**Manuals**

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## Internet-Only Manuals (IOMs)

The Internet-only Manuals (IOMs) are a replica of the Agency's official record copy. They are CMS' program issuances, day-to-day operating instructions, policies, and procedures that are based on statutes, regulations, guidelines, models, and directives. The CMS program components, providers, contractors, Medicare Advantage organizations and state survey agencies use the IOMs to administer CMS programs. They are also a good source of Medicare and Medicaid information for the general public.

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- Supplies were provided prior to onset date of therapy; and
- Stamped physician's signature.

Unassigned claims are developed for missing or incomplete information.

**A. Revised Certifications/Change in Prescription**

A revised certification is required when:

- There is a change in the attending physician's orders in the category of nutrients and/or calories prescribed;
- There is a change by more than one liter in the daily volume of parenteral solutions;
- There is a change from home-mix to pre-mix or pre-mix to home-mix parenteral solutions;
- There is a change from enteral to parenteral or parenteral to enteral therapy; or
- There is a change in the method of infusion (e.g., from gravity-fed to pump-fed).

The PEN payments are not adjusted unless a revised or renewed certification documents the necessity for the change. Payment levels for the most current certification or recertification may not be changed unless a prescription change is documented by a new recertification.

The DMERC may adjust the recertification schedule as needed.

## 100.2.3 - Evidence of Medical Necessity for Oxygen

**(Rev. 1, 10-01-03)**

**B3-4105**

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.

Suppliers that bill electronically may transmit initial, revised, and recertification CMNs by electronic media using CMS-established standard formats. Information transmitted from a revised or recertification Form CMS-484 must accompany the first claim for monthly benefits submitted after the supplier has received the hard copy Form CMS-484 from the certifying physician. If the supplier submits Form CMS-484 information to the contractor electronically, the supplier must keep the paper certification readily available so that it may be promptly furnished to the contractor 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 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

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 data, contractors 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 CMS-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.

Definitions of "Group" based on blood gas values:

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.

Contractors verify that the information shown on or accompanying the Form CMS-484 or other CMN 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, suppliers 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 CMN 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. Claims with such documentation are referred to the contractor's medical director for the coverage determination.

The following types of claims are denied without further development:

- Claims where the only qualifying test results came from oximetry tests conducted by a DME suppliers other than a hospital;
- Claims lacking information necessary to justify coverage;
- Hard copy claims where the CMN or Form CMS-484 lacks the treating physician's signature; or
- Electronic claims where the CMN or Form CMS-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.)

**B. Revised Certifications**

Contractors encourage treating physicians to file timely, revised CMNs or Form CMS-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 initial 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).

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

## 100.2.3.1 - Scheduling and Documenting Recertifications of Medical Necessity for Oxygen

**(Rev. 1, 10-01-03)**

Recertification scheduling and documentation requirements depend on the date when home oxygen therapy began. Contractors 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 CMS-484).

Contractors 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 §1834(a)(5) of the Act, 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 61$^{st}$ - 90$^{th}$ 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, contractors 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, contractors 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, they resume payments from that point of time.

**2. New Orders - In the following situations, 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:**

- If the 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).
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## 100.2.3.2 - HHA Recertification for Home Oxygen Therapy

**(Rev. 1472, Issued: 03-06-08, Effective: 05-23-07, Implementation: 04-07-08)**

Section 1834(a)(5) of the Act requires patients who receive home oxygen therapy and who at the time such services are initiated have an initial arterial blood gas value of 56 or higher or an initial oxygen saturation at or above 89 percent to be retested between 60 and 90 days after the start of oxygen therapy in order to continue to receive payment. HHAs must initiate the request for the retesting as promptly as possible because the recertification at three months must reflect the results of an arterial blood gas or oxygen saturation test conducted between the 61st and 90th day of home oxygen therapy. Payment for the fourth month of home oxygen therapy is possible only if the patient's attending physician certifies that retesting results establish the continuing medical necessity for the services. The physician must certify based on the test of the patient's

arterial blood gas value or oxygen saturation that there is a medical need for the patient to continue to receive oxygen therapy.

Value codes have been assigned for HHA reporting of the arterial blood gas and oxygen saturation. HHAs report value code 58 or 59 on every initial bill for home oxygen therapy and on the fourth month's bill. Information regarding the form locator numbers that correspond to value codes and a table to crosswalk UB-04 form locators to the 837 transaction is found in Chapter 25.

For patients receiving oxygen therapy, who are not under a plan of care (bill type 34X), HHAs obtain a physicians recertification of the retesting and maintain a copy in their files for verification.

For patients receiving oxygen therapy, who are under a plan of care (bill types 32X and 33X), HHAs obtain a physician's recertification of the retesting and reflect this on Form CMS-485 or CMS-486 for verification.

RHHIs do not continue to make payment where the HHA fails to have the patient retested to determine continuing need of oxygen therapy within the specified time frames.

## 100.2.3.3 - Contractor Review of Oxygen Certifications

**(Rev. 1, 10-01-03)**

All claims with initial certifications calling for oxygen flow rates of more than 4 liters per minute must be reviewed before payment is authorized.

Items Requiring Special Attention -

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

b. Treating Physician Identification - Contractors must ensure that the CMN or Form CMS-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).

## 100.3 - Limitations on DMERC Collection of Information

**(Rev. 1, 10-01-03)**

**B-02-031**

The Paperwork Reduction Act (PRA) of 1995 §44 USC 3500, et seq. requires that the Director of the Office of Management and Budget approve any collections of information performed by or for the Federal Government unless the collection fits within exceptions for audits and investigations. Absent such approval, the collection violates the PRA and