5101:3-10-13 **Oxygen services.**

(A) Definitions.

(1) "Blood gas study" is the measurement of such characteristics of blood as the partial pressure of oxygen (PO2) or oxygen saturation. The term applies either to an arterial blood gas (ABG) study, which is performed on blood from an artery, or to pulse oximetry, which is the noninvasive measurement of hemoglobin oxygen saturation

(2) "Group I" and "group II" criteria are sets of clinical indicators used to determine the coverage of oxygen services without prior authorization.

(a) Group I criteria.

(i) If the individual is tested while awake and at rest, the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less; or

(b) Arterial oxygen saturation at or below eighty-eight per cent.

(ii) If the individual is tested while exercising (ambulating), the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less during ambulation without oxygen, with documented improvement during ambulation with oxygen; or

(b) Arterial oxygen saturation at or below eighty-eight per cent during ambulation without oxygen, with documented improvement during ambulation with oxygen.

(iii) If the individual is tested while asleep, the following measures apply:

(a) Arterial PO2 of fifty-five mm Hg or less;

(b) Arterial oxygen saturation at or below eighty-eight per cent;

(c) A decrease in arterial PO2 of more than ten mm Hg, associated with symptoms of or signs reasonably attributable to hypoxemia; or

(d) A decrease in arterial oxygen saturation of more than five per cent, associated with symptoms of or signs reasonably attributable to hypoxemia.

(b) Group II criteria.

(i) Either of the following measures applies:

(a) Arterial PO2 of at least fifty-six mm Hg and not more than fifty-nine mm Hg; or

(b) Arterial oxygen saturation at or above eighty-nine per cent.

(ii) In addition, at least one of the following conditions applies:

(a) Dependent edema suggestive of congestive heart failure;

(b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or the presence of P pulmonale on an EKG; or

(c) Erythrocythemia with a hematocrit greater than fifty-six per cent.

(3) "Transfill unit" is a device that transfers oxygen from a source such as an oxygen concentrator or liquid oxygen canister to portable tanks.

(B) Prescribers and suppliers of oxygen services.

(1) The following eligible medicaid providers may prescribe oxygen services:

(a) An independent physician;

(b) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner); or

(c) A physician assistant.

(2) The following eligible medicaid providers may render oxygen services:

(a) A durable medical equipment (DME) supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant; or

(f) An ambulatory health care clinic.

(3) The following eligible medicaid providers may receive medicaid payment for submitting a claim for an oxygen service on behalf of a rendering supplier:

(a) A DME supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant;

(f) An ambulatory health care clinic; or

(g) A professional medical group.

(C) Certificate of medical necessity.

(1) Payment for oxygen services can be made only if an authorized provider certifies on a form, the certificate of medical necessity (CMN), that the services are medically necessary for an individual. For purposes of this rule, the CMN is form JFS 01909, "Certificate of medical necessity/prescription: oxygen services" (rev. 06/2005). A completed CMN must be signed and dated by the prescriber before a claim for a service is submitted. The certification period is limited to a maximum of twelve months after the first date of service for an individual meeting group I criteria and three months after the first date of service for an individual meeting group II criteria. According to the purpose for which a CMN is used, it may be called an initial CMN, a recertifying CMN, or a revised CMN.

(2) An initial CMN is used to document certification for new service.

(a) An initial CMN must be completed in the following circumstances:

(i) The supplier will be rendering oxygen services to an individual for the first time on a fee-for-service basis, even if the individual was using oxygen before gaining medicaid eligibility or oxygen was previously supplied through a medicaid managed care plan;

(ii) Oxygen was previously supplied to the individual on a fee-for-service basis, but a change in the individual's condition has suspended the need for oxygen for at least two full calendar

months; or

(iii) Existing equipment must be replaced because it has reached the end of its expected useful life or has been irreparably damaged, lost, or stolen.

(b) If the CMN is needed solely because equipment is being replaced, then neither a prescriber visit nor a new blood gas study is required. (The results and test date of the most recent qualifying blood gas study may be entered on the form.)

(c) If the CMN is needed for purposes other than equipment replacement alone, then the individual must be seen and evaluated by a prescriber within a specified period before the date of certification, and a blood gas study is required.

(i) If the individual started using oxygen while enrolled in a medicaid managed care plan, then the evaluation period is twelve months, and the most recent blood gas study performed while the person was in the managed care plan must be used.

(ii) If the individual is a hospital inpatient or a resident of a long-term care facility (LTCF), then the evaluation period is thirty days, and the earliest blood gas study performed within forty-eight hours before discharge must be used.

(iii) Otherwise, the evaluation period is thirty days, and the most recent blood gas study performed within thirty days before the date of certification must be used.

(3) A recertifying CMN is used to renew certification. Within ninety days before the end of the existing certification period, the individual must be seen and evaluated by a prescriber, and a blood gas study is required. (The new certification period cannot begin until both the prescriber evaluation and the blood gas study have been completed.)

(4) A revised CMN is used to modify an existing certification. No prescriber evaluation is required.

(a) The most recent blood gas study performed within thirty days before the revision date must be used for the following modifications:

(i) The prescribed maximum flow rate has changed. If the new rate is greater than four liters per minute (LPM), then a new blood gas study must be performed while the individual is receiving four LPM.

(ii) The length of need must be extended (if the prescriber has specified a length of need less than lifetime on the most recent CMN).

(iii) Certification has been given for a portable oxygen delivery system to supplement a stationary system for which certification was previously given. If the most recent qualifying study was performed during sleep, then a new blood gas study must be performed while the individual is awake, either at rest or exercising.

(b) No additional blood gas study is required for the following modifications:

(i) There is a new treating practitioner, but the oxygen order is the same.

(ii) There is a new supplier, and the new supplier does not have the most recent CMN.

(D) Coverage.

(1) Payment may be made for the following oxygen services:

(a) Stationary gaseous oxygen system (private residence only);

(b) Portable gaseous oxygen system (private residence only);

(c) Stationary liquid oxygen system (private residence only);

(d) Portable liquid oxygen system (private residence only);

(e) Oxygen contents, gaseous, including supplies (LTCF only);

(f) Oxygen contents, liquid, including supplies (LTCF only);

(g) Oxygen concentrator, single delivery port;

(h) Oxygen concentrator, dual delivery port;

(i) Portable oxygen concentrator (private residence only); and

(j) Transfill unit (private residence only).

(2) A supplier must furnish the least expensive oxygen delivery system that meets an individual's medical and personal needs.

(3) Separate payment for a portable oxygen delivery system may be made in addition to payment for a stationary system only if the following criteria are

met:

(a) The individual must have a demonstrable need for a separate portable system, either to maintain mobility in a private residence or to accomplish out-of-home activities;

(b) The individual's stationary oxygen delivery system cannot be used as a portable delivery system; and

(c) The prescribed oxygen flow is four LPM or less. If the prescribed oxygen flow is greater than four LPM, then no separate payment is made for the portable oxygen delivery system.

(4) Separate payment will not be made, however, for both a stationary and a portable oxygen concentrator.

(5) Prior authorization is not required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who either meets group I or group II criteria or is a resident of a LTCF.

(6) Prior authorization is required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who meets neither group I nor group II criteria and is not a resident of a LTCF. If approval is given, then the length of the approval period will be based on medical necessity and cannot exceed the timeframe indicated by the prescriber. The request for prior authorization must include a copy of the completed CMN.

(7) An oxygen service will be denied as not medically necessary if it is prescribed for any of the following conditions:

(a) Angina pectoris in the absence of hypoxemia;

(b) Dyspnea without cor pulmonale or evidence of hypoxemia;

(c) Severe peripheral vascular disease that results in clinically evident desaturation in one or more extremity but does not produce systemic hypoxemia; or

(d) A terminal illness that does not affect the respiratory system.

(E) Payment.

(1) All appropriate procedure codes and modifiers must be reported on claims.

(2) Payment for oxygen services is made on a monthly basis and includes the following related items and services:

(a) Setup and instruction on use;

(b) Equipment and supplies;

(c) Maintenance and repair, including the replacement of any part or attachment (such as tubing, cannula, mask, or filter) that is integral to the oxygen system or the operation of the system;

(d) Transportation or delivery charges;

(e) Emergency service, including the provision of backup equipment and supplies;

(f) Oxygen consumed (when applicable); and

(g) Equipment monitoring visits.

(3) The maximum fee for an oxygen service is the amount set forth in the appendix to this rule.

(a) When the prescribed oxygen flow is greater than four LPM, the payment amount is increased by fifty per cent.

(b) When the prescribed oxygen flow is greater than four LPM and portable oxygen is also prescribed, the payment amount is increased by fifty per cent.

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