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MEMORANDUM

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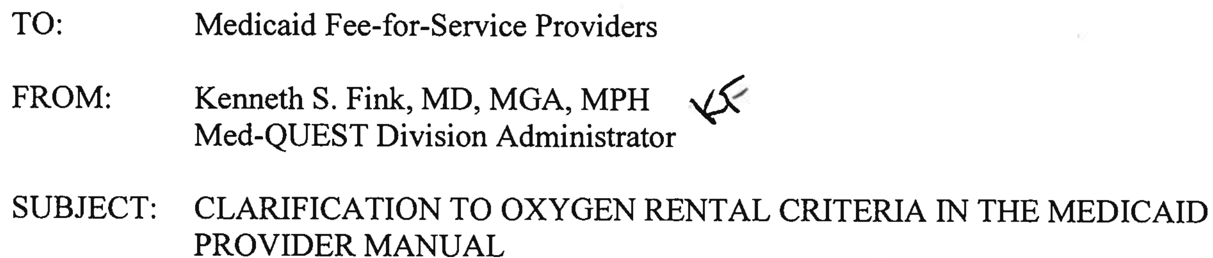

TO: Medicaid Fee-for-Service Providers

FROM: Kenneth S. Fink, MD, MGA, MPH
Med-QUEST Division Administrator

SUBJECT: CLARIFICATION TO OXYGEN RENTAL CRITERIA IN THE MEDICAID PROVIDER MANUAL

The Med-QUEST Division (MQD) has conducted an audit on oxygen utilization for calendar years 2007 and 2008. This was done to ensure that medical necessity was being met since oxygen rentals have historically been high and the prior authorization requirement was lifted in November 2007. Medicare criteria and guidelines were used for patients meeting Medicare's Group I and Group II categories.

Based on the results of the audit, the following will be additions and changes to the Medicaid Provider Manual for the fee-for-service clients. For QUEST and QUEST Expanded Access (QExA) clients, please contact the health plans for specifics regarding their oxygen rental criteria.

Ch. 10, Durable Medical Equipment, Prosthetic and Orthotic Devices, and Medical Supplies (DMEPOS)

10.5.5 Oxygen for Home Use and for Use in Nursing Facilities

- Medicaid follows Medicare criteria to justify medical necessity for oxygen for adults. (Please refer to the Medicare website for the most current Medicare criteria). The exception to this is in the retesting for oxygen levels. For continuation of oxygen, Medicaid requires **annual**

- arterial or oxygen saturation level testing. This differs from Medicare. Although Medicaid will accept oxygen levels which are documented on a Certificate of Medical Necessity (CMN), **annual** testing will still be required for dual eligibles (Medicare/Medicaid) and Medicaid only recipients.

- **Group II criteria** includes the presence of (a) an arterial PO2 of 56-59 mm Hg or an arterial blood oxygen saturation of 89% at rest (awake), during sleep for at least five (5) minutes, or during exercise; AND (b) any of the following:

  1. Dependent edema suggesting congestive heart failure, or
  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 3mm in standard leads II, III, or AVF), or
  3. Erythrocythemia with a hematocrit greater than 56%.

Initial coverage for patients meeting Group II criteria is limited to three (3) months or the physician specified length of need, whichever is shorter. When oxygen is covered based on an oxygen study obtained during exercise, there must be documentation of three (3) oxygen studies in the patient's medical record – i.e., testing at rest without oxygen, testing during exercise without oxygen, and testing during exercise with oxygen applied (to demonstrate the improvement of the hypoxemia). Results of the three (3) tests must be documented and/or available to the DMERC (Durable Medical Equipment Regional Contractor) or reviewer on request.

- **Testing** must be done by a physician or a Medicare certified/qualified laboratory. A supplier is not considered a qualified provider or qualified laboratory. Test results from oxygen testing by a DME supplier or anyone financially associated with or related to the DME supplier are not acceptable.

If you have any questions, please contact Lynette Kikuchi, R.N., Nurse Consultant, at 692-8072.