

LCD for Oxygen and Oxygen Equipment (L11468)

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

LCD Information

LCD ID Number

L11468

LCD Title

Oxygen and Oxygen Equipment

Contractor's Determination Number

OXY

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CMS National Coverage Policy

CMS Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 240.2, 240.2.1

Primary Geographic Jurisdiction

Connecticut
District of Columbia
Delaware
Massachusetts
Maryland
Maine
New Hampshire
New Jersey
New York - Entire State
Pennsylvania
Rhode Island

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Vermont

Oversight Region

Region I

DME Region LCD Covers

Jurisdiction A

Original Determination Effective Date

For services performed on or after 10/01/1993

Original Determination Ending Date

Revision Effective Date

For services performed on or after 01/01/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity.

For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not medically necessary.

Home oxygen therapy is covered only if all of the following conditions are met:

1. 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, and
2. The patient's blood gas study meets the criteria stated below, and
3. The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services, and
4. The qualifying blood gas study was obtained under the following conditions:

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- If the qualifying blood gas study is performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than 2 days prior to the hospital discharge date, or
- If the qualifying blood gas study is not performed during an inpatient hospital stay, the reported test must be performed while the patient is in a chronic stable state – i.e., not during a period of acute illness or an exacerbation of their underlying disease, and

5. Alternative treatment measures have been tried or considered and deemed clinically ineffective.

In this policy, the term blood gas study includes both an oximetry test and an arterial blood gas test.

Group I criteria include any of the following:

1. An arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent taken at rest (awake), or
2. An arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, for at least 5 minutes taken during sleep for a patient who demonstrates an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake, or
3. A decrease in arterial PO₂ more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent, for at least 5 minutes taken during sleep associated with symptoms (e.g., impairment of cognitive processes and [nocturnal restlessness or insomnia]) or signs (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis) reasonably attributable to hypoxemia, or
4. An arterial PO₂ at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during exercise for a patient who demonstrates an arterial PO₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, 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.

Initial coverage for patients meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification.)

Group II criteria include the presence of (a) an arterial PO₂ of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least 5 minutes, or during exercise (as described under Group I criteria) and (b) 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.

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Initial coverage for patients meeting Group II criteria is limited to 3 months or the physician specified length of need, whichever is shorter. (Refer to the Certification section for information on recertification.)

Group III includes patients with arterial PO₂ levels at or above 60 mm Hg or arterial blood oxygen saturations at or above 90 percent. For these patients there is a rebuttable presumption of noncoverage.

For all the sleep oximetry criteria described above, the 5 minutes does not have to be continuous.

When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep), the ABG result will be used to determine if the coverage criteria were met. If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test result will determine coverage.

If all of the coverage conditions specified above are not met, the oxygen therapy will be denied as not medically necessary. Oxygen therapy will also be denied as not medically necessary if any of the following conditions are present:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities but in the absence of systemic hypoxemia. There is no evidence that increased PO₂ will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Oxygen is covered for patients who are enrolled subjects in clinical trials approved by CMS and sponsored by the National Heart, Lung, and Blood Institute (NHLBI) and who have an arterial PO₂ from 56 to 65 mm Hg or an oxygen saturation at or above 89 percent. The additional Group 2 coverage criteria do not apply to these patients.

TESTING SPECIFICATIONS:

The qualifying blood gas study must be one that complies with the Fiscal Intermediary, Local Carrier, or A/B Medicare Administrative Contractor (MAC) policy on the standards for conducting the test and is covered under Medicare Part A or Part B. This includes a requirement that the test be performed by a provider who is qualified to bill Medicare for the test – i.e., a Part A provider, a laboratory, an Independent Diagnostic Testing Facility (IDTF), or a physician. A supplier is not considered a qualified provider or a qualified laboratory for purposes of this policy. Blood gas studies performed by a supplier are not acceptable. In addition, the qualifying blood gas study may not be paid for by any supplier. This prohibition does not extend to blood gas studies performed by a hospital certified to do such tests.

For sleep oximetry studies, the oximeter provided to the patient must be tamper-proof and must have the capability to download data that allows documentation of the duration of oxygen desaturation below a specified value.

When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the patient's medical record – i.e., testing at rest

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without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). All 3 tests must be performed within the same testing session. Only the qualifying test value (i.e., testing during exercise without oxygen) is reported on the CMN. The other results do not have to be routinely submitted but must be available on request.

The qualifying blood gas study may be performed while the patient is on oxygen as long as the reported blood gas values meet the Group I or Group II criteria.

Home Sleep Oximetry Studies:

Beneficiaries may self-administer home based overnight oximetry tests under the direction of a Medicare-enrolled Independent Diagnostic Testing Facility (IDTF). A DME supplier or another shipping entity may deliver a pulse oximetry test unit and related technology to a beneficiary's home under the following circumstances:

1. The beneficiary's treating physician has contacted the IDTF to order an overnight pulse oximetry test before the test is performed.
2. The test is performed under the direction and/or instruction of a Medicare-approved IDTF. Because it is the beneficiary who self-administers this test, the IDTF must provide clear written instructions to the beneficiary on proper operation of the test equipment and must include access to the IDTF in order to address other concerns that may arise. The DME supplier may not create this written instruction, provide verbal instructions, answer questions from the beneficiary, apply or demonstrate the application of the testing equipment to the beneficiary, or otherwise participate in the conduct of the test.
3. The test unit is sealed and tamper-proof such that test results cannot be accessed by anyone other than the IDTF who is responsible for transmitting a test report to the treating physician. The DME supplier may use related technology to download test results from the testing unit and transmit those results to the IDTF. In no cases may the DME supplier access or manipulate the test results in any form.

The IDTF must send the test results to the physician. The IDTF may send the test results to the supplier if the supplier is currently providing or has an order to provide oxygen or other respiratory services to the beneficiary or if the beneficiary has signed a release permitting the supplier to receive the report.

Oximetry test results obtained through a similar process while the beneficiary is awake, either at rest or with exercise, may not be used for purposes of qualifying the beneficiary for home oxygen therapy.

CERTIFICATION:

An Initial, Recertification, or Revised CMN must be obtained and submitted in the situations described below. The Initial Date, Recertification Date, and Revised Date specified below refer to the dates reported in Section A of the CMN.

Initial CMN is Required:

1. With the first claim for home oxygen, (even if the patient was on oxygen prior to Medicare eligibility or oxygen was initially covered by a Medicare HMO).

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2. During the first 36 months of the rental period, when there has been a change in the patient's condition that has caused a break in medical necessity of at least 60 days plus whatever days remain in the rental month during which the need for oxygen ended. Refer to the Policy Article NONMEDICAL NECESSITY COVERAGE AND PAYMENT RULES for additional information
3. When the equipment is replaced because the reasonable useful lifetime of prior equipment has been reached.
4. When the equipment is replaced because of irreparable damage, theft, or loss of the originally dispensed equipment.
 - a. Irreparable damage refers to a specific accident or to a natural disaster [e.g., fire, flood].
 - b. Irreparable damage does not refer to wear and tear over time.

Testing and Visit Requirements:

Initial CMN for situations 1 and 2

- The blood gas study must be the most recent study obtained within 30 days prior to the Initial Date.
 - For situation 1, there is an exception to the 30-day test requirement for patients who were started on oxygen while enrolled in a Medicare HMO and transition to fee-for-service Medicare. For those patients, the blood gas study does not have to be obtained 30 days prior to the Initial Date, but must be the most recent qualifying test obtained while in the HMO.
- The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.

Initial CMN for scenarios 3 and 4 (replacement equipment)

- Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
- There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

Recertification CMN is Required:

5. 12 months after Initial Certification (i.e., with the thirteenth month's claim) for Group I.
6. 3 months after Initial Certification (i.e., with the fourth month's claim) for Group II.

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Testing and Visit Requirements:

Recertification following initial certification situations 1 and 2

- For patients initially meeting Group I criteria, the most recent qualifying blood gas study prior to the thirteenth month of therapy must be reported on the Recertification CMN.
- For patients initially meeting Group II criteria, the most recent blood gas study that was performed between the 61st and 90th day following Initial Certification must be reported on the Recertification CMN. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy but the patient continues to use oxygen and a test is obtained at a later date, if that test meets Group I or II criteria, coverage would resume beginning with the date of that test.
- For patients initially meeting group I or II criteria, the patient must be seen and re-evaluated by the treating physician within 90 days prior to the date of any Recertification. If the physician visit is not obtained within the 90-day window but the patient continues to use oxygen and the visit is obtained at a later date, coverage would resume beginning with the date of that visit.

Recertification following initial situations 3 and 4 (replacement equipment)

- Repeat testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
- There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.

Revised CMN is Required:

7. When the prescribed maximum flow rate changes from one of the following categories to another:
 - a. less than 1 LPM,
 - b. 1-4 LPM,
 - c. greater than 4 LPM.

If the change is from category (a) or (b) to category (c), a repeat blood gas study with the patient on 4 LPM must be performed.

8. When the length of need expires – if the physician specified less than lifetime length of need on the most recent CMN.
9. When a portable oxygen system is added subsequent to Initial Certification of a stationary system.
10. When a stationary system is added subsequent to Initial Certification of a portable system
11. When there is a new treating physician but the oxygen order is the same.
12. If there is a new supplier and that supplier does not have the prior CMN.

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Submission of a Revised CMN does not change the Recertification schedule specified above.

If the indications for a Revised CMN are met at the same time that a Recertification CMN is due, file the CMN as a Recertification CMN.

Testing and Visit Requirements:

None of the Revised Certification situations (7-12) require a physician visit.

Revised Certification situations 7 and 8

- The blood gas study must be the most recent study obtained within 30 days prior to the Initial Date.

Revised Certification situation 9

- There is no requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the patient is at rest (awake) or during exercise within 30 days prior to the Revised Date.

Revised Certifications situations 10-12

- No blood gas study is required.
- For situations 11 and 12, the revised certification does NOT have to be submitted with the claim.

A completed and signed Certificate of Medical Necessity (CMN) is required to receive payment for oxygen. Claims submitted without a valid CMN will be denied as not medically necessary.

PORTABLE OXYGEN SYSTEMS:

A portable oxygen system is covered if the patient is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen will be denied as not medically necessary.

If coverage criteria are met, a portable oxygen system is usually separately payable in addition to the stationary system. (See exception in Liter Flow Greater Than 4 LPM.)

If a portable oxygen system is covered, the supplier must provide whatever quantity of oxygen the patient uses; Medicare's reimbursement is the same, regardless of the quantity of oxygen dispensed.

LITER FLOW GREATER THAN 4 LPM:

If basic oxygen coverage criteria have been met, a higher allowance for a stationary system for a flow rate of greater than 4 liters per minute (LPM) will be paid only if a blood gas study performed while the patient is on 4 LPM meets Group I or II criteria. If a flow rate greater than 4 LPM is billed and the coverage criterion for the higher allowance is not met, payment will be limited to the standard fee schedule allowance. (Refer to related Policy Article for additional information on

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payment for greater than 4 LPM oxygen.)

MISCELLANEOUS:

Emergency or stand-by oxygen systems for patients who are not regularly using oxygen will be denied as not medically necessary since they are precautionary and not therapeutic in nature.

Topical hyperbaric oxygen chambers (A4575) will be denied as not medically necessary.

Coding Information

CPT/HCPCS Codes

The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS:

EY – No physician or other licensed health care provider order for this item or service

RA - Replacement of a DME item

QE - Prescribed amount of oxygen is less than 1 liter per minute (LPM)

QF - Prescribed amount of oxygen is greater than 4 liter per minute (LPM) and portable oxygen is also prescribed

QG - Prescribed amount of oxygen is greater than 4 liters per minute (LPM) and portable oxygen is not prescribed

QH - Oxygen conserving device is being used with an oxygen delivery system

HCPCS CODES:

EQUIPMENT:

E0424 STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING

E0425 STATIONARY COMPRESSED GAS SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING

E0430 PORTABLE GASEOUS OXYGEN SYSTEM, PURCHASE; INCLUDES REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

E0431 PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

E0433 PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE

E0434 PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING

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- E0435 PORTABLE LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, FLOWMETER, HUMIDIFIER, CONTENTS GAUGE, CANNULA OR MASK, TUBING AND REFILL ADAPTOR
- E0439 STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING
- E0440 STATIONARY LIQUID OXYGEN SYSTEM, PURCHASE; INCLUDES USE OF RESERVOIR, CONTENTS INDICATOR, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING
- E0441 STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
- E0442 STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
- E0443 PORTABLE OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT
- E0444 PORTABLE OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT
- E0445 OXIMETER DEVICE FOR MEASURING BLOOD OXYGEN LEVELS NON-INVASIVELY
- E1390 OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE
- E1391 OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH
- E1392 PORTABLE OXYGEN CONCENTRATOR, RENTAL
- E1405 OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITH HEATED DELIVERY
- E1406 OXYGEN AND WATER VAPOR ENRICHING SYSTEM WITHOUT HEATED DELIVERY
- K0738 PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING

ACCESSORIES:

- A4575 TOPICAL HYPERBARIC OXYGEN CHAMBER, DISPOSABLE
- A4606 OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT
- A4608 TRANSTRACHEAL OXYGEN CATHETER, EACH
- A4615 CANNULA, NASAL
- A4616 TUBING (OXYGEN), PER FOOT
- A4617 MOUTH PIECE
- A4619 FACE TENT
- A4620 VARIABLE CONCENTRATION MASK
- A7525 TRACHEOSTOMY MASK, EACH
- A9900 MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE
- E0455 OXYGEN TENT, EXCLUDING CROUP OR PEDIATRIC TENTS
- E0555 HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER

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E0580	NEBULIZER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC, BOTTLE TYPE, FOR USE WITH REGULATOR OR FLOWMETER
E1353	REGULATOR
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1355	STAND/RACK
E1356	OXYGEN ACCESSORY, BATTERY PACK/CARTRIDGE FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1357	OXYGEN ACCESSORY, BATTERY CHARGER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH
E1358	OXYGEN ACCESSORY, DC POWER ADAPTER FOR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH

ICD-9 Codes that Support Medical Necessity

Not specified.

Diagnoses that Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity

Not specified.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not specified.

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Documentation Requirements

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider". It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available upon request. Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

A Certificate of Medical Necessity (CMN) which has been completed, signed, and dated by the treating physician must be kept on file by the supplier and made available upon request. The CMN may act as a substitute for a written order if it is sufficiently detailed. The CMN for home oxygen is CMS Form 484(DME form 484.03). In addition to the order information that the physician enters in Section B, the supplier can use the space in Section C for a written confirmation of other details of the oxygen order or the physician can enter the other details directly—e.g., the means of oxygen

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delivery (cannula, mask, etc.) and the specifics of varying oxygen flow rates and/or noncontinuous use of oxygen.

For patients who qualify for oxygen coverage based only on a sleep oximetry study, the oxygen saturation value reported in question 1b of the Oxygen CMN must be the lowest value (not related to artifact) during the 5 minute qualifying period reported on the sleep oximetry study. A report of the sleep study documenting the qualifying desaturation must be available upon request.

If both an arterial blood gas and oximetry test have been performed on the same day under the condition reported on the CMN (i.e., at rest/awake, during exercise, or during sleep), the ABG PO₂ must be reported on the CMN.

REPLACEMENT EQUIPMENT:

For situations 3 and 4 described in the CERTIFICATION section of the "Indications and Limitations of Coverage", the following special instructions apply:

- Initial Date should be the date that the replacement equipment is initially needed. This is generally understood to be the date of delivery of the oxygen equipment.
- The Recertification Date should be 12 months following the Initial Date when the value on the Initial CMN (for the replacement equipment) meets Group I criteria or 3 months following the Initial Date when the qualifying blood gas value on the Initial CMN meets the Group II criteria. (Note: The Initial Date [for the replacement equipment] should also be entered on the Recertification CMN.)
- Claims for the initial rental month (and only the initial rental month) must have the RA modifier (Replacement of DME item) added to the HCPCS code for the equipment when there is replacement due to reasonable useful lifetime or replacement due to damage, theft, or loss.
- Claims for the initial rental month must include a narrative explanation of the reason why the equipment was replaced and supporting documentation must be maintained in the supplier's files.

MISCELLANEOUS:

In the following situations, a new order must be obtained and kept on file by the supplier, but neither a new CMN nor a repeat blood gas study are required:

- Prescribed maximum flow rate changes but remains within one of the following categories: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM.
- Change from one type of stationary system to another (i.e., concentrator, liquid, gaseous).
- Change from one type of portable system to another (i.e., gaseous or liquid tanks, portable concentrator, transfilling system).

A new CMN is not required just because a patient changes from Medicare secondary to Medicare primary.

A new CMN is not required just because the supplier changes assignment status on the submitted claim.

Suppliers are reminded that in an audit they may be asked to provide a copy of the actual test report and/or information from the medical record to verify that coverage criteria have been met.

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Refer to the Supplier Manual for more information on documentation requirements.

Appendices

The term blood gas study in this policy refers to either an arterial blood gas (ABG) test or an oximetry test. An ABG is the direct measurement of the partial pressure of oxygen (PO₂) on a sample of arterial blood. The PO₂ is reported as mm Hg. An oximetry test is the indirect measurement of arterial oxygen saturation using a sensor on the ear or finger. The saturation is reported as a percent.

Utilization Guidelines

Refer to Indications and Limitations of Coverage and/or Medical Necessity.

Sources of Information and Basis for Decision

Reserved for future use.

Advisory Committee Meeting Notes

Start Date of Comment Period

07/20/2001

End Date of Comment Period

09/14/2001

Start Date of Notice Period

09/01/2003

Revision History Number

OXY008

Revision History Explanation

Revision Effective Date: 01/01/2010

HCPCS CODES AND MODIFIERS:

Added: E0433

Revised: E0441-E0444

Revision Effective Date: 01/01/2009 (June Revision)

INDICATIONS AND LIMITATIONS OF COVERAGE:

Clarified: Conditions for blood gas studies.

Clarified: Testing requirements when exercise test results are used to qualify.

Revised: Certification section to address new payment policy.

Moved: Information on payment of greater than 4 LPM oxygen to the Policy Article, Non-Medical

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Necessity Coverage and Payment Rules section.

HCPCS CODES AND MODIFIERS:

Added: RA modifier.

DOCUMENTATION REQUIREMENTS:

Moved: CMN instructions to Indications and Limitations of Coverage section.

Added: Instructions for replacement equipment.

Revision Effective Date: 01/01/2009

HCPCS CODES AND MODIFIERS:

Added: HCPCS Codes E1354, E1356, E1357, and E1358.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) LCD L11468 from DME PSC TriCenturion (77011) LCD L11468.

Revision Effective Date: 01/01/2008

CMS NATIONAL COVERAGE POLICY:

Added: NCD 240.2.1

HCPCS CODES AND MODIFIERS:

Deleted: QR modifier.

DOCUMENTATION REQUIREMENTS:

Deleted: Instructions for use of QR modifier.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 01/01/2007

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Statement about coverage of oxygen used in approved clinical trials.

Added: Requirements for supplier involvement with home oximetry studies.

HCPCS CODES AND MODIFIERS:

Added: QR modifier, K0738.

DOCUMENTATION REQUIREMENTS:

Noted: The form number of the new CMN.

Added: Use of QR modifier for patients in an approved clinical trial.

Added: Clarification about the need for a CMN or order when switching to K0738.

LCD ATTACHMENTS:

Attached the new CMN.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this policy was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006

HCPCS CODES AND MODIFIERS:

Added: E1392

Deleted: K0671

Revision Effective Date: 07/01/2005

HCPCS CODES AND MODIFIERS:

Added: E1405, E1406, K0671.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Clarified: Which oxygen studies are required when coverage is based on testing during exercise.

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Revision Effective Date: 04/01/2004

HCPCS CODES AND MODIFIERS:

Added: A4608, A7525, E1391.

Discontinued: A4621

INDICATIONS AND LIMITATIONS OF COVERAGE:

Substituted: A7525 for A4621.

Corrected: Code for transtracheal oxygen catheters (A4608).

Added: E1355 in Oxygen Accessories section.

Added: E1391 in the Miscellaneous section.

NONCOVERED DIAGNOSES:

Added: E1391NU and E1391UE

CODING GUIDELINES:

Added: Billing instructions for E1391.

Revision Effective Date: 01/01/2004

INDICATIONS AND LIMITATIONS OF COVERAGE:

Revised: Group I and Group II coverage criteria for sleep oximetry testing to require at least 5 minutes of desaturation.

Revised: Statements concerning who can perform qualifying blood gas tests.

Added: Specifications for oximeters used in sleep oximetry studies.

Added: Statements of retesting requirements for patients who are on oxygen when they transfer from a Medicare HMO to Medicare fee-for-service.

Revised: Statement concerning which blood gas study will be used to determine coverage if an ABG and oximetry study are performed on the same day.

Added: Statement concerning coverage of oxygen if the patient is not re-evaluated by the physician within 90 days prior to recertification.

Added: Statement regarding supplier's responsibility when providing portable oxygen contents.

Added: Statement concerning the noncoverage of topical hyperbaric oxygen chambers.

HCPCS CODES AND MODIFIERS:

Added: A4575

DOCUMENTATION REQUIREMENTS:

Added: Statement specifying the value that must be entered on the CMN if the qualifying test is a sleep oximetry study.

Added: Statement concerning what test result to report when an ABG and oximetry study are performed on the same day.

Added: Several additional scenarios concerning the requirement for an Initial, Recertification, or Revised CMN.

SOURCES OF INFORMATION:

Added: A list of articles related to the revised sleep oximetry criteria.

Revision Effective Date: 04/01/2003

HCPCS CODES AND MODIFIERS:

Added: A4606, E0445, EY modifier.

INDICATIONS AND LIMITATIONS OF COVERAGE:

Added: Standard language concerning coverage of items without an order.

Added: Noncoverage statement concerning E0445 and A4606.

CODING GUIDELINES: Removed statements concerning E1405 and E1406.

(This policy change had been previously published.)

Removed: Mention of codes ZZ010 and E1377-E1385 which have been discontinued.

DOCUMENTATION REQUIREMENTS:

Added: Standard language concerning use of EY modifier for items without an order.

Revised: Standard language concerning use of a CMN.

OTHER COMMENTS:

Moved: Definitions section to this section.

General Information

The revision dates listed below are the dates the revisions were published and not necessarily the effective dates for the revisions.

07/01/2000 - This revision incorporates changes previously published in the DMERC Dialogue. Suppliers should be aware that this is the first revision of the Oxygen policy since 1993 and numerous changes will be found in all sections of the policy. The Documentation Section has been reorganized for easier determination of when initial, revised, and recertification Certificates of Medical Necessity (CMNs) are needed.

Effective for claims with dates of service on or after July 1, 2000, codes E1405 and E1406 (oxygen and water vapor enriching system) are invalid for claim submission to the DMERC. The DMERCs have determined that the devices for which these codes were established are no longer in production. Oxygen concentrators which are capable of delivering 85% or greater oxygen concentration at the prescribed flow rate and are used with a humidifier are correctly billed using code E1390. (There is no separate billing or payment for a humidifier used in conjunction with rented oxygen equipment.) If a manufacturer or supplier has an oxygen concentrator that they thought should be coded as E1405 or E1406, they should contact the SADMERC for a coding determination.

Code ZZ010 (transtracheal oxygen catheter for patient-owned equipment) is invalid for claim submission to the DMERC. As noted in the policy, 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 are noncovered.

12/01/1993 – Corrected HAO to HA0 in the Documentation section.

Reason for Change

Last Reviewed On Date

Related Documents

Article(s)

[A33768 - Oxygen and Oxygen Equipment - Policy Article - Effective January 2010](#)

LCD Attachments

[OXY CMN CMS-484](#) (43,295 bytes)

**Article for Oxygen and Oxygen Equipment - Policy Article - Effective January 2010
(A33768)**

Contractor Information

Contractor Name

[NHIC, Corp.](#)

Contractor Number

16003

Contractor Type

DME MAC

Article Information

Article ID Number

A33768

Article Type

Article

Key Article

Yes

Article Title

Oxygen and Oxygen Equipment - Policy Article - Effective January 2010

Primary Geographic Jurisdiction

Connecticut

District of Columbia

Delaware

Massachusetts

Maryland

Maine

New Hampshire

New Jersey

New York - Entire State

Pennsylvania

Rhode Island

Vermont

DME Region Article Covers

Jurisdiction A

Original Article Effective Date

07/01/2005

Article Revision Effective Date

01/01/2010

Article Information

Article Text

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

REASONABLE USEFUL LIFETIME (RUL):

The reasonable useful lifetime for oxygen equipment is 5 years. The RUL is not based on the chronological age of the equipment. It starts on the initial date of service and runs for 5 years from that date.

RUL also does not take into account exchanges of equipment, new suppliers, or changes of modality (concentrator, gaseous, liquid).

OXYGEN EQUIPMENT:

Initial 36 months

Reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories (e.g., cannula, tubing, etc.), delivery, back-up equipment, maintenance, and repairs is included in the rental allowance. Payment for oxygen contents (stationary and/or portable) is included in the allowance for stationary equipment (E0424, E0439, E1390, E1391).

Payment for stationary equipment is increased for patients requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for patients requiring less than 1 LPM. If a patient qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, payment will be made for the stationary system at the higher allowance, but not for the portable system. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied as not separately payable.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month rental period, unless one of the following exceptions is met:

- Beneficiary relocates temporarily or permanently outside of the supplier's service area
- Beneficiary elects to obtain oxygen from a different supplier
- Individual case exceptions made by CMS or DME MAC
- Item becomes subject to competitive bidding

Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, transfilling equipment) is not permitted unless one of the following requirements is met:

- Supplier replaces the equipment with the same or equivalent item
- Physician orders different equipment
- Beneficiary chooses to receive an upgrade and signs an Advance Beneficiary Notice of Noncoverage (ABN)
- CMS or the DME MAC determines that a change in equipment is warranted

A new 36-month rental period can begin only in the following situations:

Article Information

- Specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost
- Break-in-need for at least 60 days plus the days remaining in the month of discontinuation and new medical necessity is established (see "BREAK-IN-SERVICE" below)

A new 36-month rental period does not start in the following situations:

- Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
- Providing different equipment based on a physician order or beneficiary request for an upgrade
- Break-in-need less than 60 days plus the days remaining in the month of discontinuation (see "BREAK-IN-SERVICE" below)
- Break-in-billing (see "BREAK-IN-SERVICE" below)
- Changing suppliers

Months 37-60

There is no further payment for oxygen equipment during the 5-year reasonable useful lifetime (RUL) of the equipment after 36 rental payments have been made. If use of portable equipment (E0431, E0433, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until 36 rental payments have been made for the portable equipment.

For information on payment for contents and maintenance, see separate sections below.

The supplier who provided the equipment during the 36th rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5 year reasonable useful lifetime of the equipment.

Rules for providing different equipment/modalities are the same in months 37-60 as they are in the initial 36 months (see above).

A new 36-month rental period can begin only in the following situation:

- There is a specific incident of damage beyond repair (e.g., dropped and broken, fire, flood, etc.) or the item is stolen or lost

A new 36-month rental period does not start in the following situations:

- Replacing equipment due to malfunction, wear and tear, routine maintenance, repair
- Providing different equipment based on a physician order or beneficiary request for an upgrade
- Break-in-need (see "BREAK-IN-SERVICE" below)
- Break-in-billing (see "BREAK-IN-SERVICE" below)
- Changing suppliers

Article Information

Months 61 and after

At any time after the end of the 5-year reasonable useful lifetime for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.

If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months 37-60 remain in effect. There is no separate payment for accessories or repairs. If the patient was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

If the beneficiary elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier transfers title of the equipment to the beneficiary, accessories, maintenance, and repairs are statutorily noncovered by Medicare. Contents are separately payable for patient-owned gaseous or liquid systems.

If a beneficiary enters Medicare FFS with patient-owned equipment, accessories, maintenance, and repairs are statutorily noncovered by Medicare. Contents are separately payable for patient-owned gaseous or liquid systems.

OXYGEN CONTENTS:

Payment for stationary and portable contents is included in the fee schedule allowance for stationary equipment. No payment can be made for oxygen contents in a month in which payment is made for stationary equipment.

If the patient was using stationary gaseous or liquid oxygen equipment during the 36th rental month, payment for stationary contents (E0441 or E0442) begins when the rental period for the stationary equipment ends.

If the patient was using portable gaseous or liquid equipment during the 36th rental month of stationary equipment (gaseous, liquid, or concentrator), payment for portable contents (E0443 or E0444) begins when the rental period for the stationary equipment ends. If the patient began using portable gaseous or liquid equipment after starting on stationary equipment, payment for the portable equipment would continue until the end of the 36-month rental period for that equipment even though payment was also being made for the portable contents.

If the patient is using only portable gaseous or liquid equipment and not stationary equipment during months 1 through 36 of the portable equipment rental, payment for portable contents begins when the rental period for the portable equipment begins. If stationary equipment is subsequently added, separate payment for portable contents ends because payment for contents is included in the payment for stationary equipment.

If the patient was not using gaseous or liquid equipment (stationary or portable) in the 36th month, but was subsequently switched to gaseous or liquid oxygen based on a physician order, contents may be paid.

If the patient has a stationary concentrator, portable liquid equipment, and a stationary liquid tank to fill the portable cylinders, when payment for contents begins, payment will only be made for portable liquid contents.

Suppliers must provide whatever quantity of oxygen contents are needed for a patient's activities both inside and outside the home.

A maximum of 3 months of oxygen contents may be delivered at any one time. (Refer to Billing Information section [below] for additional information concerning billing oxygen contents.)

Article Information

There is no difference in payment for oxygen contents for beneficiaries receiving more the than 4 LPM or less than 1 LPM.

MAINTENANCE OF EQUIPMENT:

Initial 36 months

There is no separate payment for maintenance and servicing (M&S).

Months 37 through 60

If a patient was using a stationary concentrator, portable concentrator, or transfilling equipment during the 36th rental month, Medicare will pay for a maintenance and servicing visit no more often than every 6 months, beginning 6 months following the end of the rental period. A supplier must actually make a visit to bill the service.

There is no M&S payment for gaseous or liquid equipment.

Month 61 and after

If the beneficiary elects not to replace a concentrator or transfilling equipment and if the supplier retains title to the equipment, coverage for M&S is the same as in months 37-60.

If the beneficiary elects not to replace a concentrator or transfilling equipment and if the supplier transfers title to the beneficiary, M&S is statutorily noncovered.

OXYGEN ACCESSORIES:

Accessories, including but not limited to, transtracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353), and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the physician. Accessories used with patient-owned oxygen equipment will be denied as noncovered.

RELOCATION and TRAVEL:

Months 1 through 36

If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), then for the remainder of the rental month for which it billed, the home supplier is required to provide the equipment and related items/service itself or make arrangements with a different supplier to provide the equipment, items, and services. For subsequent rental months that the beneficiary is outside the service area, the home supplier is encouraged to either provide the equipment and related items/services itself or assist the beneficiary in finding another supplier in the new location. The home supplier may not bill for or be reimbursed by Medicare if it is not providing oxygen equipment or has not made arrangements with a different supplier to provide the equipment on the anniversary billing date. Medicare will pay only one supplier to provide oxygen during any one-rental month.

Months 37 through 60

If the beneficiary relocates outside the supplier's service area (either short-term travel, extended temporary relocation, or permanent relocation), the home supplier is required to either provide the equipment and related items/services itself or make arrangements with a different supplier to provide the equipment and related items/services.

Article Information

Miscellaneous

Oxygen services furnished by an airline to a beneficiary are noncovered. Payment for oxygen furnished by an airline is the responsibility of the beneficiary and not the responsibility of the supplier.

Medicare does not cover items or services provided/used outside the United States and its territories. The supplier is not required to provide or arrange for oxygen use in those situations.

BREAK-IN-SERVICE:

- Break-in-billing/Part B payment without break-in-medical necessity
 - If patient enters hospital or SNF or joins Medicare HMO and continues to need/use oxygen, when patient returns home or rejoins Medicare FFS, payment resumes where it left off

- Break-in-medical necessity (break-in-need)
 - If need/use of oxygen ends for less than 60 days plus the remainder of the rental month of discontinuation and then resumes, payment resumes where it left off
 - During the 36-month rental period, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new 36 month rental period would begin
 - During months 37-60, if need/use of oxygen ends for more than 60 days plus the remainder of the rental month of discontinuation and new medical necessity is established, a new rental period does not begin. The supplier who provided the oxygen equipment during the 36th rental month must provide all necessary items and services for the duration of the reasonable useful lifetime.

MISCELLANEOUS:

Only rented oxygen equipment is eligible for coverage. Purchased oxygen equipment is statutorily noncovered.

Oximeters (E0445) and replacement probes (A4606) will be denied as noncovered because they are monitoring devices that provide information to physicians to assist in managing the patient's treatment.

Respiratory therapist services are noncovered under the DME benefit.

CODING GUIDELINES

The appropriate modifier must be used if the prescribed flow rate is less than 1 LPM (QE) or greater than 4 LPM (QF or QG). These modifiers may only be used with stationary gaseous (E0424) or liquid (E0439) systems or with an oxygen concentrator (E1390, E1391). They must not be used with codes for portable systems or oxygen contents.

Article Information

Code E1391 (Oxygen concentrator, dual delivery port) is used in situations in which two beneficiaries are both using the same concentrator. In this situation, this code should only be billed for one of the beneficiaries.

Codes E1405 and E1406 (oxygen and water vapor enriching systems) may only be used for products for which a written coding verification has been received from the PDAC.

Code E1392 describes an oxygen concentrator which is designed to be portable, is capable of delivering 85% or greater oxygen concentration, and is capable of operating on either AC or DC (e.g., auto accessory outlet) power. Code E1392 includes the device itself, an integrated battery or patient-replaceable batteries that are capable of providing at least 2 hours of remote portability at a minimum of 2 LPM equivalency, a battery charger, an AC power adapter, a DC power adapter, and a carry bag and/or cart. The combined weight of the concentrator and the battery/batteries capable of 2 hours of portability must be 20 pounds or less. If a concentrator meets all of these criteria and is also capable of functioning as a stationary concentrator, operating 24 hours per day, 7 days per week, the stationary concentrator code (E1390) is billed in addition to code E1392.

Code K0738 describes a feature of an oxygen concentrator that allows the beneficiary to fill portable gaseous oxygen cylinders from a stationary concentrator. This feature may be integrated into the stationary concentrator or be a separate component. When code K0738 is billed, code E0431 (portable gaseous oxygen system, rental) must not be used.

Code E0433 describes a feature of an oxygen concentrator that allows the beneficiary to fill portable liquid oxygen cylinders from a stationary concentrator. This feature may be integrated into the stationary concentrator or be a separate component. When code E0433 is billed, code E0434 (portable liquid oxygen system, rental) must not be used.

Suppliers should contact the Pricing, Data Analysis, and Coding (PDAC) contractor for guidance on the correct coding of these items.

BILLING INFORMATION

When billing oxygen contents (refer to the Policy Article, Non-Medical Necessity Coverage and Payment Rules section), suppliers should use a date of service (DOS) that is the anniversary date of the equipment whose rental period has ended. The billed DOS will usually not be the actual delivery date. The supplier must have a delivery slip for the actual delivery date.

A supplier does not have to deliver contents every month in order to bill every month. In order to bill for contents, the supplier must have previously delivered quantities of oxygen that are expected to be sufficient to last for one month following the DOS on the claim.

Suppliers may bill a flat rate for contents each month. The submitted charges do not have to vary with the quantity of tanks delivered.

Claims for oxygen contents and/or oxygen accessories should not be submitted in situations in which they are not separately payable.

Coding Information

Other Information

Revision History Explanation

Revision Effective Date: 01/01/2010

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Coverage for maintenance and servicing, months 37-60.

CODING GUIDELINES:

Deleted: Instructions for codes E0441-E0444.

Added: E0433

Revision Effective Date: 01/01/2009

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Updated: Entire section to account for new oxygen payment policy.

CODING GUIDELINES:

Revised: Billing instructions for oxygen contents.

Changed: SADMERC reference to PDAC.

BILLING INFORMATION:

Created: New section for billing instructions.

Added: Instructions on billing for oxygen contents.

Moved: Statement about not separately payable items to this section.

03/01/2008 - In accordance with Section 911 of the Medicare Modernization Act, this policy was transitioned to DME MAC NHIC (16003) Article A33768 from DME PSC TriCenturion (77011) Article A33768.

Revision Effective Date: 06/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised statements concerning separate payment for portable contents.

06/01/2007 - In accordance with Section 911 of the Medicare Modernization Act of 2003, Virginia and West Virginia were transitioned from DME PSC TriCenturion (77011) to DME PSC TrustSolutions (77012).

Revision Effective Date: 01/01/2007

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Statement about noncoverage of respiratory therapist services.

CODING GUIDELINES:

Revised: Billing instructions for oxygen contents.

Revised: Definition of a portable oxygen concentrator.

Added: Guidelines for code K0738.

03/01/2006 - In accordance with Section 911 of the Medicare Modernization Act of 2003, this article was transitioned to DME PSC TriCenturion (77011) from DMERC Tricenturion (77011).

Revision Effective Date: 01/01/2006

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Updated: Section with HCPCS code changes.

CODING GUIDELINES:

Updated: Section with HCPCS code changes.

Revision Effective Date: 07/01/2005

LMRP converted to LCD and Policy Article.

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: A4619 and E0455 to the list of oxygen accessories.

Revised: Denial reason for purchased oxygen systems.

CODING GUIDELINES:

Added definition of portable oxygen concentrator system.

Other Information

Related Documents

LCD(s)

[L11468 - Oxygen and Oxygen Equipment](#)