5101:3-10-13 **Oxygen: covered services and limitations in a private residence.**

(A) Coverage criteria.

(1) A current prescription is required prior to dispensing oxygen. This prescription must be renewed at least once a year. Any significant changes to the consumer's treatment plan pertaining to oxygen services require a new prescription be obtained and kept in the consumer's medical record.

A significant change to the consumer's treatment plan pertaining to oxygen services is defined as the point where the consumer's prescribed amount of oxygen requires the use of or change of an oxygen modifier code.

(2) Oxygen services are covered only for consumers with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

(a) The treating prescriber has determined that the consumer has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen services; and

(b) The consumer's blood gas and/or oxygen saturation levels indicate the need for oxygen services; and

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

(3) Non-covered diagnoses:

Oxygen services will be denied as not medically necessary if any of the following conditions are present:

(a) Angina pectoris in the absence of hypoxemia; or

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

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

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

(B) Coverage requirements.

(1) Covered blood gas and/or oxygen saturation values. A consumer is considered to have significant hypoxemia if group I or II criteria are met.

(a) Group I criteria include any of the following:

(i) An arterial partial pressure (tension) of oxygen (PO2) 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 PO2 at or below fifty-five mm Hg, or an arterial oxygen saturation at or below eighty-eight per cent taken during sleep for a patient who demonstrates an arterial PO2 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 PO2 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 the nocturnal use of oxygen.

(iv) An arterial PO2 at or below fifty-five mm Hg or an arterial oxygen saturation at or below eighty-eight per cent, taken during exercise, for a patient who demonstrates an arterial PO2 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 use 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 any of the following:

(i) An arterial PO2 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

(a) Dependent edema suggesting congestive heart failure; or

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

(2) 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 durable medical equipment (DME) provider. In addition, the qualifying blood gas or oxygen saturation measurement may not be paid for by any DME provider. However, this prohibition does not extend to blood gas or oxygen saturation measurements performed by a hospital certified to do such testing. When both arterial blood gas (ABG) and oxygen saturation (oximetry) tests have recently been performed, greater weight is given to the ABG result when determining medical necessity for oxygen services.

(3) Emergency spare oxygen cylinders are not separately reimbursable.

(C) Prior authorization, documentation and testing.

(1) Prior authorization.

(a) Prior authorization is not required for oxygen services provided to consumers who meet the group I or II criteria as defined in paragraph (B) of this rule.

(b) Prior authorization is required for oxygen services and authorization may be requested for up to twelve months for any consumer that does not meet the group I or II criteria in paragraph (B) of this rule. However, the length of approval will be dependent on diagnosis, length of need, and stability of the patient as determined by the Ohio department of job and family services (ODJFS) based on documentation submitted with the request for services. The prior authorization cannot exceed the time frame documented on the prescriber's submitted prescription, based on the date that the prescriber signs the prescription.

(2) Documentation requirements.

Requests for reimbursement submitted by the provider for oxygen services must be corroborated by documentation in the consumer's medical records that medicaid coverage criteria ~~has~~have been met. The consumer's medical records can include the prescriber's office records, hospital records, nursing home records, home health agency records, or records from other healthcare professionals. This documentation must be available for review upon request from ODJFS.

(a) The following information must be submitted and maintained by the provider for every prior authorization request for oxygen services:

(i) Form JFS 01909 ~~(rev. 6/2005)~~, "Certificate of Medical Necessity/Prescription for Oxygen Services," ~~(~~appendix A to this rule~~)~~, that is signed and dated by the attending prescriber no more than thirty days prior to the first date of service; and

(ii) Any other documentation required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(b) The oxygen provider not seeking prior authorization must have on file, prior to submitting any claim for reimbursement, a fully completed form JFS 01909 ~~(rev. 6/2005)~~, "Certificate of Medical Necessity/Prescription for Oxygen Services," appendix A to this rule, that is signed and dated no more than thirty days after the first date of service.

(c) A prescription of "Oxygen PRN" that specifies the oxygen flow rate and duration or indications for usage does meet the requirements of this rule.

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

(e) The consumer must be evaluated by the treating prescriber and a prescription written within thirty days prior to the date of initial certification. The consumer must be re-evaluated by the treating prescriber and a prescription written within ninety days prior to the date of any recertification.

(f) Documentation for the prior authorization of oxygen services must be submitted with the appropriate healthcare common procedure coding system (HCPCS) codes ~~as defined in rule 5101:3-1-19.3 of the Administrative Code~~ for the actual item or items on the same PA request.

(3) Testing requirements.

(a) The consumer's qualifying PO2 or arterial blood oxygen saturation level must be established under the following conditions prior to the initial date of service and every year thereafter for recertification in order to establish continued medical necessity:

(i) If the qualifying blood gas study is performed during an inpatient or ~~LTCF (long term care facility)~~long term care facility (LTCF) stay, the qualifying blood oxygen saturation or PO2 test must be the one obtained closest to, but no earlier than forty eight hours prior, to the hospital or LTCF discharge date, or

(ii) If the qualifying blood gas study is not performed during an inpatient or LTCF stay, the qualifying blood oxygen saturation or PO2 test cannot be dated more than thirty days prior to the initial date of service.

(b) The provider shall submit a copy of a laboratory report of an arterial blood gas (ABG) study that has been ordered and evaluated and countersigned by the attending prescriber at the time of any request for prior authorization.

(c) The provider shall keep on file a copy of a laboratory report of an arterial blood gas (ABG) study that has been ordered evaluated and countersigned by the attending prescriber when prior authorization is not required.

(d) Documentation of current pulse oximetry may be submitted to ODJFS in lieu of an ABG when ordered, evaluated and countersigned by the attending prescriber. If this occurs, a copy of the dated oximetry print-out or a dated form used to document the oximetry results, signed and dated by the prescriber, shall be submitted to ODJFS at the time of the prior authorization request or kept in the ~~providers~~provider's file when prior authorization is not required.

(e) All tests for oxygen saturation shall be performed while the consumer is in a chronic stable state and not during a period of acute illness or an exacerbation of the consumer's underlying disease.

(D) Portable/ ambulatory oxygen systems.

A portable/ambulatory oxygen system is covered with a prescription if medically necessary as an adjunct to a stationary system which has been established as medically necessary previously. The following criteria must be met in order to qualify for this coverage:

(1) The patient must be mobile within the home;

(2) It is documented in the ~~providers~~provider's file that the need for the portable oxygen system is required for the consumer to accomplish out of the home activities (~~ex.~~ e.g.,work, school, etc);

(3) In a personal residence, only rented home care oxygen systems are covered. Purchased oxygen systems will be denied as noncovered. Oxygen contents are included in the allowance for rented systems;

(4) Accessories including, but not limited to, cannulas, masks and tubing are included in the allowance for rented systems;

(5) If oxygen usage is greater than four liters per minute continuous, the portable oxygen system is included in the reimbursement fee for the stationary unit and should be billed with the "QF" modifier~~.~~; and

(6) Consumers supplied with oxygen systems that can be utilized as both a stationary and portable/ ambulatory delivery system are not eligible for consideration of an additional portable/ambulatory system. Consumers may not be supplied with both a stationary and a portable oxygen concentrator. Unless specified otherwise by the prescriber, delivery systems will be able to be utilized as both a portable and stationary system. It is expected that the consumer will be supplied with the most cost effective oxygen delivery system that will meet the consumer's clinical needs as identified by the ordering prescriber.

A cost effective system is defined by ODJFS to mean that the provider has taken into account all of the consumer's clinical and ambulatory needs in order to identify an oxygen delivery system that will meet the consumer's clinical and lifestyle requirements utilizing a specific delivery system that is

available at the lowest cost to ODJFS.

(E) Modifier requirements.

To receive a payment adjustment, one of the following modifiers must be used with the oxygen system codes specified in paragraph (F) of this rule when appropriate. Unless otherwise specified, oxygen concentrators are not subject to these modifiers.

(1) No modifier is used when:

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

(b) Supplying portable oxygen contents or a portable system rental; or

(c) The prescribed amount of oxygen is greater than four liters per minute non-continuous.

The provider must document all applicable gaseous and liquid refill amounts and delivery information in the consumer's medical record.

(2) Modifier code QE shall be used and the medicaid maximum payment amount reduced by fifty per cent of the amount set forth in appendix DD to rule 5101: 3-1-60 of the Administrative Code when the prescribed amount of oxygen is one liter per minute or less. If the QE modifier is used, the provider must document all applicable gaseous and liquid refill amounts and delivery information in the consumer's medical record.

(3) Modifier code QG shall be used and the medicaid maximum payment amount increased by fifty per cent of the amount set forth in appendix DD to rule 5101: 3-1-60 of the Administrative Code when:

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

(b) If the QG modifier is used, the provider must document all applicable gaseous and liquid refill amounts and delivery information in the consumer's medical record.

(4) Modifier code QF shall be used and the medicaid maximum payment amount increased by fifty per cent of the amount set forth in appendix DD to rule

5101: 3-1-60 of the Administrative Code when the following occurs:

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

(b) If the QF modifier is used, the provider must document all applicable gaseous and liquid refill amounts and delivery information in the consumer's medical record.

(5) Modifier code U1 shall be used when oxygen services are provided via the use of a stationary oxygen concentrator to a consumer in a private residence. A reimbursement request using this modifier code will be reimbursed at the rate of one hundred and eight per cent of the maximum allowable price currently listed in appendix DD to rule 5101:3-1-60 of the Administrative Code per month for this service.

(F) Payment for oxygen claims.

(1) The following codes are the only codes authorized to be utilized in a private residence when seeking reimbursement for oxygen services rendered:

(a) E0424-Stationary compressed gaseous oxygen system;

(b) E0431-Portable gaseous oxygen system;

(c) E0434-Portable liquid oxygen system;

(d) E0439-Stationary liquid oxygen system;

(e) E1392-Portable oxygen concentrator;

(f) K0738-Trans fill oxygen system;

(g) E1390U1-Oxygen concentrator, single port; and

(h) E1391U1-Oxygen concentrator, dual port.

(2) Trans fill oxygen system or portable concentrator codes cannot be billed to ODJFS in combination with any other oxygen code approved for use by the department for oxygen services provided in a private residence. Trans fill

oxygen systems and portable concentrators must operate as independent integrated oxygen systems.

(3) Code E1391 is used in situations in which two consumers are both using the same concentrator. In this situation, this code will only be billed for one of the consumers using the equipment. Both consumers must be using medicaid benefits in order for this code to be valid for reimbursement.

(4) Oxygen claims are paid on a per month basis. All claims must show billed charges for one month's service. Billed charges for gaseous and liquid oxygen as well as services provided by the use of an oxygen concentrator shall be no more than the provider's usual and customary charge for these services in the same setting. For consumers receiving gaseous or liquid oxygen, documentation of the amount of oxygen actually used each month (as determined from the documented refill amount and delivery information) must be maintained in the provider's file. For consumers receiving oxygen that is supplied by an oxygen concentrator, providers must keep the consumer's most current prescription on file to verify that continued oxygen services are warranted due to medical necessity.

(5) Payment will be limited to the lower of the usual and customary charge of the supplier for services provided when compared to similar services provided in the same setting to consumers with payer sources other than medicaid, or the medicaid maximum payment as set forth in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(6) When oxygen services are delivered from an oxygen concentrator, the oxygen concentrator will be serviced and maintained in accordance with the manufacturer's specifications, unless ordered otherwise by the prescriber. Service and maintenance records will be documented in the consumer's medical record or provider's file.

(7) 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.

(8) All billing for oxygen services will stop immediately when a consumer fails to meet any of the criteria contained within this rule pertaining to the qualifications necessary for the administration of oxygen services.

(9) Payment for oxygen services provided to a consumer in a personal residence is inclusive of the following components:

(a) Set up and instructions;

(b) Equipment (including concentrator) and supplies;

(c) Maintenance and repairs to include any supplies or attachments that are integral to the operation of the oxygen system being supplied;

(d) Transportation and/or delivery charges;

(e) Emergency services (to include the supply of backup oxygen supplies) or subsequent/interim visits;

(f) Oxygen consumed (when applicable); and

(g) Equipment monitoring visits.

Effective:

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Certification

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Date

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