Local Coverage Article:
Oxygen and Oxygen Equipment - Policy Article (A52514)

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	Jurisdiction B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	Jurisdiction C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	Jurisdiction A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	Jurisdiction D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

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Article Information

General Information

Article ID
A52514

Original ICD-9 Article ID
A33677
A33750
A33768
A47097

Article Title
Oxygen and Oxygen Equipment - Policy Article

Original Effective Date
10/01/2015

Revision Effective Date
XX/XX/XXXX

Revision Ending Date
N/A

Retirement Date
N/A

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES
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. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

Oxygen and oxygen equipment is covered under the Durable Medical Equipment benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment to be eligible for reimbursement the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

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).

Stationary and portable oxygen equipment is often provided at the same time therefore the RUL for both items runs concurrently. When the RUL of a beneficiary's portable oxygen equipment differs from the RUL of the beneficiary's stationary oxygen equipment, the RUL of the stationary oxygen equipment shall govern the application of RUL-based rules and processes for both types, stationary and portable, of oxygen equipment.

Until such time as the end date of the RUL of the stationary oxygen equipment is reached, the supplier must continue to furnish both the portable and stationary oxygen equipment.

1. If the end date of the RUL of the portable oxygen equipment precedes the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen

equipment is adjusted (extended) to coincide with the end date of the RUL of the stationary oxygen equipment.

2. If the end date of the RUL of the portable oxygen equipment follows the end date of the RUL of the stationary oxygen equipment, the end date of the RUL of the portable oxygen equipment is adjusted (shortened) to coincide with the end date of the RUL of the stationary oxygen equipment.

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

If the beneficiary elects to obtain replacement of the stationary and the portable oxygen equipment, both types of oxygen equipment must be replaced at the same time.

When the stationary and the portable oxygen equipment are replaced, a new 36-month rental period and new RUL is started for both the replacement stationary oxygen equipment and the replacement portable oxygen equipment.

Beginning January 1, 2011, a beneficiary who resides in a DMEPOS competitive bidding area (CBA) may obtain replacement of both the stationary and portable oxygen systems only from a contract supplier having a competitive bidding contract for the CBA in which the beneficiary permanently resides.

A grandfathered supplier for oxygen and other grandfathered equipment as of January 1, 2011, who has continued to furnish such equipment that has not yet reached the 36-month rental cap, does not qualify to furnish replacement equipment once the end date of the RUL of the stationary equipment is reached, if the beneficiary resides in the CBA when the end of the RUL has been reached, unless the status of the grandfathered supplier has changed to a contract supplier for the current round of the competitive bidding program.

OXYGEN EQUIPMENT:

<u>Initial 36 months</u>

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 beneficiaries requiring greater than 4 liters per minute (LPM) of oxygen flow and decreased for beneficiaries requiring less than 1 LPM. If a beneficiary qualifies for additional payment for greater than 4 LPM of oxygen and also meets the requirements for portable oxygen, the appropriate modifiers (QB or QF) must be used.

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, trans-filling 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 Non-coverage (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:

- 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 <u>not</u> 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

<u>Months 37-60</u>

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

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 beneficiary 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 non-covered by Medicare. Contents are separately payable for beneficiary-owned gaseous or liquid systems.

If a beneficiary enters Medicare FFS with beneficiary-owned equipment, accessories, maintenance, and repairs are statutorily non-covered by Medicare. Contents are separately payable for beneficiary-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 beneficiary 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 beneficiary was using portable gaseous or liquid equipment during the 36th rental month of stationary equipment (gaseous, liquid, or concentrator), payment for portable contents (E0443, E0444 or E0447) begins when the rental period for the stationary equipment ends. If the beneficiary 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 beneficiary was using both stationary and portable gaseous or portable equipment during the 36th rental month of stationary equipment, payment for both stationary contents (E0441 or E0442) and portable contents (E0443, E0444 or E0447) begins when the rental for the stationary equipment ends.

If the beneficiary 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 beneficiary 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 beneficiary 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 beneficiary'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.)

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

No more than 1 unit of service (UOS) for stationary contents and/or 1 UOS for portable contents per month are billable.

Refer to the Coverage Indications, Limitations and/or Medical Necessity section of the LCD for additional information about refills of oxygen contents.

MAINTENANCE OF EQUIPMENT:

Initial 36 months

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

Months 37 through 60

If a beneficiary was using a stationary concentrator, portable concentrator, or trans-filling equipment during the 36th rental month, Medicare will pay for an M&S visit no more often than every 6 months, beginning no sooner than 6 months following the end of the rental period. If the equipment is covered under a warranty that covers labor related to routine/general maintenance and servicing (e.g., inspection, changing filters, cleaning, and calibration), payment for the first M&S visit can be no sooner than 6 months following the end of that warranty.

A supplier must actually make a visit to bill the service. If multiple M&S visits are made during a 6 month period, only one will be paid.

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 trans-filling 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 trans-filling equipment and if the supplier transfers title to the beneficiary, M&S is statutorily non-covered.

OXYGEN ACCESSORIES:

Accessories, including but not limited to, trans-tracheal 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 beneficiary-owned oxygen equipment will be denied as non-covered.

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.

Miscellaneous

Oxygen services furnished by an airline to a beneficiary are non-covered. 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 beneficiary enters hospital or SNF or joins Medicare HMO and continues to need/use oxygen, when beneficiary 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 non-covered.

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

Respiratory therapist services are non-covered under the DME benefit.

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PERSUANT TO 42 CFR 410.38(g)

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located here.

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

If the supplier delivers the item prior to receipt of a written order, it will be denied as statutorily noncovered. If the written order is not obtained prior to delivery, payment will not be made for that item even if a written order is subsequently obtained. If a similar item is subsequently provided by an unrelated supplier who has obtained a written order prior to delivery, it will be eligible for coverage.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

Documentation for initial coverage requires information in the medical record showing:

- Evidence of qualifying test results done within 30 days before the initial date of service
- Evidence of an in-person visit with a treating physician done within 30 days before the initial date of service

Coverage of home oxygen therapy requires that the beneficiary be tested in the “chronic stable state” and that all co-existing diseases or conditions that can cause hypoxia must be treated sufficiently. Moreover, the beneficiary must have a severe lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm, or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy.

In order to provide coverage for these beneficiaries, there must be evidence in the medical record documenting:

A. A severe underlying lung disease, such as chronic obstructive pulmonary disease, diffuse interstitial lung disease, cystic fibrosis, bronchiectasis, widespread pulmonary neoplasm or hypoxia-related symptoms or findings that might be expected to improve with oxygen therapy; and
B. The beneficiary is not experiencing an exacerbation of their underlying lung disease described in (A) or other acute condition(s) impacting the beneficiary's oxygen saturation;
C. For beneficiaries with concurrent PAP therapy, the qualifying oxygen saturation test is performed following optimal treatment of the OSA as described in the Coverage Indications, Limitations and/or Medical Necessity.

LONG TERM OXYGEN THERAPY TRIALS (LTOT):

For LTOT Trial claims, the "clinicaltrials.gov" identifier number of the CMS approved clinical trial must be included in the narrative field on each claim.

Claims for LTOT Trial participants that meet the approved clinical trial and testing requirements described in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD must be submitted with the Q0 (Q-zero) modifier. Claims for oxygen that do not meet these criteria must not use this modifier.

CLUSTER HEADACHES:

A CMN is not required for claims for cluster headaches.

The diagnosis code(s) for the qualifying cluster headache condition must be included on the claim (reference Group 1 Diagnosis Codes that Support Medical Necessity in the related LCD).

The diagnosis code for EXAMINATION OF PARTICIPANT IN CLINICAL TRIAL (reference Group 2 Diagnosis Codes that Support Medical Necessity in the related LCD) must also be included on the claim for cluster headache if the beneficiary is enrolled in an approved study.

For cluster headache claims there must be information in the medical record justifying:

- Participation in an approved study
- The qualifying diagnosis code(s)

For cluster headache claims, the "clinicaltrials.gov" identifier number of the CMS approved clinical trial must be included in the narrative field on each claim.

Claims for oxygen used for the treatment of cluster headaches that meet the approved clinical trial and diagnosis requirements described in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD must be submitted with the Q0 (Q-zero) modifier. Claims for oxygen used for cluster headaches that do not meet these criteria must not use this modifier.

REPAIRS:

The supplier must maintain detailed records describing the need for and nature of all repairs including a detailed explanation of the justification for any component or part replaced as well as the labor time to restore the item to its functionality.

REPLACEMENT EQUIPMENT:

For situations 3 and 4 described in the CERTIFICATION section of the "Coverage Indications, Limitations and/or Medical Necessity" of the LCD, 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.

A physician’s order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item for replacement of an item.

CERTIFICATE OF MEDICAL NECESSITY (CMN)

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 the detailed written order if it contains the same information as required in a detailed written order. The CMN for home oxygen is CMS Form 484. 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 delivery (cannula, mask, etc.) and the specifics of varying oxygen flow rates and/or non-continuous use of oxygen.

For beneficiaries who qualify for oxygen coverage based only on an overnight 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 home overnight 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 PO 2 must be reported on the CMN.

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, trans-filling system)

A new CMN is not required just because a beneficiary 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.

MODIFIERS

KX, GA, GY, and GZ MODIFIERS:

Suppliers must add a KX modifier only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity" section of the related LCD have been met.

If all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section have not been met, the GA, GY or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN), a GZ modifier if they have not obtained a valid ABN, or a GY modifier if the item or service is statutorily excluded.

Claim lines billed without a KX, GA, GY or GZ modifier will be rejected as missing information.

QA, QB, QE, QF, QG and QR MODIFIERS:

42 CFR Section 414.226(e) stipulates:

1. If prescribed flow rate is different for stationary versus portable, the flow rate for stationary is used.

2. If prescribed flow rate is different for the patient at rest versus the patient with exercise, the flow rate at rest is used.
3. If prescribed flow rate is different for nighttime versus daytime use, the flow rates are averaged.

QA: For scenarios where the beneficiary has different daytime and nighttime oxygen flow requirements. Used if the average documented flow requirement from a daytime "at rest" qualifying test and flow rate for nocturnal oxygen requirement (standard arithmetic rounding rules apply) is <1 LPM.

QB: For scenarios where the beneficiary has different daytime and nighttime oxygen flow requirements. Used if the average documented flow requirement from a daytime "at rest" qualifying test and flow rate for nocturnal oxygen requirement (standard arithmetic rounding rules apply) is >4 LPM, and portable oxygen is prescribed.

QE: Used if the documented flow requirement on an "at rest" qualifying test is <1 LPM.

QF: Used if the documented flow requirement on an "at rest" qualifying test is >4 LPM, and portable oxygen is prescribed. DO NOT use a flow requirement from a "with exercise" qualifying test.

QG: Used if the documented flow requirement on an "at rest" qualifying test is >4 LPM. DO NOT use a flow requirement from a "with exercise" qualifying test.

QR: For scenarios where the beneficiary has different daytime and nighttime oxygen flow requirements. Used if the average documented flow requirement from a daytime "at rest" qualifying test and flow rate for nocturnal oxygen requirement (standard arithmetic rounding rules apply) is >4 LPM.

CODING GUIDELINES

The appropriate modifier must be used if the prescribed flow rate is less than 1 LPM (QA or QE) or greater than 4 LPM (QG or QR).

For claims with dates of service on or after 04/01/2018 the modifier "QB or QF" should be used in conjunction with claims submitted for stationary oxygen (codes E0424, E0439, E1390, or E1391) and portable oxygen (codes E0431, E0433, E0434, E1392, or K0738) when the prescribed amount of oxygen is greater than 4 liters per minute (LPM).

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 describe oxygen and water vapor enriching systems with or without heated delivery respectively. These devices both extract oxygen from the surrounding air (similar to an oxygen concentrator) and add humidification. They require substantially higher oxygen

flow rates in order to deliver the same concentration of oxygen as that achieved by standard oxygen delivery systems (for example, concentrators or liquid/gaseous systems). Since codes E1405 and E1406 require a higher flow rate but do not provide a benefit to the beneficiary in terms of the inspired concentration of oxygen, modifiers QB, QF, QG, and QR, which are appended to claim lines to indicate oxygen flow rates greater than 4 liters/minute, must not be used with codes E1405 and E1406. 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 beneficiary-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.

When oxygen is supplied as part of a CMS approved clinical trial for cluster headaches, equipment must be coded E0424 (STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING).

Refill contents used with equipment to treat cluster headaches must be coded using E0441 (STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT).

E1352 (OXYGEN ACCESSORY, FLOW REGULATOR CAPABLE OF POSITIVE INSPIRATORY PRESSURE) provides positive pressure inspiratory support for patients using oxygen. This product consists of multiple components - control unit, flow regulator, connecting hose and nasal interface (pillows). E1352 is an all-inclusive code for this product that includes all components.

Code E0467 (HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN

CONCENTRATION, DRUG NEBULIZATION, ASPIRATION, AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS) describes a ventilator that integrates the function of multiple types of equipment into a single device. Code E0467 combines the function of a ventilator with those of any combination or all of the following:

- Oxygen equipment
- Nebulizer and compressor
- Aspirator (suction device)
- Cough stimulator (multiple products)
- Positive airway pressure devices (PAP and RAD)
- Custom fabricated oral appliances

The following oxygen and oxygen equipment HCPCS codes for individual items are included in the functionality of code E0467:

- HCPCS codes E0424, E0431, E0433, E0434, E0439, E0441, E0442, E0443, E0444, E0447, E1390, E1391, E1392, E1405, E1406 and K0738

Claims for any of the HCPCS codes listed above that are submitted on the same claim or that overlap any date(s) of service for E0467 is considered to be unbundling.

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by HCPCS codes listed above is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service for any of the following scenarios are considered as a claim for same or similar equipment when the beneficiary:

- Is currently in a rental month for any of the items listed above
- Owns any of the equipment listed above that has not reached the end of its reasonable useful lifetime.
- Has oxygen equipment that reached the 36-month rental but has not reached the end of its reasonable useful lifetime.

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 should monitor usage of contents. Billing may continue on a monthly basis as long as sufficient supplies remain to last for one month as previously described. If there are insufficient contents to be able to last for a month additional contents should be provided.

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.

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Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

CPT/HCPCS Codes
N/A

ICD-10 Codes that Support Medical Necessity
Group 1 Paragraph:

The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the section on "**Coverage Indications, Limitations and/or Medical Necessity**" for other coverage criteria and payment information.

For HCPCS Code E0424 used for cluster headaches:

Group 1 Codes:

Code	Description
G44.001	Cluster headache syndrome, unspecified, intractable
G44.009	Cluster headache syndrome, unspecified, not intractable
G44.011	Episodic cluster headache, intractable
G44.019	Episodic cluster headache, not intractable
G44.021	Chronic cluster headache, intractable
G44.029	Chronic cluster headache, not intractable

Group 2 Paragraph:

Z00.6 (must be used concurrently with one of the above diagnosis codes)

Group 2 Codes:

Code	Description
Z00.6	Encounter for examination for normal comparison and control in clinical research program

ICD-10 Codes that DO NOT Support Medical Necessity
Group 1 Paragraph:

For HCPCS code E0424 all other diagnosis codes not specified above

For all codes used for long term oxygen therapy – not specified

Group 1 Codes:
N/A

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Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
XX/XX/XXXX	R9	**Revision Effective Date: XX/XX/XXXX** CERTIFICATE OF MEDICAL NECESSITY (CMN): Removed: Outdated CMN Form number ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity" ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY: Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity" *xx/xx/xxxxx: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2019	R8	**Revision Effective Date: 01/01/2019** CODING GUIDELINES: Revised: E0467 Coding Guidelines to include custom fabricated oral appliances Added: E0447, E1405, and E1406 to HCPCS codes included in E0467 *04/04/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2019	R7	**Revision History Effective Date: 01/01/2019** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Added: E0447 to Oxygen Content guidelines CODING GUIDELINES: Added: E0467 Coding Guidelines Revised: E1405 and E1406 Coding Guidelines ICD-10 CODES THAT ARE COVERED: Added: All diagnosis codes formerly listed in the LCD ICD-10 CODES THAT ARE NOT COVERED:

Revision History Date	Revision History Number	Revision History Explanation
08/01/2018	R6	Added: Notation excluding all unlisted diagnosis codes from coverage *02/14/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.* **Revision History Effective Date: 08/01/2018** CERTIFICATE OF MEDICAL NECESSITY (CMN): Removed: Flow rate instructions when answering CMN question 5 MODIFIERS: Added: GA, GY, GZ, and KX modifier requirement instructions Added: “Q” modifier instructions *06/07/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.* **Revision History Effective Date: 04/01/2018** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Oxygen Equipment: Initial 36 months Added: "the appropriate modifiers (QB or QF) must be used." in paragraph regarding flow rate greater than 4 LPM and also meets requirements for portable oxygen Added: 42 CFR 410.38(g) language, previously in POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section CERTIFICATE OF MEDICAL NECESSITY
04/01/2018	R5	Added: Flow rate guidelines for beneficiaries who require differing day and night rates CODING GUIDELINES Revised: Flow rate modifiers for beneficiaries who require differing day and night rates Revised: Coding guidelines for E1405 and E1406 to indicate that high flow rate modifiers (QB, QF, QG or QR) must not be used with these two HCPCS codes. *04/19/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.*

Revision History Date	Revision History Number	Revision History Explanation
01/01/2018	R4	**Revision History Effective Date: 01/01/2018** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Oxygen Equipment: Initial 36 months Added: "the appropriate modifiers (QB or QF) must be used." in paragraph regarding flow rate greater than 4 LPM and also meets requirements for portable oxygen Added: 42 CFR 410.38(g) language, previously in POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section CERTIFICATE OF MEDICAL NECESSITY Added: Flow rate guidelines for beneficiaries who require differing day and night rates CODING GUIDELINES Revised: Flow rate modifiers for beneficiaries who require differing day and night rates Revised: Coding guidelines for E1405 and E1406 to indicate that high flow rate modifiers (QB, QF, QG or QR) must not be used with these two HCPCS codes. *04/19/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.*
01/01/2017	R3	Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: NCD 240.2, Long Term Oxygen Therapy Trails, Cluster Headaches, 42 CFR 410.38(g), Repair, Replacement and CMN requirements CODING GUIDELINES: Effective 04/01/2017, modifier QF may be used with portable systems or oxygen. RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.
10/01/2015	R1	Revision Effective Date: 10/31/2014 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: “When required by state law” from ACA new

Revision History Date	Revision History Number	Revision History Explanation
		prescription requirements Revised: Face-to-Face Requirements for treating practitioner

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Associated Documents

Related Local Coverage Document(s)
Article(s)
A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs
LCD(s)
L33797 - Oxygen and Oxygen Equipment

Related National Coverage Document(s)
N/A
Statutory Requirements URL(s)
N/A
Rules and Regulations URL(s)
N/A
CMS Manual Explanations URL(s)
N/A
Other URL(s)
N/A