Title 23: Division of Medicaid

Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies

Chapter 1: Durable Medical Equipment and Medical Appliances

Rule 1.35: Oxygen and Oxygen Related Equipment

A. The Division of Medicaid covers oxygen and oxygen related equipment that allows for the safe delivery of oxygen as durable medical equipment (DME) and includes:

1. Stationary gaseous oxygen systems which include container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,

2. Stationary liquid oxygen systems, which include container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,

3. Portable gaseous or liquid oxygen systems, which include portable container, regulator, flow meter, humidifier, cannula or mask and tubing,

4. Oxygen concentrators, both stationary and portable, which include a humidifier, cannula or mask and tubing, or

5. Oxygen contents, liquid or gaseous.

6. Portable gaseous oxygen systems, which include home compressor used to fill portable oxygen cylinders, portable containers, regulator, flow meter, humidifier, cannula or mask and tubing.

B. The Division of Medicaid covers oxygen and oxygen related equipment for all beneficiaries when prior authorized by the Division of Medicaid or designee, for rental only when the following criteria are met:

1. The attending physician or consulting practitioner has examined the beneficiary and determined that he or she has one (1) of the following conditions that might be expected to improve with oxygen therapy:

a) A severe lung disease including, but not limited to:

1) Chronic obstructive pulmonary disease (COPD),

2) Diffuse interstitial lung disease,

3) Cystic fibrosis,

4) Bronchiectasis, or

5) Widespread pulmonary neoplasm.

b) Hypoxia-related symptoms or findings including, but not limited to:

1) Pulmonary hypertension,

2) Recurring congestive heart failure (CHF) due to cor pulmonale, or

3) Erythrocytosis.

2. When ordered by the attending physician and prior authorized by the Division of Medicaid or designee:

a) Prior to the initiation of oxygen therapy, and

b) Annually thereafter.

3. The order specifies the diagnosis necessitating oxygen therapy, oxygen flow rate, frequency, and duration of use, and estimates the period of need for oxygen and type of oxygen delivery system to be used.

4. The attending physician or consulting practitioner tried or considered alternative treatments and they were deemed clinically ineffective.

5. The qualifying blood gas study value was obtained under these conditions:

a) During an inpatient stay closest to, but no earlier than, two (2) days prior to the hospital discharge date, with oxygen therapy beginning immediately following the discharge,

b) During an outpatient encounter, within thirty (30) days of the date of the initial certification while the beneficiary is in a chronic stable state, which is when the beneficiary is not in a period of acute illness or an exacerbation of his or her underlying disease, or

c) If there is documentation in the medical record that it is detrimental to the life of the beneficiary to obtain oxygen levels on room air then Miss. Admin. Code Title 23, Part 209, Rule 1.35. B.6. is not required.

6. The beneficiary's blood gas study, either by an oximetry test or arterial blood gas (ABG), values meet either the following Group I or Group II criteria.

a) Group I criteria:

1) The beneficiary when tested on room air while at rest and awake had an:

(a) Arterial oxygen (O_2) saturation at or below eighty-eight percent (88%), or

(b) Arterial partial oxygen pressure (PO_2) at or below fifty-five (55) millimeters (mm) of mercury (Hg).

2) The beneficiary when tested during exercise and, if during the day while at rest, arterial PO_2 is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine percent (89%):

(a) Arterial PO_2 is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight (88%), and

(b) There is documented improvement of hypoxemia during exercise with oxygen.

3) The beneficiary when tested during sleep, if the arterial PO_2 is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine (89%) while awake, additional testing must show:

(a) Arterial PO_2 is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight percent (88%) for at least five (5) minutes, which do not have to be continuous, or

(b) A decrease in arterial PO_2 of more than ten (10) mm Hg or a decrease in arterial oxygen saturation greater than five percent (5%) and for at least five (5) minutes, which do not have to be continuous, and has signs and symptoms reasonably attributable to hypoxemia including, but not limited to:

(1) Cor pulmonale,

(2) "P" pulmonale on electrocardiogram (ECG),

(3) Documented pulmonary hypertension, or

(4) Erythrocytosis reasonably attributable to hypoxemia.

b) Group II criteria:

1) The beneficiary when tested on room air at rest while awake had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%) at rest and awake, or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) There is dependent edema caused by congestive heart failure, or

(2) There is documentation supportive of pulmonary hypertension or cor pulmonale determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on ECG, with P wave greater than three (3) mm in standard leads II, III, or AVF, or

(3) There is erythrocytosis with a hematocrit greater than fifty-six percent (56%).

2) The beneficiary when tested during exercise had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%), or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) Dependent edema suggesting congestive heart failure,

(2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on ECG, P wave greater than three (3) mm in standard leads II, III, or AVF, or

(3) Erythrocythemia with a hematocrit greater than fifty-six percent (56%).

3) The beneficiary when tested during sleep for at least five (5) minutes, which do not have to be continuous, had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%), or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) Dependent edema suggesting congestive heart failure,

(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 fifty-six percent (56%).

C. The Division of Medicaid does not cover oxygen and oxygen related equipment:

1. For the following conditions including, but not limited to:

a) Angina pectoris in the absence of hypoxemia.

b) Dyspnea without cor pulmonale or evidence of hypoxia.

c) Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.

d) Terminal illnesses that do not affect the respiratory system.

2. When the order is for when necessary (PRN) use only.

D. The Division of Medicaid reimburses for the rental of oxygen and oxygen related equipment, supplies and related services as follows:

1. For stationary oxygen systems, the DME provider:

a) Is allowed to bill a monthly rental fee which includes, but is not limited to, the following:

1) Regulators and flow meters,

2) Tubing,

3) Cannulas or mask,

4) Humidifier,

5) Nebulizer,

6) Oxygen contents,

7) Backup oxygen equipment,

8) Maintenance,

9) Repairs, and

10) Delivery.

b) Is allowed to bill for stationary oxygen contents when the provider includes:

1) The appropriate Healthcare Common Procedure Coding System (HCPCS) code indicating the prescribed flow rate is one (1) to (4) liters per minute (LPM), or

2) The appropriate HCPCS code and modifier indicating if the prescribed flow rate is:

(a) Less than one (1) liter per minute (LPM), or

(b) Greater than four (4) LPM.

c) Is not allowed to bill:

1) For medical supplies separately for the delivery of oxygen, or

2) For backup oxygen equipment.

d) Is not allowed to bill for a monthly rental if the beneficiary requires less than one (1) month of rental of oxygen, but must bill the daily rate for only those days the beneficiary required oxygen.

2. For portable oxygen systems, the rental is continuous and the DME provider:

a) Is allowed to bill:

1) Monthly for the portable oxygen system which includes, but is not limited to the following:

(a) Regulators and flow meters,

(b) Tubing,

(c) Cannulas or masks,

(d) Humidifiers,

(e) Portable container, and/or

(f) Supply reservoir.

2) For portable oxygen contents as medically necessary when the provider includes:

(a) The appropriate HCPCS code indicating the prescribed flow rate is less than (4) liters per minute (LPM), or

(b) The appropriate HCPCS code and modifier indicating if the prescribed flow rate is greater than four (4) LPM.

b) Is not allowed to bill portable oxygen contents exceeding one (1) unit per month.

1) A unit is defined as the quantity of oxygen the beneficiary uses per month.

2) The Division of Medicaid's reimbursement is the same regardless of the quantity of oxygen dispensed.

3. The Division of Medicaid does not reimburse for:

a) The rental of a portable home compressor and the rental of portable oxygen equipment, including contents, at the same time, or

b) Portable oxygen contents based on the modifier indicating the oxygen flow rate.

E. The DME provider must document the following information in the beneficiary's record after each visit:

1. Date of service,

2. Documentation of maintenance and/or repair, operation and safety of the oxygen equipment,

3. Determination of oxygen output,

4. Changing of filters, and

5. Proper functioning of the backup system.

Source: 42 U.S.C. § 1395m; 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2018.

Title 23: Division of Medicaid

Part 209: Durable Medical Equipment, Medical Appliances and Medical Supplies

Chapter 1: Durable Medical Equipment and Medical Appliances

Rule 1.35: Oxygen and Oxygen Related Equipment

A. The Division of Medicaid covers oxygen and oxygen related equipment that allows for the safe delivery of oxygen as durable medical equipment (DME) and includes:

1. Stationary gaseous oxygen systems which include~~s~~ container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,

2. Stationary liquid oxygen systems, which include~~s~~ container, contents, regulator, flow meter, humidifier, nebulizer, cannula or mask and tubing,

3. Portable gaseous or liquid oxygen systems, which include~~s~~ portable container, regulator, flow meter, humidifier, cannula or mask and tubing,

4. Oxygen concentrators, both stationary and portable, which include a humidifier, cannula or mask and tubing, or

5. Oxygen contents, liquid or gaseous.

6. Portable gaseous oxygen systems, which include home compressor used to fill portable oxygen cylinders, portable containers, regulator, flow meter, humidifier, cannula or mask and tubing.

B. The Division of Medicaid covers oxygen and oxygen related equipment for all beneficiaries when prior authorized by ~~the Utilization Management and Quality Improvement Organization (UM/QIO),~~ the Division of Medicaid or design~~ate~~ed ~~entity~~, for rental only when the following criteria ~~is~~ are met:

1. ~~When t~~The attending physician or consulting practitioner has examined the beneficiary and determined that he or she has one (1) of the following conditions that might be expected to improve with oxygen therapy:

   a) A severe lung disease including, but not limited to:

      1) Chronic obstructive pulmonary disease (COPD),

      2) Diffuse interstitial lung disease,

      3) Cystic fibrosis,

4) Bronchiectasis, or

5) Widespread pulmonary neoplasm.

b) Hypoxia-related symptoms or findings including, but not limited to:

1) Pulmonary hypertension,

2) Recurring congestive heart failure (CHF) due to cor pulmonale, ~~and~~ or

3) Erythrocytosis.

2. When ordered by the attending physician and prior authorized by the Division of Medicaid or designee:

a) Prior to the initiation of oxygen therapy, and

b) Annually thereafter.

3. The order specifies the diagnosis necessitating oxygen therapy, oxygen flow rate, frequency, and duration of use, and estimates the period of need for oxygen and type of oxygen delivery system to be used.

4. The attending physician or consulting practitioner tried or considered alternative treatments and they were deemed clinically ineffective.

5. The qualifying blood gas study value was obtained under these conditions:

a) During an inpatient stay closest to, but no earlier than, two (2) days prior to the hospital discharge date, with oxygen therapy beginning immediately following the discharge, ~~or~~

b) During an outpatient encounter, within thirty (30) days of the date of the initial certification while the beneficiary is in a chronic stable state, which is when the beneficiary is not in a period of acute illness or an exacerbation of his or her underlying disease, ~~.~~ or

c) ~~Repeat of the study prior to the thirteenth (13th) month of the oxygen therapy for recertification.~~If there is documentation in the medical record that it is detrimental to the life of the beneficiary to obtain oxygen levels on room air then Miss. Admin. Code Title 23, Part 209, 1.35.B.6. is not required.

6. The beneficiary's blood gas study, either by an oximetry test or arterial blood gas (ABG), values meet either the following Group I or Group II criteria.

a) Group I criteria:

1) The beneficiary when tested on room air while at rest and awake had an:

(a) Arterial oxygen (O_2) saturation at or below eighty-eight percent (88%), or

(b) Arterial partial oxygen pressure (PO_2) at or below fifty-five (55) millimeters (mm) of mercury (Hg).

2) The beneficiary ~~has~~ when tested during exercise and, if during the day while at rest, arterial PO_2 is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine percent (89%):

(a) Arterial PO_2 is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight (88%), and

(b) There is ~~D~~documented improvement of hypoxemia during exercise with oxygen.

3) The beneficiary when tested during sleep, if the arterial PO_2 is at or above fifty-six (56) mm Hg or an arterial oxygen saturation is at or above eighty-nine (89%) while awake, additional testing must show:

(a) Arterial PO_2 is at or below fifty-five (55) mm Hg or an arterial oxygen saturation is at or below eighty-eight percent (88%) for at least five (5) minutes, which do not have to be continuous, ~~taken during sleep,~~ or

(b) A decrease in arterial PO_2 of more than ten (10) mm Hg or a decrease in arterial oxygen saturation greater than five percent (5%) and for at least five (5) minutes, which do not have to be continuous, ~~taken during sleep~~ and has signs and symptoms reasonably attributable to hypoxemia including, but not limited to:

(1) Cor pulmonale,

(2) "P" pulmonale on electrocardiogram (ECG),

(3) Documented pulmonary hypertension, or

(4) Erythrocytosis reasonably attributable to hypoxemia.

b) Group II criteria:

1) The ~~B~~beneficiary when tested on room air at rest while awake ~~when tested~~ had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%) at rest and ~~(~~awake~~)~~, or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) There is dependent edema caused by congestive heart failure, or

(2) There is documentation supportive of pulmonary hypertension or cor pulmonale determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on ECG, with P wave greater than three (3) mm in standard leads II, III, or AVF, or

(3) There is erythrocytosis with a hematocrit greater than fifty-six percent (56%).

2) The ~~B~~beneficiary when tested during exercise had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%), or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) Dependent edema suggesting congestive heart failure,

(2) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on ECG, P wave greater than three (3) mm in standard leads II, III, or AVF~~)~~, or

(3) Erythrocythemia with a hematocrit greater than fifty-six percent (56%).

3) The ~~B~~beneficiary when tested during sleep for at least five (5) minutes, which do not have to be continuous, had an:

(a) Arterial oxygen saturation of eighty-nine percent (89%), or

(b) Arterial PO_2 of fifty-six (56) to fifty-nine (59) mm Hg, and

(1) Dependent edema suggesting congestive heart failure,

(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 fifty-six percent (56%).

C. The Division of Medicaid does not cover oxygen and oxygen related equipment:

1. For the following conditions including, but not limited to:

a) Angina pectoris in the absence of hypoxemia.

b) Dyspnea without cor pulmonale or evidence of hypoxia.

c) Severe peripheral vascular disease resulting in clinically evident desaturation in one (1) or more extremities. There is no evidence that increased PO_2 will improve the oxygenation of tissues with impaired circulation.

d) Terminal illnesses that do not affect the respiratory system.

2. When the order is for when necessary (PRN) use only.

D. The Division of Medicaid reimburses for the rental of oxygen and oxygen related equipment, supplies and related services as follows:

1. For stationary oxygen systems, ~~the rental is for a sixty month (60) reasonable useful lifetime (RUL) period and~~ the DME provider:

a) Is allowed to bill a monthly rental fee ~~for the first thirty-six (36) rental months which includes, oxygen related equipment, supplies and related services~~ which includes~~ing~~, but is not limited to the following:

1) Regulators and flow meters,

2) Tubing,

3) Cannulas or mask,

4) Humidifier,

5) Nebulizer,

6) Oxygen contents,

7) Backup oxygen equipment,

8) Maintenance,

9) Repairs, and

10) Delivery.

b) Is allowed to bill for stationary oxygen contents when the provider includes:

1) The appropriate Healthcare Common Procedure Coding System (HCPCS) code indicating the prescribed flow rate is one (1) to (4) liters per minute (LPM), or

2) ~~Must include t~~The appropriate HCPCS code and modifier indicating if the prescribed flow rate is:

(a) Less than one (1) liter per minute (LPM), or

(b) Greater than four (4) LPM.

~~c) Is not allowed to bill monthly for stationary oxygen rental for months thirty-seven (37) through sixty (60), but is allowed to bill for the following:~~

~~1) A six (6) month maintenance and service (M&S) fee.~~

~~(a) The DME provider must actually make a visit to bill the M&S fee,~~

~~(b) The first visit cannot be sooner than six (6) months following the end of the rental period, and~~

~~(c) The visit must include inspection, changing filters, cleaning, and calibration of the stationary oxygen and oxygen related equipment.~~

~~2) Portable oxygen contents in quantities expected to last for one (1) month, and~~

c~~d~~) Is not allowed to bill:

1) ~~f~~For medical supplies separately for the delivery of oxygen, or

2) ~~f~~For backup oxygen equipment.

~~e) May deliver new stationary oxygen equipment and oxygen related equipment and begin to bill monthly for a new thirty-six (36) month rental period, after the completion of the sixty (60) month RUL period. If the equipment does not require replacement, the DME provider can only bill for an M&S fee.~~

~~1) If the equipment does not require replacement, the DME provider can only bill for an M&S fee.~~

~~2) Prior authorization must be obtained prior to a new sixty (60) month rental period regardless if a new stationary oxygen delivery system is required.~~

d~~f~~) Is not allowed to bill for a monthly rental if the beneficiary requires less than one (1) month of rental of oxygen, but must bill the daily rate for only those days the beneficiary required oxygen.

2. For portable oxygen systems, the rental is continuous and the DME provider:

a) Is allowed to bill:

1) Monthly for the portable oxygen system which includes, but is not limited to the following:

(a) Regulators and flow meters,

(b) Tubing,

(c) Cannulas or masks,

(d) Humidifiers,

(e) Portable container, and/or

(f) Supply reservoir.

2) For portable oxygen contents as medically necessary when the provider includes:

(a) The appropriate HCPCS code indicating the prescribed flow rate is less than (4) liters per minute (LPM), or

(b) The appropriate HCPCS code and modifier indicating if the prescribed flow rate is greater than four (4) LPM.

b) Is not allowed to bill portable oxygen contents exceeding one (1) unit per month.

1) A unit is defined as the quantity of oxygen the beneficiary uses per month.

2) The Division of Medicaid's reimbursement is the same regardless of the quantity of oxygen dispensed.

3. The Division of Medicaid does not reimburse for:

a) The rental of a portable home compressor and the rental of portable oxygen equipment, including contents, at the same time, or

b) Portable oxygen contents based on the modifier indicating the oxygen flow rate.

~~3. The DME provider cannot bill separately for portable oxygen if the provider is also billing for stationary oxygen equipment during the thirty-six (36) months of rental. Starting with the thirty-seventh (37th) month, the DME provider can bill for the rental of the portable oxygen.~~

E. The DME provider must document the following information in the beneficiary's record after each visit:

1. Date of service,

2. Documentation of maintenance and/or repair, operation and safety of the oxygen equipment,

3. Determination of oxygen output,

4. Changing of filters, and

5. Proper functioning of the backup system.

~~F. The Division of Medicaid covers portable oxygen equipment for a beneficiary who needs continuous oxygen and requires portable units:~~

~~1. While en route to a practitioner's office or hospital,~~

~~2. When the practitioner has ordered an exercise program requiring the beneficiary to be away from his/her stationary oxygen, or~~

~~3. During activities that cannot be accomplished with the use of stationary oxygen equipment.~~

~~F. Requests for portable refills exceeding one (1) per day require additional justifications from the physician on the prior authorization request.~~

Source: 42 U.S.C. § 1395m; 42 C.F.R. § 440.70; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 12/01/2018.