Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1517

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents – Chapter IV	4-1 – 4-2 (2 pp.)	4-1 – 4-2 (2 pp.)
4105 – 4105 (cont.)	4-21 – 4-24 (4 pp.)	4-21 – 4-24.4 (8 pp.)

NEW/REVISED MATERIAL-- ***EFFECTIVE DATE: 4/1/01***
IMPLEMENTATION DATE: 4/1/01

Section 4105, Evidence of Medical Necessity Oxygen Claims, contains new information regarding recertification and retesting requirements.

Sections 4105.1, Home Use of DME, has been **deleted** and is currently located in the Program Integrity Manual (PIM) Chapter 5.

Section 4105.2, Evidence of Medical Necessity, has been **deleted** and is currently located in the Program Integrity Manual (PIM) Chapter 5.

Section 4105.3, Incurred Expenses for DME and Orthotic and Prosthetic Devices, has been **deleted** and is currently located in the Program Integrity Manual (PIM) Chapter 5.

Section 4105.4, Evidence of Medical Necessity Oxygen Claims, has been **deleted** and the information is now contained in §4105.

NOTE: Instructions will follow to implement systems changes.

NOTE: Effective April 1, 2001 this instruction supercedes transmittal 1685, Change Request 1135, dated November 17, 2000.

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.

CHAPTER IV

CLAIMS REVIEW AND ADJUDICATION PROCEDURES

Section

Line Review – Form HCFA-1490S

Line Review – Health Insurance Claim Form

Items and Services Having Special Review Considerations

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CLAIMS REVIEW AND ADJUDICATION PROCEDURES

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.

Recertification:

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

Group II: Must be retested between the 61st – 90th 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 Evalution

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

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.

Values in Group III establish a rebuttable presumption of non-coverage. The Form HCFA-484 certification must be supplemented by additional documentation from the treating physician designed to overcome this presumption and justify the oxygen order, including a summary of other, more conservative therapy that has not relieved the patient's condition. Refer a claim with such documentation to your medical director for the coverage determination.

Deny the following types of claims without further development:

- The claim where the only qualifying test results came from oximetry tests conducted by a supplier of DME other than a hospital;
- Claims lacking information necessary to justify coverage in accordance with guidelines in §60-4 of the Coverage Issues Manual;
- Hard copy claims where Form HCFA-484 lacks the treating physician's signature; or
- Electronic claims where Form HCFA-484 fails to indicate that the treating physician's handwritten signature is on file in the supplier's office.

An initial CMN is also required when there has been a break in medical necessity of 60 days plus whatever days remained in the rental month during which the oxygen was discontinued. (This indication does not apply if there was just a break in billing because the patient was in a hospital, nursing facility, hospice, or HMO, but the patient continued to use oxygen during that time.)

1. Medical Review.--Have your medical staff review all claims with initial certifications calling for oxygen flow rates of more than 4 liters per minute before payment is authorized.

2. Items Requiring Special Attention.--

a. Oxygen Delivery or Supply Prescribed.--If the treating physician has specified the oxygen equipment to be supplied, ensure that the equipment furnished is consistent with that prescribed.

b. Treating Physician Identification.--Ensure that the Form HCFA-484 has been signed by the treating physician. A stamped signature is unacceptable. The physician's identification number must be the Unique Physician Identification Number (UPIN).

B. Revised Certifications.--Encourage treating physicians to file timely, revised Form HCFA-484s through the supplier if their order for oxygen changes.

A revised CMN is necessary when:

1. The prescribed maximum flow rate changes from one of the following categories to another: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM. If the change is from category (a) or (b) to category (c), a repeat blood gas study with the beneficiary on 4 LPM must be performed within 30 days prior to the start of the greater than 4LPM flow.

2. Portable oxygen is added subsequent to initial certification of a stationary system. In this situation, there is no requirement for a repeat blood gas study unless the initial qualifying study was performed during sleep, in which case a repeat blood gas study must be performed while the patient is at rest (awake) or during exercise.

3. The intial certification specified an estimated length of need that is less than lifetime and the physician wants to extend the certification.

4. There is a new treating physician (no new testing is required).

Do not adjust payments on oxygen claims unless a revised certification documents the necessity for the change. Timely adjust payments, if necessary, for services since the oxygen prescription was changed.

C. Scheduling and Documenting Recertifications of Medical Necessity for Oxygen.--Recertification scheduling and documentation requirements depend on the date when home oxygen therapy began. Request the following information on all recertifications:

- Date and results of the most recent arterial blood gas or oximetry tests prior to the recertification date;

- Name of the provider conducting the most recent arterial blood gas or oximetry tests performed prior to the recertification date and the conditions under which this test were conducted; and

- Estimated length of need for oxygen (Section B on the Form HCFA-484).

Establish the schedule for recertifying the need for oxygen for patients beginning home oxygen therapy in accordance with the requirements below.

1. Recertifications.--

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

Group II: If oxygen test results on the initial certification were in Group II, according to §4152 of OBRA 1990, recertification of all oxygen patients must be performed within 90 days after initial certification for all patients who begin coverage after January 1, 1991, with an arterial blood gas result at or above a partial pressure of 55 mm Hg or an arterial oxygen saturation percentage at or above 89. Repeat blood gas study must be performed between the 61st - 90th day of home oxygen therapy. Retesting is required only if a claim for oxygen therapy will be filed for the fourth or later months.

If recertification is due, do not pay the next month's claim if the test was not performed during the required time frame. If a qualifying test is not obtained between the 61st and 90th day of home oxygen therapy, but the patient continues to use oxygen and a test is obtained at a later date, instruct suppliers to use the date of the repeat test as the date of service on a subsequent claim, and if that test meets Group II criteria, resume payments from that point of time.

2. New Orders.--In the following situation, a new order must be obtained and kept on file by the supplier, but neither a new CMN nor a repeat blood gas study are required:

- Prescribed maximum flow rate changes but remains within one of the following categories: (a) less than 1 LPM, (b) 1-4 LPM, (c) greater than 4 LPM;

- If the physician has initially specified a delivery system, and a change is made from one type of stationary system to another (i.e., concentrator, liquid, gaseous).