Home Oxygen Therapy
Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Home Oxygen Therapy		
MNG #: 098	**☒SCO ☒One Care** **☒ MA Medicare Premier** **☒MA Medicare Value** **☒RI Medicare Preferred** **☒ RI Medicare Value** **☒ RI Medicare Maximum**	**Prior Authorization Needed?** **☐ Yes (always required)** **☒ Yes (only in certain situations. See this MNG for details)** **☐ No**
Clinical: ☒	**Operational: ☒**	**Informational: ☐**
Benefit Type: **☒ Medicare** **☒ Medicaid**	**Approval Date:** 2/3/2022;	**Effective Date:** 05/07/2022;
Last Revised Date: 7/7/2022; 10/6/2022;	**Next Annual Review Date:** 2/3/2023; 7/7/2023; 10/6/2023;	**Retire Date:**

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses InterQual Smart Sheets, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

1. **SENIOR CARE OPTIONS AND ONE CARE**
   A. Requirements for Coverage: Oxygen therapy equipment is reimbursable for the treatment of severe lung diseases (for example, chronic bronchitis, emphysema, and interstitial lung disease) that cause hypoxemia and where oxygen therapy can reasonably be expected to correct the patient’s hypoxemia.
   B. Laboratory Evidence.
      1. The initial prior-authorization request for oxygen therapy equipment in the home must include laboratory evidence of chronic hypoxemia. This evidence must be in the form of an arterial blood gas analysis ($PaO2 \leq$ 55 torr while breathing room air) or an oximetry reading ($SaO2 \leq 88$ percent while breathing room air).
      2. The arterial blood gas analysis or oximetry reading must be performed *at the time of need. The time of need is defined as during the patient’s illness when the presumption is that the provision of oxygen in the home setting will improve the patient’s condition. For a hospitalized Member, the time of need is within 2 days of discharge. For those Members whose initial oxygen prescription does not originate during an inpatient hospital stay, initial requests must include a qualifying blood gas study within 90 days of the order.*

         a. There is an exception to the 90-day test requirement for members who were started on oxygen while enrolled in a different plan and transitioned to a Commonwealth Care Alliance SCO or One Care plan. For those members, the blood gas study does not have to be obtained 90 days prior to the order but must be the most recent qualifying test obtained while in the previous plan.

3. The test for evidence of hypoxemia must be performed while the recipient is in a resting state and breathing room air. Prior authorization will be deferred for services based on tests performed while the recipient is breathing supplemental oxygen unless the physician can certify that removing the oxygen from the patient could be life threatening.

C. Evidence of Hypoxemia. One or both of the following test results are sufficient evidence of hypoxemia if they are performed while the patient is breathing room air and are in association with cor pulmonale, congestive heart failure, or erythrocythemia with a hematocrit of more than 56:
   (1) PaO2 = 56 - 59 torr, or

   (2) SaO2 ≤ 89 percent.

D. Qualification for Supplemental Oxygen Therapy Equipment. Some recipients may not qualify for oxygen at rest, but may qualify for supplemental oxygen during ambulation, sleep, or exercise. Oxygen therapy equipment may be reimbursable during these specific activities when SaO2 is demonstrated to fall to 88 percent or less.

E. Requirements for Portable Oxygen. A patient meeting all of these requirements may qualify for a portable oxygen system. The prescriber must document that the recipient's activities take him or her beyond the functional limits of the stationary system.

F. Reasons for Noncoverage. Oxygen therapy shall not be approved for the following conditions:
   A. Angina pectoris in the absence of hypoxemia;
   B. Breathlessness without cor pulmonale or evidence of hypoxemia; and
   C. Peripheral vascular disease resulting in desaturation in one or more extremities without evidence of central hypoxemia.

G. Required Documentation. The provider must submit all of the following documentation with Prior Authorization requests for oxygen therapy:
   1. A written prescription; and
   2. Documentation of the medical necessity for oxygen therapy in the treatment of hypoxemia.

H. Recertification: The provider must submit all of the following with recertification requests:
   a. Documentation must include the most recent qualifying arterial blood gas or oxygen saturation prior to the thirteenth month of therapy.
   b. Re-evaluation of continue need for oxygen. This can be met by one of the following:
      i. Member seen and re-evaluated by the treating practitioner within 90 days prior to the date of recertification; or
      ii. Documentation of a qualifying arterial blood gas or oxygen saturation within 90 days of recertification.

2. MEDICARE ADVANTAGE

CCA follows applicable Medicare regulations, and InterQual Smart Sheets are used to review prior authorization requests for medical necessity.

LIMITATIONS/EXCLUSIONS:

If a CCA Member is already receiving home oxygen therapy, CCA recognizes that this is a potentially lifesaving

therapy and will not deny continuation of these services for inadequate required documentation without first making reasonable attempts at obtaining the necessary documentation from the requesting provider. For SCO and One Care, CCA will follow the fully integrated continuity requirements should a member or provider appeal a denial for ongoing services as outlined in 42 CFR 422.632.

CCA reserves the right to switch or change oxygen supplies or vendor without advanced notice should CCA become aware of an interruption in supply or potential mechanical, workmanship, or other safety concern with the equipment supplied in question.

AUTHORIZATION:
Prior authorization required for all new and continuation home oxygen requests, unless indicated in the table below.

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

<u>HOME OXYGEN THERAPY, PORTABLE SYSTEM</u>

		Prior Authorization Required	
Code	**Descriptor**	**SCO / One Care**	**Medicare Advantage**
E0431	Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	✓	✓
E0433	Portable liquid oxygen system, rental; home liquefier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge	✓ (See below)	✓ (See below)
E0435	Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor	✓	✓

E0443	Portable oxygen contents, gaseous, 1 month's supply = 1 unit	✓ (See below)	✓ (See below)
E0444	Portable oxygen contents, liquid, 1 month's supply = 1 unit	✓ (See below)	✓ (See below)
E1392	Portable Oxygen Concentrator	✓ (See below	✓ (See below
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	✓ (See below	✓ (See below

<u>HOME OXYGEN THERAPY, STATIONARY</u>

		Prior Authorization Required	
Code	**Descriptor**	**SCO / One Care**	**Medicare Advantage**
E0439	Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing	✓	✓
E0440	Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	✓	✓
E0441	Stationary oxygen contents, gaseous, 1 month's supply = 1 unit	✓ (See below)	✓ (See below)
E0442	Stationary oxygen contents, liquid, 1 month's supply = 1 unit	✓ (See below)	✓ (See below)
E1390	Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	✓ (See below)	✓ (See below)
E1391	Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each	✓ (See below	✓ (See below

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Effective 1/1/2023, the following modifications to Prior Authorization requirements will go into effect:

HCPCS Codes	Prior Authorization Not Required
E0433, E1390, E1391, E1392 and K0738	When combined with the MS modifier for maintenance and service, these codes do not require prior authorization.
E0441, E0442, E0443 and E0444	These codes used for content after the 36-month capped rental period is reached will no longer require a prior authorization
E0435, E0440	No prior authorization will be required

REGULATORY NOTES:

Medical Necessity Guidelines are published to provide a better understanding of the basis upon which coverage decisions are made. CCA makes coverage decisions on a case-by-case basis by considering the individual member's health care needs. If at any time an applicable CMS LCD or NCD or state-specific MNG is more expansive than the criteria set forth herein, the NCD, LCD, or state-specific MNG criteria shall supersede these criteria. This MNG references the specific regulations, coverage, limitations, service conditions, and/or prior authorization requirements in the following:

1. MassHealth Code of Massachusetts Regulations (CMR) 130 CMR 427 Oxygen and Respiratory Therapy Equipment.
2. Commonwealth of Massachusetts Medical Assistance Program Manual Series. Oxygen and Respiratory Therapy Manual. Transmittal letter OXY-20. Date 6/15/1997.
3. Local Coverage Determination (LCD) L33797. Noridian Healthcare Solutions, LLC. Oxygen and Oxygen Equipment. Original effective date 10/1/2015. Revision effective date 8/2/2020
4. National Coverage Determination (NCD) 240.2 Home Use of Oxygen. Effective Date 9/27/2021.
5. Local Coverage Article A52514 Oxygen and Oxygen Equipment. Noridian Healthcare Solutions, LLC. Original Effective Date 10/1/2015, Revision effective date 8/2/2020.

Disclaimer

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

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RELATED REFERENCES:

1. MassHealth Code of Massachusetts Regulations (CMR) 130 CMR 427 Oxygen and Respiratory Therapy Equipment Section 427.441; Clinical Requirements Introduction: https://www.mass.gov/regulations/130-CMR-42700-oxygen-and-respiratory-therapy-equipment.
2. Commonwealth of Massachusetts Medical Assistance Program Manual Series. Oxygen and Respiratory Therapy Manual. Transmittal letter OXY-20. Date 6/15/1997.
3. Local Coverage Determination (LCD) L33797. Noridian Healthcare Solutions, LLC. Oxygen and Oxygen Equipment. Original effective date 10/1/2015. Revision effective date 8/2/2020. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=169.
4. National Coverage Determination (NCD) 240.2 Home Use of Oxygen. Effective Date 9/27/2021. https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCDId=169.
5. Local Coverage Article A52514 Oxygen and Oxygen Equipment. Noridian Healthcare Solutions, LLC. Original Effective Date 10/1/2015, Revision effective date 8/2/2020. https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52514&ver=43.

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

REVISION LOG:

REVISION DATE	DESCRIPTION
7/7/2022	Template change. Revision to reflect product specific criteria.
10/6/2022	Updated to reflect 1/1/2023 changes in PA requirements. Clarified recertification requirement language.

APPROVALS:

Douglas Hsu, MPH, MD

CCA Senior Clinical Lead [Print]

Vice President, Medical Policy & Utilization Review

Title [Print]

Signature

2/3/2022

Date

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CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Lori Tishler, MD	Senior Vice President, Medical Services
CCA CMO or Designee [Print]	**Title [Print]**
Lori Tishler	2/3/2022
Signature	**Date**