Dear Physician,

In September 2021, the Centers for Medicare and Medicaid Services (CMS) substantially revised the National Coverage Determination (NCD) for Home Use of Oxygen (240.2). In addition to removing the "chronic stable state" requirement, CMS expanded coverage for acute and normoxemic conditions for which the patient would benefit from oxygen.

Commensurate with the CMS NCD 240.2 update, the DME MACs have updated the Oxygen and Oxygen Equipment Local Coverage Determination (LCD) (L33797) and the LCD-related Policy Article (PA) (A52514). 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 LCD and LCD-related PA. This article reviews the blood oxygen testing requirements. Refer to the Oxygen and Oxygen Equipment LCD and LCD-related PA for information on additional payment criteria.

Initial coverage of home oxygen therapy and oxygen equipment is reasonable and necessary for Groups I and II if all of 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.

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 the 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. The following table summarizes the qualifying results for each group.

Group	ABG (mm Hg)	Oximetry (% Sat)	Notes
Group I	≤55	≤88	N/A
Group II	56-59	89	Plus, additional signs and symptoms
Group III	≥60	≥90	Medical condition with distinct physiologic, cognitive, and/or functional symptoms documented in high-quality, peer-reviewed literature to be improved by oxygen therapy, such as cluster headaches (not all inclusive)
Group IV	≥60	≥90	Does not meet any Group described above. Presumed not reasonable and necessary.

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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.

Blood oxygen values may be obtained using a variety of techniques. 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
- During sleep
    - Overnight sleep oximetry
        - It may be done in the hospital or at home. Refer to the LCD for detailed information about home overnight sleep oximetry.
    - Titration polysomnogram
        - Must be used for beneficiaries with concurrent obstructive sleep apnea (OSA) in order to establish that the OSA be appropriately and sufficiently treated before oxygen saturation results obtained during sleep testing are considered qualifying.
        - Refer to the Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea LCD (https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDid=33718) for information about testing for OSA.

Note: The overnight sleep oximetry and the titration polysomnogram referenced above are not the same tests as home sleep testing used to diagnose OSA. Refer to the Oxygen and Oxygen Equipment LCD and LCD-related PA for additional information.

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.

Beneficiaries Transitioning to Fee-For-Service Medicare:

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; however, 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 and ensure there is a valid order on file with the supplier.

Please refer to the Oxygen and Oxygen Equipment LCD (https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDid=33797), the LCD-related PA (https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52514), and the Supplier Manual for additional information about coverage, billing, and documentation requirements. Thank you for your assistance in reducing the Comprehensive Error Rate Testing (CERT) program error rate.

Sincerely,

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