Home oxygen qualifying guidelines

CMS revision effective January 2019

Initial coverage:

Before submitting an initial oxygen claim to Medicare, a DME supplier must have the following documents on file:

☑ **Medical Records**

Medical records[1] must provide evidence that:

- the patient had a face-to-face visit by a treating physician within 30 days prior to the initial certification[2] date, **AND**
- the treating physician has determined that the patient has a severe lung disease or hypoxia-related symptoms* that might be expected to improve with oxygen therapy, **AND**
- alternative treatment measures have been tried or considered and deemed clinically ineffective (e.g. medications, inhalers, etc.), **AND**
- the patient had a qualifying Blood Gas Study (BGS)*, **AND**
- the patient's BGS meets group I or II criteria (see qualification test groups table below), **AND**
- the patient is mobile within the home, if ordering portable oxygen (also must be noted on the CMN).

☑ **Certificate of Medical Necessity (CMN)**

CMNs may act as a substitute for a written order if it is sufficiently detailed (see CMS form 484). Note: Some items require a written order prior to delivery in addition to a CMN (see the CGS oxygen documentation checklist)

☑ **Proof of Delivery (POD)**

The POD must provide evidence that the item and supplies were delivered to the patient or an authorized representative[3]

☑ **Patient's Authorization**

A supplier must obtain a patient or authorized representative's signature before requesting payment from Medicare.[4]

*See page 2 for definitions and examples

Qualifying test results:

Awake & resting (E1390)
Patient is mobile in the home (E1392)

SpO_2 = 89% and qualifying secondary diagnosis, or SpO_2 ≤88%. Results taken at rest, breathing room air.

Awake & exercising (E1390)
Patient is mobile in the home (E1392)

a. SpO_2 ≥90% non-qualifying result taken at rest, breathing room air, **and**
b. SpO_2 = 89% and qualifying secondary diagnosis or SpO_2 ≤88%. Results taken during exercise, breathing room air, **and**
c. SpO_2 is greater when exercising with O_2 as compared to the previous result where the patient was exercising without O_2.

Sleeping w/ out OSA (E1390)

SpO_2 = 89% and qualifying secondary diagnosis, or SpO_2 ≤88% for at least five cumulative minutes during a minimum two-hour recording time, taken during sleep (nocturnal, stationary oxygen qualification only).

Sleeping w/ OSA (E1390)

SpO_2 = 89% and qualifying secondary diagnosis, or SpO_2 ≤88% for at least five cumulative minutes during a titrated, facility-based PSG with a minimum of two-hour recording time. Patient must meet the following chronic stable state conditions (nocturnal, stationary oxygen qualification only):

- Nocturnal oximetry, for the purpose of oxygen reimbursement qualification, may only be performed after optimal positive airway pressure settings have been determined and the beneficiary is using the positive airway pressure device at those settings.
- During titration at optimal pressure settings:
  a. The AHI/RDI is reduced to less than or equal to an average of ten (10) events per hour, **or**
  b. If the initial AHI/RDI was less than an average of ten (10) events per hour, the titration demonstrates further reduction in the AHI/RDI.
- Note:
  a. Overnight oximetry performed as part of home sleep testing, or as part of any other home testing, is not considered eligible to qualify for reimbursement of home oxygen and oxygen equipment.
  b. Patients diagnosed with obstructive sleep apnea (OSA) may still qualify via the Awake & Resting or Awake & Exercising pathways.

Qualification test groups, recertification and physician visit requirements:

Initial qualification group	Oximetry SpO_2	Arterial blood gas (ABG) PaO_2	Recertification due	Physician visit required
Group I	≤88%	≤55 mm Hg	at 12 months (repeat test prior to the 13th month)	Within 90 days prior to recertification date
Group II	=89% and qualifying secondary diagnosis	=56-59 mm Hg and qualifying secondary diagnosis*	at 3 months (repeat test between the 61st and 90th day following initial certification)	
Group III	≥90%	≥60 mm Hg	Non-covered (N/A)	N/A

*Qualifying secondary diagnoses include:

- Dependent edema suggesting congestive heart failure, **or**
- 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**
- Erythrocythemia with a hematocrit greater than 56%.

Ongoing coverage:

Before submitting claims to Medicare post oxygen recertification, a DME supplier must have the following documents on file:

☑ **Recertification and/or revised CMN[5]**

Recertification is required at 3 or 12 months after initial certification and is dependent on initial group I or II certification. (See the qualification test groups, recertification and physician visit requirements table on page 1) Generally, only one recertification is required during the capped rental period regardless of group classification, unless the length of need (LON) specified on the recertification CMN is a value other than 99 (indicating lifetime). If other than lifetime is specified, the certification will expire when the specified LON time period elapses and a recertification will be required to continue coverage.

Note: A properly completed CMN stating a length of need may be used to justify continued medical need.

☑ **Continued medical need**

There must be information in the patient's medical record to support that the item continues to remain reasonable and necessary. Any of the following may justify continued medical need[6]:

- A recent order by the treating physician for refills, **or**
- A recent change in prescription, **or**
- A properly completed CMN stating a length of need, **or**
- Timely documentation* showing usage of the item

☑ **Continued use**

Continued use describes the ongoing patient utilization of supplies or a rented item. Any of the following may serve as documentation that an item continues to be used by the patient:

- Supplier records documenting patient confirmation of continued use of a rental item, **or**
- Timely documentation* showing usage of the item, related option/accessories and supplies.

*Timely documentation is defined as a record in the preceding 12 months

Qualified testing providers defined:

Under Medicare Part A

- During a Part A covered stay, payment is bundled so that services rendered are covered under a lump sum payment by Medicare. In this case, oxygen qualification testing performed in a hospital, nursing facility, Home Health or Hospice, or other covered Part A episode meets the "qualified provider" standard.
- Outside of a covered Part A stay, testing done by a Part A provider does not meet the requirement and is not valid for qualification of home oxygen reimbursement unless the entity is also a qualified provider of diagnostic testing or laboratory services for individual testing performed outside of a covered Part A stay.

Under Medicare Part B

- Testing performed and covered as "incident to" physician services meets the "qualified provider" standard.
- Laboratory testing is also reimbursed "a la carte" or on a per test basis. The entity performing the specific test must meet the requirements to perform the specific test. Testing done by an entity that meets the requirements to bill for the individual test may be used for oxygen qualification.
- Home sleep oximetry is limited solely to stand-alone, overnight pulse oximetry performed in the beneficiary's home. Overnight oximetry performed as part of home sleep testing or as part of any other home testing cannot be used for oxygen qualification purposes.
- Durable medical equipment (DME) suppliers cannot perform blood gas studies, but can deliver the tests on behalf of a qualifying Independent Diagnostic Testing Facility (IDTF).

Qualifying blood gas study (BGS):

A BGS is an arterial blood gas or oximetry test and must be obtained while the patient is awake (at rest), exercising, or sleeping* and testing must be performed by a physician or qualified provider or supplier of laboratory services (see qualified testing providers defined section).

A qualifying blood gas study must be obtained under one of 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 2 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 (see Chronic Stable State Defined below)

*Portable oxygen claims will be denied if the only BGS test was performed during sleep.

Severe lung diseases:

Chronic obstructive pulmonary disease (COPD), diffuse interstitial lung disease [known or unknown etiology], cystic fibrosis, bronchiectasis, and widespread pulmonary neoplasm. Note: This list is not all-inclusive.

Hypoxia-related conditions:

Pulmonary hypertension, recurring congestive heart failure due to cor pulmonale, erythrocytosis, impairment of cognitive process, nocturnal restlessness, and morning headache. Note: This list is not all-inclusive.

Chronic stable state defined:

Not during a period of an acute illness or an exacerbation of their underlying disease.

For patients whose initial oxygen prescription did not originate during a hospital stay, blood gas studies should be done while the patient is in the chronic stable state (CSS).

CSS requires that all of the following be met:

- Other forms of treatment (e.g. medical and physical therapy directed at secretions, bronchospasm and infection) have been tried, have not been sufficiently successful, and oxygen therapy is still required.
- Each patient must receive optimum therapy before long-term home oxygen therapy is ordered.

Payment rules reminder – home oxygen initial qualification testing

Oxygen Coverage Policy: Local Coverage Determination (LCD): OXYGEN and OXYGEN Equipment (L33797), effective January 2019

1 Medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports.
2 Initial certification may take the form of a written or dispensing order. The supplier may subsequently receive a detailed written order or CMN before billing. The initial certification date on the CMN should be either the specific date that the physician gives as the start of the medical necessity or the date of the order.
3 Local Coverage Article: Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)
4 Beneficiary Authorization, Medicare Claims Processing Manual, Chapter 1, Section 50.1.6
5 Certificate of Medical Necessity (CMN) and DME Information Form (DIF), Noridian JD, Jun 30, 2017
6 Continued Use/Continued Need, Noridian JD, Jul 7, 2017