

## Oxygen and Oxygen Equipment Coverage and Documentation Checklist

### Dispensing Order

Oxygen equipment and supplies may be delivered upon receipt of a dispensing order. A dispensing order may be verbal or written. The supplier must keep a record of the dispensing order on file. It must contain:

- Description of the item(s)
- Beneficiary name
- Prescribing physician 's name
- Date of the order and the start date, if the start date is different from the date of the order
  - Use the date the supplier is contacted by the physician (for verbal orders) or the date entered by the physician (for written dispensing orders)
- Physician signature (if a written order) or supplier signature (if verbal order)

### Detailed Written Order

An order must be obtained prior to claim submission and must contain the following:

- Beneficiary name
- Physician 's name
- Date of the order and the start date of the order, if the start date is different from the date of the order
- Detailed description of the item(s) to be provided
  - Type of oxygen equipment (liquid, gaseous, etc.)
  - Specifics of oxygen flow rates and/or noncontinuous use of oxygen
  - Method of administration (i.e., nasal cannula)
- Physician's signature and date

Signature and date stamps are not acceptable.

### New Order Requirements

A new order is required if:

- There is a change in supplier
- There is a change in the item(s) frequency of use, or amount prescribed
- There is a change in the length of need or a previously established length of need expires
- State law requires a prescription renewal

### Medical Records

For all patients, there should be documentation in the physician's records that **all** the following coverage criteria are met:

- 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
- Patient's qualifying blood gas study meets the criteria stated below

- Qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services (blood gas studies performed by durable medical equipment prosthetics, orthotics, and supplies [DMEPOS] suppliers are not acceptable)
- Qualifying blood gas study was obtained under one of the following conditions:
- Qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one closest to, but no earlier than two days prior to the hospital discharge date, or
  - 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)
- Alternate treatment measurements must have considered and deemed clinically ineffective

**Note:** Many disease conditions have standard treatment regimens associated with them. This criterion, together with the requirement that testing be done while the beneficiary is in their chronic stable state means that the usual treatment modalities need to be optimized before oxygen becomes eligible for reimbursement.

## Medicare Qualifying Test Results

Patients' test results must be within two days prior to discharge if the oxygen is initially provided at the time of discharge from a hospital or skilled nursing facility (SNF). If the test results are obtained as an outpatient, they must be within 30 days prior to the date of delivery.

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

*Oxygen qualifications for a patient tested on room air at rest:*

- Oxygen saturation  $\leq 88\%$  while awake or  $PO_2 \leq 55$  mm Hg
- Oxygen qualifications for a patient tested during exercise:
- All of the following three test results are needed and must be performed during the same testing session:
  - Room air test
    - Oxygen saturation  $\geq 89\%$  or  $PO_2 \geq 56$  mm Hg
  - During ambulation without oxygen
    - Oxygen saturation  $\leq 88\%$  or  $PO_2 \leq 55$  mm Hg
  - During ambulation with oxygen
    - Documented improvement

*Oxygen qualifications for a patient tested during sleep:*

- Oxygen saturation  $\geq 89\%$  or  $PO_2 \geq 56$  mm Hg on room air at rest, awake and either of the following taken during sleep:
  - Oxygen saturation  $\leq 88\%$  or  $PO_2 \leq 55$  mm Hg for at least 5 minutes; or
  - Decrease in oxygen saturation  $\geq 5\%$  or decrease in  $PO_2 \geq 10$  mm Hg for at least five minutes, associated with symptoms or signs reasonably attributable to hypoxemia
- Group II criteria include either of the following:
  - Oxygen saturation of  $89\%$  or  $PO_2$  of  $56\text{--}59$  mm Hg taken either at rest (awake), during exercise (as described under Group I criteria), or during sleep for at least five minutes and any one of the following:
    - Dependent edema suggesting congestive heart failure
    - Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave  $\geq 3$  mm in standard leads II, III, or AVF)
    - Erythrocythemia with a hematocrit  $\geq 56\%$

**Note:** Coverage of home oxygen therapy requires that the patient be tested in the "chronic stable state."

In the case of obstructive sleep apnea (OSA), it is required that the OSA be appropriately and sufficiently treated such that the patient is in the chronic stable state before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy.

*Portable oxygen 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

## Initial Certificate of Medical Necessity and Visit Requirements

An initial Certificate of Medical Necessity (CMN) is the first CMN filed for a particular beneficiary for oxygen and is required in the following situations:

1. With the first claim for home oxygen, (even if the patient was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare health maintenance organization [HMO])
2. During the first 36 months of the rental period, when there has been a change in the patient's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. Refer to the policy article nonmedical necessity coverage and payment rules for additional information.
3. When the equipment is replaced because the five year reasonable useful lifetime of prior equipment has been reached
4. When the equipment is replaced because of irreparable damage (a specific accident or to a natural disaster [e.g., fire, flood]), theft, or loss of the originally dispensed equipment

*Testing and visit requirements – Initial CMN:*

- Initial certification situations referenced in the situations 1 and 2 mentioned above:
- The blood gas study must be the most recent study obtained within 30 days prior to the initial date
    - For the situation referenced in bullet point one, there is an exception to the 30-day test requirement for patients who were started on oxygen while enrolled in a Medicare HMO and transitioned to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the initial date, but must be the most recent qualifying test obtained while in the HMO.
  - The patient must be seen and evaluated by the treating physician within 30 days prior to the date of the initial CMN
- Initial certification situations referenced above in the situations 3 and 4 mentioned above (replacement equipment):
- Repeat blood gas testing is not required. Enter the most recent qualifying value and test date on the CMN. This test does not have to be within 30 days prior to the initial date it could be the test result reported on the most recent prior
  - There is no physician visit that is specifically related to the completion of the CMN for replacement oxygen equipment

## Recertification Certificate of Medical Necessity and Visit Requirements

The local coverage determination for oxygen requires that the physician verify the continued medical need for oxygen, this is demonstrated through the recertification CMN.

- Twelve months after the initial certification (i.e., with the thirteenth month's claim) for Group I patients
- Recertification situations referenced in the first two bullet points above:
    - For patients initially meeting Group I criteria, the most recent **qualifying** blood gas study prior to the thirteenth month of therapy must be reported on the recertification CMN.

- Three months after the initial certification (i.e., with the fourth month's claim) for Group II patients
  - Recertification situations referenced in the first two bullet points above:
    - For patients initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following initial certification must be reported on the recertification CMN. 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.
- Patients initially meeting group I or II criteria, the patient must be seen and reevaluated by the treating physician within 90 days prior to the date of any recertification.

**Note:** If the physician visit is not obtained within the 90-day window but the patient continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

- Replacement oxygen equipment certification requirements:
  - Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the initial date. It could be the test result reported on the most recent prior CMN.
    - There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

## Revised Certification of Medical Necessity and Visit Requirements

When changes are made to an initial CMN, a revised CMN must be completed.

- When the prescribed maximum flow rate changes from one of the following categories to another:
  - Less than 1 liters per minute (LPM)
  - 1-4 LPM
  - Greater than 4 LPM
    - If the prescribed maximum flow rate changes from less than 1 LPM **or** 1-4 LPM to greater than 4 LPM, a repeat blood gas study with the patient on 4 LPM must be performed
- When the length of need expires on the most recent CMN (physician specified less than lifetime length of need)
- When a portable oxygen system is added subsequent to initial certification of a 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 the revised date
- When a stationary system is added subsequent to initial certification of a portable system
  - A new blood gas study is not required
- When there is a new treating physician but the oxygen order is the same
  - A new blood gas study is not required
  - Revised CMN does **not** have to be submitted with the claim
- If there is a new supplier and that supplier does not have the prior CMN
  - A new blood gas study is not required
  - Revised CMN does **not** have to be submitted with the claim

**Note:** If the indications for a revised CMN are met at the same time that a recertification CMN is due, file the CMN as a recertification CMN.

Submission of a revised CMN does not change the recertification schedule.

## Request for Refill

**A routine refill prescription is not needed.**

For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

Suppliers are required to have contact with the beneficiary no sooner than 14 calendar days prior to the delivery/shipping date of a new supply glucose supplies. For items that are delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary. The refill request must occur and be documented before shipment. The refill record must include:

- Beneficiary's name or authorized representative if different than the beneficiary
- A description of each item that is being requested
- Date of refill request
- Information documenting that the beneficiary's remaining supply is approaching exhaustion by the expected delivery date

## Proof of Delivery

Suppliers are required to maintain proof of delivery in their files.

**Method 1:** Direct Delivery to the Beneficiary by the Supplier. Proof of delivery (POD) documentation must include:

- Beneficiary's name
- Delivery address
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature and date of signature

**The date of signature on the delivery slip must be the date that the item was received by the beneficiary or designee.**

**Method 2:** If a supplier utilizes a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from the DMEPOS supplier to the beneficiary. The POD documentation must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery service's records
- Sufficiently detailed description to identify the item(s) being delivered (e.g., brand name, serial number, narrative description)
- Quantity delivered
- Date delivered
- Evidence of delivery

**Note:** If a supplier utilizes a shipping service or mail order, suppliers must use the shipping date as the date of service on the claim.

## Modifiers

- RR – Rental
- RA – Replacement of a DME item
- MS – Maintenance and Servicing
- QE – Prescribed amount of oxygen is less than 1 LPM
- QF – Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is also prescribed
- QG – Prescribed amount of oxygen is greater than 4 LPM and portable oxygen is not prescribed
- QH – Oxygen conserving device is being used with an oxygen delivery system

## Continued Use/Medical Need

- Ongoing supplies and rental DME items require documentation in the beneficiary's medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the date of service. Timely, documentation is defined as a record in the preceding 12 months unless otherwise specified in the policy. Any of the following may serve as documentation justifying continued medical need:
  - A recent order by the treating physician for refills
  - A recent change in prescription
  - A properly completed CMN or DME Information Form (DIF) with an appropriate length of need (if applicable)
  - Timely documentation in the beneficiary's medical record showing usage of the item

## Reminders

- Physician has documented the patient is mobile within the home if portable oxygen is prescribed
- If a 60 day + break in medical need has occurred during the 36-month cap and the patient requires oxygen again, break in need information is reported in the note (NTE) segment of the electronic claim. If the previous diagnosis code and the new diagnosis code are the same indicate the reason for the break in need (i.e., patients condition improved to the point they no longer required the oxygen).
- If the oxygen is being replaced the following information is reported in the NTE segment of the electronic claim:
  - Date patient received original equipment
  - Reason for replacement (i.e., reasonable useful lifetime, loss, theft, or irreparable damage)