TO BE RESCINDED

5101:3-10-13 **Oxygen: covered services and limitations.**

(A) Coverage criteria.

(1) A current prescription order is required prior to dispensing oxygen. This order must be renewed at least annually.

(2) Oxygen therapy is covered only for patients with significant hypoxemia in the chronic stable state provided the following conditions are met:

(a) 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;

(b) The patient's blood gas levels indicate the need for oxygen therapy; and

(c) Alternative treatment measures have been tried or considered and deemed clinically ineffective.

(3) Oxygen therapy may be considered for patients with other clinical indications when it is determined to be medically necessary.

(4) Non-covered diagnosis. Oxygen therapy will be denied as not medically necessary if any of the following conditions are present:

(a) Angina pectoris in the absence of hypoxemia.

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

(c) Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities, but in the absence of systemic hypoxemia.

(d) Terminal illnesses that do not affect the respiratory system.

(B) Portable oxygen systems.

A portable oxygen system is covered if medically necessary as an adjunct to a stationary system which has been established as medically necessary. Additional criteria is as follows:

(1) The patient must be mobile.

(2) The qualifying blood gas study must be performed while at rest (awake) or during exercise.

(3) In a personal residence, only rented oxygen systems are covered. Purchased oxygen systems will be denied as noncovered.

(4) In a long term care facility, rented oxygen systems are included in the cost report and are not separately billable. Purchased oxygen systems will be denied as noncovered.

(5) Oxygen contents are included in the allowance for rented systems. Oxygen contents are separately payable only when they are used with a patient owned system.

(6) Accessories, including but not limited to, cannulas, masks and tubing are included in the allowance for rented systems. Accessories are separately payable only when they are used with a patient owned system that was purchased prior to June 1, 1989. Accessories used with a patient owned system that was purchased on or after June 1, 1989, will be denied as noncovered.

(7) If oxygen usage is greater than four liter per minute continuous, the portable oxygen system is included in the reimbursement fee for the stationary unit when billed with the "QF" modifier.

(C) Billing requirements.

To receive a payment adjustment, one of the following modifiers must be used with stationary oxygen system codes when appropriate. This applies to oxygen used with concentrators, liquid and gaseous systems.

(1) Modifier code QE shall be used and the payment amount reduced by fifty percent when:

(a) The prescribed amount of oxygen is one liter per minute or less, or

(b) The patient has used no more than one thousand cubic feet of gaseous oxygen, or no more than eighty pounds of liquid oxygen.

(2) Modifier code QG shall be used and the payment amount increased by fifty per cent when:

(a) The prescribed amount of oxygen is greater than four liter per minute continuous and portable oxygen is not prescribed.

(b) If the QG modifier is used, the provider must check and record the appropriate meter readings or document the refill amount and delivery information.

(3) Modifier code QF shall be used and the payment amount increased by fifty per cent when:

(a) The patient resides in a personal residence.

(b) The prescribed amount of oxygen is greater than four liters per minute continuous and portable oxygen is also prescribed.

(c) If the QF modifier is used, the provider must check and record the appropriate meter readings or document the refill amount and delivery information.

(4) No modifier is used when:

(a) Supplying portable oxygen contents or a portable system rental.

(b) The prescribed amount of oxygen is greater than one liter per minute and no more than four liters per minute, or

(c) The prescribed amount of oxygen is greater than four liters per minute non-continuous and the oxygen consumed is more than one thousand cubic feet of gaseous oxygen or more than eighty pounds of liquid oxygen, or the equivalent generated by an oxygen concentrator.

(5) The department will use the "Oxygen Equipment and Contents Billing Charts" (see appendices A and B of this rule) for determining what oxygen fee schedule component is billable/payable under various equipment alternatives.

(6) For recipients who own gaseous or liquid equipment, the supply code for "oxygen contents" should be billed. Reimbursement for oxygen contents

includes all supplies for recipients residing in a personal residence. The modifiers listed in paragraph (C) of this rule should be used as appropriate.

(D) Oxygen services provided to recipients residing in a personal residence.

(1) Prior authorization.

Prior authorization is required for oxygen services and authorization may be requested for up to twenty-four months. However, the length of approval will be dependent on diagnosis, length of need, and stability of the patient as determined by the department based on documentation submitted with the request for services.

(2) Documentation requirements.

Information submitted by the supplier must be corroborated by documentation in the patient's medical records that medicaid coverage criteria have been met. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, or records from other healthcare professionals. This information must be available for review upon request.

(a) The following information must be submitted with every prior authorization request for oxygen services.

(i) Completed JFS 3142 "prior authorization" form.

(ii) Signed and completed HCFA 484 form or durable medical equipment regional carrier (DMERC) 484.2 form "Oxygen Certificate of Medical Necessity" (CMN).

(b) The date of the arterial blood gas (ABG) or pulse oximetry reading must be within thirty days prior to the initial date of the requested service, or within ninety days prior to the date of any recertification.

(c) For individuals on oxygen with CPAP who only desaturate at night, only a certificate of medical necessity (CMN) for oxygen is required at the time of recertification (arterial blood gas or pulse oximetry is not required).

(d) The patient must be evaluated by the treating physician and a prescription written within thirty days prior to the date of initial certification. The

patient must be re-evaluated by the treating physician and a prescription written within ninety days prior to the date of any recertification.

(E) Coverage requirements for oxygen services provided to recipients residing in a personal residence.

(1) Covered blood gas values. A patient is considered to have significant hypoxemia if group I, II, or III criteria are met.

(a) Group I include any of the following:

(i) An arterial PO_2 at or below fifty-five mm Hg, or an arterial oxygen saturation at or below eighty-eight per cent, taken at rest (awake).

(ii) An arterial PO_2 at or below fifty-five mm Hg, or an arterial oxygen saturation at or below eighty per cent taken during sleep for a patient who demonstrates an arterial PO_2 at or above fifty-six mm Hg or an arterial oxygen saturation at or above eighty-nine per cent, while awake.

(iii) A decrease in arterial PO_2 more than ten mm Hg, or a decrease in arterial oxygen saturation more than five per cent, taken during sleep, associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). In either of these cases, coverage is provided only for nocturnal use of oxygen.

(iv) An arterial PO_2 at or below fifty-five mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO_2 at or above fifty-six mm Hg or an arterial oxygen saturation at or above eighty-nine per cent, during the day while at rest. In this case, supplemental 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.

(b) Group II criteria include the presence of

(ii) An arterial PO_2 of fifty-six to fifty-nine mm Hg or an arterial blood oxygen saturation of eighty-nine per cent at rest (awake), during sleep, or during exercise (as described under group I criteria); and

(iii) Any of the following:

(a) Dependent edema suggesting congestive heart failure;

(b) 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 three mm in standard leads II, III, or AVF); or

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

(c) Group III includes patients with arterial PO_2 levels at or above sixty mm Hg or arterial blood oxygen saturations at or above ninety per cent in whom additional documentation substantiates the medical necessity of oxygen in the individual case. Oxygen therapy in patients with these blood gas values is rarely medically necessary.

(3) The provider of oxygen services may conduct the pulse oximetry but may not conduct the arterial blood gas measurement. A blood gas measurement must be conducted by a provider qualified to conduct such tests, other than a DME supplier. In addition, the qualifying blood gas measurement may not be paid for by any supplier. This prohibition does not extend to blood gas measurements performed by a hospital certified to do such tests.

(4) Additionally, spare tanks of oxygen or emergency oxygen inhalators will be denied as medically unnecessary since they are precautionary and not therapeutic in nature.

(F) Payment for oxygen claims - personal residence.

Payment for oxygen services for recipients residing in a personal residence is as follows:

(1) Oxygen services are paid on a monthly basis. All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen plus the usual and customary monthly rental charge for equipment and supplies; e.g., concentrator, stand or cart, regulator with flow gauge, humidifier, cannula or mask, and tubing. Billed charges for gaseous and liquid oxygen shall be the provider's usual and customary charge for the oxygen actually used by the recipient. For recipients

receiving gaseous or liquid oxygen, documentation of the amount of oxygen actually used each month (as determined from a meter reading or documented refill amount and delivery information) must be maintained in the provider's file.

(2) Payment will be limited to the lower of the usual and customary charge of the supplier, or the medicaid maximum as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(3) Payment for oxygen services provided to a recipient residing in a personal residence includes reimbursement for:

(a) Set up and instructions;

(b) Equipment (including concentrator) and supplies;

(c) Maintenance and repairs;

(d) Emergency services or subsequent/interim visits; and

(e) Oxygen consumed.

(G) Oxygen services provided to recipients residing in long-term care facilities.

(1) Prior authorization is not required for reimbursement of oxygen services to residents of LTCFs.

(2) The oxygen provider must have on file, prior to submitting any claim for reimbursement, a prescription or HCFA 484 certificate of medical necessity form, or DMERC 484.2 form, from a physician who has examined the patient within thirty days prior to the first date of service. The prescription or HCFA 484 form or DMERC 484.2 form must specify:

(a) Diagnosis;

(b) Oxygen flow rate; and

(c) Duration (hours per day); or

(d) Indications for usage.

(3) A prescription of "oxygen PRN" does not specify the oxygen flow rate and duration or indications for usage and does not meet the requirements of this rule.

(4) For each resident who receives oxygen services for six months or more, the resident's PO_2 level must be established within the period beginning sixty days prior to the first date of service and annually thereafter. The provider shall keep on file a copy of a laboratory report of an arterial blood gas (ABG) study that has been ordered and evaluated by the prescribing physician. Documentation of pulse oximetry may be kept on file in lieu of an ABG, when ordered and evaluated by the prescribing physician. A copy of the dated oximetry print-out or a dated form used to document the oximetry results, signed and dated by the prescribing physician, shall be kept in the provider's file. All tests for oxygen saturation shall be performed while the resident is in stable condition, at rest.

(H) Payment for oxygen claims - long-term care facility (LTCF).

Payment for oxygen services for recipients in an LTCF is as follows:

(1) All claims must show billed charges for one month's service. Billed charges shall be the provider's usual and customary charge for the oxygen actually used by the recipient. The amount of oxygen actually used each month (as determined from a meter reading or refill amount and delivery information) must be determined and documented by the provider prior to submitting the monthly claim for reimbursement. Documentation of the amount of oxygen used each month must be maintained in the provider's file.

(2) Provider maintenance of documentation of the amount of oxygen used does not meet the requirements of this rule when such documentation is created, or collected from sources other than the provider, after the service has been billed.

(3) Regardless of delivery modality, i.e., gaseous system, liquid system, or concentrator, amounts less than seven hundred fifty cubic feet, or the equivalent, must be billed using the special codes established for that purpose and listed in appendix A of rule 5101:3-10-03 of the Administrative Code.

(4) Payment will be limited to the lower of the usual and customary charge of the supplier, or the medicaid maximum as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(5) All equipment and supplies associated with oxygen administration to residents of an LTCF must be reimbursed through the facility's cost report as set forth in rule 5101:3-3-11 of the Administrative Code. Therefore, the cost of reservoirs, stands/carts, regulators, humidifiers, cannulas, masks, and tubing must be billed to the facility.

(6) A separate set of procedure codes has been established for oxygen services provided to a resident of an LTCF. Oxygen services provided to a resident of an LTCF must be billed to the department using these codes which are listed in the "Medicaid Supply List" (see appendix A of rule 5101:3-10-03 of the Administrative Code.)

Effective: 11/01/2007

R.C. 119.032 review dates: 05/08/2007

CERTIFIED ELECTRONICALLY

Certification

09/11/2007

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021
Prior Effective Dates:	4/7/77, 12/21/77, 12/30/77, 1/1/80, 3/1/84, 5/1/90, 6/20/90 (Emer), 9/5/90, 2/17/91, 5/25/91, 4/1/92 (Emer), 7/1/92, 3/31/94, 1/1/95, 8/1/95, 8/1/98, 10/11/01