

REIMBURSEMENT SERVICES

HELPFUL HINTS FOR FILING

OXYGEN AND OXYGEN-RELATED EQUIPMENT



OVERVIEW

The following information describes the DME Regional Carriers' (DMERCs)/DME Program Safeguard Contractors' (PSCs) medical policy for Oxygen and Oxygen-related equipment. Information was obtained from the *DMEPOS Supplier Manual* from each region. Coding, coverage, payment and documentation guidelines are listed on the following pages. This is to be used 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 local carrier, DMERC/DME PSC medical director or DME Medicare Administrative Contractor (MAC) for specific instructions.*

Definitions

Arterial Blood Gas (ABG) — An ABG is the direct measurement of the partial pressure of gases, including oxygen (noted as PO₂) in arterial blood reported in mm Hg.

Certificate of Medical Necessity (CMN) — As of January 1, 2007, DME Form 484.03 (CMS Form 484) is required to certify the need for home oxygen. Certificate of Medical Necessity (CMS) form 484.2 has been discontinued and is no longer accepted by Medicare.

Hypoxia — The deficiency of oxygen in tissue (noted as PO₂).

Hypoxemia — The deficiency of oxygen in arterial blood (noted as PaO₂).

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.

General Coverage Guidelines

Home oxygen is covered and paid by Medicare if 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.

Qualifying Arterial Blood Gas Studies

- The term 'blood gas study' in this Helpful Hints refers to both an ABG test and an oximetry test.
- A physician, Medicare Part A provider, a qualified 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**, it 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).
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 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 tamper-proof 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.

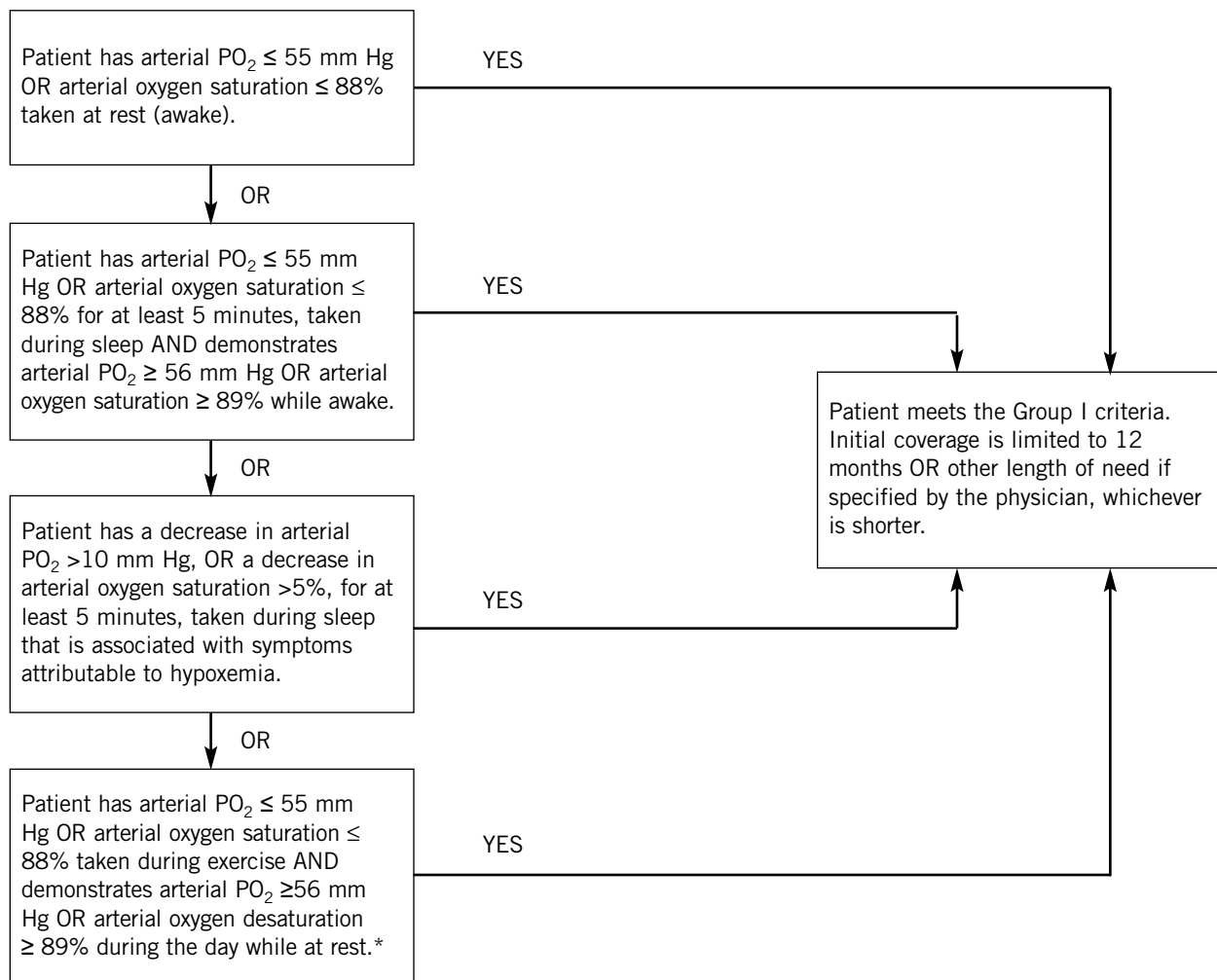
The Deficit Reduction Act (DRA) of 2005 and Oxygen Equipment and Supplies

The Deficit Reduction Act (DRA) of 2005 mandated changes to Medicare payments for oxygen equipment. Prior to the enactment of the DRA, oxygen equipment was rented indefinitely by Medicare for as long as the patient had a demonstrated medical need for the equipment. In addition, payment was “modality neutral” meaning that payment was the same regardless of the type of stationary equipment or the type of portable equipment provided.

The DRA implements a mandatory maximum payment cap on the rental of oxygen equipment of 36 months. Medicare will pay for the rental of oxygen equipment for the length of patient need but not to exceed 36 months. Once the 36-month payment cap has been reached, title and ownership of the equipment transfer to the patient. Payment is specific to the type of oxygen equipment provided. After ownership of the equipment transfers, Medicare will pay every 6 months for routine servicing of the equipment. In addition, Medicare will pay for needed accessories and supplies as well as for gas and liquid oxygen contents after transfer of equipment ownership.

On January 1, 2006, the 36-month rental period began for all oxygen equipment, including those systems already under existing rental agreements and those that began rental agreements on or after that date.

Group I

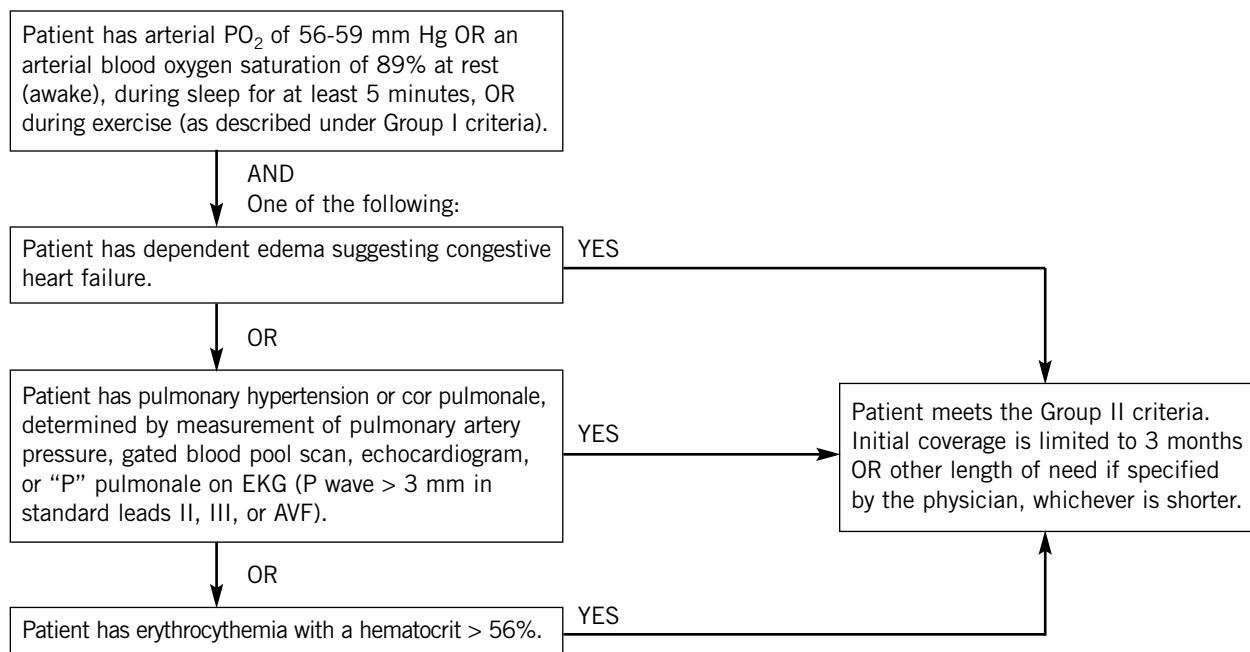


* In this case, oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.

Certificate of Medical Necessity Summary

- **Initial Certifications** — The blood gas study reported on the CMN must be the most recent study obtained prior to the initial date indicated in Section A of the CMN and this study must be obtained within 30 days prior to that initial date. Initial date indicates the date the oxygen was first needed. The patient must be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification.
- **Recertifications** — For patients initially meeting Group I criteria, the most recent blood gas study prior to the 13th month of therapy must be reported on the Recertification CMN. The patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of the Recertification.
- **Revised Certifications** — For patients initially meeting Group I criteria, if the estimated length of need on the initial CMN is less than lifetime and the physician wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the Revised Certifications. The blood gas study must be the most recent test performed prior to the date of the Revised Certification.

Group II



Certificate of Medical Necessity Summary

- **Initial Certifications** — The blood gas study reported on the CMN must be the most recent study obtained prior to the initial date indicated in Section A of the CMN and this study must be obtained within 30 days prior to that initial date. Initial date indicates the date the oxygen was first needed. The patient must be seen and evaluated by the treating physician within 30 days prior to the date of the initial certification.
- **Recertifications** — For patients initially meeting Group II criteria, the most recent blood gas study which was performed between the 61st and 90th day following initial certification must be reported on the Recertification CMN. The patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of the Recertification.

If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the patient continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test.

- **Revised Certifications** — For patients initially meeting Group II criteria, if the estimated length of need on the initial CMN is less than lifetime and the physician wants to extend coverage, a repeat blood gas study must be performed within 30 days prior to the date of the Revised Certifications. The blood gas study must be the most recent test performed prior to the date of the Revised Certification.

Group III

Group III includes patients with arterial PO₂ levels at or above 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.

Coding Guidelines for Equipment & 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
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 use of reservoir, contents (per unit), 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
E1391	Oxygen concentrator – dual delivery port	Dual delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate
E1392	Portable oxygen concentrator, rental	Reimbursement at the standard portable system add-on rate, provided medical necessity for a portable oxygen system is met
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

* Only rented oxygen systems are eligible for Medicare coverage.

Accessories are included in the monthly rental payment for oxygen. Separate payment for accessories may be made ONLY for patient-owned equipment.

HCPCS Code	Accessory	HCPCS Code	Accessory
A4608	Transtracheal oxygen catheter, each	E0455	Oxygen tent, excluding croup or pediatric tents
A4615	Nasal cannula	E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
A4616	Oxygen tubing, per foot	E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
A4617	Mouthpiece	E1353	Regulator
A4619	Face tent	E1355	Stand/rack
A4620	Variable concentration mask		
A7525	Tracheostomy mask, each		
A9900	Miscellaneous supply, accessory and/or service component of another HCPCS code (may be used to report accessories such as oxygen conserving devices)		

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*

Documentation

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 DMERC/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 HMO to traditional Medicare
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.

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 under a Medicare HMO and are switching to traditional Medicare, the blood gas study does not have to be obtained 30 days prior to the initial date of the CMS, but it must be the most recent test obtained while in the Medicare HMO.

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 DMERC/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 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 & II to Group III.</p> <ol style="list-style-type: none"> <1 LPM 1-4 LPM >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.
Stationary system is added after initial certification of a portable system	<ul style="list-style-type: none"> Repeat blood gas study not required
Length of need, as specified by physician, expires	<ul style="list-style-type: none"> Blood gas study must be the most recent performed 30 days prior to the revised date.
Patient has new treating physician (prescription remains unchanged)	<ul style="list-style-type: none"> 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:
 - <1 LPM
 - 1-4 LPM
 - >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 DMERC/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 medically necessary.

Stationary Oxygen Contents — Included in monthly rental payment. May be paid separately with patient-owned stationary gaseous or liquid systems.

Portable Oxygen Contents — May be paid separately if patient rents or owns a portable system and a concentrator. May be paid separately if patient rents or owns a portable system and has no stationary system. 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.

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.

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Reimbursement:	Contact:	Website/Phone:
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