

CHAPTER 4: PROVIDER RESPONSIBILITIES AND GUIDELINES

UNIT 4: ANCILLARY PROVIDERS

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[What Is My Service Area?](#)

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**



The PA ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.



The DE ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.



The WV ONLY symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

4.4 INTRODUCTION

Overview

An ancillary provider is a supplier of health care related equipment or services, such as durable medical equipment, prosthetics, orthotics, drugs, medical supplies, and diagnostic services.

To supplement the professional provider and facility networks, Highmark contracts with a network of ancillary providers. These include freestanding and facility-based providers in the specialties including, but not limited to:

- Durable medical equipment
- Orthotics/prosthetics
- Home infusion
- Ambulance
- Independent laboratories

Because the services and supplies provided by ancillary providers addressed in this unit bill in the professional 1500/837P format, this unit is labeled as for professional providers.

In this unit

This unit provides information and guidelines for providers of durable medical equipment and supplies, orthotics, prosthetics, and home infusion.

For diagnostic services, please see [Chapter 4.5: Outpatient Radiology and Laboratory](#).

Network participation

For information on applying to participate in Highmark's facility and ancillary networks, please see [Chapter 3.4: Organizational Provider Participation](#).

4.4 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM

Overview

Under the Durable Medical Equipment (DME)/Respiratory Supplies Management Program, specific DME and supply items require authorization. Managed care plans typically require authorization -- PPO, EPO, HMO, IPA, POS, including Medicare Advantage PPO and HMO plans. However, benefits can vary and certain employer groups may choose to opt out of this requirement; **always confirm DME authorization requirements under the member's coverage.** You can use the NaviNet® *Eligibility and Benefit Inquiry* transaction or the applicable HIPAA electronic transaction for benefit verification.

Highmark is responsible for claims processing, utilization management, and authorization functions for DME, prosthetics, orthotics, and supplies provided to Highmark members. However, some groups, such as the Pennsylvania Employees Benefit Trust Fund (PEBTF), contract with DMEnson Benefit Management Inc. for management of DME services for their members. Please verify benefits via NaviNet for a member's specific coverage.

DME requiring authorization

Highmark maintains a **List of Procedures/DME Requiring Authorization**. This list is available on the Provider Resource Center. To access the list quickly, select **REQUIRING AUTHORIZATION** from the **Quicklinks Bar**.

The list is also available by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu on the Provider Resource Center, and then **Procedures/Service Requiring Prior Authorization**.

The authorization process for DME and supplies furnished through a stand-alone, Highmark participating ancillary DME supplier for the items on the list is managed by Highmark's Clinical Services. Ordering physicians may initiate authorization requests. In Pennsylvania, DME vendors may also initiate authorization requests (after obtaining a physician order). NaviNet-enabled providers must submit the authorization request via NaviNet.

IMPORTANT!

DME that does not require authorization simply requires a prescription written by the ordering physician.

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4.4 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM,

Continued

[What Is My Service Area?](#)

Medicare Advantage



For Medicare Advantage members in Pennsylvania and West Virginia, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims that do not require authorization will process according to indications and limitations of Medicare Advantage Medical Policy. **Items and services that are not considered to be medically necessary may not be billed to Medicare Advantage members without a *Notice of Denial of Medical Coverage from Highmark* (obtained through a preservice organization determination).**

For information on preservice organization determinations for Medicare Advantage, please see [Chapter 5.3: Medicare Advantage Procedures](#).

Claim submission

Electronic claims submission is the preferred, most efficient, and most cost-effective method of submitting claims. If you are not yet submitting claims to Highmark electronically, visit the **Electronic Data Interchange (EDI) Services** website, which can be accessed by selecting **CLAIMS, PAYMENT & REIMBURSEMENT** on the Provider Resource Center. Or call EDI Operations toll-free at **1-800-992-0246**, Monday through Friday, 8 a.m. to 5 p.m. EST.

You can also submit claims electronically through NaviNet's HIPAA- approved claims submission transaction – just select **Claim Submission** from Highmark Plan Central. Once your claims are submitted to Highmark, whether through NaviNet or a HIPAA 837 electronic transaction, you are able to view the claim status and perform claim investigations in NaviNet.

DMEPOS refills

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the member or caregiver/designee prior to dispensing refills. Highmark does not support or endorse auto-shipping; if the member is enrolled in or gives approval for auto-shipment of their supplies, **the provider should not automatically ship the item(s)**. This is to ensure that the refilled item remains medically necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order.

A refill request must be obtained from a member prior to delivery of any refill items. Refill requests are to be obtained on a monthly basis; refill requests for supplies should not extend beyond thirty (30) calendar days. The member's refill request, including date of request and supplies requested, must be documented in the provider's records and provided to Highmark upon request.

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4.4 DME/RESPIRATORY SUPPLIES MANAGEMENT PROGRAM,

Continued

Documentation of trial/rental period on CMN/LMN

If a certificate of Medical Necessity (CMN) or Letter of Medical Necessity (LMN) indicates that a required trial/rental period for a DME item has occurred in the office, the provider must document the dates in which the trial occurred on the CMN/LMN.

If the dates of the in-office trial/rental are not indicated, the DME company is required to proceed as if the trial did not occur and must fulfill the trial/rental period prior to purchase.

OBSOLETE

4.4 AUTHORIZING DURABLE MEDICAL EQUIPMENT

Process

The steps listed below describe the process to obtain authorization for durable medical equipment, prosthetics, orthotics, and respiratory supplies. Ordering physicians may initiate the authorization request. In Pennsylvania, DME vendors may also initiate authorization requests (after obtaining a physician order).

This process applies to PPO, EPO, HMO, IPA, POS, and PPO Plus plans (including Medicare Advantage HMO and PPO plans in Pennsylvania and West Virginia).

STEP	ACTION
1	The requesting provider determines whether the request must be authorized by Highmark's Clinical Services. Please gather all pertinent information, including a Certificate of Medical Necessity (CMN) if required, prior to submitting the request.
2	If required, the requesting provider submits the request for authorization to Clinical Services through one of the following methods: <ul style="list-style-type: none"> • If NaviNet®-enabled, the request must be submitted via NaviNet. • For those practices not yet NaviNet-enabled, fax an authorization request form to 1-412-544-2921 or 1-888-236-6321.
3	Clinical Services will review the request. <ul style="list-style-type: none"> • If benefits are not available, go to Step 4. • If medical appropriateness cannot be determined, go to Step 5. • If the request meets criteria, Clinical Services will approve the authorization request and notify the requester.
4	If benefits are not available for the requested item or service, Clinical Services will deny the authorization request and notify the requesting provider. A denial letter from Highmark will be sent to the ordering physician, vendor, and the member. Information regarding appeal/complaint rights will be detailed in the denial letter.
5	If medical appropriateness cannot be determined from the documentation provided, Clinical Services will contact the requesting provider for additional information. This information must be returned to Clinical Services in a timely manner, preferably within forty-eight (48) hours, as regulatory time frames must be met. Proceed to Step 6.
6	<ul style="list-style-type: none"> • If medical necessity cannot be determined, the authorization request is pended and sent to a Highmark physician reviewer for review. Proceed to Step 7. • If the documentation substantiates the request, the service will be approved and the requesting provider will be notified.

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4.4 AUTHORIZING DURABLE MEDICAL EQUIPMENT, Continued

Process (continued)

STEP	ACTION	
7	If the Highmark physician reviewer determines that the authorization:	
	Is medically appropriate. . .	Is not medically appropriate. . .
	Clinical Services will approve the pended authorization request and notify the requester.	A physician will deny the pended request and send a denial letter to the ordering physician, vendor, and the member. A Clinical Services care manager will inform the requester of the denial.

OBSOLETE

4.4 SELECT DME NETWORK (PA ONLY)

Overview



To provide high-quality, cost-effective options to Highmark members in Pennsylvania, Highmark has contracted with certain durable medical equipment (DME) providers to form the Select DME Network. The more efficient, lower-cost network will provide a better value for Highmark members' health care dollars.

Highmark has carefully evaluated and selected providers for the Select DME Network to ensure that all counties in Pennsylvania have adequate coverage to meet members' needs. Additionally, there are several Select DME Network providers that provide DME on a national scale and are able to serve all counties in Pennsylvania.

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Select DME Network effective January 1, 2017



Effective January 1, 2017, the Select DME Network will be the exclusive network for all Highmark Medicare Advantage plans in Pennsylvania. For coverage of eligible DME services or supplies, Medicare Advantage members must obtain the services or supplies from a provider participating in the Select DME Network.

For Highmark commercial benefit plans, the Select DME Network applies to the highest tier level of Pennsylvania tiered health plans. For example, for a 3-tiered plan such as Connect Blue in western Pennsylvania, the Select DME Network applies to the Preferred tier level. In a two-tiered plan such as Community Blue Flex, Community Blue Premier Flex, and Alliance Flex Blue, the Select DME Network applies to the Enhanced tier level. Highmark commercial members with tiered plans have the option of choosing other DME participating providers not in the Select DME Network; however, receiving services or supplies from non-Select DME Network providers may result in higher out-of-pocket costs for members.

FOR MORE INFORMATION



Highmark provides two versions of the current list of providers in the Select DME Network. You can select a list of [all participating providers](#) or a list [organized by category](#), which includes telephone numbers. These lists of providers in the Select DME Network are also available on the Provider Resource Center. Select **HIGH PERFORMANCE NETWORKS** from the main menu on the left, and then **Select DME Network**.

Select DME Network providers can be contacted directly if you have any questions about the products or services they provide.

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4.4 SELECT DME NETWORK (PA ONLY), Continued

**Referring
Highmark
members to
DME providers**



Providers should refer their Highmark Medicare Advantage patients to Select DME Network providers for their DME equipment and supplies. Receiving services from non-Select DME Network providers would result in higher out-of-pocket costs for the member.

Highmark commercial members can continue to use providers from the broader DME network; however, you should refer Highmark commercial members to Select DME Network providers to receive the highest level of benefits possible.

OBSOLETE

4.4 BILLING FOR DMEPOS PROVIDED TO MEMBERS REGISTERED AS INPATIENTS OR OUTPATIENTS AT A FACILITY

Overview Providers who supply durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) to Highmark members when they are registered as inpatients or outpatients at a Highmark-contracted facility may bill Highmark for a very limited scope of equipment and supplies.

Billing guidelines If a Highmark member is registered as an inpatient or outpatient of a hospital or skilled nursing facility (SNF), DMEPOS providers may bill Highmark for equipment or supplies provided to the member **ONLY** when one of the following apply:

- The equipment or supplies require approval and authorization by Highmark's Clinical Services.
- The equipment or supplies are customized specifically for the individual member's use in the home setting (e.g., customized power wheelchairs, customized splints or braces provided to the member for use in the home).

For any other DMEPOS supplies or equipment furnished to members who are registered as inpatients or outpatients of a facility, it is the responsibility of the Highmark-contracted hospital or SNF to provide the supplies or equipment and to seek payment from Highmark, as appropriate. Other DMEPOS supplies or equipment include, but are not limited to, items such as crutches, walkers, canes, and soft goods.

These requirements apply to all Highmark products, including Medicare Advantage HMO and PPO products available in Pennsylvania.

Exceptions for Medicare Advantage members residing in SNFs

These requirements do not apply in the case of DMEPOS items provided to Medicare Advantage HMO or PPO members residing in a SNF who have exhausted their 100-day skilled nursing benefit or are receiving a non-skilled level of care.

Under these circumstances, the billing process should be treated as if the member is living in his or her own residence. Therefore, the DMEPOS provider would bill the claim to Highmark.



[What Is My Service Area?](#)

4.4 PAP DEVICE PROGRAM

Introduction

Highmark is committed to providing our members with access to high quality health care. To meet that commitment, we are building partnerships with providers and developing innovative programs that encourage improvement in quality of care. These programs reward those providers who achieve high levels of performance.

Highmark has been evaluating reimbursement of ancillary services in order to build programs based on quality and value. As a result, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Program was developed. The goal of the DMEPOS Quality Program is to positively impact four areas of patient care: quality, access, patient experience, and cost.

Highmark expects to see improved medical outcomes for our members through measuring performance, monitoring quality of care, and defining best practices while also managing rising health care costs for our members and employer groups. The PAP Device Program is summarized below. The DMEPOS Quality Program will be expanded over time to include additional incentive programs for other DMEPOS product categories.

PAP Device Program

Suppliers participating in the PAP Device Program are eligible to receive enhanced reimbursement for their efforts to help improve member compliance when using positive airway pressure (PAP) devices.

Under the PAP Device Program, participating suppliers are required to monitor and measure device usage compliance for members to whom they supply continuous positive airway pressure (CPAP) devices, respiratory assist devices (RADs), and/or accessories for those devices. Participating suppliers who meet program requirements and compliance criteria will be reimbursed at a higher rate than those who do not satisfy the requirements.

All Highmark commercial network participating suppliers who provide members with PAP devices and/or accessories for PAP devices are eligible to participate in the program.

FOR MORE INFORMATION

To learn more about program participation and requirements, please visit the Provider Resource Center. Select **CLAIMS, PAYMENT & REIMBURSEMENT** from the main menu, and then click on **PAP Device Program**.

4.4 HOME INFUSION THERAPY GUIDELINES

Overview

Home infusion therapy (HIT) is the administration of medically necessary fluids or drugs through a central line or peripheral vein to Highmark members in their homes or places of residence.

Drug therapies commonly administered by infusion include antibiotics, chemotherapy, pain management, and parenteral nutrition.

Here are examples of certain conditions that commonly require infusion therapy:

- Infections that are unresponsive to oral antibiotics
- Cancer and cancer-related pain
- Gastrointestinal diseases or disorders that prevent normal functioning of the gastrointestinal system
- Immune disorders

Home nursing services are also provided to ensure proper patient education and training and to monitor the care of the patient in the home.

Provider guidelines

Home infusion therapy providers must possess a current pharmacy license from the state in which they provide services. They must also maintain accreditation from one of the following: The Joint Commission (formerly the Joint Commission on Accreditation of Healthcare Organizations); Accreditation Commission for Health Care, Inc.; Community Health Accreditation Program, Inc.; The Compliance Team, Inc.; or Healthcare Quality Association on Accreditation.

Provider agree to submit claims to Highmark for all Highmark members (must use best efforts to submit claims electronically). Providers also agree to accept Highmark's payment for covered services they perform. The provider will not charge the member for covered services the provider has agreed to provide except for applicable copayment, coinsurance, and deductible amounts.

In Pennsylvania, the provider agrees to provide:

- Dedicated customer service personnel
 - A toll-free telephone number
 - Twenty-four hour availability for service and delivery
 - Twenty-four hour turnaround time to accept patient to service except for customized, specialized, or significantly customer specific product
-

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4.4 HOME INFUSION THERAPY GUIDELINES, Continued

Nursing services for home infusion therapy

Per diem rates are all-inclusive rates for medically necessary services. They include all ancillary services and supplies (e.g., durable medical equipment or supplies as needed, educational materials, basic solutions, administrative supplies, and the defined nursing hour increment).

Daily maintenance and a flush kit are integral components to the per diem allowance regardless of the mode of access. Since daily maintenance and flush kits were considered in the development of the fee schedule, Highmark will not provide separate payment for these services.

Multiple infusion therapies

Multiple infusion therapies apply to patients who require multiple concurrent infusion treatments including, but not limited to, multiple antibiotics, hydration, chemotherapy, and enteral feeding therapy. Highmark will not reimburse separately for each therapy. Instead, the provider must bill and will be reimbursed for the most costly per diem that applies plus the drug(s) administered.

When billing for multiple therapies on the same claim, bill only for the most costly procedure. Do not report zero dollar charges for the remaining therapies.

Exception: The only exception to this is aerosolized AIDS drug therapy. It is the only therapy that must be billed in conjunction with another mode of home IV therapy administration. It is also the only drug therapy that, while provided as part of a multiple-therapy treatment, can be billed as a separate service. Use procedure code S9061 to report aerosolized AIDS drug therapy.

Billing and reimbursement for drugs administered

Follow these guidelines when reporting drugs administered by home infusion therapy:

- If the patient administers the drugs, and the home infusion provider provides the drugs but no nursing services, bill for the supplies or drugs but not a per diem nursing visit.
- Report the correct procedure code according to the date of service and the effective date of your contract.
- When billing for drugs administered through home therapy infusion, bill the amount of drug based on the smallest available commercial size.
- Drug claims billed under Highmark medical benefits **require** the submission of National Drug Code (NDC) information. Please see the [List of Procedures Requiring NDC Information](#). This list is also available under **CLAIMS, PAYMENT & REIMBURSEMENT** on the Provider Resource Center.

4.4 DME SUPPLIES PROVIDED IN A PHYSICIAN'S OFFICE FOR MEDICARE ADVANTAGE (PA ONLY)

Overview



Highmark has always maintained a list of durable medical equipment (DME), prosthetics, orthotics, and supplies incidental to a physician or facility that can be furnished to members for their convenience in the physician office setting. **This list applies only to Medicare Advantage products with DME benefits.**

The list includes minor DME items, prosthetics, orthotics, and supplies incidental to a physician or facility that can be furnished to members for their convenience in the physician office setting.

These items do not require authorization and can be billed to Highmark for reimbursement at fee-for-service. Member cost-sharing may apply.

Physician Office DME Supply List for Medicare Advantage



For the complete list of DME, prosthetics, orthotics, and supplies that can be provided to Medicare Advantage members in the physician's office, [click here](#).

Note: For items not on this list, please direct members with Medicare Advantage HMO and Freedom Blue PPO to a participating network vendor.

[What is My Service Area?](#)

IMPORTANT! Always verify benefits



Please verify the member's benefits through NaviNet® prior to providing any of these items. Member cost-sharing in the form of deductible or coinsurance may apply to DME and supplies under the member's Medicare Advantage plan.

4.4 MEDICARE ADVANTAGE GUIDELINES FOR DMEPOS UPGRADES

Overview



Generally, upgrades to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are defined as items that go beyond what is medically necessary. An upgrade may be from one Healthcare Common Procedure Coding System (HCPCS) code to another HCPCS code, or it may be from one item to another within the same HCPCS.

The payment for an item must be consistent with what is considered reasonable and medically necessary to serve the intended purpose. In cases where an item is considered to be medically necessary and covered, and a member wishes to obtain an item with upgraded features, payment is based on the allowance for the item normally used for the intended purpose.

[What is My Service Area?](#)

Claim submission and reimbursement



Highmark requires providers to bill these services as they do for Medicare fee-for-service beneficiaries. The items should be billed as two (2) separate line items, one for the upgraded item and one for the standard item.

If it is determined that the upgrade was not medically necessary, payment is made on the standard item and the line item for the upgraded item will be denied. Liability will be set based on which modifiers were billed on the line.

OBSOLETE

4.4 MEDICARE ADVANTAGE CAPPED RENTALS

Overview



Highmark adopted the Centers for Medicare & Medicaid Services (CMS) payment methodology on capped rental items for all Medicare Advantage products. These items are denoted as payment class “CR” (Capped Rental) on the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule.

Under the CMS payment methodology, items denoted as payment class CR are paid for as rentals only. Generally, they cannot be purchased upfront, except in certain situations (e.g., electric wheelchairs meeting certain criteria). Upon reaching the final monthly payment on items and services in this category, ownership will transfer to the member.

Note: Claims for rental items not designated as CR will continue to be paid at the monthly allowable fee until the purchase price is met at which time ownership of the item will transfer to the Highmark patient.

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Payment methodology and required modifiers for capped rentals



The following chart outlines the payment schedule and required modifiers for capped rental items for Medicare Advantage:

SCHEDULE	PAYMENT	REQUIRED MODIFIER
Month 1	10% of purchase price paid	KH
Months 2-3	10% of purchase price paid	KI
Months 4-13 (4-15 for PEN pumps)	7.5% of purchase price paid	KJ

Exception: Power wheelchairs pay at 15% for months 1-3 and 6% for months 4-13. Modifiers are the same as above.

[Why blue italics?](#)

List of capped rental items

TIP SHEET



For a complete list of procedure codes for DMEPOS items that fall into this capped rental classification, click on the link in the Tip Sheet icon to the left.

This list is also available in the manual's **Tip Sheet Index**, which can be accessed from **ADDITIONAL RESOURCES** at the bottom of the Highmark Provider Manual's home page.

4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY

Introduction



Medicare Advantage HMO and PPO products provide coverage for medically necessary home oxygen therapy and the equipment necessary for the safe, effective delivery of that therapy.

[What Is My Service Area?](#)

Oxygen equipment limited to 36-month rental period



Reimbursement for oxygen equipment is limited to thirty-six (36) monthly rental payments to mirror the Centers for Medicare & Medicaid (CMS) payment methodology.

Payment for accessories (e.g., cannula, tubing, etc.), delivery, back-up equipment, maintenance, and repairs will be included in the rental allowance. Payment for oxygen contents (stationary and/or portable) will also be included in the allowance for stationary equipment (E0424, E0439, E1390, E1391).

After the 36-month rental period ends, according to CMS policy, Highmark will pay for oxygen contents monthly and for maintenance once every six (6) months. Ownership of the oxygen delivery equipment will remain with the equipment supplier.

Supplier responsibilities



The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment, and all related items and services, through the 36-month rental period unless one of the following exceptions is met:

- The beneficiary relocates temporarily or permanently outside of the supplier's service area;
- The beneficiary elects to obtain oxygen from a different supplier; or
- Highmark makes individual case exceptions.

Providing different oxygen equipment/modalities (e.g., concentrator [stationary or portable], gaseous, liquid, transfilling equipment) is not permitted unless one of the following requirements is met:

- The supplier replaces the equipment with the same or equivalent item;
- The physician orders different equipment;
- The member chooses to receive an upgrade and signs a *Pre-Service Denial Notice*; or
- Highmark determines that a change in equipment is warranted.

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4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

Reasonable useful lifetime (RUL)



After thirty-six (36) rental payments have been made, there will be no further payment for oxygen equipment during the 5-year reasonable useful lifetime (RUL) of the equipment. The RUL is not based on the chronological age of the equipment. It starts on the initial date of service and runs for five (5) years from that date.

If use of portable equipment (E0431, E0433, E0434, E1392, K0738) begins after the use of stationary equipment begins, payment for the portable equipment can continue after payment for the stationary equipment ends until thirty-six (36) rental payments have been made for the portable equipment.

The supplier who provided the equipment during the thirty-sixth rental month is required to continue to provide the equipment, accessories, contents (if applicable), maintenance, and repair of the oxygen equipment during the 5-year RUL of the equipment.

Any time after the end of the 5-year RUL period for oxygen equipment, the beneficiary may elect to receive new equipment, thus beginning a new 36-month rental period.

[What Is My Service Area?](#)

Payment for oxygen content



Payment for stationary and portable contents is included in the fee schedule allowance for stationary equipment. **No payment can be made for oxygen contents in a month in which payment is made for stationary equipment.**

If the patient was using stationary gaseous or liquid oxygen equipment during the thirty-sixth rental month, payment for stationary contents (E0441 or E0442) begins when the rental period for the stationary equipment ends.

Conditions for which coverage is available



Home oxygen therapy coverage is available for rented, not purchased, oxygen equipment for members with significant hypoxemia in the chronic stable state provided all of the following conditions are met:

1. The attending or consulting physician has determined that the patient suffers a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
2. The patient's blood gas levels indicate the need for oxygen therapy.
3. Alternative treatment measures have been tried or considered and have been deemed clinically ineffective.

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4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

Conditions for which coverage is not available



Coverage for oxygen therapy for Medicare Advantage members is not available for the following conditions:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased PO₂ will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Portable oxygen systems



Coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home. When submitting an authorization request, please check both the “portable” box and the “stationary” box.

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Spare tanks or emergency inhalators



Spare tanks of oxygen or emergency oxygen inhalators are considered not medically necessary since these items are precautionary and not therapeutic in nature.

Blood oxygen determinations



Initial orders for oxygen therapy must also include the results of a blood gas study, usually a measurement of the partial pressure of oxygen (PO₂) in arterial blood. **The study must be performed within thirty (30) days before the date of service.**

The study should be performed under one of the following circumstances:

- Ordered and evaluated by the attending or consulting physician.
- Ordered and evaluated by the attending physician and performed under his or her supervision.
- Performed by a qualified provider of laboratory services.

Note: Highmark does not consider suppliers as qualified to perform blood gas studies and will not pay for a qualifying blood gas study if performed by a supplier.

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4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

Conditions of blood gas studies



The conditions under which the blood gas study was performed must be specified in writing and submitted on the *Certificate of Medical Necessity* (CMN) form. Examples of this documentation may include: at rest, while sleeping, while exercising, on room air, on oxygen, etc.

Note: If the study is performed while the patient is receiving oxygen, indicate the amount, body position during testing, and any additional information required for interpretation.

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Blood gas level criteria



The table below describes three groups of blood gas levels for which coverage is provided.

GROUP	BLOOD GAS LEVEL CRITERIA
<p>GROUP 1: Medically necessary</p>	<p>Arterial PO₂ is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken at rest. OR Arterial PO₂ is at or below 55 mm Hg, or arterial oxygen saturation is at or below 88% taken during sleep for a patient who demonstrates arterial PO₂ at or above 56 mm Hg or arterial oxygen saturation at or above 89% while awake. OR A greater than normal fall in oxygen level during sleep (arterial PO₂ decreases more than 10 mm Hg, or arterial oxygen saturation decreases more than 5%) associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension, and erythrocytosis). OR Arterial PO₂ is at or below 55 mm Hg or arterial oxygen saturation at or below 88%, taken during activity for a patient who demonstrates arterial PO₂ at or above 56 mm Hg or arterial oxygen saturation at or above 89%, during the day while at rest. In this case, supplemental oxygen is provided during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.</p>

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4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

Blood gas level criteria (continued)



GROUP 2: Medically necessary	Arterial PO ₂ is 56 to 59 mm Hg or arterial blood oxygen saturation is 89% if any of the following are documented: <ul style="list-style-type: none"> • Dependent edema suggesting congestive heart failure • Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or “P” pulmonale of EKG (P wave is greater than 3 mm in Standard Leads II, III, or AVF) • Erythrocythemia with a hematocrit greater than 56%
GROUP 3: Not medically necessary	Home use of oxygen is not medically necessary for members with PO ₂ levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90%.

Additional studies



Retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity when a patient’s initial certification for oxygen is approved based on one of the following criteria:

- Arterial PO₂ was 56 mm Hg or greater
- Oxygen saturation was 89% or greater

[What Is My Service Area?](#)

Certificate of Medical Necessity (CMN)



A *Certificate of Medical Necessity* (CMN) form for home oxygen is necessary for the following:

- Initial certification
- Recertification
- Changes in the oxygen prescription

The CMN must be completed, signed, and dated by the ordering physician.

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4.4 MEDICARE ADVANTAGE HOME OXYGEN THERAPY, Continued

Obtaining authorization



Highmark's Clinical Services must authorize all home oxygen therapy for Medicare Advantage members. Follow the steps listed below to obtain authorization:

STEP	ACTION
1	<p>If NaviNet®-enabled, the vendor or physician must enter an authorization request for oxygen into NaviNet.</p> <p>A Certificate of Medical Necessity (CMN) must be completed for the situations indicated above.</p> <p>If not NaviNet-enabled, the vendor or physician should fax a CMN form to Clinical Services at 412-544-2921 or 1-888-236-6321.</p>
2	If a required CMN form has not been submitted, Clinical Services will contact the provider and request that one be completed.
3	Once all information has been received, the DMEPOS authorization process will be followed (as detailed on Pages 7-8 of this unit).

Recertification



Recertification must include the results of a recently performed arterial blood gas (ABG) or oximetry test; and it is required one to three months after initial certification under the following circumstances:

- If the patient's arterial PO₂ was 56 mm HG or greater at the initial certification.
- If the patient's oxygen saturation was 89% or greater at the initial certification.
- If the physician initially estimated that oxygen was needed for one to three months.

Note: Once recertification establishes medical necessity for continued therapy, subsequent recertification is not required except when there is a change in the oxygen prescription or the attending physician.

[What Is My Service Area?](#)

4.4 DIABETIC TESTING DEVICES FOR MEDICARE ADVANTAGE MEMBERS

Overview



Medicare Advantage HMO and PPO products provide coverage for medically necessary diabetic testing devices including glucometers, test strips, and lancets under the durable medical equipment (DME) benefit. Insulin pens and insulin pumps are also covered under the DME benefit.

Insulin and syringes will not be covered as DME, but will be covered under the Medicare Part D Prescription Drug Benefit.

[What Is My Service Area?](#)

Purchasing diabetic testing devices



Members are able to purchase diabetic testing devices from any participating, in-network DME vendor with applicable member cost-sharing under Medicare Advantage. Supplies obtained from an in-network DME supplier are covered in full after coinsurance.

Although Medicare Advantage PPO members have out-of-network benefits, those members who elect to go out-of-network to purchase DME supplies will incur additional out-of-pocket expenses. Please review the patient's specific benefit design to determine possible authorization requirements and/or coinsurance amounts and maximum annual coinsurance amounts.

Prescriptions for multiple, daily diabetic testing



If a patient is instructed to test multiple times in the same day for diabetes, treatment prescriptions for DME diabetic supplies should be written clearly to state the correct frequency of testing (e.g., "to be tested three times daily"). This will ensure that the correct amount of supplies are ordered and submitted for DME coverage under a Medicare Advantage product.

Many of the in-network DME vendors can supply increased supplies in a timely manner. If a patient requires additional supplies, the treating physician will need to provide the patient with a new prescription detailing the testing frequency. After receiving the new prescription, the patient will need to contact the DME vendor to indicate that their testing needs have increased and that their physician wrote a new prescription detailing the change.

Mail order diabetic testing supplies



Members are able to order 90-day supplies of diabetic supplies via mail order. The physician must write the prescription to reflect the long-term supply so that the member is able to submit the prescription to the mail order DME vendor and receive accurate long-term supplies.

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4.4 DIABETIC TESTING DEVICES FOR MEDICARE ADVANTAGE MEMBERS, Continued

FOR MORE INFORMATION



If you have specific questions about diabetic testing devices for Medicare Advantage members, please contact the Provider Service Center.

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OBSOLETE