

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Oxygen Therapy Supplies:

Complying with Documentation & Coverage Requirements

This fact sheet is designed to provide education on Medicare coverage of oxygen therapy supplies and to describe common Comprehensive Error Rate Testing (CERT) Program errors related to oxygen therapy. It includes a checklist of the documentation needed to support a claim submitted to Medicare for oxygen therapy supplies.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) improper payment rate, as required by the Improper Payments Information Act of 2002, and the Improper Payments Elimination and Recovery Act of 2010. CERT randomly selects a statistically-valid sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

In order to accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims improper payment rate and a provider compliance improper payment rate and publishes the results of these reviews annually.

CMS strives to eliminate improper payments in the Medicare Program in order to maintain the Medicare Trust Fund while protecting patients from medically unnecessary services or supplies.

Common Oxygen and Oxygen Equipment Errors

1. Missing documentation showing that the patient was seen by a physician within the appropriate timeframes for certification or recertification of the need for oxygen supplies.
2. Missing documentation of original blood gas or saturation test results.
3. Missing documentation indicating that the patient needs or is using oxygen and supplies.
4. Missing documentation to show that the patient is mobile within the home (for portable oxygen).
5. Missing physician order for oxygen supplies.
6. Missing the most recent Certificate of Medical Necessity (CMN).

Overlooked Policy Requirements

1. Medicare requires home oxygen to be ordered by a physician after evaluating a patient's medical need. This visit must occur either prior to, but no earlier than, 2 days prior to the inpatient hospital discharge date, or while the patient is in a chronic stable state. The physician notes must establish the need for oxygen based upon Local Coverage Determination (LCD) requirements and show that the visit (and test) does not exceed 30 days from the Initial Date on the CMN.
2. For Medicare to pay for oxygen equipment, a patient must have both a continued need for oxygen in the home and must also be using the equipment.
3. For patients to qualify for portable oxygen, they must be mobile within the home and be tested under specific conditions (during exercise or at rest).
4. Medicare requires all patients who use home oxygen to first be tested either by arterial blood gas (ABG) or oximetry test (SAT). There must be a record of the test results in the physician's notes to verify that the test occurred.

Oxygen Documentation Checklist

Medicare requires the following documentation for Medicare oxygen therapy:

Detailed Written Order

The detailed written order must include:

- Patient name;
- Detailed description of the items being provided, including:
 - a. The means of oxygen delivery,
 - b. The specifics of varying oxygen flow rates and/or non-continuous use of oxygen, and
 - c. The length of need;
- Treating physician's signature and date order signed; and
- Start date of the order (only required if the start date is different from the signature date).

Coverage

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

- 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.
- The patient's blood gas study meets the criteria stated below.
 - The qualifying blood gas study was performed by a physician or by a qualified provider or supplier of laboratory services.
 - The qualifying blood gas study was obtained under the following conditions (a or b):



- a. 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**
 - b. 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 (that is, not during a period of acute illness or an exacerbation of his or her underlying disease).
- Alternative treatment measures have been tried or considered and deemed clinically ineffective.

□ **Medicare Qualifying Saturation Test Results**

Medicare covers home oxygen therapy only if the patient’s arterial saturation test results meet the following criteria:

- The patient’s test results must be within 48 hours of the date of delivery, unless the arterial saturation tests were taken during an outpatient encounter or during the patient’s sleep. If tests were taken during an outpatient encounter or during the patient’s sleep, the patient’s arterial saturation test results must be within 30 days of the date of delivery.
- Arterial saturation test results that qualify for coverage are classified into Group I or Group II. The group determines specific CMN requirements. The criteria for each group are listed in Table 1 and Table 2 below.

Table 1. Group I Criteria

Patient on Room Air at Rest	Patient Tested During Exercise	Patient Tested During Sleep
While awake: <ul style="list-style-type: none"> • Arterial oxygen saturation at or below 88%; or • Arterial Partial Pressure of Oxygen (PO₂) at or below 55 mm Hg. 	<ul style="list-style-type: none"> • Room air at rest arterial saturation results above 56 mm Hg or an arterial oxygen saturation at or above 89%; or • Arterial saturation results during ambulation and without oxygen below 55 mm Hg or an arterial oxygen saturation at or below 88%; and • Documented improvement of hypoxemia during ambulation with oxygen. 	If arterial PO ₂ at or above 56 mm Hg or an arterial oxygen saturation at or above 89% while awake, additional testing must show: <ul style="list-style-type: none"> a. Arterial PO₂ at or below 55 mm Hg, or an arterial oxygen saturation at or below 88%, for at least 5 minutes taken during sleep; or b. Decrease in arterial PO₂ of more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5%, for at least 5 minutes, taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia.

Table 2. Group II Criteria

Patient on Room Air at Rest	Patient Tested During Exercise	Patient Tested During Sleep
<p>While awake:</p> <ul style="list-style-type: none"> • Arterial oxygen saturation of 89%; or • Arterial PO₂ of 56-59 mm Hg; and <ol style="list-style-type: none"> a. Dependent edema suggesting congestive heart failure; b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale on electrocardiography (EKG) (P wave greater than 3 mm in standard leads II, III, or AVF); or c. Erythrocythemia with a hematocrit above 56%. 	<ul style="list-style-type: none"> • Arterial oxygen saturation of 89%; or • Arterial PO₂ of 56-59 mm Hg; and <ol style="list-style-type: none"> a. Dependent edema suggesting congestive heart failure; b. 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 c. Erythrocythemia with a hematocrit above 56%. 	<p>During sleep for at least 5 minutes:</p> <ul style="list-style-type: none"> • Arterial oxygen saturation of 89%; or • Arterial PO₂ of 56-59 mm Hg; and <ol style="list-style-type: none"> a. Dependent edema suggesting congestive heart failure; b. 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 c. Erythrocythemia with a hematocrit above 56%.

Note: A portable oxygen system is covered if the patient is mobile within the home and the qualifying blood gas study was performed at rest while awake or during exercise.

Certificate of Medical Necessity (CMN) Requirements

Complete the CMN using Certificate of Medical Necessity – Oxygen DME 484.03 (Form CMS-484). A completed CMN, signed and dated by the treating physician, must be kept on file by the supplier and made available upon request. Claims submitted without a valid CMN will be denied as not medically necessary. Specific CMN reporting requirements, including the type of CMN, testing, and visits by the treating physician are described in Tables 3, 4, and 5.



Table 3. Initial CMN Requirements

Initial CMN Required	Testing Requirements	Physician Visit Requirements
<p>1. With the first claim for home oxygen, even if the patient was on oxygen prior to Medicare eligibility or the oxygen was initially covered by a Medicare Health Maintenance Organization (HMO); or</p> <p>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 Oxygen and Oxygen Equipment – Policy Article – Effective October 2011 (A33750)* at http://www.cms.gov/medicare-coverage-database/license/cpt-license.aspx?from=~/overview-and-quick-search.aspx&npage=/medicare-coverage-database/details/article-details.aspx&articleId=33750&ver=33&ContrId=140&ContrVer=2&CtrctrSelected=140*2&bc=AgCAAAAAAAAA& on the CMS website.</p>	<ul style="list-style-type: none"> • The blood gas study must be the most recent study obtained within 30 days prior to the Initial Date. <ul style="list-style-type: none"> ◦ For Initial Certification 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 transitioned to Medicare FFS. 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. 	<p>The patient must be seen and evaluated by the treating physician within 30 days prior to the date of Initial Certification.</p>
<p>3. When equipment is replaced because the reasonable useful lifetime of the prior equipment has been reached; or</p> <p>4. When equipment is replaced because of irreparable damage (a specific accident or natural disaster, such as a fire or a flood), theft, or loss of the originally dispensed equipment.</p>	<p>Repeat blood gas testing is not required for an Initial CMN submitted for replacement equipment. Enter the most recent qualifying blood gas study value and test date. The 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.</p>	<p>There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.</p>

* Policy Article A33750 is the Local Coverage Article for Jurisdiction C. Similar policy articles are also available for the other three jurisdictions. All four jurisdictions have LCDs as well.

Table 4. Recertification CMN Requirements

Recertification CMN Required	Testing Requirements	Physician Visit Requirements
<ol style="list-style-type: none"> 1. 12 months after Initial Certification; that is, with the 13th month's claim, for Group I; or 2. 3 months after Initial Certification; that is, the fourth month's claim, for Group II. 	<p>A Recertification CMN submitted for a patient initially meeting Group I criteria following Initial Certification situations 1 and 2 should report the most recent qualifying blood gas study prior to the 13th month of therapy.</p> <p>A Recertification CMN submitted for a patient initially meeting Group II criteria should report the most recent blood gas study performed between the 61st and 90th day following Initial Certification. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, the patient continues to use oxygen, and a test is obtained at a later date that meets Group I or II criteria, coverage would resume beginning with the date of that test.</p> <p>A Recertification following Initial Certification for situations 3 and 4 (replacement equipment) should report 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.</p>	<p>For patients initially meeting Group I or II criteria, the treating physician must see and re-evaluate the patient within 90 days prior to the date of any Recertification. If the treating physician sees and re-evaluates the patient after the 90-day window and the patient continues to use oxygen, coverage would resume beginning with the date of that visit.</p> <p>There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.</p>



Table 5. Revised CMN Requirements

Revised CMN Required	Testing Requirements	Physician Visit Requirements
<p>1. When the prescribed maximum flow rate changes from one of the following categories to another:</p> <ul style="list-style-type: none"> a. Less than 1 Liter per Minute (LPM), b. 1-4 LPM, or c. Greater than 4 LPM. <p>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.</p> <p>2. When the length of need expires, if the physician specified less than lifetime length of need on the most recent CMN.</p>	<p>The blood gas study must be the most recent study obtained within 30 days prior to the Initial Date.</p>	<p>There is no requirement for a physician visit.</p>
<p>3. When a portable oxygen system is added subsequent to Initial Certification of a stationary system.</p>	<p>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.</p>	<p>There is no requirement for a physician visit.</p>
<p>4. When a stationary system is added subsequent to Initial Certification of a portable system.</p>	<p>No blood gas study is required.</p>	<p>There is no requirement for a physician visit.</p>
<p>5. When there is a new treating physician, but the oxygen order is the same; or</p> <p>6. If there is a new supplier, and that supplier does not have the prior CMN.</p>	<p>No blood gas study is required. The Revised Certification does not have to be submitted with the claim.</p>	<p>There is no requirement for a physician visit.</p>

Note: 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.

Oxygen and Oxygen Equipment

Medicare allows payment on a monthly basis for oxygen and oxygen equipment for use in the patient's home under certain conditions. Each payment for oxygen and oxygen equipment includes payment for all equipment, accessories, oxygen, and supplies that the patient needs for the entire month. After 36 months of continuous use, payment for oxygen equipment is capped, but payment can continue to be made for oxygen contents for use with liquid or gaseous systems or periodic maintenance and servicing of systems that do not require delivery of oxygen contents (that is, concentrators or transfilling equipment). The supplier of oxygen equipment in the 36th month of use must continue to furnish the oxygen and oxygen equipment for the remainder of the 5-year reasonable useful lifetime of the equipment. It is important for suppliers to know that the patient's need for, and use of, oxygen delivery equipment should be documented by the treating physician on a regular basis.

What Do I Need to Know to Prevent Errors?

1. Verify that the physician noted the need for oxygen based upon policy requirements. The visit (and test) should not exceed 30 days from the Initial Date on the CMN or 90 days from the Recertification Date.
2. Ensure that your documentation shows a continued need for oxygen and continued use of the equipment by the patient.
3. For portable oxygen, make sure your documentation indicates that the patient is mobile within the home. In addition, ensure the patient's oxygen test was conducted while he or she was either exercising or at rest. If the test is conducted while the patient is asleep, the patient does not qualify for portable oxygen.
4. It is important that you have the results of the qualifying test, whether ABG or SAT. Retain a copy of the test for your files in the event of an audit. The results of the test can be either printed data from the test or written in the physician's notes.

Common Misconceptions Specific to the Oxygen and Oxygen Equipment Policy

Misconception: Once a patient is recertified, a supplier does not need to obtain more documentation.

Fact: Please remember that Medicare should only pay for an item when it is in use by a patient. This includes oxygen. For Medicare to continue to pay for home oxygen, a patient should both need and use the equipment. Therefore, the physician should **regularly document** the patient's need for, and use of, oxygen equipment through the patient's medical records.

Misconception: I do not need to have a copy of the ABG or SAT score because it is listed on the CMN.

Fact: While the test score is listed on the CMN, an auditing agency such as the CERT contractor can ask for documentation to ensure that the score listed on the CMN is documented by printed data from the test or from the record listed in the physician's notes. Therefore, a copy of the patient's ABG and/or SAT score(s) should be maintained.

Misconception: I do not have to maintain documentation when the 36-month cap has been met and the patient is on maintenance and service.

Fact: Although the 36-month cap has been met, documentation **must** be maintained for continued use of oxygen therapy.

Resources

- Detailed education is available from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) serving Jurisdictions A, B, C, and D. DME MACs provide education in a variety of formats including: self-paced online tutorials, podcasts, video education, and webinars.
- For a list of seminars, workshops, and webinars, available in English and Spanish, visit <http://www.cgsmedicare.com/jc> on the Internet.
- For more information on oxygen and oxygen equipment and documentation prior to DME claim submission, visit <https://www.noridianmedicare.com/dme/train> on the Internet.
- For more information about DME, or to find your DME MAC, visit the DME Center at <http://www.cms.gov/center/dme.asp> on the CMS website.
- For more information on basic billing requirements, visit the “Medicare Claims Processing Manual,” Chapter 20, at <http://www.cms.gov/manuals/downloads/clm104c20.pdf> on the CMS website.
- To download a podcast from the Medicare Learning Network® (MLN) based on this fact sheet, visit the MLN Multimedia web page at <http://www.cms.gov/MLNProducts/MLM/list.asp> on the CMS website.
- For oxygen billing tips, refer to MLN Matters® Special Edition Article SE1103 at <http://www.cms.gov/MLNMattersArticles/Downloads/SE1103.pdf> on the CMS website.
- For a complete list of national educational products related to provider compliance, including CERT, visit the MLN Provider Compliance web page at http://www.cms.gov/MLNProducts/45_ProviderCompliance.asp on the CMS website.

MLN Guided Pathways to Medicare Resources

MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about Medicare compliance, refer to the “Protecting the Medicare Trust Fund” section in the “MLN Guided Pathways to Medicare Resources - Basic Curriculum for Health Care Professionals, Suppliers, and Providers” booklet at http://www.cms.gov/MLNEdWebGuide/Downloads/Guided_Pathways_Basic_Booklet.pdf on the CMS website. For all other “Guided Pathways” resources, visit http://www.cms.gov/MLNEdWebGuide/30_Guided_Pathways.asp on the CMS website.



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information, visit the MLN's web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.

Your feedback is important to us and we use your suggestions to help us improve our educational products, services and activities and to develop products, services and activities that better meet your educational needs. To evaluate Medicare Learning Network® (MLN) products, services and activities you have participated in, received, or downloaded, please go to <http://www.cms.gov/MLNProducts> and click on the link called 'MLN Opinion Page' in the left-hand menu and follow the instructions.

Please send your suggestions related to MLN product topics or formats to MLN@cms.hhs.gov.