Medicare Minute MD – Oxygen and Oxygen Equipment

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Hello and welcome to another edition of Medicare Minute MD. I'm Dr. Robert Hoover, medical director at CGS Administrators, the Jurisdictions B and C DME MAC.

I'm once again hosting our unique education series, "Medicare Minute MD". Today I'm going to focus on the new Home Use of Oxygen national coverage determination issued by the Centers for Medicare and Medicaid Services in September 2021 and the DME MAC Oxygen and Oxygen Equipment local coverage determination or LCD. The two are very similar but there is additional information in the LCD and I'll cover that in this video. As with all of our educational offerings, I encourage you to read the entire LCD and its related Policy Article for full details.

Three of the biggest changes in the oxygen coverage relate to:

1. Elimination of the "chronic stable state" requirement;

2. Allowing coverage for acute conditions; and,

3. Allowing coverage for normoxemic conditions expected to improve with oxygen therapy, like cluster headaches.

Reflective of these coverage changes, the DME MAC's Oxygen and Oxygen Equipment LCD divides patients into 4 groups for initial coverage, based on their condition and their blood gas results. These groups are shown on your screen now:

In this first slide, Group 1 is very similar to the old NCD and LCD. Oxygen is still covered for an arterial PO2 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest while breathing room air; desaturation during sleep; desaturation with exercise; or a relative decrease in saturation from baseline.

Similarly, Group 2 is little different from the old NCD and LCD and comprises those patients with an arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent plus certain signs and symptoms of hypoxemia.

Group 3 is a new group and is for those patients with normoxemic blood gas studies but for whom the medical literature demonstrates that home oxygen therapy will improve their disease condition. An example is oxygen for the treatment of cluster headaches.

And finally, Group 4 is comprised of patients for whom oxygen therapy is not reasonable and necessary.

You'll note that I mentioned "initial coverage." That's because there are criteria for the initiation of oxygen coverage and, for Group II and Group III, continued coverage beyond the

first 90 days. We'll get to that in a minute. First, let's talk about some of the general coverage requirements that apply to Group I and Group II.

On your screen now you'll see those initial coverage criteria. Importantly, you need to order and evaluate a qualifying blood gas study that meets one of the three groups I just discussed. You should document these results in your patient's medical record, along with your rationale for prescribing oxygen therapy.

This initial coverage does not require an in-person or telehealth visit; however, good clinical practice would dictate that you'll likely want to have some type of patient encounter before prescribing home oxygen therapy.

A second point about these criteria – time of need. Recall the old oxygen policy required a visit within 30 days of ordering oxygen. CMS no longer mandates a visit but rather you must evaluate the blood gas study and prescribe the oxygen at the "time of need." CMS defines "time of need" in the NCD 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 an inpatient hospital patient anticipated to require oxygen upon discharge, the time of need would be within 2 days of discharge.

So summarizing these requirements, you should document in the beneficiary's medical record the results of the qualifying test and your rationale for prescribing home oxygen, based on the results of the qualifying blood gas study. At that point, you'll write a standard written order for the oxygen that includes:

• The patient's name or Medicare Beneficiary Identifier or MBI

• Order Date

• General description of the item - either a general description (e.g., oxygen concentrator plus portable tanks), or it could be a HCPCS code, a HCPCS code narrative, or a brand name/model number. You may also include any options, accessories or additional features

• Quantity to be dispensed, if applicable. There's really not a quantity for oxygen but you do have the option to list liter flow rate or length of need here but it's not required on the order. Just make sure you have that information in your patient's record. And finally, your Name or NPI, and your signature

Let's move on to continued coverage, which are shown on your screen now.

Continued coverage beyond the initial coverage requirements has been simplified. For Group I patients, in order to continue payment of oxygen and oxygen equipment claims, there must be evidence in the patient's medical record that the oxygen therapy and oxygen equipment remain reasonable and necessary. In other words, you should follow good standards of medical care to ensure that you monitor your patient on oxygen and document their continued necessity for oxygen therapy during routine patient visits. There's not a Medicare requirement for a periodic visit or re-testing.

Group II and Group III are a little different from Group I but overall, the re-testing requirement for Group II is unchanged from the old NCD and LCD. Group III in the Oxygen LCD is a new group, the normoxemic patients, and does have a re-testing requirement.

Initial coverage of oxygen for patients with Group II and Group III qualifying blood gas tests is initially limited to 3 months. To continue beyond the 3 months, the patient must be re-tested between the 61st and 90th days after initiation of home oxygen therapy. This requirement is in the Social Security Act, the law governing Medicare. If the patient is retested and continues to qualify for oxygen, you just need to document your evaluation of that test and write a new Standard Written Order.

As with initial qualification, for continued coverage you're evaluating the qualifying blood gas study and documenting your rationale for continuing oxygen therapy. Medicare does not have an in-person or telehealth encounter requirement for continued coverage though, as I mentioned earlier, good medical care may dictate seeing the patient periodically, depending on their medical condition.

Thanks for hanging in there with me, just a couple more topics to cover.

The first is patients transitioning into fee for service Medicare from another type of insurance, like a private commercial plan.

In order to have an item or service covered by Medicare, a beneficiary must meet Medicare's policy requirements at the time of the first claim when under Medicare eligibility. Your patient does not need to obtain a new blood gas study, but there must be documentation in your patient's medical record of the most recent qualifying blood gas study that meets the criteria specified in the Oxygen and Oxygen Equipment LCD. You must evaluate the results of this blood gas study, document the results and write a new Standard Written Order.

The Second topic is your obligations when it's time to replace your patient's oxygen equipment.

Medicare will reimburse a supplier for replacing oxygen equipment when it is lost, stolen or irreparably damaged OR the equipment has been in continuous use for greater than five (5) years, also referred to as Reasonable Useful Life (RUL).

When the end date of the RUL of the stationary oxygen equipment occurs, your patient may elect to obtain replacement of both the stationary and portable oxygen equipment.

Once the RUL is reached, the medical equipment supplier may contact you for a new order for the replacement equipment. There is no new blood gas testing or face-to-face or telehealth examination required; however, a new order is required.

Finally, let me talk about patients with obstructive sleep apnea.

Recall in those general oxygen coverage criteria I mentioned "Time of Need"? For the patient with suspected OSA, the "time of need" would result from a qualifying test conducted during the in-lab split night or titration polysomnogram. As stated in the Oxygen and Oxygen Equipment LCD:

In the case of OSA, it is required that the OSA be appropriately and sufficiently treated before oxygen saturation results obtained during sleep testing are considered qualifying for oxygen therapy and oxygen equipment (see Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea LCD L33718 for additional information).

As a result of the requirement above, "time of need" may only be determined once the OSA has been appropriately and sufficiently treated. This, by definition, takes place during the titration PSG.

That does it for this edition of Medicare Minute MD. I'm Dr. Robert Hoover. Thanks for watching and have a great day!

