b>E1355</b>	STAND/RACK
<b>E1356</b>	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
<b>E1357</b>	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
<b>E1358</b>	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH

**ICD-10 CODES FOR OXYGEN**

<b>C34.00-C34.90</b>	<b>MALIGNANT NEOPLASM OF BRONCHUS AND LUNG</b>
<b>C78.00-C78.02</b>	SECONDARY MALIGNANT NEOPLASM OF LUNG
<b>C94.00-D45</b>	ACUTE OR CHRONIC ERYTHREMIA
<b>D14.30-D14.32</b>	BENIGN NEOPLASM OF BRONCHUS AND LUNG
<b>D02.20-D02.22</b>	CARCINOMA IN SITU OF BROCNCHUS AND LUNG
<b>E84.0-E84.9</b>	CYSTIC FIBROSIS
<b>D58.1-D58.2</b>	HEREDITARY ELLIPTOCYTOSIS AND OTHER HEMOGLOBINOPATHIES
<b>D45 &amp; D75.0-D75.1</b>	POLYCYTHEMIA VERA AND SECONDARY AND FAMILIAL POLYCYTHEMIA
<b>I26.01-I26.09</b>	PULMONARY EMBOLISM WITH /OR ACUTE COR PULMONALE
<b>I27.0-I27.81, I27.9</b>	CHRONIC PULMONARY HEART DISEASE
<b>I50.20-I50.9</b>	CONGESTIVE HEART FAILURE, UNSPECIFIED
<b>J05.0</b>	CROUP
<b>J12.0-J18.9</b>	PNEUMONIA
<b>J40-J41.8</b>	BRONCHITIS
<b>J45.20-J45.998</b>	ASTHMA
<b>J47.9-J47.1</b>	BRONCHIECTASIS
<b>J44.9</b>	CHRONIC AIRWAY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
<b>J84.10, J84.89</b>	POSTINFLAMMATORY PULMONARY FIBROSIS
<b>P29.3</b>	PERSISTENT FETAL CIRCULATION
<b>Q33.4</b>	CONGENITAL BRONCHIECTASIS
<b>P27.0-P27.8</b>	CHRONIC RESPIRATORY DISEASE ARISING IN THE PERINATAL PERIOD
<b>R06.00-R06.89</b>	OTHER DYSPNEA AND RESPIRATORY ABNORMALITIES
<b>R09.02</b>	HYPOXEMIA

ICD-10 codes above may indicate medical necessity. Not an all-inclusive list. An ICD-10 code alone is insufficient to qualify for coverage. See coverage guidelines and documentation requirement sections for additional information. There may be other diagnoses or ICD-10 codes that may indicate medical necessity.

**ICD-10 CODES for HCPCS CODE E0424**

<b>G44.001-G44.029</b>	CLUSTER HEADACHES
<b>Z00.6</b>	EXAMINATION OF A PARTICIPANT IN A CLINICAL TRIAL. MUST BE USED CONCURRENTLY WITH ONE OF THE ABOVE DIAGNOSIS CODE

**PRECERTIFICATION GUIDELINES**

1. Precertification is required with the initial placement/ request for home oxygen.
2. During the first 36-month capped rental period if there is a change in the member's condition that caused a break in the need for oxygen in the span of 60 days or greater. This indication does not apply if there was just a break in billing because the patient was in a hospital, nursing facility, hospice, or Medicare HMO, but the patient continued to need oxygen during that time. Failure to notify The Health Plan of this condition may adversely impact reimbursement.
3. When the equipment has been replaced due to the reasonable useful lifetime (RUL). Repeat testing or physician visit specifically for completion of authorization is not usually required in this instance. Please report the most recent qualifying value and test date. The initial date is generally understood as the member's equipment delivery date. The initial rental month must have the RA modifier added to the HCPCS code; whether replaced due to RUL or irreparable damage. The provider must give a replacement reason with supporting documentation with precertification. Physician face-to-face within six months of replacement is required.
4. When replaced because of irreparable damage (specific accident or natural disaster), theft, or loss of the original equipment. This does not include wear and tear over time. Repeat testing or physician visit is not required in this instance. The initial date is generally understood as the member's equipment delivery date. The initial rental month must have the RA modifier added to the HCPCS code; whether replaced due to RUL or irreparable damage. The provider must give a replacement reason with supporting documentation with precertification replacement oxygen requires precertification with reason equipment is being replaced. Nurse reviewer may require repeat testing dependent on diagnosis and previous testing.
5. Changing plans within The Health Plan or coming to The Health Plan from another insurance company.
6. Changing from non-contracted to contracted provider or from contracted to non-contracted provider.
7. Changing between contracted suppliers.  
**Note:** If there is a new supplier, that supplier must be able to provide a CMN or the supporting clinical documentation on request. That CMN would not necessarily be an Initial CMN or the first CMN for that patient. If the supplier obtains a new CMN, it would be accepted for precertification if all relevant clinical information is included.
8. When previous authorization was less than lifetime (e.g., less than the 36 months to capitate).
9. Portable subsequently added to an existing stationary system. There is no requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the patient is at rest (awake) or during exercise within 30 days prior to precertification/delivery of oxygen.

10. Stationary subsequently added to a portable system, subsequent to initial. In this situation, there is no requirement for a repeat blood gas study. Rationale for addition is required.
11. Member is being enrolled in Medicare approved clinical trial (i.e., O2 for treatment cluster headaches).
12. When the member did not initially meet coverage criteria, but is retested, and now meets coverage criteria. The initial precertification date is that of the subsequent qualifying blood gas study.
13. The Health Plan nurse reviewer will decide if a new precertification is required when there is a new treating physician but the oxygen order is the same. In this situation, there is no requirement for a repeat blood gas study.
14. When the length of need expires. If the physician specified less than lifetime length of need on the most recent CMN. In this situation, a blood gas study must be performed within 30 days prior to the precertification.

The patient must be seen and evaluated by the treating physician within a reasonable time of requesting and obtaining oxygen. The generally accepted time is 30 days prior to the date of the initial precertification. However, in order to meet ACA guidelines will allow the physician face-to-face to have been within the last six months prior to the order. There must have been a discussion and an assessment regarding the need for oxygen during that visit to qualify as a face-to-face for oxygen.

The patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any updated requests for oxygen.

**Additional notification is required with the following and will not result in a new capped rental period for:**

1. Change in modalities
2. Change in liter flow
3. Change in anniversary date. May be submitted with claim. Notify The Health Plan with reason for the change.

Providers are to notify The Health Plan when changing modalities, or a change in liter flow, and/or change in ordering physician. Although new 36-month capped period does not begin, reimbursement of future contents or M&S may be impacted. See MIPPA rules at end of policy.

## DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
  - a. Member's name

- b. Date
- c. Description of item. The medical record must contain the information that supports the request for each item, and must be submitted with the precertification if the item requires precertification, or with the claim, if no precertification was required
- d. Order must include diagnosis code
- e. Physician signature with date. Date stamps are not appropriate
- f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per The Health Plan policy.
3. Proof of delivery to be kept on file by the provider of the item.

**Note:** If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), and all of the required information is not included, The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

**Note:** Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

For initial certifications, the blood gas study reported must be the most recent study obtained prior to the initial date. If providers are submitting a Medicare CMN, the initial date is indicated in Section A of the CMN and the study and physician face-to-face must be obtained within 30 days prior to that initial date.

The Health Plan does not require the 13<sup>th</sup> month recertification CMN on a routine basis; however, **The Health Plan reserves the right to request a repeat blood gas or ABG at any time for any situation described above when The Health Plan feels it is necessary to make a determination for coverage.**

For any revised CMN, the blood gas study reported on the CMN must be the most recent test performed prior to the revised date.

#### **COVERAGE OF OXYGEN WHILE MEMBER IN PART A FACILITY**

Reimbursement for oxygen provided to a member while the member is admitted in an acute hospital, rehabilitation, or skilled nursing unit is based on specific contract information with the individual facility. Oxygen therapy is usually included in the per diem for Part A facilities.

#### **EQUIPMENT RETAINED FROM A PRIOR PAYOR:**

The Health Plan will not pay in excess of the contracted purchase or capitation price for any item in this policy. If the provider is seeking payment from The Health Plan, the item must be precerted and The

Health Plan will pay the remaining rental months up to purchase or capitation price- if the member meets guidelines above.

## **BILLING GUIDELINES: OXYGEN EQUIPMENT**

### **Initial 36 months**

Reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories (e.g., cannula, tubing, etc.), delivery, back-up equipment, maintenance, and repairs is included in the rental allowance. Payment for oxygen contents (stationary and/or portable) is included in the allowance for stationary equipment (E0424, E0439, E1390, E1391).

Payment for stationary equipment is increased for patients requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for patients requiring less than 1 LPM. If a patient qualifies for additional payment for greater than 4 LPM of oxygen and meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month rental period, unless one of the following exceptions is met:

- Beneficiary relocates temporarily or permanently outside of the supplier's service area
- Beneficiary elects to obtain oxygen from a different supplier
- Individual case exceptions made by The Health Plan

Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, trans-filling equipment) is not permitted unless one of the following requirements is met:

- Supplier replaces the equipment with the same or equivalent item
- Physician orders different equipment
- Beneficiary chooses to receive an upgrade and signs an Advance Beneficiary Notice of Non-coverage (ABN)
- The Health Plan determines that a change in equipment is warranted

### **A new 36-month rental period can begin only in the following situations:**

- Specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost
- Break-in need for at least 60 days plus the days remaining in the month of discontinuation and new medical necessity is established (*see BREAK-IN SERVICE below*). Break-in billing does not count.
- Changing supplier's d/t competitive bidding – A supplier is going out of business and/or no longer supplying and/or servicing oxygen.

### **A new 36-month rental period does not start in the following situations:**

- Replacing equipment due to malfunction, wear and tear, routine maintenance, repair

- Providing different equipment based on a physician order or beneficiary request for an upgrade (i.e., change in modality (gas to liquid, liquid to gas, change from gas or liquid portable to portable concentrator, etc.))
- Break-in need less than 60 days plus the days remaining in the month of discontinuation (*see BREAK-IN SERVICE below*)
- Break-in billing
- Changing suppliers, unless there is documented evidence of bankruptcy of current supplier. (*Please refer to proof of bankruptcy requirements at the end of this policy.*)

### **Months 37 – 60**

There is no further payment for oxygen equipment during the five year reasonable useful lifetime (RUL) of the equipment after 36 rental payments have been made. If use of portable equipment (E0431, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until 36 rental payments have been made for the portable equipment.

For information on payment for contents and maintenance, see separate sections below.

The supplier who provided the equipment during the 36th rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the five year RUL of the equipment.

Rules for providing different equipment/modalities are the same in months 37 - 60 as they are in the initial 36 months (*see above*).

#### **A new 36-month rental period can begin only in the following situation:**

- There is a specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost.
- Changing supplier's d/t competitive bidding – A supplier is going out of business and/or no longer supplying and/or servicing oxygen.

#### **A new 36-month rental period does not start in the following situations:**

- Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
- Providing different equipment based on a physician order or beneficiary request for an upgrade
- Break-in need (*see BREAK-IN SERVICE below*)
- Break-in billing (*see BREAK-IN SERVICE below*)
- Changing suppliers, unless there is documented evidence of bankruptcy of current supplier. (*Please refer to proof of bankruptcy requirements at end of policy.*)

### **Months 61 and after**

At any time after the end of the five year RUL for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.

If the beneficiary elects not to receive new equipment after the end of the five year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months

37 - 60 remain in effect. There is no separate payment for accessories or repairs. If the patient was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

If the beneficiary elects not to receive new equipment after the end of the five year RUL, and the supplier transfers title of the equipment to the beneficiary; the accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for patient-owned gaseous or liquid systems.

For patient owned equipment, Medicare statutorily excludes accessories, maintenance, and repairs from coverage. If a beneficiary enters The Health Plan with patient-owned oxygen equipment, The Health Plan will follow this policy across all product lines and will only cover the contents.

### **BILLING GUIDELINES: OXYGEN CONTENTS**

Payment for stationary and portable contents is included in the allowance for stationary equipment. No payment can be made for oxygen contents in a month in which payment is made for stationary equipment.

If the patient was using stationary gaseous (E0424) or liquid oxygen (E0439) equipment during the 36th rental month, payment for stationary contents (E0441 or E0442) begins when the rental period for the stationary equipment ends.

If the patient was using portable gaseous (E0431) or liquid (E0434) equipment during the 36th rental month of stationary equipment (gaseous, liquid, or concentrator), payment for portable contents (E0443 or E0444) begins when the rental period for the stationary equipment ends. If the patient began using portable gaseous or liquid equipment after starting on stationary equipment, payment for the portable equipment would continue until the end of the 36-month rental period for that equipment even though payment was also being made for the portable contents.

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

If the patient was not using gaseous or liquid equipment (stationary or portable) in the 36th month, but was subsequently switched to gaseous or liquid oxygen based on a physician order, contents may be paid.

If the patient has a stationary concentrator, portable liquid equipment, and a stationary liquid tank to fill the portable cylinders, when payment for contents begins, payment will only be made for portable liquid contents.

There will be no payment for contents after the 36-month rental period for stationary or portable oxygen concentrator E1390, E1391, E1392.

There is no payment for contents after the 36-month rental period for portable trans-filling equipment coded K0738 (gaseous) and E1399 (liquid).

Suppliers must provide whatever quantity of oxygen contents required for a patient's activities both inside and outside the home.

A maximum of three months of oxygen contents may be delivered at any one time.

There is no difference in payment for oxygen contents for beneficiaries receiving more than 4 LPM or less than 1 LPM.

Following the stationary oxygen equipment payment cap, suppliers should bill for oxygen contents on the anniversary date of the oxygen equipment billing.

For subsequent months, the supplier does not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of three months of oxygen contents can be delivered at one time.

- In these situations, the delivery date of the oxygen contents does not have to be the DOS (anniversary date) on the claim. However, in order to bill for contents for a specific month, the supplier must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim.
- Suppliers should have proof of delivery for each actual delivery of oxygen, but as discussed above, this may be less often than monthly.

Beginning with dates of service on or after the end date of service for the month representing the 36th payment for code E0424, E0439, E0431, or E0434, the supplier may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

<b>Equipment Furnished In Month 36</b>	<b>Monthly Contents Payment After Stationary Cap</b>
<b>Oxygen Concentrator (E1390, E1391, or E1392)</b>	None
<b>Portable Gaseous Trans-filling Equipment (K0738)</b>	None
<b>Portable Liquid Trans-filling Equipment (E1399)</b>	None
<b>Stationary Gaseous Oxygen System (E0424)</b>	Stationary Gaseous Contents (E0441)
<b>Stationary Liquid Oxygen System (E0439)</b>	Stationary Liquid Contents (E0442)
<b>Portable Gaseous Oxygen System (E0431)</b>	Portable Gaseous Contents (E0443)
<b>Portable Liquid Oxygen System (E0434)</b>	Portable Liquid Contents (E0444)

Although suppliers should document the amount of contents (tanks or cylinders) that are provided, the contents allowable limit are monthly fees and will not vary according to the number of units provided. The units of service for contents codes are always one. If the patient owns a stationary system and uses a portable system, the portable content fee is paid in addition to the stationary content fee.

Providers can refer to following link to educate themselves on appropriate billing of oxygen contents in different scenarios: [noridianmedicare.com/dme/news/manual/chapter5.html%3f](http://noridianmedicare.com/dme/news/manual/chapter5.html%3f)

**BILLING: MAINTENANCE AND SERVICE****Initial 36 Months**

There is no separate payment for maintenance and servicing (M&S).

**Months 37 – 60**

If a patient was using a stationary concentrator, portable concentrator, or transfilling equipment during the 36th rental month, payment will be made for a maintenance and servicing visit no sooner than six months following the end of the rental period. A supplier must actually make a visit to bill the service.

If equipment is covered under warranty that covers labor related to routine/general maintenance, a servicing (e.g., inspection, changing filters, cleaning, and calibration), payment for M&S will occur no sooner than six months following the end of the warranty.

There is no M&S payment for gaseous or liquid equipment.

**Month 61 and after**

If the beneficiary elects not to replace a concentrator or transfilling equipment and if the supplier retains title to the equipment, coverage for M&S is the same as in months 37 - 60.

If the beneficiary elects not to replace a concentrator or transfilling equipment and if the supplier transfers title to the beneficiary, M&S is statutorily non-covered.

Providers are reminded that The Health Plan is following MIPPA for M&S reimbursement of specific HCPCS codes, unless otherwise stipulated by contract or plan benefit requirements.

Providers please click link below for helpful educational tool published by the Medicare Learning Network: [www.cms.gov](http://www.cms.gov) › Outreach and Education › MLN Homepage

**RELOCATION AND TRAVEL****Months 1 – 36**

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

**Months 37 – 60**

If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), the home supplier is required to either provide the

equipment and related items/services itself or make arrangements with a different supplier to provide the equipment and related items/services.

**BREAK-IN SERVICE:**

- Break-in billing/Part B payment without break-in medical necessity
  - If patient enters hospital or LTAC or changes plans and continues to need/use oxygen, when patient returns home or rejoins The Health Plan, payment resumes where it left off
- Break-in medical necessity (break-in need)
  - If need/use of oxygen ends for less than 60 days plus the remainder of the rental month of discontinuation and then resumes, payment resumes where it left off
  - During the 36-month rental period, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new 36-month rental period would begin
  - During months 37-60, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new rental period does not begin. The supplier who provided the oxygen equipment during the 36th rental month must provide all necessary items and services for the duration of the reasonable useful lifetime.

A new CMN or order are not required when switching between standard portable oxygen cylinders (E0431) and portable cylinders filled from a home compressor (K0738). However, the provider is to notify The Health Plan, and this does not extend capped rental period.

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

**Note:** Although The Health Plan does not require a CMN per se, providers must have all of the information on the CMN indicated above at the time of precertification, recertification, i.e., restart of care, break-in cap rental time frame, etc.

The Health Plan will accept the Medicare CMN with the supporting documentation.

When billing for oxygen contents, the following codes are to be used:

- E0441 stationary gaseous contents
- E0442 stationary liquid contents
- E0443 portable gaseous contents
- E0444 portable liquid contents

For these codes, one unit of service equals one month's supply.

These codes are used regardless of whether the supplier or beneficiary has title to the equipment.

The appropriate modifier must be used if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). These modifiers may only be used with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). They must not be used with codes for portable systems or oxygen contents.

For claims use the initial date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment.

When billing oxygen contents, suppliers should use a date of service (DOS) that is the anniversary date of the equipment whose rental period has ended. The billed DOS will usually not be the actual delivery date. The supplier must have a delivery slip for the actual delivery date.

A supplier does not have to deliver contents every month in order to bill every month. In order to bill for contents, the supplier must have previously delivered quantities of oxygen that are expected to be sufficient to last for one month following the DOS on the claim.

Suppliers may bill a flat rate for contents each month. The submitted charges do not have to vary with the quantity of tanks delivered.

Claims for oxygen contents and/or oxygen accessories should not be submitted in situations in which they are not separately payable.

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

### **Oxygen Replacement Because of Bankruptcy**

The Health Plan will allow a new 36-month capped rental period and a new reasonable lifetime period for a supplier delivering equipment to a member because of the previous supplier going bankrupt. It will fall under “lost” equipment. Billed with RA HCPCS modifier, the initial date will be date of delivery of the equipment from the new supplier. It will require a precertification. The Health Plan will need to verify that that supplier went bankrupt/went out of business and was not sold or merged with another supplier.

### **Replacement Oxygen when a Suppliers has Exited the Business**

When a supplier is no longer going to provide oxygen services to a member because they are exiting the business, whether due to voluntary or involuntary circumstances, The Health Plan will consider that equipment “lost”. See Code of Federal Regulations (CFR), Section 414.210(f).

Once the situation has been investigated and confirmed by The Health Plan Medical Management Department /Provider Services Department, the member can elect a new provider. A new 36 month capped rental would be authorized, if the initial authorization was for 36 months. No new testing would be required in that situation.

### **KX, GA, and GZ MODIFIERS**

Suppliers may submit a claim with a KX modifier only if all the criteria for that item are met.

If the coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

### ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

**NOTE:** Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

### PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Please refer to PDAC website for the appropriate product classification list. [dmepdac.com/](http://dmepdac.com/)

### MEDICARE DEFINITIONS AND DESCRIPTION

#### REASONABLE USEFUL LIFETIME (RUL)

The RUL for oxygen equipment is five years. The RUL is not based on the chronological age of the equipment. It starts on the initial date of service and runs for five years from that date.

Example: If member received equipment in 1/1/2004, member would be eligible for a new 36-month capped rental in 1/01/2009.

RUL also does not take into account exchanges of equipment, new suppliers, or changes of modality (concentrator, gaseous, liquid).

If both portable and stationary systems are provided at the same time, the RUL will run concurrently. When the beneficiaries portable system differs from the stationary system's, the RUL for the stationary system shall determine the RUL rules for both types of systems.

For example:

1. RUL of the portable system comes prior to the RUL of the stationary system. The RUL of the portable is extended to coincide with the RUL end date of the stationary system.
2. RUL of the portable comes after the RUL of the stationary system. The RUL of the portable is shortened to coincide with the RUL end date of the stationary system.

Once the RUL of the stationary equipment has been reached, *the beneficiary* may elect to obtain replacement of both the stationary and portable oxygen equipment. If the beneficiary replacement, both types of systems must be replaced **at the same time**. A new 36-month capped rental period and new RUL period will then begin.

For The Health Plan at the time of posting of this policy, competitive bidding rules do not apply. Oxygen can be obtained from contracted providers as long as the medical, contractual, and RUL criteria/obligations have been met.

Code **E1391** (oxygen concentrator, dual delivery port) is used in situations in which two beneficiaries are both using the same concentrator. In this situation, this code should only be billed for one of the beneficiaries.

Codes **E1405** and E1406 (oxygen and water vapor enriching systems) may only be used for products for which a written coding verification has been received from the PDAC.

Code **E1392** describes an oxygen concentrator, which is designed to be portable, is capable of delivering 85 percent or greater oxygen concentration, and is capable of operating on either AC or DC (e.g., auto accessory outlet) power. Code E1392 includes the device itself, an integrated battery or patient-replaceable batteries that are capable of providing at least two hours of remote portability at a minimum of 2 LPM equivalency, a battery charger, an AC power adapter, a DC power adapter, and a carry bag and/or cart. The combined weight of the concentrator and the battery/batteries capable of two hours of portability must be 20 pounds or less. If a concentrator meets all of these criteria and is capable of functioning as a stationary concentrator, operating 24 hours per day, seven days per week, the stationary concentrator code (E1390) is billed in addition to code E1392.

Code **K0738** describes a feature of an oxygen concentrator that allows the beneficiary to fill portable gaseous oxygen cylinders from a stationary concentrator. This feature may be integrated into the stationary concentrator or be a separate component. When code K0738 is billed, code E0431 (portable gaseous oxygen system, rental) must not be used.

Code **E0433** describes a feature of an oxygen concentrator that allows the beneficiary to fill portable liquid oxygen cylinders from a stationary concentrator. This feature may be integrated into the stationary concentrator or be a separate component. When code E0433 is billed, code E0434 (portable liquid oxygen system, rental) must not be used.

The term **blood gas study** in this policy refers to either an arterial blood gas (ABG) test or an oximetry test. An ABG is the direct measurement of the partial pressure of oxygen (PO<sub>2</sub>) on a sample of arterial blood. The PO<sub>2</sub> is reported as mm Hg. An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percent.

**Baseline saturation:** mean saturation level during the duration of the test.

**Chronic stable state:** not during a period of an acute illness or exacerbation of their underlying disease.

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#### MEDICARE CERTIFICATE OF MEDICAL NECESSITY:



DME Certificate of  
Medical Necessity CI

### INTERNET LINKS AND SOURCES

National Government Services website. Medical Policy Center. Durable Medical Equipment. Local Coverage Determination and Article Jurisdiction B. Oxygen and Oxygen equipment. LCD L27221 Article A47097. Last accessed 10/30/18. Retrieved

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