18.2.1.2 Oxygen Concentrators

The attending physician, or a consultant physician who has personally examined the beneficiary at the request of the attending physician, must have seen the beneficiary within 30 – 60 days of prescribing oxygen therapy.

Initial requests for oxygen concentrators must include a prescription which is signed and dated by the treating physician and which includes:

1. Oxygen flow rate;

2. Frequency and duration of use;

3. Estimate of the period of need; and

4. Results of a current blood gas laboratory report done at rest and at room air (performed no more than 30 days prior to the prescription) from an appropriate facility giving the arterial blood gases (ABGs) and arterial saturation. However, oxygen saturation may be determined by pulse oximetry when ABGs cannot be taken.

The following diagnostic findings support the need for oxygen therapy:

Group I

1. Current ABG with a P02 at or below 55 mm Hg, or arterial oxygen saturation at or below 88 percent or below 88 percent, taken at rest, breathing room air;

2. Current ABG with a P02 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep; or if there is a significant drop during sleep of more than 10 mm Hg of the arterial P02, or a drop of more than 5 percent of the arterial oxygen saturation, and this drop is associated with symptoms or signs reasonably attributable to hypoxemia; and

   Example: PO2 while awake - 75 mm HG
   PO2 while asleep - 64 mm HG
   Symptoms: nocturnal restlessness; and

3. Current ABG with a P02 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during exercise for a beneficiary who demonstrates an arterial P02 at or above 56mm Hg, or an arterial saturation at or below 89 percent while awake at rest. In this case, supplemental oxygen is provided during the exercise if there is evidence that use of oxygen improves the hypoxemia experienced during exercise while breathing room air.

Group II

1. Coverage is available for beneficiaries whose current arterial P02 is 56-59 mm hg or whose arterial blood oxygen saturation is 89 percent, if there is evidence of:

   a. Dependent edema suggesting congestive heart failure (CHF) (documentation from the physician must indicate the degree of edema and if it is associated with CHF);

   b. "P" pulmonale on a current electrocardiogram (EKG) (documentation from the physician must indicate if the AP@ wave on an EKG taken within the last 30 days was greater than 3 mm in standard leads II, III of AVF); or

   c. Erythrocythemia with a current hematocrit greater than 56 percent.

Group III

Medicaid reimbursement will not be made for beneficiaries with arterial P02 levels at or above 60 mm Hg, or arterial blood saturation at or above 90 percent.

Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the beneficiary's treating physician with the prior authorization request. Portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.
For beneficiaries under 21 years of age only, portable oxygen may be approved when needed for travel to and from school.

Reimbursement for Oxygen Concentrators

Payment for an oxygen concentrator also includes the cost of providing all routine maintenance and servicing, and monitoring the proper usage in the home by a respiratory therapist. At the time of the initial request for PA, the DME provider must describe a plan for routine checking and servicing of the machine and a plan for monitoring the proper usage in the home by a respiratory therapist as a prerequisite to authorization of purchase or rental of an oxygen concentrator from that provider.

Reimbursement will be the flat fee on file for the date of service.

Portable Oxygen

Portable oxygen equipment will be reimbursed for beneficiaries who need continuous oxygen and require portable units while in route to a doctor's office, hospital or medically necessary appointment.

Documentation of medical necessity as well as the anticipated number of visits per month needed must be submitted by the beneficiary's treating physician with the prior authorization request. Portable systems will not be approved to be used on a standby basis only. Units will be authorized per month based on review of submitted medical justification. An example of justification for refills includes, but is not limited to, multiple weekly visits for radiation or chemotherapy.

For beneficiaries under 21 years of age only, portable oxygen may be approved when needed for travel to and from school.

Beneficiaries may require multiple units of portable oxygen per month for medical appointments, treatment, and/or travel to and from school (for beneficiaries under 21 years of age).

In order to adhere to the CMS National Correct Coding Initiative (NCCI) edits, only one (1) unit per HCPCS for portable oxygen contents is allowed per claim line regardless of the date(s) of service. Multiple claim lines for the HCPCS for portable oxygen contents may be billed for the same dates of service.