Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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CHANGE REQUEST 2041

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
4105 - 4105 (Cont.)	4-21 – 4-22 (2 pp.)	4-21 – 4-22 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: July 1, 2002

Section 4105, Evidence of Medical Necessity Oxygen Claims is being revised to remove information that conflicts with §9051, which provides an exception to oxygen testing requirements for beneficiaries who were previously enrolled in the Medicare + Choice program who transition to fee for service.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

Items and Services Having Special Review Considerations

4105. EVIDENCE OF MEDICAL NECESSITY OXYGEN CLAIMS

Oxygen coverage is determined by the results of an arterial blood gas or oximetry test. A CMN for oxygen equipment must include results of specific testing before coverage can be determined. (See CIM 60-4.)

Suppliers that bill electronically may transmit initial, revised, and recertification CMNs by electronic media using HCFA-established standard formats. In initial claims for home oxygen therapy, the electronic version of Form HCFA-484 must accompany the claim. Information transmitted from a revised or recertification Form HCFA-484 must accompany the first claim for monthly benefits submitted after the supplier has received the hard copy Form HCFA-484 from the certifying physician. If the supplier submits Form HCFA-484 information to you electronically, the supplier must keep the paper certification readily available so that it may be promptly furnished to you if requested for purposes of audits of medical necessity documentation.

Blood Oxygen Testing

The medical necessity of home oxygen is documented by the results of a blood oxygen test. The blood oxygen test may be either an arterial blood gas or an oximetry test. The following timeliness requirements must be met.

Initial Certification:

Groups I and II: Must be tested within 30 days prior to the date of initial certification. If the oxygen is begun immediately following discharge from an acute care facility, the test must be within two days prior to discharge.

There is an exception to this requirement for beneficiaries transitioning from a Medicare HMO/ managed care organization to traditional fee for service. See §9051 for more details.

Recertification:

Group I: Retesting requirements are to be determined by the contractor.

Group II: Must be retested between the 61^{st} – 90^{th} day after the date of the initial certification.

Revised Certifications

Group I and II: Must be tested within 30 days prior to the date of the revised certification if the initial certification specified a length of need that is less than lifetime.

Physician Evaluation

Initial Certification:

Groups I and II: Must be seen and evaluated by the treating physician within 30 days prior to the date of initial certification, unless the beneficiary is transitioning from a Medicare HMO to fee for service (see §9051).

Recertifications:

Group I and II: Must be seen and re-evaluated by the treating physician within 90 days prior to any recertification date.

A. Initial Certifications.--In reviewing the claim and the supporting Form HCFA-484, compare certain items, especially pertinent dates of treatment. For example, the start date of home oxygen coverage cannot precede the date of prescription or the date of the test(s) whose results establish that the special coverage criteria are met. Once coverage is established, the estimated length of need in Section B on the Form HCFA-484, and the circumstances and the results of testing that established the medical necessity at the start of home oxygen therapy, determines the recertification schedule. (See §4105C.)

Definitions of "Group" based on blood gas values (see CIM §60-4 for more detailed explanations and further qualifications of the following definitions):

Group I - An arterial PO_2 at or below 55 mm Hg, or arterial blood oxygen saturation at or below 88 percent.

Group II - An arterial PO_2 is 56 to 59 mm Hg or arterial blood oxygen saturation is 89 percent.

Group III - An arterial PO_2 at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90 percent.

When oxygen is prescribed in an institution, in order to establish medical necessity it is necessary that the institution would have to recheck the oxygen level no sooner than 2 days before discharge. Clinical documentation will be reviewed to confirm the fact that the prescribing of continued oxygen was based upon the "chronic stable state" (was done while the patient was in a chronic stable state - i.e., not during a period of acute illness or an exacerbation of the patient's underlying disease) of the patient.

Verify that the information shown on or accompanying the Form HCFA-484 supports the need for oxygen as billed.

When both arterial blood gas (ABG) and oxygen saturation (oximetry) tests have recently been performed on the same day, instruct suppliers to report only the ABG result. That test is generally acknowledged as the more reliable indicator of hypoxemia.

Test results from oximetry tests performed by a DME supplier, or anyone financially associated with or related to the DME supplier, are not acceptable.