Reimbursement Fast Facts: Oxygen Concentrators

This tool will assist you in understanding Medicare coding and coverage for oxygen concentrators.

**Oxygen concentrators** are medical devices that provide oxygen to assist patients with significant hypoxemia by taking room air and concentrating it to a purity of 85% or greater. Oxygen concentrators may be categorized based on portability.

<table>
<thead>
<tr>
<th>Device</th>
<th>Description</th>
<th>HCPCS Code</th>
<th>Medicare CBR2 Reimbursement*</th>
<th>Medicare CBNE Phase-in Reimbursement*</th>
<th>Medicare CBNE July 1 Reimbursement*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen concentrator</td>
<td>Single delivery port, capable of delivering 85% or greater oxygen concentration at the prescribed flow rate</td>
<td>E1390</td>
<td>$70.00–$89.86</td>
<td>Non-rural: $135.14–$140.56 Rural: $141.74</td>
<td>Non-rural: $74.40–$81.46 Rural: $86.61</td>
</tr>
<tr>
<td>Portable oxygen concentrator</td>
<td>Portable oxygen concentrator, rental</td>
<td>E1392</td>
<td>$33.97–$42.00</td>
<td>Non-rural: $46.69–$47.82 Rural: $49.27</td>
<td>Non-rural: $36.41–$39.68 Rural: $42.16</td>
</tr>
</tbody>
</table>

*Oxygen's 36-month capped rental payment amount includes the equipment, contents, supplies and accessories (i.e. cannula or mask, and tubing)."

**Billing criteria for oxygen**

Oxygen equipment is covered by Medicare for patients with significant hypoxemia who meet the medical documentation, laboratory evidence and health conditions specified in the Medicare coverage requirements.²

Conditions for which oxygen therapy may be covered include severe lung diseases (e.g. COPD, cystic fibrosis and bronchiectasis), as well as hypoxia-related symptoms expected to improve with oxygen therapy (e.g. pulmonary hypertension, recurring congestive heart failure due to chronic cor pulmonale, erythrocythemia and nocturnal restlessness).

Coverage is also contingent upon documentation of qualified blood gas studies (oximetry test or arterial blood gas test) that meets the oxygen desaturation criteria (see next page). Blood gas studies should be done while the patient is in a chronic stable state.

**Coverage criteria**

Home oxygen therapy is reasonable and necessary only if all of the following conditions are met:

1. The treating physician has determined that the beneficiary has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
2. The beneficiary's blood gas study meets the criteria stated below, and
3. The qualifying blood gas study was performed by a physician, qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:
   - If the qualifying blood gas study was 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 was performed outside of an inpatient hospital stay, the reported test must be performed while the beneficiary 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.

In this policy, the term “blood gas study” refers to either an oximetry test or an arterial blood gas test.
Group I criteria include any of the following:
1. An arterial PO$_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88% taken at rest (awake), or
2. An arterial PO$_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, for at least 5 minutes, taken during sleep for a beneficiary who demonstrates an arterial PO$_2$ at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake, or
3. A decrease in arterial PO$_2$ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5% from baseline saturation, for at least 5 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, (the results must be at or below 88% or 55 mm Hg), or
4. An arterial PO$_2$ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, taken during exercise for a beneficiary who demonstrates an arterial PO$_2$ at or above 60 mm Hg or an arterial oxygen saturation at or above 90% during the day while at rest. In this case, oxygen is provided for exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise over the result recorded while the beneficiary was exercising and breathing room air; a uniquely documented result of exercise with O$_2$ must be recorded in the medical record. This is different than a recovery result.

Initial coverage for beneficiaries meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. (Refer to the “documentation requirements” section for information on recertification.)

Group II criteria include the presence of:
A. An arterial PO$_2$ of 56–59 mm Hg, or an arterial blood oxygen saturation of 89% at rest (awake), during sleep for at least 5 minutes or during exercise (as described under Group I criteria), and
B. 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%

Initial coverage for beneficiaries meeting Group II criteria is limited to 3 months or the physician-specified length of need, whichever is shorter. (Refer to the “documentation requirements” section for information on recertification.)

Group III includes beneficiaries with arterial PO$_2$ levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90%. Group III beneficiaries are generally not covered.

Documentation requirements:
Documentation to support initial medical necessity of oxygen may include:
- Detailed Written Order or Certificate of Medical Necessity (CMN) if sufficiently detailed and meets signature, date and other requirements,
- Medical records that support the patient meets the Local Coverage Determination (LCD) coverage and payment requirements:
  - Treating physician has determined the patient has severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy, and
  - The patient’s most recent blood gas study met the qualification criteria and was conducted by a qualified professional, conducted during an inpatient stay or conducted while the patient was in a chronic stable state, and
  - Alternative treatment measures were tried or considered, and deemed clinically ineffective
- Proof of Delivery

Documentation for recertification to support continued medical necessity of oxygen may include:
- Recertification CMN
- Medical records documenting that the patient was seen and re-evaluated by the treating physician between the 61st–90th day for Group II or 90 days prior to the date of the recertification for Group I
- Continued medical need for the equipment, accessories and/or supplies is verified by:
  - One of the following documents dated within 12 months of the date of service under review: A refill order, a change in prescription, a CMN with appropriate length of need or medical record showing use of the item

Documentation for Portable Oxygen Systems may include:
- Medical records supporting that the patient is mobile within the home and the qualifying blood gas study was performed while awake (at rest or during exercise)

Documentation for liter flow greater than 4 LPM may include:
- A copy of the blood gas study showing blood gas levels in the Group I or Group II range while the patient was receiving oxygen at the rate of at least 4 LPM
Q & A

Q: When oxygen qualification testing is obtained from a titration polysomnogram, is portable oxygen covered?
No, as with overnight oximetry, only stationary oxygen may be justified based on titration polysomnography (PSG).

Q: What testing is required for patients with suspected or known obstructive sleep apnea (OSA) to qualify for home oxygen?
During qualification testing, the patient must be in a chronic stable state, meaning obstructions need to be resolved during testing. Therefore, an OSA patient must qualify while they are awake or during a titration PSG conducted at sleep. CGS has provided a helpful decision tree to illustrate this point (see chart below).9

Q: What maintenance and servicing fees are applicable to oxygen concentrators?
A maintenance and servicing fee of ~$70 is paid every 6 months, either beginning: 1) 6 months after the 36th paid rental month, or 2) when the item is no longer covered under the supplier’s or manufacturer’s warranty (whichever is later). Only one maintenance and servicing payment can be made for beneficiaries using both stationary (E1390) and portable oxygen concentrators (E1392). Note: Neither beneficiary-owned gaseous nor liquid oxygen equipment (stationary or portable) is eligible for maintenance and servicing payments.10 Service must be performed and documented via a service ticket to bill for maintenance fees.
Q: What oxygen equipment is billable for contents post 36-month cap?

Only gaseous and liquid tank systems are eligible for post 36-month cap content billing. Oxygen Concentrators and Transfilling Equipment are not eligible for contents payment.11

<table>
<thead>
<tr>
<th>Oxygen equipment furnished in month 36</th>
<th>Monthly contents payment after the stationary cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxygen Concentrator (E1390 or E1391)</td>
<td>None</td>
</tr>
<tr>
<td>Portable Gaseous or Liquid Transfilling Equipment (K0738, E1392 or E0433)</td>
<td>None</td>
</tr>
<tr>
<td>E0424 Stationary Gaseous System</td>
<td>E0441 Stationary Gaseous Contents</td>
</tr>
<tr>
<td>E0439 Stationary Liquid System</td>
<td>E0442 Stationary Liquid Contents</td>
</tr>
<tr>
<td>E0431 Portable Gaseous System</td>
<td>E0443 Portable Gaseous Contents</td>
</tr>
<tr>
<td>E0434 Portable Liquid System</td>
<td>E0444 Portable Liquid Contents</td>
</tr>
</tbody>
</table>

Q: How does payment change for patients who need more than 4 LPM or less than 1 LPM?

If the beneficiary is prescribed both stationary and portable gaseous oxygen at a rate that exceeds 4 LPM, suppliers use the modifier “QF” to increase the monthly stationary oxygen payment amount by 50%. If the prescribed amount is less than 1 LPM, suppliers use the modifier “QE” to decrease the monthly stationary oxygen payment amount by 50%.13 When billing for higher liter flow reimbursement, separate payment for portable O2 is not allowed.14

Q: Can oximetry data from ApneaLink™ Air or AirView™ (when an oximeter is connected to a positive airway pressure device) be used to qualify a patient for home oxygen?

No, patients with known or suspected OSA must be tested in-person, either via an overnight titration polysomnogram or via an awake in-person oximetry test. All awake oximetry results must be obtained in-person by a qualified medical professional with the exception of overnight oximetry. Unsupervised or remotely supervised awake home testing does not qualify as a valid test. For beneficiaries with OSA, a qualifying oxygen saturation test may only occur during a titration polysomnographic study or during an in-person, supervised, awake test.16

Q: Do all oxygen items require a detailed written order prior to delivery (DWOPD)?

No, the following items do not require a DWOPD: oxygen concentrators (E1390 or E1391), portable oxygen concentrators (E1392) and portable gaseous equipment (K0738). While a DWOPD is not required for these specific items, a detailed written order (DWO) is required prior to billing and may be obtained prior to delivery when possible. Note, the other items in the table above do require a DWOPD.12

1 MLN Matters (MM6297) Changes in Payment for Oxygen Equipment as a Result of the 2008 MIPPA and Additional Instructions Regarding Payment for DMEPOS; revised May 17, 2011
2 National Coverage Determination (NCD) for Long-Term Oxygen Treatment Trial (LTTT); NCT00692198
3 CMS Signature Requirements, April 22, 2010
4 Program Integrity Manual Chapter 1 Supplier Documentation
5 Local Coverage Determination (LCD)
6 Oxygen and Oxygen Equipment (E13897)
7 Oxygen and Oxygen Equipment Beneficiaries Meeting Group I Criteria Documentation Checklist; CGS January 25, 2016
8 Oxygen and Oxygen Equipment Beneficiaries Meeting Group II Criteria Documentation Checklist; CGS January 25, 2016
9 Frequently Asked Questions: Oxygen Use in Beneficiaries with Obstructive Sleep Apnea (November 22, 2013)
10 MLN Matters (MM6792) Maintenance and Servicing Payment for Certain Oxygen Equipment after July 1, 2010
11 MLN Matters (MM7416) Payment for Oxygen Contents
12 MLN Matters (MM8304) Detailed Written Orders and Face-to-Face Encounters; revised July 1, 2013
13 Payment rules found in the "Medicare Claims Processing Manual", Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)) Section 130.6 (Billing for Oxygen and Oxygen Equipment)
14 Local Coverage Article: Oxygen and Oxygen Equipment – Policy Article – Effective October 2010
15 MLN Matters (MM7416) Maintenance and Servicing Payment for Certain Oxygen Equipment after July 1, 2010
16 MLN Matters (MM7416) Payment for Oxygen Contents
17 MLN Matters (MM8304) Detailed Written Orders and Face-to-Face Encounters; revised July 1, 2013
18 Payment rules found in the "Medicare Claims Processing Manual", Chapter 20 (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)) Section 130.6 (Billing for Oxygen and Oxygen Equipment)