Priority Health	BILLING POLICY No. 082
OXYGEN AND OXYGEN SUPPLIES	
Effective date: Aug. 25, 2025 **Date of origin: Mar. 18, 2025**	**Review dates: 6/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

This policy identifies the payment and documentation requirements associated with oxygen and oxygen equipment.

MEDICAL POLICY

- Durable Medical Equipment (#91110)
- Pulse Oximetry for Home Use (#91452)

POLICY SPECIFIC INFORMATION

Reasonable Useful Lifetime (RUL)

The RUL for oxygen equipment is 5 years, starting from the initial date of service.

Rental period

Reimbursement for oxygen equipment is limited to 36 monthly rental payments. After 36 months, the supplier must continue to provide the equipment without additional payment for up to 60 months.

Equipment and accessories

- Accessories, such as, trans-tracheal catheters (A4608), cannulas (A4615), tubing (A4616), mouthpieces (A4617), face tent (A4619), masks (A4620, A7525), oxygen conserving devices (A9900), oxygen tent (E0455), humidifiers (E0555), nebulizer for humidification (E0580), regulators (E1353) and stand/rack (E1355) are included in the allowance for rented oxygen equipment. The supplier must provide any accessory ordered by the treating practitioner.
- Rented oxygen equipment is payable. Purchased oxygen equipment is non-covered.

Initial 36 Months: Includes payment for accessories, delivery, back-up equipment, maintenance and repairs.

A new 36-month rental period for oxygen equipment can begin if:

- Damage beyond repair
- Stolen or lost
- A break in the need for at least 60 days

Months 37-60: No further payment for equipment, but the supplier must continue to provide necessary items and services.

Months 61 and After: Members may elect to receive new equipment, starting a new 36-month rental period. If the member elects not to receive new equipment after the end of the 5-year reasonable useful lifetime and if the supplier retains title to the equipment, all elements of the payment policy for months 37-60 remain in effect. There is no separate payment for accessories or repairs. If the member was using gaseous or liquid oxygen equipment during the 36th rental month, payment can continue to be made for oxygen contents.

Oxygen contents

- Payment for stationary and portable contents is included in payment for stationary equipment. No payment can be made for oxygen contents in a month in which payment is made for stationary equipment.
- A maximum of 3 months of oxygen contents may be delivered at any one time.
- No more than 1 unit for stationary contents and/or 1 unit for portable contents per month are billable.

Place of service

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements

Modifiers

As indicated in our Durable Medical Equipment medical policy, the below modifiers will be required:

HCPCS modifiers

- **KX modifier**: Modifier should be appended to indicate that policy criteria has been met. Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ modifiers**: . See more information about this modifiers in our Provider Manual.
- Specific modifiers (N1, N2, N3, QA, QB, QE, QF, QG and QR) must be used based on the beneficiary's condition and oxygen requirements (Medicare)

Frequency limits

Capped rental devices should be billed with a date span that encompass the month being billed for the DME rental. The "from" date will identify the date the item was furnished to the member and the "to" date should reflect the last date of the date span for the item or supply. Accurately defining this date span will allow for accurate processing of the claim.

- Claims with dates of service that overlap will result in a denial
- Supplies that are billed for a date span should also follow the "From" / "To" date guidelines
- A Calendar Month is the period of duration from a day of one month to the corresponding day of the next month
- To receive separate reimbursement for bilateral items, appropriate laterality modifiers must be used. Up to one unit per side, with a maximum of two rental rates within the same calendar month. Modifiers RT and LT should be submitted on separate lines for the same HCPCS code.

Code	Limit
A4606	1 Per Year
A4614	1 Per Year
E0424, E0431, E0441, E0442, E0443, E0445	1 Per Month
E0455	1 Per 3 Months
E1356	1 Per Year
E1357	1 Per 3 Years
E1390	1 Per Month
E1405	10 Per Year with Modifier RR
E1406	10 Per Year with Modifier RR

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
June 19, 2025	Added “Frequency limits” section to outline limits that align with industry standards and limits set by CHAMPS