



Helpful hints for filing

Oxygen and oxygen-related equipment



Overview

The following information describes the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) medical policy for oxygen and oxygen-related equipment. Coding, coverage, payment, and documentation guidelines are listed on the following pages. This is to be used only as a guide.

For an item to be covered by Medicare, the following conditions apply:

(1) item must be eligible for a defined Medicare benefit category, (2) item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and (3) the item must meet all applicable Medicare statutory and regulatory requirements.

Please refer to your Supplier Manual or contact your DME MAC medical director or provider helpline for specific instructions.

Definitions

Arterial Blood Gas (ABG) – An ABG is the direct measurement of the partial pressure of gases, including oxygen (noted as PO_2) in arterial blood reported in mm Hg.

Certificate of Medical Necessity (CMN) – DME Form 484.03 (CMS 484 - Oxygen) is required to certify the need for home oxygen.

Hypoxia – The deficiency of oxygen in tissue (noted as PO_2).

Hypoxemia – The deficiency of oxygen in arterial blood (noted as PaO_2).

Oximetry – An oximetry test is the indirect measurement of arterial oxygen saturation using an oximeter sensor on the ear or finger. The saturation is reported as a percent.

Groups I, II, III – Medicare determines coverage of home oxygen based on the patient's blood gas test results. Results are categorized into three defined groups shown in the flow charts that follow.

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General coverage guidelines

Home oxygen is covered and paid by Medicare if all of the following conditions are met:

1. The patient has a severe lung disease or hypoxia-related symptoms that the physician has determined may improve with oxygen therapy.
2. The patient's blood gas study meets qualifying oxygen levels.
3. The treating physician tried or considered alternative treatment measures and determined them to be ineffective.

Medicare will deny oxygen for patients with the following conditions:

- Angina pectoris in the absence of hypoxemia dyspnea without cor pulmonale or evidence of hypoxemia
- Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia
- Terminal illnesses that do not affect the respiratory system

Medicare may cover oxygen for patients enrolled in certain CMS approved clinical trials.

Qualifying arterial blood gas studies

- The term 'blood gas study' in this Helpful Hints document refers to both an ABG test and an oximetry test.
- A qualified physician, laboratory, or independent diagnostic testing facility (IDTF) must perform the blood gas study. A DME supplier may not perform or pay for the qualifying blood gas study (this exclusion does not apply to blood gas studies performed by a hospital certified to do tests).
- If an ABG and an oximetry test are both performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), report the PO₂ from the ABG on the CMN. If the ABG PO₂ result at rest (awake) is not a qualifying value, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test will be used to determine coverage.
- If an oximetry measurement is taken during sleep, the patient must meet the qualifying oxygen saturation level for at least five minutes. The qualifying five-minute reading does not have to be continuous.
- The qualifying 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.
- Medicare has the discretion to request a repeat blood gas at any time.

The blood gas study must be performed according to the following guidelines:

1. The qualifying blood gas study is performed by a physician or by a qualified provider or supplier of laboratory services.

2. If the test is performed during an inpatient hospital stay, the reported test must be the test performed closest to, but no earlier than, two days prior to the discharge.
3. If the test is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state (not during an acute illness or exacerbation of his or her underlying disease).
4. For sleep oximetry studies, the oximeter provided to the patient must be tamperproof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specific value.

Home sleep oximetry studies

Beneficiaries may self-administer home-based overnight oximetry tests under the direction of a Medicare-enrolled Independent Diagnostic Testing Facility (IDTF). A DME supplier or another shipping entity may deliver a pulse oximetry test unit and related technology, used to collect and transmit test results to the IDTF, to a beneficiary's home under the following circumstances:

1. The beneficiary's treating physician has ordered an overnight pulse oximetry test before the test is performed.
2. The test is performed under the direction and/or instruction of a Medicare-approved IDTF. Because it is the beneficiary who self-administers this test, the IDTF must provide clear written instructions to the beneficiary on proper operation of the test equipment and must include access to the IDTF in order to address other concerns that may arise. The DME supplier may not create this written instruction, provide verbal instructions, answer questions from the beneficiary, apply or demonstrate the application of the testing equipment to the beneficiary, or otherwise participate in the conduct of the test.
3. The test unit is sealed and tamperproof such that test results cannot be accessed by anyone other than the IDTF who is responsible for transmitting a test report to the treating physician. The DME supplier may use related technology to download test results from the testing unit and transmit those results to the IDTF. In no case may the DME supplier access or manipulate the test results in any form.

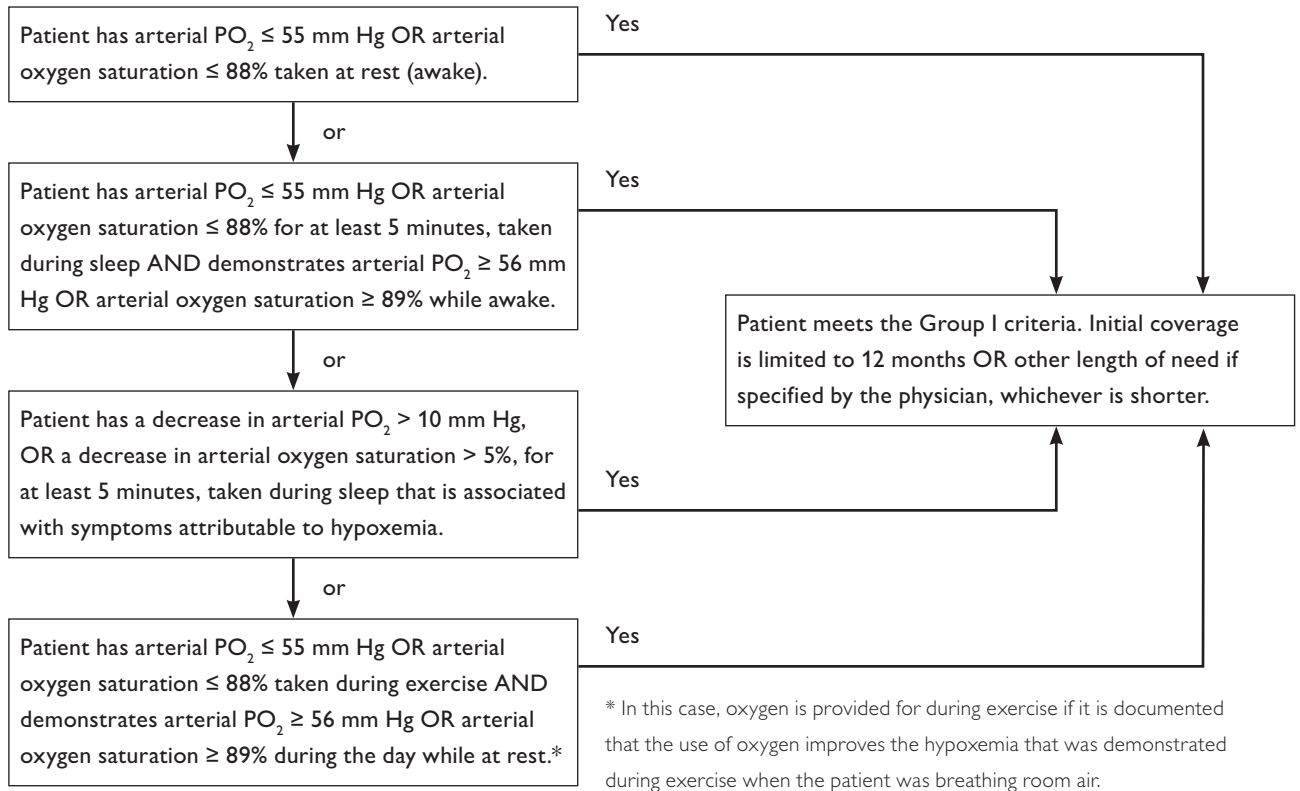
The IDTF must send the test results to the physician.

The IDTF may send the test results to the supplier if the supplier is currently providing, or has an order to provide, oxygen or other respiratory services to the beneficiary or if the beneficiary has signed a release permitting the supplier to receive the report.

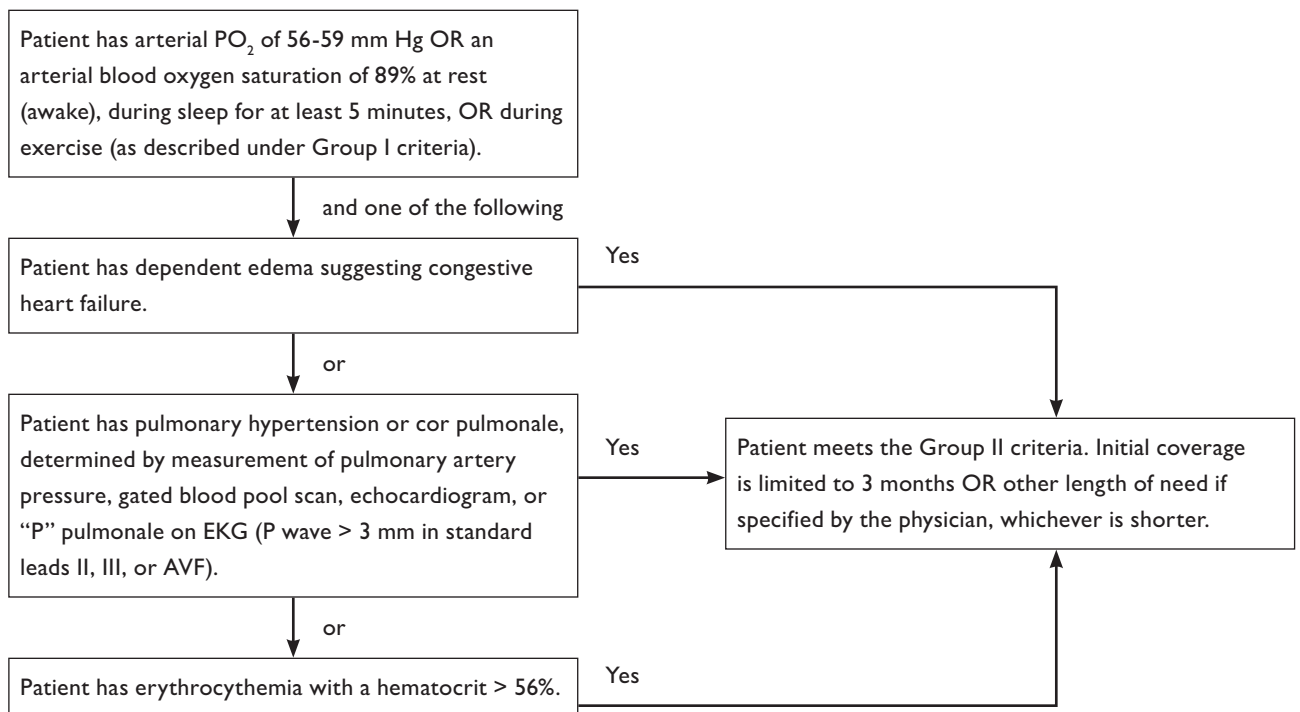
Oximetry test results obtained through a similar process while the beneficiary is awake, either at rest or with exercise, may not be used for purposes of qualifying the beneficiary for home oxygen therapy.

Medicare determines coverage of home oxygen based on the patient's blood gas test results. Results are categorized into three defined groups shown in the following flow charts.

Group I



Group II



Group III

Group III includes patients with arterial PO₂ levels ≥ 60 mm Hg OR arterial blood oxygen saturation levels greater than or equal to 90%. Coverage for Group III patients is decided on a case-by-case basis. Medicare states however, that “there is a rebuttable presumption of non-coverage” meaning that the claims are typically denied based on lack of medical necessity. Additional physician documentation would be required for coverage consideration.

Medicare payment for oxygen and oxygen equipment

Medicare payment for oxygen and oxygen equipment is made on a monthly basis. One bundled monthly payment amount is made for all covered stationary equipment, stationary and portable contents, and all accessories used in conjunction with

the oxygen equipment. An add-on payment may also be made for those beneficiaries who require portable oxygen if the patient does not need more than 4 LPM.

Medicare payment for oxygen equipment will not continue beyond 36 months of continuous use. After the 36 month rental cap, Medicare will continue to make monthly rental payments for oxygen contents. Payment is made on a monthly basis for oxygen contents for beneficiaries with liquid or gaseous oxygen equipment. Up to three months of contents can be delivered at one time. However, payment will be made monthly for one month at a time. For example, three months of contents are delivered on June 1. The supplier would bill Medicare for those contents on June 1, July 1, and August 1.

Coding guidelines for equipment and accessories

HCPCS code	Equipment	Description
E0424	Stationary compressed gaseous oxygen system, rental	Includes container, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0425*	Stationary compressed gas system, purchase	Includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0430*	Portable gaseous oxygen system, purchase	Includes regulator, flowmeter, humidifier, cannula or mask, and tubing
E0431	Portable gaseous oxygen system, rental	Includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing
E0433	Portable liquid oxygen system, rental	Home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flow meter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge
E0434	Portable liquid oxygen system, rental	Includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing
E0435*	Portable liquid oxygen system, purchase	Includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor
E0439	Stationary liquid oxygen system, rental	Includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0440*	Stationary liquid oxygen system, purchase	Includes use of reservoir, contents indicator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing
E0441	Oxygen contents, gaseous, per unit	For use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned; one month's supply = 1 unit
E0442	Oxygen contents, liquid, per unit	For use with owned liquid stationary systems or when both stationary and portable liquid system are owned; one month's supply = 1 unit
E0443	Portable oxygen contents, gaseous, per unit	For use only with portable gaseous systems when no stationary gas or liquid system is used; one month's supply = 1 unit
E0444	Portable oxygen contents, liquid, per unit	For use only with portable liquid systems when no stationary gas or liquid system is used; one month's supply = 1 unit
E1390	Oxygen concentrator – single delivery port	Single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, each
E1391	Oxygen concentrator – dual delivery port	Dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate, each

*Only rented oxygen systems are eligible for Medicare coverage.

Coding guidelines for equipment and accessories (continued)

HCPCS code	Equipment	Description
E1392	Portable oxygen concentrator, rental	Reimbursement at the standard portable system add-on rate, provided medical necessity for a portable oxygen system is met
E1405	Oxygen and water vapor system	Reimbursement not subject to DME ceiling or floor payment amounts
E1406	Oxygen and water vapor enriching system without heated delivery	Reimbursement not subject to DME ceiling or floor payment amounts
K0738	Portable gaseous oxygen system, rental	Home compressor used to fill portable oxygen cylinders; includes portable containers, regulator, flowmeter, humidifier, cannula or mask, and tubing

Accessories are included in the monthly rental payment for oxygen. Separate payment for accessories may be made ONLY once the five-year useful life of the equipment has been reached.

HCPCS code	Accessory	HCPCS code	Accessory
A4606	Oxygen probe for use with oximeter device, replacement	E0455	Oxygen tent, excluding croup or pediatric tents
A4608	Transtracheal oxygen catheter, each	E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
A4615	Nasal cannula	E0580	Nebulizer, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
A4616	Oxygen tubing, per foot	E1353	Regulator
A4617	Mouthpiece	E1354	Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each
A4619	Face tent	E1355	Stand/rack
A4620	Variable concentration mask	E1356	Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each
A7525	Tracheostomy mask, each	E1357	Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each
A9900	Miscellaneous supply, accessory and/or service component of another HCPCS code (may be used to report accessories such as oxygen conserving devices)	E1358	Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each

HCPCS modifiers: The appropriate modifiers must be included on oxygen claims for flow rates less than 1 LPM or greater than 4 LPM. Do not include modifiers on claims for portable systems or oxygen contents.

QE – Prescribed oxygen is < 1 LPM

QF – Prescribed oxygen is > 4 LPM and portable oxygen is also prescribed

QG – Prescribed oxygen is > 4 LPM and portable oxygen is not prescribed

QH – Oxygen conserving device is being used with an oxygen delivery system

Certificate of Medical Necessity (CMN) documentation guidelines and requirements

The DME supplier must keep a physician's order on file.

The order must be signed and dated by the treating physician, specifying the oxygen delivery system and accessories.

The CMN may be used as the physician's order if it

contains the details of the oxygen order (delivery system, flow rate, etc.)

Initial certification requirements

The initial claim filed to the DME MAC	<ul style="list-style-type: none"> • Required for new patients placed on oxygen • Required for patients that have been on home oxygen prior to qualifying for Medicare • Required for patients switching from a Medicare Advantage plan to Medicare fee-for-service
A break in medical necessity of at least 60 days	<ul style="list-style-type: none"> • The break in medical necessity would also include the days remaining in the month in which the interruption began. • This does not include break in billing (i.e. patients in hospitals, nursing home, etc.) for patients who continue to need oxygen.
Group I patients with length of need less than or equal to 12 months failing to have repeat blood gas study prior to revised certification or recertification	<ul style="list-style-type: none"> • If qualifying study is subsequently performed, a new CMN is required. • The initial date of the new CMN is the date of the subsequent qualifying blood gas study.
Group II patients failing to have repeat blood gas studies between 61st and 90th day	<ul style="list-style-type: none"> • If a qualifying blood gas study is obtained after the 90th day, a new CMN is required. • The initial date of the new CMN is the date of the subsequent qualifying blood gas study.
Change in supplier due to an acquisition	<ul style="list-style-type: none"> • If the previous supplier did not file a recertification when it was due and requirements for recertification were not met at that time. • The initial date of the new CMN is the date of the subsequent qualifying blood gas study.
Reasonable useful lifetime of prior equipment has been reached	<ul style="list-style-type: none"> • Replacement equipment is required • A new blood gas test is not required
Equipment has been irreparably damaged, stolen or lost	<ul style="list-style-type: none"> • Irreparable damage refers to a specific accident or natural disaster like a fire or flood and does not refer to normal wear and tear • A new blood gas test is not required

Blood gas study – (1) must be the most recent study performed prior to the initial date on CMN and (2) must be performed within 30 days prior to the initial date of CMN. For patients who were on oxygen through a managed Medicare plan and are switching to Medicare fee-for-service, the blood gas study does not have to be obtained 30 days prior to the initial date of the CMN, but it must be the most recent test obtained while enrolled in the Medicare Advantage plan.

Recertification requirements

Used to indicate continued oxygen need after initial CMN period. Physician must re-evaluate patient within 90 days before recertification date.	
Group I: 12 months after the initial claim	<ul style="list-style-type: none"> • Recertifications are required with the 13th-month claim. • Blood gas study must be the most recent study performed prior to the recertification date. • If patient with a lifetime length of need was not re-evaluated by the physician within 90 days before the 12-month recertification, but was subsequently seen, the date on the recertification CMN should be the date of the physician visit.
Group II: 3 months after the initial claim	<ul style="list-style-type: none"> • Recertifications are required with the 4th-month claim. • Blood gas study must be the most recent study performed between the 61st and 90th day after the initial date.
At the discretion of the DME MAC	<ul style="list-style-type: none"> • Blood gas study must be the most recent performed 30 days prior to the recertification date.
Change in supplier due to an acquisition	<ul style="list-style-type: none"> • If the previous supplier did not file a recertification when it was due but requirements for recertification were met when it was due. • Recertification date would be 3 or 12 months after the initial claim depending on whether the patient was initially Group I or II.

Revised certification requirements

Used to indicate a change in patient's condition requiring a change in oxygen prescription or delivery system.	
Change in oxygen prescription	<p>A repeat blood gas study is required if the order changes from group I and II to group III.</p> <ul style="list-style-type: none"> I. < 1 LPM II. 1-4 LPM III. > 4 LPM <ul style="list-style-type: none"> • Blood gas study must be performed with patient on 4 LPM within 30 days prior to the start date of category 3.
Portable system is added after initial certification of stationary system	<ul style="list-style-type: none"> • Blood gas study is not required unless the initial qualifying test was performed while patient was sleeping. • Study must be performed while patient is at rest (awake) or during exercise within 30 days before the revised date.

If conditions for a revised certification and a recertification are met at the same time, the CMN should be filed as a recertification.

Revised certification requirements (continued)

Used to indicate a change in patient's condition requiring a change in oxygen prescription or delivery system.

Stationary system is added after initial certification of a portable system

- Repeat blood gas study not required.

Length of need, as specified by physician, expires

- Blood gas study must be the most recent performed 30 days prior to the revised date.

Patient has new treating physician (prescription remains unchanged)

- Repeat blood gas study is not required. Revised CMN is not required with claim but should be retained in supplier's files.

If conditions for a revised certification and a recertification are met at the same time, the CMN should be filed as a recertification.

Other documentation requirements

Under the following conditions, a new order must be obtained and kept on file by the supplier. Neither a new CMN nor a repeat blood gas study is required.

- Change in prescribed oxygen level that remains within one of the following category ranges:
I. < 1 LPM II. 1-4 LPM III. > 4 LPM
- Change from one type of oxygen delivery system to another (gaseous, liquid, concentrator). However, a new CMN or order is not required when switching between standard portable oxygen cylinders (E0431) and portable cylinders filled from a home compressor (K0738).

-EY modifier

Claims for oxygen submitted to the DME MAC, before a signed and dated order is on file with the supplier, must include an -EY modifier attached to each affected HCPCS code.

Additional coverage guidelines

Portable oxygen systems – Patient must be mobile in the home. Qualifying blood gas study must be done while patient is at rest (awake) or during exercise. Coverage will be denied if qualifying test was done while patient was sleeping. If qualifying criteria are met, a portable oxygen system is separately payable in addition to a stationary system.

Greater than 4 LPM – A higher payment allowance may be established if qualifying blood gas study is performed while the patient is on 4 LPM. Payment will not be made for both a portable system and allowance for greater than 4 LPM. If both are billed in the same month, the portable system will be denied as being not separately payable.

Stationary oxygen contents – Contents are only reimbursable once the 36-month payment cap on the equipment has been reached. A higher payment allowance may be established if qualifying blood gas study is performed while the patient is on 4 LPM. Payment will not be made for both a portable system and allowance for greater than 4 LPM. If both are billed in the same month, the portable system will be denied as being not medically necessary.

Portable oxygen contents – Contents are only reimbursable once the 36-month payment cap on the equipment has been reached. Contents for a portable system can only be reimbursed for systems that actually require content delivery. There is no reimbursement for contents for oxygen-generating portable systems such as portable oxygen concentrators or liquid/gas in-home oxygen generating systems. The supplier is required to provide whatever quantity of oxygen the patient uses. Medicare reimbursement levels will remain the same regardless of the quantity of oxygen dispensed by the supplier.

Travel oxygen – It is the beneficiary's responsibility to arrange for oxygen when traveling outside of their supplier's usual service area. Medicare will only pay one supplier for a patient's oxygen during any one rental month. Oxygen services furnished by an airline are considered noncovered by Medicare and are the responsibility of the beneficiary, not the supplier.

Maintenance and Servicing Fee Payment

For oxygen equipment, other than stationary or portable gaseous or liquid oxygen equipment (furnished on or after July 1, 2010), a maintenance and servicing fee is paid every six months, either beginning six months after the 36th paid rental month or when the item is no longer covered under the supplier's or manufacturer's warranty (whichever is later).

Noncovered items/services:

- Emergency/stand-by oxygen systems
- Topical hyperbaric oxygen chambers (HCPCS A4575)
- Oximeters (HCPCS E0445) and replacement probes (A4606)

NOTE: Inclusion or exclusion of a procedure, specific product, or supply code does not imply any health insurance coverage or reimbursement policy.

This information should not be considered to be either legal or reimbursement advice. Given the rapid and constant change in public and private reimbursement, Philips Respironics cannot guarantee the accuracy or timeliness of this information and urges you to seek your own counsel and experts for guidance related to reimbursement, including coverage, coding and payment.

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