DOCUMENTATION CHECKLIST

JURISDICTIONS B & C

OXYGEN AND OXYGEN EQUIPMENT:
BENEFICIARIES MEETING GROUP I & II CRITERIA

REQUIRED DOCUMENTATION

All Claims for Group I and Group II Oxygen

- ☐ **Standard Written Order (SWO)**
  - ○ Beneficiary's name or Medicare Beneficiary Identifier (MBI)
  - ○ Order Date
  - ○ General description of the item
    - ☐ The description can be either a general description (e.g., Oxygen concentrator), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - ☐ For equipment – In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
    - ☐ For supplies – In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (list each separately)
  - ○ Quantity to be dispensed, if applicable
  - ○ Treating Practitioner Name or NPI
  - ○ Treating Practitioner's signature
    - ☐ Practitioner's signature on the written order meets CMS Signature Requirements 100-08 Program Integrity Manual (PIM), Chapter 3, Section 3.3.2.4
  - ○ Standard Written Order was obtained prior to submitting the claim to Medicare
  - ○ Any changes or corrections have been initialed/signed and dated by the ordering practitioner
- ☐ **Proof of Delivery**
  - ○ Beneficiary's name
  - ○ Quantity delivered
  - ○ A description of the item(s) being delivered. The description can be either a narrative description (e.g., Oxygen concentrator), a HCPCS code, the long description of a
  - ○ HCPCS code, or a brand name/model number.
  - ○ Delivery date
  - ○ Beneficiary (or designee) signature
- ☐ **Medical Record Documentation**
  - ○ Medical Records supporting that the beneficiary meets the basic coverage criteria specified in the Oxygen and Oxygen Equipment LCD.
    - ☐ The treating practitioner has ordered and evaluated the results of a qualifying blood gas study performed at the time of need; and,
    - ☐ The beneficiary's blood gas study meets the criteria stated below; and,
    - ☐ The qualifying blood gas study was performed by a treating practitioner or by a qualified provider or supplier of laboratory services; and,
    - ☐ The provision of oxygen and oxygen equipment in the home setting will improve the beneficiary's condition.
    - ☐ Practitioner's signature on the written order meets CMS Signature Requirements 100-08 Program Integrity Manual (PIM), Chapter 3, Section 3.3.2.4

- A qualifying blood gas study which is 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.

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) while breathing room air, Or
2. An arterial PO2 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent, taken during sleep for a beneficiary who demonstrates an arterial PO2 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake. In this instance, oxygen and oxygen equipment is only reasonable and necessary during sleep, Or
3. A decrease in arterial PO2 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent from baseline saturation, taken during sleep and associated with symptoms of hypoxemia such as impairment of cognitive processes and nocturnal restlessness or insomnia (not all inclusive). In this instance, oxygen and oxygen equipment is only reasonable and necessary during sleep, 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 beneficiary 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 instance, portable oxygen and oxygen equipment is only reasonable and necessary while awake and during exercise.

When oxygen therapy and oxygen equipment is covered based on an oximetry study obtained during exercise, there must be documentation of three (3) oximetry studies in the beneficiary's medical record:

1. Testing at rest without oxygen; and,
2. Testing during exercise without oxygen; and,
3. Testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia).

All 3 tests must be performed within the same testing session. Exercise testing must be performed in-person by a treating practitioner or other medical professional qualified to conduct exercise oximetry testing.

*Oximetry obtained after exercise while resting, sometimes referred to as "recovery" testing, is not part of the 3 required test elements and is not valid for determining eligibility for oxygen therapy and oxygen equipment coverage.

Group II criteria include all of the following:

- An arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89 percent; and,
- Any of the following:
  - Dependent edema suggesting congestive heart failure; or,
  - 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,
  - Erythrocythemia with a hematocrit greater than 56 percent.

For continued coverage, there must be evidence in the medical record documenting:

- Group I
  - The oxygen therapy and oxygen equipment remain reasonable and necessary
- Group II
  - A re-evaluation and a repeat qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy; and,
  - A new SWO by the treating practitioner.

Portable Oxygen:

☐ Medical records that support:

- ○ The beneficiary is mobile within the home for Groups I and II
- ○ The qualifying blood gas study was performed while at rest (awake) or during exercise

Liter Flow Greater Than 4 LPM:

☐ A copy of a blood gas study showing blood gas levels in the Group I or Group II range while the beneficiary was receiving oxygen at the rate of 4 LPM or greater

Beneficiaries Entering Fee-For Service Medicare:

When a beneficiary receiving Oxygen from another payer (including a Medicare Advantage plan) becomes eligible for FFS Medicare, the first claim for that item or service is considered a new initial Medicare claim. Medicare does not automatically continue coverage for any item obtained from another payer when a beneficiary transitions to Medicare coverage.

All Medicare coverage, coding, and documentation requirements (outlined above) must be met.

☐ SWO dated after the beneficiary became eligible for FFS Medicare.
☐ Qualifying blood gas study (which was ordered and evaluated by the treating practitioner) can be dated prior to enrollment into FFS Medicare.
☐ Proof of delivery

- ○ A statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item, meets the proof of delivery requirements; **and**
- ○ A supplier attestation that the item meets Medicare requirements.
  Note: The first day of the first rental month in which Medicare payments are made for the item (i.e., DOS) serves as the start date of the reasonable useful lifetime and period of continuous use.

Replacement after the 5 Year Reasonable Useful Lifetime (RUL):

The beneficiary may elect to obtain replacement of both the stationary and the portable oxygen equipment when the end date of the 5-year RUL of the stationary oxygen is reached.

☐ A new SWO (see required elements listed above)
☐ A new proof of delivery (see required elements listed above)
☐ A new blood gas study is not required
☐ RA modifier must be appended to the first month's rental claim with a narrative explaining the reason for replacement.

REMINDERS

- For oxygen claims covered by Medicare prior to April 1, 2023, suppliers may continue to use the KX modifier or may use the N-modifiers for claims with dates of service on or after April 1, 2023.
- For initial claims for oxygen or new 36-month oxygen rental periods with dates of service on or after April 1, 2023, suppliers must use the N1, N2 or N3 modifier as described below:
  - N1 modifier only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have been met for Group I beneficiaries.
  - N2 modifier only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have been met for Group II beneficiaries.
  - N3 modifier only if all of the criteria in the Coverage Indications, Limitations and/or Medical Necessity section of the related LCD have been met for Group III beneficiaries.
- 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.

- Depending on the claim date of service described above, claim lines billed without a GA, GY, GZ, KX, N1, N2, or N3 modifier will be rejected as missing information.
- 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.

ONLINE RESOURCES

- **DME MAC Supplier Manual**
  - **JB:** https://www.cgsmedicare.com/jb/pubs/supman/index.html
  - **JC:** https://www.cgsmedicare.com/jc/pubs/supman/index.html
- **Local Coverage Determinations (LCDs) and Policy Articles**
  - **JB:** https://www.cgsmedicare.com/jb/coverage/lcdinfo.html
  - **JC:** https://www.cgsmedicare.com/jc/coverage/LCDinfo.html
- **Oxygen Resources**
  - **JB:** https://www.cgsmedicare.com/jb/mr/oxygen_resources.html
  - **JC:** https://www.cgsmedicare.com/jc/mr/oxygen_resources.html

DISCLAIMER

This document was prepared as an educational tool and is not intended to grant rights or impose obligations. This checklist 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 written law or regulations. Suppliers are encouraged to consult the *DME MAC Supplier Manual* and the Local Coverage Determination/Policy Article for full and accurate details concerning policies and regulations.