Oxygen Therapy Ordering Guidelines & Reimbursement Fast Facts

UNDERSTANDING MEDICARE CODING AND COVERAGE CRITERIA

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when the beneficiary meets all the requirements in the Oxygen and Oxygen Equipment Local Coverage Decisions (LCD) and LCD-related PA. This document reviews the blood oxygen testing requirements. Refer to the Oxygen and Oxygen Equipment LCD and LCD-related PA for information on additional payment criteria. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33797

BILLING CRITERIA FOR OXYGEN

Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for Groups I and II (Table 1) if all the following conditions are met:

1. The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need*; and,
2. The beneficiary's blood gas study meets the criteria stated below; and,
3. The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and,
4. The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.

Qualification Tests

Blood oxygen levels are used to assess the beneficiary's degree of hypoxemia. Either of two different test methods may determine blood oxygen levels:

- Arterial blood gas (ABG) measurement
- Pulse oximetry

Arterial blood gas (ABG) measurements are more accurate and therefore are the preferred measurement method. When both ABGs and oximetry are performed on the same day, the ABG value must be used for reimbursement qualification.

The LCD describes the following as acceptable oximetry testing methods:

- At rest and awake – often referred to as "spot" oximetry
- During exercise – requires a series of 3 tests done during a single testing session:
  - At rest, off oxygen – showing a non-qualifying result
  - Exercising, off oxygen – showing a qualifying result
  - Exercising, on oxygen – test results obtained while exercising with oxygen therapy showed improvement

Timing of Testing

Oxygen qualification testing must be performed at the time of need to improve the beneficiary's condition in the home setting. *Time of need is defined as during the patient's illness when the presumption is that the provision of oxygen will improve the patient's condition in the home setting. For oxygen initially prescribed at the time of hospital discharge, testing must be performed within 2 days prior to discharge. This 2-day prior-to-discharge rule does not apply to discharges from nursing facilities.

Qualifying Test Results

The results of a blood oxygen study ordered and evaluated by the treating practitioner are used as one of the criteria for determining Medicare reimbursement. Medicare classifies qualification results into four groups, regardless of the test methodology. Table 1 summarizes (group 1 and 2; classification groups that Inogen specialize in)

Table 1. Medicare Oxygen Classification

Group	ABG (mm HG)	Oximetry (%Sat)	Notes
Group I	≤ 55	≤ 88	N/A
Group II	56-59	89	And 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 percent.

Continued Coverage Criteria by Oxygen Group

In order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the medical record documenting the following:

Group I There is no formal requirement for re-evaluation and retesting; however, treating practitioners should ensure that once qualified for home oxygen therapy, the oxygen therapy and oxygen equipment remain reasonable and necessary.

Group II and Group III 1. A re-evaluation of a repeat qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy; and 2. A new Standard Written Order (SWO) by the treating practitioner.

For ongoing supplies and rented DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary's medical record to support that the item continues to remain reasonable and necessary. Inogen obtains a new prescription from the patient's physician annually to ensure compliance with state regulations and CMS's continued medical necessity requirements.

Still have questions?

SCAN THE CODE for answers to frequently asked questions about oxygen coverage.

Oxygen and Oxygen Equipment: Policy Article

Local Coverage Determination: Oxygen and Oxygen Equipment

PM250076 EN_EX_USA | Rx Only.
859 Ward Drive, Suite 200, Goleta, CA 93111

References:
https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33797
https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=169
https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=55426
https://cgsmedicare.com/jb/dpl/dpl_home_oxy.pdf
https://www.cgsmedicare.com/jb/help/faqs/current/oxygen.html

* Time of need is defined as during the patient's illness when the presumption is that the provision of oxygen will improve the patient's condition in the home setting.