Revised 3/20/2024

From: Maureen M. Corcoran, Director

To: Ohio Department of Medicaid Clearance Reviewers

Subject: Amendment of Ohio Administrative Code rule 5160-10-13 ("DMEPOS: oxygen")

Summary

Rule 5160-10-13 of the Ohio Administrative Code, "DMEPOS: oxygen," sets forth coverage and payment policies for oxygen under the durable medical equipment, prostheses, orthoses, and supplies (DMEPOS) benefit. Pursuant to section 106.03 of the Ohio Revised Code, "Agency Review of Existing Rules," the Ohio Department of Medicaid (ODM) has conducted a systematic review of this rule. As a result of this review, a number of changes will be made to the rule, mostly for the purpose of clarification.

- A new term, 'group III criteria', is introduced to designate indicators of the medical necessity of oxygen that do not fall within group I or group II. Examples of such indicators include cluster headaches and illnesses for which a public health emergency has been declared.
- The associated certificate of medical necessity (CMN), form ODM 01909, has been updated.
- Phrasing has been revised to clarify that grouping criteria apply to health conditions rather than to individuals.
- Dates or lengths of certain time periods have been revised.
- The phrase 'sleep study' has been corrected to 'respiratory study'.
- The exclusion of payment for both a stationary oxygen concentrator and a portable oxygen concentrator has been removed.
- The appendix to the rule is being rescinded because the information it presents has already been incorporated into the appendix to rule 5160-10-01 of the Ohio Administrative Code.

Additional Information

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Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

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The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov.

5160-10-13 **DMEPOS: oxygen.**

(A) Definitions.

(1) "Blood gas study" is the measurement of such characteristics of blood as the partial pressure of oxygen (PO2) or oxygen saturation. The term applies either to pulse oximetry or to an arterial blood gas (ABG) study.

(2) "Group I" and "group II" criteria are sets of clinical indicators used to determine the coverage of oxygen without prior authorization.

(a) Group I criteria.

(i) If the individual is tested while awake and at rest, either of the following measures applies:

(a) Arterial PO2 of fifty-five millimeters of mercury (mm Hg) or less; or

(b) Arterial oxygen saturation at or below eighty-eight per cent.

(ii) If the individual is tested while ambulating, either of the following measures applies:

(a) Arterial PO2 of fifty-five mm Hg or less during ambulation without oxygen, with documented improvement during ambulation with oxygen; or

(b) Arterial oxygen saturation at or below eighty-eight per cent during ambulation without oxygen, with documented improvement during ambulation with oxygen.

(iii) If the individual is tested while asleep, any of the following measures applies:

(a) Arterial PO2 of fifty-five mm Hg or less;

(b) Arterial oxygen saturation at or below eighty-eight per cent;

(c) A decrease in arterial PO2 of more than ten mm Hg, associated with symptoms of or signs reasonably attributable to hypoxemia; or

(d) A decrease in arterial oxygen saturation of more than five per cent, associated with symptoms of or signs reasonably attributable to hypoxemia.

(b) Group II criteria.

(i) Either of the following measures applies:

(a) Arterial PO2 of at least fifty-six mm Hg and not more than fifty-nine mm Hg; or

(b) Arterial oxygen saturation at or above eighty-nine per cent.

(ii) In addition, at least one of the following conditions applies:

(a) Dependent edema suggestive of congestive heart failure;

(b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or the presence of P pulmonale on an EKG; or

(c) Erythrocythemia with a hematocrit greater than fifty-six per cent.

(3) "Group III criteria" is an informal designation for any other clinical indicators used to determine, through the prior authorization (PA) process, the medical necessity of oxygen. Such indicators include but are not limited to the following examples:

(a) Cluster headaches; or

(b) An illness for which a public health emergency has been declared.

~~(3)~~(4) "Transfill unit" is a device that transfers oxygen from a source such as an oxygen concentrator to portable tanks.

(B) Providers.

(1) The following eligible medicaid providers may prescribe oxygen:

(a) A physician;

(b) An advanced practice registered nurse with a relevant specialty; or

(c) A physician assistant.

(2) The following eligible medicaid providers may supply oxygen:

(a) A durable medical equipment (DME) provider;

(b) A pharmacy;

(c) A physician;

(d) An advanced practice registered nurse with a relevant specialty;

(e) A physician assistant; or

(f) An ambulatory health care clinic.

(3) The following eligible medicaid providers may receive medicaid payment for submitting a claim for oxygen:

(a) A DME provider;

(b) A pharmacy;

(c) A physician;

(d) An advanced practice registered nurse with a relevant specialty;

(e) A physician assistant;

(f) An ambulatory health care clinic; or

(g) A professional medical group.

(C) Certification of medical necessity.

(1) Payment for oxygen can be made only if a prescriber certifies that the oxygen is medically necessary for an individual. A completed certificate of medical necessity (CMN) needs to be signed and dated by the prescriber before a claim is submitted. The default form is the ODM 01909, "Certificate of Medical Necessity: Oxygen" (rev. ~~7/2021~~ 10/2024).

(2) On the CMN, the prescriber specifies an estimated length of need (certification period), which may range from one month to a lifetime.

(a) For an individual with a condition meeting group I criteria, each certification period is limited to a maximum of twelve months after the first date of service.

(b) For an individual with a condition meeting group II criteria, ~~each~~ the initial certification period immediately following the first date of service is limited to a maximum of three months ~~after the first date of service~~, and each certification period thereafter is limited to a maximum of twelve months.

(3) An initial CMN is used to document certification for new service.

(a) An initial CMN needs to be completed if oxygen has not been supplied under medicaid to an individual for at least two full calendar months.

(b) The individual needs to be seen and evaluated by a prescriber ~~within a specified period before the date of certification~~, and a blood gas study is needed.

(i) If the individual is a hospital inpatient or resident of a long-term care facility (LTCF), ~~who is being discharged or will be discharged, then the evaluation period is thirty days,~~ and the most recent blood gas study performed within forty-eight hours before discharge is used.

(ii) Otherwise, ~~the evaluation period is thirty days, and~~ the most recent blood gas study performed within ~~thirty days before the date of certification is~~ the preceding twelve months may be used.

(4) A renewing CMN is used to extend certification.

(a) If the need for oxygen was established through a ~~sleep~~ respiratory study in which a positive airway pressure device was shown to be effective only when supplemental oxygen was administered simultaneously, then the need for oxygen is presumed to last as long as the need for the positive airway pressure device, and no further ~~sleep~~ respiratory study is needed to confirm a continued need for oxygen.

(b) Otherwise, the provider obtains a new prescription within ninety days before the end of the existing certification period (or, for lifetime certification, within ninety days before the expiration of the current prescription). ~~, the individual needs to be seen and evaluated by a prescriber, and a~~ A new blood gas study is not needed. ~~(The new certification period cannot begin until both the prescriber evaluation and the blood gas study have been completed.).~~

(5) A revised CMN is used to modify an existing certification. ~~No prescriber evaluation is needed.~~

(a) The most recent blood gas study performed within thirty days before the revision date is used as the basis for any of the following modifications:

(i) The prescribed maximum flow rate has changed. If the new rate is greater than four liters per minute (LPM), then a new blood gas study needs to be performed while the individual is receiving four LPM.

(ii) Certification ~~has been~~ is being given for a portable oxygen delivery system to supplement a stationary system for which certification was previously given. If the most recent qualifying study was performed during sleep, then a new blood gas study needs to be performed while the individual is awake, either at rest or ambulating.

(b) No additional blood gas study is needed for the following modifications:

(i) There is a new prescriber, but the oxygen order is the same.

(ii) There is a new provider, and the new provider does not have the most recent CMN.

(D) Coverage.

(1) Payment may be made for oxygen supplied in the following forms:

(a) Stationary gaseous oxygen system (private residence only);

(b) Portable gaseous oxygen system (private residence only);

(c) Stationary liquid oxygen system (private residence only);

(d) Portable liquid oxygen system (private residence only);

(e) Oxygen contents, gaseous, including supplies (LTCF only);

(f) Oxygen contents, liquid, including supplies (LTCF only);

(g) Oxygen concentrator, single delivery port;

(h) Oxygen concentrator, dual delivery port;

(i) Portable oxygen concentrator (private residence only); and

(j) Transfill unit (private residence only).

(2) Separate payment for a portable oxygen delivery system may be made in addition to payment for a stationary system only if the following criteria are met:

(a) The individual has a demonstrable need for a separate portable system, either to maintain mobility in a private residence or to accomplish out-of-home activities;

(b) The individual's stationary oxygen delivery system cannot be used as a portable delivery system; and

(c) The prescribed oxygen flow is four LPM or less. If the prescribed oxygen flow is greater than four LPM, then no separate payment is made for the portable oxygen delivery system.

(3) ~~Separate payment will not be made, however, for both a stationary and a portable oxygen concentrator.~~

~~(4)~~(3) ~~Prior authorization (PA)~~ PA is not needed when a supplier has obtained a properly completed CMN and furnishes oxygen to an individual ~~who e~~ither who has a condition that meets group I or group II criteria or who is a resident of a LTCF.

~~(5)~~(4) PA is needed when a supplier has obtained a properly completed CMN and furnishes oxygen to an individual who has a condition that meets neither group I nor group II criteria and who is not a resident of a LTCF. If authorization is given, then the length of the authorization period will be based on medical necessity and cannot exceed the timeframe indicated by the prescriber. The PA request needs to include a copy of the completed CMN.

~~(6)~~(5) Oxygen is not medically necessary if it is prescribed for any of the following conditions:

(a) Angina pectoris in the absence of hypoxemia;

(b) Dyspnea without cor pulmonale or evidence of hypoxemia;

(c) Severe peripheral vascular disease that results in clinically evident desaturation in one or more extremity but does not produce systemic hypoxemia; or

(d) A terminal illness that does not affect the respiratory system.

(E) Claim payment.

(1) Payment for oxygen is made on a monthly basis and includes the following related items and services:

(a) Setup and instruction on use;

(b) Equipment and supplies;

(c) Maintenance and repair, including the replacement of any part or attachment (such as tubing, cannula, mask, or filter) that is integral to the oxygen system or the operation of the system;

(d) Transportation or delivery charges;

(e) Emergency service, including the provision of backup equipment and supplies;

(f) Oxygen consumed (when applicable); and

(g) Equipment monitoring visits.

(2) The maximum payment for oxygen is the amount set forth in the appendix to this rule. When the prescribed oxygen flow is greater than four LPM, the payment amount is increased by fifty per cent.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02
Prior Effective Dates:	04/07/1977, 12/21/1977, 12/30/1977, 01/01/1980, 03/01/1984, 05/01/1990, 06/20/1990 (Emer.), 09/05/1990, 02/17/1991, 05/25/1991, 04/01/1992 (Emer.), 07/01/1992, 03/31/1994, 01/01/1995, 08/01/1995, 08/01/1998, 10/11/2001, 11/01/2007, 07/31/2009 (Emer.), 10/29/2009, 08/02/2011, 12/31/2013, 07/16/2018, 07/01/2021

Oxygen and related parts and services
Appendix to OAC rule 5160-10-13
Payment schedule effective 07/01/2021

BR -- Payment by report
Limit based – PA is required when the frequency limit is exceeded
PA -- Payment by prior authorization

HCPCS CODE	DESCRIPTION	UNIT	SUBCATEGORY/ APPLICATION	CURRENT MAXIMUM PAYMENT AMOUNT	PAYMENT AMOUNT EFFECTIVE DATE	RESIDENCE	RENTAL OR PURCHASE	LIMIT OR FREQUENCY	PRIOR AUTHORIZATION	NOTES
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING	Each	Gaseous oxygen	$100.00	07/16/2018	Non-institutional only	Rental only	1 per month	Limit based	
E0431	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	Each	Liquid oxygen	$40.00	01/01/2014	Non-institutional only	Rental only	1 per month	Limit based	
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING	Each	Liquid oxygen	$40.00	01/01/2014	Non-institutional only	Rental only	1 per month	Limit based	
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING	Each	Liquid oxygen	$220.00	07/01/2021	Non-institutional only	Rental only	1 per month	Always required	
E0441	STATIONARY OXYGEN CONTENTS, GASEOUS, 1 MONTH'S SUPPLY = 1 UNIT	Each	Supply	$50.00	07/16/2018	LTCF only	Rental only	1 per month	Limit based	
E0442	STATIONARY OXYGEN CONTENTS, LIQUID, 1 MONTH'S SUPPLY = 1 UNIT	Each	Supply	$50.00	07/16/2018	LTCF only	Rental only	1 per month	Limit based	
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE	Each	Concentrator	$100.00	07/16/2018	Non-institutional only	Rental only	1 per month	Limit based	
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE	Each	Concentrator	$50.00	07/16/2018	LTCF only	Rental only	1 per month	Limit based	
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH	Each	Concentrator	$100.00	07/16/2018	Non-institutional only	Rental only	1 per month	Limit based	
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH	Each	Concentrator	$50.00	07/16/2018	LTCF only	Rental only	1 per month	Limit based	
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	Each	Concentrator	$40.00	07/16/2018	Non-institutional only	Rental only	1 per month	Limit based	
K0738*	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	Each	Compressor	$40.00	07/16/2018	Non-institutional only	Rental only	1 per month	Limit based	
K0740	REPAIR OR NONROUTINE SERVICE FOR OXYGEN EQUIPMENT REQUIRING THE SKILL OF A TECHNICIAN, LABOR COMPONENT, PER 15 MINUTES	Each	Labor	$12.17	07/01/2021	All		1 per 120 days	Always required	Only for customer-owned oxygen equipment
E1390 U1 **AND** E1392	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE **AND** PORTABLE OXYGEN CONCENTRATOR, RENTAL		Concentrator	$140.00	02/01/2020	Non-institutional only	Rental only	per month	Limit based	The U1 modifer is used only when E1390 and E1392 are provided together. When a claim is submitted for E1390 U1 and E1392, the E1392 detail will be denied and the E1390 U1 detail will be paid at $140.00.

*Note: K0738 formerly represented the combination of a stationary oxygen concentrator and a transfill unit.
U1 modifiers are not needed to differentiate between non-institutional and institutional residences. They will pay based on place of service.

Modifier	Description	Applicable Procedure Codes	Payment Multiplier
QF	Prescribed oxygen flow greater than 4 LPM, both stationary and portable	E0424, E0431, E0434, E0439, E0441, E0442	1.50
QG	Prescribed oxygen flow greater than 4 LPM, stationary only	E0424, E0439, E0441, E0442	1.50

Ohio Department of Medicaid

CERTIFICATE OF MEDICAL NECESSITY: OXYGEN

Identifying Information [This section may be completed by the provider.]

Individual	**Prescriber**	**Provider**
Name	Name	Name
Medicaid ID number	Medicaid provider number	Medicaid provider number
Date of birth	NPI	NPI
	Telephone number	

NOTE: Prior authorization is required *unless* oxygen is being supplied to an individual who either (a) meets group I or group II criteria or (b) is a resident of a long-term care facility (LTCF).

Certification [This section may be transcribed by the provider.]

Mark all items that apply.

☐ **Initial**	☐ **Renewing**	☐ **Revised**
Diagnosis code(s)	Date of evaluation	Prior PA number

Results of most recent blood gas study

At rest ..... PO2 _____ Saturation _____ Date ___/___/_____

Ambulating ..... PO2 _____ Saturation _____ Date ___/___/_____

Sleeping ..... PO2 _____ Saturation _____ Date ___/___/_____

[Other] _____... PO2 _____ Saturation _____ Date ___/___/_____

Estimated length of need / Certification period

☐ Group I — 12 months

At rest: PO2 ≤ 55 mm Hg *or* saturation ≤ 88%

Ambulating: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% and documented improvement with oxygen

Sleeping: PO2 ≤ 55 mm Hg *or* saturation ≤ 88% *or* PO2 decrease > 10 mm Hg *or* saturation decrease > 5%

☐ Group II — 3 months

PO2 56–59 mm Hg *or* saturation ≥ 89% and dependent edema, pulmonary hypertension or cor pulmonale, or hematocrit > 56%

☐ _____ month(s) [≤ 12]

☐ Lifetime

Specifications

System: ☐ Stationary only ☐ Stationary/portable ☐ Supplementary portable

Flow rates: ☐ Continuous, ____ LPM ☐ Noncontinuous (____ hours/day)

Ambulating, ____ LPM

Sleeping, ____ LPM

[Other] _____, ____ LPM

Interface: ☐ Nasal cannula ☐ Mask ☐ Transtracheal catheter ☐ Positive airway pressure device

Attestation [This section must be completed by the prescriber.]

I hereby attest that the certification information above is true, correct, and complete.	
Signature of prescriber	Date of signature

False certification constitutes Medicaid fraud.