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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

January 2011

How to Successfully Bill for an Oxygen Denial

National Government Services, the Jurisdiction B Durable Medical Equipment Administrative Contractor (DME MAC) has received several questions regarding how to bill in order to receive an oxygen denial. In situations where suppliers are aware that the beneficiary **does not** meet the medical necessity coverage criteria as outlined in the Local Coverage Determination (LCD) for Oxygen and Oxygen Equipment (L27221). An example would be a situation in which the ordering physician has prescribed oxygen for a diagnosis unrelated to severe lung disease or hypoxia-related diagnosis (i.e., migraine headaches).

If a required blood gas study or oxygen saturation test was **not** performed, suppliers must include **"No test performed billing for denial & ICD-9 diagnosis code"** in the Note segment (NTE) of the electronic claim format or Item 19 of the CMS-1500 paper claim form.

Suppliers should also transmit with the claim an electronic Certificate of Medical Necessity (CMN), or for paper submitters a hard-copy CMN, with the question set answered as follows:

1b) 99
1c) date of service of claim
2) 1
3) 1
4) D
5) 2
6) Blank
7) Y
8) N
9) N

Suppliers should execute an Advance Beneficiary Notice of Noncoverage (ABN) advising the Medicare patient that Medicare will deny payment for oxygen therapy as not medically necessary due to the coverage criteria not being met. If an ABN was properly executed, **modifier GA** should be appended on the claim—this will result in the appropriate patient responsibility (PR-50) denial. You can access additional information concerning ABNs in the *Jurisdiction B DME MAC Supplier Manual,* Chapter 10, Advance Beneficiary Notice of Noncoverage.

Last Modified: 8/2/12