



**DME MAC JURISDICTION B SUPPLIER MANUAL  
WINTER 2025**

*We IMPACT lives.*

January 2025

Dear Supplier:

The Winter 2025 version of the *DME MAC Jurisdiction B Supplier Manual* has been released. Please read the updated manual carefully. The *DME MAC Jurisdiction B Supplier Manual* is designed to provide vital, current DME MAC information. Supplier Manual updates are issued quarterly.

Any new or revised material in this revision is shown in **red text**, while all text that has remained unchanged is shown in black text. Note that Web addresses/hyperlinks are an exception to this rule, as they are displayed in blue or teal. A summary of the changes is listed below.

We strongly recommend using electronic copies of the Supplier Manual to ensure that you are using the most recent version. You can find the latest version of the Supplier Manual on our website at <https://www.cgsmedicare.com/jb/pubs/supman/index.html>.

Please be sure to visit the “News” page on our website (<https://www.cgsmedicare.com/jb/pubs/news/index.html>) for special notices concerning changes in regulations issued between publication releases. To receive automatic notification via email of the posting of policies, publications, and other important Medicare announcements, subscribe to our electronic mailing list at <https://www.cgsmedicare.com/email.html>.

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WINTER 2025



# Supplier Manual

DME MAC Jurisdiction B

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## Welcome

Welcome to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction B Supplier Manual. This manual is provided for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who serve beneficiaries in Jurisdiction B. This manual contains an overview of important and useful information for DMEPOS suppliers regarding the Medicare program. It is the first resource that you should use for Medicare billing questions.

The *Supplier Manual* is updated on a quarterly basis and is available on our website at <https://www.cgsmedicare.com>.

In every quarterly *Supplier Manual* revision, all text that has been added or revised from the previous quarter's version of the manual is shown in red text. All unchanged text is shown in black text. Please note that additions/revisions do not necessarily denote a change in policy. Some additions/revisions are added solely to provide greater clarity and understanding.

To stay up to date on the most recent Medicare news, subscribe to our electronic mailing list (formerly known as the ListServ). This email newsletter gives you immediate access to the latest Medicare information, including publications, important updates, educational workshops, and medical review information. Sign up today at <https://www.cgsmedicare.com/email.html>.

### Internet-only Manual (IOM) References

Most of the information in this manual is derived from the Centers for Medicare and Medicaid Services' (CMS) Internet-only Manuals (IOMs). The IOMs are a replica of the CMS 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.

In order to give you an easy way to cross-reference the information in the IOM with the information in the *DME MAC Jurisdiction B Supplier Manual*, you will find references to the applicable IOM sections



throughout each chapter of the *Supplier Manual*. The references are listed beneath title headings in the following format:

**CMS Manual System, Publication Number, *Publication Name*, Chapter, §Section**

You can access the IOMs at the following website: <https://www.cms.gov/medicare/regulations-guidance/manuals/internet-only-manuals-ioms> (refer to Chapter 15 in this manual for more information about the CMS Manual System).

## **1. CGS's Role as a DME MAC**

The Centers for Medicare & Medicaid Services (CMS), the government agency which oversees the Medicare program, selected four companies to process DMEPOS claims for the Medicare program. These companies function as DME MACs. Each DME MAC is responsible for processing DMEPOS claims for beneficiaries residing in their specific jurisdiction.

CGS is the DME MAC for Jurisdiction B. Jurisdiction B includes Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Our role is strictly that of processing and paying Medicare claims in accordance to the Social Security Act, Medicare Modernization Act, health insurance regulations and laws, and the Centers for Medicare & Medicaid Services rulings.

For the administration of the DME MAC Jurisdiction B contract, our offices are located in Nashville, Tennessee.

## **2. What Is Medicare?**

**CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 1, §§10-10.1 & 10.3**

The Medicare program is a federal health insurance program for:

- People age 65 or older,
- People under age 65 with certain disabilities, and
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare is run by the Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services (DHHS).

Medicare is divided into several different parts which pay for certain types of services or situations. Hospital insurance (Medicare Part A) helps pay for inpatient hospital care, inpatient care in a skilled nursing facility, home health care, and hospice care. Medical insurance (Medicare Part B) helps pay for medically necessary services by a physician, outpatient hospital services, home health care, and a number of other medical services and supplies that are not covered by Part A, including durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for home use.

Prescription Drug Coverage (Medicare Part D) pays for prescription drugs for Medicare-eligible beneficiaries who are enrolled in a Medicare prescription drug plan. Medicare prescription drug plans are available in every part of the country and all plans cover both brand name and generic drugs.

All topics covered in this manual refer to Medicare Part B DMEPOS.

### **3. What Is DME?**

CMS Manual System, Pub. 100-2, *Medicare Benefit Policy Manual*, Chapter 15, §110.1

Durable medical equipment is equipment which:

- Can withstand repeated use,
- Is primarily and customarily used to serve a medical purpose,
- Generally is not useful to a person in the absence of an illness or injury, and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be durable medical equipment.

### **4. Deductible and Coinsurance**

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 3, §§20.1-2

Medicare beneficiaries must meet a deductible each calendar year before payment can be made by Medicare Part B. The beneficiary may be billed for any amount applied to the deductible on both assigned and nonassigned claims. The deductible is applied to approved charges only (the deductible is not applied to any non-covered charge). **The Medicare Part B deductible for 2025 is \$257.** The deductible is subject to change every calendar year.

In order for Medicare Part B to reimburse for covered medical services, a beneficiary must satisfy the annual deductible regardless of when during the calendar year he or she became eligible.

**NOTE:** Expenses are allocated to the deductible in the order in which claims are received and processed by Medicare, not necessarily in order of date of service.

**You can use the myCGS Web Portal to determine current deductible status for a beneficiary. Refer to Chapter 13 of this manual for information about myCGS.**

After the Medicare Part B deductible has been satisfied for the calendar year, Medicare reimburses 80 percent of the amount allowed by Medicare for an item/service. The remaining 20 percent of the allowed amount is the responsibility of the beneficiary. This amount is referred to as the coinsurance.

## **5. Eligibility**

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2

Medicare eligibility is determined by the Social Security Administration (SSA). An individual may become entitled through Social Security based on his or her own earnings or that of a spouse, parent, or child. Anyone who becomes entitled to premium-free hospital insurance (Medicare Part A) is automatically enrolled in medical insurance (Medicare Part B), except in Puerto Rico. Medicare Part B is a voluntary program for which the insured must pay a monthly premium; therefore, individuals who do not want coverage may refuse Medicare Part B enrollment. The effective date of Medicare Part B coverage depends on the month in which enrollment takes place. An individual's Medicare Part B coverage ends when the individual requests disenrollment, does not pay premiums, dies, or, for individuals less than 65 years of age, when hospital insurance entitlement ends. Beneficiaries who have Medicare Part A (Hospital Insurance) and/or Medicare Part B (Medical Insurance) are also eligible for Medicare Part D (Prescription Drug Coverage).

You can use the [myCGS Web Portal](#) to determine beneficiary eligibility. Refer to Chapter 13 of this manual for information about myCGS.

### **Aged Insureds (65 years of age)**

An aged insured is a person 65 years of age or older who is eligible for monthly Social Security or Railroad Retirement cash benefits or equivalent federal government benefits. Premium-free hospital insurance becomes effective on the first of the month in which the individual reaches age 65 if he or she applies for the benefit within six months of his/her birth month. Age 65 is considered to be reached on the day before the 65th birthday. For instance, an individual born on August 1st reaches age 65 on July 31st, and thus hospital insurance would be effective July 1st.

Some aged individuals do not qualify for premium-free hospital insurance due to insufficient Social Security Quarters of Coverage but may purchase Medicare Part A coverage. The individual must be a United States resident and either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously for five years or more. This person must also enroll (or already be enrolled) in Supplementary Medical Insurance (SMI). This type of enrollee must pay a monthly premium for both Medicare Part A and Medicare Part B coverage. If the premium is not paid within a specified period, then coverage is terminated.

### **Under Age 65 with Permanent Kidney Failure (End Stage Renal Disease)**

Eligibility for coverage of a permanent kidney failure patient begins the third month after the month in which a course of renal dialysis begins, unless the individual receives a kidney transplant on or before the third month. In that case, eligibility begins the month the individual is admitted as an inpatient to a hospital for procedures in preparation for, or in anticipation of, a kidney transplant, provided that the transplant surgery takes place within the following two months. When the transplant is delayed more than two months after the preparatory hospitalization, eligibility begins with the second month prior to the month of transplant.

Also, Medicare entitlement can begin in the first month of a course of dialysis if the individual participates in a self-dialysis training program in a Medicare-approved facility prior to the third month after the course of dialysis. The individual is expected to complete the training and self-dialyze thereafter. If a beneficiary is entitled to Medicare only because of permanent kidney failure, Medicare protection will end 12 months after dialysis ends or 36 months after the month of a kidney transplant. If the transplant fails during or after that 36-month period and the beneficiary again resumes maintenance dialysis or receives another transplant, Medicare coverage will continue or be reinstated immediately without any waiting period.

## **Under Age 65 and Permanently Disabled**

Medicare entitlement for the disabled begins with the 25th month after an individual has been eligible for Social Security Disability benefits. Subsequently, if the beneficiary is no longer entitled to Social Security disability payments, then his or her Medicare coverage will generally continue for one more calendar month after he/she is sent notice of the termination of the disability payments.

## **6. Medicare ID— Health Insurance Claim Number (HICN) and Medicare Beneficiary Identifier (MBI)**

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2, §§50.2-50.4.2

The Health Insurance Claim Number (HICN) has served as the traditional beneficiary identification number for Medicare entitlement. The HICN is shown on old versions of the beneficiary's Medicare card. Beginning April 1, 2018, CMS is replacing the traditional HICN with the new Medicare Beneficiary Identifier (MBI) on Medicare cards.

Whereas the general format of the HICN was based on a Social Security Number (SSN), the new MBI is a completely new alpha-numeric ID that does not contain any link to a beneficiary's SSN. Removing SSNs from Medicare cards will help to prevent fraud, fight identity theft, and keep taxpayer dollars safe.

During the MBI transition period, which began April 1, 2018, and ended December 31, 2019, either the HICN or MBI could be used in all data transactions with Medicare contractors, including claim submission, web portal transactions, and any other type of data transaction. Beginning January 1, 2020, Medicare claims must be submitted using MBIs (with a few exceptions).

The Medicare ID (HICN or MBI) is probably the most important piece of information you can have about your Medicare patient. Claims cannot be paid if the Medicare ID is missing or incorrect.


For additional information about the new Medicare Card and MBI, visit <https://www.cms.gov/training-education/partner-outreach-resources/new-medicare-card/medical-beneficiary-identifiers-mbis>.

## **7. The Medicare Card**


A Medicare card is issued to every person who is entitled to Medicare benefits. This card identifies the Medicare beneficiary and includes the following information:

- Name (exactly as it appears on the Social Security records)
- HICN (for cards issued prior to April 1, 2018) or MBI (for cards issued April 1, 2018, and after)
- Beginning date of Medicare entitlement for hospital (Part A) and/or medical (Part B) insurance

The following is an example of an HICN-based Medicare card:

|   |  |   |                         |  |
|---|--|---|-------------------------|--|
| <b>MEDICARE</b>                               |  |  | <b>HEALTH INSURANCE</b> |  |
| <b>1-800-MEDICARE (1-800-633-4227)</b>        |  |   |                         |  |
| NAME OF BENEFICIARY<br><b>JANE DOE</b>        |  |   |                         |  |
| MEDICARE CLAIM NUMBER<br><b>000-00-0000-A</b> |  | SEX<br><b>FEMALE</b>  |                         |  |
| IS ENTITLED TO<br><b>HOSPITAL (PART A)</b>    |  | EFFECTIVE DATE<br><b>07-01-1986</b>   |                         |  |
| <b>MEDICAL (PART B)</b>                       |  | <b>07-01-1986</b>   |                         |  |
| SIGN HERE _____                               |  |   |                         |  |

The following is an example of an MBI-based Medicare card:

|   |  |  |  |
|---|--|--|--|
|  |  | <b>MEDICARE HEALTH INSURANCE</b>                       |  |
| Name/Nombre<br><b>JOHN L SMITH</b>  |  |  |  |
| Medicare Number/Número de Medicare<br><b>1EG4-TE5-MK72</b>                        |  |  |  |
| Entitled to/Con derecho a<br><b>HOSPITAL (PART A)</b>                             |  | Coverage starts/Cobertura empieza<br><b>03-01-2016</b> |  |
| <b>MEDICAL (PART B)</b>   |  | <b>03-01-2016</b>                                      |  |

We recommend that you obtain a copy of the Medicare card and incorporate it in the beneficiary's file for accuracy of claim submissions.

For additional information about the new MBI-based Medicare cards, visit <https://www.cms.gov/training-education/partner-outreach-resources/new-medicare-card/medical-beneficiary-identifiers-mbis>.

## 8. Termination of Enrollment

There are times when a beneficiary's enrollment in Medicare may terminate for various reasons. This may not be reflected on the Medicare card. If you receive a denial from Medicare indicating no entitlement for the dates of service on the claim, there are several items you can check:

1. Did you copy the correct and complete Medicare ID from the Medicare card?
2. Is this the correct date of service? Be sure to check the year.
3. Has the beneficiary's enrollment been terminated? Check with the beneficiary to verify this possibility. The DME MAC generally does not have any details regarding the reason of termination of a beneficiary's enrollment.

**9. Medicare Advantage Plans**

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 2, §60

As an alternative to the traditional fee-for-service Medicare plan, beneficiaries have the option of enrolling in a Medicare Advantage Plan. Medicare Advantage Plans include Medicare Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Medicare Special Needs Plans, and Medicare Private Fee-for-Service Plans. Claims for these plans must be filed with the contractor administering that particular plan. Do not file claims for Medicare Advantage Plans to CGS.

**10. Other Government Insurance Plans****Railroad Retirement Board (RRB)**

Claims for DMEPOS items for beneficiaries eligible for Railroad Retirement Board (RRB) benefits are also processed by CGS for beneficiaries in Jurisdiction B.

**United Mine Workers Association (UMWA)**

In the event a claim is filed to our office for the United Mine Workers Association (UMWA), the claim will be returned to you to resubmit to the UMWA for processing. A statement to that effect will be printed on your Medicare Remittance Advice. A statement will also be printed on the beneficiary's Medicare Summary Notice (MSN). These notices will let you and the beneficiary know that future claims should be filed with the appropriate office. Contact Information for the UMWA can be found in Chapter 15 of this Supplier Manual.

**11. Privacy Act of 1974 and HIPAA Privacy Rules**

CMS Manual System, Pub. 100-01, *Medicare General Information, Eligibility and Entitlement Manual*, Chapter 6, §§10 & 190

The purpose of the Privacy Act and HIPAA Privacy Rules is to provide safeguards for individuals against an invasion of privacy. Federal agencies are required to permit individuals to:

1. Determine what records pertaining to him/her are collected, used, or disseminated by such agencies.
2. Prevent records pertaining to him/her from being used for another purpose without their consent.
3. Gain access to information pertaining to him/her in federal agency records, and to correct such records when appropriate.

Disclosure of information about a beneficiary to any party other than the beneficiary (or his/her legal guardian) him/herself is prohibited without the beneficiary's (or legal guardian's) explicit written authorization. This authorization may be in any form, but it must:

- Include the beneficiary's name and Medicare ID;
- Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;

- Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
- Specify the records, information, or types of information that may be disclosed;
- A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as “at the request of the individual”);
- Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary’s enrollment in the health plan);
- Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative’s authority to act for the individual must also be provided;
- A statement describing the individual’s right to revoke the authorization along with a description of the process to revoke the authorization;
- A statement describing the inability to condition treatment, payment, enrollment, or eligibility for benefits on whether or not the beneficiary signs the authorization;
- A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.

Blanket consents to disclose all of the beneficiary's records to unspecified individuals or organizations will not be honored. The consent must specify the item/service for which the disclosure is requested and should only include those items/services prescribed by the beneficiary’s physician.

## **12. Freedom of Information Act (FOIA)**

The Freedom of Information Act (FOIA) requires that most records in custody of CMS (and its contractors) be made available to the general public when requested. The FOIA does not apply to materials specifically prepared for public distribution or sale, e.g., press releases, speeches, fact sheets, listings (names and business addresses) of Medicaid and/or Medicare providers, information brochures, and any publication which has been assigned a CMS, Health and Human Services, Government Printing Office, or National Technical Information Service (NTIS) publication number, etc.

The FOIA covers records (paper or electronic/tape) only. It does not cover information which may be requested and imparted orally or in writing. For example, requests for dates, addresses, figures such as the Medicare enrollment for a state, which need not be responded to with the production of a document are not FOIA requests. Such requests should be directed to the proper public inquiries office.

### **FOIA examples:**

- Existing records (handwritten, printed, or electronic)
- Excerpts from the Medicare manuals, Code of Federal Regulations, supplier manuals, and newsletters

- Supplier name lists
- Fee schedules
- Coding reports and letters
- Claim data reports

**Non-FOIA examples:**

- Requests for dates
- Addresses
- Figures (i.e., Medicare enrollment for a state)
- General questions about coverage or policy interpretation
- HCPCS coding information

All FOIA requests are subject to fees for search, review, and copy/duplication. Before submitting your request, you may want to see if the information can be obtained from our website, <https://www.cgsmedicare.com>. FOIA requests must be submitted in writing and should provide details that will help us identify and find the records being requested. If there is insufficient information, we will ask you for more. Include your name and telephone number(s) to help us reach you if we have questions.

Please send FOIA requests to the following address:

**CGS**

Attn: Jurisdiction B DME MAC Freedom of Information Coordinator  
Suite ST610  
26 Century Blvd  
Nashville, TN 37214



## Chapter 2 Contents

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## Overview

This chapter outlines the enrollment requirements that you must meet in order to receive payment in the Medicare program as a DMEPOS supplier.

All DMEPOS suppliers who serve Medicare beneficiaries and meet the supplier standards listed in this chapter must enroll and obtain a supplier number, which is also known as a Provider Transaction Access Number (PTAN), with the National Provider Enrollment (NPE) DMEPOS contractors. The Centers for Medicare & Medicaid Services (CMS) has contracted with the East and West NPE DMEPOS contractors to distribute applications, verify data, and maintain national DMEPOS supplier files. The NPE contractors do not process or maintain information on claims.

Before enrolling with the NPE contractor, you must obtain a National Provider Identifier (NPI). Applying for an NPI is a separate process from enrollment with the NPE contractor.

All claims filed to Medicare must include your NPI. Legacy supplier numbers (PTANs) issued by the NPE contractor are no longer permitted in the claim filing process.

## 1. National Provider Identifier (NPI)

The Administrative Simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* mandated the adoption of standard unique identifiers for health care providers, as well as the adoption of standard unique identifiers for health plans. For health care providers, the National Provider Identifier (NPI) is the standard unique identifier. The CMS has developed the National Plan and Provider Enumeration System (NPPES) to assign these unique identifiers. For more information about NPI enumeration, visit <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>.

Please note that each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

The CMS requires that suppliers obtain their NPI prior to enrolling or updating their enrollment record with the NPE contractor. The NPE contractor will not process an enrollment application without the NPI and a copy of the NPI notification letter received from the NPPES or the organization requesting an NPI.

You can apply for an NPI online at <https://NPPES.cms.hhs.gov>. If you prefer to apply through a paper application, you may obtain the NPI Application/Update Form (CMS-10114) from the CMS website at <https://www.cms.gov/cmsforms/downloads/CMS10114.pdf> or by request from the NPI Enumerator at the following contact information:

**NPI Enumerator**

7125 Ambassador Rd. Ste 100  
Windsor Mill, MD 21244

**Phone:** 1.800.465.3203

**TTY:** 1.800.692.2326

**Email:** [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com)

## 2. National Provider Enrollment (NPE) DMEPOS Contractor

After obtaining an NPI, you must enroll with the NPE contractor by completing the CMS-855S enrollment application. This must be done in order to obtain a supplier number, also known as a Provider Transaction Access Number (PTAN). You must have both an NPI and a PTAN in order to be eligible to receive Medicare payment for covered DMEPOS services.

**The NPE contractor enrollment process:**

1. Complete and submit the Medicare enrollment application form (CMS-855S) and any necessary supporting documentation (including the NPI notification letter) or complete the online version of the CMS-855S through the Provider Enrollment Chain Ownership System (PECOS) at <https://pecos.cms.hhs.gov/>.
2. The NPE contractor will review the application and conduct a site visit to verify compliance with the supplier standards (see below).
3. After completing its review, the NPE contractor will notify you of its enrollment decision in writing.

**The CMS 855S Form**

All DMEPOS suppliers initially enrolling with the NPE contractor must complete the CMS-855S form. You may also need to complete the CMS-855S form and submit it to the NPE contractor in other situations, such as if you are:

- Currently enrolled in Medicare as a DMEPOS supplier and need to report changes to your business, other than enrolling a new business location (e.g., you are adding, deleting, or

changing existing information under this Medicare supplier billing number). Changes must be reported within 30 days of the effective date of the change.

- Currently enrolled in Medicare as a DMEPOS supplier but need to enroll a new business location. This is to add a new location to an organization with a tax identification number already listed with the NPE contractor. (This differs from changing information on an already existing location.)

**Note:** 42 C.F.R. 424.57(b)(1) requires suppliers to enroll separate physical locations, other than warehouses or repair facilities.

- Currently enrolled in Medicare as a DMEPOS supplier and have been asked to reenroll in order to verify or update your information. This includes situations where you have been asked to attest your organization is still eligible to receive Medicare payments.
- Reactivating your Medicare DMEPOS supplier billing number (e.g., your Medicare supplier billing number was deactivated because of non-billing, and you wish to receive payment from Medicare for future claims).
- Voluntarily terminating your Medicare DMEPOS supplier billing number.

If you wish to enroll or update your enrollment information online, visit the CMS PECOS website (<https://pecos.cms.hhs.gov/>).

You are accountable for the accuracy of the information on the CMS 855S form. Any deliberate misrepresentation or concealment of material information may subject your company to liability under civil and criminal laws.

The NPE contractor will contact you if a CMS 855S form is incomplete or has inconsistent information. Furthermore, all suppliers are subject to a site visit in order to determine compliance with the supplier standards, which can be found in this chapter. Suppliers found in noncompliance with the supplier standards are subject to denial or revocation of their NPE issued supplier number. The denial/revocation notification outlines the appeals process available to suppliers, including instructions on requesting an appeal.

**NOTE:** According to Pub 100-8, Chapter 15, Section 15.8.4, a supplier that is denied enrollment in the Medicare program cannot submit a new enrollment application until the following has occurred:

- If the denial was not appealed, the provider or supplier may reapply after its appeal rights have lapsed.
- If the denial was appealed, the provider or supplier may reapply after it received notification the determination was upheld.

Furthermore, 42 C.F.R 424.530 (published in April 2006) requires the NPE contractor to return any application received 30 days prior to the date the business was established (Section 4A of the CMS 855S) and to deny any application where the supplier is not operational. 42 C.F.R. 424.502 defines *operational* as follows:

*“Operational means the provider or supplier has a qualified physical practice location, is open to the public for the purpose of providing health care related services, is prepared to submit valid Medicare claims, and is properly staffed, equipped and stocked to furnish these items or services.”*

Each DMEPOS supplier applying for a Medicare supplier number must disclose ownership on the CMS 855S form in accordance with Section 1124A of the Social Security Act and Section 4313 of the Balanced Budget Act of 1997, by including:

- The names and social security numbers of the owners, managing employees, those with controlling interest of 5% or more, and/or authorized representatives/members of the board of directors (including non-profit corporations) as well as any partnership regardless of the percentage of ownership.
- The names of all owners, managing employees and/or authorized representatives/members of the board of directors who have received penalties, been sanctioned, or excluded by the Medicare, Medicaid and/or other federal and state authorities or programs.

The term *managing employee* is defined as any individual, including a general manager, business manager, or administrator, who exercises operational or managerial control over the DMEPOS supplier, or who conducts the day-to-day operations of the DMEPOS supplier. For Medicare enrollment purposes, “managing employee” also includes individuals who are not actual employees of the DMEPOS supplier but, either under contract or through some other arrangement, manage the day-to-day operations of the DMEPOS supplier.

An *authorized official* must be an owner, general partner, chairman of the board, chief financial officer, chief executive officer, or president, OR must hold a position of similar status and authority within the supplier's organization. This individual must have the authorization to legally bind the organization to a contract. The authorized official has the authority to sign the initial CMS 855S application on behalf of the supplier and to notify the NPE contractor of any change or that the supplier number is no longer valid due to sale of the entity. Only the authorized official can add, change, or delete delegated officials or sign off on the change of the authorized official.

Adding delegated officials is an option and is not required. *Delegated officials* may be either a managing employee of the supplier or hold a 5% direct ownership interest or partnership interest in the supplier. Managing employees include general managers, business managers, or administrators—individuals who exercise operational or managerial control over the supplier, or who conduct the day-to-day operations of the supplier. A delegated official must be an employee of the supplier, and proof, such as a W-2 form, may be requested.

Delegated officials may not delegate their authority to any other individual. Once a delegated official has been designated, he/she may make any changes and/or updates to the provider status including enrolling additional locations, re-enrolling the supplier, reactivating the supplier, or adding new part-owners.

Suppliers may have as many authorized and delegated officials as desired as long as the individual meets the respective definition. These officials are not location specific, but rather are supplier specific. For example, if a supplier has multiple locations under one tax ID number, the authorized and delegated officials appointed will be the authorized signers for all locations.

### **Additional Forms and Documentation Requirements**

When submitting your CMS-855S form to the NPE contractor, you must also include additional documentation such as your NPI notification provided by NPPES and the CMS-588 Electronic Funds Transfer (EFT) Form. These two requirements are documented below.

**NPI Notification**

You must include the submission of your National Provider Identifier (NPI) and a copy of the NPI notification furnished by the National Plan and Provider Enumeration System (NPPES). You should provide your NPI where requested and submit a copy of the notification verifying the NPI. If you are unable to locate your NPI notification you may contact the NPPES at 1.800.465.3203 or send an email to [customerservice@npienumerator.com](mailto:customerservice@npienumerator.com).

Applying for an NPI is a process separate from Medicare enrollment. To obtain an NPI, you may apply online at <https://NPPES.cms.hhs.gov>. For more information about NPI enumeration, visit <https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/>.

**Note:** Each enrolled supplier of DMEPOS that is a covered entity under HIPAA must designate each practice location (if it has more than one) as a subpart and ensure that each subpart obtains its own unique NPI. Federal regulations require that each location of a Medicare DMEPOS supplier have its own unique billing number. In order to comply with that regulation, each location must have its own unique NPI.

In addition, the address listed on the NPI notification must match the address listed on the CMS-855S. The CMS requires a copy of the notification to be submitted with all enrollment documentation, which includes initial applications, changes of information, reenrollments and reactivations.

**EFT Form (CMS-588)**

You must complete and submit the most current version of the Authorization Agreement for Electronic Funds Transfer (CMS-588) to the appropriate NPE when initially enrolling a physical location or submitting an application for a new location. Your bank information must be applicable for all four DME MAC Jurisdictions.

If you need to make changes to existing EFT information, submit updates to the appropriate NPE for processing.

Along with each completed CMS-588 form, you must include one of the following verifying the account information:

- Voided check
- Deposit slip
- Notification on bank letterhead verifying the account information

Please note that the DME MAC is not able to answer inquiries pertaining to EFT applications. Instead, you must contact the NPE.

**3. Supplier Standards**

Medicare regulations have defined standards that a supplier must meet to receive and maintain their billing privileges. These standards, in their entirety, are listed in 42 C.F.R. 424.57(c) and can be found on the NPE contractor's website. An abbreviated version is listed below.

**You must disclose these standards to all customers who are Medicare beneficiaries (see standard #16).**

1. A supplier must be in compliance with all applicable federal and state licensure and regulatory requirements.
2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days.
3. An authorized individual (one whose signature is binding) must sign the application for billing privileges.
4. A supplier must fill orders from its own inventory or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs or from any other federal procurement or non-procurement programs.
5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment and of the purchase option for capped rental equipment.\*
6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable state law and repair or replace free of charge Medicare covered items that are under warranty.
7. A supplier must maintain a physical facility on an appropriate site and must maintain a visible sign with posted hours of operation. The location must be accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records.
8. A supplier must permit CMS or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards.
9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited.
10. A supplier must have comprehensive liability insurance in the amount of at least \$300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations.
11. A supplier is prohibited from direct solicitation to Medicare beneficiaries. For complete details on this prohibition see 42 CFR 424.57 (c) (11).
12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items and maintain proof of delivery and beneficiary instruction.
13. A supplier must answer questions and respond to complaints of beneficiaries and maintain documentation of such contacts.
14. A supplier must maintain and replace at no charge or repair directly or through a service contract with another company Medicare-covered items it has rented to beneficiaries.

15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries.
16. A supplier must disclose these standards to each beneficiary it supplies a Medicare-covered item.
17. A supplier must disclose any person having ownership, financial or control interest in the supplier.
18. A supplier must not convey or reassign a supplier number (i.e., the supplier may not sell or allow another entity to use its Medicare billing number).
19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility.
20. Complaint records must include the name, address, telephone number and health insurance claim number of the beneficiary; a summary of the complaint; and any actions taken to resolve it.
21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations.
22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals).
23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened.
24. All supplier locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare.
25. All suppliers must disclose upon enrollment all products and services, including the addition of new product lines for which they are seeking accreditation.
26. A supplier must meet the surety bond requirements specified in 42 C.F.R. 424.57(c).
27. A supplier must obtain oxygen from a state-licensed oxygen provider.
28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f).
29. A supplier is prohibited from sharing a practice location with other Medicare providers and suppliers.
30. A supplier must remain open to the public for a minimum of 30 hours per week except physicians (as defined in section 1848 (j) (3) of the Act) or physical and occupational therapists or a DMEPOS supplier working with custom made orthotics and prosthetics.

\*Although CMS has revised payment rules for capped rental items, supplier standard 5 still applies for inexpensive and routinely purchased items that do not fall into the capped rental category and applicable capped rental items (i.e., complex rehabilitative power wheelchairs and parental/enteral pumps, etc.).

## 4. Reenrollment

42 C.F.R. section 424.57(e) requires the National Provider Enrollment (NPE) DMEPOS contractors to reenroll suppliers every three years. The NPE contractors are the central entity responsible for maintaining supplier identification and ownership data, as well as other business data. Part of that responsibility requires the NPE contractors to share this information with the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) for provider relations and claims processing.

Therefore, it is imperative that the NPE contractors have the most accurate information on file. The reenrollment process also allows the NPE contractor to determine if you are in compliance with the supplier standards.

The reenrollment process takes approximately 60 days, which includes a site visit, if required. Also, workload and the time spent requesting any additional information required to complete the reenrollment package play a part in determining the processing time. Be sure to respond to requests for information from the NPE contractor timely to avoid having your supplier number inactivated and having to begin the process again.

Please contact the NPE contractor for additional information regarding reenrollment.

## 5. Change of Information

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 10, §7.1

Any changes or updates to information provided on the CMS 855S form must be reported to the NPE contractor within 30 days after such changes have taken place.

Updated information should be submitted on the CMS 855S form. Failure to provide the updated information is grounds for denial or revocation of the Medicare supplier number.

In order to timely receive information from the DME MACs, the NPE contractor must have your correct address. The NPE contractor maintains your correspondence address information and transmits this information to the DME MACs.

Be sure to attach all location specific licenses to any Change of Information form that includes a change of physical location. This will be required before any changes can be made to your supplier file. This will serve as notice you should apply for any new location specific licenses from the specific licensing board (such as Board of Pharmacy, business license offices, etc.) as quickly as possible to ensure compliance with supplier standard #1.

## 6. Participating/Nonparticipating

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30

A Medicare participating supplier is one who voluntarily enters into an agreement to accept assignment for all services furnished to Medicare beneficiaries during a 12-month period, beginning January 1 of each year. Suppliers who choose not to sign the participation contract are referred to as nonparticipating suppliers. Nonparticipating suppliers may choose to accept assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, Indian Health Services). Accepting assignment means accepting the Medicare approved



amount as payment in full. Participation status is part of the enrollment process through the National Provider Enrollment (NPE) DMEPOS contractor.

Open enrollment forms (CMS-460, Medicare Participating DMEPOS Supplier Agreement) are mailed to all suppliers every November. If you are an existing nonparticipating supplier and want to become participating, then you must send the agreement form to the NPE contractor during open enrollment. The form must be postmarked before December 31st of that year.

If you are a participating supplier and want to become nonparticipating, you may request to become nonparticipating by sending the request to the NPE contractor on your company letterhead. The request must be postmarked and received before December 31st of the year to become nonparticipating effective January 1st of the next year.

New legislation each year provides incentives for you to become a participating supplier. These incentives are outlined in the participation enrollment letter sent to all suppliers each year, along with other valuable information.

## **7. Site Visits**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 10, §22**

Site Visits:

- Are a tool used by the NPE contractors to assist in making a determination as to whether or not a supplier is in compliance with the supplier standards
- Are conducted in all fifty states and territories
- Are completed for initial applications, reenrollments, and reactivations
- Can and will be conducted at anytime if deemed necessary

The site visit along with the application and supporting documentation are considered in making a determination to issue, deny, or revoke a supplier's billing privileges. Refer to the NPE contractor's website for additional information regarding site visits.

## **8. Do Not Forward**

**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §80.5**

If you are changing your correspondence or special payment address, you should be aware that any mail returned as undeliverable might result in a "Do Not Forward" (DNF) flag being placed on your account.

The DME MAC uses "return service requested" envelopes for all hardcopy checks and Medicare Remittance Advice (RA), allowing the U.S. Postal Service to return undeliverable mail. When the post office returns checks or RAs, the DME MAC will notify the NPE contractor and cease generating payments (whether you are enrolled for Electronic Funds Transfer or receive hardcopy checks) until you furnish a new address and that address is verified by the NPE contractor. The NPE contractor will also notify the other DME MACs of the DNF issue and these contractors will also stop payments until the issue has been resolved with the NPE contractor.

Also note that a DNF flag will be placed on your account if the DME MAC is notified by your bank of a change in your Electronic Funds Transfer (EFT) banking information. The flag will be removed once the NPE contractor receives updated EFT banking information on a valid CMS 588 form. You can avoid this situation by immediately notifying the NPE contractor of any changes to your bank account.

Any changes to your EFT banking information should be submitted on the CMS 588 EFT form to the applicable NPE contractor.

## **9. Directory of Medicare Suppliers**

The CMS is responsible for producing a directory of all Medicare Suppliers. Please note, this directory will not include any physicians or ambulatory surgical centers, but does include optometrists. The directory of Medicare suppliers can be found online at <https://www.medicare.gov/Supplier/Home.asp>.

## **10. Change of Ownership**

When there is a change of ownership, a new supplier number must be issued unless the new owners assume all liabilities and the tax identification number of the existing supplier. Otherwise, the new owner may not use the existing supplier number. The new owner must submit form CMS 855S to the NPE contractor within thirty (30) days of the change of ownership, along with a bill of sale, articles of incorporation filed with the state, and any other documents that show the exact nature of the transaction.

If there is a change in the tax identification number, the outgoing owner must notify the NPE contractor by completing the CMS 855S as a “Voluntary Termination of Billing Number.” The request to voluntarily terminate the supplier number must be submitted on the CMS 855S. Pub 100-08, Chapter 10, Section 7 states all changes must be reported on the CMS 855S.

The old supplier number will be inactivated. If the NPE contractor determines the new owners have met all requirements, the new number will be effective from the date of the change of ownership. Claims for items furnished between the date of the change of ownership and the issuance of the new supplier number may be submitted to the DME contractor once the supplier has received the new number.

Instructions and further information regarding the completion of the CMS 855S as a voluntary termination may be found on the NPE contractor’s website.

## **11. National Provider Enrollment Contractor Resource**

Find your NPE contractor at [https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact\\_list.pdf](https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf).

## **12. Supplier Audit and Compliance Unit (SACU)**

The Supplier Audit and Compliance Unit (SACU) is tasked to review new applicants and existing suppliers to determine if they are in compliance with current supplier standards. Most suppliers and supplier organizations are interested in fraud and abuse control to protect their industry's image with the public and Congress. This task is, by its nature, a cooperative effort. It involves some beneficiaries, state Medicaid agencies, the DME MACs, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG), the Department of Health and Human Services (DHHS), and the United States Attorney's Office (USAO).

The SACU has the authority to deny new applicants and to recommend revocation to CMS and/or inactivate existing supplier numbers when it is determined that such suppliers are not in compliance with the published standards. In addition, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 created criminal and civil penalties for suppliers who submit fraudulent applications to a government health care organization. Fully developed cases are submitted for prosecution to the U. S. Attorney's Office, Columbia, South Carolina. The U. S. Attorney has jurisdiction nationwide because all the applications are received, and the supplier numbers issued, by the NPE contractors in Columbia, South Carolina (NPWEST) and Mechanicsburg, Pennsylvania (NPEAST).

## **13. DMEPOS Accreditation**

In order to enroll or retain Medicare billing privileges, certain DMEPOS suppliers need to complete the accreditation process and be in compliance with certain quality standards prior to enrolling as a supplier.

Information about the DMEPOS accreditation is located on the CMS "Enroll as a DMEPOS Supplier" webpage at <https://www.cms.gov/medicare/provider-enrollment-and-certification/enroll-as-a-dmepos-supplier>.

## **14. Surety Bonds**

A DMEPOS surety bond is a bond issued by an entity (the surety) guaranteeing that a DMEPOS supplier will fulfill an obligation or series of obligations to a third party (the Medicare Program). If the obligation is not met, the third party will recover its losses via the bond.

Suppliers enrolling in the Medicare Program for the first time, existing suppliers undergoing a change of ownership, or existing suppliers establishing a new practice location are required to submit a surety bond to the NPE contractor with their CMS-855S Medicare Enrollment Application – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Suppliers. Absent an exception to the bonding requirement, the NPE contractor will reject a pending supplier's enrollment application if the supplier has not submitted a valid surety bond.

For information about surety bond requirements, refer to the CMS DMEPOS Enrollment webpage at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSEnrollment.html>.

## Chapter 3 Contents

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### 1. General Information

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5; Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. The "reasonable and necessary" criteria are based on Social Security Act §1862(a)(1)(A) provisions.

Before submitting a claim to the DME MAC, you must have on file a standard written order (SWO), a written order prior to delivery (WOPD) (if applicable), information from the treating practitioner concerning the beneficiary's diagnosis<sup>1</sup>, and any information required for the use of specific modifiers or attestation statements as defined in certain Local Coverage Determinations (LCDs) (see Chapter 9 of this manual for information about LCDs). You should also obtain as much documentation from the beneficiary's medical record as you determine you need to assure that coverage criteria for an item have been met. If the information in the beneficiary's medical record does not adequately support the medical necessity for the item, you are liable for the dollar amount involved unless a properly executed advance beneficiary notice of non-coverage (ABN) (see Section 9 below) of possible denial has been obtained.

All documentation must be maintained in the supplier's files for seven (7) years from the date of service (DOS) and be available upon request.

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<sup>1</sup> Diagnosis codes are required on all claims.

If the Medicare qualifying supplier documentation is older than seven years, proof of continued medical necessity of the item or necessity of the repair can be used as the supporting Medicare qualifying documentation.

Note: As of January 1, 2023, CMS has eliminated CMNs and DIFs. Therefore, for dates of service on or after January 1, 2023, CMNs and DIFs must not be submitted with claims.

## 2. Definition of Physician

**CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §40.4; Pub. 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 5, §70; Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)**

Physician means any of the following entities legally authorized to practice by a state in which he/she performs this function. The services performed by a physician within these definitions are subject to any limitations posed by the State on the scope of practice.

- Doctor of medicine
- Doctor of osteopathy (including osteopathic practitioner) - must be licensed to practice medicine and surgery
- Doctor of dental surgery or dental medicine
- Chiropractor (see below)
- Doctor of podiatry (see below) or surgical chiropody
- Doctor of optometry

The following practitioners may document the medical necessity of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) items, including completing orders, in place of a physician provided that they meet the practitioner requirements defined in Chapter 15 of the Benefit Policy Manual (Publication 100-02), the services performed are within their scope of practice as defined by their state, and they are treating the beneficiary for the condition for which the item is needed.

- Physician assistant
- Nurse practitioner
- Clinical nurse specialist

The term physician does not include such practitioners as Christian Science practitioner or naturopath. There is no Medicare benefit for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items ordered by these entities.

Medicare coverage for all items and services furnished or ordered by chiropractors is statutorily excluded, with the exception of treatment by means of manual manipulation of the spine to correct a subluxation. Therefore, all DMEPOS items ordered by chiropractors are denied.

Medicare coverage for all items and services furnished or ordered by podiatrists is limited by state statutes governing the scope of practice for podiatry. You should be familiar with the limitations imposed by the statutes of the state(s) in which you operate and dispense DMEPOS items. Claims

submitted to the DME MAC, when furnished or ordered by podiatrists practicing outside the limits of their licensure, will be denied as statutorily non-covered. Podiatrists are excluded by statute from ordering a power operated vehicle (POV) or power wheelchair.

### **3. Prescription (Order) Requirements**

*CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.3.2.4 & Chapter 5, §5.2; Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

All items billed to Medicare require a prescription from the treating practitioner as a condition of payment. For each DMEPOS item billed, you must have a signed order/prescription from the treating practitioner. You must keep the order on file and make it available upon request. If these order/prescription requirements and those below are not met, then an EY modifier must be added to each affected HCPCS code when submitting the claim. Note: The claim submitted for the affected HCPCS codes (with EY modifier added) must be separate from claims submitted for HCPCS codes in which you have a complete and compliant order/prescription on file.

#### **STANDARD WRITTEN ORDER (SWO)**

An SWO must be communicated to the supplier prior to claim submission. For certain items of DMEPOS, a written order is required prior to delivery (WOPD) of the item(s) to the beneficiary.

An SWO must contain all of the following elements:

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item
  - The description can be a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
  - For equipment – In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately)
  - For supplies – In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (list each separately)

Note: If such items are not concurrently ordered, they nonetheless require an order for payment purposes.

- Quantity to be dispensed, if applicable
- Treating practitioner's name or National Provider Identifier (NPI)
- Treating practitioner's signature

The "order date" ideally should reflect the date the order was first communicated to you by the treating practitioner.

Note also that while the SWO has a limited number of required order elements, additional elements may be included to provide clarity for issues such as length of need (LON), frequency of use, dosage

form/strength, refills frequency, etc. This additional information shall be corroborated by information in the medical record.

Suppliers may also wish to consult state law or regulation since some states may have additional requirements for the elements of an order/prescription (e.g., refill frequency).

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating practitioner must specify on the standard written order, the type of supplies needed in such a manner that the supplier may calculate the necessary disbursement and assess the continued need for refill with the beneficiary. DME MACs, UPICs, and other contractors evaluate supply utilization information as part of their medical necessity and coverage determinations for DMEPOS.

Reimbursement shall be based on the specific utilization amount that is supported by contemporaneous medical records, including orders that indicate “PRN” or “as needed” utilization estimates for replacement frequency, use, or consumption.

Stamped signatures are not typically acceptable; however, use of a rubber stamp for signature is permitted in the case of an author with a physical disability who can provide proof to a of their inability to sign their signature due to their disability. Signatures must comply with the CMS signature requirements. Refer to the “Signature Requirements” section in this chapter.

The SWO must be available upon request.

An exception to the requirement for a written order applies in those limited instances in which the treating practitioner is also the supplier and is permitted to furnish specific items of DMEPOS and fulfill the role of the supplier in accordance with any applicable laws and policies. In such cases, a separate order is not required, but the medical record must still contain all of the required order elements.

Medical information intended to demonstrate compliance with coverage criteria may be included on a prescription but must be corroborated by information contained in the medical record.

### **NEW ORDER REQUIREMENTS**

A new order/prescription is required:

- For all claims for purchases or initial rentals;
- There is a change in the order/prescription for the DMEPOS item (e.g., quantity);
- On a regular basis (even if there is no change in the order) only if so specified in the documentation section of a particular medical policy;
- When an item is replaced (see explanation below); or
- When there is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier.

A new order is required when an item is being replaced because the item is worn, or the beneficiary’s condition has changed. Your records should also include beneficiary-specific information regarding the need for the replacement item. This information should be maintained in your files and be available to the DME MACs or UPICs upon request. Failure to provide the appropriate documentation or providing documentation that contains broad, nonspecific explanations will result in claim(s) denial.

A new order is required before replacing lost, stolen, or irreparably damaged items to reaffirm the medical necessity of the item. Proof of loss or damage through documentation such as a police report, picture, or corroborating statement should be kept on file and available to the contractor upon request.

**WRITTEN ORDERS PRIOR TO DELIVERY (WOPD)****GENERAL**

A WOPD is a completed SWO that is communicated to the DMEPOS supplier before delivery of the item(s).

Pursuant to Final Rule 1713 (84 Fed. Reg Vol 217) and 42 CFR §410.38, CMS created the “Master List of DMEPOS Items Potentially Subject to Face-to-Face Encounter and Written Order Prior to Delivery and/or Prior Authorization Requirements.” The Master List serves as a library of DMEPOS items from which items may be selected for inclusion in either, or both, of the following lists:

- Required Face-to-Face Encounter and Written Order Prior to Delivery List;
- Required Prior Authorization List.

Items included in either Required List are subject to the face-to-face encounter and WOPD or prior authorization requirements, respectively, as a condition of payment.

CMS and the DME MACs post on their websites the Required Face-To-Face Encounter and Written Order Prior to Delivery List, which contains the selected HCPCS codes, once also published through the Federal Register for notice. The published effective date will also be included on the DME MACs’ websites. The Required Face-To-Face Encounter and Written Order Prior to Delivery List will be periodically updated.

Note that the face-to-face encounter and WOPD requirements are statutorily required for PMDs, and in accordance with this statutory obligation, both will continue to be required, and will be included in any future publications of the Required List.

The date of the WOPD shall be on or before the date of delivery or on or before the date shipped if the shipping date is used as the date of service.

A WOPD must be completed within six (6) months after the required face-to-face encounter.

For PMDs, the treating practitioner who conducted the face-to-face encounter must also complete the SWO for the PMD base item. If the treating practitioner who conducted the face-to-face encounter is not the same practitioner who wrote the order for the PMD base item, the claim will be denied as statutorily non-covered pursuant to the Social Security Act, Title XVIII, §1834(a)(1)(E)(iv).

Upon request by a contractor, DMEPOS suppliers must provide documentation of the completed WOPD.

**Nurse Practitioner or Clinical Nurse Specialist Rules Concerning Orders**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.7**

A nurse practitioner or clinical nurse specialist may write and sign the standard written order in the following situations:

- They are treating the beneficiary for the condition for which the item is needed;



- They are practicing independently of a physician;
- They bill Medicare for other covered services using their own provider number; and
- They are permitted to do all of the above in the State in which the services are rendered.

Signatures must comply with CMS signature requirements. Refer to the “Signature Requirements” section in this chapter.

### **Physician Assistant Rules Concerning Orders**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.8

Physician assistants may write and sign the standard written order if they satisfy all the following requirements:

- They meet the definition of physician assistant found in §1861(aa)(5)(A) of the Act;
- They are treating the beneficiary for the condition for which the item is needed;
- They are practicing under the supervision of a Doctor of Medicine or Doctor of Osteopathy;
- They have their own NPI; and
- They are permitted to perform services in accordance with State law.

Signatures must comply with CMS signature requirements. Refer to the “Signature Requirements” section in this chapter.

### **Supply Replacement/Utilization – Evidence of Medical Necessity**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.11

If replacement supplies are needed for the therapeutic use of purchased DMEPOS, the treating practitioner must specify on the standard written order the type of supplies needed in such a manner that the supplier may calculate the necessary disbursement and assess the continued need for refill with the beneficiary. DME MACs, UPICs, and other contractors evaluate supply utilization information as part of their medical necessity and coverage determinations for DMEPOS.

The DME MACs and/or UPICs have procedures in place to monitor utilization of replacement supplies. You must submit updated medical information of the beneficiary’s condition resulting in changes of the equipment device, or supply utilization. Claims submitted with unexpected increases in supply utilization without supportive documentation will be denied. You must provide this information with the claim where indicated in published policy or make it available to the DME MACs or UPICs on request.

### **Acceptability of Faxed and Electronic Orders**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5

When reviewing claims and orders, DME MACs and UPICs may encounter faxed, copied, and electronic orders in supplier files. These documents are accepted by the DME MACs and UPICs.

The DME MACs and UPICs retain the authority to request additional documentation to support the claim. If a DME MAC finds indications of potential fraud or misrepresentation of these documents or the claims submitted, they will refer the matter to the UPIC for development.

## **4. Documentation in the Beneficiary's Medical Record**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.9; Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15; Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 12; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

Medicare does not automatically assume payment for a DMEPOS item that was covered prior to a beneficiary becoming eligible for the Medicare Fee-for-Service (FFS) program. When a beneficiary receiving a DMEPOS item from another payer (including Medicare Advantage plans) becomes eligible for the Medicare FFS program, Medicare will pay for continued use of the DMEPOS item only if all Medicare coverage, coding, and documentation requirements are met. Additional documentation to support that the item is reasonable and necessary may be required upon request of the DME MAC.

For any DMEPOS item to be covered by Medicare, the beneficiary's medical record must contain sufficient documentation of the beneficiary's medical condition to substantiate the necessity for the type and quantity of items ordered and for replacement (if applicable). The information should include the beneficiary's diagnosis and other pertinent information including, but not limited to, duration of the beneficiary's condition, clinical course (worsening or improving), prognosis, nature and extent of functional limitations, other therapeutic interventions and results, past experience with related items, etc.

Neither a practitioner's order, nor a supplier-prepared statement, nor a practitioner's attestation by itself provides sufficient documentation of medical necessity, even though it is signed by the treating practitioner or you. There must be information in the beneficiary's medical record that supports the medical necessity for the item and substantiates the information on a supplier-prepared statement or practitioner's attestation (if applicable).

Forms are subject to corroboration with information in the medical record.

Templates utilized by practitioners and licensed/certified medical professionals (LCMPs) in the documenting and gathering of clinical information during patient visits are considered part of the medical record for medical review purposes. Templates that offer limited options and space for documentation (such as those that make use of "check boxes"), may fail to capture sufficient clinical information to demonstrate coverage and coding requirements for items/services were met.

The beneficiary's medical record is not limited to the treating practitioner's office records. It may include hospital, nursing home, or home health agency records, records from other professionals, etc. (not all-inclusive). Records from suppliers or healthcare professionals with a financial interest in the claim outcome are not considered sufficient by themselves for the purpose of determining that an item is reasonable and necessary.

The documentation in the beneficiary's medical record does not need to be routinely sent to you or to the DME MACs or UPICs; however, the DME MAC or UPIC may request this information. If the DME MAC or UPIC does not receive the information when requested, or if the information in the beneficiary's medical record does not adequately support the medical necessity for the item, then for assigned claims you are liable for the dollar amount involved unless a properly executed advance beneficiary notice of non-coverage (ABN) of possible denial has been obtained. See the Advance Beneficiary Notice of Non-coverage section below for information about ABNs.

### **FACE-TO-FACE ENCOUNTER**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

*Note: This section pertains to the Final Rule CMS-1713-F face-to-face requirements associated with the "Required Face-to-Face Encounter and Written Order Prior to Delivery List."*

As a condition for payment, 42 CFR §410.38 and Final Rule CMS-1713-F (84 Fed. Reg Vol 217) require that a treating practitioner have a face-to-face encounter with a beneficiary within the six months prior to prescribing items that appear on the **Required Face-to-Face Encounter and Written Order Prior to Delivery List**.

The face-to-face encounter must support payment for the item(s) ordered/prescribed, and be documented in the pertinent portion of the medical record (for example, history, physical examination, diagnostic tests, summary of findings, progress notes, treatment plans, or other sources of information that may be appropriate). The supporting documentation must include subjective and objective beneficiary specific information used for diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.

This face-to-face requirement also includes examinations conducted via the CMS-approved use of telehealth examinations, which must meet the requirements of 42 CFR §§410.78 and 414.65 for purposes of DMEPOS coverage.

A WOPD must be completed within six months after the required face-to-face encounter.

Refer to the applicable LCD-related Policy Article NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section for more information regarding documentation requirements.

The six-month timing requirement does not supplant other coverage or documentation requirements.

There must be sufficient medical information included in the medical record to demonstrate that all other applicable coverage criteria are met. Refer to the applicable Local Coverage Determination for information about the medical necessity criteria for the item(s) being ordered.

For items other than PMDs that appear on the Required Face-to-Face Encounter and Written Order Prior to Delivery List, the treating practitioner that conducted the face-to-face encounter does not need to be the prescriber for the DMEPOS item; however, the prescriber must:

- Verify that a qualifying face-to-face encounter occurred within the six months prior to the date of their prescription; and,
- Have documentation of the qualifying face-to-face encounter that was conducted.

A qualifying face-to-face encounter is required each time a new order/prescription for one of the specified items on the Required Face-to-Face Encounter and Written Order Prior to Delivery List is ordered. A single face-to-face encounter may document the clinical conditions necessitating multiple DMEPOS items. In this situation, regardless of whether the DMEPOS items are prescribed on different dates, the single face-to-face encounter may be utilized in support of the multiple items, so long as the encounter date is within six months prior to the date of the orders.

The CMS and DME MACs post on their websites the Required Face-to-Face Encounter and Written Order Prior to Delivery List of selected HCPCS codes, once published through the Federal Register Notice. The List will be periodically updated.

Upon request by a contractor, all DMEPOS suppliers must provide documentation of the face-to-face encounter.

### **Claim Denial**

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes in the “Required Face-to-Face Encounter and Written Order Prior to Delivery List.”

Claims for the specified items subject to Final Rule 1713 (84 Fed. Reg Vol 217) that do not meet the face-to-face encounter and WOPD requirements specified in the LCD-related *Standard Documentation Requirements Article (A55426)* will be denied as not reasonable and necessary.

If a supplier delivers an item prior to receipt of a WOPD, it will be denied as not reasonable and necessary. If the WOPD is not obtained prior to delivery, payment will not be made for that item even if a WOPD is subsequently obtained by the supplier. If a similar item is subsequently provided by an unrelated supplier who has obtained a WOPD, it will be eligible for coverage.

DME MAC LCD-related Policy Articles also include information pertinent to the required Face-to-Face Encounter and Written Order Prior to Delivery List. This information is located within the section labeled “REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217).”

Suppliers are reminded that some DME MAC LCDs include requirements of an “in-person” visit or encounter between the practitioner and beneficiary. This “in-person” visit or encounter is not the requisite “face-to-face” encounter of the Required Face-to-Face Encounter and Written Order Prior to Delivery List requirements. While the “in-person” encounter requirement in LCDs and the “face-to-face” encounter in the Face-to-Face Encounter and Written Order Prior to Delivery List are separate requirements of documentation, both can be satisfied by a single qualifying interaction between the practitioner and the beneficiary when the requirements of each are supported in the medical record of the single interaction.

#### PMD Denials:

As a condition of payment pursuant to 42 CFR §410.38, Power Mobility Devices (PMDs) require a standard Written Order Prior to Delivery (WOPD) for the base item. If the supplier does not receive the order/prescription for the base item prior to delivery, the claim will be denied as not reasonable and necessary.

Pursuant to the Social Security Act, Title XVIII, §1834(a)(1)(E)(iv), payment may not be made for a motorized or power wheelchair unless the treating practitioner conducts the face-to-face encounter and writes the Standard Written Order (SWO). If the treating practitioner does not conduct the face-to-face encounter or write the SWO for the PMD base item, the claim will be denied as statutorily noncovered.

#### **CONTINUED MEDICAL NEED**

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered; therefore, beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription. For purchased items, initial months of a rental item or for initial months of ongoing supplies or drugs, information justifying reimbursement will come from this initial time period. Entries in the beneficiary’s medical record must have been created prior to, or at the time of, the initial date of service to establish whether the initial reimbursement was justified based upon the applicable coverage policy.

For ongoing supplies and rental DME items, in addition to information described above that justifies the initial provision of the item(s) and/or supplies, there must be information in the beneficiary’s medical record to support that the item continues to be used by the beneficiary and remains reasonable and necessary. Information used to justify continued medical need must be timely for the date of service under review. Any of the following may serve as documentation justifying continued medical need:

- A recent order/prescription by the treating practitioner for refills of supplies
- A recent order/prescription by the treating practitioner for repairs
- A recent change in order/prescription
- Timely documentation in the beneficiary's medical record showing usage of the item

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified in policy.

### **CONTINUED USE**

Continued use describes the ongoing utilization of supplies or a rental item by a beneficiary.

You are responsible for monitoring utilization of DMEPOS rental items and supplies. Monitoring of purchased items or capped rental items that have converted to a purchase is not required. You must discontinue billing Medicare when rental items or ongoing supply items are no longer being used by the beneficiary.

Beneficiary medical records or your records may be used to confirm that a DMEPOS item continues to be used by the beneficiary. Any of the following may serve as documentation that an item submitted for reimbursement continues to be used by the beneficiary:

- Timely documentation in the beneficiary's medical record showing usage of the item, related option/accessories, and supplies.
- Your records documenting the request for refill/replacement of supplies in compliance with the refill documentation requirements section. This is deemed to be sufficient to document continued use for the base item as well.
- Your records documenting beneficiary confirmation of continued use of a rental item.

Timely documentation is defined as a record in the preceding 12 months unless otherwise specified in policy.

## **5. Signature Requirements**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.3.2.4**

For medical review purposes, Medicare requires that the persons responsible for the care of the beneficiary, including providing, ordering, and certifying items and services, be identifiable.

For medical review, signatures are required for two purposes:

1. To satisfy specific signature requirements in statute, regulation, national coverage determination (NCD), or local coverage determination (LCD); and,
2. To resolve authenticity concerns related to legitimacy or falsity of the documentation.

When a signature is required for the purposes above and the signature requirement(s) is not met, it may lead to a claim denial, corrective actions, or a fraud referral.

You should review the documentation to ensure that signature requirements in a statute, regulation, NCD, or LCD are met (when applicable) and to ensure that signature information is available when authenticity may be of concern. When a necessary signature is illegible or missing, you should submit a signature log or signature attestation statement.

### **Signature Log**

A signature log lists the typed or printed name of the author who is associated with an illegible signature or initials. The signature log could be included on the actual page where the illegible signature or initials are located or could be provided as a separate document. It is recommended that the author also list their credentials in the log.

### **Signature Attestation Statement**

A signature attestation statement may be submitted to authenticate an illegible or missing signature on medical records and orders. To be considered valid for Medicare medical review purposes, the attestation statement must be signed and dated by the author of the medical record entry or order and must contain sufficient information to identify the beneficiary.

Signature attestations that meet the requirements will be considered regardless of the date the attestation was created, except in instances where a statute, regulation, NCD, or LCD indicate that a signature must be in place prior to a given event or a given date.

## **6. Refills of DMEPOS Items Provided on a Recurring Basis**

*CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.2.6; Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

For DMEPOS items and supplies that are provided on a recurring basis, billing must be based on prospective, not retrospective use. The following scenarios are illustrative of this concept:

Scenario 1: The treating practitioner writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order, delivers 100 units, and bills the claim with a date of service as the date of delivery indicating 100 units. This is an example of prospective billing and is acceptable.

Scenario 2: The treating practitioner writes an order for enteral nutrition which translates into the dispensing of 100 units of nutrient for one month. The supplier receives the order and delivers 100 units. A claim is not billed. At the end of the month, the supplier determines that the beneficiary used 90 units for the month and delivers 90 units to replace the nutrient used. A claim is then submitted with a date of service as the date of delivery indicating 90 units of enteral nutrition. This is an example of retrospective billing and is not acceptable.

For DMEPOS products that are supplied as refills to the original order, you must contact the beneficiary or caregiver/designee and document an affirmative response, prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are expected to end, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply. For delivery of refills, you must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee and document an affirmative response, prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request and an affirmative response from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

You must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. You must stay attuned to changed or atypical utilization patterns on the part of your clients. You must verify with the prescribing practitioner that any changed or atypical utilization is warranted.

DME MACs allow for the processing of claims for refills delivered/shipped prior to the beneficiary exhausting their supply.

### **REFILL DOCUMENTATION**

A routine refill prescription is not needed. A new prescription is needed when:

- There is a change in the supplier, and the new supplier is unable to obtain a copy of a valid order/prescription for the DMEPOS item from the transferring supplier.
- There is a change in the order/prescription for the DMEPOS item.
- When an item is replaced.
- On a regular basis (even if there is no change in the order) only if it is so specified in the documentation section of a particular medical policy.

For items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

For items that are delivered to the beneficiary, documentation of a request for refill must be individualized to the beneficiary (i.e., the beneficiary or their caregiver/designee affirms the need for refill) and documented in the record. Medicare does not prescribe the mode of communication used to gather the information. For example, the refill request communication may be performed via automated text messaging or email as long as each required aspect of the refill request is captured. The refill request and affirmative response must occur and be documented before shipment. A retrospective attestation statement by you or the beneficiary is not sufficient.

The refill record must include:

- The beneficiary's name or authorized representative, if different than the beneficiary.
- A description of each item that is being requested.
- Documentation of affirmative response indicating a need for refill.
- Date of refill request.

This information must be kept on file and be available upon request.

## 7. Beneficiary Authorization

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1

You may only receive Medicare payment if the beneficiary assigns his or her Medicare benefits to you. Regulations authorize Medicare to pay for claims submitted by a supplier only if the beneficiary or the person authorized to request payment on the beneficiary's behalf assigns the claims to the supplier and the supplier accepts assignment. For all claims submitted on or after January 1, 2005, payment shall be made to physicians and suppliers even without a beneficiary-signed assignment of benefits (AOB) form when the service can only be paid on an assignment related basis. This includes any mandatory assignment situations and participating physician or supplier situations. When you accept assignment, you must accept Medicare's determination of the approved amount as the full fee for the service(s) rendered. For more information about beneficiary authorization, see the Chapter 6 of this manual.

## 8. Proof of Delivery (POD)

### SUPPLIER PROOF OF DELIVERY DOCUMENTATION REQUIREMENTS

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 17, §80.3.3; Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 4, §4.7.3.1 – 4.7.3.1.3 & Chapter 5, §5.10; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

You are required to maintain proof of delivery documentation in your files. Documentation must be maintained in your files for seven years.

Proof of delivery is one of the supplier standards as noted in 42 CFR §424.57(c)(12) and in Chapter 2 of this manual. In certain instances, compliance with proof of delivery may be required as a condition of payment and must be available to the DME MAC, RAC, SMRC, CERT, and UPIC on request. For such items, if the supplier does not have appropriate POD documentation within the prescribed timeframes, associated claims will be denied and overpayments will be recouped. Note that non-compliance with supplier standards may also result in revocation from the Medicare program. If you consistently do not provide documentation to support your services, you may be referred to the Office of Inspector General or the National Provider Enrollment (NPE) for investigation and/or imposition of sanctions. If the beneficiary is newly eligible to Medicare FFS, the proof of delivery standards require the supplier to obtain a statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item, and the supplier must attest that the item meets Medicare requirements.

### PROOF OF DELIVERY AND DELIVERY METHODS

For the purpose of the delivery methods noted below, **designee** is defined as any person who can sign and accept the delivery of DMEPOS on behalf of the beneficiary.

You, your employees, or anyone else having a financial interest in the delivery of the item(s) are prohibited from signing and accepting an item on behalf of a beneficiary (i.e., acting as a designee on behalf of the beneficiary). The relationship of the designee to the beneficiary should be noted on the delivery document that you obtain (i.e., spouse, neighbor, etc.). The signature of the designee should be legible. If the signature of the designee is not legible, you (or the shipping service) should note the name of the designee on the delivery document.

There are three methods of delivery:



1. Delivery directly to the beneficiary or authorized representative
2. Delivery via shipping or delivery service
3. Delivery of items to a nursing facility on behalf of the beneficiary

Regardless of the method of delivery, the contractor must be able to determine that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are received by a specific Medicare beneficiary.

**Method 1—Direct Delivery to the Beneficiary**

You may deliver directly to the beneficiary or the designee. In this case, POD to a beneficiary must be a signed and dated delivery document. The POD document must include:

- Beneficiary's name
- Delivery address
- A description of the item(s) being delivered. The description can be a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
- Quantity delivered
- Date delivered
- Beneficiary (or designee) signature

The date delivered on the POD must be the date that the DMEPOS item was received by the beneficiary or designee. The date of delivery may be entered by the beneficiary, designee, or you. When your delivery documents have both your entered date and a beneficiary or beneficiary's designee signature date on the POD document, the beneficiary or beneficiary's designee-entered date is the date of service.

In instances where the supplies are delivered directly by you, the date the beneficiary received the DMEPOS supply must be the date of service on the claim.

**Method 2—Delivery via Shipping or Delivery Service Directly to a Beneficiary**

If you utilize a shipping service or mail order, the POD documentation must be a complete record tracking the item(s) from you to the beneficiary. An example of acceptable proof of delivery would include both your detailed shipping invoice and the delivery service's tracking information. Your record must be linked to the delivery service record by some clear method like the delivery service's package identification number or your invoice number for the package sent to the beneficiary.

The POD document must include:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, your invoice number, or alternative method that links your delivery documents with the delivery service's records

- A description of the item(s) being delivered. The description can be a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number.
- Quantity delivered
- Date delivered
- Evidence of delivery

If you utilize a shipping service or mail order, you have two options for the DOS to use on the claim:

1. You may use the shipping date as the DOS. The shipping date is defined as the date the delivery/shipping service label is created or the date the item is retrieved by the shipping service for delivery. However, such dates should not demonstrate significant variation.
2. You may use the date of delivery as the DOS on the claim.

You may also utilize a return postage-paid delivery invoice from the beneficiary or designee as a POD. This type of POD document must contain the information specified above.

### **Method 3—Delivery to Nursing Facility on Behalf of a Beneficiary**

For items directly delivered by you to a nursing facility or when a delivery service or mail order is used to deliver the item(s) to a nursing facility, then you must have:

1. Documentation demonstrating delivery of the item(s) to the facility by you or delivery entity; and
2. Documentation from the nursing facility demonstrating receipt and/or usage of the item(s) by the beneficiary. The quantities delivered and used by the beneficiary must justify the quantity billed.

This information must be available upon request.

## **EXCEPTIONS**

### **Early Delivery to an Inpatient Facility in Anticipation of Discharge**

Per the *Medicare Program Integrity Manual*, Chapter 4, you may deliver DME, prosthetic, or orthotic items, but not supplies, to a beneficiary in an inpatient facility that does not qualify as the beneficiary's home, for the purpose of fitting or training the beneficiary in the proper use of the item. Delivery may be done up to two days prior to the beneficiary's anticipated discharge to their home. You must bill the date of service on the claim as the date of discharge and shall use the Place of Service (POS) as 12 (home). The item must be medically necessary on the date of discharge and the item must be for subsequent use in the beneficiary's home. On the date of discharge, you must ensure that the beneficiary takes the item home, or that you pick up the item at the facility and deliver it to the beneficiary's home. No billing may be made for the item on those days the beneficiary was receiving training or fitting in the hospital or nursing facility.

#### **Example:**

1. A beneficiary is admitted to a hospital stay on June 1.

2. The beneficiary will require the use of a walker upon discharge and must be trained on its use while in the hospital. The walker is provided to the beneficiary in the hospital on June 5.
3. The beneficiary is discharged from the hospital on June 6.

You would then bill the claim to the DME MAC using June 6 as the date of service.

### **Early Delivery to Home in Anticipation of Discharge**

In some cases, it would be appropriate for you to deliver a medically necessary item of DME, a prosthetic, or an orthotic (but not supplies) to a beneficiary's home in anticipation of discharge to a Place of Service (POS) that qualifies as home. You may deliver an item of DME, a prosthetic or an orthotic to a beneficiary's home in anticipation of discharge from a hospital or nursing facility. You may arrange for actual delivery of the item(s) no sooner than two days prior to the beneficiary's anticipated discharge to their home. You shall bill the date of service on the claim as the date of discharge and shall use the POS as 12 (home).

### **Early Delivery of Immunosuppressive Drugs**

Per the *Medicare Program Integrity Manual*, Chapter 4, delivery of immunosuppressive drugs may be made to the beneficiary's home (i.e., their own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution— such as an assisted living facility or an intermediate care facility for individuals with intellectual disabilities [ICF/IID], but not a hospital or skilled nursing facility). In certain cases, a beneficiary who has received a transplant does not return home immediately after discharge. In order to ensure beneficiary access to prescribed immunosuppressive medications at the time of discharge, you may deliver the initial prescriptions of a beneficiary's immunosuppressive drugs to an alternate address, such as the inpatient hospital that performed the transplant or alternative location where the beneficiary is temporarily staying (e.g., temporary housing), instead of delivering the drugs to the beneficiary's home address.

This is an optional, not mandatory, process. If you ship immunosuppressive drugs to an alternate address, all parties involved, including the beneficiary and the transplant facility, must agree to the use of this approach. You will not receive additional payment for delivery to an alternate location.

Note that the following conditions also apply:

1. The facility remains responsible for all immunosuppressive drugs required by the beneficiary for the duration of the beneficiary's inpatient stay. You must not receive separate payment for immunosuppressive drugs prior to the date the beneficiary is discharged.
2. You must not mail or otherwise dispense the drugs any earlier than two days before the beneficiary is discharged. It is your responsibility to confirm the beneficiary's discharge date if they choose to utilize this option. You must enter the date of discharge as the date of service on the claim.
3. You must not submit a claim for payment prior to the beneficiary's date of discharge.

### **General Information**

No billing may be made for any day prior to the date of discharge. You may not bill for drugs or other DMEPOS items used by the beneficiary prior to the beneficiary's discharge from the hospital or a Medicare Part A nursing facility stay. Billing the DME MAC for surgical dressings, urological supplies, or ostomy supplies that are provided during a stay in an inpatient facility that does not qualify as the beneficiary's home is not allowed. These items are payable to the facility under Medicare Part A. This applies even if the beneficiary wears the item home from the hospital or

nursing facility. Any attempt by you and/or the facility to substitute an item that is payable to you for an item that, under statute, should be provided by the facility, may be considered to be fraudulent. These statements apply to durable medical equipment delivered to a beneficiary in hospitals, skilled nursing facilities (Place of Service = 31), or nursing facilities (Place of Service = 32).

There is no separate payment from either Medicare or the beneficiary if, for any reason, redelivery is necessary. All other applicable Medicare and DME MAC billing requirements continue to apply.

### **Equipment Retained from a Prior Payer**

When a beneficiary receiving a DMEPOS item from another payer (including a Medicare Advantage Plan) becomes eligible for the Medicare FFS program, the first Medicare claim for that item or service is considered a new initial Medicare claim for the item. Even if there is no change in the beneficiary's medical condition, the beneficiary must meet all Medicare coverage, coding, and documentation requirements for the DMEPOS item in effect on the date of service of the initial Medicare claim.

A POD is required for all items, even those in the beneficiary's possession provided by another insurer prior to Medicare eligibility. To meet the POD requirements for a beneficiary transitioning to Medicare you, the supplier, must have on record:

- A statement, signed and dated by the beneficiary (or beneficiary's designee), that you have examined the item; and
- Your attestation, that the item meets Medicare requirements.

For the purposes of reasonable useful lifetime and calculation of continuous use, the first day of the first rental month in which Medicare payments are made for the item (i.e., date of service) serves as the start date of the reasonable useful lifetime and period of continuous use. In these cases, the proof of delivery documentation serves as evidence that the beneficiary is already in possession of the item.

Please refer to the Internet Only Manual (IOM), 100-08, Chapter 4, for additional information regarding all proof of delivery requirements.

## **9. Advance Beneficiary Notice of Non-coverage (ABN)**

**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, §120 & Chapter 30, §§40.2.1-40.2.2 & §50**

An Advance Beneficiary Notice of Non-coverage (ABN) is a written notice that allows the beneficiary to make an informed consumer decision as to whether or not to receive the items or services for which he or she may be required to pay out of pocket or through other insurance.

You must issue an ABN to a Medicare beneficiary before providing items and/or services when such items and/or services are those generally paid for by Medicare, but for which, in a particular situation, are expected to deny. In this scenario, the issuance of an ABN is considered mandatory. An ABN must be issued prior to dispensing an item or service expected to be disallowed for the following reasons:

- Lack of medical necessity
- Prohibited, unsolicited telephone contacts

- Supplier number requirements not met
- Medical equipment and/or supplies denied in advance
- Noncontracted suppliers in a competitive bidding area (CBA)

If you fail to issue a properly executed ABN, you will be held liable for the item and/or service and may not bill or collect, or must refund amounts collected, from the beneficiary.

Other situations may prompt provision of an ABN in which the use of the ABN is considered optional (not mandatory) yet strongly encouraged. Situations applicable to voluntary issuance of an ABN include notification to the beneficiary that an item or service is not covered by the Medicare Program due to either statutory exclusion or having not met a technical benefit requirement. When a voluntary ABN is issued, the beneficiary should not be asked to sign the notice or select an option box in the form. Voluntary ABNs are courtesy notifications informing beneficiaries of impending financial obligations.

You must retain a copy of the signed ABN on file. The ABN should not be submitted with the claim, but is required when responding to an additional documentation request for a complex review, in which case CGS will conduct a face validity assessment of the ABN to ensure liability is assigned appropriately in accordance with the Limitation of Liability Provisions.

The current version of the Advance Beneficiary Notice of Non-coverage (ABN) is form CMS-R-131 (Exp. 01/31/2026). Other forms will be considered invalid. The ABN form CMS-R-131 (Exp. 01/31/2026) and step-by-step completion instructions are available on CMS' Beneficiary Notices Initiative web page at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

For an ABN to be acceptable, it must:

- Be on the approved CMS-R-131 (Exp. 01/31/2026) form;
- Clearly identify your name, address, and telephone number;
- Clearly identify the beneficiary;
- Clearly identify the particular item and/or service;
- State that you believe Medicare is likely (or certain) to deny payment for the particular item and/or service; and
- Give your reason(s) for your belief that Medicare is likely (or certain) to deny payment for the item and/or service.
- Give a reasonable estimate cost of the noncovered item and/or service
- Be signed and dated by the beneficiary or representative.

As of October 14, 2021, once you have secured a valid ABN, the ABN remains effective and a new ABN is not required unless there is a change in any of the following:

- Care from what is described on the original ABN (such as the addition of items or services to the beneficiary's treatment that were not included on the original ABN).
- The beneficiary's health status which would require a change in the subsequent treatment for the non-covered condition.

- The Medicare coverage guidelines for the items or services in question (i.e., updates or changes to the policy of an item or service).

For items or services that are repetitive or continuous in nature, notifiers may issue another ABN to a beneficiary after one year for subsequent treatment for the non-covered condition. However, this is not required unless any of the conditions described above apply to the given situation .

ABNs apply to assigned and nonassigned claims, as there are financial liability provisions under Medicare law for both claim types:

**Limitation of liability (LOL)** applies to **assigned** claims for DMEPOS services disallowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or medical equipment and supplies denied in advance. Under LOL, a beneficiary can be held liable for a service denied due to reasons cited on the ABN.

**Refund requirements (RR)** apply to **assigned and non-assigned** claims for DMEPOS services disallowed because of medical necessity, due to prohibition on unsolicited telephone calls, no supplier number, or no ADMC. RR state that suppliers must make refunds of any amounts collected if the beneficiary was not properly notified of possible disallowed Medicare claims. The RR provisions require that the beneficiary is notified and agrees to be financially liable.

If you render a service which Medicare considers not medically necessary to a beneficiary, you should notify the beneficiary in writing, **before rendering the service**, that Medicare is likely to deny the claim and that the beneficiary will be responsible for payment. Modifier “GA” should be indicated on the Medicare claim with the appropriate HCPCS code when it is filed. See Chapter 16 of this manual for more information about modifiers.

The following statements are examples of reasons for your belief that Medicare is likely to deny payment:

- Medicare does not usually pay for this many treatments or services
- Medicare usually does not pay for this service
- Medicare does not pay for this because it is a treatment that has yet to be proved effective (experimental)
- Medicare does not pay for this many services within this period of time
- Medicare does not pay for such an extensive treatment

General statements such as “I never know if Medicare will deny payment” are not acceptable.

The beneficiary or their representative has the right to appeal a claim decision if there is dissatisfaction with the amount of payment, denial of coverage for services or supplies, or if the original claim was not acted upon within a reasonable time. You have the right to appeal a claim decision when you accept assignment.

As a supplier providing items and services to Medicare beneficiaries, you may appeal an initial determination if:

- You accepted assignment on the claim; or
- You are acting as the duly authorized representative of the beneficiary.

- You are a non-participating supplier of DME potentially responsible for making a refund to the beneficiary under §1834(a)(18) of the Act.
- You are a supplier of medical equipment and supplies not taking assignment and who is responsible for making a refund to the beneficiary under §1834(j)(4) of the Act.

See chapter 13 of this manual for more information about appeals.

When you furnish an upgraded item of DMEPOS and expect Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, you must give an ABN to the beneficiary for signature for holding the beneficiary liable for the additional expense.

In general, the “routine” use of ABNs is not effective. By “routine” use, CMS means giving ABNs to beneficiaries where there is no specific, identifiable reason to believe Medicare will not pay. Notifiers should not give ABNs to beneficiaries unless the notifier has some genuine doubt that Medicare will make payment as evidenced by their stated reasons. Giving routine notices for all claims or services is not an acceptable practice. If the contractor identifies a pattern of routine notices in situations where such notices clearly are not effective, it will write to the notifier and remind it of these standards. In general, routinely given ABNs are defective notices and will not protect the notifier from liability. However, ABNs may be routinely given to beneficiaries when all or virtually all beneficiaries may be at risk of having their claims denied. Please refer to the IOM, 100-04, Chapter 30, §40.2.2 for circumstances in which ABNs may be routinely given.

For complete instructions on using an ABN, refer to the CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 30, §50, which is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf>. Instructions are also available on the Beneficiary Notices Initiative Web page at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html>.

## **10. Amendments, Corrections, and Delayed Entries in Medical Documentation**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, §3.3.2.5

Per CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, all services provided to beneficiaries are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In these cases, the documentation will need to be amended, corrected, or entered after rendering the service. All amendments, corrections, or delayed entries will be reviewed in accordance with the *Medicare Program integrity Manual*, Chapter 3, Section 3.3.2.4.

## **11. Repair/Maintenance/Replacement**

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§110.2 & 120; Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

Under the circumstances specified in the *Medicare Benefit Policy Manual*, payment may be made for repair, maintenance, replacement, and delivery of medically-required DME which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part B of the Medicare program. In addition, payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer’s or supplier’s warranty.

**Repairs/Replacement to DMEPOS (Except Artificial Limbs)**

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §110.2; Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.10.1; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

**Repair**

A treating practitioner's order is not needed for repairs.

In the case of repairs to a beneficiary-owned DMEPOS item, if Medicare paid for the base equipment initially, medical necessity for the base equipment has been established. With respect to Medicare reimbursement for the repair, there are two documentation requirements:

1. The treating practitioner must document that the DMEPOS item being repaired continues to be reasonable and necessary (see Continued Medical Need section above); and
2. Either the treating practitioner or you must document that the repair itself is reasonable and necessary.

You must maintain detailed records describing the need for and nature of all repairs, including a detailed explanation of the justification for any component or part replaced, as well as the labor time to restore the item to its functionality.

**Replacement**

The CMS *Medicare Benefit Policy Manual* (IOM, Pub. 100-02), Chapter 15, §110.2.C, generally defines replacement as the provision of an entirely identical or nearly identical item when it is lost, stolen, or irreparably damaged.

Beneficiary-owned items, capped rental items, or oxygen equipment may be replaced in cases of loss or irreparable damage. Irreparable damage may be due to a specific accident or to a natural disaster (e.g., fire, flood). Contractors may request documentation confirming details of the incident (e.g., police report, insurance claim report).

Replacement of items due to irreparable wear takes into consideration the reasonable useful lifetime (RUL) of the item. The RUL of DME is determined through program instructions. In the absence of program instructions, carriers may determine the RUL, but in no case can it be less than five years. If the item has been in continuous use by the beneficiary on either rental or purchase basis for its RUL, the beneficiary may elect to obtain a replacement.

Medicare does not cover replacement for items in the frequent and substantial servicing payment category or inexpensive or routinely purchased rental items.

A treating practitioner's order, when required, is needed to reaffirm the medical necessity for replacement of an item.

**Repair/Replacement Applying to Artificial Limbs**

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §120; *Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)*

Adjustments and repairs of prostheses and prosthetic components are covered under the original order for the prosthetic device.

Medicare payment may be made for the replacement of prosthetic devices which are artificial limbs, or for the replacement of any part of such devices, without regard to continuous use or useful lifetime



restrictions if a treating practitioner determines that the replacement device, or replacement part of such a device, is necessary.

Claims involving the replacement of a prosthesis or major component (foot, ankle, knee, socket) must be supported by a new treating practitioner's order and documentation supporting the reason for the replacement. The reason for replacement must be documented by the treating practitioner, either on the order or in the medical record, and must fall under one of the following:

1. A change in the physiological condition of the beneficiary resulting in the need for a replacement. Examples include but are not limited to: changes in beneficiary weight, changes in the residual limb, and beneficiary functional need changes; or
2. An irreparable change in the condition of the device or in a part of the device resulting in the need for a replacement; or
3. The condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

The prosthetist must retain documentation of the prosthesis or prosthetic component replaced, the reason for replacement, and a description of the labor involved irrespective of the time since the prosthesis was provided to the beneficiary. This information must be available upon request. It is recognized that there are situations where the reason for replacement includes but is not limited to: changes in the residual limb, functional need changes, or irreparable damage or wear/tear due to excessive beneficiary weight or prosthetic demands of very active amputees.

Refer to the individual medical policies for specific coverage and payment provisions.

## **12. Delivery and Service Charges**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 20, §60*

Delivery and service are an integral part of the costs of doing business if you are an oxygen and durable medical equipment (DME) supplier. Such costs are ordinarily assumed to have been taken into account (along with all other overhead expenses) in setting the prices that you charge for covered items and services. As such, these costs, whether rented or purchased, have already been accounted for in the calculation of the fee schedules. Therefore, separate delivery and service charges for DMEPOS items will not be allowed except in rare and unusual circumstances when the delivery is outside the normal range of your sphere of operation. For example, a reasonable delivery charge might be allowed if you had to deliver a DMEPOS item to a beneficiary who lived outside your usual customer area and who had no access to another supplier located nearer. You must fully document these "unusual circumstances" on claims filed for delivery charges. These claims will be considered on an individual basis.

## **13. Same/Similar Equipment and Advance Beneficiary Notices of Non-coverage (ABN)**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 30*

This concerns ANSI Reason Code M3 - "Equipment is the same or similar to equipment already being used." See Chapter 17 of this manual for information about ANSI Reason Codes.

Numerous claims for durable medical equipment are denied because the equipment involved is the same as or similar to equipment already in the possession of the beneficiary. The statutory basis for denial of such claims is medical necessity; therefore, the limitation of liability provision under §1879 of the law applies. Backup equipment (standby and precautionary) has no coverage benefit and is considered not medically necessary. See the section *Backup Equipment* below.

Liability is assessed on claims denied based on "same or similar equipment." You are expected to be familiar with DME MAC coverage policies and any additional pertinent information that may have an impact on medical necessity determinations. In order to be protected under the limitation of liability provision, you must provide a proper advance beneficiary notice of non-coverage (ABN) for each item that you believe is likely to be denied as not medically necessary.

There must be a specific, identifiable reason to believe that Medicare may not pay for certain DME items (e.g., "same or similar equipment"). This means that you must obtain all the possible information from beneficiaries in order to determine whether "same or similar equipment" has previously been provided to that beneficiary. You should ask very specific questions when providing items to Medicare beneficiaries. When providing equipment to beneficiaries, the following information should always be obtained:

- The beneficiary's correct Medicare ID
- If the beneficiary has employer insurance or is enrolled in a Medicare Advantage Plan
- If the beneficiary currently has or had rental or ownership of an identical or similar item(s) in the past, you should obtain specific information about:
  - a. When the beneficiary received the item(s), and if the item(s) was returned, when and why
  - b. Who supplied the item(s)
- Where the item will be used
- A signed and dated written order from the prescribing practitioner
- Clinical documentation that demonstrates any change in medical need

You may also access information about previously submitted same or similar equipment through the myCGS Web Portal or the CGS Interactive Voice Response (IVR) System. For more information about myCGS and the IVR, see Chapter 13 of this manual. Also refer to the myCGS page on our website at <https://cgsmedicare.com/jb/mycgs/index.html>.

You should make certain that the beneficiary understands that items such as wheelchairs and power-operated vehicles are considered "similar equipment" and that Medicare will not cover both items when they are used simultaneously. You should strongly encourage the beneficiary to inform you if the medical need for the item changes and the beneficiary requires a different piece of equipment that serves a similar purpose. The Medicare program will only allow items that meet the beneficiary's current needs.

For example, if a beneficiary is renting a manual wheelchair and their condition worsens to the point that only a different wheelchair, such as a power wheelchair, will meet their medical need, coverage will be allowed for the power wheelchair and any subsequent claims for the manual wheelchair will be denied.

If there is no indication that same or similar equipment has been previously obtained, you would not have reason to provide an ABN. If the beneficiary or the beneficiary's authorized representative is unable to respond fully on the issue of "same or similar equipment," you may issue an ABN. In situations where the beneficiary is planning to use a piece of equipment as a backup (e.g., an extra wheelchair to keep in the car), you should ALWAYS obtain a signed ABN. In the event that you appeal a Medicare claim decision, you must submit a copy of the ABN with the appeal request (see Chapter 13 of this manual for information about appeals).

Same or similar rules may not necessarily apply to situations where a new device with additional technological features becomes available. The DME MAC or UPIC must evaluate whether the new feature(s) meets the beneficiary's medical need and that the need is not met by their current equipment. If the new feature or device meets a current medical need that is not met by the current equipment because the appropriate technology was not available at the time the beneficiary obtained the item, even if there has been no change in the beneficiary's condition, the five-year useful lifetime rules do not apply and the new item may be provided. However, if the new item is meeting the same medical need as the old item but in a more efficient manner or is more convenient, AND there is no change in the beneficiary's condition, Medicare will NOT reimburse for the new item.

The following examples illustrate these instructions:

1. The beneficiary receives a power wheelchair *without* power tilt/recline. Subsequently it is determined that the beneficiary needs a tilt/recline AND he/she has needed it since the provision of the initial power wheelchair. Often, the old wheelchair base will not accommodate the new tilt/recline system; therefore, in addition to the tilt/recline, you ask for a wheelchair base to be reimbursed. In this case one of the following options would apply:
  - A. If the old wheelchair is rented, an additional amount for the tilt/recline would be allowed but not a new rental period for the new wheelchair base.
  - B. If the old wheelchair was purchased, only reimbursement of the tilt/recline would be allowed and not the purchase of a new wheelchair base.
2. Code E2101 represents a code for a home glucose monitor that integrates the lancing and application of blood to the glucose testing strip in one machine. The Glucose Monitors LCD allows payment for these devices for beneficiaries with manual dexterity problems. If a beneficiary had manual dexterity problems at the time that an E0607 monitor was purchased and the technology of monitors coded E2101 was not available at the time the beneficiary obtained the E0607, they would be allowed to purchase the E2101 to address their medical need for a monitor that accommodates their dexterity problem. No "same or similar" denial would apply. The E0607 did not accommodate their medical need and while their medical need did not change, technology changed such that their medical need could now be met by the new technology.

These rules apply when the new device with advanced features is classified by the same HCPCS code as the older device or when described by a different HCPCS code. If, however, the new device is described by a different code, the beneficiary must also meet the coverage criteria of the new item.

Medicare regulation specifically forbids payments for multiple claims for rental of the same or similar equipment from either the same or a different supplier during the same rental month.

## 14. Pick-up Slips

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.14

A pick-up slip is written confirmation, provided by you, that you have removed an item of DME from the beneficiary's home. When making determinations, DME MACs or UPICs must ascertain not only whether equipment is present in the home, but must determine which equipment is actually being used by the beneficiary. Therefore, it is inappropriate to determine, solely based on lack of a pick-up slip that a piece of equipment may still be in use.

## 15. Backup Equipment

Backup medical equipment is defined as an identical or similar device that is used to meet the same medical need for the beneficiary but is provided for precautionary reasons to deal with an emergency in which the primary piece of equipment malfunctions. **Medicare does not pay separately or make an additional payment for backup equipment.**

When a determination is made that if a particular piece of equipment breaks down or malfunctions it will result in immediate life-threatening consequences for the beneficiary, Medicare will place that item in the frequent and substantial servicing payment category (see Chapter 5 of this manual for information about payment categories). For items in this payment category, Medicare will reimburse for monthly rental payments for as long as the equipment is medically necessary. Consequently, you are responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment.

The expectation is that an acceptable plan would involve input from the beneficiary and the treating practitioner and would take into account the severity of the beneficiary's condition and time restraints in providing emergency support. This means that you are responsible for ensuring that the beneficiary's medical needs for the use of this equipment will be met on a continuous and ongoing basis and that there is a plan to deal with any interruptions in the use of the equipment that would be life-threatening to the beneficiary. The plan may be as simple as furnishing backup equipment; however, Medicare will not pay separately and/or make any additional payment for the backup equipment. The payment for the primary piece of equipment would include the cost of that piece of equipment and the frequent and substantial servicing plan that you must provide to ensure that the beneficiary always has a piece of equipment that is in working order. If the backup equipment is billed, it will be denied as not being reasonable and necessary.

Backup equipment must be distinguished from multiple medically necessary items that are defined as identical or similar devices, each of which meets a different medical need for the beneficiary. Although Medicare does not pay separately for backup equipment, Medicare will make separate payment for a second piece of equipment if it is required to serve a different purpose that is determined by the beneficiary's medical needs.

Examples (not all-inclusive) of situations in which multiple items may be covered are:

1. A beneficiary requires one type of ventilator (e.g., a negative pressure ventilator with a chest shell) for part of the day and needs a different type of device (e.g., positive pressure respiratory assist device with a nasal mask) during the rest of the day.
2. A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the beneficiary may be prone to certain

medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

3. A beneficiary requires one type of infusion pump for a particular drug (e.g., a pump with beneficiary control features for parenteral morphine) and needs a different type of pump for another drug (e.g., continuous infusion chemotherapy).

Examples (not all-inclusive) of situations in which a second or other multiple pieces of equipment would be considered a backup and therefore would not be covered are:

1. A ventilator-dependent beneficiary is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.
2. The drug epoprostenol (Flolan) is administered using an ambulatory infusion pump, and a second infusion pump is provided and billed as a precaution in case of malfunction of the primary pump. Because interruption of a continuous infusion of this drug results in immediate life-threatening consequences, a unique code, K0455, has been established for an infusion pump used to administer this drug, and the code is in the frequent and substantial servicing payment category.

## **16. Correct Coding**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §3.3**

Correct coding is a determination that the item(s) provided to the beneficiary has been billed using the appropriate HCPCS code for the item. You are required to correctly code for the items billed. An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, or DME MAC articles. Information that is sufficiently detailed to unambiguously identify the specific product delivered to the beneficiary and the HCPCS code used to bill for that item must be maintained by the supplier and be available upon request.

For LCDs and LCD-related Policy Articles that use International Classification of Diseases 10<sup>th</sup> Edition Clinical Modification (ICD-10-CM) diagnosis codes, correct coding of the ICD-10-CM code is required. A diagnosis is correctly coded when it meets all the coding guidelines listed in International Classification of Diseases Guidelines (ICD), CMS ICD policy or guideline requirements, LCDs, or DME MAC articles. Information that is sufficiently detailed to unambiguously justify the ICD-10-CM code used to bill for DMEPOS items must be contained in the beneficiary's medical record and be available upon request.

## **17. Miscellaneous HCPCS Codes**

Unusual services and items are generally reported to the contractor with miscellaneous HCPCS codes. These miscellaneous HCPCS codes do not have established fee schedule reimbursement rates. Each item/service is processed based on individual consideration. In these situations you must include a narrative on your claim that describes the service or item, manufacturer name, product name and number, supplier price list (PL) amount, and HCPCS code of a related item (if applicable). If it is a customized option/accessory, the statement must clearly describe what was customized. When necessary, consultants' advice will be obtained.

If the description, manufacturer name, product name, and product number, supplier PL amount, and HCPCS code of a related item (if applicable) are not provided with the claim, then the claim will be rejected for missing information and you will be responsible for resubmitting the claim with the appropriate information.

A claim for an option/accessory code as a replacement must be submitted with the make and model/brand name of the base equipment to which the replacement item is being added, along with the date of the purchase for the base equipment. Documentation of the medical necessity for the item must be kept on file and available upon request.

The definitions of HCPCS codes are meant to be broadly inclusive. All related components are included in the codes and should generally not be billed separately unless specifically allowed in the definition or description of a HCPCS code. If you choose to bill separately for an included component, consult DME MAC articles and applicable LCDs and LCD-related Policy Articles for specific coding and coverage information (where available) for such components. Unless specified otherwise in a DME MAC article or medical policy, when billing separately for an included component, you must use HCPCS code A9900 (MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE) for DME-related components, and L9900 (ORTHOTIC AND PROSTHETIC SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS "L" CODE) for orthotic and prosthetic-related components. Claim lines submitted for either HCPCS code (A9900 or L9900) will be denied as not separately payable.

## **18. Evidence of Medical Necessity: Power Mobility Devices (PMD)**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5**

As the result of the way that the Social Security Act defines durable medical equipment, a power mobility device (PMD) is covered by Medicare only if the beneficiary has a mobility limitation that significantly impairs their ability to perform activities of daily living **within the home**. The beneficiary's mobility limitation cannot be sufficiently and safely resolved by the use of an appropriately fitted cane or walker. If the PMD is needed in the home, the beneficiary may also use it outside the home.

In order for Medicare to provide reimbursement for a PMD, there are specific requirements that must be met:

### **Standard Written Order**

As a condition of payment pursuant to 42 CFR §410.38, PMDs require a standard written order prior to delivery (WOPD) for the base item. The order must only be written after the in-person visit has occurred and the medical evaluation is completed.

Pursuant to the Social Security Act, Title XVIII, §1834(a)(1)(E)(iv), the standard written order for the PMD base item must be written and signed by the treating practitioner who performed the face-to-face encounter.

You may provide a template, listing the elements of a WOPD, but you must not fill in or complete any of these elements.

An SWO is required prior to claim submission for all options, accessories, and/or supplies that are separately billed in addition to the base. This SWO obtained prior to claim submission may be prepared by someone other than a treating practitioner. If someone other than a treating practitioner

prepares the SWO for separately billed options, accessories, and/or supplies, a treating practitioner must review and sign the order.

The treating practitioner who reviews and signs the SWO for separately billable options, accessories, and/or supplies does not need to be the same treating practitioner who completed the WOPD for the PMD base and conducted the face-to-face encounter. In this situation, the treating practitioner who orders the options, accessories, and/or supplies must:

- Verify that a qualifying face-to-face encounter occurred within six months prior to the date of the WOPD for the base item;
- Have documentation of the qualifying face-to-face encounter that was conducted for the base item; and,
- Review and sign their order.

### **Face-to-Face Encounter**

There must be a face-to-face practitioner-beneficiary encounter (the face-to-face encounter may be an in-person or Medicare-approved telehealth visit). The face-to-face encounter must be conducted within six months prior to the order date on the WOPD for the PMD (base item).

Note: The face-to-face examination requirement does not apply when only accessories for power mobility devices are being ordered, nor does it apply for the ordering of replacement PMDs. A replacement PMD would be the same device as previously ordered. However, if a beneficiary has a POV but would like to replace the POV with a power wheelchair, then a face-to-face examination would need to be conducted.

Practitioners shall document the encounter in a detailed narrative note in their charts in the format that they use for other entries. The note must clearly indicate that a major reason for the visit was a mobility encounter. The evaluation should be tailored to the individual beneficiary's conditions. The history should paint a picture of your beneficiary's functional abilities and limitations on a typical day. It should contain as much objective data as possible. The physical examination should be focused on the body systems that are responsible for the beneficiary's ambulatory difficulty or impact on the beneficiary's ambulatory ability. The evaluation must clearly distinguish the beneficiary's mobility needs within the home from their needs outside the home.

Documentation can also include copies of previous notes, consultations with other practitioners, and reports of pertinent laboratory, x-ray, or other diagnostic tests if they will help to support the severity of the beneficiary's ambulatory problems.

The practitioner may refer the beneficiary to a licensed/certified medical professional, such as a physical therapist (PT) or occupational therapist (OT), to perform part of the face-to-face encounter. This person may have no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT or OT working in the inpatient or outpatient hospital setting may perform part of the face-to-face encounter.)

To accommodate the requirements at 42 CFR §410.38, when the treating practitioner sees the beneficiary, regardless of whether a referral to an LCMP is made, that visit date starts the six-month timeline for completion of the SWO for the wheelchair base. If the treating practitioner chooses to refer the beneficiary to an LCMP for a mobility evaluation, the treating physician's co-signature, dating and indicating agreement or disagreement with the LCMP evaluation must occur within this six-month timeframe. In cases where the LCMP evaluation is being adopted into the physician's documentation to substantiate the need for the base item, the SWO may not be written until the LCMP report is signed, dated and agreement/disagreement indicated.

**Home Assessment**

An on-site home assessment must be conducted to consider the home's physical layout, doorway widths, doorway thresholds, and floor surfaces. The beneficiary's home must provide adequate access between rooms, maneuvering space, and surfaces for the operation of the PMD. The assessment must be done prior to or at the time of delivery of the PMD. The written report of this evaluation must be available on request.

You should refer to the individual medical policies for specific coverage and payment provisions.

As defined in the CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, if data analysis indicates potentially aberrant billing, contractors shall continue to follow the general guidance for performing medical review on claims.

For more information regarding power mobility devices, please consult the appropriate LCD and Policy Article.

**19. Comprehensive Error Rate Testing (CERT)**

**CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 12**

The Centers for Medicare & Medicaid Services (CMS) developed the Comprehensive Error Rate Testing (CERT) program to produce the Medicare Fee-For-Service improper payment rate, a national, contractor-specific, and service-specific claims error rate. The program has independent reviewers who periodically review representative random samples of Medicare claims. The independent reviewers medically review claims that are paid and claims that are denied to ensure the claim decision was appropriate. CERT was first developed by CMS in 1996 to measure Medicare FFS Improper Payment Rate for the purpose of reducing costs associated with improperly completed and improperly paid Medicare claims. It was later amended to comply with Improper Payment information Act of 2002 and again amended by Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012.

The CERT contractor selects a random sample of claims processed by each Medicare contractor, including the DME MACs. They then request medical records, Certificates of Medical Necessity, and supporting documentation from the provider of the service to verify services billed were paid or denied properly under Medicare coverage, coding, and billing rules. If you are contacted for a CERT review, you will be provided with the details regarding the needed information and how to submit it.

When no medical records or supporting documentation are received, a denial decision is made which ultimately results in a request for refund from the provider if the claim had been paid originally. These claims may be appealed through normal channels at the DME MAC (see Chapter 13 of this manual for information about appeals).

When records and/or documentation are received, the CERT contractor's medical review professionals (including nurses, physicians, and other qualified healthcare practitioners) then perform a complete review of the claims. If documentation fails to support the item(s) billed, an error is called and a refund will be requested. Documentation that supports the medical need will result in no further action needed by the provider.

Additional information about CERT may be found on the CERT C3HUB website at <https://c3hub.certrc.cms.gov/> and through our website at <https://www.cgsmedicare.com/jb/claims/cert/index.html>.



## Chapter 4 Contents

1. Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)
2. CMN and DIF Completion Instructions
3. CMNs as Orders and Claim Submission
4. Oxygen CMNs
5. CMN Common Scenarios

### 1. Certificates of Medical Necessity (CMNs) and DME MAC Information Forms (DIFs)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §100.2.1

**NOTE:** For claims with dates of service on or after January 1, 2023, you no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned.

**For claims with dates of service prior to January 1, 2023, if a CMN or DIF is required, it must be submitted with the claim or be on file with a previous claim.**

A Certificate of Medical Necessity (CMN) or DME Information Form (DIF) is required to help document the medical necessity and other coverage criteria for selected durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items. The documentation section of a Local Coverage Determination (LCD) shows which items require one of these forms. See Chapter 9 of this manual for more information about LCDs.

Only Office of Management and Budget (OMB)-approved, active CMNs that are in use for the date of service on the claim under consideration for reimbursement will be recognized in support of medical need or, when completed properly, as a substitute for a written order. Use of inactive or “retired” CMNs will not be recognized for either medical necessity purposes or as a substitute for a written order.

CMNs contain four sections, A through D. You may complete sections A and C. Sections B and D must be completed by the beneficiary’s physician.

A DIF is a supplier-completed form and used by the DME MAC for claim processing purposes. It does not require a physician signature or a narrative description of equipment and cost. You may complete and sign a DIF in its entirety.

For certain items or services billed to a DME MAC, you must receive a signed CMN from the treating physician. You must have a faxed, photocopied, original signed order or an electronic CMN in your records before you can submit a claim for payment to Medicare. CMNs and DIFs are referred to by their CMS form numbers. The CMS form number is located in the bottom left corner of the form. DME MAC form numbers identify the CMN on electronic claims submitted to the DME MAC.

Signatures must comply with CMS signature requirements. Refer to Chapter 3 of this manual for information about signature requirements.

You must maintain a faxed, photocopied, original signed order or an electronic signed CMN/DIF and it must be available to the DME MACs or Unified Program Integrity Contractors (UPICs) on request. When hardcopy CMNs/DIFs are submitted to the DME MACs or UPICs, you must include a copy of

the front side. When CMNs are submitted electronically to the DME MAC, information from sections A and B are required.

**Types of CMNs**

There are three types of CMNs:

1. **Initial** – Establishes the initial medical need for an item
2. **Revised** – Documents a change in the order (such as a change in the physician, a change in the number of units prescribed, etc.)
3. **Recertification** – Confirms that the medical need is still present for oxygen equipment

**CMNs**

The following table indicates the current DME MAC CMN forms.

| DME MAC FORM | CMS FORM | ITEMS ADDRESSED                                    |
|--------------|----------|--|
| 484.03       | 484      | Oxygen   |
| 04.04B       | 846      | Pneumatic Compression Devices                      |
| 04.04C       | 847      | Osteogenesis Stimulators                           |
| 06.03B       | 848      | Transcutaneous Electrical Nerve Stimulators (TENS) |
| 07.03A       | 849      | Seat Lift Mechanisms                               |
| 11.02        | 854      | Section C Continuation Form                        |

**DIFs**

The following table indicates the DIFs for external infusion pumps and enteral/parenteral nutrition.

| DME MAC FORM | CMS FORM | ITEMS ADDRESSED                  |
|--------------|----------|----------------------------------|
| 09.03        | 10125    | External Infusion Pumps          |
| 10.03        | 10126    | Enteral and Parenteral Nutrition |

Printable copies of CMNs and DIFs are available on the CMS website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>. To find the CMN/DIF you are looking for on the website, enter the name of the CMN/DIF in the “Filter On” field. For instance, if you are searching for the Oxygen CMN, enter the word “oxygen.” After finding the appropriate CMN/DIF, press the Form # link, and then open the PDF found under Downloads.

## 2. CMN and DIF Completion Instructions

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.5

The "Initial Date" found in Section A of the CMN or DIF should be either the specific date that the physician gives as the start of the medical necessity or, if the physician does not give a specific start date, the "Initial Date" would be the date of the order.

The "Signature Date" is the date the physician signed and dated Section D of the CMN or that you signed the DIF. This date will usually not be the same as the "Initial Date." Signatures must comply with CMS signature requirements. Refer to Chapter 3 of this manual for information about signature requirements.

The "Delivery Date/Date of Service" on the claim must not precede the "Initial Date" on the CMN or DIF or the start date on the written order. To ensure that an item is still medically necessary, the delivery date/date of service must be within three months after the "Initial Date" of the CMN or DIF or three months from the date of the physician's signature. The DME MACs and UPICs have the authority to request to verify the information on a CMN or DIF at any time. If the information contained either in your records or in the beneficiary's medical record maintained by the ordering physician fails to substantiate the CMN or DIF, or if it appears that the CMN or DIF has been altered, the DME MAC or UPIC will deny the service and initiate the appropriate administrative or corrective actions.

For revised and recertification CMNs or DIFs, physicians (or suppliers, for DIFs only) must enter the total cumulative number of months from the initial date in which the item will be needed when entering the estimated length of need. For instance, if an initial CMN has an original length of need of five months and the physician wishes to extend the length of need for an additional three months, then the length of need on the revised CMN must be entered as eight months (the total number of months from the initial date).

A new Initial DIF is required when:

1. An enteral formula billed with a different code, which has not been previously certified, is ordered; or,
2. For either enteral formulas or administration via pump, there has been a break in billing of more than 60 days (plus the remaining days in the rental month) and there has been a change in the underlying medical condition that justifies coverage for the item(s); or,
3. A beneficiary receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump\*.

*\*Change in method of administration from gravity or syringe to a pump requires a new initial DIF for the pump and a revised DIF for the enteral nutrient.*

A Revised DIF is required when:

1. There is a change in HCPCS code for the current enteral nutrient billed; or,
2. The number of days per week administered is changed; or,
3. The physician provides a new order changing the amount of calories administered; or,
4. Change in the method of administration from gravity to syringe or syringe to gravity (See above for gravity or syringe to pump); or,

5. Change in administration from tube feeding to oral feeding (if billing for denial); or,
6. The length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s);
7. For infusion pumps:
  - a. A beneficiary begins using an infusion for one drug and subsequently the drug is changed, another drug is added, or the code for a current drug changes. The additional new or changed drug or the new HCPCS code for the existing drug must be listed along with all other drugs for which the pump is used.
  - b. There is a change in the route of administration or a change in the method of administration of a drug.
  - c. The length of need previously entered on the DIF has expired and the ordering physician is extending the length of need for the item(s).

In the event of an audit, you must be able to produce the CMN or DIF and, if requested by the DME MAC or UPIC, produce information to substantiate the information on the CMN or DIF. If you cannot produce this information, the DME MAC or UPIC will deny the service and initiate the appropriate administrative or corrective actions.

### **CMN Cover Letters**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 5, §5.3.2**

The Social Security Act was amended in 1994 to specify the types of information that you may provide to physicians in a CMN. These are limited to an identification of the supplier and beneficiary, a description of the equipment and supplies being ordered, procedure codes for the equipment and supplies, and other administrative information not related to the medical condition of the beneficiary.

Cover letters may be used as a method of communication between you and the physician. It is not CMS's intent to restrict necessary communication between you and the physician. The CMS does not require nor regulate the cover letter.

Information contained in cover letters should address issues relating to CMS or Contractor regulation/policy changes, brief descriptions of the item(s) being provided, and changes in the patient regimen. You are encouraged to include language in your cover letters to remind physicians of their responsibility to determine both the medical need for, and the utilization of, all healthcare services and to assure that information relating to the beneficiary's condition is correct.

Section C of the CMN was designed not only to provide the physician with charge information, but also to function as a confirmation of the physician's order. However, if you wish to duplicate physician order information in a cover letter, you should feel free to do so.

### **Transmission of the CMN to and from the Physician, Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist**

When the CMN or DIF is submitted electronically and you choose to maintain a hardcopy CMN or DIF, the font may be modified as follows:

- Pitch may vary from 10 characters per inch (cpi) to 17.7 cpi;
- Line spacing must be 6 lines per inch;

- Each form must have a minimum ¼-inch margin on all four sides.

Without exception, these modified hardcopy forms must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/definitions printed on the back. CMN question sets may not be combined.

You and the physician may choose to utilize electronic CMNs (e-CMNs) or electronic DIFs (e-DIFs). E-CMNs or e-DIFs must adhere to all privacy, security, and electronic signature rules and regulations promulgated by CMS and DHHS. Additionally, e-CMNs or e-DIFs must contain identical questions/wording to the CMS forms, in the same sequence, with the same pagination, and identical instructions/definitions as printed on the back of the hardcopy form.

When the UPIC is investigating potentially fraudulent behavior by a supplier, it is the supplier's responsibility to prove the authenticity/validity of the claim(s) under investigation. The UPIC may require you to prove the authenticity/validity of the signature on the CMN, DIF, order, or any other questionable portion of the claim(s) under investigation.

### Changes to a Completed CMN

If there is a change made to any section of the CMN after the physician has signed the CMN, the physician **must** line through the error and initial and date the correction; or you may choose to have the physician complete a new CMN.

### Treating Physician of Record No Longer Involved With Beneficiary

If the physician of record is no longer the treating physician, you should obtain a revised CMN from the treating physician currently responsible for the beneficiary's pulmonary condition. No new testing is required. This CMN is not routinely submitted to the DME MAC or UPIC, but must be available on request.

### Physicians Charging for CMN Completion

Charging suppliers a fee for completing Medicare-required CMNs may be considered a potential felony by the Office of Inspector General (OIG). When physicians bill for their services, including examination, diagnosis, and treatment, any costs associated with paperwork are considered part of the charges made for their professional services. If a physician's patient genuinely needs an item of durable medical equipment, the completion of a CMN is a service to the physician's patient rather than to the supplier.

## 3. CMNs as Orders and Claim Submission

The CMN can serve as the physician's detailed written order if the narrative description in section C is sufficiently detailed. This would include quantities needed and frequency of replacement on accessories, supplies, nutrients, and drugs. For items requiring both a CMN and a written order prior to delivery (seat lift mechanisms and TENS units), you may utilize a completed and physician-signed CMN for this purpose. Otherwise, a separate order in addition to a subsequently completed and signed CMN is necessary.

You may not complete the information in section B of the CMN. A supplier who knowingly and willfully completes section B of the form is subject to a civil monetary penalty up to \$1,000 for each form or document so distributed.

You must complete the fee schedule amount, narrative description of the items furnished, and your charge for the medical equipment or supplies being furnished on a CMN prior to the CMN being furnished to the physician. If you knowingly and willfully fail to include this information, you may be subject to a civil monetary penalty up to \$1,000 for each form or document so distributed.

If an item requires a CMN or a DIF and you do not have a faxed, photocopied, or original hardcopy or an electronic signed CMN or DIF in your records before you submit a claim to Medicare, the claim will be denied. If the CMN or DIF is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category.

In cases where two or more suppliers merge, the resultant supplier should make all reasonable attempts to secure copies of all active CMNs or DIFs from the supplier(s) purchased. This document should be kept on file by the resultant supplier for future presentation to the DME MAC or UPIC.

When reviewing claims where the medical record contains a copied, faxed, or electronically maintained CMN or DIF (any CMN or DIF created, modified, and stored via electronic means, such as commercially available software packages and servers), the DME MAC or UPIC will accept the copied, faxed, or electronic document as fulfilling the requirements for these documents.

Upon request by the DME MAC or UPIC, you must provide the CMN or DIF, in a format that the DME MAC or UPIC can accept, in a timely manner. Upon medical review, the DME MAC or UPIC should not deny claims solely because the CMN or DIF is faxed, copied, or electronic. The DME MAC or UPIC may request you to download and print a hard copy of an electronic order, CMN, or DIF if the DME MAC or UPIC cannot access it electronically.

For items that require a CMN, and for accessories, supplies, and drugs related to an item requiring a CMN, the CMN may serve as the written order if the narrative description in Section C is sufficiently detailed (as described above). This applies to both hard copy and electronic orders or CMNs. A DIF does not contain a section for a narrative description and thus is not applicable.

Only OMB-approved, active CMNs that are in use for the date of service on the claim under consideration for reimbursement will be recognized as a substitute for a written order. Use of inactive or "retired" CMNs will not be recognized for either medical necessity purposes or as a substitute for a written order.

You must have a hard copied, faxed, or electronic order, CMN, or DIF in your records before you can submit a claim for payment to Medicare. You must ensure the security and integrity of electronically maintained CMNs or DIFs are in accordance with any regulations published by CMS.

## Supporting Medical Documentation

Refer to Chapter 3 of this manual for information regarding supporting medical documentation.

## 4. Oxygen CMNs

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.9.1

### Evidence of Medical Necessity for the Oxygen CMN

If DME MACs or UPICs learn that the physician of record is no longer the treating physician, you must obtain a current, fully-completed oxygen CMN from the physician currently responsible for the beneficiary's pulmonary condition. After review of this oxygen CMN, DME MACs continue monthly

payments if the evidence establishes medical necessity. Your records must be updated to identify the new treating physician.

For more information concerning coverage and claim submission for oxygen therapy, refer to the *Oxygen and Oxygen Equipment Local Coverage Determination (LCD)*.

### Initial Oxygen Certifications

For the situations that require an initial oxygen CMN, refer to the LCD entitled "Oxygen and Oxygen Equipment." In determining coverage, the dates of treatment and testing are critical. For example, the initial date of need for home oxygen coverage cannot precede the date of the order or the date of the test(s), the results of which are used to determine if the coverage criteria are met. Once coverage is established, the estimated length of need, along with the circumstances and results of testing that established the medical necessity at the start of home oxygen therapy, will determine when recertification is necessary.

Qualifying tests must be conducted by the treating physician or a provider certified to conduct such tests. Because of the potential for conflict of interest, the results of oximetry tests conducted by a DME supplier cannot be accepted to establish the need for home oxygen therapy services, either in initial claims or when accompanying recertification CMNs. This prohibition does not extend to the results of tests conducted by a hospital that is a certified provider of such services that may also be furnishing home oxygen therapy to the beneficiary.

The date of oxygen testing must be within 30 days prior to the date of initial certification. Therefore, for initial oxygen certifications the CMN may be completed by the physician no more than 30 days prior to initial coverage of oxygen. An exception to this is if a beneficiary begins taking oxygen while under a Medicare Advantage Plan. In this case, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins; however, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN. In this situation the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in the medical policy. It is important to note that, just because a beneficiary qualified for oxygen under a Medicare Advantage Plan, it does not necessarily follow that he/she will qualify for oxygen under FFS. These instructions apply whether a beneficiary voluntarily returns to FFS or if he or she involuntarily returns to FFS because their Medicare Advantage Plan no longer participates in the Medicare + Choice program.

When both arterial blood gas (ABG) and oxygen saturation (oximetry) tests have recently been performed, greater weight is given to the ABG result. That test is generally acknowledged as the more reliable indicator of hypoxemia. In a review situation, if documentation in the medical record contains the result of an ABG performed on the same day as an oximetry saturation recorded on the CMN, and they are the most recent tests taken on or before the certification date on the CMN, the ABG will be used to determine oxygen coverage for that certification. If the ABG does not substantiate the need for oxygen therapy, the claim(s) will be denied as not reasonable and necessary.

There are no professionally accepted formulas for converting the results of tests taken while the beneficiary is on oxygen to what the same beneficiary would have shown had he or she been breathing room air. Coverage may not be established by use of any suggested formula to convert this information.

Where PO<sub>2</sub> levels exceed 59 mm Hg or the arterial blood oxygen saturation exceeds 89 percent at rest, a rebuttable presumption of noncoverage exists. Form CMS-484 certification must be supplemented by additional documentation from the attending physician designed to overcome this

presumption and justify the oxygen order, including a summary of other, more conservative therapy that has not relieved the beneficiary's condition.

The CMS stipulates that claims may be denied **without development** if:

- The only qualifying test results came from oximetry tests conducted by a supplier of DME other than a hospital;
- The claim lacks information necessary to justify coverage in accordance with guidelines in section 240.2 of the *Medicare National Coverage Determinations Manual* (Pub. 100-03);
- Hardcopy claims where Form CMS-484 lacks the certifying physician's original signature; or
- Electronic claims where Form CMS-484 fails to indicate that the attending physician's handwritten signature is on file in the supplier's office.

### Treating Physician Identification

Form CMS-484 must be personally signed and dated by the treating physician, nurse practitioner, physician assistant, or clinical nurse specialist.

### Revised Oxygen Certifications

New medical documentation written by the beneficiary's treating physician must be submitted to the DME MAC in support of revised oxygen requirements when there has been a change in the beneficiary's condition and need for oxygen therapy; therefore, physicians are encouraged to file a revised Form CMS-484 as soon as possible when the order for oxygen changes. A revised certification is appropriate under the circumstances described in the "Oxygen and Oxygen Equipment" LCD.

### Recertifications of Oxygen CMNs

Recertification scheduling and documentation requirements depend on the date when home oxygen therapy began. See the "Oxygen and Oxygen Equipment" LCD for situations requiring a recertification. The following information is needed on all recertifications:

- Date and results of the most recent arterial blood gas or oximetry tests conducted prior to the recertification date;
- Name of the provider conducting the most recent ABG or oximetry tests prior to the recertification date;
- The conditions under which these tests were conducted;
- Estimated length of need for oxygen (in section B of Form CMS-484);
- Date of the **current** oxygen order;
- Details of the **current** oxygen order.

Additionally, for beneficiaries who initially qualify for oxygen coverage with Group II blood gases, a repeat blood gas study must be performed between the 61st and 90th day of home oxygen therapy (see below).

The schedule for recertifying the need of oxygen for beneficiaries beginning home oxygen therapy is established in accordance with the requirements below.



### Recertification Required at Three Months for Group II Patients

Recertification is required for beneficiaries who initially qualify for oxygen coverage with Group II results (an ABG result of 56-59 mm Hg or an arterial oxygen saturation of 89 percent). Payment may be made for the fourth month of service **only** upon presentation of test results that meet presumed coverage levels. The recertification at three months must reflect the results of an ABG or oxygen saturation test conducted between the 61st and 90th day of home oxygen therapy. If the beneficiary no longer requires home oxygen therapy after three months, retesting is not necessary.

Recertifications at three months should be completed in full. If the order has already been discontinued, the physician should write the date that it was stopped.

You, or the current oxygen supplier, must make the request for recertification to the physician. The physician should be instructed to complete the recertification CMN and return it to you. You must then forward a copy of this information with a hardcopy claim or transcribe it exactly as it appears into the record of an electronic claim for the fourth monthly payment for oxygen therapy. The physician should be encouraged to retain a copy of this recertification CMN. You or physician must retain a copy of the completed CMN (photocopy, facsimile image, electronically maintained, or original "pen and ink" document) Form CMS-484. No payment will be made for the fourth or later months of oxygen service unless the recertification CMN and retest results establish continuing medical necessity.

### Recertification for Long Term Therapy

If additional tests have been conducted since the prior certification, these results and other pertinent information must be recorded on the recertification. Additional testing will not be requested for beneficiaries with established chronic pulmonary problems.

You must send recertification requests to the attending physician for completion. You should emphasize that the completed Form CMS-484 is to be returned to you in all cases. To reduce misrouting problems, you may want to provide self-addressed, return envelopes. You must forward a copy of the completed Form CMS-484 with its next claim for monthly rental of oxygen equipment. It is advisable for the physician to retain a copy of the completed Form CMS-484 with other records for the beneficiary. You or physician must retain a copy of the completed CMN (photocopy, facsimile image, electronically maintained or original "pen and ink" document) Form CMS-484.

While the recertification is being obtained, payments will continue through the 12th month of service, based on the estimated length of need for oxygen therapy in the initial certification. Payment will be suspended for the 13th or later months if a satisfactory recertification CMN, including any test results that may be required, has not been received by the time the payment would otherwise be authorized.

### Subsequent Recertifications

Most beneficiaries who require home oxygen therapy beyond a few months require it lifelong. Therefore, once a Form CMS-484 recertification establishes that the medical necessity continues, subsequent recertifications are not routinely required; however, they may be requested in conjunction with quality control sampling or if there is an indication of significant change in the beneficiary's status, e.g., large, unexplained variations in the use of oxygen or evidence of confinement to a hospital or skilled nursing facility (SNF) throughout an equipment rental period. Because orders have a fixed, prospective life and payments can only be made pursuant to a currently valid order, physicians must keep orders current at all times. You must also retain orders so as to be immediately available should they be requested during medical review audits or for other purposes.

### 5. CMN Common Scenarios

Suppliers frequently approach the DME MACs or UPICs with questions about what CMN type should be submitted for a given situation. All CMN requirements detailed below are based on assumptions about the most common scenarios seen by the DME MACs. The facts of any individual supplier's claim may result in an alternate requirement. You should use this information only as general guidance and should consult with the DME MAC Customer Support department as necessary (see Chapter 13 of this manual for information about Customer Support).

| #  | Capped Rental Equipment   | Certification Required      | Notes   |
|----|---|-----------------------------|---------|
| 1  | Break in service > 60 days (change in medical condition)<br>No change in HCPCS                              | initial                     | 1       |
| 2  | Break in service > 60 days (no change in medical condition)<br>No change in HCPCS                           | none                        | 1       |
| 3  | Break in service < 60 days (change in medical condition)<br>No change in HCPCS                              | none                        | 1       |
| 4  | Break in service < 60 days (no change in medical condition)<br>No change in HCPCS                           | none                        | 1       |
| 5  | Break in service > 60 days (change in medical condition)<br>Change in HCPCS (e.g., K1 to K3 or K3 to K1)    | initial                     | 1, 3    |
| 6  | Break in service > 60 days (no change in medical condition)<br>Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial                     | 1, 3    |
| 7  | Break in service < 60 days (change in medical condition)<br>Change in HCPCS (e.g., K1 to K3 or K3 to K1)    | initial                     | 1, 3    |
| 8  | Break in service < 60 days (no change in medical condition)<br>Change in HCPCS (e.g., K1 to K3 or K3 to K1) | initial                     | 1, 3    |
| 9  | Change in supplier (no break in service, no change in HCPCS)  | revised in supplier's files | 1, 2    |
| 10 | Change in supplier (no break in service,  | initial                     | 1, 2, 3 |

|    |   |                             |  |
|----|---|-----------------------------|--|
|    | HCPSC changed e.g., K1 to K3)                                       |                             |  |
| 11 | Initial CMN did not qualify, patient re-evaluated and now qualifies | initial                     |  |
| 12 | Change in doctor  | revised in supplier's files |  |
| 13 | Added elevating leg rests after wheelchair provided                 | none                        |  |
| 14 | Changed billing assignment (non-assigned to assigned)               | none                        |  |
| 15 | Change from Medicare secondary to Medicare primary                  | none                        |  |
| 16 | Change from non-Medicare insurance to Medicare                      | initial                     |  |

Notes:

1. "Break in service" for the purpose of this table is defined as break in monthly billing.

"Change in medical condition" means that the patient's condition changed to the point that they no longer needed the original device. The patient's condition then changed again and the patient needed to resume using the original item. It could be for the same or different diagnosis.

"No change in medical condition" means that there is a break in billing but the patient still needed the same equipment. For example, the patient was in a SNF, hospital, Medicare Advantage Plan, or hospice and the DME MAC was not being billed during this time. This could also include situations in which the patient continued to need the equipment, but it was removed from the patient's home.

2. Requirement is for the new supplier.
3. Submission of a new Initial CMN does not guarantee that a new capped rental period will be started.

## Chapter 5 Contents

### Introduction

1. Inexpensive or Other Routinely Purchased DME (IRP)
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## Introduction – DMEPOS Fee Schedule Categories

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30

Reimbursement for most durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) is established by fee schedules. Payment is limited to the lower of the actual charge or the fee schedule amount. See Chapter 10 of this manual for more information about fee schedules and pricing.

The fee schedule classifies most DMEPOS into one of the six categories explained below:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Customized items
- Other prosthetic and orthotic devices
- Capped rental items
- Oxygen and oxygen equipment

To determine in which category a specific HCPCS code is classified, see *Appendix-A HCPCS* at the end of this manual.

*NOTE: For claims with dates of service on or after January 1, 2023, you no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned.*

*For claims with dates of service prior to January 1, 2023, if a CMN or DIF is required, it must be submitted with the claim or be on file with a previous claim.*

**1. Inexpensive or Other Routinely Purchased DME (IRP)**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.1

Payment for this type of equipment is made for rental or lump sum purchase, depending on the beneficiary’s choice. The total payment amount may not exceed the actual charge or the fee for a purchase.

- Inexpensive DME  
This category is defined as equipment whose purchase price does not exceed \$150.
- Other Routinely Purchased DME  
This category consists of equipment that is purchased at least 75 percent of the time.

Modifiers used in the IRP category are as follows\*:

|           |   |
|-----------|---|
| <b>RR</b> | Rental  |
| <b>NU</b> | Purchase of new equipment. Only use if new equipment was delivered.   |
| <b>UE</b> | Purchase of used equipment. Used equipment is any equipment that has been purchased or rented by someone before the current purchase transaction. Used equipment also includes equipment that has been used under circumstances where there has been no commercial transaction (e.g., equipment used for trial periods or as a demonstrator). |

\*These modifiers are not all-inclusive.

**Transcutaneous Electrical Nerve Stimulator (TENS)**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.1.2

TENS devices constitute an exception to the IRP category. Up to two months rental is allowed prior to the purchase of a TENS in order to permit an attending physician time to determine whether the purchase of a TENS is medically appropriate for a particular beneficiary. The purchase price is determined under the same rules as any other frequently purchased item, except that there is no reduction in the allowed amount for purchase due to the two months rental.

**2. Items Requiring Frequent and Substantial Servicing**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.2

Equipment in this category is paid on a rental basis only. Payment is based on the monthly fee schedule amounts until the medical necessity ends. No payment is made for the purchase of equipment, maintenance and servicing, or for replacement of items in this category.

Supplies and accessories are not allowed separately.

Modifiers used in the Frequent and Substantial Servicing category are as follows\*:

|           |        |
|-----------|--------|
| <b>RR</b> | Rental |
|-----------|--------|

\*These modifiers are not all-inclusive.

### **3. Certain Customized Items**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.3

Coverage and allowable amounts for custom equipment will be decided by individual evaluation based on medical indication.

The beneficiary's physician must prescribe the customized equipment and provide information regarding the beneficiary's physical and medical status to warrant the need for the equipment.

Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual beneficiary will be paid in a lump-sum amount. The payment amount for the purchase of a customized item is based upon the DME MAC's individual consideration for that item.

You must submit the following information with the claim in order for coverage to be considered:

1. Detailed description of the item
2. Description of feature(s) that make the item unique
3. Acquisition or production cost of the item (i.e., line item cost of materials and/or labor)

The date of service for custom-made equipment is the actual date the beneficiary receives the item. Do not use the date the item was ordered when billing Medicare.

### **4. Other Prosthetic and Orthotic Devices**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.4

These items consist of all prosthetic and orthotic devices excluding:

- Items requiring frequent and substantial servicing;
- Certain customized items;
- Parenteral/enteral nutritional supplies and equipment; and,
- Intraocular lenses.

Other than these exceptions, prosthetic and orthotic devices will be paid on a lump-sum purchase basis.

The date of service for custom-made equipment is the actual date the beneficiary receives the item. Do not use the date the item was ordered when billing Medicare.

### **Artificial Limbs, Braces, and Other Custom-Made Items Ordered but Not Furnished**

If a custom-made item was ordered but not furnished to a beneficiary because the individual died or because the order was canceled by the beneficiary or because the beneficiary's condition changed and the item was no longer reasonable and necessary or appropriate, payment can be made either on an assigned or unassigned claim basis, based on your expenses. If the beneficiary, for any other reason, canceled the order, payment can be made to the supplier only. In such cases, the expense is considered incurred on either:

- The date the beneficiary died;
- The date that you learned of the cancellation of the item; or
- The date that you learned that the item was no longer reasonable and necessary or appropriate for the beneficiary’s condition.

The allowed amount is based on the services furnished and materials used, up to the date you learned of the beneficiary’s death or of the cancellation of the order or that the item was no longer reasonable and necessary or appropriate. The DME MAC determines the services performed and the allowable amount appropriate in the particular situation, taking into account any salvage value of the device. Where you breach an agreement to make a prosthesis, brace, or other custom-made device for a Medicare beneficiary, e.g., an unexcused failure to provide the article within the time specified in the contract, payment may not be made for any work or material expended on the item. Whether a particular supplier has lived up to its agreement, of course, depends on the facts in the individual case.

**5. Capped Rental Items**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5

Items in this category are paid on a monthly rental basis not to exceed a period of continuous use of 13 months.

**Rental Fee Schedule**

For the first three rental months, the rental fee schedule is calculated so as to limit the monthly rental of 10 percent of the average of allowed purchase prices on assigned claims for new equipment during a base period, updated to account for inflation. For each of the remaining months, the monthly rental is limited to 7.5 percent of the average allowed purchase price (in other words, the payment is reduced by 25% beginning in the fourth month of rental). After paying the rental fee schedule amount for 13 months, no further payment may be made. *Note that for power wheelchairs and parenteral/enteral pumps, the monthly rental percentage may differ (see below for more information).*

Modifiers used in the Capped Rental category are as follows\*:

|           |                                     |
|-----------|-------------------------------------|
| <b>RR</b> | Rental                              |
| <b>KH</b> | First rental month                  |
| <b>KI</b> | Second and third rental months      |
| <b>KJ</b> | Fourth to the fifteenth months      |
| <b>BR</b> | Beneficiary has elected to rent     |
| <b>BP</b> | Beneficiary has elected to purchase |

|           |   |
|-----------|---|
| <b>BU</b> | Beneficiary has not informed supplier of decision after 30 days |
| <b>MS</b> | Maintenance and Servicing                                       |
| <b>NU</b> | New Equipment   |
| <b>UE</b> | Used Equipment  |

\*These modifiers are not all-inclusive.

**Payments during a Period of Continuous Use**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5.4  
 CMS Change Requests (CR) 5010 & 5370

After 13 months of rental, the title for the capped rental item must be transferred to the beneficiary. Once the beneficiary owns the item, Medicare pays for reasonable and necessary maintenance and servicing (i.e., for parts and labor not covered by a supplier’s or manufacturer’s warranty) of the item. You must follow applicable state and federal laws when transferring the title for the item to the beneficiary. This transfer must occur on the first day after the last rental month.

Note that parenteral (or enteral) nutrition (PEN) pumps follow different capped rental rules. Refer to the Parenteral/Enteral Pumps section below for details.

Additional information about these rules can be found in the MLN Matters articles MM5010 and MM5370. MLN Matters articles can be found on the CMS website at: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>.

**Period of Continuous Use**

A period of continuous use allows for temporary interruptions in the use of equipment. In order for a new rental period to begin, interruptions must exceed 60 consecutive days plus the days remaining in the rental month in which the use ceases (not calendar month, but the 30-day rental period). When an interruption continues beyond the end of the rental month in which use ceases, no additional payment will be made until the use of the item resumes. A new date of service will be established when use resumes. Unreimbursed months of interruption will not apply toward the 13 (or 15) month limit.

If an interruption does exceed 60 plus consecutive days, a new rental period may begin even though the original capped rental has been exhausted. In these situations, you must obtain from the ordering physician a new prescription, a new Certificate of Medical Necessity (CMN) and a statement describing the reasons for the interruption. Please be thorough, as the documentation will be reviewed carefully.

**Change of Address**

If the beneficiary moves during or after the rental period, either permanently or temporarily, it does not result in a new rental period.



**Modification or Substitutions of Equipment**

If equipment is changed to different but similar equipment, and the beneficiary's condition has substantially changed to support the medical necessity for the new item, a new rental period will begin. Otherwise (if the beneficiary's condition has not changed), the rental will continue to count against the current rental period and payment will be based on the least expensive medically appropriate equipment. If the rental period has already expired, no additional rental payment will be made for modified or substituted equipment in the absence of substantial change in medical need.

If modification is added to existing equipment and there is a substantial change in medical need, the rental period for the original equipment continues and a new rental period begins for the added equipment.

**Change in Suppliers**

If the beneficiary changes suppliers during the rental period, a new rental period will not begin

**Purchase Options of Capped Rental Items**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5.2-3

**Standard Power Wheelchairs (HCPCS codes K0813-K0831 and K0898)**

Prior to January 1, 2011, beneficiaries had the option to either rent or purchase standard power wheelchairs; however, Section 3136 of the Affordable Care Act of 2010 eliminated the lump sum purchase option for standard power wheelchairs (HCPCS codes K0813-K0831 and K0898). Standard power wheelchairs with dates of service on or after January 1, 2011 must be rented following standard capped rental rules.

For power wheelchair rentals beginning on or after January 1, 2011, monthly rental payment amounts under the DMEPOS fee schedule are calculated using a different percentage of the purchase price than the percentage used for regular capped rental items. Payment for the first three months of rental is 15 percent (instead of 10 percent) of the purchase price of the power wheelchair, and payment for months 4 through 13 is 6 percent (instead of 7.5 percent).

Note: There is an exception to these rules for beneficiaries residing in any of the nine Competitive Bidding Areas (CBAs) for the Round One Rebid of the DMEPOS Competitive Bidding Program. For information about competitive bidding, refer to the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html> or the Competitive Bidding Implementation Contractor (CBIC) website at <https://www.dmecompetitivebid.com>.

**Complex Rehabilitative Power Wheelchairs (HCPCS codes K0835-K0843 and K0848-K0864) and Wheelchair Options/Accessories Furnished for Use with a Complex Rehabilitative Power Wheelchair**

Complex rehabilitative power wheelchairs (HCPCS codes K0835-K0843 and K0848-K0864) and options/ accessories furnished for use with a complex rehabilitative power wheelchair can be either rented or purchased. You must give beneficiaries entitled to these power wheelchairs and options/accessories the option of purchasing at the time you first furnish the item. No rental payment will be made for the first month until you notify the DME MAC that the beneficiary has been given the option to either purchase or rent. If the beneficiary chooses to purchase, payment will be made on a lump sum purchase basis. In this case, the modifiers billed on the claim for purchase must be NU (or UE, if used), KH, and BP (in addition to any modifiers required by the Local Coverage Determination). If the beneficiary declines the purchase in the first month, payment will be made on

a rental basis. Effective for dates of service on and after October 1, 2018, the KH modifier is no longer required for purchased (NU or UE) wheelchairs and accessories.

For power wheelchair rentals beginning on or after January 1, 2011, monthly rental payment amounts under the DMEPOS fee schedule are calculated using a different percentage of the purchase price than the percentage used for regular capped rental items. Payment for the first three months of rental is 15 percent (instead of 10 percent) of the purchase price of the power wheelchair, and payment for months 4 through 13 is 6 percent (instead of 7.5 percent). The purchase fee schedule amount for complex rehabilitative power wheelchairs is equal to the monthly rental fee schedule amount divided by 0.15.

### **Parenteral/Enteral Pumps**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.7.1

Parenteral/enteral pumps can be either rented or purchased. When rented, they are processed similarly to capped rental items, with a few notable exceptions. First, they are not subject to the 25% reduction payment for the fourth rental month and after. Second, a beneficiary may elect to purchase a parenteral/enteral pump at any time, but must be offered the opportunity to do so by the tenth month if he/she has not already done so. If the beneficiary decides to purchase the pump once rentals have been paid, the purchase allowance will consist of the used purchase allowance less the amount allowed to date for rentals. If the beneficiary elects to continue to rent the pump, rental payments will continue up to 15 months.

Additional rental payments after the 15-month limit has been reached or after the pump has been purchased will only be considered if the attending physician changes the prescription between parenteral and enteral nutrients.

A change in suppliers during the 15-month rental period does not begin a new 15-month rental period. The new supplier is entitled to the balance remaining on the 15-month rental period.

The supplier that collects the last month of rental (i.e., the 15th month) is responsible for ensuring that the beneficiary has a pump for as long as it is medically necessary and for maintenance and servicing of the pump during the period of medical necessity.

### **All Other Capped Rental Items**

For capped rental items, rental payments will continue until a total of 13 continuous rental months have been paid (except for parenteral and enteral pumps). No additional payment beyond the 13th month will be made. On the first day after 13 continuous months have been paid, you must transfer title of the equipment to the beneficiary.

Modifiers used for the rent/purchase option are as follows:

|           |   |
|-----------|---|
| <b>BR</b> | Beneficiary has elected to rent                                 |
| <b>BP</b> | Beneficiary has elected to purchase                             |
| <b>BU</b> | Beneficiary has not informed supplier of decision after 30 days |

You must use one of these modifiers to notify the DME MAC of the beneficiary's decision. Since HCPCS modifiers are used, it is not necessary for you to submit documentation signed by the

beneficiary that he/she has been offered the rent/purchase option; however, you must maintain documentation in the files supporting the HCPCS modifier entered on the claim form.

## Maintenance and Service

### Maintenance and Servicing of Parenteral/Enteral Pumps

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §40.3

Necessary maintenance and servicing of parenteral/enteral pumps after the 15-month rental limit is reached may include repairs and extensive maintenance that involve the breaking down of sealed components, or performing tests that require specialized testing equipment not available to the beneficiary or nursing home. Payment will only be made for actual incidents of maintenance, servicing, or replacement. For enteral pumps, maintenance and servicing may be considered for payment every six months, beginning six months after the last rental month for the pump. For parenteral pumps, maintenance and servicing may be considered for payment every three months, beginning three months after the last rental month for the pump. Claims for replacement of parenteral/enteral pumps purchased more than eight years ago will be considered for payment.

The modifier used in for maintenance and servicing is as follows:

|           |   |
|-----------|---|
| <b>MS</b> | Maintenance and servicing (six-month maintenance and servicing fee for reasonable and necessary parts and labor that are not covered under any manufacturers or supplier warranty). |
|-----------|---|

### Starting a New Capped Rental Period

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.5.4

This defines two major reasons a new rental period would begin for a similar (same code) or related (different code) item of durable medical equipment (DME) that is in the Capped Rental payment category. These statements reflect current national policy and are provided as a clarification in response to inquiries from suppliers.

1. **For an item described by the same code, a new capped rental period would begin if there has been an interruption in the medical necessity for the item and that interruption lasted for 60-plus consecutive days.**

If there is an interruption in the billing of a capped rental DME item to the DME MAC because the beneficiary is in a hospital and/or nursing facility, a new capped rental period does not automatically begin if/when billing to the DME MAC resumes. If the billing is for the same item, or for a similar item using the same code, a new capped rental period would begin if there has been an interruption in the medical necessity for the item and that interruption lasted for 60-plus consecutive days.

The CMS defines a 60-plus consecutive day interruption as a period including two full rental months **plus** whatever days are remaining in the rental month during which the need ends. An interruption in medical necessity is defined as a resolution of the condition that created the first period of medical necessity and the subsequent development of a second event that creates a new period of medical necessity.

For example, a beneficiary has a wheelchair following a major injury to his legs. Rental starts on January 15 and rentals are billed on the 15th of the subsequent months (e.g., February and March). The beneficiary recovers and does not need the wheelchair anymore, and returns the wheelchair on March 25. The beneficiary subsequently has another injury and

again needs a similar wheelchair (same code). A new capped rental period would begin if the wheelchair is provided in the home on or after June 15. This is an interruption of two full rental months, April and May, plus the remainder of the month of discontinuation, March 25 through April 14. Note: In this example, if a similar wheelchair (same code) is needed and is provided in the home prior to June 15, a new capped rental period would not start because there is not a 60-plus consecutive day interruption of medical necessity.

A new capped rental period does not start just because there is an interruption in billing to the DME MAC. For example, if the beneficiary is in the middle of a capped rental period for a wheelchair that was needed because of permanent hemiplegia from a stroke and is admitted to a hospital and/or nursing facility for 60-plus days or enrolls in a hospice program for 60-plus days, the capped rental period for the wheelchair resumes where it left off once the beneficiary returns home or disenrolls from the hospice program, even if it is from a different supplier. Even though billing to the DME MAC was interrupted, there was no interruption in the medical necessity for the wheelchair.

- 2. For an item described by a different code, a new capped rental period would begin if there is a substantive change in the beneficiary's condition that necessitates a significantly different item.**

For example, a beneficiary has a K0001 wheelchair for short-term use following an injury. The beneficiary then has a stroke, which results in a dense hemiplegia and, after a one-month stay in a hospital and skilled nursing facility, it is determined that a K0004 wheelchair is needed. A new capped rental period would begin for the K0004 wheelchair because there had been a substantive change in the beneficiary's condition and a significantly different item was provided.

In another example, a beneficiary who meets the criteria for a group II support surface is provided a powered mattress overlay (E0372). After three months, the pressure ulcers heal and the beneficiary is switched to a group I mattress (e.g., E0186). A new capped rental period would begin for the group I mattress because there has been a substantive change in the beneficiary's condition and a significantly different item was provided.

*Note: The following groups of support surfaces will be considered "significantly different" for purposes of starting a new capped rental period: group 1 overlays, group 1 mattresses, group 2 overlays, group 2 mattresses and beds, and group 3 beds.*

If the beneficiary again develops a Stage IV pressure ulcer, restarts the powered mattress overlay (E0372), and meets the criteria for a group II support surface, the capped rental period would restart at the month in which it had been discontinued. If a significantly different item (e.g., E0277) in group II was started, a new capped rental period would begin.

For support surfaces, a new capped rental period does not start just because an item with another code was provided, if that item is not significantly different from the prior item (see groupings above). An example would be a beneficiary who has a Stage IV pressure ulcer, meets coverage criteria for a group II support surface, and is furnished with a powered mattress overlay (E0372). If the ulcer worsens and the beneficiary is switched to a non-powered group II overlay (E0371), a new capped rental period does *not* start, even if it is a different supplier. This is because even though the beneficiary's condition changed, the new item is not significantly different from the previous item. However, if the beneficiary had been switched to a group II mattress (e.g., E0277), a new capped rental period would start because there had been a substantive change in the beneficiary's condition *and* a significantly different item was provided.

The following guidelines pertain to claim submission for both situations 1 and 2 above. If you are billing for a new capped rental period, the code must have the KH modifier (indicating the first month of rental) and, if a Certificate of Medical Necessity (CMN) is required for the code, an *initial* CMN must accompany the claim. When the DME MAC receives a claim for a capped rental code that has been previously approved and there has been any interruption of billing to the DME MAC, the presumption is that there has been no interruption in medical necessity for the item unless it is clearly documented. Therefore, if there is a 60-plus day interruption of billing for a code and you think that starting a new capped rental period is justified, narrative documentation must accompany the claim. The documentation must include, but is not limited to:

1. A description of the beneficiary's prior medical condition that necessitated the previous item,
2. A statement explaining when and why the medical necessity for the previous item ended, and
3. A statement explaining the beneficiary's new or changed medical condition and when the new need began.

This information must be entered in the NTE segment/line note of an electronic claim or attached to a paper claim.

## **6. Oxygen and Oxygen Equipment**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §30.6

Reimbursement for oxygen equipment is made on a rental basis only. The total number of continuous rental months for which Medicare will pay for oxygen equipment is limited to 36 months.

Fee schedule payments for stationary oxygen system rentals are all-inclusive and represent a monthly allowance per beneficiary. This allowance includes payment for the equipment, contents, and accessories furnished during a rental month.

### **After the 36-Month Cap**

After the 36-month rental period has ended, the title of the equipment remains with the supplier of the equipment. Under no circumstances will a new rental period start following the completion of the 36-month rental period unless the equipment is replaced because it is lost, stolen, or irreparably damaged or is replaced after the reasonable, useful lifetime expires.

As the supplier of the oxygen equipment, you are required to continue furnishing the equipment, supplies, and accessories for any period of medical need for the remainder of the reasonable, useful lifetime of the equipment. This requirement includes use of equipment following temporary breaks of in-home oxygen services (e.g., due to a hospital or other facility stay) of any duration after the 36-month rental cap.

The supplier who furnished the liquid or gaseous oxygen equipment during the 36-month rental period is responsible for furnishing the oxygen contents used with the supplier-owned oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable, useful lifetime of the equipment. Medicare will pay for oxygen contents for any gaseous or liquid (stationary or portable) oxygen equipment. You should use HCPCS codes E0441 through E0444 in order to bill and receive payment for furnishing oxygen contents (see the section on oxygen contents below).

Medicare can pay for one general maintenance and servicing (MS) visit for concentrators or transfilling equipment every six months beginning six months after the end of the 36-month rental period. Other than this general maintenance and servicing payment, payment is not allowable for any repair or maintenance and servicing of supplier-owned oxygen equipment, including any replacement part furnished as part of any repair or maintenance and servicing of oxygen equipment. Claims for maintenance and servicing of concentrators or transfilling equipment must be billed with the MS modifier.

You are responsible for furnishing all of the same items and services after the 36-month rental period as you furnished during the 36-month rental period. With the exceptions of oxygen contents and the general maintenance and servicing visit, you must furnish these items and services without charging Medicare or the beneficiary.

Payment is not allowable for supplier pickup or disposal of oxygen tanks or cylinders that are no longer needed.

### **Replacement of Oxygen Equipment**

If oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged, the beneficiary may elect to obtain a new piece of equipment. In these situations, a new 36-month rental period and a new reasonable, useful lifetime is started on the date that the new replacement item is furnished.

**Note:** Irreparable damage refers to a specific incident of damage to equipment, such as equipment falling down a flight of stairs, as opposed to equipment that is worn out over time.

When billing the first month of rental for replacement oxygen equipment, you should append the RA modifier to the appropriate HCPCS code for the equipment. You also must include a narrative explanation of the reason why the equipment was replaced and maintain supporting documentation in your files. For example, if equipment is stolen, you should keep a copy of the police report in your files. For lost or irreparably damaged equipment, you should maintain any documentation that supports the narrative account of the incident. For reasonable, useful lifetime replacements, the narrative explanation should include the date that the beneficiary received the equipment being replaced. *Note: Please do not include the RA modifier on the second or subsequent months of rental.*

When submitting claims electronically for replacement of oxygen equipment, you may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 5010A1 professional electronic claim format. If you are billing a paper claim using the Form CMS-1500, you may report this information in item 19 of the claim form. For more information about claim submission, please see Chapter 6 of this manual.

A new certificate of medical necessity (CMN) is required in situations where oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged. New testing, however, is not required unless it is necessary in order to meet existing medical review guidelines for oxygen and oxygen equipment. You should continue to follow the existing guidelines requiring recertification CMNs for all situations in which oxygen equipment is being replaced. The most recent qualifying value and testing date should be entered on the CMN.

As is the case for all DME items, you must maintain proof of delivery documentation in your files for replacement oxygen equipment. In addition, for equipment that is being replaced because it has been in continuous use by the beneficiary for the reasonable, useful lifetime and the beneficiary has

elect to obtain new equipment, you must also have proof of delivery documentation in your files for the item being replaced that documents that the oxygen equipment has been in use for at least five years.

### **Change in Oxygen Equipment during the Reasonable, Useful Lifetime Period**

The reasonable, useful lifetime for stationary or portable oxygen equipment begins when the oxygen equipment is first delivered to the beneficiary and continues until the point at which the stationary or portable oxygen equipment has been used by the beneficiary on a continuous basis for five years. Computation of the reasonable, useful lifetime is not based on the age of the equipment.

If there is a change in oxygen equipment modalities (e.g., from a concentrator to a stationary liquid oxygen system) prior to the end of the reasonable, useful lifetime period, this does **not** result in the start of a new reasonable, useful lifetime period or a new 36-month payment period. In addition, if you have to replace oxygen equipment that is not functioning properly prior to the end of the reasonable, useful lifetime period, this does not result in the start of a new reasonable, useful lifetime period or a new 36-month payment period. Finally, if the beneficiary switches to a new supplier and new equipment prior to the end of the reasonable, useful lifetime period, this does not result in the start of a new reasonable, useful lifetime period or a new 36-month payment period.

A beneficiary may elect to obtain new oxygen equipment at the end of the five-year reasonable, useful lifetime period in these situations.

### **Continuous Use of Oxygen and Oxygen Equipment**

The instructions pertaining to payments for capped rental items during a period of continuous use also apply to the monthly payment amounts for oxygen and oxygen equipment and the portable oxygen equipment add-on payments.

A period of continuous use allows for temporary interruptions in the use of the equipment. For breaks in need (beneficiary no longer needs or uses the equipment) of less than 60 days plus the days remaining in the last paid rental month, the period of continuous use does not start over and so the count of continuous months picks up where it left off before the break. For example, if the last paid rental month is month #31 and there is a 50-day break in need, the next paid rental month would be month #32.

If, however, there is a break in need more than 60 days plus the days remaining in the last paid rental month, and the need for the equipment resumes at a later date, a new period of continuous use, a new 36-month payment period, and a new reasonable, useful lifetime period would begin provided that you have submitted the following:

- New medical necessity documentation (i.e., a new CMN) and retesting for oxygen and oxygen equipment and/or portable oxygen equipment; AND
- A narrative explanation describing the reason for the interruption which shows that medical necessity in the prior episode ended. When submitting claims electronically for replacement of oxygen equipment, you may use, for the narrative explanation, loop 2400 (line note), segment NTE02 (NTE01=ADD) of the ASC X12, version 5010A1 professional electronic format. If you are billing a paper claim using the Form CMS-1500, you may report this information in item 19 of the claim form. You are not to use modifier RA on these claims.

**Note:** If medical necessity for the equipment continues during a break in billing/Part B payment (e.g., the beneficiary is hospitalized for 70 days but continues to use oxygen equipment during the hospital stay), this DOES NOT constitute a break in need, and therefore, a new period of continuous use

DOES NOT begin. In these situations, the count of continuous months picks up where it left off before the break.

**Beneficiary Relocation Issues**

If the beneficiary relocates before the end of the 36-month rental period, he/she should work with his or her supplier to make arrangements to continue receiving oxygen and oxygen equipment from a new supplier at his or her new place of residence.

If the beneficiary relocates after the 36-month rental period, the supplier is required to continue furnishing oxygen and oxygen equipment, and therefore must make arrangements for the beneficiary to continue receiving oxygen services at his or her new place of residence.

**Modifiers**

The monthly payment amount for stationary oxygen is subject to adjustment depending on the amount of oxygen prescribed (liters per minute, or LPM) and whether or not portable oxygen is also prescribed.

|           |  |
|-----------|--|
| <b>QE</b> | Use if the prescribed amount of oxygen is <b>less</b> than 1 LPM.                              |
| <b>QF</b> | Use if the prescribed amount of oxygen <b>exceeds</b> 4 LPM and portable oxygen is prescribed. |
| <b>QG</b> | Use if the prescribed amount of oxygen is <b>greater</b> than 4 LPM.                           |
| <b>QH</b> | Use if an oxygen conserving device is being used with an oxygen delivery system.               |
| <b>RR</b> | Rental   |
| <b>MS</b> | Maintenance and Service  |

**Oxygen Contents**

When a stationary oxygen system is being rented, the monthly allowance includes payment for all required contents (during the 36-month rental period). It would be considered “unbundling” if you billed the beneficiary separately for contents in this scenario. If the beneficiary owns an oxygen stationary system other than an oxygen concentrator or uses a portable system only, payment may be made for contents.

If a patient owns both a stationary gaseous or liquid system and a portable gaseous or liquid system, bill two codes—one for the stationary contents (E0441, E0442) and one for the portable contents (E0443, E0444).

These contents codes are a monthly allowance. Contents may only be billed once a month, not daily or weekly.



**Contents after the 36-Month Cap**

If you furnished liquid or gaseous oxygen equipment during the 36-month rental period, you are responsible for furnishing the oxygen contents used with the oxygen equipment for any period of medical need following the 36-month rental cap for the remainder of the reasonable, useful lifetime of the equipment. In these situations, you can bill for and receive a monthly payment for furnishing oxygen contents (see chart below).

Payment for both oxygen contents used with stationary oxygen equipment and oxygen contents used with portable oxygen equipment is included in the 36 monthly payments for oxygen and oxygen equipment (stationary oxygen equipment payment) made for codes E0424, E0439, E1390, or E1391. Beginning with dates of service on or after the end date of service for the month representing the 36<sup>th</sup> payment, you may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

| <b>Equipment Furnished in Month 36</b>          | <b>Monthly Contents Payment after Stationary Cap</b> |
|---|--|
| Oxygen Concentrator (E1390, E1391, or E1392)    | None   |
| Portable Gaseous Transfilling Equipment (K0738) | None   |
| Portable Liquid Transfilling Equipment (E1399)  | None   |
| Stationary Gaseous Oxygen System (E0424)        | Stationary Gaseous Contents (E0441)                  |
| Stationary Liquid Oxygen System (E0439)         | Stationary Liquid Contents (E0442)                   |
| Portable Gaseous Oxygen System (E0431)          | Portable Gaseous Contents (E0443)                    |
| Portable Liquid Oxygen System (E0433, E0434)    | Portable Liquid Contents (E0444)                     |

You may not bill for stationary oxygen contents if the beneficiary uses a stationary concentrator and you may not bill for portable oxygen contents if the beneficiary uses a portable concentrator or transfilling equipment.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431, E0433, or E0434) more than one month after they began using stationary oxygen equipment, monthly payments for portable gaseous or liquid oxygen contents (E0443 or E0444) may begin following the stationary oxygen equipment payment cap AND prior to the end of the portable equipment payment cap (code E0431 or E0434). As long as the beneficiary is using covered gaseous or liquid portable oxygen equipment, payments for portable oxygen contents may begin following the stationary oxygen equipment payment cap. This will result in a period during which monthly payments for E0431 and E0443, in the case of a beneficiary using portable gaseous oxygen equipment, or E0434 and E0444, in the case of a beneficiary using portable liquid oxygen equipment, overlap. In these situations, after the 36-month portable oxygen equipment payment cap for E0431, E0433, or E0434 is reached, monthly payments for portable oxygen contents (E0443 or E0444) would continue.

If the beneficiary began using portable gaseous or liquid oxygen equipment (E0431, E0433, or E0434) following the 36-month stationary oxygen equipment payment period, payments may be made for both the portable equipment (E0431 or E0434) and portable contents (E0443 or E0444).

In all cases, separate payment for oxygen contents (stationary or portable) would end in the event that a beneficiary receives new stationary oxygen equipment and a new 36-month stationary oxygen equipment payment period begins (i.e., in situations where stationary oxygen equipment is replaced because the equipment has been in continuous use by the beneficiary for the equipment's reasonable, useful lifetime or is lost, stolen, or irreparably damaged). Again, the monthly payment for stationary oxygen equipment includes payment for BOTH stationary AND portable oxygen contents. Therefore, under no circumstances can you receive both the monthly stationary oxygen equipment payment and payment for either stationary OR portable oxygen contents.

The following are some examples:

**Example #1**

The beneficiary has a stationary liquid oxygen system (E0439) which has capped out and a portable liquid oxygen system (E0434) which has not capped out. You may bill for liquid stationary contents (E0442), the portable liquid system (E0434), and portable liquid contents (E0444) simultaneously. Once the portable liquid system (E0434) has also capped out, you would bill both contents codes (E0442 and E0444) for the remainder of the reasonable, useful lifetime of the equipment.

**Example #2**

The beneficiary has a portable liquid system (E0434) which has capped out and a stationary liquid system (E0439) which has not capped out. In this case, the only code that you may bill is the E0439. Contents would not be payable until the E0439 has also capped out. Once the E0439 has capped out, then you may bill contents for both stationary and portable (E0442 and E0444).

Following the stationary oxygen equipment payment cap, you may bill for oxygen contents (stationary and/or portable in accordance with the chart above) on the anniversary date of the oxygen equipment billing. For example, if the 36<sup>th</sup> month of continuous use of the stationary oxygen equipment begins on March 11<sup>th</sup> and ends on April 10<sup>th</sup>, you may begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11<sup>th</sup>.

For subsequent months, you do not need to deliver the oxygen contents every month in order to continue billing for the contents on a monthly basis. A maximum of three months of oxygen contents can be delivered at one time. In these situations, the delivery date of the oxygen contents does not have to be the date of service (anniversary date) on the claim; however, in order to bill for contents for a specific month, you must have previously delivered quantities of oxygen that are sufficient to last for one month following the date of service on the claim. You are required to have proof of delivery for each actual delivery of oxygen, but as discussed above, this may be less often than monthly. For example, if you deliver 30 oxygen tanks on April 11<sup>th</sup> and the beneficiary only uses 15 tanks from April 11<sup>th</sup> through May 10<sup>th</sup> and 15 tanks from May 11<sup>th</sup> through June 10<sup>th</sup>, you may bill for contents on April 11<sup>th</sup> and again on May 11<sup>th</sup> for contents delivered on April 11<sup>th</sup> that were used for two months.

**Oxygen Equipment and Contents Billing Chart**

The following chart indicates what oxygen fee schedule component is billable/payable under various transaction scenarios.

**Situation: Beneficiary Uses a Stationary System Only**

1. Rental

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | No                   | No                     |
| Gaseous        | No*                      | No                   | No                     |
| Liquid         | No*                      | No                   | No                     |

\* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

2. Purchase (or Capped)

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | No                   | No                     |
| Gaseous        | E0441                    | No                   | No                     |
| Liquid         | E0442                    | No                   | No                     |

**Situation: Beneficiary Uses Both a Stationary and Portable System**

1. Rents Stationary/Rents Portable

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | E1392                | No                     |
| Gaseous        | No*                      | E0431                | No*                    |
| Liquid         | No*                      | E0433, E0434         | No*                    |

\* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

2. Rents Stationary/Owns (or Capped) Portable

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | No                   | No                     |
| Gaseous        | No*                      | No                   | No*                    |
| Liquid         | No*                      | No                   | No*                    |

\* Contents are included in the allowance for rented oxygen stationary system during the 36-month rental period

3. Owns (or Capped) Stationary/Owns (or Capped) Portable

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | No                   | No                     |
| Gaseous        | E0441                    | No                   | E0443                  |
| Liquid         | E0442                    | No                   | E0444                  |

4. Owns (or Capped) Stationary/Rents Portable

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | E1392                | No                     |
| Gaseous        | E0441                    | E0431                | E0443                  |
| Liquid         | E0442                    | E0433, E0434         | E0444                  |

**Situation: Beneficiary Uses a Portable System Only**

1. Rents Portable System

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | E1392                | No                     |
| Gaseous        | No                       | E0431                | E0443                  |
| Liquid         | No                       | E0433, E0434         | E0444                  |

2. Owns (or Capped) Portable System

| Type of System | Stationary Contents Code | Portable System Code | Portable Contents Code |
|----------------|--------------------------|----------------------|------------------------|
| Concentrator   | No                       | No                   | No                     |
| Gaseous        | No                       | No                   | E0443                  |
| Liquid         | No                       | No                   | E0444                  |

**Supplier Exit from the Oxygen Equipment Business**

CMS issued instructions to the DME MACs to process claims for replacement oxygen and oxygen equipment in the event that a supplier exits the Medicare oxygen business, whether voluntarily or due to revocation of billing privileges, and is no longer able to continue furnishing oxygen and oxygen equipment. This applies to both competitive bid and non-competitive bid areas.

In these situations, CMS considers the equipment "lost" under the Medicare regulations at 42 CFR §414.210(f), which provides that a patient may elect to obtain a new piece of equipment if the equipment has been in continuous use by the patient for the equipment's reasonable useful lifetime or has been lost, stolen, or irreparably damaged. When considering "lost" equipment, the DME MACs will establish a new 36-month rental period and reasonable useful lifetime for the new supplier furnishing replacement oxygen and oxygen equipment on the date that the replacement equipment is furnished to the beneficiary.

**Obligations of Exiting Supplier**

Suppliers voluntarily exiting the Medicare program are reminded that they are in violation of their regulatory and statutory obligations. Section 1834(a)(5)(F)(ii)(I) requires that the supplier that received the 36th month rental payment continue furnishing the oxygen equipment during any period of medical need for the remainder of the equipment's reasonable useful lifetime. Further, 42 CFR

414.226(g)(1) requires, barring a few exceptions, that the supplier that furnishes oxygen equipment in the first month during which payment is made must continue to furnish the equipment for the entire 36-month period of continuous use, unless medical necessity ends. As such, oxygen suppliers that do not fulfill their oxygen obligations and voluntarily exit the Medicare oxygen business are not in compliance with the DMEPOS supplier standards set forth at 42 CFR 424.535(c). Violations of the supplier standards are reported to the National Supplier Clearinghouse.

Suppliers voluntarily exiting the program are strongly encouraged to provide a minimum of 30 days notice to the beneficiary of their intention to no longer provide oxygen therapy services. This should be provided in writing and may take one of two forms:

- A letter to the beneficiary notifying them of the supplier's intention to discontinue oxygen therapy services. The letter must specify a date upon which this will occur; or,
- Working with the beneficiary, a letter to a new supplier selected by the beneficiary, transferring provision of oxygen therapy services to the new supplier as of a specific date.

Suppliers exiting through revocation are not subject to the notification requirements suggested above.

### **Obligations of New Supplier**

For suppliers who receive beneficiaries from providers who have exited the Medicare oxygen business, claims for replacement equipment must:

- For the first month claim, append the RA modifier (Replacement of a DME item) on the claim line(s) for the replacement equipment; and,
- Document in the narrative field of the claim that "Beneficiary acquired through supplier voluntarily exiting Medicare program" or similar statement.
  - When submitting claims electronically, use loop 2400 (line note), segment NTE02 (NTE01+ADD) of the ASC X12, version 5010A1 electronic claim format.
  - When billing using the Form CMS-1500 paper claim, include the narrative information in item 19 of the claim form.
  - Home health agencies billing using the UB-04 paper claim may report this information in Form Locator 80 (Remarks).

In addition to providing the above information on the replacement equipment claim, in the event of an audit, suppliers should be prepared to provide documentation demonstrating that the beneficiary was transferred from a supplier exiting the Medicare oxygen program. Examples of documentation to meet this requirement include:

- Copy of notice sent to the beneficiary from the old supplier indicating that the supplier's services were being terminated; or,
- Letter from the old supplier to the new supplier indicating transfer of the beneficiary due to the voluntary exit from the Medicare program; or,
- Attestation statement from the beneficiary indicating that the beneficiary (or their caregiver) has attempted to contact their existing supplier and has been unable to obtain service.

If the new supplier is unable to obtain the documentation required above, the supplier may not append the RA modifier to the claim and may not initiate a new 36-month capped rental period.

Suppliers accepting transfer of beneficiaries are reminded that all Medicare rules apply. This includes obtaining:

1. New order
2. Medical necessity documentation as outlined in the [Oxygen and Oxygen Equipment Local Coverage Determination \(LCD\)](#)

Be sure to review the entire [Oxygen and Oxygen Equipment LCD and related Policy Article](#) for additional information on coding, coverage, and documentation requirements.

## **7. Medicare Advantage Plan Beneficiaries Transferring to Fee-For-Service Medicare**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §10.3

A beneficiary who was previously enrolled in a Medicare Advantage Plan, returning to traditional Fee-For-Service (FFS) Medicare, is subject to the same benefits, rules, requirements, and coverage criteria as a beneficiary who has always been enrolled in FFS Medicare. Therefore, if a beneficiary received any items or services from their Medicare Advantage Plan, they may only continue to receive such items and services if they would be entitled to them under FFS Medicare coverage criteria and documentation requirements.

For example, a beneficiary who has obtained a capped rental item (e.g., hospital bed) through a Medicare Advantage Plan must, under traditional FFS Medicare, obtain a Certificate of Medical Necessity (CMN), if applicable (for claims with dates of service prior to January 1, 2023), and meet FFS Medicare criteria for the item before a new capped rental period would begin.

A partial exception to this rule involves home oxygen claims. If a beneficiary begins taking oxygen while under a Medicare Advantage Plan, you must obtain an initial CMN and submit it to the DME MAC at the time that FFS coverage begins (for claims with dates of service prior to January 1, 2023). In this situation, the beneficiary does not have to obtain the blood gas study on the CMN within 30 days prior to the date on the CMN, but the test must be the most recent study the beneficiary obtained while in the Medicare Advantage Plan, under the guidelines specified in Local Coverage Determination. It is important to note that just because a beneficiary qualified for oxygen under a Medicare Advantage Plan does not necessarily mean that he or she will qualify for oxygen under FFS. These instructions apply whether a beneficiary voluntarily returns to FFS or if he/she involuntarily returns to FFS because their Medicare Advantage Plan no longer participates in the Medicare+Choice program.

You should maintain open communication with beneficiaries and determine, prior to delivery of an item or continued rental, whether there has been a change in enrollment from a Medicare Advantage Plan to FFS Medicare. You may contact our Interactive Voice Response (IVR) unit at 1.877.299.7900 to determine if a beneficiary is enrolled in a Medicare Advantage Plan.

## **8. Supplies and Accessories Used with Beneficiary-Owned Equipment**

For supplies and accessories used with beneficiary-owned equipment (equipment that is owned by the beneficiary, but was not paid for by the DME MAC/fee-for-service Medicare), all of the following information must be submitted with the initial claim in Item 19 on the CMS-1500 claim form or in the NTE segment for electronic claims:

- HCPCS code of base equipment
- A notation that this equipment is beneficiary-owned
- Date the patient obtained the equipment

Claims for supplies and accessories must include all three pieces of information listed above. Claims lacking any one of the above elements will be denied for missing information.

Medicare requires that supplies and accessories only be provided for equipment that meets the existing coverage criteria for the base item. In addition, if the supply or accessory has additional, separate criteria, these must also be met. In the event of a documentation request from the DME MAC or a redetermination request, you should provide information justifying the medical necessity for the base item and the supplies and/or accessories. Refer to the applicable Local Coverage Determination(s) and related Policy Article(s) for information on the relevant coverage, documentation, and coding requirements at <http://www.cgsmedicare.com/jb/coverage/LCDinfo.html>.

## **9. Repairs, Maintenance, and Replacement**

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 15, §§110.2(A) – 110.2(C)

Under the circumstances specified below, payment may be made for repair, maintenance, and replacement of medically required DME, including equipment which had been in use before the beneficiary enrolled in Part B of the Medicare program. **Payments for repair and maintenance may not include payment for parts and labor covered under a manufacturer's or supplier's warranty.**

### **A – Repairs**

To repair means to fix or mend and to put the equipment back in good condition after damage or wear. Repairs to equipment which a beneficiary owns are covered when necessary to make the equipment serviceable. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment can be made for the amount of the excess.

Repairs of rented equipment are not covered. This includes items in the frequent and substantial servicing, oxygen equipment, capped rental, and IRP payment categories which are being rented.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

When billing for repairs, include the HCPCS code and date of purchase of the item being repaired (if the HCPCS code is not available, include the manufacturer's name, product name, and model number of the equipment), the manufacturer's name, product name, model number, and supplier price list amount of the repair item provided, and the justification of the repair.



Use the RB modifier on DMEPOS claims to indicate replacement parts of a DMEPOS item (base equipment/device) furnished as part of the service of repairing the DMEPOS item (base equipment/device).

## **B – Maintenance**

Routine periodic servicing, such as testing, cleaning, regulating, and checking of the beneficiary's equipment, is not covered. The beneficiary is expected to perform such routine maintenance rather than the supplier or some other person who charges the beneficiary. Normally, purchasers of DME are given operating manuals which describe the type of servicing an owner may perform to properly maintain the equipment. It is reasonable to expect that beneficiaries will perform this maintenance. Thus, hiring a third party to do such work is for the convenience of the beneficiary and is not covered.

More extensive maintenance which, based on the manufacturers' recommendations, is to be performed by authorized technicians, is covered as repairs for medically necessary equipment which a beneficiary owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

Maintenance of purchased items that require frequent and substantial servicing is not covered. Maintenance of rented equipment other than the maintenance and servicing fee established for capped rental items is not covered.

A new CMN and/or physician's order is not needed for covered maintenance.

## **C – Replacement**

Replacement refers to the provision of an identical or nearly identical item. Equipment which the beneficiary owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.).

Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable, useful lifetime of the equipment. If the equipment has been in continuous use by the beneficiary on either a rental or purchase basis for the equipment's useful lifetime, then the beneficiary may elect to obtain a new piece of equipment.

The reasonable, useful lifetime of durable medical equipment is determined through program instructions. In the absence of program instructions, DME MACs determine the reasonable, useful lifetime of equipment, but in no case can it be less than five years.

Computation of the useful lifetime is based on when the equipment is delivered to the beneficiary, not the age of the equipment. Replacement due to wear is not covered during the reasonable, useful lifetime of the equipment. During the reasonable, useful lifetime, Medicare does cover repair up to the cost of replacement (but not actual replacement) for medically necessary equipment owned by the beneficiary.

For a replacement to be covered, a new physician order and/or new CMN (if required) is needed to reaffirm the medical necessity of the item.

Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment will be investigated and denied where the DME MAC determines that it is unreasonable to make program payment under the circumstances.

The following documentation is required when filing a Medicare claim for replacement:

- Reason for replacement
- New CMN (if required)

Use the RA modifier on DMEPOS claims to denote instances where an item is furnished as a replacement for the same item which has been lost, stolen, or irreparably damaged. *NOTE:* Use of the RA modifier implies that the entire DMEPOS item (base equipment) is being replaced. If a specific part is being replaced, but not the base equipment, the service is considered a repair and the RB modifier should be used on the claim.

### **Prior Authorization for Replacement of Power Mobility Devices (PMDs)**

Beginning June 2, 2024, Prior Authorization is required on all replacement PMDs on the Required Prior Authorization List ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS\\_PA\\_Required-Prior-Authorization-List.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf)). This includes lost, stolen, or irreparably damaged items. CGS will deny claims for replacement PMDs with the RA modifier that did not receive prior authorization.

### **Replacement Due to Loss, Theft, or Irreparable Damage**

Include this documentation with your request:

- Information and detailed reports that explain the reasons leading to the need for replacement:
  - Loss or theft (for example, a police report), or
  - Irreparable damage due to a specific accident or to a natural disaster such as a fire or flood.
- A physician's Written Order Prior to Delivery. The DME MACs require a new order for replacement items.
- If the original Prior Authorization was affirmed, the DME MACs will not review for medical necessity.
- Select "Expedited Request" and give the reason for replacement.

### **Replacements Due to Change in Medical Need or Reasonable Useful Lifetime Met**

Include this documentation with your request:

- A new face-to-face evaluation.
- Written Order Prior to Delivery.
- Documentation from the medical record that supports the need for the item ordered and documentation to support the change in condition if applicable.

### **How to Submit a Prior Authorization Request**

- DME myCGS web portal (<https://www.cgsmedicare.com/jc/mycgs/index.html>) – the fastest, easiest way to send Prior Authorization requests and check the status.

- Mail, fax, and esMD – use the Prior Authorization Submission Form ([https://www.cgsmedicare.com/jc/mr/pdf/prior\\_authorization\\_coversheet.pdf](https://www.cgsmedicare.com/jc/mr/pdf/prior_authorization_coversheet.pdf)).

Refer to Chapter 9 of this manual for additional information about Prior Authorization.

### **Wheelchair Replacements When the Manufacturer Exits Wheelchair Business**

CMS has issued instructions for replacement power or manual wheelchairs when the manufacturer exits the wheelchair business. These instructions apply to dates of service on or after July 8, 2024, when:

1. The manufacturer exits the wheelchair business resulting in the wheelchair ceasing to exist on the market, and
2. There is no availability of aftermarket repair or replacement parts to make the manufacturer's equipment operable.

The beneficiary may no longer have wheelchair mobility when the wheelchair stops working due to the need for repairs that can no longer be made. In this scenario, Medicare may consider the wheelchair equipment as lost so the beneficiary can get new equipment. Suppliers should follow current instructions for replacement when equipment is lost, stolen, or irreparably damaged.

This does not apply to situations where a manufacturer stops manufacturing or no longer supports a wheelchair product line, but repair parts to make the manufacturer's equipment operable for the reasonable useful lifetime of the equipment remain available. This replacement scenario applies when there are no repair parts to make the manufacturer's equipment operable.

Follow the Prior Authorization process when replacing a power mobility device.

#### **Claim instructions for dates of service on or after July 8, 2024:**

- Use the RA modifier on the first month.
- For capped rental payment, use the KH modifier (DMEPOS item, initial claim, purchase or first month rental), except for purchased complex rehabilitation power mobility devices (PMDs).
- Add a claim narrative stating "Replacement due to manufacturer exiting wheelchair business" or a similar statement.
- For PMDs: the unique tracking number (UTN) from the prior authorization decision.

### **Repair Labor Billing and Payment Policy**

The following table contains repair units of service allowances for commonly repaired items billed under HCPCS code K0739 (Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes). This applies to non-rented and out-of-warranty items. Units of service include basic troubleshooting and problem diagnosis. One unit of service = 15 minutes. Please note that there is no Medicare payment for travel time or equipment pick-up and/or delivery.

| <b>Type of Equipment</b>   | <b>Part Being Repaired/Replaced</b>       | <b>Allowed Units of Service (UOS)</b> |
|----------------------------|---|---------------------------------------|
| Power Wheelchair           | Batteries (includes cleaning and testing) | 2                                     |
| Power Wheelchair           | Joystick (includes programming)           | 2                                     |
| Power Wheelchair           | Charger                                   | 2                                     |
| Power Wheelchair           | Drive wheel motors (single/pair)          | 2/3                                   |
| Power Wheelchair           | Shroud/Cowling                            | 2                                     |
| Power or Manual Wheelchair | Armrest or armpad                         | 1                                     |
| Power or Manual Wheelchair | Wheel/Tire (all types, per wheel)         | 1                                     |
| Manual Wheelchair          | Anti-tipping device                       | 1                                     |
| Hospital Bed               | Pendant                                   | 2                                     |
| Hospital Bed               | Headboard/footboard                       | 2                                     |
| CPAP                       | Blower Assembly                           | 2                                     |
| Seat Lift                  | Hand Control                              | 2                                     |
| Seat Lift                  | Scissor mechanism                         | 3                                     |
| Patient Lift               | Hydraulic Pump                            | 2                                     |

You may only bill the allowable units of service listed in the above table for each repair, regardless of the actual repair time. Claims for repairs must include narrative information itemizing each repair and the time taken for each repair. Please note that Medicare does not pay for repairs to capped rental items during the rental period or items under warranty.

**Repair/Replacement Chart**

The following chart on repairs and replacements indicates when original or new suppliers need new CMNs or orders, or when the original CMN or order will be adequate for repairing or replacing DME.

**CAPPED RENTAL (Rented) EQUIPMENT/DURABLE ACCESSORIES**

| Original Item Requires CMN           |                                       |   |                           | Original Item Requires Only Order    |                                       |   |                           |
|--------------------------------------|---------------------------------------|---|---------------------------|--------------------------------------|---------------------------------------|---|---------------------------|
| Repair before or after 5 years       | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years | Repair before or after 5 years       | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years |
| N/A because covered by rental or M/S | N/A because covered by rental or M/S  | N-CMN plus doc of why replacement necessary     | N-CMN                     | N/A because covered by rental or M/S | N/A because covered by rental or M/S  | N-ORD plus doc of why replacement necessary     | N-ORD                     |

**INEXPENSIVE/ROUTINELY PURCHASED (IRP) (Rented) EQUIPMENT/DURABLE ACCESSORIES**

| Original Item Requires CMN    |                                       |   |                                    | Original Item Requires Only Order |                                       |   |                                    |
|-------------------------------|---------------------------------------|---|------------------------------------|-----------------------------------|---------------------------------------|---|------------------------------------|
| Repair before 5 years         | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years          | Repair before or after 5 years    | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years          |
| N/A because covered by rental | N/A because covered by rental         | N/A because covered by rental                   | N/A because not rented for 5 years | N/A because covered by rental     | N/A because covered by rental         | N/A because covered by rental                   | N/A because not rented for 5 years |

**CAPPED RENTAL (Purchased) OR IRP (Purchased) EQUIPMENT/DURABLE ACCESSORIES**

| Original Item Requires CMN  |                                       |   |                           | Original Item Requires Only Order   |                                       |   |                           |
|---|---------------------------------------|---|---------------------------|---|---------------------------------------|---|---------------------------|
| Repair before or after 5 years  | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years | Repair before or after 5 years  | Replacement before 5 years (for wear) | Replacement before 5 years (for loss or damage) | Replacement after 5 years |
| Doc of why repair, but no order for actual repair; Repair up to \$Rplcmnt | N/A - Only Cover Repair               | N-CMN and doc of why replacement                | N-CMN                     | Doc of why repair, but no order for actual repair; Repair up to \$Rplcmnt | N/A - Only Cover Repair               | N-ORD and doc of why replacement                | N-ORD                     |

**ACCESSORIES FOR DME  
Requiring More Frequent Replacement  
Same Supplier or New Supplier**

| Original Item Requires CMN  |  | Original Item Requires Only Order   |  |
|---|--|---|--|
| Repair before or after 5 years  | Replacement before 5 years   | Repair before or after 5 years  | Replacement before 5 years   |
| Doc of why repair, but no order for actual repair; Repair up to \$Rplcmnt | O-CMN or N-CMN stating frequency of replacement; Frequency of replacement at discretion of DME MAC | Doc of why repair, but no order for actual repair; Repair up to \$Rplcmnt | O-ORD or N-ORD stating frequency of replacement; Frequency of replacement at discretion of DME MAC |

**N-CMN** = New CMN required

**N-ORD** = New Order required

**M/S** = Maintenance and service

**N/A** = Not applicable

**DOC** = Documentation

**\$Rplcmnt** = Cost (dollar amount) of replacement

**Temporary Replacement Items (HCPCS K0462)**

Medicare allows a one-month rental payment for temporary replacement (HCPCS K0462) for beneficiary-owned equipment being repaired. When billing temporary replacement equipment under HCPCS code K0462, you must provide information pertaining to both the beneficiary-owned equipment and the temporary replacement equipment.

Claims must include a narrative describing:

- HCPCS code of patient-owned equipment being repaired, including manufacturer, brand name/number, and date of purchase
- Replacement equipment, including manufacturer and brand name/number
- Description of what was repaired
- Description of why the repair took more than one day to complete

When billing HCPCS code K0462, claims will be denied for missing information if the above narrative isn't included. If the claim denies, you will receive the following message: "The claim is missing information needed to make payment. Refer to the Denial Explanation Number for additional assistance. Resubmit the claim with all of the needed information."

*Note that there is no fee schedule for code K0462, as payment is based on the type of replacement equipment that is provided. Payment will not exceed the rental allowance for the patient-owned equipment being repaired.*

**10. DMEPOS Competitive Bidding Program**

Some of the rules and regulations discussed in this manual may be affected by the DMEPOS Competitive Bidding Program. For information about the rules and regulations of the DMEPOS Competitive Bidding Program, including exceptions to normal DME MAC guidelines, please refer to the CMS website at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/index.html> or the Competitive Bidding Implementation Contractor (CBIC) website at <http://www.dmecompetitivebid.com>.

**Chapter 6 Contents***Introduction*

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**Introduction**

This chapter has important information about filing claims to the DME MAC. Most Medicare suppliers are required to bill claims electronically (rather than paper) in accordance with the Administrative Simplification Compliance Act (ASCA). If you do meet one of the ASCA exceptions, as detailed in this chapter, then the information in this chapter should serve as your primary source of guidance regarding how to submit paper claims to the DME MAC. The information contained in the claim completion instructions below is also valuable for suppliers who are billing claims electronically. All suppliers should be familiar with the rules and guidance of this chapter. For information about filing claims electronically, see Chapter 8 of this manual.

*Before billing a claim to the DME MAC, you must obtain a National Provider Identifier (NPI) and register with the National Provider Enrollment (NPE) contractors. See Chapter 2 of this manual for information about obtaining an NPI and registering with the NPE Contractor.*

*NOTE: For claims with dates of service on or after January 1, 2023, you no longer need to submit CMNs or DIFs with claims. Due to electronic filing requirements, claims received with these forms attached will be rejected and returned.*

*For claims with dates of service prior to January 1, 2023, if a CMN or DIF is required, it must be submitted with the claim or be on file with a previous claim.*



## 1. Mandatory Claim Filing

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30.3.9

In many situations, claim filing is mandatory. The rules below outline the CMS claims filing policy.

### The Centers for Medicare & Medicaid Services (CMS) Claims Filing Policy

- For services furnished on or after September 1, 1990, physicians and suppliers must complete and submit both assigned and nonassigned Part B claims for beneficiaries.
- The claims filing requirement applies to all suppliers who provide covered services to Medicare beneficiaries.
- You are not required to take assignment of Medicare benefits unless you are enrolled in the Medicare Participating Supplier Program or except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, etc.).
- You may not charge the beneficiary for preparing and filing a Medicare claim. The beneficiary may also not be charged for the completion of a Certificate of Medical Necessity (CMN) form.
- The DME MAC will monitor supplier compliance with the Medicare claims filing requirement.
- Suppliers who do not submit Medicare claims for Medicare beneficiaries may be subject to a civil monetary penalty of up to \$2,000 for each violation.
- Medicare claims must be filed within one year from the service date (see “Time Limit for Filing Claims” below).
- The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless you meet certain “exceptions” described within the law (see below for more information about ASCA).
- If an ASCA exception is met, a Medicare paper claim must be submitted on the Health Insurance Claim Form [CMS-1500 (02/12)]. No superbills can be accepted.
- If you determine that the beneficiary has other insurance which may pay primary to Medicare, you may file a claim with the primary insurer on the beneficiary's behalf; however, you are not required by law to submit claims to other payers. If you receive a determination on the claim directly from the primary payer, you are responsible for submitting a claim to Medicare for secondary payment. If the beneficiary files a claim to the primary insurer, he/she may forward the primary payer information to you to submit the Medicare Secondary Payer (MSP) claim. You must submit the secondary claim to Medicare for the beneficiary in accordance with the mandatory claims filing requirements.

### Mandatory Claim Filing Does Not Affect the Following:

- Supplier/Beneficiary Payment Arrangements - Suppliers who do not accept assignment may continue to request payment in full at the time that the service is provided if the claim for this service is unassigned. We encourage you to file the claims about the same time you request payment. This will reduce a potential financial hardship for the beneficiary and reduce future inquiries you may receive regarding the status of the claim.
- Providing Suppliers Information on Non-Assigned Claims - By not accepting assignment of Medicare benefits, suppliers are not a party to the Medicare payment transaction between

Medicare and the Medicare beneficiary. The transaction is covered by the Privacy Act. Our office can only give limited information on non-assigned claims. The DME MAC cannot disclose payment amounts.

- **Statutorily-Excluded Medicare Services** - Suppliers are not required to file claims on behalf of Medicare beneficiaries for items that do not have a covered Medicare benefit or for other health insurance benefits. However, if the beneficiary (or his/her representative) believes that a service may be covered or desires a formal Medicare determination, you must file a claim for that service to effectuate the beneficiary's right to a determination. You should note on the claim your belief that the service is noncovered and that it is being submitted at the beneficiary's insistence. The documentation should state the beneficiary-specific reason why you consider the item to be noncovered, and the modifier GY should be appended to the HCPCS code(s) on the claim. Use of this modifier does not generate an automatic denial of the service. Coverage decisions are made based on the item billed and other pertinent information on the claim without regard to the presence or absence of this modifier.

**2. Assignment Agreement**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §30  
 CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 4, §4.24

An assignment agreement is between a supplier of services and a Medicare beneficiary. The option of accepting assignment belongs solely to the supplier. Participating suppliers have signed a contract agreeing to accept assignment on all services rendered to Medicare beneficiaries. Nonparticipating suppliers have the option of accepting assignment on a claim-by-claim basis except where CMS regulations require mandatory assignment (i.e., Medicare covered drugs, etc.).

Once entered into, the assignment agreement may not be rescinded by nonparticipating suppliers unless done so by mutual written agreement of the supplier and beneficiary. This agreement must be communicated to the DME MAC before the DME MAC has made, and sent notice of, the claim determination. Participating suppliers may not rescind the assignment agreement during the period of their participation contract.

When you accept assignment, you are bound by law to accept the DME MAC's determination of the approved amount as the full fee for the service rendered. You may not bill, or accept payment for, the amount of the reduced charges; however, an attempt must be made to collect (1) twenty percent of the approved charge (coinsurance), (2) any amount applied to the deductible and (3) any noncovered charges subject to the Limitation of Liability provisions.

**Example of Assigned Claim:**

|  |         |
|--|---------|
| Submitted fee  | \$25.00 |
| Approved charge (paid at 80% assuming that the annual deductible has been met)                             | \$20.00 |
| Allowable charge reduction which cannot be collected from any source (submitted fee minus approved charge) | \$5.00  |
| Payment (80% of the approved charge)   | \$16.00 |

Coinsurance (20% of approved charge)

\$4.00

If you repeatedly violate the assignment agreement, you could be charged and found guilty of a misdemeanor, punishable by a maximum fine of \$2,000, up to six months imprisonment, or both.

### **Mandatory Assignment for Covered Drugs Billed to Medicare**

Section 114 of the Benefits Improvement and Protection Act of 2000 (BIPA) states, in part, "Payment for a charge for any drug or biological for which payment may be made under this part may be made only on an assignment-related basis." Mandatory assignment applies only to those drugs "for which payment may be made" – i.e., Medicare-covered drugs. Drugs that would never be paid (e.g., no benefit category, never medically necessary) are not subject to mandatory assignment.

You may not render a charge or bill to anyone for these drugs and biologicals for any amount other than the Medicare Part B deductible and coinsurance.

If you submit an unassigned claim for a drug or biological, the DME MAC will process the claim as though you accepted assignment.

If the beneficiary already paid for the billed services, enter the amount paid for covered services, coinsurance, and deductible in block 29 of the CMS-1500 claim form.

The DME MAC will reimburse the beneficiary any amount they paid over the patient responsibility amount shown on the Medicare Remittance Advice (RA). You must issue the beneficiary a refund within 30 days of the date of the RA for the difference between the beneficiary's payment to you and the total of the amount shown as the patient responsibility and as paid to the beneficiary on the RA. See Chapter 17 of this manual for more information about RAs.

## **3. Administrative Simplification Compliance Act (ASCA)**

**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 24, §90**

Section 3 of the Administrative Simplification Compliance Act (ASCA), Public Law (PL) 107-105, and the implementing regulation at 42 CFR 424.32, requires that **all initial claims** for reimbursement under Medicare (except from small providers) be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a MAC for the first time, including:

- Resubmitted previously rejected claims
- Claims with paper attachments
- Demand claims
- Claims where Medicare is secondary and there is only one primary payer
- Nonpayment claims

Further, ASCA amendment to Section 1862(a) of the Act prescribes that "no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services" for which a claim is submitted in a non-electronic form. Consequently, unless you fit one of the exceptions listed below, any paper claims that you submit to Medicare will not be paid. In addition, if

it is determined that you are in violation of the statute or rule, you may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

Medicare will not cover claims submitted on paper unless they meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (Noncovered charge[s]) and remark code M117 (Not covered unless submitted via electronic claim). See Chapter 17 of this manual for information about claim reason and remark codes.

### **Exceptions to Electronic Claim Submission**

There are some exceptions to the electronic claim submission requirement that allow suppliers to continue to bill paper claims. The exceptions include the following:

1. You are a small provider. To qualify as a small provider, DMEPOS suppliers must have fewer than 10 full time employees (FTEs). A small provider can elect to submit all, some, or none of their claims electronically;
2. Dental Claims;
3. Claims submitted by participants in a Medicare demonstration project for services or items covered under that demonstration project when paper claim filing is required as result of the inability of the HIPAA claim implementation guide to handle data essential for that demonstration;
4. Roster claims for mass immunizations, such as flu or pneumonia injections—Paper roster bills cover multiple beneficiaries on the same claim. This exception applies to providers who do not have an agreement in place with a Medicare contractor that commits them to electronic submission of mass immunization claims;
5. Claims sent to Medicare when more than one other insurer was liable for payment prior to Medicare;
6. Claims submitted by providers that rarely treat Medicare patients and that submit fewer than 10 claims a month to Medicare in total (total of all claims sent to all Medicare contractors including the Railroad Medicare Carrier);
7. Home oxygen therapy claims for which the CR5 segment is required in an X12 837 version 4010A1 claim but for which the requirement notes in either CR513, CR514 and/or CR515 do not apply, e.g., oxygen saturation is not greater than 88%, arterial PO<sub>2</sub> is more than 60 mmHg;
8. Claims submitted by beneficiaries;
9. Claims from providers that only furnish services outside of the United States;
10. Claims from providers experiencing a disruption in their electricity or communication connection that is outside of their control and is expected to last longer than two days. This exception applies only while electricity or electronic communication is disrupted; and
11. Providers that can establish that some other “unusual circumstance” exists that precludes submission of claims electronically.

The process for post-payment based enforcement is as follows:

- The DME MAC will analyze reports displaying the number of paper claims that all suppliers submitted each quarter.

- By the end of the month following the quarter, selected suppliers who have submitted the highest numbers of paper claims will be reviewed.
- The DME MAC will ask these suppliers to provide information that establishes the exception criteria listed above.

If you, as one such supplier, do not respond to this initial “Request for Documentation” letter within 45 days of receipt, the DME MAC will notify you by mail that Medicare will deny and not pay any paper claims that you submit beginning ninety days after the date of the initial request letter. If you do respond to this initial letter but your response does not establish eligibility to submit paper claims, the DME MAC will notify you by mail of your ineligibility to submit paper claims. This Medicare decision is not subject to appeal.

In these letters, the DME MAC will also tell you how to obtain free and commercially available HIPAA-compliant billing software packages (also see Chapter 8 of this manual).

If you respond with information that does establish eligibility to submit paper claims, the DME MAC will notify you by mail that you meet one or more exception criteria to the requirements in Section 3 of the ASCA, Pub.L.107-105 (ASCA), and the implementing regulation at 42 CFR 424.32, and you will be permitted to submit paper claims. However, you will be cautioned that if your situation changes to the point that you no longer meet the exception criteria, you will be required to begin electronic submission of your claims.

If you are permitted to submit paper claims, the DME MAC will not review your eligibility to submit paper claims again for at least two years.

#### **4. CMS-1500 Claim Form**

**CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26, §10**

The CMS-1500 claim form answers the needs of many health insurers. It is the basic form prescribed by CMS for Medicare claims from suppliers. It has also been adopted by CHAMPUS/TRICARE and has received the approval of the American Medical Association (AMA) Council on Medical Services. The CMS-1500 form is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned.

The White House Office of Management and Budget (OMB) recently approved a revised version of the CMS-1500 form, version 02/12. All claims received on and after April 1, 2014, must be submitted on the current version 02/12 form. Claims using any previous versions of the CMS-1500 form will not be accepted.

Instructions for completing the CMS-1500 claim form are provided in this chapter. Instructions are also available in Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26 (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26.pdf>).

#### **Ordering the Form**

You are responsible for purchasing your own CMS-1500 forms. In order to purchase claim forms, contact the U.S. Government Printing Office at 1.866.512.1800, local printing companies in your area, and/or office supply stores. The form can be obtained from any printer or printed in-house as long as they follow the CMS approved specifications developed by the American Medical Association. Photocopies of the CMS-1500 form are NOT acceptable. Medicare accepts any type of the form (i.e., single sheet, snap-out, continuous feed, etc.) for processing.

## 5. Guidelines for Filing Paper Claims

*\*\* Failure to follow these guidelines could cause a delay in processing, denial of the claim, or the accuracy of payment. \*\**

The Administrative Simplification Compliance Act (ASCA) mandates the submission of electronic claims to Medicare unless you meet certain “exceptions” described within the law. If you believe you meet the exception criteria and will be submitting your claims on paper, please adhere to the following guidelines.

1. Do not submit black CMS-1500 forms. This includes submitting copies or carbon copies. Always submit a RED CMS-1500 form.
2. Do not write or stamp information in red ink. Information in red will not show up on the image and will not be available during processing.
3. Do not use light print or a dot matrix printer which causes broken lines. Check to make sure the ink is dark. Laser or inkjet printers are preferred.
4. Do not use small font type and size. For best processing results we recommend font type Lucida Console and size 10.
5. Do not use handwriting. It may be too light or simply unrecognizable.
6. Do not highlight items on the CMS-1500 form or attachments. This will cause the claim to be illegible which slows down the processing of the claim and may cause processing errors.
7. Do not use stamps or stickers within the body of the claim. If you must use a stamp or sticker, put it at the top of the claim within the blank area.
8. Do not leave block 11 blank. If no primary insurance exists, enter “NONE” in the field.
9. Do not use extra verbiage within the body of the claim. If you must put extra verbiage on the claim, use block 19 or an attachment.
10. Do not put a description next to the diagnosis code in block 21. All that is needed is the ICD-10 alpha/numeric diagnosis code.
11. Do not submit more than 12 diagnosis codes within block 21.
12. Do not submit more than one diagnosis pointer in block 24e. Only the first pointer will be used for processing.
13. Do not submit more than six service lines within block 24.
14. Do not put a description of the HCPCS procedure codes or times/units underneath the line item in blocks 24a – 24j. It is not needed and may cause processing errors.
15. Do not place the number of units/days in block 24g too close to the charges in 24f. This may cause the units/days to be read as a part of the submitted charges and the number of units/days to default to 1. Right justifying the days/units in block 24g will give more space between the two fields.
16. The supplier signature in block 31 must be that of an individual, not a company name.

17. Do not put a phone number on the first line of block 33. Submit the phone number below your name and address.
18. Do not omit the zip code in block 33. This block is used as the mailing address when a claim is returned.
19. Do not change the size of EOBs or copy them across to two pages. This may cause your EOB to be illegible.
20. Submit claims to PO Box 20013, Nashville, TN 37202 only.

## 6. Claim Completion Instructions

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26

### Responsibility for Accurate Claims

**You are ultimately responsible for the accuracy of claims filed for your services.** We recommend that your office set a policy to ensure that all necessary information is included on the initial claim submission and that the information is correct. Please refer to the Claim Completion Instructions below for guidance on completing the claim form.

### Health Insurance Claim Form CMS-1500

The Form CMS-1500 (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. The Form CMS-1500 is the prescribed form for claims prepared and submitted by physicians or suppliers (except for ambulance suppliers), whether or not the claims are assigned.

A sample of the CMS-1500 can be found at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf>.

### Legend Description

MM    Month (e.g., December = 12)  
DD    Day (e.g., Dec 15 = 15)  
YY    2 position Year (e.g., 1998 = 98)  
CCYY 4 position Year (e.g., 1998 = 1998)

**(MM | DD | YY) or (MM | DD | CCYY)** – A space must be reported between month, day, and year (e.g., 12 | 15 | 98 or 12 | 15 |1998). This space is delineated by a dotted vertical line on the Form CMS-1500.

**(MMDDYY) or (MMDDCCYY)** – No space may be reported between month, day, and year (e.g., 121598 or 12151998). The date must be recorded as one continuous number.

### Claims that are Incomplete or Contain Invalid Information

If a claim is submitted with incomplete or invalid information, it will be returned to the submitter as unprocessable.

**Items 1-13 – Patient and Insured Information**

**Item 1** – Show the type of health insurance coverage applicable to this claim by checking the appropriate box. For Medicare claims, check “Medicare.”

**Item 1a** – Enter the patient's Medicare Beneficiary Identifier (MBI) whether Medicare is the primary or secondary payer. This is a required field.

**Item 2** – Enter the patient's last name, first name, and middle initial (if any) as shown on the patient's Medicare card. This is a required field.

**Item 3** – Enter the patient's 8-digit birth date (MM | DD | CCYY) and sex.

**Item 4** – If there is insurance primary to Medicare, either through the patient's or spouse's employment or any other source, list the name of the insured here. When the insured and the patient are the same, enter the word SAME. If Medicare is primary, leave blank.

**Item 5** – Enter the patient's mailing address and telephone number. On the first line enter the street address; the second line, the city and state; the third line, the ZIP code and phone number.

**Item 6** – Check the appropriate box for patient's relationship to insured when item 4 is completed.

**Item 7** – Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.

**Item 8** –Leave blank.

**Item 9** – Enter the last name, first name, and middle initial of the enrollee in a **Medigap** policy if it is different from that shown in item 2. Otherwise, enter the word SAME. If no Medigap benefits are assigned, leave item 9 blank.

**NOTE:** Only participating physicians and suppliers are to complete item 9 and its subdivisions and only when the beneficiary wishes to assign his/her benefits under a MEDIGAP policy to the Participating Physician or Supplier. Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary. Participating physicians/suppliers sign an agreement with Medicare to accept assignment of Medicare benefits for **all** Medicare patients. A claim for which a beneficiary elects to assign his/her benefits under a Medigap policy to a participating physician/supplier is called a mandated Medigap transfer.

**Medigap** – Medigap policy meets the statutory definition of a "Medicare supplemental policy" contained in §1882(g)(1) of title XVIII of the Social Security Act (the Act) and the definition contained in the NAIC Model Regulation that is incorporated by reference to the statute. It is a health insurance policy or other health benefit plan offered by a private entity to those persons entitled to Medicare benefits and is specifically designed to supplement Medicare benefits. It fills in some of the "gaps" in Medicare coverage by providing payment for some of the charges for which Medicare does not have responsibility due to the applicability of deductibles, coinsurance amounts, or other limitations imposed by Medicare. It does not include limited benefit coverage available to Medicare beneficiaries such as "specified disease" or "hospital indemnity" coverage.

Also, it explicitly excludes a policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members.

Do not list other supplemental coverage in item 9 and its subdivisions at the time a Medicare claim is filed. Other supplemental claims are forwarded automatically to the private insurer if the private insurer contracts with the Coordination of Benefits Contractor (COBC) to send Medicare claim



information electronically. If there is no such contract, the beneficiary must file his/her own supplemental claim. See Chapter 7 of this manual for more information about supplemental insurance.

If the beneficiary wants Medicare payment data forwarded to a Medigap insurer through the Medigap claim-based crossover process, you must (if you are participating) accurately complete all of the information in items 9, 9a, and 9d. Otherwise, the DME MAC cannot forward the claim information to the Medigap insurer.

**Item 9a** – Enter the policy and/or group number of the Medigap insured preceded by MEDIGAP, MG, or MGAP.

**NOTE:** Item 9d must be completed if the provider enters a policy and/or group number in item 9a.

**Item 9b** – **Leave blank.**

**Item 9c** – Leave blank if item 9d is completed. Otherwise, enter the claims processing address of the Medigap insurer. Use an abbreviated street address, two-letter postal code, and ZIP code copied from the Medigap insured's Medigap identification card. Example: "1257 Anywhere St. MD 21204"

**Item 9d** – Enter the Medigap COBA ID number of the Medigap insurer.

When seeking to have the beneficiary's claim crossed over to a Medigap insurer, you must only enter the COBA Medigap claim-based ID within item 9d. If you enter the PAYERID of the Medigap insurer program or its plan name within item 9d, the DME MAC will be unable to forward the claim information to the Coordination of Benefits Contractor (COBC) for transfer to the Medicare insurer.

**NOTE:** Claim-based Medigap COBA ID numbers are 5-digit numbers in the range 55000-59999 and are assigned by the COBC. A list of Medigap companies and their corresponding COBA ID numbers is available on the CMS website at: <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html>.

**Items 10a through 10c** – Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services described in item 24. Enter the state postal code. Any item checked "YES" indicates there may be other insurance primary to Medicare. Identify primary insurance information in item 11.

**Item 10d** – Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter patient's Medicaid number preceded by 'MCD'.

**Item 11** – **THIS ITEM MUST BE COMPLETED;** it is a required field. By completing this item, you acknowledge having made a good faith effort to determine whether Medicare is the primary or secondary payer.

If there is insurance primary to Medicare, enter the insured's policy or group number and proceed to items 11a - 11c. Items 4, 6, and 7 must also be completed.

**NOTE:** Enter the appropriate information in item 11c if insurance primary to Medicare is indicated in item 11. If there is no insurance primary to Medicare, enter the word "NONE" and proceed to item 12. If the insured reports a terminating event with regard to insurance which had been primary to Medicare (e.g., insured retired), enter the word "NONE" and proceed to item 11b.

**Insurance Primary to Medicare** – Circumstances under which Medicare payment may be secondary to other insurance include:

- Group Health Plan Coverage
- Working Aged
- Disability (Large Group Health Plan)
- End Stage Renal Disease
- No Fault and/or Other Liability
- Work-Related Illness/Injury
- Workers' Compensation
- Black Lung
- Veterans Benefits

**NOTE:** For a paper claim to be considered for Medicare secondary payer (MSP) benefits, a copy of the primary payer's explanation of benefits (EOB) notice must be forwarded along with the claim form.

See Chapter 11 of this manual for more information about MSP.

**Item 11a** – Enter the insured's 8-digit birth date (MM | DD | CCYY) and sex if different from item 3.

**Item 11b** – Enter employer's name, if applicable. If there is a change in the insured's insurance status (e.g., retired), enter either a 6-digit (MM | DD | YY) or 8-digit (MM | DD | CCYY) retirement date preceded by the word "RETIRED."

**Item 11c** – Enter the 9-digit PAYERID number of the primary insurer. If no PAYERID number exists, then enter the **complete** primary payer's program or plan name. If the primary payer's EOB does not contain the claims processing address, record the primary payer's claims processing address directly on the EOB. This is required if there is insurance primary to Medicare that is indicated in item 11.

**Item 11d** – Leave blank. Not required by Medicare.

**Item 12** – The patient or authorized representative must sign and enter either a 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or an alpha-numeric date (e.g., January 1, 1998) unless the signature is on file. In lieu of signing the claim, the patient may sign a statement to be retained in the provider, physician, or supplier file. If the patient is physically or mentally unable to sign, a representative may sign on the patient's behalf. In this event, the statement's signature line must indicate the patient's name followed by "by" the representative's name, address, relationship to the patient, and the reason the patient cannot sign. The authorization is effective indefinitely unless the patient or the patient's representative revokes this arrangement.

**NOTE:** This can be "Signature on File" and/or a computer generated signature. The patient's signature authorizes release of medical information necessary to process the claim. It also authorizes payment of benefits to the provider of service or supplier when the provider of service or supplier accepts assignment on the claim.

**Signature by Mark (X)** – When an illiterate or physically handicapped enrollee signs by mark, a witness must enter his/her name and address next to the mark.

**Item 13** – The patient’s signature or the statement “signature on file” in this item authorizes payment of medical benefits to you. The patient or his/her authorized representative signs this item or the signature must be on file separately with you as an authorization. However, note that when payment can only be made on an assignment-related basis or when payment is for services furnished by a participating supplier, a patient’s signature or a “signature on file” is not required in order for Medicare payment to be made directly to you.

The presence of or lack of a signature or “signature on file” in this field will be indicated as such to any downstream coordination of benefits trading partners (supplemental insurers) with whom CMS has a payer-to-payer coordination of benefits relationship. Medicare has no control over how supplemental claims are processed, so it is important that you accurately address this field as it may or may not affect supplemental payments to you and/or your patients.

In addition, the signature in this item authorizes payment of mandated Medigap benefits to the participating supplier if required Medigap information is included in item 9 and its subdivisions. The patient or his/her authorized representative must sign this item or the signature must be on file as a separate Medigap authorization. The Medigap assignment on file in the participating supplier's office must be insurer specific. It may state that the authorization applies to all occasions of service until it is revoked.

**NOTE:** This can be "Signature on File" signature and/or a computer generated signature.

**Items 14-33 - Provider of Service or Supplier Information**

**Reminder:** For date fields other than date of birth, all fields shall be one or the other format, 6-digit: (MM | DD | YY) or 8-digit: (MM | DD | CCYY). Intermixing the two formats on the claim is not allowed.

**Item 14** – Leave blank. Not required by the DME MAC.

**Item 15** – Leave blank. Not required by Medicare.

**Item 16** – Leave blank. Not required by the DME MAC.

**Item 17** – Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician. All physicians who order services or refer Medicare beneficiaries must report this data. When a claim involves multiple referring and/or ordering physicians, a separate Form CMS-1500 shall be used for each ordering/referring physician.

Additionally enter one of the following qualifiers as appropriate to identify the role that this physician (or non-physician practitioner) is performing:

| Qualifier | Provider Role        |
|-----------|----------------------|
| DN        | Referring Provider   |
| DK        | Ordering Provider    |
| DQ        | Supervising Provider |

Enter the qualifier to the left of the dotted vertical line on item 17.

The term "physician" when used within the meaning of §1861(r) of the Act and used in connection with performing any function or action refers to:

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he/she performs such function or action;
2. A doctor of dental surgery or dental medicine who is legally authorized to practice dentistry by the State in which he/she performs such functions and who is acting within the scope of his/her license when performing such functions;
3. A doctor of podiatric medicine for purposes of §§(k), (m), (p)(1), and (s) and §§1814(a), 1832(a)(2)(F)(ii), and 1835 of the Act, but only with respect to functions which he/she is legally authorized to perform as such by the State in which he/she performs them;
4. A doctor of optometry, but only with respect to the provision of items or services described in §1861(s) of the Act which he/she is legally authorized to perform as a doctor of optometry by the State in which he/she performs them; or
5. A chiropractor who is licensed as such by a State (or in a State which does not license chiropractors as such), and is legally authorized to perform the services of a chiropractor in the jurisdiction in which he/she performs such services, and who meets uniform minimum standards specified by the Secretary, but only for purposes of §§1861(s)(1) and 1861(s)(2)(A) of the Act, and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation). For the purposes of §1862(a)(4) of the Act and subject to the limitations and conditions provided above, chiropractor includes a doctor of one of the arts specified in the statute and legally authorized to practice such art in the country in which the inpatient hospital services (referred to in §1862(a)(4) of the Act) are furnished.

**Referring physician** - is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program.

**Ordering physician** - is a physician or, when appropriate, a non-physician practitioner who orders non-physician services for the patient. Examples of services that might be ordered include diagnostic laboratory tests, clinical laboratory tests, pharmaceutical services, durable medical equipment, and services incident to that physician's or non-physician practitioner's service.

The ordering/referring requirement became effective January 1, 1992, and is required by §1833(q) of the Act. **All claims** for Medicare covered services and items that are the result of a physician's order or referral shall include the ordering/referring physician's name. See item 17b below for further guidance on reporting the referring/ordering provider's NPI.

**Item 17a** – Leave Blank (effective May 23, 2008, **17a is not to be reported**, but 17b **MUST** be reported when a service was ordered or referred by a physician)

**Item 17b** – Enter the NPI of the referring/ordering physician listed in item 17. All physicians who order services or refer Medicare beneficiaries must report this data.

**Item 18** – Leave blank. Not required by the DME MAC.

**Item 19** – Enter additional information that may be needed for claim processing. Below are several instances when item 19 may be required for DMEPOS claims (this list is not all-inclusive).

- Enter the drug's name and dosage when submitting a claim for Not Otherwise Classified (NOC) drugs.

- Enter a concise description of an "unlisted procedure code" or an NOC code if one can be given within the confines of this box. Otherwise an attachment shall be submitted with the claim.
- Enter all applicable modifiers when modifier -99 (multiple modifiers) is entered in item 24d. If modifier -99 is entered on multiple line items of a single claim form, all applicable modifiers for each line item containing a -99 modifier should be listed as follows: 1=(mod), where the number 1 represents the line item and "mod" represents all modifiers applicable to the referenced line item.
- Enter the statement, "Patient refuses to assign benefits" when the beneficiary absolutely refuses to assign benefits to a *non-participating physician/supplier who accepts assignment on a claim*. In this case, *payment can only be made directly to the beneficiary*.
- Method II suppliers shall enter the most current HCT value for the injection of Aranesp for ESRD beneficiaries on dialysis. (See Pub. 100-04, Chapter 8, Section 60.7.2.)

**Item 20** – Leave blank. Not required by the DME MAC.

**Item 21** – Enter the patient's diagnosis/condition. You must use an ICD-10 code number and code to the highest level of specificity for the date of service. Enter up to 12 diagnoses in priority order. All narrative diagnoses for non-physician specialties must be submitted on an attachment.

**Item 21 ICD Ind.** – Enter "0" or leave blank. Currently not required by Medicare.

**Item 22** – Leave blank. Not required by Medicare.

**Item 23** – Leave blank. Not required by the DME MAC.

**Item 24** – The six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the billed service. The top portion in each of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 service lines.

When required to submit NDC drug and quantity information for Medicaid rebates, submit the NDC code in the red shaded portion of the detail line item in positions 01 through position 13. The NDC is to be preceded with the qualifier N4 and followed immediately by the 11-digit NDC code (e.g. N499999999999). Report the NDC quantity in positions 17 through 24 of the same red shaded portion. The quantity is to be preceded by the appropriate qualifier: UN (units), F2 (international units), GR (gram) or ML (milliliter). There are six bytes available for quantity. If the quantity is less than six bytes, left justify and space-fill the remaining positions (e.g. UN2 or F2999999).

At this time, the shaded area in 24a through 24h is not used by Medicare. Future guidance will be provided on when and how to use this shaded area for the submission of Medicare claims.

**Item 24A** – Enter a 6-digit (MMDDYY) or 8-digit (MMDDCCYY) date for each procedure, service, or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column G. This is a required field.

**Item 24B** – Enter the appropriate place of service code(s). Identify the location, using a place of service code, for each item used or service performed. This is a required field. (See the "Place of Service" section below for additional information.)

**NOTE:** For DMEPOS claims, the place of service is considered to be the place where the beneficiary will primarily use the DMEPOS item.

**Item 24C** – Medicare providers are not required to complete this item.

**Item 24D** – Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code. The Form CMS-1500 (02-12) has the ability to capture up to four modifiers. If more than four modifiers are needed, use modifier 99 (overflow) as the fourth modifier and enter the additional modifiers in item 19.

Enter the specific procedure code without a narrative description. However, when reporting an "unlisted procedure code" or a "not otherwise classified" (NOC) code, include a narrative description in item 19 if a coherent description can be given within the confines of that box. Otherwise, an attachment must be submitted with the claim. If an "unlisted procedure code" or an NOC code is indicated in item 24d, but an accompanying narrative is not present in item 19 or on an attachment, the claim will be returned as unprocessable.

This is a required field.

**Item 24E** – Enter the diagnosis code reference number as shown in item 21 to relate the date of service and the items or services rendered to the primary diagnosis. Enter only one reference number per line item. When multiple items or services are rendered, enter the primary reference number for each service, either a 1, a 2, a 3, or a 4. This is a required field.

If a situation arises where two or more diagnoses are required for a procedure code, reference only one of the diagnoses in item 21.

**Item 24F** – Enter the charge for each listed service.

**Note for electronic claim submissions:** The maximum number of characters that can be submitted in any dollar amount field is seven characters. Claims containing a dollar amount in excess of \$99,999.99 will be rejected. If the claim total exceeds \$99,999.99, bill the lines on separate claims so that the total of any one claim does not exceed \$99,999.99. If one line exceeds \$99,999.99, but represents multiple services, split the line and bill on separate claims so that the total of any one claim does not exceed \$99,999.99.

**Item 24G** – Enter the number of days or units. If only one service is performed, the numeral 1 must be entered.

Some services require that the actual number or quantity billed be clearly indicated on the claim form (e.g., multiple ostomy or urinary supplies). When multiple items or services are provided, enter the actual number provided.

**NOTE:** This field should contain at least one day or unit. The DME MAC will default to "1" unit when the information in this field is missing to avoid returning as unprocessable.

**Item 24H** – Leave blank. Not required by Medicare.

**Item 24I** – Leave blank. Not required by the DME MAC.

**Item 24J** – Enter your NPI number in the lower unshaded portion.

**NOTE:** Effective May 23, 2008, the shaded portion of 24J is not to be reported.

**Item 25** – Enter your Federal Tax ID (Employer Identification Number or Social Security Number) and check the appropriate check box. You are not required to complete this item for crossover purposes since the DME MAC will retrieve the tax identification information from their

internal provider file for inclusion on the COB outbound claim. However, tax identification information is used in the determination of accurate National Provider Identifier reimbursement. Reimbursement of claims submitted without tax identification information will/may be delayed.

**Item 26** – Enter the patient's account number assigned by your accounting system. This field is optional to assist you in patient identification. As a service, any account numbers entered here will be returned to you.

**Item 27** – Check the appropriate block to indicate whether you accept assignment of Medicare benefits. If Medigap is indicated in item 9 and Medigap payment authorization is given in item 13, you must also be a Medicare participating supplier and accept assignment of Medicare benefits for all covered charges for all patients.

The following providers of service/suppliers and claims can only be paid on an assignment basis (the services applicable to DME MAC are **bolded**):

- Clinical diagnostic laboratory services;
- Physician services to individuals dually entitled to Medicare and Medicaid;
- **Participating physician/supplier services;**
- Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, and clinical social workers;
- Ambulatory surgical center services for covered ASC procedures;
- Home dialysis supplies and equipment paid under Method II;
- Ambulance services;
- **Drugs and biologicals;** and
- Simplified Billing Roster for influenza virus vaccine and pneumococcal vaccine.

**Item 28** – Enter total charges for the services (i.e., total of all charges in item 24f).

**Item 29** – Enter the total amount the patient paid on the **covered services only**.

**NOTE:** This field may/will affect payment if assignment was accepted.

**Item 30** – Leave blank. Not required by Medicare.

**Item 31** – Enter your signature (or that of your authorized representative) and either the 6-digit date (MM | DD | YY), 8-digit date (MM | DD | CCYY), or alphanumeric date (e.g., January 1, 1998) the form was signed.

**NOTE:** This is a required field; however, the claim can be processed if the following is true: If a physician, supplier, or authorized person's signature is missing, but the signature is on file; or if any authorization is attached to the claim, or if the signature field has "Signature on File" and/or a computer-generated signature.

**Item 32** – If the services were furnished in a hospital, clinic, laboratory, or any facility other than the patient's home or physician's office, enter the name, address, and ZIP code of the facility. Only one

name, address, and zip code may be entered in the block. If additional entries are needed, separate claim forms must be submitted.

For foreign claims, only the enrollee can file for Part B benefits rendered outside of the United States.

**Item 32a** – If required by Medicare claims processing policy, enter the NPI of the service facility

**Item 32b** – Effective May 23, 2008, Item 32b is not to be reported.

**Item 33** – Enter your billing name, address, ZIP code, and telephone number. This is a required field.

**Item 33a** – Enter your NPI. This is a required field.

**Item 33b** – Effective May 23, 2008, Item 33b is not to be reported (unless billed via Indirect Payment Procedure (IPP); if you are an IPP biller, please follow IPP billing guidelines).

### **Supplier Signature Requirements (CMS-1500, Item 31)**

**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §50.1.6(B)**

The rules below apply to both assigned and unassigned claims.

To fulfill the signature requirement of item 31 of the Form CMS-1500, you may:

- a) Sign item 31 of Form CMS-1500.
- b) Sign a one time certification letter for machine-prepared claims submitted on other than paper vehicles.
- c) Authorize an employee (e.g., nurse, administrative assistant) to enter the supplier signature in item 31 of the Form CMS-1500 (manually, by stamp-facsimile or block letters, or by computer).
- d) Authorize a non-employee agent (e.g., billing service or association) to enter the supplier signature in item 31 of the Form CMS-1500, followed by the agent's name, title, and organization (e.g., a billing agent might enter by stamp "Dr. Tom Jones by Robert Smith, Secretary, Ajax Billing Service"). Alternatively, the agent may simply enter the supplier signature.

### **Beneficiary Signature Requirements (CMS-1500, Items 12 & 13)**

**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §50.1.6(A)**

A request for payment signed by the beneficiary must be filed on or with each claim for charge basis reimbursement except as provided below. All rules apply to both assigned and unassigned claims unless otherwise indicated.

1. No beneficiary signature is required when:
  - a) An unassigned claim is submitted by a public welfare agency on a bill which is paid.
  - b) The beneficiary is deceased, the bill is unpaid, and you agree to accept the Medicare approved amount as the full charge.
2. A signature by mark is permitted when:



The beneficiary is unable to sign his/her name because of illiteracy or physical handicap.

3. Another person may sign on behalf of the beneficiary when:
  - a) A beneficiary who is a resident of a nonprofit retirement home gives power of attorney to the administrator of the home.
  - b) A beneficiary is physically or mentally unable to transact business—the request may be signed by a representative payee, legal representative, relative, friend, representative of an institution providing the beneficiary care/support, or a representative of a governmental agency providing him/her assistance.
  - c) A beneficiary is physically or mentally unable to transact business and full documentation is supplied that the beneficiary has no one else to sign on his/her behalf—the physician, supplier, or clinic may sign.
  - d) The beneficiary is deceased and the bill is paid or liability assumed—the person claiming payment should sign. If Form CMS-1500 was signed before the enrollee dies, claimant should sign separate request for underpayment.
  
4. When the request retained in your file may cover an extended future period:
  - a) Assignment in files of a welfare agency covers all services furnished during the period when the enrollee is on medical assistance.
  - b) Authorization in files of organization approved under the indirect payment procedure (CMS Pub. 100-4, Chapter 1, § 30.2.8.3) covers all services paid for by that organization.
  - c) Assignment in the files of group practice prepayment plan covers services furnished by the plan during the period of the beneficiary’s membership.
  - d) Assignment in the files of a participating provider (hospital, SNF, home health agency, outpatient physical or speech therapy provider or comprehensive rehabilitation facility) or ESRD facility covers physician services for which the provider or facility is authorized to bill, and may cover the physician services furnished in the provider or facility as follows:
    - Inpatient services - effective for period of confinement.
    - Outpatient services - effective indefinitely.
  - e) Assignment in files of individual physician, supplier (except in the case of unassigned claims for rental of durable medical equipment), or qualified reassignee under CMS Pub. 100-4, Chapter 1, § 30.2 - Assignment of Provider’s Right to Payment, is effective indefinitely.

You may obtain and retain in your files a one-time payment authorization from a beneficiary (or the beneficiary’s representative) applicable to any current and future services. You should have the beneficiary sign a brief statement such as:

Name of Beneficiary

HICN/MBI

I request that payment of authorized Medicare benefits be made either to me or on my behalf to (supplier)\_\_\_\_\_ for any services furnished me by that supplier. I authorize any holder of medical information about me to release to the Centers for

Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Once you have obtained the beneficiary's one-time authorization, later claims can be filed without obtaining an additional signature from the beneficiary. These claims may be on an assigned or non-assigned basis with the exception of durable medical equipment rentals. The one-time authorization for DME rental claims is limited to assigned claims.

## **7. Claim Filing Jurisdiction**

Unlike other Medicare claims, DMEPOS claim jurisdiction is based on the beneficiary's address on file with the Social Security Administration. A DMEPOS claim should be sent to the DME MAC jurisdiction for the state in which the beneficiary resides.

For a listing of the four DME MAC jurisdictions with the included states/territories and the addresses to which paper claims should be filed, refer to Chapter 15 of this manual.

## **8. Time Limit for Filing Claims**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §70*

All Medicare claims for services must be filed within one year after the date of service. For example, if the date of service took place on April 1, 2016, then the claim must be filed by April 1, 2017, in order to be considered for payment.

### **Effects of Time Limitations**

If you accept assignment within the time limit for filing and then delay submission of the claim until no payment can be made to you or the beneficiary, you cannot charge the beneficiary for the services shown on the bill except for the 20 percent coinsurance and any unmet part of the deductible.

## **9. Clean Claims – Payment Floor and Ceiling**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §80.2.1.2*

A "clean" claim is one that does not require investigation or development outside the DME MAC operation on a prepayment basis.

A "paper claim" is one that is submitted on paper.

An "electronic claim" is one that is received by the DME MAC via tape, direct data entry, modem, etc.

The Medicare statute provides for claims payment "floors" and "ceilings." A floor is the minimum amount of time a claim must be held before payment can be released. A ceiling is the maximum time allowed for processing a "clean" claim before Medicare owes interest to a supplier of services.

If you file paper claims, you will not be paid before the 29th day after the date of receipt of your claims (i.e., a 28-day payment floor). However, clean claims filed electronically can be paid as early as 14 days after receipt (i.e., a 13-day payment floor).

The difference in payment floors is further incentive for you to consider use of electronic claims submission to improve your cash flow, record keeping, and claim status tracking ability.

The DME MAC has a 30-day ceiling to process a clean claim. On the 31<sup>st</sup> day after the date of receipt for clean claims (electronic and paper) that are not yet paid, interest will be owed.

## **10. Electronic Funds Transfer (EFT)**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24, §60.5.3

Electronic Funds Transfer (EFT) is the process through which payment on Medicare claims is electronically transferred directly to your bank account. This process eliminates mail and deposit time and is available to all suppliers. As your Medicare contractor, we can deposit your Medicare payments directly into your bank account via Electronic Funds Transfer. EFT benefits us as well as other taxpayers because it reduces Medicare administrative spending by eliminating the process of issuing paper checks and the postage costs for mailing.

Other benefits to the Electronic Funds Transfer process are:

- Quicker payment
- Increased convenience
- Assurance of timely payment in the bank
- Elimination of multi-handling risks
- Prevention of lost or delayed checks
- Easier bank reconciliation
- Administration efficiency

There are no charges for EFT and you do not have to file your claims electronically to receive your payments sent by direct deposit.

You must complete and submit the most current version of the Authorization Agreement for Electronic Funds Transfer (CMS-588) to the appropriate NPE when initially enrolling a physical location or submitting an application for a new location. Your bank information must be applicable for all four DME MAC Jurisdictions.

If you need to make changes to existing EFT information, submit updates to the appropriate NPE for processing.

Along with each completed CMS-588 form, you must include one of the following verifying the account information:

- Voided check
- Deposit slip
- Notification on bank letterhead verifying the account information

Please note that the DME MAC is not able to answer inquiries pertaining to EFT applications. Instead, you must contact the NPE.

## 11. Place of Service

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 26, §10.5

For DMEPOS claims, the place of service is considered to be the place where the beneficiary will primarily use the DMEPOS item. Coverage for any DMEPOS items will be considered if the place of service is:

|           |   |
|-----------|---|
| <b>01</b> | Pharmacy  |
| <b>04</b> | Homeless Shelter  |
| <b>12</b> | Home  |
| <b>13</b> | Assisted Living Facility  |
| <b>14</b> | Group Home  |
| <b>16</b> | Temporary Lodging   |
| <b>27</b> | Outreach Site/Street  |
| <b>33</b> | Custodial Care Facility   |
| <b>54</b> | Intermediate Care Facility/Individuals with Intellectual Disabilities                     |
| <b>55</b> | Residential Substance Abuse Treatment Facility  |
| <b>56</b> | Psychiatric Residential Treatment Center  |
| <b>65</b> | End Stage Renal Disease Treatment Facility (valid POS for Parenteral Nutritional Therapy) |

Coverage consideration for DMEPOS items in a Skilled Nursing Facility (31), unless the beneficiary is in a covered Part A stay\*\*, or a Nursing Facility (32) is limited to the following:

- Prosthetics, orthotics and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings

- Oral anticancer drugs
- Oral antiemetic drugs
- Therapeutic shoes for Diabetics
- Parenteral/enteral nutrition (including E0776BA, the IV pole used to administer parenteral/enteral nutrition and supplies)
- Immunosuppressive drugs
- Lymphedema Compression Treatment Items

A complete list of place of service codes is available on the CMS website at [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html), as well as in the Internet-only Manual (IOM): CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 26, §10.5. You can access the IOM at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>.

\*\*It is important to note that this list does not apply to situations in which the beneficiary is in a Part A covered Skilled Nursing Facility (SNF) stay. Please see the “Consolidated Billing” section below for information regarding DMEPOS items when the beneficiary’s SNF stay is covered by Part A.

## 12. Consolidated Billing

### Skilled Nursing Facility (SNF) Residents

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §211

Section 4432(b) of the Balanced Budget Act (BBA) requires Consolidated Billing (CB) for the SNF. The CB requirement essentially confers on the SNF itself the Medicare billing responsibility for the entire package of care that its residents receive, except for a limited number of specifically excluded services.

For services and supplies furnished to a SNF resident covered under the Part A benefit, SNFs are not able to unbundle services to an outside provider of services or supplies that can then submit a separate bill directly to the Medicare Contractor. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider of the service or supplies, bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement (See 42 CFR 424.73.). **As a result, if you have supplied an item or service to a beneficiary who is a resident in a covered Part A stay, you must look to the SNF, rather than to the beneficiary or the DME MAC, for payment.** The SNF may collect any applicable deductible or coinsurance from the beneficiary. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an outside provider, for a resident of a SNF in a covered Part A stay are included in the SNF’s bill to the A/B MAC.

It is your responsibility to check with the facility to see if your patient is a resident in a covered Part A stay. If so, all services must be billed to Medicare by the SNF except for certain excluded items. A complete list of these excluded items (listed by HCPCS code) may be found on the CMS website at <https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing>. **If a HCPCS code appears on this list, then it may be billed to the DME MAC for payment, even if the beneficiary is in a covered Part A SNF stay.** Note: in order to access the list, click on the link

above, select the appropriate “Part A MAC Update” (whichever year in which the service took place), and then open the ZIP file found in the Downloads section.

**SNF Consolidated Billing - Capped Rental DME**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §211

Medicare pays for durable medical equipment (DME) when it is medically necessary for use in a beneficiary’s home.

For capped rental items of DME in which you submit a monthly bill, the date of delivery on the first claim must be the “from” or anniversary date on all subsequent claims for the item.

The DME benefit is only meant for items a beneficiary is using in his or her home. For a beneficiary in a Part A stay, a SNF is not defined as a beneficiary’s home. Medicare does not make separate payment for DME when a beneficiary is in a SNF. The SNF is expected to provide all medically necessary DMEPOS during a beneficiary’s covered Part A stay.

However, in accordance with DMEPOS payment policy, Medicare will make a separate payment for a full month of rental for DME items, provided the beneficiary was in the home on the “from” date or anniversary date defined above. Medicare will make payment for the entire month, even if the “from” date is the date of discharge from the SNF.

If a beneficiary using DME is in a covered Part A stay in a SNF for a full month, Medicare will not make payment for the DME for that month.

If the beneficiary is in a Part A covered stay, but not for the entire month, the discharge date becomes the new anniversary date for subsequent claims. In this situation, you must submit a new claim using the date of discharge as the “from” date. You should note in the NTE segment/line note (field 19 for paper claims) that the beneficiary was in a SNF, resulting in the need to establish a new anniversary date.

**Home Health Prospective Payment System (PPS)**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §140.2

The Balanced Budget Act of 1997 requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician (referred to as a “home health episode”). Consequently, billing for all such items and services will be made to a single home health agency (HHA) overseeing that plan.

The law states that payment will be made to the primary HHA whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements existed with the primary agency, or “otherwise.” Payment for all items is scheduled in the home health PPS episode payment that the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision include:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;

- Medical social services;
- Routine and non-routine medical supplies (see below);
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of a HHA that is affiliated or under common control with that hospital; and
- Care for homebound patients involving equipment too cumbersome to take to the home.

### **Routine and Non-Routine Medical Supplies**

When a beneficiary is in a 60-day home health episode, these items are included in the PPS episode payment. HHAs must bill for all supplies provided during the 60-day episode, including those not related to the Plan of Care, because of the consolidated billing requirements.

The “Home Health Consolidated Billing Master Code List” is a list of the HCPCS codes which apply to home health consolidated billing. It is available on the CMS website at [https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding\\_billing.html](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/coding_billing.html). **If a HCPCS code appears on this list, it may not be billed to the DME MAC when the beneficiary is in a home health episode.**

## **13. DMEPOS and an Inpatient Stay**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §110.3

### **Pre-Discharge Delivery of DMEPOS for Fitting and Training**

The following are CMS policy and billing procedures regarding the circumstances under which you may deliver durable medical equipment, prosthetics, and orthotics (but not supplies) to a beneficiary who is in an inpatient facility that does not qualify as the beneficiary's home.

#### **Conditions That Must Be Met:**

In some cases, it would be appropriate for a supplier to deliver a medically necessary item of durable medical equipment (DME), a prosthetic, or an orthotic—but not supplies—to a beneficiary who is an inpatient in a facility that does not qualify as the beneficiary's home. The CMS will presume that the pre-discharge delivery of DME, a prosthetic, or an orthotic (hereafter referred to as “item”) is appropriate when all the following conditions are met:

The item is medically necessary for use by the beneficiary in the beneficiary's home.

1. The item is medically necessary on the date of discharge, i.e., there is a physician's order with a stated initial date of need that is no later than the date of discharge for home use.
2. The supplier delivers the item to the beneficiary in the facility solely for the purpose of fitting the beneficiary for the item, or training the beneficiary in the use of the item, and the item is for subsequent use in the beneficiary's home.
3. The supplier delivers the item to the beneficiary no earlier than two days before the day the facility discharges the beneficiary.
4. The supplier ensures that the beneficiary takes the item home, or the supplier picks up the item at the facility and delivers it to the beneficiary's home on the date of discharge.

5. The reason the supplier furnishes the item is not for the purpose of eliminating the facility's responsibility to provide an item that is medically necessary for the beneficiary's use or treatment while the beneficiary is in the facility. Such items are included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates.
6. The supplier does not claim payment for the item for any day prior to the date of discharge.
7. The supplier does not claim payment for additional costs that the supplier incurs in ensuring that the item is delivered to the beneficiary's home on the date of discharge. The supplier cannot bill the beneficiary for redelivery.
8. The beneficiary's discharge must be to a qualified place of service, e.g., home, custodial care facility, but not to another facility (e.g., inpatient or skilled nursing) that does not qualify as the beneficiary's home.

**Date of Service for Pre-Discharge Delivery of DMEPOS:**

For DMEPOS, the general rule is that the date of service is equal to the date of delivery. However, pre-discharge delivery of items intended for use upon discharge is considered provided on the date of discharge. In this case, the date of service on the claim should be the date of discharge.

**14. DMEPOS and Hospice**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §10.2

When hospice coverage is elected, the beneficiary waives all rights to Medicare Part B payments for services that are related to the treatment and management of his/her terminal illness. During any period in which the hospice benefit election is in force, all items related to the treatment and management of his/her terminal illness are paid by the intermediary. If the items are not related to the terminal illness, the supplier should submit the claim to the DME MAC.

For services provided to a beneficiary enrolled in a plan participating in the Value Based Insurance Design (VBID) Model's hospice benefit component, Medicare will deny payment for all claims with dates of service during a hospice election (with a hospice election start date on or after January 1, 2021, through December 31, 2024) and upon discharge or revocation, through the end of the month. Suppliers MUST still submit claims for these services to Medicare and can expect the following messaging:

- Claim Adjustment Reason Code (CARC) 96: Non-covered charge(s)
- Remittance Advice Remark Code (RARC) MA73: Information remittance associated with a Medicare demonstration. No payment issued under Fee-For-Service Medicare as patient has elected managed care
- Group Code CO



## 15. Upgrades

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 30, §50.13

### A. ABNs for Upgrades

An upgrade is an item with features that go beyond what is medically necessary. DME upgrades involve situations in which the upgraded item or component has a different HCPCS code than the item that will be covered by Medicare. Advance Beneficiary Notices (ABNs) cannot be used to charge beneficiaries for premium quality services described as “excess components.” Similarly, ABNs cannot be used to shift liability for an item or service that is described on the ABN as being “better” or “higher quality” on an ABN but do not exceed the HCPCS code description.

When you know or believe that the DMEPOS item does or may not meet Medicare’s reasonable and necessary rules under specific circumstances, it is your responsibility to notify the beneficiary in writing via an Advance Beneficiary Notice (ABN) if you want to collect money from a beneficiary if an item is denied.

When you furnish an upgraded item of DMEPOS and you expect Medicare to reduce the level of payment based on a medical necessity partial denial of coverage for additional expenses attributable to the upgrade, you must give an ABN to the beneficiary for signature in order to hold the beneficiary liable for the additional expense.

See Chapter 3 of this manual for information about ABNs.

#### General Instructions for the Use of ABNs for Upgrading DMEPOS Items

1. DME upgrades involve situations in which the upgraded item or component has a different HCPCS code than the item that will be covered by Medicare. ABNs cannot be used to charge beneficiaries for premium quality services described as “excess components.”
2. The upgrade must be within the range of items or services that are medically appropriate for the beneficiary’s medical condition and the purpose of the physician’s order. ABNs may not be used to substitute a different item or service that is not medically appropriate for the beneficiary’s medical condition for the original item or service. The upgraded item must still meet the intended medical purpose of the item the physician ordered.
3. Use of an ABN to furnish an upgraded item or service, with the beneficiary being personally responsible for the difference between the costs of the standard and upgraded item or service, does not change coverage or payment rules, statutory provisions, or manual instructions for the particular benefit involved.
4. In cases where the DME MACs would make payment for the item the physician ordered on a rental basis, you must furnish the upgrade on a rental basis.
5. If you are furnishing an upgrade and using an ABN, you must submit a claim and include information on the claim that identifies the upgrade features. You must submit a claim for upgraded items and services using the GA modifier on the upgraded line item to indicate that the beneficiary signed an ABN. For paper claims, you must list upgrade features in Item 19 of the CMS-1500 form or as an attachment to the claim. For electronic claims, you must use the NTE segment/line note on the 837 electronic claim format.
6. Denials should be based on medical necessity.

**Billing Instructions**

**You must bill two line items for upgraded DMEPOS items** where the beneficiary requests an upgrade. You must bill both lines on the same claim in the following order:

Line 1: Bill the appropriate HCPCS code for the upgraded item that you actually provided to the beneficiary with the dollar amount of the upgraded item. If you have a properly obtained ABN on file signed by the beneficiary, use the GA modifier. If you did not properly obtain an ABN signed by the beneficiary, use the GZ modifier.

Line 2: Bill the appropriate HCPCS code for the reasonable and necessary item with the actual charge for the item. Use the GK modifier.

You must bill your full submitted charge on the claim line for the upgraded item (Line 1) and the full amount for the reasonable and necessary item (Line 2). If the upgrade is within a code, you still bill two line items, using the same code on both lines, but Line 1 would have the higher dollar amount. You must bill both lines on the same claim in sequential order. Line 1 and the associated Line 2 must follow each other.

Claims that have invalid ABN upgrade information will be returned as unprocessable.

**Definitions of Modifiers that May be Associated with ABNs**

GA – Waiver of Liability Statement on file (expected to be denied as not reasonable and necessary, ABN on file)

GZ – Item or Service not Reasonable or Necessary (expected to be denied as not reasonable and necessary, no ABN on file)

GK – Reasonable and necessary item/service associated with GA or GZ modifier

**B. Providing Upgrades of DMEPOS without Any Extra Charge**

Instead of using ABNs and charging beneficiaries for upgraded items, suppliers in certain circumstances may decide to furnish beneficiaries with upgraded equipment but charge the Medicare program and the beneficiary the same price they would charge for a non-upgraded item. The reason for this may be that a supplier prefers to carry only higher level models of medical equipment in order to reduce the costs of maintaining an inventory that includes a wide variety of different models and products. Also, a supplier may be able to reduce its costs for replacement parts and repairs if it includes in its inventory only certain product lines. The supplier may also be accommodating a physician order for an upgrade.

**Policy**

You are permitted to furnish upgraded DMEPOS items and to charge the same price to Medicare and the beneficiary that they would charge for a non-upgraded item. This policy allows you to furnish to beneficiaries, at no extra costs to the Medicare program or the beneficiary, a DMEPOS item that exceeds the non-upgraded item that Medicare considers to be medically necessary. Therefore, even though the beneficiary received an upgraded DMEPOS item, Medicare's payment and the beneficiary's coinsurance would be based on the Medicare allowed amount for a non-upgraded item that does not include features that exceed the beneficiary's medical needs.

**Billing Instructions**

When you decide to furnish an upgraded DMEPOS item but not charge Medicare and the beneficiary for the non-upgraded item, you must bill for the non-upgraded item rather than the item you actually furnished. The claim must include only the charge and HCPCS code for the non-upgraded item. The HCPCS code for the non-upgraded item must be accompanied by the following modifier:

GL – Medically Unnecessary Upgrade Provided Instead of Non-upgraded Item, No Charge, No ABN

In Item 19 of a paper claim, or as an attachment, you must specify the make and model of the item actually furnished (the upgraded item) and describe why this item is an upgrade. For electronic claims, you must use the NTE segment/line note on the 837 electronic claim format.

The DME MAC pays based on Medicare’s payment amount for the non-upgraded item if it meets Medicare’s coverage and payment requirements. A Certificate of Medical Necessity (CMN), if applicable, must be completed for the HCPCS code that identifies the non-upgraded item, but not for the upgraded item.

**C. DMEPOS Upgrade Chart**

The following chart indicates upgrade situations in which an ABN is required, the claim modifiers needed, and whether or not the beneficiary is responsible for payment of the upgrade.

| <b>Upgrade Situation</b>                                      | <b>ABN Required</b> | <b>Required Modifier(s)</b> | <b>DME MAC Payment</b>  | <b>Beneficiary Pays for Upgrade</b> |
|---|---------------------|-----------------------------|-------------------------|-------------------------------------|
| <b>1. Physician orders upgrade:</b>                           |                     |                             |                         |                                     |
| a. Supplier provides upgrade free of charge to beneficiary    | No                  | GL                          | R&N item only (GL line) | No                                  |
| b. Supplier bills beneficiary for upgrade                     | Yes                 | GA/GK                       | R&N item only (GK line) | Yes                                 |
| <b>2. Patient requests upgrade:</b>                           |                     |                             |                         |                                     |
| a. Supplier provides upgrade free of charge to beneficiary    | No                  | GZ/GK                       | R&N item only (GK line) | No                                  |
| b. Supplier bills beneficiary for upgrade                     | Yes                 | GA/GK                       | R&N item only (GK line) | Yes                                 |
| <b>3. Supplier provides upgrade for supplier convenience:</b> |                     |                             |                         |                                     |
| a. Supplier provides upgrade free of charge to beneficiary    | No                  | GL                          | R&N item only (GL line) | No                                  |

Table Footnotes:

GK or GL is added to the HCPCS code for the item that meets Medicare coverage requirements. When GK is used, GA or GZ is added to the HCPCS code for the item that is provided. See the sections above for further details.

R&N = Reasonable and necessary

## 16. PWK (Paperwork) Segment

When submitting an electronic claim, there may be times when additional documentation is needed in order for the claim to be properly adjudicated. If the information can be sent using the claim narrative (NTE segment), we encourage you to use the NTE segment. In instances when the NTE or narrative segment is insufficient, the PWK (paperwork) segment is a function within the 837 Professional and Institutional electronic transactions which allows for an electronic submission of additional claim documentation via mail or fax. Use of the PWK segment is entirely voluntary. Refer to Chapter 8 of this manual for additional information about electronic claim submission.

If using the PWK segment, please keep the following in mind:

- You must use the PWK Fax/Mail Cover Sheet ([http://www.cgsmedicare.com/jb/forms/pdf/pwk\\_coversheet.pdf](http://www.cgsmedicare.com/jb/forms/pdf/pwk_coversheet.pdf)), available on our website at <https://www.cgsmedicare.com/jb/forms/index.html>.
- You must send the additional documentation AFTER the claim has been electronically submitted and accepted with the PWK segment.
- You must accurately and completely record data on the fax/mail cover sheet that relates the faxed/mailed data to the PWK Loop on the claim.
- If PWK data submission is incomplete or incorrectly filled out, the DME MAC will manually return the cover sheet and all attachments.
- Use of the PWK segment does not guarantee that the DME MAC will review the submitted paperwork. Additional claim documentation (including the claim narrative) is only reviewed when needed by the DME MAC.
- When needed for claim adjudication, the DME MAC will allow seven calendar “waiting” days (from the date of receipt) for additional information to be faxed or ten calendar “waiting” days for additional information to be mailed.
- You must send ALL relevant PWK data at the same time for the same claim.
- If the additional documentation is not received within the seven calendar waiting days for faxes or ten calendar waiting days for mailed submissions, the DME MAC will begin normal processing procedures on your claim.
- If the PWK documentation is not sufficient in a given situation, the DME MAC may send a development request for specific claim documentation.
- Medicare will not send the PWK documentation to the Coordination of Benefits Contractor to accompany crossover claims.

## **17. Electronic Submission of Medical Documentation (esMD)**

Electronic Submission of Medical Documentation (esMD) is a way to submit electronic documentation **after** it has been requested by the DME MAC. If you receive a request for additional documentation from Jurisdiction B and wish to respond electronically, you can submit your documentation (as a PDF file) through the CMS esMD gateway. We will receive your file and process your claim accordingly.

For information about how to connect to the esMD gateway, as well as additional information about esMD, visit the CMS esMD Web page at <https://www.cms.gov/data-research/computer-data-systems/esmd>.

*Please note that you may only submit esMD documentation for a claim if you have received a documentation request letter from DME MAC Jurisdiction B that contains a documentation case ID number or if you are submitting a Prior Authorization Request for a code that is part of the Prior Authorization Demonstration.*

## Chapter 7 Contents

### Introduction

1. Coordination of Benefits Agreement
2. Medigap

## Introduction – Crossover Claims

Crossover is the transfer of processed claim data from Medicare operations to Medicaid (or state) agencies and private insurance companies that sell supplemental insurance benefits to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) Coordination of Benefits (COB) program identifies the health benefits available to a Medicare beneficiary and coordinates the payment process to ensure appropriate payment of Medicare benefits. There are two ways for Medicare contractors to be notified that Medicare claim information should be crossed over to the beneficiary's supplemental insurance company:

- Coordination of Benefits Agreement (COBA) crossovers
- Medigap claim-based crossovers

## 1. Coordination of Benefits Agreement

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 28, §70.6

The Coordination of Benefits Agreement (COBA) program establishes a nationally-standard contract between the CMS Benefits Coordination and Recovery Center (BCRC) (formerly the Coordination of Benefits Contractor), and supplemental insurers and Medicaid agencies. This process consolidates the activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. For eligibility-based COBA crossovers, private insurers and Medicaid agencies supply the BCRC with their eligibility file and indicate the types of claims they would like to receive. This information is stored at each CWF host site and is used to flag Medicare claims for crossover as they are sent to CWF for processing. The claims that have been flagged for crossover are then stored in the contractor's processing system until the claims have completed the processing cycle and are released for payment. At that time the contractor sends the claims to the BCRC. The BCRC will then combine all the claims for a particular insurer based on their COBA ID and send them to that insurer following the terms of the COBA that the insurer has on file with the BCRC. When claims are sent to the BCRC, the MA18 (supplemental insurance) or MA07 (Medicaid) codes will be reported on the Medicare remittance advice (RA) (see Chapter 17 of this manual for more information about remittance advice codes).

In some instances, claims that were flagged for crossover will be rejected from the BCRC because of claim data errors. You will be notified by letter advising you when a claim has been rejected from the crossover process. The letter will include specific information about the claim, such as the claim control number and the beneficiary's Medicare ID and last name, as well as an explanation of the data error. If a claim has been rejected from the crossover process, you will need to manually submit the claim with a copy of your RA to the beneficiary's crossover company.

## 2. Medigap

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 28

A Medigap policy is a health insurance policy or other health benefit plan offered by a private company to those entitled to Medicare benefits. It provides reimbursement for Medicare charges not reimbursable because of the applicability of deductibles, coinsurance amounts, or other Medicare imposed limitations. A policy or plan offered by an employer to employees or former employees, as well as that offered by a labor organization to members or former members, is not considered part of the Medigap provision.

The BCRC is responsible for Medigap claim-based crossover as well as eligibility-based Medigap crossover. Claim-based Medigap crossover is only available for participating suppliers. Beneficiaries must provide the claim-based Medigap COBA ID number of the supplemental insurer and their individual policy number to you for inclusion on each claim. The submitted COBA ID must be validated at CWF in order for claims to be flagged for crossover. After validation of the COBA ID, the claims are stored in the contractor's processing system and sent to the BCRC in the same manner as eligibility-based COBA crossover claims.

### Medigap Procedures

Medicare beneficiaries initiate the automatic transmittal of claims information by exercising their right to assign payment of Medigap, as well as Medicare benefits, for the services of participating suppliers.

It is recommended that the beneficiaries show you their Medigap enrollment card (supplied by the Medigap insurer) to ensure actual coverage is available. The card should clearly indicate that the policy is designated as Medicare supplemental coverage. Always try to maintain a copy of the card in your beneficiary's file.

The Medigap policy information should be shown in items 9-9d of the CMS-1500 (02/12) claim form:

- The word "Medigap" (or an abbreviation of the word; e.g., MG) and individual Medigap policy number must be present on the claim in item 9a of the CMS-1500 form.
- The Medigap COBA ID number must be present on the claim in item 9d on the CMS-1500 form.

**NOTE:** Claim-based Medigap COBA ID numbers are 5-digit numbers in the range 55000-59999 and are assigned by the BCRC. A list of Medigap companies and their corresponding COBA ID numbers is available on the CMS website at <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/COBA-Trading-Partners/Coordination-of-Benefits-Agreements/Coordination-of-Benefits-Agreement-page.html> in the Downloads Section. Refer to the PDF document titled *September 2020 – Medigap Claim-Based COBA IDs for Billing Purposes*.

Medicare beneficiaries must indicate that they have assigned their Medigap benefits to you by signing item 13 of the CMS 1500 (02/12) claim form. This authorization is in addition to their assignment of Medicare benefits as indicated by their signature in item 12. Separate signatures authorizing Medigap assignment must be retained in your files when signature on file is authorized.

The following is suggested wording for the Medigap assignment agreement authorization:

**Patient's Assignment Authorization (CMS-1500, Item 13):**

|                     |  |
|---------------------|--|
| NAME OF BENEFICIARY | BENEFICIARY'S MEDICARE ID<br>MEDIGAP POLICY NUMBER |
|---------------------|--|

"I request that payment of authorized Medigap benefits be made on my behalf to \_\_\_\_\_ for any services furnished me by that supplier. I authorize any holder of medical information about me to release to (Name of Medigap insurer) any information needed to determine these benefits or the benefits payable for related services."

Signature \_\_\_\_\_ Date \_\_\_\_\_

Missing signature or the lack of an indication of signature on file is reason for the contractor not to transfer claim information to the BCRC.

If you bill electronically, you must enter the 5-digit Medigap claim-based COBA ID in field NM109 of the NM1 segment in loop 2330B and the Medigap policy number in field NM109 of the NM1 segment in loop 2330A of the Health Insurance Portability and Accountability Act (HIPAA) American National Standards Institute (ANSI) X12-N 837 professional claim for purposes of triggering Medigap claim-based crossovers. Retail pharmacies that wish to trigger claim-based crossovers to Medigap when billing in the NCPDP format should enter the Medigap claim-based COBA ID in the 301-C1 (Group ID) portion of the Transmission Insurance Segment in the NCPDP format version D.0. The beneficiary's Medigap policy number is reported in the 359-2A (Medigap ID) portion of the Insurance Segment of the NCPDP format version D.0.

It should be noted that no development for missing or incomplete information will be done by the DME MAC. When any of the required information is missing or incomplete, no transfer of claim information will occur.

When submitting claims under this procedure, you agree:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment.
2. To incorporate, by stamp or otherwise, the following information on any bills you send to Medicare beneficiaries: "Do not use this bill for claiming Medicare benefits. A claim has been or will be submitted to Medicare on your behalf." This requirement is necessary to prevent beneficiaries from submitting duplicate claims.
3. To cancel the authorization upon request of the beneficiary.
4. To make the beneficiary signature files available for contractor inspection upon request.

When Medigap claims are sent to the BCRC, the MA18 (supplemental insurance) code will be reported on the remittance advice. When Medigap claims are **not** sent to the BCRC due to incomplete or invalid information, the MA19 code will be reported on the remittance advice; you will have to file a separate claim to the Medigap insurer with a copy of the RA. Within a reasonable time, if you have not heard from the Medigap insurer, it will be necessary for you to **follow up with the Medigap insurer**.

The DME MAC's responsibility ends when Medicare payment data has been sent to the BCRC, thus we would be unable to furnish you any information about Medigap benefits. The law states that the Medigap insurer must treat the Medicare claim data as a request for payment if you are participating in the Medicare program.



## Chapter 8 Contents

### Introduction

1. Benefits of EDI
2. ASCA
3. Addition Electronic Options
4. Common Electronic Data Interchange (CEDI)

## Introduction

**Electronic Data Interchange (EDI)** is the computer-to-computer electronic exchange of business documents using standard format. EDI gives you the ability to transmit Electronic Media Claims (EMC) to Medicare in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. National Government Services administers The Common Electronic Data Interchange (CEDI) contract for EDI services for all DME MAC suppliers. More information on CEDI can be found in the “Common Electronic Data Interchange” section of this chapter.

The following pages describe the benefits of billing electronically and additional electronic options available. Details and instructions on what you will need to do to begin billing electronically can be found on the CEDI’s website at <https://www.ngscedi.com/> under “Resources.” The website contains valuable information including technical information, manuals, and enrollment materials.

If you require additional EDI information, please contact the CEDI Help Desk toll-free at 866.311.9184.

**Note:** The acceptable HIPAA compliant format is the American National Standards Institute (ANSI) X12N Version 5010 837 transaction and the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard Version D.0.

## 1. Benefits of EDI

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24

Electronic Data Interchange (EDI) will simplify time-consuming, labor-intensive jobs and ultimately enable you to increase your productivity. The following are a few of the benefits experienced by utilizing the EDI options offered by Medicare:

- Faster payments: the payment floor for electronic claims is shorter than that of paper claims
- Ease of billing electronically (support is available)
- More efficient and accurate claims filing; data is received precisely as input by your office, eliminating the chance of processing errors
- Electronic front-end edit reports: confirmation can be downloaded via modem within 48 hours of transmission. This report verifies the acceptance of claims and Certificates of Medical Necessity (CMNs) & DME Information Forms (DIFs).
- Online or batch versions of Claim Status Inquiry (CSI)
- Availability of Electronic Remittance Advice (ERAs) for faster payment posting

- Lower administrative, postage, and handling costs
- Ability to submit claims and CMNs/DIFs seven days a week, including holidays

If you would like more information about electronic billing and enrollment, please visit CEDI's website at <https://www.ngscedi.com/> or contact the CEDI Help Desk by phone at 866.311.9184.

## 2. ASCA

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 24, §90

Section 3 of the Administrative Simplification Compliance Act (ASCA), Public Law (PL) 107-105, and the implementing regulation at 42 CFR 424.32 require that **all initial claims** for reimbursement under Medicare (except from small providers) be submitted electronically as of October 16, 2003, with limited exceptions. Initial claims are those claims submitted to a MAC for the first time, including:

- Resubmitted previously rejected claims
- Claims with paper attachments
- Demand claims
- Claims where Medicare is secondary and there is only one primary payer
- Nonpayment claims

Medicare will not cover claims submitted on paper unless they meet the limited exception criteria. Claims denied for this reason will contain claim adjustment reason code 96 (Noncovered charge[s]) and remark code M117 (Not covered unless submitted via electronic claim). See Chapter 17 of this manual for information about claim reason and remark codes.

Further details on the ASCA provision, exception criteria, and how to apply for a waiver can be found on the CGS website at: <https://cgsmedicare.com/jb/claims/sub/claimform.html>.

## 3. Additional Electronic Options

There are additional electronic options available which will increase your business' productivity. These options include Claim Status Inquiry (CSI), payable Certificate of Medical Necessity (CMN) status, 270/271, 276/277, and Electronic Remittance Advice (ERA).

### Claim Status Inquiry (CSI)

Claim Status Inquiry (CSI) allows you to electronically check the status of production claims after they have passed front-end editing and received Claim Control Numbers (CCNs).

At least three working days after you successfully file an electronic claim, you will be able to locate your claim in the processing cycle. Through CSI you will know if your claim has been paid, denied, or is still pending. If you are checking the status of pending claims, there are additional screens available which contain more detailed status information. CSI is available for both electronic and paper claims. The DME MAC provides support for CSI.

CSI uses the Direct Data Entry format, which allows the user to input data into predefined fields, and then are instantaneously provided with a response. This type of inquiry does not require the format of an actual file and it does not return a report to the user. For more information regarding CSI and enrollment, visit our CSI page at <https://www.cgsmedicare.com/jb/claims/csi/csi.html>.

Note that myCGS, the Jurisdiction B web portal, offers all the functionality you will find in CSI, plus much more. We encourage all Jurisdiction B suppliers to use myCGS, rather than CSI. For information about myCGS, refer to Chapter 13 of this manual and the myCGS page on our website at <https://www.cgsmedicare.com/jb/mycgs>.

### **270/271**

The HETS 270/271 application allows providers or clearinghouses to submit HIPAA compliant 270 eligibility request files over a secure connection. HETS 270/271 submitters must have a mechanism to send 270 eligibility requests and receive 271 eligibility responses in a real-time environment. For information about the real-time version of eligibility, visit the CMS website at <https://www.cms.gov/data-research/cms-information-technology/hipaa-eligibility-transaction-system>.

### **276/277**

The Health Care Claim Status Request (276) and Health Care Information Status Notification (277) provides information regarding specified claims. For information about 276/277 and enrollment, visit the CEDI website at <https://www.ngscedi.com/>.

## **Electronic Remittance Advice (ERA)**

An **Electronic Remittance Advice (ERA)** is an electronic data file that shows claims that have been paid and the dollar amounts for each. It also shows claims that have been denied and the reason for denial. This document contains the same information as the paper Remittance Advice (RA) suppliers receive through the mail. See Chapter 17 of this manual for information about RAs.

When the ERA file has been downloaded, it must be run through ERA reader software to allow you to view and print out the document in a readable format. ERA reader software may be purchased from a software vendor. CMS has developed free software called Medicare Remit Easy Print (MREP) that enables suppliers to view and print RAs. This software is available through the CMS website at <https://www.cms.gov/data-research/cms-information-technology/access-cms-data-application/medicare-remit-easy-print>.

## **4. Common Electronic Data Interchange (CEDI)**

The CEDI provides a single front end solution for the submission and retrieval of DME MAC electronic transactions. CEDI handles these transactions for all DME MACs.

CEDI handles:

- Electronic claims (ANSI X12 837 and NCPDP)
- Delivery of all electronic front end reports
- Enrollment and delivery of electronic remittance advice
- 276/277 (claim status request/response) transactions

The CEDI Help Desk answers questions and provides support for the following:

- CEDI Enrollment Status
  - X12 837 Claims
  - NCPDP Claims
  - X12 276 Claim Status Request
  - X12 835 Electronic Remittance Advice
  - X12 277 Claim Status Response
- CEDI Password Resets
- Free/Low-Cost Software Support
  - PC-ACE Pro32
  - MREP
- Verification of the receipt of files
- Support for Electronic Formats
  - X12 837 Claims
  - NCPDP Claims
  - X12 276 Claim Status Request
  - X12 835 Electronic Remittance Advice
  - X12 277 Claim Status Response
- Support for CEDI TA1, TRN, 999, and 277CA transactions for X12 837 version 5010A1 claims (NOTE: Software vendors will be responsible for providing these transactions in readable formats for their customers.)
- Support for DME MAC Receipt and CMN Reject Reports (RPT Reports)
- Support for NCPDP D.0 Transmission Response Report (NOTE: Software vendors will be responsible for providing these transactions in readable formats for their customers.)
- Testing Support for Vendors and Trading Partners (Electronic Submitters)

The CEDI Help Desk does not provide support for the topics below. Any questions regarding these topics should be directed to the appropriate DME MAC.

- Claim Status Inquiry (CSI), VPIQ, and/or PINQ
  - Enrollment or setup status
  - Logon or User ID
  - Password resets

- Education
- Electronic Funds Transfer (EFT)
  - Setup Status
  - Questions regarding payments or banking information
- Status of claims in the Jurisdiction A, B, C, and/or D DME MAC processing system
- Questions regarding the adjudication of claims
- Questions regarding the content of an Electronic Remittance Advice
  - Amount paid on a claim
  - Deductible or co-payments applied
  - Denied claims

You may contact the CEDI Help Desk for assistance at 866.311.9184.

For information on front end rejections, refer to the CEDI website at <https://www.ngscedi.com/>.

## Chapter 9 Contents

### Introduction

1. DMEPOS Benefit Categories
2. Medical Review Program
3. Medical Policies
4. Advance Determination of Medicare Coverage (ADMC) for Wheelchairs
5. Condition of Payment Required Prior Authorization Program
6. Denial Categories

## Introduction

In this chapter, you will find information regarding Durable Medical Equipment, Prosthetics and Orthotics, and Supplies (DMEPOS) benefit categories, the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Medical Review Department, medical policies, Advance Determination of Medicare Coverage (ADMC) process, and Prior Authorization. In order for any item to be covered by the DME MAC, it must fall into one of the benefit categories defined below. The medical policies used by the DME MAC to make coverage determinations may be either national or local. The national policies can be found on the Centers for Medicare and Medicaid Services (CMS) website in the *Medicare National Coverage Determinations Manual* and in the *Medicare Benefit Policy Manual*. Both of these manuals can be viewed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. The local policies can be found in Local Coverage Determinations (LCDs), which are available at <https://www.cgsmedicare.com/jb/coverage/LCDinfo.html>. See the “Medical Policies” section below for more specific information.

## 1. DMEPOS Benefit Categories

CMS Manual System, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §§50.5.1, 50.5.3, 50.5.4, 50.6 & 100-140

All Medicare Part B covered services processed by the DME MAC fall into one of the following benefit categories specified in the Social Security Act (§1861(s)):

1. Durable medical equipment (DME)
2. Prosthetic devices (including nutrition)
3. Leg, arm, back, and neck braces (orthoses) and artificial legs, arms, and eyes, including replacement (prostheses)
4. Surgical dressings
5. Immunosuppressive drugs
6. Therapeutic shoes for persons with diabetes
7. Oral anticancer drugs
8. Oral antiemetic drugs (replacement for intravenous antiemetics)

9. Intravenous immune globulin for primary immune deficiency
10. Lymphedema compression treatment items

General definitions and coverage issues relating to the preceding categories are listed below.

*Note: The home infusion services temporary transitional payment ended on December 31, 2020. The permanent Home Infusion Therapy services benefit went into effect the following day, on January 1, 2021.*

*The Part B Home Infusion Therapy services benefit (established at SSA §1861(s)(2)(GG)) was developed pursuant to section 5012 of the 21<sup>st</sup> Century Cures Act. This benefit is separate from the Part B DME benefit.*

*Durable infusion pumps and supplies (including home infusion drugs) remain under the Part B DME benefit. Items and services covered under the separate Home Infusion Therapy services benefit include professional services (such as nursing services), training and education (not otherwise paid for under DME), and remote (and other types) of monitoring services.*

*Effective January 1, 2021, home infusion therapy items and services provided under the Home Infusion Therapy services benefit are not processed by DME MACs. Claims for these items and services (that are represented by specified Level II HCPCS "G" codes) are processed by the A/B MACs.*

### **Durable Medical Equipment (DME)**

Durable medical equipment is equipment which (a) can withstand repeated use (i.e., can be rented), (b) for items classified as DME after January 1, 2012, has an expected life of at least three years, (c) is primarily and customarily used to serve a medical purpose, (d) generally is not useful to a person in the absence of an illness or injury, and (e) is appropriate for use in the home.

Supplies and accessories that are necessary for the effective use of medically necessary DME are covered. Supplies may include drugs and biologicals that must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment.

Repairs, skilled maintenance, and replacement of medically necessary DME are covered.

### **Prosthetic Devices**

Prosthetic devices are items which replace all or part of an internal body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ. The test of permanence is considered met if the medical record, including the judgment of the treating practitioner, indicates that the condition is of long and indefinite duration.

In addition to artificial arms and legs, coverage under this benefit includes, but is not limited to, breast prostheses, eye prostheses, parenteral and enteral nutrition, ostomy supplies, urological supplies in beneficiaries with permanent urinary incontinence, and glasses or contact lenses in beneficiaries with aphakia or pseudophakia.

**Enteral and Parenteral Nutrition** therapy is covered under the prosthetic device benefit provision, which requires that the beneficiary must have a permanently inoperative internal body organ or function thereof.

Supplies that are necessary for the effective use of a medically necessary prosthetic device are covered. Equipment, accessories, and supplies (including nutrients) which are used directly with an enteral or parenteral nutrition device to achieve the therapeutic benefit of the prosthesis or to assure the proper functioning of the device are covered.

Repairs, adjustments, and replacement of medically necessary prosthetic devices are covered.

Dental prostheses (i.e., dentures) are excluded from coverage. Claims for internal prostheses (e.g., intraocular lens, joint implants, etc.) are not processed by the DME MAC.

### **Braces (Orthotics)**

A brace is a rigid or semi-rigid device that is used for the purpose of supporting a weak or deformed body member or restricting or eliminating motion in a diseased or injured part of the body. The orthotic benefit for braces is limited to leg, arm, back, and neck, and used independently, rather than in conjunction with, or as components of, other medical or non-medical equipment. Accessories used in conjunction with, and necessary for the full functioning of, durable medical equipment fall under the durable medical equipment benefit. You must not use L-codes or miscellaneous codes to bill for items that are components of, or used in conjunction with, wheelchairs. These items are correctly billed using the appropriate wheelchair accessory codes.

Repairs, adjustments, and replacement of medically necessary braces are covered.

### **Surgical Dressings**

Surgical dressings are therapeutic and protective coverings applied to surgical wounds or debrided wounds. Surgical dressings include primary and secondary dressings.

### **Immunosuppressive Drugs**

Immunosuppressive drugs used in beneficiaries who have received a Medicare-covered organ transplant are covered. Immunosuppressive drugs used for indications other than transplantation do not fall into the DME MAC's jurisdiction.

Supplies used in conjunction with parenterally administered immunosuppressive drugs are not covered under this benefit category.

### **Therapeutic Shoes for Persons with Diabetes**

Custom molded or extra-depth shoes and inserts for use by beneficiaries with diabetes are covered under this benefit.

### **Oral Anticancer Drugs**

Certain oral cancer drugs are covered if they have the same chemical composition and indications as the parenteral form of the drug.

### **Oral Antiemetics (used as full replacement for IV form)**

Certain oral antiemetic drugs are covered when used as full replacement for the intravenous (IV) form of the same drug during chemotherapy treatment.



**Intravenous Immune Globulin**

Intravenous immune globulin is covered when it is administered in the home to treat primary immunodeficiency. As of January 1, 2024, this benefit has been amended to include coverage of services and supplies utilized in the provision of the intravenous immune globulin.

**Lymphedema Compression Treatment Items**

Lymphedema compression treatment items are standard and custom-fitted gradient compression garments and other items used to treat lymphedema. Professional services, including lymphedema treatment services, are not eligible for coverage under this benefit.

**2. Medical Review Program**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 1, §1.3.8

The goal of the medical review program is to reduce payment errors by preventing the initial payment of claims that do not comply with Medicare's coverage, coding, payment, and billing policies. The medical review staff at CGS consists of medical directors (physicians), a research team, clinical staff (registered nurses and other allied health professionals), and experienced support personnel.

**Medical Review Responsibilities**

- Develop Local Coverage Determinations (coverage policies)
- Publish educational articles
- Analyze claim data, identify and address billing errors, and take action to correct future billing
- Perform reviews and audits to determine supplier compliance using Targeted Probe & Educate
- Notify suppliers of review findings
- Perform corrective actions to correct the behavior in need of change in order to prevent future inappropriate billing
- Conduct Advance Determination of Medicare Coverage (ADMC) reviews
- Conduct Condition of Payment Prior Authorization Program reviews
- Develop an annual Medical Review Strategy, based on data analysis, that details the problems and interventions in the jurisdiction
- Partner with the Provider Outreach & Education team to provide education

### 3. Medical Policies

CMS Manual System, Pub. 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1  
CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 13

#### General Information

Medical policies may be either national or local. Local policies are termed Local Coverage Determinations (LCDs) and national policies are National Coverage Determinations (NCDs).

National Coverage Determinations are established by the Centers for Medicare and Medicaid Services (CMS). These policies are found on the CMS website in the *Medicare National Coverage Determinations Manual* and in the *Medicare Benefit Policy Manual*. Both manuals can be viewed at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>. You can search for National Coverage Determinations (NCDs) using the Medicare Coverage Database at <https://www.cms.gov/medicare-coverage-database>. The DME MACs, CERT, and Unified Program Integrity Contractors (UPICs) follow, and Administrative Law Judges (ALJs) are bound by, national policy when it exists.

Local Coverage Determinations are developed jointly by the DME MACs. The DME MACs have the authority and responsibility to establish LCDs when there is no national policy on a subject or when there is a need to further define an NCD. The LCDs are identical for all DME MACs.

Local medical policies consist of three separate, though closely related, documents: an LCD, an LCD-related Policy Article, and the LCD-related Standard Documentation Requirements for All Claims Submitted to DME MACs Article. All LCD-related articles are referenced as links in the Associated Documents section of each LCD. A link to the CMS Medicare Coverage Database and the LCDs can be found on the home page of CGS's DME MAC Jurisdiction B website, listed under Local Coverage Determinations (<https://www.cgsmedicare.com/jb/coverage/LCDinfo.html>).

#### Major Sections of an LCD

##### *Issue Description*

This field appears in final LCDs published after June 23, 2022. The field, when displayed in a final LCD published as a result of a proposed LCD, provides a summary of coverage information presented in the proposed LCD. This field, when displayed in a final LCD that is not published as a result of a proposed LCD (such as a final LCD published with non-substantive revisions or with non-discretionary coverage updates to reflect changes in NCDs), provides a summary pertinent to the coverage information and/or relevant updates presented in the final LCD. (Note: This field is also displayed in proposed LCDs as of June 23, 2022, and provides a summary of coverage information presented in the proposed LCD.)

##### *Issue - Explanation of Change Between Proposed LCD and Final LCD*

This field appears in final LCDs published after June 23, 2022. This field, when displayed in a final LCD published as a result of a proposed LCD, provides a summary of coverage information as it appears in the final LCD, including a description of changes between the proposed LCD and the resulting final LCD. This field, when displayed in a final LCD that is not published as a result of a proposed LCD (such as a final LCD published with non-substantive revisions or with non-discretionary coverage updates to reflect changes in NCDs), provides information which conveys that a proposed LCD was not published in connection with the final LCD publication.

## *Coverage Indications, Limitations, and/or Medical Necessity*

Defines coverage criteria based on a determination of whether an item is eligible for a defined Medicare benefit category, reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member and meets all other applicable Medicare statutory and regulatory requirements. Items addressed in this section are based on Social Security Act §1862(a)(1)(A) provisions. When an item does not meet these criteria, it will be denied as “not reasonable and necessary.”

## *Summary of the Evidence\**

Summary of the evidence used for coverage determinations.

## *Analysis of Evidence (Rationale for Determination)\**

Explanation of the rationale that supports the determination.

## *HCPCS Codes and Modifiers*

Lists the HCPCS codes and modifiers that are applicable to the LCD. The presence of a code in this section does not necessarily indicate coverage.

## *Documentation Requirements*

States the necessary documentation requirements that you must have on file and/or submit with your claim for a specific policy. Refer to the LCD-related Standard Documentation Requirements article for additional information regarding these requirements.

## *Bibliography\**

List of all evidentiary sources used in determination.

## *Revision History Information*

Explanation of revisions along with an effective date and reason for change are listed here.

## *Attachments*

CMN or DIF (if applicable, for claims with dates of service on or before January 1, 2023)

Other suggested forms (if applicable)

## *Related Local Coverage Documents*

Links to other related LCDs and Policy Articles

## *Related National Coverage Documents*

Links to related NCDs

*\*For LCDs published for comment and notice on or after June 11, 2017, as required by the 21st Century Cures Act.*

**Major Sections of a Policy Article***Non-Medical Necessity Coverage and Payment Rules*

Identifies situations in which an item does not meet the statutory definition of a benefit category (e.g., durable medical equipment, prosthetic devices, etc.) or when it doesn't meet other requirements specified in regulations. It also identifies situations in which an item is statutorily excluded from coverage for reasons other than medical necessity. In these situations, the term used to describe the denial is "noncovered." This section may also include statements defining when an item will be denied as "not separately payable" or situations in which claim processing for the item is not within the DME MAC's jurisdiction.

*Requirements for Specific DMEPOS Items Pursuant to Final Rule 1713 (84 Fed. Reg Vol 217)*

Provides information regarding the requirement for standard written orders (SWOs), face-to-face encounters and written order prior to delivery (WOPD) for certain HCPCS codes, as specified in CMS' Final Rule CMS-1713-F.

*Policy Specific Documentation Requirements*

States the necessary documentation requirements that you must have on file and/or submit with your claim for this specific policy. Refer to the LCD-related Standard Documentation Requirements article for additional information regarding these requirements.

*Coding Guidelines*

Provides detailed information about the characteristics and features of products that qualify for inclusion under specific HCPCS codes.

*Modifiers*

Contains billing and coding information specific to modifier usage when submitting claims for specified items/services. The presence of a modifier in this section does not necessarily indicate coverage.

*ICD-10-CM Codes that Support Medical Necessity*

Diagnosis codes listed in this section relate to coverage criteria (described in the Coverage Indications, Limitations, and/or Medical Necessity section of the LCD) and/or statutory or regulatory coverage (as described in the Non-Medical Necessity Coverage and Payment Rules section of the LCD-related PA).

*ICD-10-CM Codes that DO NOT Support Medical Necessity*

Diagnosis codes listed in this section are not covered as specified.

*Revision History Information*

Explanation of revisions along with an effective date are listed here.

*Related Local Coverage Documents*

Links to related LCDs and Policy Articles

Posting of new and revised policies will be announced in an electronic mailing list message from CGS and on our website at <https://www.cgsmedicare.com/jb>.

The Local Coverage Determinations page on our website includes links to current/active LCDs and Policy Articles, Future LCDs and Policy Articles, Proposed LCDs, Archived LCDs and Policy Articles, and information related to New and Reconsideration LCD requests. This page can be viewed here: <https://www.cgsmedicare.com/jb/coverage/LCDinfo.html>.

### **Request for a New LCD Process**

The New LCD Request process is a mechanism by which interested parties within a contractor's jurisdiction may request a new LCD. This process has different requirements from an LCD Reconsideration Request, the path by which an interested party requests modification of an existing, active LCD. Information for requesting an LCD Reconsideration may be found on the LCD Reconsideration Process page (<https://www.cgsmedicare.com/jb/coverage/reconsideration.html>). The process for developing a new LCD is described below.

#### ***Informal Teleconference (Optional):***

Prior to submitting a formal LCD request, the DME MACs encourage requestors to schedule an informal conference call to review the requirements for a valid LCD request.

DME MAC participation in the call may include DME MAC medical policy ancillary staff, in addition to the DME MAC Medical Directors, on behalf of each DME MAC jurisdiction. The Pricing, Data Analysis, and Coding (PDAC) contractor Medical Director(s) and ancillary staff may also be invited to attend these calls. (If you prefer that the DME MACs solely attend the informal conference call, then please specify such in your call request.)

A request for a call may be submitted via email to [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com) and should include the following information:

1. "Request for New LCD Call – [Topic for New LCD]" in the subject line of the email.
2. Several options for dates and times for a call.
3. *(Required)* Teleconference number with enough lines to accommodate a minimum of 30 participants.
4. Summary information (1-2 paragraphs, maximum) for the LCD request.
5. *(Optional)* A web link for you to visually present materials during the call. (Note: If you provide a web link, please know it is still required that a teleconference number be provided, as some attendees may not have access to the link at the time of the meeting.)

Once the DME MAC has received your informal conference call request, the DME MAC will communicate with you to confirm the date and time for participation in the meeting.

At least one week in advance of the confirmed informal conference call date, the DME MACs and PDAC\* will anticipate receipt of an agenda, presentation documents (if applicable), and an attendee list (including participants' names and titles who will attend on behalf of the informal conference call requestor). You should send these materials to each of the following email addresses:

Noridian Healthcare Solutions, DME MAC Jurisdictions A and D: [DMERecon@noridian.com](mailto:DMERecon@noridian.com)

CGS Administrators, LLC, DME MAC, Jurisdiction B: [LCDRECONJB@cgsadmin.com](mailto:LCDRECONJB@cgsadmin.com)

CGS Administrators, LLC, DME MAC, Jurisdiction C: [LCDRECONJC@cgsadmin.com](mailto:LCDRECONJC@cgsadmin.com)

Palmetto GBA, LLC, PDAC\* Contractor: [pdac.hcpcs@palmettogba.com](mailto:pdac.hcpcs@palmettogba.com)

\*If you specified in your informal conference call request that you prefer the DME MACs solely attend the call, then the PDAC will not attend the call and you may exclude the PDAC email address from the list of recipients to which you send the agenda, presentation documents (if applicable), and attendee list.

For your convenience, CGS has prepared an Informal Teleconference request form ([https://www.cgsmedicare.com/jb/forms/pdf/lcd\\_informal\\_call.pdf](https://www.cgsmedicare.com/jb/forms/pdf/lcd_informal_call.pdf)) that you may fill out and submit with your informal conference call request. This form is optional.

**New LCD Request Submission Criteria (Required):**

Following the informal discussion, should the requestor wish to continue with a formal new LCD request, a valid request must include all the following:

1. Be submitted by one of the following:
  - Beneficiaries residing or receiving care in a contractor's jurisdiction;
  - Health care professionals doing business in a contractor's jurisdiction; and
  - Any interested party doing business in a contractor's jurisdiction.
2. Clearly identify the statutorily-defined Medicare benefit category to which the requestor believes the item or service falls under;
3. Provide a rationale justifying the proposed assignment of the Medicare benefit category;
4. Identify the language which the requestor wants in a new LCD;
5. Submission of all available evidence, as well as all related FDA approval correspondence, marketing designations, decision summaries pertinent to the product or service, 510(k)/PMA/De Novo notifications, SSED data sheet, FDA Panel Minutes and Post-Approval Study Result/Outcome Submissions.  
  
Submitted literature and references should be limited to published, full-text, peer-reviewed evidence, indexed in PubMed of the US National Library of Medicine, National Institutes of Health. The failure to include the specific literature with the request will render the LCD request incomplete.
6. Must include information which addresses the relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service in the Medicare-eligible population; and
7. Must include information which fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

The level of evidence required for LCD development may be found in the *CMS Program Integrity Manual*, Chapter 13.

CGS has the discretion to consolidate valid requests if similar requests are received. Any request for a new LCD that, in the judgment of the contractor, does not meet these criteria is invalid.

**New LCD Request Letter Details:**

Request letters sent to the DME MACs are subject to public disclosure. By sending the DME MACs a request letter, the sender is consenting to public posting of the letter. The following list provides request letter details to consider when submitting the request to the DME MACs:

1. Request letters sent to the DME MAC **must** be 508-compliant when submitted. If the request letter is not 508-compliant, it will be returned to the requestor for correction. The 508 compliance instructions and information on the technical standards can be reviewed on CMS' Section 508 webpage (<https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/section508>).
2. Request letters **must not** contain protected health information (PHI) or personally identifiable information (PII). If the request letter contains PHI and/or PII, the requestor will be required to resubmit the request letter with the PHI/PII removed or redacted.
3. Should the requestor include proprietary, privileged, or confidential information in the request, it is the requestor's responsibility to note such information. If proprietary, privileged, or confidential information is necessary for the validity of the new LCD request, the requestor is asked to submit two versions of the request, one with proprietary, privileged, or confidential information redacted and one without redaction. The redacted version will be posted to the public.
4. All valid request letters will be posted on the Medicare Coverage Database (MCD). Therefore, if a requestor provides personal contact information (such as phone numbers or email addresses), which the requestor does not wish to be publicly disclosed, then the requestor has the option to submit a redacted version of the request. The redacted version will be posted to the public.

If the requestor needs to submit a redacted version of the letter to the DME MAC, the requestor must provide the redacted version at the same time as providing the version without redaction.

**How to Submit a New LCD Request:**

For your convenience, CGS has prepared a New LCD Request form ([https://www.cgsmedicare.com/jb/forms/pdf/new\\_lcd.pdf](https://www.cgsmedicare.com/jb/forms/pdf/new_lcd.pdf)) that you may fill out and submit with your request. This form is optional; however, it will assist you in ensuring the requirements for a complete request are met.

New LCD requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Pertinent information for each of the three methods is listed below:

1. **Email (Preferred Method):** [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com)
  - Electronic requests should be sent with "New LCD Request – [Topic for New LCD]" in the subject line.
  - If the attachment size for clinical citations exceeds 15 MB, the requestor must send the articles and supporting documents via multiple, smaller emails.
  - Please contact [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com) for alternative methods for submitting large electronic files or if you have difficulty submitting a New LCD Request.
2. **Fax:** 615.660.5997
  - Please address your fax cover sheet to DME New LCD – [Topic for New LCD] – Attn: Dr. Sunil Lalla.
  - Note: This fax line is only for the LCD process described above. This is not the fax line for appealing individual claims (Redeterminations).
3. **Mail:**

CGS Administrators, LLC  
Attn: Sunil V. Lalla, MD, FACS, CPC  
DME LCD Reconsiderations  
26 Century Blvd STE ST610  
Nashville, TN 37214-3685

**Please note that this information is for NEW DME MAC LCD requests only.** Information for submitting an LCD request for the Jurisdiction 15 A/B MAC may be found at the J15 website (<https://www.cgsmedicare.com/partb/index.html>).

### **Next Steps:**

CGS will review the materials received to determine whether the request is valid. A valid request must meet criteria 1-7 listed above. CGS will respond to the request within 60 calendar days upon receipt.

If CGS determines that the request is not valid, CGS will notify the requestor in writing that the request is not valid and will provide the rationale for this decision.

If the request is valid, CGS will begin the LCD development process outlined in the *Program Integrity Manual*, Chapter 13 (Internet-only Manual Pub.100-08). The response to the requestor is an acknowledgement by CGS of the receipt of a valid, complete request. CGS' request response does not convey that a determination has been made in regard to the likelihood of coverage or non-coverage under 1862(a)(1)(A) of the Act, but is confirmation that CGS plans to proceed with development of a new LCD or place the requested LCD on the wait-list for development at a later time.

If the request is valid and a new LCD is developed, CGS will follow the process outlined in the *Program Integrity Manual*, Chapter 13. This involves:

1. Consultation with the requestor or subject matter experts (if necessary);
2. Contractor Advisory Committee (CAC) meeting (if necessary);
3. Publication of a proposed LCD\*\*;
4. Open meeting to solicit comments from the public on the proposed LCD;
5. Opportunity for public comment in writing (minimum of 45 days following posting of proposed LCD);
6. Publication of a final LCD, including:
  - a. A response to public comments received;
  - b. Notice to public of new policy at least 45 days in advance of the effective date.

\*\*A proposed LCD will include the requestor's name and/or company information, along with a copy of the request. This information may also be included in other publicly available resources on the Medicare Coverage Database and/or the DME MAC websites.

Proposed LCDs will be finalized or retired within a rolling calendar year of publication date on the Medicare Coverage Database (365 days).

For additional information on the New LCD Request process, please see CGS' Request New LCD Process webpage at [https://cgsmedicare.com/jb/coverage/lcd\\_request\\_process.html](https://cgsmedicare.com/jb/coverage/lcd_request_process.html).



**LCD Reconsideration Process**

The Local Coverage Determination (LCD) Reconsideration process is a method by which interested parties may request a revision to an active LCD. CGS follows the Centers for Medicare & Medicaid Services (CMS) Program Integrity Manual (Internet-only Manual 100-08), Chapter 13 process for LCD Reconsiderations. The reconsideration process is available for final, effective LCDs only. The entire LCD or any part of it is subject to reconsideration. The process for LCD Reconsideration is outlined below.

***Informal Teleconference (Optional):***

Prior to submitting a formal LCD Reconsideration, the DME MACs encourage requestors to schedule an informal conference call to review the requirements for a valid LCD Reconsideration request.

DME MAC participation in the call may include DME MAC medical policy ancillary staff, in addition to the DME MAC Medical Directors, on behalf of each DME MAC jurisdiction. The Pricing, Data Analysis, and Coding (PDAC) contractor Medical Director(s) and ancillary staff may also be invited to attend these calls. (If you prefer that the DME MACs solely attend the informal conference call, then please specify such in your call request.)

A request for a call may be submitted via email to [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com), and should include the following information:

1. "Request for LCD Reconsideration Call – [Title of LCD]" in the subject line of the email.
2. Several options for dates and times for a call.
3. (*Required*) Teleconference number with enough lines to accommodate a minimum of 30 participants.
4. Summary information (1-2 paragraphs, maximum) for the LCD reconsideration request.
5. (*Optional*) A web link for you to visually present materials during the call. (Note: If you provide a web link, please know it is still required that a teleconference number be provided, as some attendees may not have access to the link at the time of the meeting.)

Once the DME MAC has received your informal conference call request, the DME MAC will communicate with you to confirm the date and time for participation in the meeting.

At least one week in advance of the confirmed informal conference call date, the DME MACs and PDAC\* will anticipate receipt of an agenda, presentation documents (if applicable), and an attendee list (including participants' names and titles who will attend on behalf of the informal conference call requestor). You should send these materials to each of the following email addresses:

Noridian Healthcare Solutions, DME MAC Jurisdictions A and D: [DMERecon@noridian.com](mailto:DMERecon@noridian.com)

CGS Administrators, LLC, DME MAC, Jurisdiction B: [LCDRECONJB@cgsadmin.com](mailto:LCDRECONJB@cgsadmin.com)

CGS Administrators, LLC, DME MAC, Jurisdiction C: [LCDRECONJC@cgsadmin.com](mailto:LCDRECONJC@cgsadmin.com)

Palmetto GBA, LLC, PDAC\* Contractor: [pdac.hcpcs@palmettogba.com](mailto:pdac.hcpcs@palmettogba.com)

\*If you specified in your informal conference call request that you prefer the DME MACs solely attend the call, then the PDAC will not attend the call and you may exclude the PDAC email address from the list of recipients to which you send the agenda, presentation documents (if applicable), and attendee list.

For your convenience, CGS has prepared an Informal Teleconference request form ([https://www.cgsmedicare.com/jb/forms/pdf/lcd\\_informal\\_call.pdf](https://www.cgsmedicare.com/jb/forms/pdf/lcd_informal_call.pdf)) that you may fill out and submit with your informal conference call request. This form is optional.

**LCD Reconsideration Request Submission Criteria (Required):**

Following the informal discussion, should the requestor wish to continue with a formal LCD Reconsideration request, a valid request must meet all the following requirements:

1. Be submitted by one of the following:
  - Beneficiaries residing or receiving care in a contractor's jurisdiction;
  - Health care professionals doing business in a contractor's jurisdiction; and
  - Any interested party doing business in a contractor's jurisdiction.
2. Include the specific language that the requestor proposes to be added to or deleted from the LCD; and,
3. Submission of all available evidence, as well as all related FDA approval correspondence, marketing designations, decision summaries pertinent to the product or service, 510(k)/PMA/De Novo notifications, SSED data sheet, FDA Panel Minutes and Post-Approval Study Result/Outcome Submissions.

Submitted literature and references should be limited to published, full-text, peer-reviewed evidence, indexed in PubMed of the US National Library of Medicine, National Institutes of Health. The failure to include the specific literature with the request will render the LCD request invalid.

4. Only request reconsideration of an LCD published in final form. Requests will not be accepted for other documents including:
  - National Coverage Determinations (NCDs);
  - Coverage provisions in interpretive manuals;
  - Proposed LCDs;
  - Template LCDs, unless or until they are adopted by the contractor;
  - Retired LCDs;
  - Individual claim determinations;
  - Bulletins, articles, training materials; and
  - Any instance in which no LCD exists, i.e., requests for development of an LCD.

The level of evidence required for LCD reconsideration is the same as that required for new LCD development (see the *Program Integrity Manual*, Chapter 13).

CGS has the discretion to consolidate valid requests if similar requests are received.

Any request for LCD reconsideration that, in the judgment of the contractor, does not meet these criteria is invalid.

CGS may revise or retire their LCDs at any time on their own initiatives.

If modification of the final LCD would conflict with an NCD, the request will not be valid.

For information about the NCD reconsideration process, reference Medicare Coverage Determination Process at [https://www.cms.gov/DeterminationProcess/01\\_overview.asp](https://www.cms.gov/DeterminationProcess/01_overview.asp). Information about requesting an NCD or an NCD revision is found under "How to Request an NCD" in the Coverage Process section.

### **LCD Reconsideration Request Letter Details:**

Request letters sent to the DME MACs are subject to public disclosure. By sending the DME MACs a request letter, the sender is consenting to public posting of the letter. The following list provides request letter details to consider when submitting the request to the DME MACs:

1. Request letters sent to the DME MACs **must** be 508-compliant when submitted. If the request letter is not 508-compliant, it will be returned to the requestor for correction. The 508 compliance instructions and information on the technical standards can be reviewed on CMS' Section 508 webpage (<https://www.cms.gov/research-statistics-data-and-systems/cms-information-technology/section508>).
2. Request letters **must not** contain protected health information (PHI) or personally identifiable information (PII). If the request letter contains PHI and/or PII, the requestor will be required to resubmit the request letter with the PHI/PII removed or redacted.
3. Should the requestor include proprietary, privileged, or confidential information in the request, it is the requestor's responsibility to note such information. If proprietary, privileged, or confidential information is necessary for the validity of the reconsideration request, the requestor is asked to submit two versions of the request, one with proprietary, privileged, or confidential information redacted and one without redaction. The redacted version will be posted to the public.
4. All valid request letters will be posted on the Medicare Coverage Database (MCD). Therefore, if a requestor provides personal contact information (such as phone numbers or email addresses), which the requestor does not wish to be publicly disclosed, then the requestor has the option to submit a redacted version of the request. The redacted version will be posted to the public.

If the requestor needs to submit a redacted version of the letter to the DME MACs, the requestor must provide the redacted version at the same time as providing the version without redaction.

### **How to Submit an LCD Reconsideration Request:**

For your convenience, CGS has prepared an LCD Reconsideration request form ([https://www.cgsmedicare.com/jb/pdf/lcd\\_reconsideration\\_form.pdf](https://www.cgsmedicare.com/jb/pdf/lcd_reconsideration_form.pdf)) that you may fill out and submit with your request. This form is optional; however, it will assist you in ensuring the requirements for a complete request are met.

LCD Reconsideration requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Pertinent information for each of the three methods is listed below:

1. **Email (Preferred Method):** [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com)
  - Electronic requests should be sent with "LCD Reconsideration Request – **[Name of LCD]**" in the subject line.
  - If the attachment size for clinical citations exceeds 15 MB, the requestor must send the articles and supporting documents via multiple, smaller emails.
  - Please contact [LCDReconJB@cgsadmin.com](mailto:LCDReconJB@cgsadmin.com) for alternative methods for submitting large electronic files or if you have difficulty submitting an LCD Reconsideration request.

2. **Fax:** 615.660.5997
  - Please address your fax cover sheet to DME LCD Reconsideration – Attn: Dr. Sunil Lalla.
  - Note: This fax line is only for the LCD reconsideration process described above. This is not the fax line for appealing individual claims (Redeterminations).
3. **Mail:**
  - CGS Administrators, LLC
  - Attn: Sunil V. Lalla, MD, FACS, CPC
  - DME LCD Reconsiderations
  - 26 Century Blvd STE ST610
  - Nashville, TN 37214-3685

**Please note that this information is for DME MAC LCD reconsiderations only.** Information for submitting an LCD reconsideration request for the Jurisdiction 15 A/B MAC may be found at the J15 LCD Reconsideration Process page (<https://www.cgsmedicare.com/partb/medicalpolicy/reconsiderationprocess.html>).

**Next Steps:**

CGS will review the materials received to determine whether the request is valid. A valid request must meet criteria 1-4 listed above. CGS will respond to the request within 60 calendar days upon receipt.

If CGS determines that the request is not valid, CGS will notify the requestor in writing that the request is not valid and will provide the rationale for this decision.

If the request is valid, CGS will begin the LCD development process outlined in the *Program Integrity Manual*, Chapter 13 (Internet-only Manual Pub.100-08). The response to the requestor is an acknowledgement by CGS of the receipt of a valid, complete request. A request response from CGS does not convey that a determination has been made in regard to the likelihood of coverage or non-coverage under 1862(a)(1)(A) of the Act, but is confirmation that CGS plans to proceed with reconsidering the LCD or place the requested LCD reconsideration on the wait-list for development at a later time.

If the request is valid and the LCD is accepted for reconsideration, CGS will follow the process outlined in the *Program Integrity Manual*, Chapter 13. This involves:

1. Consultation with the requestor or subject matter experts (if necessary);
2. Contractor Advisory Committee (CAC) meeting (if necessary);
3. Publication of a proposed LCD\*\*;
4. Open meeting to solicit comments from the public on the proposed LCD;
5. Opportunity for public comment in writing (minimum of 45 days following posting of proposed LCD);
6. Publication of a final LCD, including:
  - a. A response to public comments received;
  - b. Notice to public of the new policy at least 45 days in advance of the effective date.

\*\*A proposed LCD will include the requestor's name and/or company information, along with a copy of the request. This information may also be included in other publicly available resources on the Medicare Coverage Database and/or the DME MAC websites.

Proposed LCDs will be finalized or retired within a rolling calendar year of the publication date on the Medicare Coverage Database (365 days).

For additional information on the LCD Reconsideration process, please see CGS' LCD Reconsideration Process webpage at <https://cgsmedicare.com/jb/coverage/reconsideration.html>.

### **LCD Tracking**

When the DME MACs receive a valid request to revise an existing LCD, or to develop a new LCD, the DME MACs follow the LCD development process outlined in the *CMS Program Integrity Manual*, Chapter 13.

For up-to-date information on LCDs under reconsideration or development, please see CGS' LCD Tracking webpage at <https://www.cgsmedicare.com/jb/coverage/tracking.html>.

### **Claim Determination in the Absence of Medical Policy**

Per the Social Security Act, §1862(a)(1)(A), all services billed to Medicare must be reasonable and necessary. Consequently, in addition, Social Security Act §1893(b)(1) authorizes the DME MACs to review any claim even if there is no formal national or local policy. In those situations, the contractor first determines whether the item falls within a statutory benefit category that is within its jurisdiction. If it is, then the reviewer determines whether the item is reasonable and necessary for the individual beneficiary. This may include a review of pertinent medical literature. It also includes review of detailed documentation from the treating practitioner and supplier supporting the medical necessity of the item.

## **4. Advance Determination of Medicare Coverage (ADMC) for Wheelchairs**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 5, §5.18

Advance Determination of Medicare Coverage (ADMC) is an optional process by which the DME MAC provides you and the beneficiary with a coverage decision prior to delivery of an item.

An ADCM is available only for the following wheelchair base HCPCS codes and related options and accessories:

### **Manual Wheelchairs**

**E1161**

**E1231–E1234**

**K0005**

**K0008**

**K0009**

**Power Wheelchairs****Group 5: K0890, K0891****Custom Motorized/Power Wheelchair: K0013**

When a particular wheelchair base is eligible for ADMC, all wheelchair options and accessories ordered by the treating practitioner for that beneficiary along with the base HCPCS code will be eligible for ADMC.

The ADMC request should include the wheelchair base and each option and accessory that is to be provided. Do not submit an ADMC request for options and/or accessories without a wheelchair base.

**All ADMC requests must clearly indicate “ADMC” on the first page.** For your convenience, an ADMC request form is provided on the DME MAC Jurisdiction B website. You can access and fill out the form online at [https://www.cgsmedicare.com/jb/forms/pdf/JB\\_ADMC\\_request\\_form.pdf](https://www.cgsmedicare.com/jb/forms/pdf/JB_ADMC_request_form.pdf).

ADMC requests may be submitted by the following methods:

1. **Electronically:**
  - MyCGS Web Portal: <https://mycgsportal.com/mycgs>
  - esMD: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD>
2. **Fax:** 615.660.5988
3. **Mail:**

CGS  
Attn: ADMC  
P.O. Box 20007  
Nashville, TN 37202

The first page of the ADMC request must contain all of the following demographic information:

- **Beneficiary information**
  - Name
  - Medicare Number
  - Address
  - Date of birth
  - Diagnosis code (narrative description is not sufficient)
  - Place of Service
- **Supplier information**
  - Company Name with a contact name

- PTAN
- Address
- Phone number
- **Physician information**
  - Name
  - NPI
  - Address
  - Phone number

**If the information listed above is not present, the request will be rejected.** You will receive written notification of the rejection.

### **Rejections**

ADMC requests are reviewed to determine whether or not they meet the requirements for ADMC requests. **Reasons to reject an ADMC request include:**

1. The item being submitted is not one of the ADMC eligible wheelchair bases.
2. The request exceeds the limit of two within six months.
3. The beneficiary does not live in Jurisdiction B.
4. The request does not include the item codes (HCPCS) and/or item descriptions.
5. The request is missing demographic information (i.e., beneficiary's name, current address, date of birth, Medicare identification number, the supplier's PTAN and/or the provider's National Provider Identification [NPI] number).
6. It is the 2<sup>nd</sup> request, but no new information was submitted.
7. Two different wheelchair base item codes (HCPCS) are listed on the request and it cannot be determined which base is to be reviewed for medical necessity.
8. A faxing error has occurred which resulted in missing, blackened, partial and/or incomplete documentation.
9. A duplicate request is submitted.
10. A request is submitted for an advance determination on previously denied accessories and/or additional accessories when the base was previously approved.
11. The item that is being submitted for advanced determination is NOT a wheelchair.
12. The base is covered under the Condition of Payment Required Prior Authorization Program for PMDs (see section 5 below).

**Power Wheelchair Documentation**

Include **all** of the following items with the ADMC request:

1. The **written order** (also referred to as the Standard Written Order [SWO]). The SWO must contain the following elements:
  - i. Beneficiary's name or Medicare Beneficiary Identifier (MBI)
  - ii. Order date
  - iii. General description of the item
    - The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - For equipment—in addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately)
  - iv. Quantity to be dispensed, if applicable
  - v. Treating practitioner name or NPI
  - vi. Treating practitioner's signature

You may provide a template to the treating practitioner for their use in creating the order for the base item. The template may list the elements of an order, but you are prohibited from filling in or completing any of these elements. It is a statutory requirement that the treating practitioner who conducted the face-to-face requirements write the SWO for the power mobility device (base item). The SWO for the power mobility device must be written within six months of the face-to-face encounter and be received by you, the supplier, prior to delivery of the power mobility device.

Refer to the Power Mobility Devices (PMD) LCD (<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33789>) and Policy Article (PA) (<https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=52498>) for information regarding the reasonable and necessary and statutory requirements for PMDs.

If you do not receive a written order containing all of these required elements prior to delivery, an EY modifier must be added to the HCPCS codes for the PMD and all accessories. The order must be available on request.

2. An SWO for related options and accessories (if not included on the SWO for the base item). Refer to the PMD Local Coverage Determination (LCD) and related Policy Article for additional information.
3. A report of the **examination**. The treating practitioner must conduct an examination of the beneficiary (via an in-person or Medicare-approved telehealth visit) before writing the order. Refer to the PMD LCD and related Policy Article for guidance about the type of information to be included in the in-person examination and specialty evaluation performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and who documents the medical necessity for the wheelchair and its special features.



4. **Attestation of “no financial involvement.”** The PMD LCD requires a signed and dated affirmation from the supplier that the LCMP or practitioner who performed the specialty evaluation has no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.) CGS will also accept an attestation of no financial relationship from the LCMP or practitioner conducting the specialty evaluation.
5. **Evidence of RESNA certification by the supplier’s Assistive Technology Professional (ATP).** A copy of a RESNA certificate or screen print from the RESNA website is acceptable proof, but other documentation to show the supplier employs an ATP is acceptable. Examples of acceptable documentation include, but are not limited to, beneficiary evaluation and/or home assessment signed by the supplier’s ATP (must be able to identify supplier); signed statement from the supplier that they employ the specific ATP involved in the in-person wheelchair selection process; narrative statement in the LCMP’s or practitioner’s specialty evaluation identifying the ATP and their employer. The RESNA website is [www.resna.org](http://www.resna.org).
6. **Evidence of “direct, in-person involvement” in the selection of the product.** Documentation of direct in-person interaction with the beneficiary by the ATP in the wheelchair selection process must be complete and detailed enough so a third party can understand the nature of the ATP involvement. A home assessment completed by a supplier-employed ATP does not meet the requirement unless the documentation shows how the ATP applied the assessments and measurements to the wheelchair selection process.
7. A report of the **on-site home assessment** which establishes that the beneficiary is able to use the wheelchair ordered to assist with Activities of Daily Living (ADLs) in the home.

### **Manual Wheelchair Documentation**

For all manual wheelchair bases, the following items must be submitted with the ADMC request:

1. An SWO for the manual wheelchair base and related options/accessories.
2. Information from the beneficiary’s medical record that documents that the coverage criteria defined in the Manual Wheelchair Bases LCD have been met.
3. A home assessment which establishes that the beneficiary or caregiver is able to use the wheelchair ordered to assist with ADLs in the home.

Additionally, for applicable HCPCS codes, the following must also be submitted:

4. A specialty evaluation performed by a licensed/certified medical professional (LCMP), such as a PT or OT, or practitioner who has specific training and experience in rehabilitation wheelchair evaluations and who documents the medical necessity for the wheelchair and its special features.
5. The LCMP or practitioner who performed the specialty evaluation has no financial relationship with the supplier. (Exception: If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.) CGS will accept an attestation of no financial relationship from the LCMP or practitioner conducting the specialty evaluation.
6. Demonstration of an ATP in-person involvement in the wheelchair selection

Refer to the Manual Wheelchair Bases LCD (<https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?lcdid=33788>) and related Policy Article (<https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleid=52497>) for information regarding the reasonable and necessary and statutory requirements for manual wheelchairs.

### **Additional Guidance on Documentation**

Any information that is provided that explains the medical necessity for separately-billed options and accessories must use the same short description for the item that is used in the standard written order.

Even if the majority of the in-person examination for a power wheelchair (PWC) is performed by the LCMP or practitioner, the ADMC request must also include the report of the examination performed by the treating practitioner.

For wheelchair cushions, include the manufacturer, product name, model number, and the width of the wheelchair cushion(s) that is provided. Make certain that the product is listed on the Pricing, Data Analysis and Coding (PDAC) Contractor Product Classification List and that the HCPCS code on the ADMC is the one specified by the PDAC (consult the PDAC website at <https://www.dmepdac.com/>). See Chapter 16 of this manual for information about the PDAC.

If the beneficiary currently has a wheelchair or a power operated vehicle (POV), the ADMC request must indicate the reason why it is being replaced.

### **ADMC Process**

Upon receipt of an ADMC request, the DME MAC will make a determination within 30 calendar days. The DME MAC will provide you and the beneficiary with its determination, either affirmative or negative, in writing. If it is a negative determination, the letter will indicate why the request was denied - e.g., not medically necessary, insufficient information submitted to determine coverage, statutorily non-covered.

If a wheelchair base receives a negative determination, all accessories will also receive a negative determination. If a wheelchair base receives an affirmative determination, each accessory will receive an individual determination.

An affirmative determination only relates to whether the item is reasonable and necessary based on the information submitted. An affirmative determination does not provide assurance that the beneficiary meets Medicare eligibility requirements, nor does it provide assurance that any other Medicare requirements (e.g., place of service, Medicare Secondary Payer) have been met. Only upon submission of a complete claim can the DME MAC make a full and complete determination. An affirmative determination does not extend to the price that Medicare will pay for the item.

An affirmative ADMC is only valid for items delivered within six months following the date of the determination. If the wheelchair is not delivered within that time, you have the option of either submitting a new ADMC request (prior to providing the item) or filing a claim (after providing the item).

When submitting a claim with HCPCS code K0108 for the ADMC approved options/accessories, the narrative description on the claim must be the same description used in the ADMC request.

A negative ADMC may not be appealed because it does not meet the regulatory definition of an initial determination since no request for payment is being made. However, if the ADMC request for

the wheelchair base is denied and if you obtain additional medical documentation, an ADMC request may be resubmitted. ADMC requests may only be resubmitted once during the six-month period following a negative determination. If the wheelchair base is approved, but one or more accessories are denied, an ADMC request may not be resubmitted for those accessories. If you provide a wheelchair and/or accessories following a negative determination, a claim for the item should be submitted. If new information is provided with the claim, coverage will be considered. If the claim is denied, it may be appealed through the usual process (see Chapter 13 of this manual for information about appeals).

Finally, the DME MAC may review selected claims on a pre-payment or post-payment basis and may deny a claim or request an overpayment if it determines that an affirmative determination was made based on incorrect information.

## **5. Condition of Payment Required Prior Authorization Program**

CMS Manual System, Pub. 100-08, *Medicare Program Integrity Manual*, Chapter 3, §§3.10, 3.10.1 & Chapter 5, §5.3  
CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 1, §10.1.5.1

1. Medicare requires that all HCPCS codes that appear on the Required Prior Authorization List ([https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS\\_PA\\_Required-Prior-Authorization-List.pdf](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf)) must be submitted for prior authorization prior to delivery and claim submission.
2. Claims to Medicare for a HCPCS code for which the required prior authorization applies must be associated with a prior authorization request as a condition of payment. Lack of a provisionally affirmed prior authorization request will result in the supplier of the HCPCS code receiving a claim denial.
3. Claims for HCPCS codes subject to the required prior authorization submitted without a prior authorization determination and a corresponding unique tracking number (UTN) will be automatically denied.

**Exceptions** to the above (1-3) are **only** for certain HCPCS codes and **only** for **acute situations**. For additional information, please see the “Braces (Orthotics)” section, as well as the “Orthoses Prior Authorization – What Suppliers Need to Know” page at: [https://cgsmedicare.com/jb/mr/orth\\_whatknow.html](https://cgsmedicare.com/jb/mr/orth_whatknow.html).

### **General Prior Authorization Request (PAR) Program Documentation**

Submitters are encouraged to include the following data elements in all PARs to avoid potential delays in processing:

- A. Beneficiary Information (as written on their Medicare card):
  - Beneficiary Name
  - Beneficiary Medicare Number (also known as the MBI)
  - Beneficiary Date of Birth
  - Beneficiary Address

- Place of Service
- Diagnosis Code

**B. Supplier Information:**

- Supplier Name
- Provider Transaction Access Number (PTAN)
- Supplier National Provider Enrollment (NPE) Number
- Supplier National Provider Identification
- Supplier Address
- Supplier Phone Number

**C. Requestor Information:**

- Requestor Name
- Requestor Phone Number
- NPI (if applicable)
- Requestor Address

**D. Other Information:**

- HCPCS Code
- Submission Date
- Indicate if the request is an initial or subsequent review
- Indicate if the request is expedited and the reason why
- Indicate if the request includes an upgrade

Submitters should note that the beneficiary and supplier addresses listed in the PAR will not be used by the DME MACs when sending review decision letters. The decision letters for suppliers and beneficiaries will be mailed to the supplier address on file with the NPE and the beneficiary address on file with the Social Security Administration. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address.

The Condition of Payment Prior Authorization Program requires all documentation to support a prior authorization request must meet all applicable rules, policies, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and LCD-related policy article requirements. For additional information visit: [https://cgsmedicare.com/jb/mr/condition\\_of\\_payment\\_prior\\_auth.html](https://cgsmedicare.com/jb/mr/condition_of_payment_prior_auth.html).

Additional Required Documentation:

- Documentation from the medical record to support the medical necessity of the items
- Any other relevant documents as deemed necessary by the DME MAC to process the PAR

**Submission of Prior Authorization Requests**

Requests may be submitted by either the beneficiary or the supplier. The submitter is encouraged to complete, and include with their request, a Condition of Payment Prior Authorization Request Coversheet, which is available at:

[https://cgsmedicare.com/jb/mr/pdf/prior\\_authorization\\_coversheet.pdf](https://cgsmedicare.com/jb/mr/pdf/prior_authorization_coversheet.pdf).

Requesters/submitters have the option to submit a prior authorization request via **the myCGS Web Portal, esMD (indicate document/content type 8.4), fax, or U.S. mail**. The receipt date will be applied to all documents submitted using a Julian date format.

Prior authorization requests may be submitted by any of the following methods:

**1. Electronically:**

- myCGS Web Portal: <https://mycgportal.com/mycgs>
- esMD: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD>

**2. Fax:** 615.660.5992

**3. Mail:**

CGS – **JUR B** DME Medical Review – Condition of Payment Program  
 PO Box 23110  
 Nashville, TN 37202-4890

**Power Mobility Devices (PMDs)**

As a condition of payment, Medicare requires a prior authorization for the following Power Operated Vehicle (POV) and Power Wheelchair (PWC) base HCPCS codes for all states and territories:

| <b>HCPCS Codes</b> | <b>Code Descriptions</b>                      |
|--------------------|---|
| K0800-K0802        | Group 1 Power Operated Vehicles               |
| *K0806-K0808       | Group 2 Power Operated Vehicles               |
| K0813–K0816        | Group 1 Power Wheelchairs                     |
| K0820–K0829        | Group 2 Power Wheelchairs                     |
| K0835–K0840        | Group 2 Single Power Option Power Wheelchairs |

|             |   |
|-------------|---|
| K0841–K0843 | Group 2 Multiple Power Option Power Wheelchairs |
| K0848–K0855 | Group 3 No Power Option Power Wheelchairs       |
| K0856–K0860 | Group 3 Single Power Option Power Wheelchairs   |
| K0861–K0864 | Group 3 Multiple Power Option Power Wheelchairs |

\*NOTE: Group 2 POV HCPCS codes K0806, K0807, and K0808 are currently not covered as reasonable and necessary and will not be affirmed on prior authorization.

The LCD states that for PWC bases, the coverage criteria for certain accessories/options must be met to meet coverage criteria for the base. Therefore, the appropriate supporting documentation, as outlined in the LCD to support the PWC base, should also be submitted as part of the prior authorization request.

The Condition of Payment Prior Authorization Request for a POV or PWC HCPCS code must include the following documentation:

- WOPD for a POV or PWC base
- SWO for related options/accessories, if applicable
- Treating practitioner’s face-to-face encounter
- Specialty evaluation performed by an LCMP or practitioner for Group 2 single and multiple power option bases and Group 3 bases
- Attestation of “no financial involvement” if the specialty evaluation, performed by the LCMP or practitioner, is to be considered part of the face-to-face encounter
- ATP in-person assessment for Group 2 single and multiple power option bases and Group 3 bases
- ATP’s RESNA certification for Group 2 single and multiple power option bases and Group 3 bases
- Documentation from the medical record to support the medical necessity

Initial Submission:

For the initial submission of the prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester **within five business days (not to exceed seven calendar days)**. The requesters will be notified of the decision, which will include specific reasons for the decision. The DME MAC will notify the beneficiary of the decision if the beneficiary was the prior authorization requester or if the beneficiary asked to be notified. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. If the DME MAC exceeds the **five business days (not to exceed seven calendar days from the postmarked date)** requirement of the initial submission, the request is not automatically affirmed.

**Resubmission:**

For a resubmitted prior authorization request, the DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically to the supplier and/or the beneficiary (if specifically requested by the beneficiary) **within five business days (not to exceed seven calendar days)** of receipt of the resubmission. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. An unlimited number of resubmissions are allowed.

A claim which has received an affirmed prior authorization decision will be paid so long as all other technical and Medicare requirements are met upon claim submission. If a prior authorization request receives a non-affirmed decision, the DME MAC will make the requester(s) aware that one or more Medicare requirements have not been met and provide a detailed explanation of which requirements have not been met. Upon receipt of a non-affirmed decision, the requester(s) may make changes and resubmit the prior authorization request. The DME MAC will have an additional **five business days (not to exceed seven calendar days)** to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s). An unlimited number of resubmissions are allowed.

**Expedited Review:**

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations, the DME MAC will communicate the decisions within two business days (excluding federal holidays and weekends) of receipt of all applicable Medicare required documentation.

You, the supplier, should request an expedited review for replacement PMDs if the item is lost, stolen, or irreparably damaged within the 5-year reasonable lifetime. The PAR request must include supporting documentation that explains the circumstances leading to the need for the replacement, such as detailed reports of loss, theft, or damage and an SWO. The DME MAC will communicate the decisions within two business days (excluding federal holidays and weekends) of receipt of all applicable documentation.

An affirmative prior authorization determination for the HCPCS code is only valid for items delivered within six months following the date of the determination.

**Power Mobility Device (PMD) Accessory Voluntary Prior Authorization**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, §§3.10, 3.10.1 & Chapter 5, §5.3**  
**CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 1, §10.1.5.1**

Medicare has implemented a voluntary prior authorization program for certain power mobility device accessories.

The following accessories are available for voluntary prior authorization for all US states and territories:

| HCPCS Code | Code Description  |
|------------|---|
| E0950      | Wheelchair accessory, tray, each  |
| E0955      | Wheelchair accessory, headrest, cushioned, any type, includes fixed mounting hardware, each |

|       |   |
|-------|---|
| E1002 | Wheelchair accessory, power seating system, tilt only   |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction   |
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction   |
| E1005 | Wheelchair accessory, power seating system, recline only, with power shear reduction  |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction   |
| E1007 | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction   |
| E1008 | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction  |
| E1009 | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and leg rest, each  |
| E1010 | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair  |
| E1012 | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each   |
| E1029 | Wheelchair accessory, ventilator tray, fixed  |
| E1030 | Wheelchair accessory, ventilator tray, gimbaled   |
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware |
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed          |



|       |   |
|-------|---|
|       | mounting hardware   |
| E2312 | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware  |
| E2313 | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors, and mounting hardware, each  |
| E2321 | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware  |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware   |
| E2323 | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated   |
| E2324 | Power wheelchair accessory, chin cup for chin control interface   |
| E2325 | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swing away mounting hardware   |
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface  |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware  |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware  |
| E2329 | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware |
| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed                 |

|       |   |
|-------|---|
|       | mounting hardware   |
| E2351 | An electronic interface for speech generating device  |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware          |
| E2377 | Power wheelchair accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at initial issue |
| E2601 | General use wheelchair seat cushion width less than 22 inches   |
| E2602 | General use wheelchair seat cushion width 22 inches or greater  |
| E2603 | Skin protection wheelchair seat cushion, width less than 22 inches, any depth   |
| E2604 | Skin protection wheelchair seat cushion, width 22 inches or greater, any depth  |
| E2605 | Positioning wheelchair seat cushion, width less than 22 inches, any depth   |
| E2606 | Positioning wheelchair seat cushion, width 22 inches or greater, any depth  |
| E2607 | Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth   |
| E2608 | Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth  |
| E2611 | General use wheelchair back cushion width less than 22 inches, any height includes mounting hardware  |
| E2612 | General use wheelchair back cushion width 22 inches or greater, any height, includes mounting hardware  |
| E2613 | Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware                   |
| E2614 | Positioning wheelchair back cushion, posterior, width 22 inches or greater,   |

|       |  |
|-------|--|
|       | any height, including any type mounting hardware   |
| E2615 | Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including any type mounting hardware                  |
| E2616 | Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware                 |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware  |
| E2621 | Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware |
| E2622 | Skin protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth  |
| E2623 | Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth   |
| E2624 | Skin protection and positioning wheelchair seat cushion, adjustable, width less than 22 inches, any depth  |
| E2625 | Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth   |
| K0020 | Fixed, adjustable height armrest, pair   |
| K0195 | Elevating leg rests, pair with capped rental wheelchair base   |

Submitting a voluntary PAR for a PMD accessory is not mandatory and does not create a condition of payment. Prior authorization requests (PARs) submitted for a PMD accessory must include the related PMD base item. If the PAR request does not include a required PMD base, the PAR will be rejected. If the base item on the PAR is non-affirmed, the accessory will also be non-affirmed.

A prior authorization decision will be rendered for both the PMD base and the PMD accessory item(s). If the PMD base is affirmed, but the accessory item(s) is non-affirmed, you may not resubmit a prior authorization request solely for the non-affirmed accessory item(s).

An SWO for related options and accessories (if not included on the SWO for the base item) is required. For additional information regarding accessory requirements, refer to the Wheelchair Options/Accessories LCD (L33792) (<https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33792>) and LCD-related PA (A52504)

(<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52504>), as well as the Wheelchair Seating LCD (L33312) (<https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=33312>) and LCD-related PA (A52505) (<https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=52505>) for the specific coverage criteria and documentation requirements to support medical necessary for the item.

Additional information regarding PAR and the PMD accessories eligible for voluntary prior authorization can be located in the Prior Authorization Process for Certain DMEPOS Items Operational Guide at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/Operational-Guide-for-DMEPOS-PA-current.pdf>.

**Group 2 Pressure Reducing Support Surfaces (PRSSs)**

As a condition of payment, Medicare requires a prior authorization for the following Group 2 PRSS HCPCS codes for all states and territories.

The following Group 2 PRSS HCPCS codes are subject to the Required Prior Authorization program:

| HCPCS Code | Code Description   |
|------------|--|
| E0193      | Powered Air Flotation Bed (Low Air Loss Therapy)   |
| E0277      | Powered Pressure-Reducing Air Mattress   |
| E0371      | Nonpowered Advanced Pressure Reducing Overlay For Mattress, Standard Mattress Length and Width |
| E0372      | Powered Air Overlay For Mattress, Standard Mattress Length and Width                           |
| E0373      | Nonpowered Advanced Pressure Reducing Mattress   |

The Condition of Payment Prior Authorization Request for a Group 2 PRSS HCPCS code must include the following documentation:

- SWO
- Documentation from the medical record to support the medical necessity

Initial Submission:

For the initial submission of the Group 2 PRSS prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester **within five business days (not to exceed seven calendar days)**. The requesters will be notified of the decision, which will include specific reasons for the decision. The DME MAC will notify the beneficiary of the decision if the beneficiary was the prior authorization requester or if the beneficiary asked to be notified. A

physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. If the DME MAC exceeds the **five business days (not to exceed seven calendar days from the postmarked date)** requirement of the initial submission, the request is not automatically affirmed.

**Resubmission:**

For a resubmitted Group 2 PRSS prior authorization request, the DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically to the supplier and/or the beneficiary (if specifically requested by the beneficiary) **within five business days (not to exceed seven calendar days)** of receipt of the resubmission. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. An unlimited number of resubmissions are allowed.

A claim which has received an affirmed prior authorization decision will be paid so long as all other technical and Medicare requirements are met upon claim submission. If a prior authorization request receives a non-affirmed decision, the DME MAC will make the requester(s) aware that one or more Medicare requirements have not been met and provide a detailed explanation of which requirements have not been met. Upon receipt of a non-affirmed decision, the requester(s) may make changes and resubmit the prior authorization request. The DME MAC will have an additional **five business days (not to exceed seven calendar days)** to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s). An unlimited number of resubmissions are allowed.

**Expedited Review:**

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations, the DME MAC will communicate the decisions within two business days (excluding federal holidays and weekends) of receipt of all applicable Medicare required documentation.

An affirmative prior authorization determination for the Group 2 PRSS HCPCS code is only valid for items delivered within one month following the date of the determination.

**Lower Limb Prosthetics (LLPs)**

As a condition of payment, Medicare requires a prior authorization for the following LLP HCPCS codes, for all states and territories.

The following LLP HCPCS codes are subject to the Required Prior Authorization program:

| HCPCS Code | Code Description   |
|------------|--|
| L5856      | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor(s), any type |
| L5857      | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor(s), any type       |

|       |   |
|-------|---|
| L5858 | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type |
| L5973 | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source                             |
| L5980 | All lower extremity prostheses, flex foot system  |
| L5987 | All lower extremity prosthesis, shank foot system with vertical loading pylon   |

The Condition of Payment Prior Authorization Request for an LLP HCPCS code must include the following documentation:

- SWO
- Documentation from the medical record to support the medical necessity

Initial Submission:

For the initial submission of the LLP prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester **within five business days (not to exceed seven calendar days)**. The requesters will be notified of the decision, which will include specific reasons for the decision. The DME MAC will notify the beneficiary of the decision if the beneficiary was the prior authorization requester or if the beneficiary asked to be notified. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. If the DME MAC exceeds the **five business days (not to exceed seven calendar days from the postmarked date)** requirement of the initial submission, the request is not automatically affirmed.

Resubmission:

For a resubmitted LLP prior authorization request, the DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically to the supplier and/or the beneficiary (if specifically requested by the beneficiary) **within five business days (not to exceed seven calendar days)** of receipt of the resubmission. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. An unlimited number of resubmissions are allowed.

A claim which has received an affirmed prior authorization decision will be paid so long as all other technical and Medicare requirements are met upon claim submission. If a prior authorization request receives a non-affirmed decision, the DME MAC will make the requester(s) aware that one or more Medicare requirements have not been met and provide a detailed explanation of which requirements have not been met. Upon receipt of a non-affirmed decision, the requester(s) may make changes and resubmit the prior authorization request. The DME MAC will have an additional **five business days (not to exceed seven calendar days)** to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s). An unlimited number of resubmissions are allowed.

Expedited Review:

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations, the DME MAC will communicate the decisions within two business days (excluding federal holidays and weekends) of receipt of all applicable Medicare required documentation. For expedited review requests, utilize [the myCGS Web Portal](#), [esMD](#), or [fax](#) to avoid delays with mailing.

An affirmative prior authorization determination for the LLP HCPCS code is only valid for items delivered within 120 days following the date of the determination.

**Braces (Orthotics)**

As a condition of payment, Medicare requires a prior authorization for the following brace HCPCS codes for all states and territories.

The following brace HCPCS codes are subject to the Required Prior Authorization program:

| HCPCS Code | Code Description  |
|------------|---|
| L0631      | Lumbar-sacral orthosis (LSO), sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise   |
| L0637      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise  |
| L0639      | Lumbar-sacral orthosis (LSO), sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise |
| L0648      | Lumbar-Sacral Orthosis, Sagittal Control, With Rigid Anterior and Posterior Panels, Posterior Extends from Sacrococcygeal Junction To T-9 Vertebra, Produces Intracavitary Pressure To Reduce Load On The Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf   |

|       |  |
|-------|--|
| L0650 | Lumbar-Sacral Orthosis, Sagittal-Coronal Control, With Rigid Anterior and Posterior Frame/Panel(S), Posterior Extends from Sacrococcygeal Junction To T-9 Vertebra, Lateral Strength Provided By Rigid Lateral Frame/Panel(S), Produces Intracavitary Pressure To Reduce Load On Intervertebral Discs, Includes Straps, Closures, May Include Padding, Shoulder Straps, Pendulous Abdomen Design, Prefabricated, Off-The-Shelf |
| L1832 | Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid Support, Prefabricated Item That Has Been Trimmed, Bent, Molded, Assembled, Or Otherwise Customized To Fit A Specific Patient By An Individual With Expertise  |
| L1843 | Knee orthosis (KO), single upright, thigh, and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise   |
| L1845 | Knee orthosis (KO), double upright, thigh, and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise   |
| L1851 | Knee Orthosis (Ko), Single Upright, Thigh and Calf, With Adjustable Flexion And Extension Joint (Unicentric Or Polycentric), Medial-Lateral And Rotation Control, With Or Without Varus/Valgus Adjustment, Prefabricated, Off-The-Shelf  |
| L1951 | Ankle foot orthosis (AFO), spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment  |

**Exceptions** to claims submitted that may otherwise be subject to prior authorization requirements are for HCPCS codes L0631, L0637, L0639, L0648, L0650, L1832, L1843, L1845, L1851, and L1951, and **only for acute situations**:

- **Acute situations** – When the two-day review would delay care and risk the health or life of certain beneficiaries in need of an orthoses, prior authorization requirements are suspended.

Claims with dates of service on or before December 31, 2023, for these HCPCS codes are to be billed using modifier ST and will be subject to 100% prepayment review. Claims with dates of service on or after January 1, 2024, for these HCPCS codes are to be billed using modifier ST and will be subject to a 50% prepayment review.

The Condition of Payment Prior Authorization Request for a brace HCPCS code must include the following documentation:

- WOPD



- Treating practitioner's face-to-face encounter
- Documentation from the medical record to support the medical necessity

**Initial Submission:**

For the initial submission of the brace prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester within five business days (not to exceed seven calendar days). The requesters will be notified of the decision, which will include specific reasons for the decision. The DME MAC will notify the beneficiary of the decision if the beneficiary was the prior authorization requester or if the beneficiary asked to be notified. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. If the DME MAC exceeds the **five business days (not to exceed seven calendar days from the postmarked date)** requirement of the initial submission, the request is not automatically affirmed.

**Resubmission:**

For a resubmitted brace prior authorization request, the DME MAC will ensure that the written decision is faxed, postmarked, or delivered electronically to the supplier and/or the beneficiary (if specifically requested by the beneficiary) within five business days (not to exceed seven calendar days) of receipt of the resubmission. A physician/practitioner letter will be sent on request if there is a form, signed by the physician/practitioner, that includes the address. An unlimited number of resubmissions are allowed.

A claim which has received an affirmed prior authorization decision will be paid so long as all other technical and Medicare requirements are met upon claim submission. If a prior authorization request receives a non-affirmed decision, the DME MAC will make the requester(s) aware that one or more Medicare requirements have not been met and provide a detailed explanation of which requirements have not been met. Upon receipt of a non-affirmed decision, the requester(s) may make changes and resubmit the prior authorization request. The DME MAC will have an additional five business days (not to exceed seven calendar days) to conduct the medical review, make the decision(s), and notify the requester(s) of the decision(s). An unlimited number of resubmissions are allowed.

**Expedited Review:**

You, the supplier, may request an expedited review process where applying the standard timeframe for making a prior authorization decision could jeopardize the life or health of the beneficiary. In these situations, the DME MAC will communicate the decisions within two business days (excluding federal holidays and weekends) of receipt of all applicable Medicare required documentation. For expedited review requests, utilize **the myCGS Web Portal, esMD, or fax** to avoid delays with mailing.

An affirmative prior authorization determination for the brace HCPCS code is only valid for items delivered within 60 days following the date of the determination.

## **6. Denial Categories**

The Medicare Program provides coverage for a wide range of services to improve the health of persons with Medicare. Medicare, however, does not cover every service that is related to the health care of its beneficiaries. Coverage and exclusion of services are defined in the Social Security Act, which in turn are implemented through federal regulations, Medicare manuals, instructions from CMS, and decisions by the individual DME MACs.

This section provides an overview of the denial categories for services billed to Medicare. It is important to understand the basic concepts for proper submission, as well as supplier and beneficiary liability issues. This section is a general summary; there are occasional exceptions to some of the statements made below. Specific coverage guidelines are published in the individual medical policies on our website.

### **Benefit Denials**

Section 1861(s) of the Social Security Act defines the medical and other health services that are covered by Medicare. Items or services that are not included in the benefit category definitions are considered benefit category denials. While these services may be reasonable and important health care services, they are just not included in the benefit package specified by the law.

Examples (not all-inclusive) of items in this category include:

1. Disposable supplies other than surgical dressings, supplies required for the effective use of DME or prosthetic devices, or supplies necessary for the administration of intravenous immune globulin in the home when used to treat primary immune deficiency disease
2. Equipment that does not primarily and customarily serve a medically therapeutic function
3. Most oral and injectable medications

### **Medical Necessity Denials**

Section 1862(a)(1)(A) of the Social Security Act excludes services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” CMS issues NCDs that are binding on all Medicare jurisdictions. In addition, the DME MAC has the authority and responsibility to make medical necessity determinations on all aspects of medical practice not defined nationally.

Items and services that are considered investigational or experimental are denied under this exclusion. Preventive services are excluded from coverage under this section of the Act because they do not diagnose or treat an established condition (not because they are inherently unreasonable or unnecessary).

### **Other Statutory Exclusion Denials**

Sections 1862(a)(2)–1862(a)(25) of the Social Security Act list other categories of services that are excluded from coverage by Medicare. Those that may be related to DMEPOS items are as follows:

1. Routine services and appliances (Section 1862[a][7]). Some examples of items excluded from coverage under this section are:
  - a. Eyeglasses and contact lenses except in those beneficiaries who have had cataract extraction or have had their lens removed for other indications
  - b. Hearing aids
2. Orthopedic shoes or other supportive devices for the feet. An exception is a shoe that is an integral part of a leg brace. Another exception is a special shoe and inserts used for the prevention or management of foot ulcers in persons with diabetes.
3. Personal comfort items.

4. Services received outside of the United States.
5. Services for which another government program is primary (e.g., Veteran's Administration).
6. Services provided to an immediate relative or members of the household.
7. Services relating to war injuries received after the beneficiary is eligible for Medicare coverage.
8. Services for which the beneficiary has no legal obligation to pay.
9. Services paid under Workers' Compensation.

**Fragmented Coding**

The Medicare allowance for an individual HCPCS code often includes several component items. An individual HCPCS code will be denied if it is determined that the item described by that code is included in the allowance for another code that has also been billed. In this case, even though the item provided may be covered—the payment for the code is being denied.

**Duplicate Claims**

If a claim is received for a service that has been previously processed, and a Medicare allowed amount has been established, the second claim will be denied as a duplicate. An example scenario, for claims denied as duplicate, appears below.

When a second supplier submits a diabetic test strip claim for a span date already approved for the same beneficiary for a different supplier, the DME MAC will deny the second supplier's claim as a duplicate claim, when the following conditions are met:

- Same beneficiary Medicare ID;
- Overlapping span DOS (From DOS and through DOS);
- Same HCPCS code;
- Same type of service on the incoming claim matches a previously approved claim in history;  
and
- The item is a diabetic testing supply.

**Incomplete Claims**

You are required to submit complete claims for items provided to Medicare beneficiaries. Claims lacking beneficiary information, diagnosis codes, procedure codes, ordering practitioner's name/NPI, or billing supplier information will be rejected as unprocessable claims. These claims will be considered for payment when the missing information is supplied on a resubmitted claim.

## Chapter 10 Contents

### Introduction

1. Fee Schedules
2. Drug Pricing
3. Single Payment Amount
4. Individual Consideration

## Introduction – Pricing

Pricing for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), is based on the fee schedules and payment methodologies provided by CMS.

The major DMEPOS payment methodologies are:

- **Fee Schedules** – applies to the allowed amount for inexpensive or other routinely purchased (IRP) items, those items that require frequent and substantial servicing, other prosthetic and orthotic devices, capped rental items, oxygen and oxygen supplies, parenteral and enteral nutrition (PEN), and therapeutic shoe claims. The CMS provides an annual fee schedule for DMEPOS and updates to those fees as applicable.

*Note: Fee schedules can change as the result of CMS revisions and/or through the application of inherent reasonableness, which is a review to determine if the existing prices are appropriate. The factors used to determine inherent reasonableness include, but are not limited to, price markup, differences in charges cost and utilization.*

- **Drug Pricing** – applies to the allowed amount for drugs that are billable to the DME MAC. The CMS provides a file quarterly with fees for most drugs that are billable to the DME MAC.
- **Single Payment Amount** – applies to the allowed payment amount for an item furnished under a competitive bidding program.

## 1. Fee Schedules

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 20, §§40.1, 50, 50.1, & 190

### DMEPOS Fee Schedule

Most payments of durable medical equipment (DME) are based on a fee schedule calculated by the Centers for Medicare and Medicare Services (CMS). A fee is established for each DMEPOS item by state. Payment is calculated using either the fee schedule amount or the actual charge submitted on the claim, whichever is lower.

The DME fee schedules include items of DME as well as supplies needed to use the DME and are divided into the following categories:

- Inexpensive or other routinely purchased DME (IRP)
- Items requiring frequent and substantial servicing
- Capped Rental

- Oxygen and Oxygen Equipment
- Ostomy, Tracheostomy, & Urologicals
- Surgical Dressings
- Prosthetics & Orthotics
- Supplies
- TENS
- Therapeutic Shoes
- Lymphedema Compression Treatment Items

### **PEN Fee Schedule**

The Balanced Budget Act of 1997 § 4315 authorized the Secretary to implement a fee schedule for parenteral and enteral nutrition (PEN) items and services. These items were previously paid on a reasonable charge basis. The PEN fee schedule is effective for claims with dates of service on or after January 1, 2002.

### **Gap Filling**

The fee schedule for items for which charge data is not available is calculated based on:

- Fee schedule amounts for comparable equipment
- Fee schedule amounts of other DME MACs
- Supplier price lists

Where supplier price lists are used, efforts are made to obtain prices in effect during the base year (1986-1987). Mail order catalogs are often used as sources of price information. A deflation factor is applied if the price information is from a period other than the base period. This is done in order to approximate the base year price for gap filling purposes.

## **2. Drug Pricing**

*CMS Manual System, Pub. 100-04, Medicare Claims Processing Manual, Chapter 17, §§20-20.3*

Effective January 1, 2005, the vast majority of drugs and biologicals not paid on a cost or prospective payment basis will be paid based on the average sales price (ASP) methodology. Pricing for compounded drugs is performed by the local contractor. The ASP methodology is based on quarterly data submitted to CMS by manufacturers. The CMS supplies contractors with the ASP drug pricing files for Medicare Part B/DME MAC drugs on a quarterly basis.

Beginning January 1, 2005, the payment allowance limits for Medicare Part B/DME MAC drugs and biologicals that are not paid on a cost or prospective payment basis are 106 percent of the ASP. The CMS updates the payment allowance limits quarterly. There are exceptions to this general rule and those that impact the DME MAC are summarized below:

- The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment on or after January 1, 2005 will continue to be 95 percent of the AWP

reflected in the published compendia as of October 1, 2003, unless the drug is compounded. The payment allowance limits for infusion drugs furnished through a covered item of durable medical equipment that were not listed in the published compendia as of October 1, 2003, (i.e., new drugs) are 95 percent of the first published AWP unless the drug is compounded. Effective for claims with date of service on or after January 1, 2017, infusion drugs furnished through a covered item of durable medical equipment are no longer an exception to the ASP methodology. Per Section 5004 of the 21<sup>st</sup> Century Cures Act, which was signed into law on December 13, 2016, payment of infusion drugs furnished through a covered item of DME will be based on Section 1847A of the Social Security Act. That means they reimburse based on the ASP methodology.

- The payment allowance limits for drugs that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing file are based on 106 percent of the published wholesale acquisition cost (WAC) or invoice pricing.
- Effective October 26, 2022, the payment allowance limits for new drugs and biologicals that are produced or distributed under a new drug application (or other new application) approved by the Food and Drug Administration, that are first sold on or after January 1, 2005, and that are not included in the ASP Medicare Part B Drug Pricing File or Not Otherwise Classified (NOC) Pricing File, are based on either the WAC as determined per the Medicare Claims Processing Manual instructions, or invoice pricing. For claims with dates of service before January 1, 2019, the add-on percentage for these WAC-based payments is 6 percent. For claims with dates of service on or after January 1, 2019, the add-on percentage for WAC-based payments determined by MACs for new drugs before an ASP-based payment limit is available is up to 3 percent.

### 3. Single Payment Amount

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 36, §40

The Medicare DMEPOS Competitive Bidding Program (CBP) is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (the MMA) (Pub. L. 108-173). The MMA amended section 1847 of the Social Security Act and requires that competitive bidding programs be established and implemented in areas throughout the United States. In general, the statute requires the implementation of a competitive bidding program that replaces the current DMEPOS fee schedule methodology for determining payment rates for certain DMEPOS items in competitive bidding areas (CBAs).

The single payment amount (SPA) is established for each competitive bid item for each CBA based on the bids submitted by DMEPOS suppliers and accepted for that item. The single amount is determined by CMS and remains in effect for the duration of a contract period and is not adjusted for inflation.

A listing of the single payment amounts is posted at the Competitive Bidding Implementation Contractor (CBIC) website at <https://www.dmecompetitivebid.com>.

Starting January 1, 2019, there will be a temporary gap in the DMEPOS CBP that CMS expects will last until December 31, 2020. During the temporary gap period, payment for all items and services that were included in the CBP are based on the lower of the supplier's charge for the item or fee schedule amounts adjusted in accordance with sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Social Security Act. The fee schedule amounts for items furnished in areas that are CBAs as of December 31, 2018, will be adjusted based on the SPAs for each specific CBA, increased by the

projected percentage change in the Consumer Price Index for all Urban Consumers (CPI-U) for the 12-month period ending January 1, 2019.

Round 2021 of the DMEPOS CBP was implemented on January 1, 2021, and extends through December 31, 2023. Off-The-Shelf (OTS) Back Braces and OTS Knee Braces are included in Round 2021. CMS did not award contracts to any of the other product categories for Round 2021. For items that were included in Round 2021 but where contracts have not been awarded in Round 2021 of the CBP, pursuant to §414.210(g)(10), the fee schedules for these items and services furnished in CBAs are based on the SPAs in effect in the CBA on the last day before the CBP contract period of performance ended (i.e., December 31, 2018), increased by the projected percentage change in the CPI-U for the 12-month period on the date after the contract periods ended. The fee schedule amounts are increased once every 12 months on the anniversary date of the first day after the contract period ended with the CPI-U.

Starting January 1, 2024, there will be a temporary gap period in the DMEPOS CBP. Additional information on the gap period can be found at <https://www.cms.gov/medicare/payment/fee-schedules/dmepos-competitive-bidding>.

Adjusted fees in former competitive bidding areas (CBAs) are based on 100% of the single payment amount for the CBA increased by the projected percentage change in the Consumer Price Index for All Urban Consumers (CPI-U) from January 2023–January 2024.

The adjusted fee schedule for former CBAs and the former CBA ZIP codes public use files (PUFs) will be available on the CMS website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html>.

## 4. Individual Consideration

Unusual services and items are generally reported to the DME MAC with miscellaneous HCPCS codes. In these situations, you must include the following documentation with your claim:

- Description of the item or service
- Manufacturer name
- Product name and number
- Supplier Price List (PL) amount
- HCPCS code of related item (if applicable)

When necessary, consultants' advice will be obtained by the DME MAC.

## Chapter 11 Contents

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## Introduction – Medicare Secondary Payer (MSP)

The term *Medicare Secondary Payer (MSP)* refers to situations when the Medicare program is not responsible for paying a claim first. There are several situations which may result in a beneficiary having an insurance which is primary to Medicare. MSP is essentially the Medicare program's coordination of benefits with other insurers including the following:

- Employer Group Health Plans
- Accident/Injury Insurance
- Other Government Sponsored Health Plans

The information in this chapter outlines the specific situations in which these insurers would be primary to Medicare, how Medicare processes MSP claims, and your responsibilities in MSP situations.

### Identifying Beneficiary Insurance Coverages

The reporting of MSP has been mandated by the Centers for Medicare & Medicaid Services (CMS). Prior to billing Medicare, you must take an active role in the identification of MSP claims/cases.

Information obtained at the time of contact with the beneficiary is essential in making the Medicare primary or secondary payer determination. After a Medicare beneficiary leaves your office, it is often difficult for pertinent information to be obtained for billing purposes.

A recommended Medicare Secondary Payer Questionnaire to be completed by the beneficiary or registration personnel is available on our website at the link below. When providing services to a Medicare beneficiary, use of this form should facilitate the identification and proper billing of MSP cases. This will help maximize your reimbursement and shorten claim-processing time.

Medicare Secondary Payer Questionnaire

[https://www.cgsmedicare.com/jb/forms/pdf/JB\\_msp\\_questionnaire.pdf](https://www.cgsmedicare.com/jb/forms/pdf/JB_msp_questionnaire.pdf) (35K) 



## 1. Employer Sponsored Group Health Plan Coverage

### Working Aged

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §10

Medicare is secondary for beneficiaries 65 years or older who have Employer Group Health Plan (EGHP) coverage through their own current employment or the current employment of a spouse. An EGHP is a health insurance or benefit plan that is offered through an employer of 20 or more employees. The "20 or more employees" threshold is met when an employer has 20 or more full and/or part-time employees for each working day in each of 20 or more calendar weeks in the current or preceding year. The 20 calendar weeks do not have to be consecutive.

### Disability

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §30

Medicare is secondary for beneficiaries under age 65 who are entitled to Medicare on the basis of permanent disability who have health insurance coverage under a Large Group Health Plan (LGHP) either through their own current employment or the current employment of a family member. An LGHP is a health insurance or benefit plan that is offered through an employer who has 100 or more employees or is part of a multi-employer trust or association which has at least one employer of 100 or more employees. The "100 or more employees" threshold is met when an employer has 100 or more full and/or part-time employees on 50 percent or more of its business days during the previous calendar year.

### End Stage Renal Disease (ESRD)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §20

Medicare is secondary for beneficiaries under age 65 who are entitled to Medicare **solely** on the basis of ESRD who have health insurance coverage under an employer sponsored Group Health Plan (GHP) as a result of the current or former employment of the beneficiary or a family member regardless of the size of the employer.

Medicare is the secondary payer to GHPs for individuals eligible for or entitled to Medicare benefits based on ESRD for the following coordination of benefit (COB) periods:

| Date of Medicare Eligibility         | COB Period |
|--------------------------------------|------------|
| October 1, 1981 - January 31, 1990   | 12 months  |
| February 1, 1990 - February 29, 1996 | 18 months  |
| March 1, 1996 - Present              | 30 months  |

### Dually Entitled Beneficiaries

When an individual is eligible for or entitled to Medicare based on ESRD and also entitled on the basis of age or disability, they are considered dually entitled to Medicare and other provisions apply. Effective August 10, 1993, GHPs are subject to the ESRD COB period for any plan enrollee eligible for or entitled to Medicare based on ESRD, regardless of whether that individual also is entitled to Medicare on the basis of age or disability. However, if Medicare is primary for an individual who is

already entitled on the basis of age or disability when he/she becomes eligible on the basis of ESRD, the ESRD COB period would not apply.

## 2. Accident/Injury Insurance

### Workers' Compensation

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §50

Medicare payment may not be made for covered items or services to the extent that payment has been made or can reasonably be expected to be made under a workers' compensation (WC) law or plan. However, Medicare secondary, primary, or conditional payments may be made in certain situations.

Secondary payment may be made by Medicare if the WC plan does not pay your full charge. However, if you accept or are required under the WC law to accept the WC payment as payment in full, Medicare secondary payment is not allowed. When submitting claims to Medicare for secondary payment, you should attach a copy of the WC explanation of benefits (EOB).

Generally speaking, Medicare primary payment may be made for services not covered under WC, assuming the services are otherwise covered by Medicare. Primary payment may also be made by Medicare for services that are clearly unrelated to the injuries covered under WC.

Conditional Medicare payments may be made when a WC claim is contested. Furthermore, Medicare is authorized to make payment if the WC insurer will not pay or will not pay promptly (120 days). This is allowed in order to avoid imposing a hardship on the Medicare beneficiary, since a long delay may occur between the occurrence of an injury or illness and the final decision regarding the case by the WC agency. Conditional payments issued by Medicare are subject to recovery by Medicare when the WC case is settled.

### Workers' Compensation Medicare Set-aside Arrangements (WCMSAs)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §50.1

A WCMSA is an allocation of funds from a workers' compensation (WC) settlement, judgment, or award for future medical and/or future prescription drug expenses related to the WC injury and/or illness/disease. Where a WC settlement specifies that a portion of the settlement is for a WCMSA, Medicare may not pay for future medical and/or prescription drug services until the administrator of the WCMSA provides evidence that payments were made appropriately for services that Medicare would otherwise reimburse and that the funds deposited in the WCMSA account were appropriately exhausted (disbursed only for services related to the WC injury or illness/disease). In addition, Medicare will not pay conditionally for diagnosis codes related to the set-aside occurrence. Once the set-aside amount is exhausted and accurately accounted for, Medicare will pay primary for future Medicare covered medical and/or prescription drug expenses related to the WC injury or illness/disease.

### No-Fault

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 2, §60

Medicare is secondary to both automobile and non-automobile no-fault insurance. No-fault insurance is insurance that pays for medical expenses due to injuries sustained on the property or premises of the insured, or in the use, occupancy, or operation of an automobile regardless of who may have been responsible for causing the accident. It is sometimes called "medical payments coverage," "personal injury protection," or "medical expense coverage." Services covered under no-fault insurance **must** be billed to the no-fault insurer first. If the charges are not paid in full, a claim may

be submitted to Medicare for possible secondary benefits. Claims for services covered under no-fault insurance should be submitted with an explanation of benefits from the no-fault insurer or evidence that the no-fault insurance benefits have been exhausted.

Under certain circumstances, Medicare may make conditional payments if the no-fault insurance will not pay or will not pay promptly (i.e., 120 days after receipt of the claim). Conditional payments are conditioned on reimbursement to the Medicare program to the extent that payment with respect to the same items or services has been made, or could be made, under no-fault insurance.

### **No-Fault Medicare Set-aside Arrangements (NFMSAs)**

A NFMSA is an allocation of funds from an auto/no-fault related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of NFMSA funds.

#### **Liability**

*CMS Manual System, Pub. 100-05, Medicare Secondary Payer Manual, Chapter 2, §40*

Medicare is secondary to any liability insurance (e.g., automobile liability insurance and malpractice insurance). When you have reason to believe that you provided covered services to a Medicare beneficiary for which payment under liability insurance may be available, you should bill only the liability insurer, unless you have evidence that the liability insurer will not pay within the 120 day promptly period. If you have such evidence, you may bill Medicare for conditional payment, provided you supply documentation to support the fact that payment will not be made promptly. After the 120 day promptly period has ended, you may (but are not required to) bill Medicare for conditional payment if the liability insurance claim is not finally resolved.

If you choose to bill Medicare, you must withdraw claims against the liability insurer or a lien placed on the beneficiary's settlement. If you choose to continue your claim against the liability insurance settlement, you may not also bill Medicare. You may not collect payment from the beneficiary until after the proceeds of liability insurance are available to the beneficiary.

### **Liability Medicare Set-aside Arrangements (LMSAs)**

A LMSA is an allocation of funds from a liability related settlement, judgment, award, or other payment that is used to pay for an individual's future medical and/or future prescription drug treatment expenses that would otherwise be reimbursable by Medicare. Medicare does not make claims payment for future medical expenses associated with a settlement, judgment, award, or other payment because payment "has been made" for such items or services through use of LMSA funds.

#### **Ongoing Responsibility for Medicals (ORM)**

*CMS Manual System, Pub. 100-05, Medicare Secondary Payer Manual, Chapter 5, §20.4*

Medicare is precluded from making payment where payment has been made, or can reasonably be expected to be made under liability insurance (including self-insurance), no-fault insurance, or a workers' compensation law or plan, hereafter referred to as Non-Group Health Plan (NGHP). When "applicable plans" (liability insurance (including self-insurance), no-fault insurance, and workers' compensation laws or plans) assume ongoing responsibility for medicals (ORM) associated to specified medical conditions, Medicare cannot pay. Where ORM has been reported, the primary plan has assumed responsibility to pay, on an ongoing basis, for certain medical care related to the

NGHP claim. Consequently, Medicare is not permitted to make payment for such associated claims absent documentation that the ORM has terminated or is otherwise exhausted.

### **3. Other Government-Sponsored Health Plans**

#### **Black Lung**

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 5, §40.1.1.1

Medicare is the secondary payer for beneficiaries entitled to benefits under the Federal Black Lung Program for items and services provided for certain respiratory conditions. Claims with black lung diagnoses should have an EOB or payment determination from the Federal Black Lung Program in order for Medicare to consider payment.

Send claims related to Black Lung Disease to:

Federal Black Lung Program  
PO Box 828  
Lanham-Seabrook, MD 20703-0828

Phone: 1.800.638.7072

#### **Federal Public Health**

CMS Manual System, Pub. 100-02, *Medicare Benefit Policy Manual*, Chapter 16, §50

Medicare will not make payment for services authorized and eligible under another federal program, such as Federal Public Health.

Claims for services authorized or guaranteed under other federal programs should be submitted to that program for payment. No claim should be submitted to Medicare until after the authorizing agency has processed the claim.

If a claim is filed to Medicare because of a denial or a balance owed after the other program pays, a copy of the denial notice or explanation of benefits from the other program should be submitted with the Medicare claim.

### **4. Electronic Billing of MSP Claims**

#### **When Medicare is the Secondary Payer Following One Primary Payer**

There are situations where one primary payer pays on a Medicare Part B claim and Medicare may make a secondary payment on the claim. You must comply with Section 1.4.1, titled "Coordination of Benefits," found in the 837 version 5010A1 Professional Implementation Guide (IG) regarding the submission of Medicare beneficiary MSP claims (The IG can be found at <http://www.wpc-edi.com>). You must follow model 1 in section 1.4.1.1 that discusses the provider-to-payer-to-provider methodology of submitting electronic claims. You must use the appropriate loops and segments to identify the other payer paid amount and any associated adjustments amounts on the 837.

#### **Primary Payer Paid Amount:**

For line level services, you must indicate the primary payer paid amount for that service line in loop ID 2430 SVD02 of the 837.

For claim level information, you must indicate the other payer paid amount for that claim in loop ID 2320 AMT02 AMT01=D of the 837.

**Adjustments Made by the Primary Payer**

Adjustments made by the payer are reported in the CAS on the 835 Electronic Remittance Notice (ERA) or on hardcopy remittance advice. Providers must take the CAS segment adjustments (as found on the 835 ERN) and report these adjustments on the 837 (unchanged) when sending the claim to Medicare for secondary payment. The appropriate Claim Adjustment Reason Code (CARC) should be used to explain the reason for the adjustment. A complete list of these codes can be found at <http://www.wpc-edi.com>.

**Obligated to Accept as Payment in Full Amount (OTAF):**

If you are obligated to accept, or voluntarily accept, an amount as payment in full from the primary payer, you must use the group code Contractual Obligation (CO) to identify your contractual adjustment amount, also known as the Obligated to Accept as Payment in Full Adjustment (OTAF). Suppliers should no longer identify the OTAF in the CN1 segment of the 837.

**5. Medicare Secondary Claim Filing Tips**

- A claim should be submitted to the primary insurer first.
- An explanation of benefits (EOB) or payment determination from the primary insurer must accompany each claim submitted to Medicare.
- If Medicare is secondary to a GHP, items 11, 11a, 11b and 11c of the CMS-1500 must be completed.
- If the claim is due to an accident, items 10a, 10b, and 10c should be completed.
- Do not enter the primary insurer's payment amount in item 29 of the CMS-1500. Complete the field only if payment is received from the beneficiary for covered services.
- The claim must be submitted for the total charge, not the difference between your usual charge and the primary insurer's payment (i.e., co-pay). The total charge should not be reduced to reflect the Medicare or primary insurer's allowed amounts.
- Refer to the patient responsibility (PT RESP) field on the Medicare Remittance Advice (RA) to determine how much to bill the beneficiary. The coinsurance (COINS) and deductible (DEDUCT) fields are calculated based on the Medicare primary payment and do not apply to a secondary claim.

**6. MSP on Capped Rental Items**

Capped rental items, other than power wheelchairs and enteral/parenteral pumps, are rented for a continuous 13 months and then ownership transfers to the beneficiary. When Medicare is the secondary payer, we will make secondary payments for these rental months if all guidelines are met and we could have made a primary payment. A copy of the primary payer's explanation of benefits must be attached to each Medicare claim.

The primary insurance does not have to honor the purchase option if it is not consistent with their policy requirements; however, a claim must be submitted to the primary insurance first.

Medicare as secondary payer cannot pay more than we would have paid as a primary payer. If the primary insurance pays for the lump sum purchase of a capped rental item (except complex rehabilitative power wheelchairs and enteral/parenteral pumps), Medicare cannot make a secondary payment. Medicare would not make a primary payment and therefore could not make a secondary payment for the lump sum purchase of the capped rental item.

Complex rehabilitative power wheelchairs and enteral/parenteral pumps are the only exceptions to capped rental guidelines. Medicare as primary payer could pay for lump sum purchase or rental. When Medicare is the secondary payer, the primary insurance must be filed first and Medicare would process the claim as secondary.

Medicare may not pay secondary benefits when the primary payer pays your charges in full or when you are either obligated to accept, or voluntarily accept, the primary payer's payment as payment in full.

## 7. MSP Payment Calculation

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 5, §50

Medicare secondary payments are based on the higher allowable charge between the primary insurer and Medicare unless you are obligated to accept the primary insurer's allowable as payment in full. At no time will Medicare pay more secondary benefits than it would have paid as primary payer. All MSP claims are subject to Medicare coverage criteria. The MSP payment calculation applies to both assigned and non-assigned claims.

Secondary payments are calculated as follows:

1. The Medicare primary payment is determined in the usual manner (i.e., as if there were no other coverage).
2. The higher of the Medicare allowable charge or the primary insurer's allowable charge is determined (unless you are obligated to accept the primary insurer's allowable charge)
3. The amount paid by the primary insurer is subtracted from the amount determined in Step 2 above.
4. Medicare pays the lower of Step 1 or 3.

The following are examples of Medicare secondary payment calculations:

**Example 1:**

|                           |       |
|---------------------------|-------|
| Submitted Charge          | \$500 |
| Unmet Medicare Deductible | \$0   |
| Medicare Allowable        | \$375 |

|  |       |
|--|-------|
| Primary Allowable  | \$500 |
| Primary Paid   | \$400 |
| <ol style="list-style-type: none"> <li>1. Medicare primary payment is <math>\\$375 \times 80\% = \\$300</math></li> <li>2. Primary allowed of \$500 is the higher allowed amount</li> <li>3. Primary allowed minus primary paid is <math>\\$500 - \\$400 = \\$100</math></li> <li>4. The lower of Step 1 or 3 is \$100. (This claim will pay \$100)</li> </ol> |       |

**Example 2:**

|   |       |
|---|-------|
| Submitted Charge  | \$300 |
| Unmet Medicare Deductible   | \$0   |
| Medicare Allowed  | \$250 |
| Primary Allowed   | \$200 |
| Primary Paid  | \$160 |
| <ol style="list-style-type: none"> <li>1. Medicare primary payment is <math>\\$250 \times 80\% = \\$200</math></li> <li>2. Medicare allowed of \$250 is the higher allowed amount</li> <li>3. Medicare allowed minus primary paid is <math>\\$250 - \\$160 = \\$90</math></li> <li>4. The lower of Step 1 or 3 is \$90. (This claim will pay \$90)</li> </ol> |       |

**MSP and Deductible**

**Example 1:**

|  |       |
|--|-------|
| Submitted Charge   | \$150 |
| Unmet Medicare Deductible (this amount does not reflect current deductible amount) | \$100 |
| Medicare Allowed   | \$120 |
| Primary Allowed  | \$150 |

|   |       |
|---|-------|
| Primary Paid  | \$120 |
| <ol style="list-style-type: none"> <li>1. Medicare primary payment is <math>\\$120 - \\$100</math> (deductible) <math>\times 80\% = \\$16</math></li> <li>2. Primary allowed of <math>\\$150</math> is the higher allowed amount</li> <li>3. Primary allowed minus primary paid is <math>\\$150 - \\$120 = \\$30</math></li> <li>4. The lower of Step 1 or 3 is <math>\\$16</math>. (This claim will pay <math>\\$16</math>)</li> </ol> |       |
| <p>If the claim is filed assigned, the patient responsibility would be the difference between the Medicare allowed amount and the total amount paid. The patient responsibility is zero and the Medicare deductible is satisfied by this claim.</p>   |       |

**Example 2:**

|  |       |
|--|-------|
| Submitted Charge   | \$200 |
| Unmet Medicare Deductible  | \$0   |
| Medicare Allowed   | \$120 |
| Unmet Primary Deductible   | \$150 |
| Primary Allowable  | \$150 |
| Primary Paid   | \$0   |
| <ol style="list-style-type: none"> <li>1. Medicare primary payment is <math>\\$120 \times 80\% = \\$96</math></li> <li>2. Primary allowed of <math>\\$150</math> is the higher allowed amount</li> <li>3. Primary allowed minus primary paid is <math>\\$150 - 0 = \\$150</math></li> <li>4. The lower of Step 1 or 3 is <math>\\$96</math>. (This claim will pay <math>\\$96</math>)</li> </ol> |       |
| <p>If the claim is filed assigned, the patient responsibility would be the difference between the Medicare allowed amount and the total amount paid. The patient responsibility is <math>\\$24</math> for this claim. The Medicare deductible is satisfied by this claim.</p>  |       |

**Obligated to Accept**

"Obligated to Accept" is a term used when a supplier has a contractual agreement with the primary insurer to accept the primary insurer's allowed amount as payment in full. When you are obligated to accept, the secondary payment is based solely on the primary insurer's allowed amount.



**Example 1:**

|                           |       |
|---------------------------|-------|
| Submitted Charge          | \$300 |
| Unmet Medicare Deductible | 0     |
| Medicare Allowed          | \$300 |
| Primary Allowed           | \$250 |
| Primary Payment           | \$200 |

Supplier is **obligated to accept** the primary allowed as payment in full.

1. Medicare primary payment is  $\$300 \times 80\% = \$240$
2. Primary allowed of \$250 is the higher allowed amount
3. Primary allowed minus primary paid is  $\$250 - \$200 = \$50$
4. The lower of Step 1 or 3 is \$50. (This claim will pay \$50)

**8. MSP Overpayment Refunds**

It is your responsibility to refund overpayments on MSP claims. To expedite the refund process, please include the following:

1. Explanation of benefits from the third party payer;
2. Type of primary insurance (i.e., EGHP, liability, workers compensation, no fault);
3. Medicare Explanation of Benefits; and
4. Check in the amount of the original Medicare payment.

The claim will then be adjusted according to the MSP guidelines and any additional benefits will be issued at that time.

All refunds should be made payable to CGS and sent to:

CGS  
 DME MAC Jurisdiction B  
 PO Box 953479  
 St. Louis, MO 63195-3479

## **9. MSP Contractor**

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 5, §10

The Centers for Medicare & Medicaid Services (CMS) has established a centralized Coordination of Benefits (COB) operation by consolidating under a single contractor, the MSP Contractor (formerly Benefits Coordination & Recovery Center [BCRC]), the performance of all activities that support the collection, management, and reporting of other insurance coverage for Medicare beneficiaries. The purposes of the MSP Contractor are to identify the health benefits available to a Medicare beneficiary and to coordinate the payment process to prevent mistaken payment of Medicare benefits. The MSP Contractor does not process claims, nor does it handle any mistaken payment recoveries or claims specific inquiries. The DME MACs are responsible for processing claims submitted for primary or secondary payment.

### **Supplier Requests and Questions Regarding Claims Payment**

DME MACs process claims submitted for primary or secondary payment. Claims processing is not a function of the MSP Contractor. Questions concerning how to bill for payment (e.g., value codes, occurrence codes) should be directed to the DME MAC. In addition, you must return inappropriate Medicare payments to the DME MAC which processed the claim. Do not send checks to the MSP Contractor. Questions regarding Medicare claim denials and adjustments should be directed to the DME MAC. If you submit a claim on behalf of a beneficiary and there is an indication of MSP, but not sufficient information to disprove the existence of MSP, the claim will be investigated by the MSP Contractor. This investigation will be performed with the supplier that submitted the claim. MSP investigations are not a function of the DME MAC. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct primary and secondary payments by the responsible party. Providers, physicians, and other suppliers benefit not only from lower administrative claims costs, but also through enhanced customer service to their Medicare patients.

### **Medicare Secondary Payer Auxiliary Records in CMS's Database**

The MSP Contractor is the sole authority to ensure the accuracy and integrity of the MSP information contained in CMS's database, known as the Common Working File (CWF). Information received as a result of MSP gathering and investigation is stored on the CWF in an MSP auxiliary file. The MSP auxiliary file allows for the entry of several auxiliary records, where necessary. MSP data may be updated, as necessary, based on additional information received from external parties (e.g., beneficiaries, providers, attorneys, third party payers). Beneficiary, spouse, and/or family member changes in employment, reporting of an accident, illness, or injury, Federal program coverage changes, or any other insurance coverage information should be reported directly to the MSP Contractor. The CMS also relies on providers and suppliers to ask their Medicare patients about the presence of other primary health care coverage and to report this information when filing claims with the Medicare program.

### **Contacting the MSP Contractor**

MSP Contractor Customer Service Representatives are available to assist you Monday through Friday, from 7:00 am to 7:00 pm Central Time (except holidays), at 1.855.798.2627 or TTY/TDD (for the hearing and speech impaired) at 1.855.797.2627.

Additional information about the MSP Contractor is available on the CMS website at <https://www.cms.gov/medicare/coordination-benefits-recovery/overview/coordination-benefits>.

## Chapter 12 Contents

1. Overpayments and Refunds
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## 1. Overpayments and Refunds

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 3, §170.6

The Centers for Medicare & Medicaid Services (CMS) requires the DME MAC to request refunds on non-MSP overpayments of \$25 or more. If you owe several small overpayments, each of which is less than \$25, the total amount owed will be considered in the decision to request the refund. Refunds will be requested for overpayments totaling \$25 or more. Although not requested by the DME MAC, refunds of less than \$25 will be accepted. If a lump sum refund would cause a severe financial hardship, repayment may be accepted over an extended period. You must submit specific documentation to support such a request. The \$25 tolerance does not apply to MSP overpayments.

It is your responsibility to refund overpayments.

1. If you have received a demand letter you should respond to the request for refund according to the instructions provided in that letter.
2. If you are submitting a voluntary refund check(s) to the DME MAC, **you must either use the myCGS Web Portal (<https://mycgportal.com/mycgs>) to submit an Overpayment Recovery Request (refer to Chapter 13 of this manual for information about myCGS) or mail/fax the Voluntary Overpayment Refund form (see below) to ensure proper recording and receipt of the check. This will allow for the timely processing of your refund. If you are returning funds due to Medicare Secondary Payer, you must submit the primary insurance company's explanation of benefits in order for CGS to complete your request. Incomplete/Inaccurate forms will delay processing and may lead to loss of appeal rights in certain situations.**

The Voluntary Overpayment Refund form is available on our website at <https://www.cgsmedicare.com/jb/forms> or by following the link below:

Voluntary Overpayment Refund Form

([https://www.cgsmedicare.com/jb/forms/pdf/jb\\_overpay\\_form.pdf](https://www.cgsmedicare.com/jb/forms/pdf/jb_overpay_form.pdf))  PDF

As stated on the form, voluntary overpayment refunds should be made payable to CGS and mailed to:

CGS  
DME MAC Jurisdiction B  
PO Box 953479  
St. Louis, MO 63195-3479

3. You can initiate an adjustment for an overpaid claim. Examples of when you would initiate an adjustment include: item returned, billing error, or overpayments involving Medicare Secondary Payer (MSP). Refer to Chapter 11 of this manual for information about MSP.

When submitting a request for adjustment of an overpaid claim, please include any supporting documentation, such as a corrected claim or, for MSP, a copy of the primary insurance explanation of benefits.

To initiate an adjustment for an overpaid claim, **use the myCGS Web Portal (<https://mycgportal.com/mycgs>) to submit an Overpayment Recovery Request (refer to Chapter 13 of this manual for information about myCGS)** or complete the Overpayment Recovery Request Form and submit it to CGS through fax or mail to the fax number or mailing address listed on the Overpayment Recovery Request Form.

The Overpayment Recovery Request form is available on our website at <https://www.cgsmedicare.com/jb/forms> or by following the link below:

Overpayment Recovery Request Form

([https://www.cgsmedicare.com/jb/forms/pdf/dme\\_overpay\\_recovery\\_form.pdf](https://www.cgsmedicare.com/jb/forms/pdf/dme_overpay_recovery_form.pdf))  PDF

## 2. Overpayment Offsets

You will be notified by letter when an overpayment has been identified and a refund is requested. If a balance remains after 30 days, interest will be assessed on the principal balance. If after 10 additional days you have not contacted our office regarding the overpayment, offset withholdings are initiated.

You may request an overpayment be placed into immediate offset. If the principal amount is offset prior to 30 days from the date of the letter, no interest will be assessed. If a balance remains after 30 days, interest will be assessed on the principal balance. Please include the DCN number located on the demand letter on your request or any other correspondence sent to our office in reference to the overpayment. If requesting immediate offset, please **use the myCGS Web Portal (<https://mycgportal.com/mycgs>) to submit an Offset Request (refer to Chapter 13 of this manual for information about myCGS)** or complete the form "Offset Request" located below and fax to 1.615.782.4508 or mail to CGS JB DME MAC, PO Box 20007, Nashville, TN 37202.

Offset withholdings sometimes create a difficulty in bookkeeping for a supplier's office. Understanding the offset information on a Medicare Remittance Advice (RA) may alleviate some of the confusion. When an overpayment has been identified and a recoupment is set up, the recoupment is reported on the RA in a two-step process, as detailed below.

### **Step 1—Reversal and correction of the payment (actual recoupment of money has not yet occurred).**

When reporting the correction of the payment, the RA displays the following information:

- Reason code FB (Forward Balance)\*
- Claim Control Number (CCN) of the adjusted claim being recouped
- Patient Account Number of the beneficiary on the claim being recouped (if reported on the claim)
- Medicare ID of the beneficiary on the claim being recouped (only if the Patient Account Number was not reported or is not available)

- DCN of the overpayment (previously labeled as FCN)
- Dollar amount of the adjustment

### Step 2—Reporting of the actual recoupment (money is offset).

When a recoupment (offset) has been taken, the RA displays the following information:

- Reason code WO (Overpayment Recovery)
- Claim Control Number (CCN) of the adjusted claim being recouped
- Patient Account Number of the beneficiary on the claim being recouped (if reported on the claim)
- Medicare ID of the beneficiary on the claim being recouped (only if the Patient Account Number was not reported or is not available)
- DCN of the overpayment (previously labeled as FCN)
- Dollar amount recouped

Note that the RA will display only one of either the Patient Account Number or the Medicare ID. If the Patient Account Number was reported on the original claim, then it will display in the overpayment information on the RA. If there was no Patient Account Number reported on the original claim, then the Medicare ID will display on the RA.

The DCN is the Medicare document control number for the overpayment case. Previously on the RA, this was labeled as the FCN.

### Immediate Offsets

You can elect to have your profile updated to always place any and all overpayments (supplier and/or contractor identified) into immediate offset at the time of determination, which would eliminate the need to submit multiple requests at the time of receipt of demand letters. To initiate this profile update, complete the Offset Request Form and select the "Provider/Supplier level offset - Offset the current overpayment and all future overpayments" option.

**Note: CGS does not accept offset requests at the time of claim reopenings/adjustments. If you would like to request an immediate offset, you must wait until you receive a demand letter.**

Requesting an immediate offset will waive potential receipt of interest payment pursuant to Section 1893(f)(2) for the overpayment.

The Offset Request Form is available on our website at <https://www.cgsmedicare.com/jb/forms> or by following the link below:

Offset Request Form ([https://www.cgsmedicare.com/jb/forms/pdf/jb\\_offset\\_request\\_form.pdf](https://www.cgsmedicare.com/jb/forms/pdf/jb_offset_request_form.pdf))   
PDF

The Offset Request Form is a PDF that allows you to fill in the information on your computer by typing in the fields. Typing directly in the form, rather than completing the form by hand, allows us to process your offsets in a faster, more efficient manner.

## Sending in an Offset Request

You can either use the myCGS Web Portal (<https://mycgportal.com/mycgs>) to submit an Offset Request (refer to Chapter 13 of this manual for information about myCGS) or complete the Offset Request form on our website at <https://www.cgsmedicare.com/jb/forms> and mail or fax the completed form.

When submitting a request for an Immediate Offset, you must provide the following:

1. Complete the form with the Date of the Overpayment Letter, Provider/Supplier Name, Provider/Supplier Number or PTAN, Provider/Supplier NPI, Amount of Overpayment, and the Document Control Number.

**Note:** The Amount of the Overpayment Letter should equal the total amount of the demand letter and not an individual claim.

**Note:** The Document Control Number (Accounts Receivable or FCN) can be located in the lower right-hand corner of the overpayment demand letter. The lower right-hand corner of the overpayment demand letter shows a series of numbers such as this example: 999 1XXXXXXXXXXXXX 0000011. Please only enter the 14-digit middle number (the number listed as 1XXXXXXXXXXXXX in the example).

2. Select only one offset type option.
3. Complete the Signature of Requestor field with a signature, fill in the Date of Request, and provide a contact phone number in the Requestor Contact Information.
4. Include at least the first page of the overpayment letter for the corresponding offset request.

## 4. Referral of Delinquent Debt

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 4, §§70.1 - 70.7

If the overpayment amount has not been refunded in full (principal plus interest) before the time the overpayment is 90 days delinquent (120 days from the determination date), another demand letter will be sent. This demand letter is referred to as an "Intent to Refer" letter. It will provide specific notice to debtors before referring a debt to the Department of Treasury or its designated Debt Collection Center (DCC) for cross servicing/offset collection efforts. The "Intent to Refer" letter may be sent for debt currently ineligible for referral based on the status if the contractor believes the debt shall become eligible for referral in the future. If the "Intent to Refer" letter is returned as undeliverable and a better address cannot be located, the DME MAC will refer the debt to Treasury upon receipt.

Once the debt is referred for cross servicing, active collection efforts by the DME MAC and/or CMS shall cease except for internal recoupment, financial reporting, and interest accrual. The types of payments that can be offset by the Department of Treasury may include tax refunds, vendor payments, benefit payments with certain restrictions, and eligible state payments. All inquiries need to be directed to the Department of Treasury or its designated Debt Collection Center for consideration.

## 5. Extended Repayment Schedule

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 4, §50

According to CMS guidelines, a supplier is expected to repay any overpayment as quickly as possible. If CGS notifies you of an overpayment and you acknowledge that the overpayment exists but are unable to refund the entire amount within 30 days, you may contact CGS to request an Extended Repayment Schedule (ERS).

CMS established the ERS process to enable suppliers experiencing hardship to maintain their cash flow from Medicare. In order for Medicare to evaluate hardship, you must provide certain financial documents along with your request. Not all requests will meet the hardship eligibility requirements, and some requests may be approved for timeframes other than those requested. Requests for less than six months will not be considered.

A repayment schedule may be established for all or part of an overpayment and may be requested at any time as long as the overpayment is outstanding and has not been referred to the Treasury. If you have also requested an appeal on the overpayment, it is in your best interest to include a copy of your most recent appeal decision letter with your request to assist in determining the appropriate balance. Additionally, overpayments established after or outside of an ERS request are not automatically included in the ERS, and you must separately request repayment plans or submit revised requests to include those overpayments.

An ERS request must be made timely to avoid withholding of the unpaid balance. You must make your first proposed payment in addition to sending the required documents and must continue to make your scheduled payments during the review in order to prevent a full withholding until a decision on the ERS request has been made. Proposed and good faith payments should be based on an amortization schedule which includes interest to be accrued over the life of the loan and must not be less than 1/60th of the total amount owed.

A request for an ERS does not stop interest accrual, and all payments are applied first to interest and then to principal. After each payment, interest will continue to accrue on the remaining principal balance at the interest rate referenced in the Medicare overpayment letter. The proposed amortization schedule should include this interest. If a request is made more than 30 days after the date of the initial Medicare overpayment letter, repayment of any remaining balances of previously accrued interest should also be included in the schedule. CGS has provided some examples of amortization schedules at <https://cgsmedicare.com/ers/amortization.html>.

You may receive a tentative amortization schedule to follow during review of your application and, if so, will be expected to follow this schedule instead of your own proposed schedule until Medicare makes a decision on the ERS request. On approving an ERS request, Medicare will provide a final amortization schedule for you to follow. In some cases, scheduled tentative or approved ERS payments will be automatically deducted from Medicare payments. Medicare will notify you in advance via an ERS tentative or approval letter if this is going to occur. Should changes in your billing practices or other events later prevent recoupment of these ERS payments, you should contact CGS to make other payment arrangements because such delays may result in additional interest charges and changes to the loan amortization. Cumulative shortages in monthly payments may also result in a default status if not addressed.

Supplier with an approved ERS may request refund of an underpayment identified by submitting an Underpayment/Manual Refund Election form, which is available at [https://cgsmedicare.com/ers/ers\\_underpayment\\_refund\\_election.pdf](https://cgsmedicare.com/ers/ers_underpayment_refund_election.pdf). This must be done within 15 calendar days from the underpayment notification letter in order to be considered.



Payments made by check must be received on or before the due date. If you do not make monthly payments as scheduled, additional interest charges may accrue which can result in changes to the loan amortization and final payment amount. Missing one payment will result in default of the installment plan. Should you default on an approved ERS, the remaining balance of the loan will become due in full, and Medicare will initiate withholding from your Medicare payments.

### Sending in a Request

In submitting a request for an Extended Repayment Schedule, you must submit the following:

1. A signed written request that provides the specific overpayment for which the extended repayment is being requested, the number of months requested, and the approximate monthly payment amount.

#### Request for an Extended Repayment Schedule

([https://www.cgsmedicare.com/ers/ers\\_form\\_re.pdf](https://www.cgsmedicare.com/ers/ers_form_re.pdf)) 

2. A completed *Extended Repayment Schedule Checklist*.

**Sole Proprietor Checklist** ([https://www.cgsmedicare.com/ers/sole\\_ers\\_checklist\\_re.pdf](https://www.cgsmedicare.com/ers/sole_ers_checklist_re.pdf)) 

**Other Entity Checklist** ([https://www.cgsmedicare.com/ers/sole\\_ers\\_checklist\\_re.pdf](https://www.cgsmedicare.com/ers/sole_ers_checklist_re.pdf)) 

3. A copy of each document referenced on the *Extended Repayment Schedule Checklist*.

Note: If you are unable to furnish one or more of the applicable Checklist documents with the request, you must explain the reason why the document is unavailable or will be provided later. All items must be received within 15 days of the request.

4. The first payment referencing the provider number and “ERS Request” made payable to CGS Administrators, LLC and sent to the payment address noted in the Medicare overpayment letter

Note: A list of available CGS payment addresses can be found at [https://www.cgsmedicare.com/ers/payment\\_addresses.html](https://www.cgsmedicare.com/ers/payment_addresses.html). A copy of the check should also be included with the request documents.

Failure to provide any of the above items within 15 days will result in closure of the request and normal collection activities will resume.

All ERS requests and documentation should be faxed to 615.664.5949 or mailed to:

CGS Administrators, LLC  
ATTN: CFO Extended Repayments  
P.O. Box 20018  
Nashville, TN 37202

If you have questions about a pending or approved ERS, send an email to [CGS.ERS.CORR@CGSADMIN.COM](mailto:CGS.ERS.CORR@CGSADMIN.COM).



**6. Overpayment Appeals**

CMS Manual System, Pub. 100-06, *Medicare Financial Management Manual*, Chapter 3, §200

Section 935 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (which amended Title XVIII of the Social Security Act to add a new paragraph to Section 1893) limits Medicare's recoupment rights for overpayments that are appealed for certain types of cases. This means that when a provider files an appeal on a case that is "935" eligible, then Medicare cannot recoup payments until after the appeal has been effectuated. This does not change any appeal rights on "non-935" overpayments, only Medicare's right to recoup.

For more information about appeals, please see Chapter 13 of this manual.

**Chapter 13 Contents**

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**1. myCGS—The Jurisdiction B Web Portal**

The myCGS portal is a Web-based application developed by CGS that is available to DMEPOS suppliers who serve beneficiaries in Jurisdiction B. Using myCGS is a fast and easy way to get the Medicare claim and billing information that you need.

myCGS offers a wide range of functionality and support, such as:

- **Beneficiary Eligibility**  
Find beneficiary eligibility, Medicare Secondary Payer, Medicare Advantage Plan, home health episode, hospice, and inpatient stay information.
- **Claim Status**  
Check on the status of claims you've submitted to Jurisdiction B (or C).
- **Same or Similar Information**  
Search beneficiary claim history for same or similar items.
- **Claim Correction**  
Make simple corrections to a claim.
- **ADR Viewing and Responding**  
View ADR cases and letters (i.e., TPE) and submit your response.
- **Redeterminations and Reopenings Submission and Status**  
Submit and check the status of your Redetermination and Reopening requests directly through myCGS.
- **ADMC and Prior Authorization Submission and Status**  
Submit and check the status of ADCM and Prior Authorization requests.
- **Automatic NPI/PTAN Combinations**

myCGS will automatically give you access to all of the NPI/PTAN combinations that are associated with your existing Tax ID and will automatically add all NPI/PTAN combinations for any newly added Tax IDs.

- **MBI Lookup Tool**

Find a beneficiary's Medicare Beneficiary Identifier (MBI) when you have a patient who has been mailed a new Medicare Card with MBI, but you do not have a record of the MBI itself.

- **Overpayment Recovery Form Submission**

Submit either an [Offset Request form](#) or an [Overpayment Recovery Request form](#).

For a complete listing of all that myCGS has to offer and information about how to register, visit our website at <https://www.cgsmedicare.com/jb/mycgs>.

## 2. Telephone Inquiries

### Interactive Voice Response (IVR) Unit

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §50.1

CGS offers a toll-free Interactive Voice Response (IVR) unit for the exclusive use of DMEPOS suppliers in Jurisdiction B. The IVR is available by calling 1.877.299.7900. The IVR system is capable of responding to a variety of supplier inquiries and requests including:

- Claim status (line by line explanation of the payment/denial, expected payment amount and check date for claims on the payment floor, Claim Control Number (CCN), and appeal rights on denied claims)
- Pending claim information (payment floor information, pending claims at the Common Working File (CWF), and other pending claims)
- Redetermination status (pending, reversed, partially reversed, upheld, or dismissed)
- Ordering duplicate Remittance Advice
- Ordering/referring provider information
- Beneficiary eligibility (Part A and B entitlement dates, current and previous calendar year Part B deductible, Medicare Advantage Plan enrollment, home health information, and Medicare Secondary Payer information). **Beginning February 28, 2025, Beneficiary Eligibility will no longer be available through the IVR.**
- Skilled Nursing Facility (SNF)/inpatient hospital stay information. **Beginning February 28, 2025, SNF/inpatient hospital stay information will no longer be available through the IVR.**
- Hospice information. **Beginning February 28, 2025, hospice information will no longer be available through the IVR.**
- CMN status (HCPCS code of same or similar equipment, initial, revised, and/or recertification date, length of need, previous supplier's phone number for rented items, and total months paid for rented items)
- Oxygen CMN status (most current stationary CMN information, most current portable CMN information, initial, revised, and/or recertification date, length of need, previous supplier's phone number, last paid date with modifier, total number of paid claims per modality, and other oxygen CMNs on file)

- Diabetic supplies and shoes
- Pricing information (fee schedules)
- Check information (outstanding check dates and amount and the last five checks issued)
- Offset information
- General information

For instructions on using the IVR, refer to the IVR User Guide on our website at <https://www.cgsmedicare.com/jb/help/ivr.html>. For an abbreviated version, refer to the IVR flow chart at [https://www.cgsmedicare.com/jb/help/pdf/DME\\_IVR\\_checklist.pdf](https://www.cgsmedicare.com/jb/help/pdf/DME_IVR_checklist.pdf).

The IVR is available 24/7 with the exception of periodic system upgrades or routine maintenance. The IVR menu options which require system access are available Monday–Friday, 6 am–9 pm CT and Saturday, 6 am–4 pm CT.

### **Customer Support**

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §30

When the IVR system cannot answer your questions or provide the assistance you need, you may disconnect from the IVR and call 1.866.590.6727 to speak to a Customer Service Representative (CSR).

**NOTE:** CSRs are not able to provide you with information that is readily available on the IVR. You must contact the IVR for the types of inquiries listed above.

CSRs are trained to answer supplier questions and resolve problems. They should be your first contact with our office when you need assistance.

When calling, please have available your National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), the last five digits of your tax identification number (TIN) and, if appropriate, the beneficiary's name, Medicare ID, and date of service. So that we may assist as many callers as possible, you are limited to three separate inquiries per phone call. Lengthy requests should be submitted in writing.

CSRs are available to assist suppliers Monday–Friday, 7 am–4 pm CT. CSRs are not available on the following holidays: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving holiday (Thursday and Friday), Christmas Eve, and Christmas Day. Please also note that the contact center is closed the 2nd and 4th Friday each month from 9:30 am to noon CT for staff training (except for weeks in which there is a federal holiday closing). The contact center may also close to observe other Federal holidays. An electronic mailing list message will be sent out informing you of additional closings or changes in availability. To join our electronic mailing list, visit our website at <https://www.cgsmedicare.com>.

### **Customer Support is able to:**

- Clarify the denial reason associated with a claim
- Provide general information regarding Medicare coverage
- Explain terminology and information published in issues of the *DME MAC Jurisdiction B Insider* and this *Supplier Manual*
- Assist with other complex issues

## **Customer Support is *not* able to:**

- Provide claim status, beneficiary eligibility, or other information which is available through the IVR
- Give preauthorization of beneficiary entitlement for specific DMEPOS
- Adjust a claim, unless the claim was processed incorrectly by the DME MAC (please call Telephone Reopenings at 1.844.240.7490)
- Answer questions about supplier enrollment (please call **the NPEAST at 1.866.520.5193 or NPWEST at 1.866.238.9652**)
- Answer questions about electronic billing software or claims that have not been received in our claim processing system (please call CEDI at 1.866.311.9184)
- Answer inquiries from beneficiaries or their representatives (please call 1.800.MEDICARE – 1.800.633.4227)
- Review documentation related to redetermination cases or Automated Development Letter responses

## **Before You Call...**

Before calling Customer Support, you should take the following steps:

- Consult your Remittance Advice (RA)
- Consult the Claim Denial Resolution Tool ([https://www.cgsmedicare.com/medicare\\_dynamic/jb/claim\\_denial\\_resolution\\_tool/search.aspx](https://www.cgsmedicare.com/medicare_dynamic/jb/claim_denial_resolution_tool/search.aspx)) on the CGS website
- For medical necessity and coverage issues, consult the appropriate Local Coverage Determination (LCD)
- For general questions about DME MAC, consult this *Supplier Manual*

When calling Customer Support, please be sure to have the following information ready to give to the CSR:

- Your NPI number
- Your Provider Transaction Access Number (PTAN)
- The last five digits of your tax identification number (TIN)
- Beneficiary's Medicare ID, name, date of service, and/or date of birth (if appropriate)

## **Three Levels of Customer Support**

When calling Customer Support, you will initially speak to a Tier 1 CSR. Tier 1 CSRs are capable of handling most supplier inquiries. In some cases, Tier 1 CSRs may need to transfer the call to a Tier 2 CSR (also known as the Help Desk). If a callback is required, a Tier 2 CSR will return your call within 10 business days.

If you have a complex inquiry that goes above and beyond the normal scope of a Tier 1 or Tier 2 CSR, the inquiry will be forwarded to the third level of Customer Support, the Provider Relations Research Specialist (PRRS) team. The PRRS will research the inquiry and respond either by phone or by mail within 45 business days.

**3. Written Inquiries**

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §30.3

CGS is committed to providing the highest level of service to our Medicare suppliers. It is our goal to handle all written inquiries in a timely and efficient manner. When writing, please state your question or concern as clearly as possible including all pertinent information, i.e., NPI, PTAN, the last 5-digits of your TIN, and, if appropriate, the beneficiary's name, Medicare ID, and date of service (note that email inquiries must not contain sensitive personal information). Please send letters and faxes on official letterhead and attach your official letterhead to email inquiries. The supplier's name and address should be included on the letterhead, RA, or preformatted inquiry form. If there is more than one location listed, make sure at least one matches the practice location address on file. You must also include your name and phone number. Including this information will allow us to respond more specifically to the inquiry. After the correspondence is received by the DME MAC, a Written Correspondent will respond to the inquiry within 45 business days.

Please send all general written inquiries to:

CGS  
DME MAC Jurisdiction B  
PO Box 20007  
Nashville, TN 37202  
ATTN: Correspondence Department

Fax: 615-782-4624

Email inquiries may be submitted through our website at <https://www.cgsmedicare.com/jb/help/contact/onlinehelp.html>. Information that is personal/private (e.g., Medicare ID, Social Security numbers, Tax ID numbers, financial information, etc.) must not be included in the inquiry. A response will be returned via email. Responses that require personal/private information will be returned by phone or in writing.

**4. Provider Outreach and Education (POE) Department**

CMS Manual System, Pub. 100-09, *Medicare Contractor Beneficiary and Provider Communications Manual*, Chapter 6, §20

CGS offers several different methods of educational training that offer the latest and most up-to-date Medicare information. Visit <https://www.cgsmedicare.com/jb/education/index.html> for a complete listing of seminars, online training, workshops, and more.

You can find our calendar of scheduled educational events at [https://www.cgsmedicare.com/medicare\\_dynamic/wrkshp/dme\\_coe/dme\\_coe\\_b/jb\\_report.aspx](https://www.cgsmedicare.com/medicare_dynamic/wrkshp/dme_coe/dme_coe_b/jb_report.aspx).

**5. Reopenings for Minor Errors and Omissions**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 34, §10

There is no need to request an appeal/redetermination if you have made a minor error or omission during filing of the claim. In the case where a minor error or omission is involved, you can request Medicare to reopen the claim so the error or omission can be corrected, rather than having to go through the appeal process. You have one year to request a reopening from the date on your Remittance Advice (RA). No action can be taken until a final claim determination is issued. See Chapter 17 of this manual for more information about RAs.

The easiest and fastest way to correct or reopen a claim is to utilize the myCGS Web Portal. To do so, use the Claim Correction or Reopening Form Submission option in the Reprocessing menu. You may also request a reopening by telephone or in writing. Refer to the myCGS User Manual (<https://cgsmedicare.com/mycgs/manual/dme/index.html>) for instructions.

If you need to submit a written reopening request by mail, send it to the following address:

CGS  
DME MAC Jurisdiction B  
ATTN: Clerical Error Reopening Department  
PO Box 20007  
Nashville, TN 37202

You may also send written requests for a reopening with an underpayment via fax to 615.660.5978.

Written reopening requests should be made using the Medicare Reopening Request Form ([https://www.cgsmedicare.com/jb/forms/pdf/dme\\_reopening.pdf](https://www.cgsmedicare.com/jb/forms/pdf/dme_reopening.pdf)) available on our website at <https://www.cgsmedicare.com/jb/forms/index.html>. If you wish to send a written request instead of using the Medicare Reopening Request form, be sure to include the following information:

- The beneficiary's name and MBI
- The specific services(s) and/or item(s) for which the reopening is being requested and the specific date(s) of service
- The name of the person filing the request

Examples of minor errors or omissions include:

- Mathematical or computational mistakes
- Transposed procedure or diagnostic codes
- Inaccurate data entry
- Misapplication of a fee schedule
- Computer errors
- Incorrect data items, such as the use of a modifier or date of service, and capped rental denials that have received payment(s) for some months
- Claims denied for being filed after the claim filing time limit

Because some issues are more complicated than others and may require more research or consulting medical staff, the DME MAC reserves the right to decline the clerical error reopening and request that you submit a written redetermination request.

In situations where you or the beneficiary request a redetermination and the issue involves a minor error or omission, irrespective of the request for a redetermination, the DME MAC will treat the request as a request for a clerical error reopening.

The following issues cannot be handled as a reopening:

- Not reasonable and necessary (not medically necessary) claim denials **MUST** be appealed through redeterminations
- Unprocessable/returned claims (i.e., ANSI code 16) – resubmit the claim with the corrected information

- Addition, change, and/or removal of KX, GA, GY, GW, and/or GZ modifiers MUST be appealed through redeterminations
- Inquiries on the status of a claim(s)
- Claims audited by an outside entity (Recovery Auditor Contractor (RAC), Specialty Medical Review Contractor (SMRC), Unified Program Integrity Contractor (UPIC), Comprehensive Error Rate Testing (CERT))
- Target Probe and Educate audits (TPE)
- Corrected PTANs
- Recoupment requests which should be submitted to overpayment recovery

NOTE: For information regarding COVID-19, visit <https://www.cgsmedicare.com/jb/covid-19.html>.

### Telephone Reopenings

The DME MAC telephone reopening number is 1.844.240.7490. The line is available Monday–Friday, 7 am–4 pm CT. The telephone reopenings line follows the same holiday and training schedule as the Provider Contact Center—refer to the Telephone Inquiries section above for details.

*NOTE: An easier and faster way to complete a clerical error request is by using the Claim Correction feature in myCGS. Refer to the myCGS User Manual (<https://cgsmedicare.com/mycgs/manual/dme/index.html>) for instructions.*

You must have the following information on-hand before placing the call for a telephone reopening:

- Your NPI, PTAN, and last five digits of your TIN
  - The Medicare Claim Control Number (CCN) and reason for denial
  - Beneficiary name and MBI
  - Date of service
  - Any additional information to support why you believe the decision is not correct. This includes having the correct procedure code(s), modifier(s), diagnoses, units of service, etc.
1. Use the telephone reopening process to resolve minor errors or omissions involving:
    - Units of service
    - Service dates
    - Healthcare Common Procedure Code System (HCPCS) coding
    - Diagnosis codes and diagnosis reference
    - Modifiers (excluding the KX, GA, GY, GW, and GZ modifiers)
    - Place of service
    - Claim incorrectly denied as duplicate charges
  2. The following issues are examples of what **cannot** be handled on the telephone reopening line:
    - Claims denied for being filed after the claim filing time limit
    - Unprocessable/returned claims (i.e., CO-16 denials)



- Medicare Secondary Payer (MSP)/other insurance involvement issues—A secondary payer is an insurance plan that covers medical expenses only after a primary insurer has made payment on a claim
- Any claim that requires additional documentation
- Reopening requests for break in service issues
- CMN or DIF issues or changes
- Claims audited by an outside entity
- Claims denied for medical necessity

3. Consult this *Supplier Manual* and applicable medical policy guidelines before calling.

Because some issues are more complicated than others and may require more research, the DME MAC reserves the right to decline a telephone reopening. These requests should be submitted using the myCGS web portal or by sending a written reopening request.

To effectively service all callers, each call is limited to five claim issues.

## 6. Appeals

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29

The Medicare program offers suppliers and beneficiaries the right to appeal claim determinations made by the DME MAC. The purpose of the appeals process is to ensure the correct adjudication of claims. A party to the Appeal or their representatives may appeal an initial claim reimbursement determination.

The Medicare law consists of five levels of appeal. The appellant must begin at the first level after receiving an initial determination. Each level after the initial determination has procedural steps that must be taken before an appeal may be taken to the next level. The following table lists the types of appeal, the order in which appeals must be followed, and the filing requirements for each.

| Appeal Level                   | Time Limit for Filing Request   | Where to File an Appeal  | Monetary Threshold  |
|--------------------------------|---|--|---|
| Redetermination                | 120 days from the date of receipt of the initial determination or overpayment demand letter | CGS Jurisdiction B DME MAC                                       | None  |
| Reconsideration                | 180 days from the date of receipt of the Medicare Redetermination Notice                    | Follow the instructions in your Redetermination decision letter. | None  |
| Administrative Law Judge (ALJ) | 60 days from the date of receipt of the reconsideration notice                              | Follow the instructions in your Reconsideration decision letter. | For requests filed on or after January 1, 2025, at least \$190 remains in |

|   |  |  |  |
|---|--|--|--|
|   |  |  | controversy.   |
| Departmental Appeals Board (DAB) Review/Appeals Council | 60 days from the date of receipt of the ALJ decision/dismissal                                   | Follow the instructions in your ALJ decision letter. | None   |
| Federal Court (Judicial) Review                         | 60 days from the date of receipt of the Appeals Council decision or declination of review by DAB |  | For requests filed on or after January 1, 2025, at least \$1,900 remains in controversy. |

**Parties to an Appeal**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §260

An appeal request must be submitted by someone who is considered a party to the appeal. Any of the following are considered proper parties to an appeal:

- A beneficiary;
- A participating supplier;
- A non-participating supplier taking assignment for a specific item or service;
- A non-participating supplier of DME potentially responsible for making a refund to the beneficiary under Section 1834(a)(18) of the Act;
- A supplier of medical equipment and supplies not taking assignment and who is responsible for making a refund to the beneficiary under Section 1834(j)(4) of the Act;
- A Medicaid State agency or party authorized to act on behalf of the State; or
- Any individual whose rights may be affected by the claim being reviewed.

**Appointment of Representative**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §270

A person/supplier/physician who files an appeal request on behalf of a beneficiary is not, by virtue of filing the appeal, a representative. To act as the beneficiary’s representative, a person/supplier/physician must submit a properly executed appointment of representative form— Form CMS-1696 (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf>); however, the appointment of representative form is not necessary. A written statement containing all the required elements is also acceptable as a valid appointment of representative. A valid appointment of representative statement must:

- Be in writing, signed (handwritten or electronic, digital, and/or digitized), and dated by both the party and the individual agreeing to be the representative;
- Provide a statement appointing the representative to act on behalf of the party, and authorizing the adjudicator to release identifiable health information to the appointed representative;
- Include a written explanation of the purpose and scope of the representation;

- Contain both the party's and appointed representative's name, phone number, and address;
- Contain a unique identifier of the party being represented. If the party being represented is the beneficiary, the Medicare number must be provided. If the party being represented is a provider or supplier, the National Provider Identifier number must be provided;
- Include the appointed representative's professional status or relationship to the party; and
- Be filed with the entity processing the party's initial determination or appeal (i.e., the DME MAC).

The appointment of representative is valid for one year from either: (1) The date signed by the party making the appointment, or (2) The date the appointment is accepted by the representative—whichever is later.

The appointment remains valid for any subsequent levels of appeal on the claim/service in question unless the party specifically withdraws the representative's authority. However, if during an appeal the appointment of representative expires, a new form is necessary.

The appeal will be dismissed if the person making the request is not a proper party.

## **7. Redeterminations – First Level of Appeal**

**CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §310**

The first step in the appeals process is the redetermination which is conducted by the DME MAC. The redetermination process provides a re-examination of the initial claim decision. Any new information or medical evidence should be submitted with the request for redetermination and will be evaluated fully in accordance with the Medicare law regulating the redetermination process. Every effort will be made by the redetermination specialist to clarify any questions that may arise in the course of the redetermination by requesting additional information/documentation from the beneficiary, supplier, or the appointed representative. The redetermination specialist is someone who did not participate in the original decision.

For redeterminations of claims denied following a complex prepayment review, a complex post-payment review, or an automated post-payment review by a contractor, CMS has instructed MACs to limit their review to the reason(s) the claim or line item at issue was initially denied. Prepayment reviews occur prior to Medicare payment, when a contractor conducts a review of the claim and/or supporting documentation to make an initial determination. Post-payment review or audit refers to claims that were initially paid by Medicare and subsequently reopened and reviewed by, for example, a Unified Program Integrity Contractor (UPIC), Recovery Auditor, MAC, Specialty Medical Review Contractor (SMRC), or Comprehensive Error Rate Testing (CERT) contractor, and revised to deny coverage, change coding, or reduce payment. Complex reviews require a manual review of the supporting medical records to determine whether there is an improper payment. Automated reviews use claims data analysis to identify improper payments. If an appeal involves a claim or line item denied on an automated pre-payment basis, MACs may continue to develop new issues and evidence at their discretion and may issue unfavorable decisions for reasons other than those specified in the initial determination.

The time limit for requesting a redetermination is 120 days from the date of issuance of the Medicare Remittance Advice (RA) or the date of the overpayment demand letter. The CGS website includes an Appeals Time Limit Calculator

([https://cgsmedicare.com/medicare\\_dynamic/jb/time\\_limit\\_calculator/time\\_limit\\_calculator.aspx](https://cgsmedicare.com/medicare_dynamic/jb/time_limit_calculator/time_limit_calculator.aspx)) to aid you in determining the timelines of your redetermination requests.

NOTE: If you are submitting a request that is past timely filing, please provide good cause for late filing.

The DME MAC Redetermination staff has 60 days to complete a redetermination. If additional documentation is requested or if the appellant submits additional documentation after the redetermination request is submitted, the processing time limit is 74 days from the date of initial receipt.

### **Redetermination Requests**

The easiest way to submit a redetermination request is by using the Redeterminations Form Submission feature in myCGS. Refer to the myCGS User Manual (<https://cgsmedicare.com/mycgs/manual/dme/index.html>) for instructions.

The party to the appeal or their representative may submit a request for redetermination using the current Medicare DME Redetermination Request Form, which is available on the Forms page (<https://www.cgsmedicare.com/jb/forms/index.html>) of our website or at the following link:

Medicare DME Redetermination Request Form

([https://www.cgsmedicare.com/jb/forms/pdf/dme\\_redetermination.pdf](https://www.cgsmedicare.com/jb/forms/pdf/dme_redetermination.pdf))  PDF

If you wish to send a written request instead of using the Medicare DME Redetermination Request Form, your written request **must** contain the following elements:

- The beneficiary's name;
- The Medicare ID of the beneficiary;
- The specific service(s) and/or item(s) for which the redetermination is being requested and the specific date(s) of service (listing the CCN alone is not sufficient to meet this requirement); and
- The name of the party or the representative of the party filing the request.

Please include all CCNs per beneficiary on your redetermination request.

Incomplete requests will be dismissed with an explanation of the missing information. You will be instructed to resubmit the request with all of the missing information. Incomplete requests that are resubmitted for appeal must be submitted within 120 days from the date of the Medicare Remittance Advice (RA) or the overpayment demand letter. Incomplete requests that are resubmitted past the 120-day timely filing limit will be dismissed.

There are three ways to submit a redetermination request: the myCGS Web Portal, fax, or mail.

- To submit a redetermination request through myCGS, refer to the myCGS User Manual (<https://cgsmedicare.com/mycgs/manual/dme/index.html>).
- Send redetermination requests via fax through our appeals fax line at 615.660.5976.
- If you prefer to mail your request, send your redetermination to:

CGS  
DME MAC Jurisdiction B  
PO Box 20007  
Nashville, TN 37202

If you need to send more than one redetermination request in a single fax transmission, you can do so by using the CGS Separator Sheet ([https://www.cgsmedicare.com/jb/forms/pdf/jb\\_separator\\_sheet.pdf](https://www.cgsmedicare.com/jb/forms/pdf/jb_separator_sheet.pdf)), which is available on the Forms page (<https://www.cgsmedicare.com/jb/forms/index.html>) of our website. Doing so will ensure each individual request is recognized and handled in the most timely and efficient manner. Whether you have two, three, or more separate redetermination requests, simply insert the Separator Sheet in between each of the requests in your fax. When we receive the fax, our scanning technology will detect the Separator Sheet and know to separate each section of the fax automatically.

There are two ways you can use the Separator Sheet depending on how you send faxes:

- If you send faxes electronically, download the Separator Sheet and insert it in between each of your requests.
- If you use a traditional fax machine (i.e., you print your request and then fax it), print the Separator Sheet and insert it in between each of your requests.

Note that the Separator Sheet is only for use with redetermination requests.

Please send your redetermination request to the correct contractor (and correct jurisdiction). CGS often receives **misdirected redetermination requests**, which creates delays. Sending requests to the correct contractor helps you receive your decision faster and saves costs for the Medicare program.

You can use myCGS or the Interactive Voice Response (IVR) system to verify receipt of your redetermination request. Verification via the myCGS and IVR is available 10 days after CGS receives the request. myCGS and the IVR will provide confirmation and a status of your request. Duplicate submissions of your redetermination request will not accelerate the review and decision process.

## **Submitting Redetermination Requests for Overpayments**

If you disagree with a request to refund an overpayment, you have the right to a first level (redetermination) appeal. Take these actions when you receive the initial demand letter to refund an overpayment:

1. It is in your best interest to **immediately refund** the requested amount. This will help you avoid an offset and accruing interest.
2. **File your appeal** using the Medicare DME Redetermination Request Form on our website.\*
  - a. Select YES in the Overpayment Appeal section of the form.
  - b. Indicate who requested the overpayment—Medical Review, Unified Program Integrity Contractor (UPIC), Comprehensive Error Rate Testing Contract (CERT), Recovery Auditor (RAC), Supplemental Medical Review Contractor (SMRC), Office of Inspector General (OIG), etc.

*\*Using the Medicare DME Redetermination Request Form is not required, but it is highly recommended for faxed or mailed requests. You can access the Redetermination Request Form on our website by visiting <https://www.cgsmedicare.com/jb/forms/index.html>.*

When submitting a redetermination request regarding an overpayment, it is very important that you:

- Complete the Redetermination Request Form in its entirety.
- Provide the CCN of the adjusted claim that reflects the overpayment.
- Include a copy of the audit results letter (for example, a notification letter from the contractor who audited your claims, such as the UPIC, RAC, Medical Review, etc.).
- Include a copy of the CGS overpayment demand letter (containing the total amount of the overpayment, information on where to send payment, and appeal rights).
- Submit one redetermination request per demand letter.
- When preparing your request for an extrapolated appeal, it is very helpful if you prepare the documents in the following order:

Page 1: A letter identifying supplier, contact information, ARDCN, Invoice Number or Letter Number, reason for appeal, etc.

Page 2: A copy of the original demand letter that has the beneficiary names listed OR a complete list of beneficiary names, Medicare IDs, DOS, and items appealed.

Page 3: Documentation needed to support the appeal.

Note: Please specify in your request if you wish to appeal the entire amount of the overpayment demand letter or only certain claims. For cases involving multiple beneficiaries, it may be helpful to include a spreadsheet or list containing all of the items identified in bullet three above for each claim you wish to appeal.

### **Submitting Documentation with the Redetermination Request**

Original claim denials are often upheld at the redetermination level of appeal due to the lack of documentation supporting the medical necessity of services rendered. Before requesting a redetermination, consult the appropriate LCD(s) and/or supplier bulletins on our website at <https://www.cgsmedicare.com/jb/index.html>. These resources contain all applicable medical policy and documentation guidelines for each piece of equipment/supply. Failure to include all appropriate documentation with the appeal may result in an unfavorable appeal decision.

When submitting a redetermination request:

- Include documentation that is relevant to the reason why your claim denied.
- If you received a letter requesting additional documentation for your claim from a UPIC, DME MAC Medical Review, RAC, CERT, SMRC, OIG, or any other Medicare contractor, always include each item that was requested on the letter with your redetermination request.
- All medical documentation must be signed and dated by a health care professional.

For detailed instructions on submitting documentation with your redetermination request in myCGS, refer to the myCGS User Manual (<https://cgsmedicare.com/mycgs/manual/dme/index.html>).

### **Redetermination Decisions**

The redetermination decision will result in one of three dispositions:

**Affirmation (Unfavorable)**

A Medicare Redetermination Notice (MRN) will be sent to the appellant explaining the decision and the grounds on which the affirmation is based. A copy of all decisions will be sent to all parties of the appeal.

**Reversal (Favorable or Partially Favorable)**

A fully favorable reversal will result in an adjusted claim with an accompanying Medicare Summary Notice (MSN) sent to the beneficiary and Remittance Advice (RA) sent to you, serving as notice of the decision. A partially favorable decision will result in an adjusted claim with an accompanying MSN and RA, as well as an MRN to the appellant explaining the reason for the partially favorable decision. The DME MACs have 30 days to initiate the effectuation or to determine the payment amounts from the date of the decision. Once the payment amount has been determined, the effectuation has 30 days to complete.

**Dismissal**

**CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §200.C**

A dismissal letter will be sent if the redetermination request was not filed timely, was missing required elements of a redetermination request, was submitted in response to an action not considered an initial determination, or the proper Appointment of Representative documents are not received.

If you would like to request that we vacate a dismissal, you must file a request within six months of the date of receipt of the dismissal notice. In your request, please explain why you believe you have good and sufficient cause for filing late or for not including all required items in your request.

Parties to the redetermination have the right to appeal a dismissal of a redetermination request to the Qualified Independent Contractor (QIC) that conducts level 2 appeals (reconsiderations—see below) if they believe the dismissal is incorrect.

The reconsideration request must be filed at the QIC within 60 days of the date of the dismissal letter. When the QIC performs its reconsideration of the dismissal, it will decide if the dismissal was correct. If it determines that the DME MAC incorrectly dismissed the redetermination, it will vacate the dismissal and remand the case to the DME MAC for redetermination.

**8. Reconsideration – Second Level of Appeal**

**CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §320  
MLN Matters Article SE1521**

The second level in the appeals process is a reconsideration. The reconsideration is conducted by the Qualified Independent Contractor (QIC). A redetermination must be issued on the date of service and item/service in dispute before requesting a reconsideration.

The reconsideration process will provide a re-examination of the reason(s) stated in the redetermination decision letter. Any new information or medical evidence must be submitted with the request for reconsideration and will be evaluated fully in accordance with the Medicare law regulating the reconsideration process.

The adjudicator performing the reconsideration is an independent reviewer of the appeal. Requests on claims that were denied due to medical necessity will be reviewed by a panel of physicians and other health professionals.

The QIC has 60 days to render a reconsideration decision.

**Reconsideration Requests**

To exercise your right to a reconsideration, you must file a request in writing to the QIC contractor within 180 days of receiving the MRN. You may submit the request by any of the following ways:

- Complete the Reconsideration Request Form included with the MRN;
- Complete the Jurisdiction B Reconsideration Request Form located on the CGS website at [https://www.cgsmedicare.com/jb/forms/pdf/JB\\_reconsideration\\_form.pdf](https://www.cgsmedicare.com/jb/forms/pdf/JB_reconsideration_form.pdf);
- Complete CMS 20033 Medicare Reconsideration Request Form located at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms20033.pdf>; or
- Submit a written request containing **all** of the following information:
  - The beneficiary's name;
  - The beneficiary's Medicare health insurance claim number;
  - The specific service(s) and item(s) for which the reconsideration is requested, and the specific date(s) of service;
  - The name of the party or representative of the party; and
  - The name of the contractor that made the redetermination.

Send your request for reconsideration to the QIC at the address below. Ensuring that you send your reconsideration requests to the correct contractor reduces processing time, ensuring that you will receive a decision in a timely manner, as well as reducing administrative costs to the Medicare program. If the reconsideration request is incorrectly sent to the DME MAC, processing of that request could be delayed by up to 60 days.

Maximus Federal Services, Inc.  
Medicare DME  
3750 Monroe Avenue, Suite 777  
Pittsford, NY 14534-1302  
Phone: 585-348-3200  
Toll Free: 833-974-2363 (833-9QI-CDME)

Website: [www.medicaredmeappeals.com](http://www.medicaredmeappeals.com)

Requests can also be submitted via the QIC Appeals Portal at <https://qicappeals.cms.gov/qicportal/>.

The DME MACs must be notified of the effectuation (favorable or partially favorable decisions) by the QIC. The DME MACs cannot accept copies of the decision letters from suppliers, beneficiaries, or representatives to effectuate the QIC's decision. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the QIC.



**9. Administrative Law Judge (ALJ) Hearing – Third Level of Appeal**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §330

If you remain dissatisfied following the QIC reconsideration and the remaining amount in controversy is **\$190 or more for requests filed on or after January 1, 2025**, you have the right to request a hearing before an Administrative Law Judge (ALJ). The request for an ALJ hearing must be made in writing within 60 days after receipt of the notice of the QIC's reconsideration decision letter. To request an ALJ hearing, use the form "Request for an Administrative Law Judge (ALJ) Hearing or Review of Dismissal - OMHA-100" found on the Office of Medicare Hearings and Appeals (OMHA) website at: <https://www.hhs.gov/about/agencies/omha/filing-an-appeal/forms/index.html>.

Requests for all ALJ hearings must be filed to the address listed on your reconsideration notice.

The DME MACs must be notified of the effectuation (favorable or partially favorable decisions) by the AdQIC. The DME MACs cannot accept copies of the decision letters from suppliers, beneficiaries, or representatives in order to effectuate the ALJ's decision. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the AdQIC.

**10. Departmental Appeals Board Review**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §340

If you remain dissatisfied following the Administrative Law Judge's (ALJ) hearing decision or dismissal order, you may file an appeal requesting the Departmental Appeals Board to review it. To file an appeal, you must submit a written request to the Departmental Appeals Board within 60 days from the date you receive the ALJ hearing decision letter or dismissal order. Your ALJ decision letter outlines the proper process for requesting a Departmental Appeals Board review.

When the Departmental Appeals Board has rendered its final decision, a copy will be sent to you and the case file will be returned to the DME MAC for completion. The DME MACs have 60 days to complete the effectuation from the date of receipt of the effectuation notification from the AdQIC.

For additional information, refer to the Departmental Appeals Board website at <https://www.hhs.gov/about/agencies/dab/index.html>.

**11. Federal Court Review**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 29, §345

If you remain dissatisfied following the Departmental Appeals Board decision and the remaining amount in controversy is **\$1,900 or more for requests filed on or after January 1, 2025**, you may request a court review of the decision. The complaint must be filed with a United States District Court.

## Chapter 14 Contents

### *Introduction*

1. Unified Program Integrity Contractor (UPIC)
2. Defining Fraud and Abuse
3. Procedures for Handling Fraud and Abuse Situations
4. Protect Yourself from Fraud
5. UPIC Contact Information

## Introduction – Medicare Fraud and Abuse

The Medicare program provides reimbursement for health care services for millions of beneficiaries and provides payment to tens of thousands of providers and suppliers of services. Numerous public and private organizations are involved in the program's administration. Within a program of such complexity and magnitude, the opportunities for fraud, abuse, and waste are considerable. The quality control effort to eliminate fraud, abuse, and waste is necessarily a cooperative effort involving the beneficiaries, contractors, Quality Improvement Organizations, state Medicaid agencies, and federal agencies such as the Centers for Medicare & Medicaid Services (CMS), the Office of the Inspector General (OIG) and the Department of Health and Human Services (DHHS). Most suppliers and supplier organizations are also interested in fraud and abuse control to protect their industry's image with the public and Congress.

### **1. Unified Program Integrity Contractor (UPIC)**

*CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4, §4.2*

Unified Program Integrity Contractors (UPICs) are responsible for ensuring the integrity of all Medicare-related claims under Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims) and coordination of Medicare-Medicaid data matches (Medi-Medi). UPICs are divided into five zones across the country, one of which covers the states that encompass Jurisdiction B.

The functions and activities of the UPICs allow Medicare Administrative Contractors (MACs) to place greater focus on claims processing and customer service, while the UPICs concentrate on benefit integrity issues. UPICs are responsible for identifying cases of suspected fraud and making referrals of all such cases to the OIG, regardless of dollar thresholds or subject matter.

UPICs use a variety of tools including data analysis, fraud complaints, and referrals. They also develop innovative tools and techniques to identify potential Medicare fraud and abuse. These approaches are used in building and referring cases to law enforcement involving those who are suspected of perpetrating Medicare fraud.

CoventBridge Group is the UPIC which services DME MAC Jurisdiction B.

**UPIC Responsibilities**

The UPICs have the responsibility to:

- Investigate allegations of fraud made by beneficiaries, providers, suppliers, CMS, OIG, and other sources, including proactive data analysis results and pre and post pay medical review for benefit integrity.
- Explore all available sources of fraud leads in its zone.
- Refer investigations to the Office of Inspector General/Office of Investigations (OIG/OI) for consideration of civil and criminal prosecution and/or application of administrative sanctions.
- Support law enforcement in requests for information, including but not limited to data and data analysis, cost report data, and medical review.
- Recommend administrative actions to CMS, such as suspending Medicare payment, identifying and recouping overpayments, pursuing civil monetary penalties, and recommending program exclusions.
- Prevent fraud by identifying program vulnerabilities to CMS.
- Work cooperatively with law enforcement and other partners, including CMS, affiliated contractors (MACs), Harkin Grantees, providers, suppliers, and other UPICs to fight fraud and abuse
- Initiate and maintain networking, education, and outreach activities to ensure effective interaction and exchange of information with internal components as well as outside groups, suppliers, providers, and beneficiaries.

**2. Defining Fraud and Abuse**

**CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 4, §4.2.1**

Fraud is intentional deception or misrepresentation that an individual makes, knowing it to be false and that it could result in some unauthorized benefit to them.

Abuse describes incidents or practices of providers, physicians, or suppliers of services and equipment which, although not usually fraudulent, are inconsistent with accepted sound medical, business, or fiscal practices. These practices may, directly or indirectly, result in unnecessary costs to the Medicare program, improper payment, or payment for services which fail to meet professionally recognized standards of care or which are medically unnecessary.

**Defining a Complaint of Fraud and Abuse**

A complaint is a statement, oral or written, alleging that a provider, supplier, or beneficiary received a Medicare benefit of monetary value, directly or indirectly, overtly or covertly, in cash or in kind, to which they are not entitled under current Medicare law, regulations, and/or program policy. Included are allegations of misrepresentation and violations of Medicare requirements applicable to persons or entities that bill for Medicare-covered items and services.

Examples of complaints include:

- Allegations that items or services are not received;
- Allegations that the services received are inconsistent with the services billed (as indicated on the Medicare Summary Notice);
- Allegations that a supplier has billed both the beneficiary and Medicare for the same item or service;
- Allegations regarding the waiver of coinsurance or deductibles;
- Allegations that a supplier has misrepresented itself as having an affiliation with an agency or department of state, local, or federal government, whether expressed or implied; and/or
- Beneficiary inquiries concerning payment for an item or service, which in his or her opinion, may far exceed a reasonable payment for the service which they received, (i.e., the supplier or physician has “upcoded” to receive a higher payment).

The following are not fraud and abuse complaints:

- Complaints (or inquiries) regarding Medicare coverage policy;
- Complaints (or inquiries) regarding the status of claims;
- Requests for claims appeal or complaints regarding the appeals process; and/or
- Complaints concerning suppliers (other than those complaints meeting the criteria established) which are general in nature and are policy or program oriented.

## **Fraud**

The most frequent type of fraud arises from a false statement or misrepresentation which is material to entitlement or payment under the Medicare program. The violator may be a supplier of durable medical equipment, a beneficiary, or some other person or business entity (e.g., a prescribing physician).

Fraud in the Medicare program takes such forms as, but is not limited to:

- Billing for services or supplies that were not provided;
- Supplier claim forms which have been altered to obtain a higher payment amount (i.e., falsifying a beneficiary’s address to a DME MAC jurisdiction with higher fee schedule amounts; or using a beneficiary’s home address when in fact the beneficiary is in a nursing home);
- Supplier’s deliberate application for duplicate payment (i.e., billing both Medicare and the beneficiary for the same service or billing both Medicare and another insurer in an attempt to get paid twice);
- Soliciting, offering, receiving, or giving a kickback, bribe, or rebate, in exchange for referring a patient or arranging for referral of a patient;
- Physician signing of Certificates of Medical Necessity (CMNs) for patients not personally and professionally known to the physician;

- False representation with respect to the nature of services rendered, amounts charged for services rendered, identity of the person receiving the services, dates of services, etc.;
- Claims for non-covered services billed as covered services;
- Claims involving collusion between a provider and a beneficiary or between a supplier and a provider resulting in unwarranted or higher costs or charges to the Medicare program;
- Use of another person's Medicare card in obtaining medical services;
- Repeated violations of the participation agreement or the assignment agreement;
- Unbundled or fragmented charges (e.g., billing for parts of an ostomy bag);
- Falsification of CMNs (e.g., misrepresenting the diagnosis for the patient to justify the services or equipment furnished, indicating a patient cannot swallow—when in fact he or she can—to justify enteral nutrition);
- Falsification of qualifying tests (e.g., exercising a patient before oximetry or ABG testing).

## **Abuse**

The type of abuse to which Medicare is most vulnerable is over-utilization of medical and healthcare services.

Abuse takes such forms as, but is not limited to:

- Breaches of assignment agreements which result in beneficiaries being billed for disallowed amounts on the basis that such charges exceeded the reasonable charge criteria (unless Advance Beneficiary Notice applies);
- Claims for services not medically necessary or not medically necessary to the extent rendered (e.g., an electric hospital bed is supplied where a manual bed would be medically sufficient);
- Routine waiver of coinsurance and/or deductibles;
- Excessive charges for services or supplies;
- Improper billing practices which include:
  - Supplier failure to file non-assigned claims,
  - Supplier billing Medicare at a higher and different fee schedule rate than they would for a non-Medicare patient,
  - Submission of bills to Medicare instead of third-party payers which are primary insurers for Medicare beneficiaries, and/or
  - Unbundled or fragmented charges;
- Supplier violations of Medicare participation agreements or supplier standards (see Chapter 2 of this manual for a list of the supplier standards).

Although these types of practices may initially be categorized as abusive in nature, under certain circumstances they may develop into fraud.

### **Other Illegal Activities**

Other illegal activities include (but are not limited to):

- A supplier completing the sections of a Certificate of Medical Necessity (CMN) which must be completed by a physician.
- A supplier misrepresenting itself as having an affiliation with any agency or department of state, local, or federal government, whether expressed or implied.

### **Bribes, Kickbacks, and Rebates**

Under federal law, Section 1877 (b) and 1909 (b) of the Social Security Act [42 USC 1395 nn (b) and 42 USC 1396h (b)], it is a felony for anyone to knowingly and willfully offer, pay, solicit, or receive any payment in return for referring an individual to another person for the furnishing, or arranging for the furnishing, of any item or service that may be paid for by the Medicare or Medicaid program. Individuals convicted under these felony provisions may be fined up to \$25,000 or imprisoned up to five years, or both.

Anyone who accepts or solicits any payment for referring patients to any practitioner, durable medical equipment supplier, home health agency, laboratory, or any other health provider or facility which furnishes items or services that may be paid for by Medicare or Medicaid may be subject to prosecution.

The criminal statute applies regardless of whether the payment for referral is made directly or indirectly, overtly or covertly, in cash or in kind.

The following are examples of potential violations of federal law if the services are covered under the Medicare or Medicaid programs:

- Physicians who are offered percentages of Medicare payment either acting in the capacity of a consultant, attending physician, etc., if they refer patients needing DMEPOS services to specific DMEPOS suppliers.
- Skilled Nursing Facilities or Nursing Homes who are offered at no charge Durable Medical Equipment (DME), formula for non-Medicare-eligible beneficiaries (i.e., Medicaid-eligible beneficiaries), or computers and/or billing services, or a rebate on the 20 percent coinsurance as an inducement to refer patients needing Parenteral or Enteral Nutrition (PEN) to a specific PEN supplier.
- Hospital social workers or discharge planners who receive payment from DME suppliers for referring hospital patients who will need home medical equipment once they are discharged from the hospital.

In the examples listed above, the unlawful activity is not the referral but the solicitation, receipt, offering, or giving of payment or free items/services. A referral of a patient that does not involve a solicitation or offer, or result in the receipt of a gift of any payment or free items would not be considered a violation of the statute. Furthermore, these examples are not all-inclusive of the types of kickback arrangements that are violations of the law.

### 3. Procedures for Handling Fraud and Abuse Situations

You may contact the appropriate UPIC using the contact information found at the end of this chapter. You may also call the OIG at their fraud hotline at 1-800-HHS-TIPS. Please be specific about the potential fraud you suspect. You may remain anonymous if you prefer.

#### Documentation

Unsubstantiated allegations from suppliers will be accepted and recorded in Benefit Integrity Unit files; however, investigative action will not be initiated until some verification of the allegation is received. This not only will preserve limited investigative resources, but will protect innocent suppliers from false or vindictive allegations by unfriendly competitors.

#### Penalties

Providers and suppliers may be subject to up to a \$25,000 fine and a five-year imprisonment term, or both per violation, under the applicable federal law and suspended from the Medicare program. Civil penalties include \$2,000 fines plus double damages per violation and exclusion. Administrative remedies for abuse include revocation of assignment privileges, withholding of payments, recovery of overpayments, educational contacts and/or warnings, as well as exclusion from the Medicare program.

Keep in mind that the suspects in Medicare fraud and abuse are seldom beneficiaries. Most often the suspects are suppliers or physicians. Many times the beneficiaries are witnesses in suspected fraud and abuse cases.

### 4. Protect Yourself from Fraud

What you can do as a Medicare supplier to protect yourself from fraud:

- **Be informed:**  
It is important to understand Medicare eligibility criteria, coverage guidelines, billing, and cost report requirements. Seek clarification from your DME MAC as necessary and attend training opportunities by CMS and Medicare contractors.
- **Be an educator:**  
Keep beneficiaries properly informed and educated about the care or supplies you are providing, and ensure the physician is actively involved in the planning and delivery of your service to the beneficiary. Many recent OIG hotline reports by beneficiaries relate to billing and service issues. You can prevent inappropriate referrals from beneficiaries if you have informed beneficiaries and family members of Medicare rules and policy. Always provide complete and accurate information to beneficiaries according to your participation agreement.
- **Be in compliance:**  
If your agency does not have a compliance program in place, development of one should be considered. The OIG has developed a number of model compliance programs for providers and suppliers to use as guidance in developing individual agency programs. These programs, along with other pertinent information can be found on the OIG website at <http://oig.hhs.gov>, or by contacting the OIG directly.

- **Be a responsible employer:**  
Every supplier should be aware of and use the OIG's Sanction List. This list identifies Medicare providers who have been restricted from participation in government programs. For your protection, the list should be checked prior to hiring new employees to ensure the government has not sanctioned the prospective employee. The OIG Sanction List can be accessed via the OIG website at address <http://oig.hhs.gov>.
- **Be a Medicare Anti-Fraud Team member:**  
You may contact the appropriate UPICs using the contact information found at the end of this chapter. You may also call the OIG at their fraud hotline at 1.800.HHS.TIPS. Please be specific about the potential fraud you suspect. You may remain anonymous.

## **5. UPIC Contact Information**

You may contact the appropriate UPIC using the information below:

### **CoventBridge Group**

#### **Unified Program Integrity Contractor, Midwestern Jurisdiction**

*Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin*

**Note:** The Midwestern Jurisdiction includes other states outside of Jurisdiction B not listed above.

Website: <https://coventbridge.com/midwest-upic/>



**Chapter 15 Contents***Introduction*

1. [Durable Medical Equipment Medicare Administrative Contractors](#)
2. [Jurisdiction B Resources](#)
3. [Additional Resources](#)
4. [Web Resources](#)

**Introduction**

The following addresses and telephone numbers are provided so that you will know where to obtain the information/materials you need or where to send inquiries.

**1. Durable Medical Equipment Medicare Administrative Contractors****Jurisdiction A**

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

Noridian Administrative Services

PO Box 6780

Fargo, ND 58108-6780

Phone/IVR: 1.866.419.9458

Website: <https://www.noridianmedicare.com>

**Jurisdiction B**

Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin

CGS

PO Box 20007

Nashville, TN 37202

Phone: 1.866.590.6727

IVR: 1.877.299.7900

Telephone Reopenings: 1.844.240.7490

Website: <https://www.cgsmedicare.com>

**Jurisdiction C**

Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, West Virginia

CGS

PO Box 20010

Nashville, TN 37202

Phone: 1.866.270.4909

IVR: 1.866.238.9650

Telephone Reopenings: 1.866.813.7878

Website: <https://www.cgsmedicare.com>

**Jurisdiction D**

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

Noridian Administrative Services  
PO Box 6727  
Fargo, ND 58108-6727  
Phone/IVR: 1.877.320.0390  
Website: <https://www.noridianmedicare.com>

**2. Jurisdiction B Resources****Advance Determination of Medicare Coverage (ADMC)**

CGS  
ATTN: ADMC  
PO Box 20007  
Nashville, TN 37202  
Fax: 1.615.660.5988

**Common Electronic Data Interchange**

National Government Services  
Phone: 1.866.311.9184  
Email address: [ngs.cedihelpdesk@anthem.com](mailto:ngs.cedihelpdesk@anthem.com)  
Website: <https://www.ngscedi.com>

**Correspondence**

CGS  
DME MAC Jurisdiction B  
PO Box 20007  
Nashville, TN 37202

**Paper Claim Submission**

CGS  
PO Box 20013  
Nashville, TN 37202

**Prior Authorization Requests**

CGS – DME Medical Review – Prior Authorization  
PO Box 23110  
Nashville, TN 37202  
Fax: 1.615.660.5992

**Provider Outreach and Education (POE)**

CGS  
DME MAC Jurisdiction B  
PO Box 20007  
Nashville, TN 37202  
ATTN: POE Department

**Refund Checks**

CGS  
DME MAC Jurisdiction B  
PO Box 953479  
St. Louis, MO 63195-3479

**Unified Program Integrity Contractor (UPIC) (Midwestern)****CoventBridge Group**

*Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin*  
Website: <https://coventbridge.com/midwest-upic/>

**Appeals and Reopenings****Clerical Error Reopenings**

CGS  
DME MAC Jurisdiction B  
PO Box 20007  
Nashville, TN 37202  
For a reopening with an underpayment, fax to: 1.615.660.5978  
For a reopening with an overpayment, fax to: 1.615.782.4508  
Telephone Reopenings: 1.844.240.7490

**Redeterminations**

CGS  
ATTN: Redetermination Department  
PO Box 20007  
Nashville, TN 37202  
Fax: 1.615.660.5976

**Reconsiderations**

Maximus Federal Services, Inc.  
Medicare DME  
3750 Monroe Avenue, Suite 777  
Pittsford, NY 14534-1302  
Phone : 585-348-3200  
Toll Free: 833-974-2363 (833-9QI-CDME)  
Website: [www.medicaredmeappeals.com](http://www.medicaredmeappeals.com)

Requests can also be submitted via the QIC Appeals Portal at <https://qicappeals.cms.gov/qicportal/>.

**Administrative Law Judge (ALJ)**

Requests for ALJ hearings must be filed to the Office of Medicare Hearings and Appeals (OMHA) at the address listed on your reconsideration notice.

**3. Additional Resources****CMS-1500 (12/90) Claim Form**

U. S. Government Printing Office  
Superintendent of Documents  
Washington, DC 20402  
Phone: 1.866.512.1800

**Coding Assistance**

Pricing, Data Analysis and Coding (PDAC) Contractor  
Palmetto GBA  
PO Box 100320  
Columbia, SC 29202-3320  
Phone: 1.877.735.1326  
Website: <https://www.dmepdac.com>

**Competitive Bidding**

Competitive Bidding Implementation Contractor (CBIC)  
Palmetto GBA  
2743 Perimeter Parkway Ste 200-400  
Augusta, GA 30909-6499  
Phone: 1.877.577.5331  
Website: <https://www.dmecompetitivebid.com>

**Benefits Coordination & Recovery Center (BCRC)**

Medicare – MSP General Correspondence  
PO Box 138897  
Oklahoma City, OK 73113-8897  
Phone: 1.855.798.2627  
TTY/TDD: 1.855.797.2627 (for the hearing and speech impaired)  
Fax: 1.405.869.3307

**Office of Inspector General (OIG) Hotline**

1.800.HHS.TIPS (1.800.447.8477)

**Provider Enrollment Chain Ownership System (PECOS)**

<https://pecos.cms.hhs.gov/>

**Social Security Administration (SSA)**

Contact your local SSA office or call 1.800.772.1213.

**Supplier Enrollment/Inquiries**

NPE contractor list: [https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact\\_list.pdf](https://www.cms.gov/medicare/provider-enrollment-and-certification/medicareprovidersupenroll/downloads/contact_list.pdf)

The supplier enrollment form, CMS 855S, is available at  
<https://www.cms.gov/cmsforms/downloads/cms855s.pdf>.

**United Mine Workers Association (UMWA)**

U.M.W.A. Health and Retirement Funds  
PO Box 619099  
Dallas TX 75261-9741  
Phone: 1.888.865.5290

**4. Web Resources**

The DME MAC Jurisdiction B website is available at <https://www.cgsmedicare.com/jb>. From the Jurisdiction B website, you can access a variety of resources, including the *DME MAC Jurisdiction B Supplier Manual*, Fee Schedules, Frequently Asked Questions, myCGS, and much more.

**The Centers for Medicare & Medicaid Services (CMS)** – <https://www.cms.gov>

**CMS Manual System** – <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

Beginning October 1, 2003, CMS transitioned from a paper-based manual system to a Web-based system. The transition included streamlining, updating, and consolidating various CMS program instructions into an electronic Web-based manual system for all users. The new online CMS Manual System is organized by functional area, (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity). The manuals are listed below.

- Pub. 100-01 — Medicare General Information, Eligibility, and Entitlement
- Pub. 100-02 — Medicare Benefit Policy
- Pub. 100-03 — Medicare National Coverage Determinations
- Pub. 100-04 — Medicare Claims Processing
- Pub. 100-05 — Medicare Secondary Payer
- Pub. 100-06 — Medicare Financial Management
- Pub. 100-07 — State Operations
- Pub. 100-08 — Medicare Program Integrity
- Pub. 100-09 — Medicare Contractor Beneficiary and Provider Communications
- Pub. 100-10 — Quality Improvement Organization
- Pub. 100-11 — Reserved
- Pub. 100-12 — State Medicaid
- Pub. 100-13 — Medicaid State Children’s Health Insurance Program
- Pub. 100-14 — Medicare End Stage Renal Disease Network Organization
- Pub. 100-15 — State Buy-In
- Pub. 100-16 — Medicare Managed Care
- Pub. 100-17 — CMS/Business Partners Systems Security
- Pub. 100-18 — Reserved
- Pub. 100-19 — Demonstrations
- Pub. 100-20 — One-Time Notification
- Pub. 100-21 — Recurring Update Notification

**Medicare Coverage Database** – <https://www.cms.gov/medicare-coverage-database/search.aspx>

This site includes National Coverage Determinations, National Coverage Analyses, and Local Medical Review Policies.

**CMS Forms** – <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html>

*CGS does not review or control the content and accuracy of websites referenced in this manual, except the CGS website, and is therefore not responsible for their content or accuracy.*

## Chapter 16 Contents

1. [The Pricing, Data Analysis and Coding \(PDAC\) Contractor](#)
2. [Level II HCPCS Codes](#)
3. [Coding Jurisdiction](#)
4. [Modifiers](#)

### 1. The Pricing, Data Analysis and Coding (PDAC) Contractor

Palmetto GBA is contracted by the Centers for Medicare & Medicaid Services (CMS) to serve as the Pricing, Data Analysis and Coding (PDAC) Contractor. The PDAC assists suppliers and manufacturers in the proper use of the Healthcare Common Procedure Coding System (HCPCS). The HCPCS is used to identify items of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for purposes of Medicare billing.

The PDAC plays a key role in the regionalization of DMEPOS claim processing. Some of their responsibilities include:

- Supports the integrity of the Medicare DMEPOS benefit
- Advises manufacturers and suppliers on the appropriate HCPCS for billing DMEPOS items
- Receives, evaluates, and processes coding verification applications for DMEPOS
- Establishes, maintains, and updates all coding verification decisions on the Product Classification List housed within the Durable Medical Equipment Coding System (DMECS)
- Establishes, maintains, and distributes the National Drug Codes (NDC)/HCPCS Crosswalk and Oral Anti-Cancer Drugs (OACD) pricing files
- Conducts DMEPOS statistical analysis and reporting

The PDAC also operates a help line to provide DMEPOS coding advice. The help line telephone number is 1.877.735.1326. The hours of operation are Monday–Friday, 9:30 am–5 pm ET.

You can also reach the PDAC at their website: <https://www.dmepdac.com/>

Or by mail:

Palmetto GBA  
PO Box 100320  
Columbia, SC 29202-3320

#### DMECS—Online Coding Assistance from the PDAC

The Durable Medical Equipment Coding System (DMECS) is an online application that provides HCPCS coding assistance and national pricing information 24 hours a day. DMECS is designed to help Medicare providers and suppliers quickly classify DMEPOS by combining information from a variety of sources to make HCPCS coding determinations for claim submission to the DME MACs easier.

DMECS is available on the PDAC website (<https://www.dmepdac.com/>).

## 2. Level II HCPCS Codes

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 23, §20

Level II HCPCS codes are CMS assigned and consist of an alpha followed by four numeric digits. The Level II HCPCS listed in Appendix A of this manual are provided as a guide for identifying items that are processed by the DME MACs. The appearance of a code in the appendix does not necessarily indicate coverage.

## 3. Coding Jurisdiction

A spreadsheet containing an updated list of the HCPCS for DME MACs is maintained by CMS. A recurring update notification is published when CMS updates the list. The list is made available on the CMS website. The jurisdiction list is located in the subcategory of Coding under the Important Links references at <https://www.cms.gov/Center/Provider-Type/Durable-Medical-Equipment-DME-Center.html>.

## 4. Modifiers

Modifiers can be alphas, numeric, or a combination of both, but will always be two digits for Medicare purposes. Some modifiers cause automated pricing changes, while others are used to convey information only.

Below is a list of modifiers used with procedure codes for DMEPOS:

|           |   |
|-----------|---|
| <b>99</b> | MODIFIER OVERFLOW (EFFECTIVE DATE 7/1/2003)   |
| <b>A1</b> | DRESSING FOR ONE WOUND (EFFECTIVE DATE 1/1/2003)  |
| <b>A2</b> | DRESSING FOR TWO WOUNDS (EFFECTIVE DATE 1/1/2003)   |
| <b>A3</b> | DRESSING FOR THREE WOUNDS (EFFECTIVE DATE 1/1/2003)   |
| <b>A4</b> | DRESSING FOR FOUR WOUNDS (EFFECTIVE DATE 1/1/2003)  |
| <b>A5</b> | DRESSING FOR FIVE WOUNDS (EFFECTIVE DATE 1/1/2003)  |
| <b>A6</b> | DRESSING FOR SIX WOUNDS (EFFECTIVE DATE 1/1/2003)   |
| <b>A7</b> | DRESSING FOR SEVEN WOUNDS (EFFECTIVE DATE 1/1/2003)   |
| <b>A8</b> | DRESSING FOR EIGHT WOUNDS (EFFECTIVE DATE 1/1/2003)   |
| <b>A9</b> | DRESSING FOR NINE OR MORE WOUNDS (EFFECTIVE DATE 1/1/2003)  |
| <b>AU</b> | ITEM FURNISHED IN CONJUNCTION WITH A UROLOGICAL, OSTOMY, OR TRACHEOSTOMY SUPPLY (EFFECTIVE DATE 1/1/2003) |
| <b>AV</b> | ITEM FURNISHED IN CONJUNCTION WITH A PROSTHETIC DEVICE, PROSTHETIC OR ORTHOTIC (EFFECTIVE DATE 1/1/2003)  |
| <b>AW</b> | ITEM FURNISHED IN CONJUNCTION WITH A SURGICAL DRESSING (EFFECTIVE DATE 1/1/2003)                          |

- AX** ITEM FURNISHED IN CONJUNCTION WITH DIALYSIS SERVICES (EFFECTIVE DATE 1/1/2003)
- AY** ITEM OR SERVICE FURNISHED TO AN ESRD PATIENT THAT IS NOT FOR THE TREATMENT OF ESRD (EFFECTIVE 01/01/2011)
- BA** ITEM FURNISHED IN CONJUNCTION WITH PARENTERAL ENTERAL NUTRITION (PEN) SERVICES (EFFECTIVE DATE 1/1/2003)
- BO** ORALLY ADMINISTERED NUTRITION, NOT BY FEEDING TUBE (EFFECTIVE DATE 1/1/2003)
- BP** THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO PURCHASE THE ITEM
- BR** THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND HAS ELECTED TO RENT THE ITEM
- BU** THE BENEFICIARY HAS BEEN INFORMED OF THE PURCHASE AND RENTAL OPTIONS AND AFTER 30 DAYS HAS NOT INFORMED THE SUPPLIER OF HIS/HER DECISION
- CC** PROCEDURE CODE CHANGE (USE 'CC' WHEN THE PROCEDURE CODE SUBMITTED WAS CHANGED EITHER FOR ADMINISTRATIVE REASONS OR BECAUSE AN INCORRECT CODE WAS FILED). (SUPPLIERS SHOULD NOT SUBMIT MODIFIER CC.)
- CG** POLICY CRITERIA APPLIED (EFFECTIVE DATE 07/01/2008)
- CR** CATASTROPHE/DISASTER RELATED
- EA** ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER CHEMOTHERAPY (EFFECTIVE DATE 1/1/2008)
- EB** ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA DUE TO ANTI-CANCER RADIOTHERAPY (EFFECTIVE DATE 1/1/2008)
- EC** ERYTHROPOETIC STIMULATING AGENT (ESA) ADMINISTERED TO TREAT ANEMIA NOT DUE TO ANTI-CANCER RADIOTHERAPY OR ANTI-CANCER CHEMOTHERAPY (EFFECTIVE DATE 1/1/2008)
- EJ** SUBSEQUENT CLAIMS FOR A DEFINED COURSE OF THERAPY, E.G., EPO, SODIUM HYALURONATE, INFLAXIMAB
- EM** EMERGENCY RESERVE SUPPLY (FOR ESRD BENEFIT ONLY)
- EX** EXPATRIATE BENEFICIARY
- EY** NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE (EFFECTIVE DATE 1/1/2003)
- F1** LEFT HAND, SECOND DIGIT (EFFECTIVE DATE 01/01/1995)
- F2** LEFT HAND, THIRD DIGIT (EFFECTIVE DATE 01/01/1995)
- F3** LEFT HAND, FOURTH DIGIT (EFFECTIVE DATE 01/01/1995)
- F4** LEFT HAND, FIFTH DIGIT (EFFECTIVE DATE 01/01/1995)
- F5** RIGHT HAND, THUMB (EFFECTIVE DATE 01/01/1995)



|           |  |
|-----------|--|
| <b>F6</b> | RIGHT HAND, SECOND DIGIT (EFFECTIVE DATE 01/01/1995)   |
| <b>F7</b> | RIGHT HAND, THIRD DIGIT (EFFECTIVE DATE 01/01/1995)  |
| <b>F8</b> | RIGHT HAND, FOURTH DIGIT (EFFECTIVE DATE 01/01/1995)   |
| <b>F9</b> | RIGHT HAND, FIFTH DIGIT (EFFECTIVE DATE 01/01/1995)  |
| <b>FA</b> | LEFT HAND, THUMB (EFFECTIVE DATE 01/01/1995)   |
| <b>FC</b> | PARTIAL CREDIT RECEIVED FOR REPLACED DEVICE (EFFECTIVE DATE 1/1/2008)  |
| <b>GA</b> | WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, INDIVIDUAL CASE (EFFECTIVE 10/02/1995)   |
| <b>GD</b> | UNITS OF SERVICE EXCEEDS MEDICALLY UNLIKELY EDIT VALUE AND REPRESENTS REASONABLE AND NECESSARY SERVICES (END DATE 12/31/2019)  |
| <b>GK</b> | REASONABLE AND NECESSARY ITEM/SERVICE ASSOCIATED WITH A GA OR GZ MODIFIER (UPDATED 1/1/2008)   |
| <b>GL</b> | MEDICALLY UNNECESSARY UPGRADE PROVIDED INSTEAD OF NON-UPGRADED ITEM, NO CHARGE, NO ADVANCE BENEFICIARY NOTICE (ABN) (UPDATED 1/1/2008)                                 |
| <b>GU</b> | WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, ROUTINE NOTICE (EFFECTIVE 01/01/2011)  |
| <b>GW</b> | SERVICE NOT RELATED TO THE HOSPICE PATIENT'S TERMINAL CONDITION  |
| <b>GX</b> | NOTICE OF LIABILITY ISSUED, VOLUNTARY UNDER PAYER POLICY (EFFECTIVE 4/1/2010)  |
| <b>GY</b> | ITEM OR SERVICE STATUTORILY EXCLUDED, DOES NOT MEET THE DEFINITION OF ANY MEDICARE BENEFIT OR, FOR NON-MEDICARE INSURERS, IS NOT A CONTRACT BENEFIT (UPDATED 1/1/2008) |
| <b>GZ</b> | ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE OR NECESSARY. (EFFECTIVE 1/1/2002)   |
| <b>J4</b> | DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED BY A HOSPITAL UPON DISCHARGE (EFFECTIVE 01/01/2010)  |
| <b>J5</b> | DMEPOS COMP BID FUR BY PT/OT (EFFECTIVE 10/01/2020)  |
| <b>JA</b> | ADMINISTERED INTRAVENOUSLY (EFFECTIVE DATE 01/01/2007)   |
| <b>JB</b> | ADMINISTERED SUBCUTANEOUSLY (EFFECTIVE DATE 01/01/2007)  |
| <b>JG</b> | DRUG OR BIOLOGICAL ACQUIRED WITH 340B DRUG PRICING PROGRAM DISCOUNT, REPORTED FOR INFORMATIONAL PURPOSES (DELETED EFF. 12/31/2024)                                     |
| <b>JK</b> | ONE MONTH SUPPLY OR LESS OF DRUG OR BIOLOGICAL (EFFECTIVE DATE 04/01/2023)   |
| <b>JL</b> | THREE MONTH SUPPLY OF DRUG OR BIOLOGICAL (EFFECTIVE DATE 04/01/2023)   |
| <b>JW</b> | DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT (EFFECTIVE 01/01/2003)   |
| <b>JZ</b> | ZERO DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT (EFFECTIVE DATE 01/01/2023)   |

- K0** LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 0 - DOES NOT HAVE THE ABILITY OR POTENTIAL TO AMBULATE OR TRANSFER SAFELY WITH OR WITHOUT ASSISTANCE AND A PROSTHESIS DOES NOT ENHANCE THEIR QUALITY OF LIFE OR MOBILITY
- K1** LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 1 - HAS THE ABILITY OR POTENTIAL TO USE A PROSTHESIS FOR TRANSFERS OR AMBULATION ON LEVEL SURFACES AT FIXED CADENCE. TYPICAL OF THE LIMITED AND UNLIMITED HOUSEHOLD AMBULATOR
- K2** LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 2 - HAS THE ABILITY OR POTENTIAL FOR AMBULATION WITH THE ABILITY TO TRAVERSE LOW LEVEL ENVIRONMENTAL BARRIERS SUCH AS CURBS, STAIRS OR UNEVEN SURFACES. TYPICAL OF THE LIMITED COMMUNITY AMBULATOR
- K3** LOWER EXTREMITY PROSTHESIS FUNCTIONAL LEVEL 3 - HAS THE ABILITY OR POTENTIAL FOR AMBULATION WITH VARIABLE CADENCE. TYPICAL OF THE COMMUNITY AMBULATOR WHO HAS THE ABILITY TO TRANSVERSE MOST ENVIRONMENTAL BARRIERS AND MAY HAVE VOCATIONAL, THERAPEUTIC OR EXERCISE ACTIVITY THAT DEMANDS PROSTHETIC UTILIZATION BEYOND SIMPLE LOCOMOTION.
- K4** LOWER PROSTHESIS FUNCTIONAL LEVEL 4 - HAS THE ABILITY OR POTENTIAL FOR PROSTHETIC AMBULATION THAT EXCEEDS THE BASIC AMBULATION SKILLS, EXHIBITING HIGH IMPACT, STRESS, OR ENERGY LEVELS, TYPICAL OF THE PROSTHETIC DEMANDS OF THE CHILD, ACTIVE ADULT, OR ATHLETE
- KA** ADD ON OPTION/ACCESSORY FOR WHEELCHAIR (EFFECTIVE DATE 01/01/1994)
- KB** BENEFICIARY REQUESTED UPGRADE FOR ABN, MORE THAN 4 MODIFIERS IDENTIFIED ON CLAIM. (EFFECTIVE DATE 1/1/2003)
- KC** REPLACEMENT OF SPECIAL POWER WHEELCHAIR INTERFACE. (EFFECTIVE DATE 01/01/05)
- KD** DRUG OR BIOLOGICAL INFUSED THROUGH DME. (EFFECTIVE DATE 01/01/04)
- KE** BID UNDER ROUND ONE OF THE DMEPOS COMPETITIVE BIDDING PROGRAM FOR USE WITH NON-COMPETITIVE BID BASE EQUIPMENT (EFFECTIVE 01/01/2009)
- KF** ITEM DESIGNATED BY FDA AS CLASS III DEVICES (EFFECTIVE DATE 04/01/04)
- KG** DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 1 (EFFECTIVE DATE 07/01/2007)
- KH** DMEPOS ITEM, INITIAL CLAIM, PURCHASE OR FIRST MONTH RENTAL
- KI** DMEPOS ITEM, SECOND OR THIRD MONTH RENTAL
- KJ** DMEPOS ITEM, PARENTERAL ENTERAL NUTRITION (PEN) PUMP OR CAPPED RENTAL, MONTHS FOUR TO FIFTEEN
- KK** DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 2 (EFFECTIVE DATE 07/01/2007)
- KL** DMEPOS ITEM DELIVERED VIA MAIL (EFFECTIVE DATE 07/01/2007)
- KM** REPLACEMENT OF FACIAL PROSTHESIS INCLUDING NEW IMPRESSION/MOULAGE
- KN** REPLACEMENT OF FACIAL PROSTHESIS USING PREVIOUS MASTER MODEL

|           |   |
|-----------|---|
| <b>KO</b> | SINGLE DRUG UNIT DOSE FORMULATION   |
| <b>KP</b> | FIRST DRUG OF A MULTIPLE DRUG UNIT DOSE FORMULATION   |
| <b>KQ</b> | SECOND OR SUBSEQUENT DRUG OF A MULTIPLE DRUG UNIT DOSE FORMULATION  |
| <b>KR</b> | RENTAL ITEM, BILLING FOR PARTIAL MONTH  |
| <b>KS</b> | GLUCOSE MONITOR SUPPLY FOR DIABETIC BENEFICIARY NOT TREATED WITH INSULIN  |
| <b>KT</b> | BENEFICIARY RESIDES IN A COMPETITIVE BIDDING AREA AND TRAVELS OUTSIDE THAT COMPETITIVE BIDDING AREA AND RECEIVES A COMPETITIVE BID ITEM (UPDATED 04/01/2008)                              |
| <b>KU</b> | CR9520 UNADJUSTED FEE SCHEDULE (EFFECTIVE DATE 07/01/2007; DESCRIPTION CHANGE EFFECTIVE 01/01/2016))  |
| <b>KV</b> | DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED AS PART OF A PROFESSIONAL SERVICE (EFFECTIVE DATE 1/1/2008)   |
| <b>KW</b> | DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 4 (EFFECTIVE DATE 1/1/2008)  |
| <b>KX</b> | REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET (EFFECTIVE DATE 7/1/2002)  |
| <b>KY</b> | DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 5 (EFFECTIVE DATE 1/1/2008)  |
| <b>LT</b> | LEFT SIDE (USED TO IDENTIFY ITEM PROVIDED FOR THE LEFT SIDE OF THE BODY)  |
| <b>M2</b> | MEDICARE SECONDARY PAYER (MSP) (EFFECTIVE DATE 01/01/2007)  |
| <b>MS</b> | SIX MONTH MAINTENANCE AND SERVICING FEE FOR REASONABLE AND NECESSARY PARTS AND LABOR WHICH ARE NOT COVERED UNDER ANY MANUFACTURER OR SUPPLIER WARRANTY                                    |
| <b>N1</b> | GROUP 1 OXYGEN COVERAGE CRITERIA MET (EFFECTIVE DATE 01/01/2023)  |
| <b>N2</b> | GROUP 2 OXYGEN COVERAGE CRITERIA MET (EFFECTIVE DATE 01/01/2023)  |
| <b>N3</b> | GROUP 3 OXYGEN COVERAGE CRITERIA MET (EFFECTIVE DATE 01/01/2023)  |
| <b>NB</b> | NEBULIZER SYSTEM, ANY TYPE, FDA-CLEARED FOR USE WITH SPECIFIC DRUG (EFFECTIVE 01/01/2011)   |
| <b>NR</b> | NEW WHEN RENTED (USE THE 'NR' MODIFIER WHEN DME WHICH WAS NEW AT THE TIME OF RENTAL IS SUBSEQUENTLY PURCHASED) (EFFECTIVE DATE 01/01/1984)  |
| <b>NU</b> | NEW DURABLE MEDICAL EQUIPMENT PURCHASE  |
| <b>PD</b> | DIAGNOSTIC OR RELATED NON DIAGNOSTIC ITEM OR SERVICE PROVIDED IN A WHOLLY OWNED OR OPERATED ENTITY TO A PATIENT WHO IS ADMITTED AS AN INPATIENT WITHIN 3 DAYS (EFFECTIVE DATE 01/01/2012) |
| <b>PL</b> | PROGRESSIVE ADDITION LENSES (EFFECTIVE DATE 01/01/89)   |
| <b>Q0</b> | INVESTIGATIONAL CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY  |

|           |   |
|-----------|---|
|           | THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY (EFFECTIVE DATE 1/1/2008)  |
| <b>Q1</b> | ROUTINE CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY (EFFECTIVE DATE 1/1/2008)   |
| <b>Q2</b> | DEMONSTRATION PROCEDURE/SERVICE (UPDATED DESCRIPTION 01/01/2017)  |
| <b>QA</b> | PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS IS LESS THAN 1 LITER PER MINUTE (LPM) (EFFECTIVE DATE 04/01/2018)                               |
| <b>QB</b> | PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED (EFFECTIVE DATE 04/01/2018) |
| <b>QE</b> | PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS LESS THAN 1 LITER PER MINUTE (LPM) (UPDATED DESCRIPTION 04/01/2018)   |
| <b>QF</b> | PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED (UPDATED DESCRIPTION 04/01/2018)   |
| <b>QG</b> | PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS GREATER THAN 4 LITERS PER MINUTE (LPM) (UPDATED DESCRIPTION 04/01/2018)   |
| <b>QH</b> | OXYGEN CONSERVING DEVICE IS BEING USED WITH AN OXYGEN DELIVERY SYSTEM   |
| <b>QJ</b> | SERVICES/ITEMS PROVIDED TO A PRISONER OR PATIENT IN STATE OR LOCAL CUSTODY, HOWEVER THE STATE OR LOCAL GOVERNMENT, AS APPLICABLE, MEETS THE REQUIREMENTS IN 42 CFR 411.1(B) (EFFECTIVE DATE 1/1/2003)                             |
| <b>QQ</b> | CLAIM SUBMITTED WITH A WRITTEN STATEMENT OF INTENT  |
| <b>QR</b> | PRESCRIBED AMOUNTS OF STATIONARY OXYGEN FOR DAYTIME USE WHILE AT REST AND NIGHTTIME USE DIFFER AND THE AVERAGE OF THE TWO AMOUNTS IS GREATER THAN 4 LITERS PER MINUTE (LPM) (EFFECTIVE DATE 04/01/2018)                           |
| <b>RA</b> | REPLACEMENT OF A DME, ORTHOTIC OR PROSTHETIC ITEM (EFFECTIVE 01/01/2011)  |
| <b>RB</b> | REPLACEMENT OF A PART OF A DME, ORTHOTIC OR PROSTHETIC ITEM FURNISHED AS PART OF A REPAIR (EFFECTIVE 01/01/2011)  |
| <b>RD</b> | DRUG PROVIDED TO BENEFICIARY, BUT NOT ADMINISTERED "INCIDENT-TO" (EFFECTIVE 01/01/2004)   |
| <b>RE</b> | FURNISHED IN FULL COMPLIANCE WITH FDA-MANDATED RISK EVALUATION AND MITIGATION STRATEGY (REMS) (EFFECTIVE 01/01/2009)  |
| <b>RR</b> | RENTAL (USE THE 'RR' MODIFIER WHEN DME IS TO BE RENTED)   |
| <b>RT</b> | RIGHT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE RIGHT SIDE OF THE BODY)  |
| <b>SC</b> | MEDICALLY NECESSARY SERVICE OR SUPPLY (EFFECTIVE DATE 01/01/2001)   |
| <b>ST</b> | RELATED TO TRAUMA OR INJURY (EFFECTIVE DATE 01/01/2003)   |

*NOTE:* Modifier ST is used for Prior Authorization exceptions due to acute or emergent conditions.

- T1** LEFT FOOT, SECOND DIGIT (EFFECTIVE DATE 01/01/1995)
- T2** LEFT FOOT, THIRD DIGIT (EFFECTIVE DATE 01/01/1995)
- T3** LEFT FOOT, FOURTH DIGIT (EFFECTIVE DATE 01/01/1995)
- T4** LEFT FOOT, FIFTH DIGIT (EFFECTIVE DATE 01/01/1995)
- T5** RIGHT FOOT, GREAT TOE (EFFECTIVE DATE 01/01/1995)
- T6** RIGHT FOOT, SECOND DIGIT (EFFECTIVE DATE 01/01/1995)
- T7** RIGHT FOOT, THIRD DIGIT (EFFECTIVE DATE 01/01/1995)
- T8** RIGHT FOOT, FOURTH DIGIT (EFFECTIVE DATE 01/01/1995)
- T9** RIGHT FOOT, FIFTH DIGIT (EFFECTIVE DATE 01/01/1995)
- TA** LEFT FOOT, GREAT TOE (EFFECTIVE DATE 01/01/1995)
- TB** DRUG OR BIOLOGICAL ACQUIRED WITH 340B DRUG PRICING PROGRAM DISCOUNT, REPORTED FOR INFORMATIONAL PURPOSES (REVISED 01/01/2025)
- UE** USED DURABLE MEDICAL EQUIPMENT PURCHASE
- V1** DEMONSTRATION MODIFIER 1 (EFFECTIVE DATE 01/01/2017)
- V2** DEMONSTRATION MODIFIER 2 (EFFECTIVE DATE 01/01/2017)
- V3** DEMONSTRATION MODIFIER 3 (EFFECTIVE DATE 01/01/2017)
- V4** DEMONSTRATION MODIFIER 4 (EFFECTIVE DATE 10/01/2020)
- VP** APHAKIC PATIENT (EFFECTIVE DATE 01/01/1984)
- ZA** NOVARTIS/SANDOZ (DELETED EFF. 03/31/2018)
- ZB** PFIZER/HOSPIRA (EFFECTIVE DATE 04/05/2016) (DELETED EFF. 03/31/2018)
- ZC** MERCK/SAMSUNG BIOEPIS (EFFECTIVE DATE 07/24/2017) (DELETED EFF. 03/31/2018)

## Chapter 17 Contents

1. Claim Development Procedures
2. Medicare Summary Notice (MSN)
3. Medicare Remittance Advice (RA)
4. Biller Purged Claim Report
5. ANSI Codes

### 1. Claim Development Procedures

When a Medicare claim requires additional information, the DME MAC will send a development letter (sometimes referred to as an “ADS” or “ADR” letter) requesting information for the incomplete or inaccurate claim. These are not denial letters. The claims they refer to are suspended in the computer system waiting for a response.

You may receive several letters asking the same questions if several claims submitted were lacking the same information. Each letter with the response must be returned so it can be matched to the corresponding claim. The requested information may be written directly on the development letter or documentation may be attached to the letter. Be sure to respond to each question asked.

Responses to development letters should be returned immediately to avoid processing delays. If the response is delayed and the claim is subsequently denied, the claim may need to be refiled or an appeal requested, depending on the denial code.

If you receive a request for additional documentation from Jurisdiction B and wish to respond electronically, you can submit your documentation (as a PDF file) through the CMS esMD gateway. Refer to Chapter 6 of this manual for information about Electronic Submission of Medical Documentation (esMD).

You can also respond to a request electronically via the myCGS Web Portal. myCGS allows you to view ADR letters sent to you, submit a response, and view status updates. You can also use myCGS to respond to messages from CGS staff regarding your submissions. Refer to Chapter 13 of this manual for information about myCGS. For complete instructions on how to respond to an ADR request in myCGS, refer to the myCGS User Manual at [https://www.cgsmedicare.com/jb/mycgs/pdf/mycgs\\_user\\_manual.pdf](https://www.cgsmedicare.com/jb/mycgs/pdf/mycgs_user_manual.pdf).

### 2. Medicare Summary Notice (MSN)

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 21

A Medicare Summary Notice (MSN) is sent to Medicare beneficiaries for each claim that is processed. The MSN explains which claim is involved, the type of services, the supplier, and other identifying information. Statements on the MSN explain the basis for the payment and/or denial. The MSN also includes information that may affect future reimbursement, such as explaining that a Certificate of Medical Necessity (CMN) has expired. Remind your beneficiaries to review each MSN carefully and report any suspected errors as soon as possible. The information on an MSN is provided to you on your Remittance Advice.

The beneficiary will be issued an MSN every 120 days on both assigned and nonassigned claims.

### **3. Medicare Remittance Advice (RA)**

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 22

You will be notified of the claim determination on all claims that you submit that complete processing, whether they are assigned or nonassigned. The notification is provided by issuance of a Remittance Advice (RA). RAs, which may also be referred to as Remits, include information on one or more claims that you have submitted to the DME MAC. The notices are mailed daily; therefore, you should receive notification shortly after your claims are processed.

All original RAs should be kept in your records, as they provide valuable facts regarding your claims. There may be occasions in the future when you will need to refer to an earlier RA.

The claims will be listed in alphabetical order by beneficiary last name. On the same line as the beneficiary's name, you will find the Medicare ID (in the MID field) and internal control number (ICN), also referred to as a claim control number. The ICN will be different for every claim. These numbers are important when calling or writing regarding a claim.

Special attention should be made to the claim remarks and ANSI codes. The claim remarks are listed at the end of the first line in the MOA field and an explanation of each code can be found at the bottom of the RA. The ANSI codes are listed at the end of each line item, prefaced by a group code (CO, PR or OA). Explanations for the ANSI code and the group code will be listed at the bottom of the RA. The codes will explain the basis for payment, reason(s) for denial, and other pertinent claim information.

When you look at an RA, do not just look at the "PAY PROV" column. The other information given is very important in helping you understand the way a claim was processed. As an example, the "PAY PROV" column may show "00." This does not mean the claim was denied. There may have been approved charges that were applied to the beneficiary's deductible, resulting in no payment.

RAs are also available as an electronic data file. This type of remittance is referred to as an Electronic Remittance Advice (ERA). See Chapter 8 of this manual for information about ERAs.

### **4. Biller Purged Claim Report**

The Biller Purged Claim Report(s) represents a claim which has been deleted from our system due to an error(s) on the claim.

In most cases, the report has an error message in the bottom left-hand corner of the printout. For each claim contained within the report, you must verify all information on the claim, make any necessary changes, and submit a new claim. Please do not return the Biller Purged Claim Reports to the DME MAC. If you discover the errors were caused by your software, you must contact your software vendor or programmer for assistance.

The most common error messages fall into two categories: Beneficiary Information or Provider Information.

#### **Beneficiary Information:**

Most of the errors in this category occur when the beneficiary information (name, Medicare number, sex, etc.) submitted on the claim does not match the information we have on file for that beneficiary and/or that Medicare number. The beneficiary's name and Medicare number must be submitted on the claim exactly as they appear on the beneficiary's Medicare card. Do not use nicknames,

abbreviations or middle names unless included on the Medicare card. It is recommended that you maintain in your records a copy of the beneficiary's Medicare card for verification purposes. If the information submitted on the claim exactly matches the beneficiary's Medicare card, contact the Jurisdiction B DME MAC by calling 1.866.590.6727 for further assistance.

Beneficiary information errors include:

0001 - HICN SUFFIX, SEX - The suffix used for the Medicare number does not match the sex indicated for this beneficiary, or an incorrect Medicare number was submitted.

0007 - BENE REC CLOSED - The master record for this Medicare number was closed because a previous claim was submitted with inappropriate patient information.

0047 - NAME-KEY MISMATCH - The beneficiary's name on the claim does not match the name on file for this Medicare number.

0049 - SEX-KEY MISMATCH - The sex indicated on the claim does not match the sex on file for this Medicare number.

0058 - RESPONSE REVIEW - An incorrect Medicare number was submitted for the beneficiary.

**Provider information:**

4076 – PROV NOT FOUND – The claim could not be processed due to an issue with your National Provider Identifier (NPI). This edit typically indicates a problem with your NPI as it relates to the supplier number assigned by the National Supplier Clearinghouse. You must correct your information with the National Plan and Provider Enumeration System (NPPES) and/or the National Provider Enrollment (NPE) contractor before submitting a new claim.

**Remember**—DO NOT return Biller Purged Claim Reports. Changes must be submitted as a new claim.

## 5. ANSI Codes

CMS Manual System, Pub. 100-04, *Medicare Claims Processing Manual*, Chapter 22, §60

ANSI (American National Standard Institute) codes are used to explain the adjudication of a claim. The following information describes the types of codes that will appear on your RA.

**Claim Adjustment Reason Codes** are codes developed for use by all healthcare payers. Consequently, these codes have generic messages and a number of them do not apply to Medicare. A complete list of these codes can be found at <https://x12.org/codes>.

**Remittance Advice Remark Codes** give further explanation to reason codes. Remark codes are maintained by CMS. A complete list of remark codes can be found at <https://x12.org/codes>.

The definitions of the reason and remark codes which appear on an RA can be found at the bottom of the RA.

When you receive a claim denial, the reason and remark codes will help you to determine the problem. CGS has developed a Claim Denial Resolution Tool to assist you with common denials. The Claim Denial Resolution Tool is available on our web site at [https://www.cgsmedicare.com/medicare\\_dynamic/jb/claim\\_denial\\_resolution\\_tool/search.aspx](https://www.cgsmedicare.com/medicare_dynamic/jb/claim_denial_resolution_tool/search.aspx).



**Group Codes**, which are provided with all reason code(s), establish financial liability for the amount of the adjustment or to identify a post-initial-adjudication adjustment. Group codes are not used with Medicare REF or MIA/MOA remarks code entries. The following chart contains definitions of the group codes used by the DME MAC.

|           |   |
|-----------|---|
| <b>PR</b> | <p>Patient responsibility. This signifies the amount that may be billed to the beneficiary or to another payer on the beneficiary's behalf. For example, PR would be used with the reason code for:</p> <ul style="list-style-type: none"><li>• Patient's deductible or coinsurance,</li><li>• The patient assumed financial responsibility for a service not considered reasonable and necessary,</li><li>• Cost of therapy or psychiatric services after the coverage limit had been reached,</li><li>• A charge denied as a result of the patient's failure to supply primary payer or other information,</li><li>• Where a patient is responsible for payment of excess non-assigned physician charges.</li></ul> <p><b>Charges that have not been paid by Medicare and/or are not included in a PR group are:</b></p> <ul style="list-style-type: none"><li>• Late filing penalty (reason code B4),</li><li>• Excess charges on an assigned claim (reason code 42),</li><li>• Excess charges attributable to rebundled services (reason code B15),</li><li>• Charges denied as a result of the failure to submit necessary information by a provider who accepts assignment,</li><li>• Services that are not reasonable and necessary for care (reason code 50 or 57) for which there are no indemnification agreements are the liability of the provider.</li></ul> <p><b>Providers may be subject to penalties if they bill a patient for charges not identified with the PR group code.</b></p> |
| <b>CO</b> | <p>Contractual obligations. This includes any amounts for which the provider is financially liable, such as:</p> <ul style="list-style-type: none"><li>• Participation agreement violations,</li><li>• Assignment amount violations,</li><li>• Excess charges by a managed care plan provider,</li><li>• Late filing penalties,</li><li>• Gramm-Rudman reductions,</li><li>• Medical necessity denials/reductions.</li></ul> <p><b>The patient may not be billed for these amounts.</b></p>   |
| <b>OA</b> | <p>Other adjustment. This would only be used if neither PR nor CO applied. At least one PR, CO or OA group must appear on each remittance advice. For example, OA would be used when a claim is paid in full at initial adjudication with reason code 93 and a zero amount. Neither the patient nor the provider can be held responsible for any amount classified as an OA adjustment</p>  |

**Acronyms and Abbreviations**

|             |   |
|-------------|---|
| <b>AARP</b> | American Association of Retired Persons         |
| <b>ABG</b>  | Arterial Blood Gas                              |
| <b>ABN</b>  | Advance Beneficiary Notice                      |
| <b>ACA</b>  | Affordable Care Act                             |
| <b>ADMC</b> | Advance Determination of Medicare Coverage      |
| <b>ADS</b>  | Automated Development Letter                    |
| <b>ADR</b>  | Additional Documentation Request                |
| <b>ALJ</b>  | Administrative Law Judge                        |
| <b>AMA</b>  | American Medical Association                    |
| <b>ANSI</b> | American National Standard Institute            |
| <b>ASCA</b> | Administrative Simplification Compliance Act    |
| <b>AWP</b>  | Average Wholesale Pricing                       |
| <b>BBA</b>  | Balanced Budget Act                             |
| <b>BCRC</b> | Benefits Coordination & Recovery Center         |
| <b>BIPA</b> | Benefits Improvement and Protection Act of 2000 |
| <b>CBA</b>  | Competitive Bidding Area                        |
| <b>CBIC</b> | Competitive Bidding Implementation Contractor   |
| <b>CCN</b>  | Claim Control Number                            |
| <b>CEDI</b> | Common Electronic Data Interchange              |
| <b>CERT</b> | Comprehensive Error Rate Testing                |
| <b>CFR</b>  | Code of Federal Regulations                     |
| <b>CMN</b>  | Certificate of Medical Necessity                |
| <b>CMR</b>  | Comprehensive Medical Review                    |
| <b>CMS</b>  | Centers for Medicare and Medicaid Services      |

|                |   |
|----------------|---|
| <b>CNS</b>     | Clinical Nurse Specialist                                       |
| <b>COB</b>     | Coordination of Benefits  |
| <b>CPAP</b>    | Continuous Positive Airway Pressure                             |
| <b>CPI</b>     | Consumer Price Index  |
| <b>CSI</b>     | Claim Status Inquiry  |
| <b>CSR</b>     | Customer Service Representative                                 |
| <b>CSS</b>     | Chronic Stable State  |
| <b>CWF</b>     | Common Working File   |
| <b>DCN</b>     | Document Control Number   |
| <b>DHHS</b>    | Department of Health and Human Services                         |
| <b>DIF</b>     | DME MAC Information Form  |
| <b>DME</b>     | Durable Medical Equipment                                       |
| <b>DME MAC</b> | Durable Medical Equipment Medicare Administrative Contractor    |
| <b>DMEPOS</b>  | Durable Medical Equipment, Prosthetics, Orthotics, and Supplies |
| <b>DO</b>      | Doctor of Osteopathy  |
| <b>DOJ</b>     | Department of Justice   |
| <b>DOS</b>     | Date of Service   |
| <b>DPM</b>     | Doctor of Podiatric Medicine                                    |
| <b>DRA</b>     | Deficit Reduction Act of 2005                                   |
| <b>EDI</b>     | Electronic Data Interchange                                     |
| <b>EFT</b>     | Electronic Funds Transfer                                       |
| <b>e.g.</b>    | For example   |
| <b>EGHP</b>    | Employer Group Health Plan                                      |
| <b>EIN</b>     | Employer Identification Number                                  |
| <b>EMC</b>     | Electronic Media Claims   |
| <b>EOB</b>     | Explanation of Benefits   |
| <b>EOMB</b>    | Explanation of Medicare Benefits                                |

|                |   |
|----------------|---|
| <b>ERL</b>     | Electronic Receipt Listing                          |
| <b>ERA</b>     | Electronic Remittance Advice                        |
| <b>esMD</b>    | Electronic Submission of Medical Documentation      |
| <b>ESRD</b>    | End Stage Renal Disease                             |
| <b>FCN</b>     | Financial Control Number                            |
| <b>FDA</b>     | Food and Drug Administration                        |
| <b>Fed Reg</b> | Federal Register                                    |
| <b>FFS</b>     | Fee-for-Service                                     |
| <b>FOIA</b>    | Freedom of Information Act                          |
| <b>FTF</b>     | Face To Face  |
| <b>GHP</b>     | Group Health Plan                                   |
| <b>HCPCS</b>   | Healthcare Common Procedure Coding System           |
| <b>HHA</b>     | Home Health Agency                                  |
| <b>HHS</b>     | Health and Human Services                           |
| <b>HICN</b>    | Health Insurance Claim Number                       |
| <b>HIPAA</b>   | Health Insurance Portability and Accountability Act |
| <b>HME</b>     | Home Medical Equipment                              |
| <b>HMO</b>     | Health Maintenance Organization                     |
| <b>HO</b>      | Hearing Officer                                     |
| <b>IIC</b>     | Inflation-Indexed Charge                            |
| <b>IOL</b>     | Intraocular lens                                    |
| <b>IPPB</b>    | Intermittent Positive Pressure Breathing            |
| <b>IRP</b>     | Inexpensive or Other Routinely Purchased            |
| <b>IV</b>      | Intravenous   |
| <b>IVR</b>     | Interactive Voice Response                          |
| <b>LCD</b>     | Local Coverage Determination                        |
| <b>LCL</b>     | Lowest Charge Level                                 |
| <b>LGHP</b>    | Large Group Health Plan                             |
| <b>LSO</b>     | Lumbar Sacral Orthosis                              |

|                |   |
|----------------|---|
| <b>MAC</b>     | Medicare Administrative Contractor            |
| <b>MBI</b>     | Medicare Beneficiary Identifier               |
| <b>MD</b>      | Medical Director                              |
| <b>MEDPARD</b> | Medicare Participating Suppliers Directory    |
| <b>MHO</b>     | Medicare Hearing Officer                      |
| <b>MMA</b>     | Medicare Modernization Act (of 1999)          |
| <b>MS</b>      | Maintenance and Servicing                     |
| <b>MSE</b>     | Metropolitan Statistical Area                 |
| <b>MSN</b>     | Medicare Summary Notice                       |
| <b>MSP</b>     | Medicare Secondary Payer                      |
| <b>NCD</b>     | National Coverage Determination               |
| <b>NDC</b>     | National Drug Code                            |
| <b>NOC</b>     | Not Otherwise Classified                      |
| <b>NP</b>      | Nurse Practitioner                            |
| <b>NPE</b>     | National Provider Enrollment                  |
| <b>NPI</b>     | National Provider Identifier                  |
| <b>NPPES</b>   | National Plan and Provider Enumeration System |
| <b>NSC</b>     | National Supplier Clearinghouse               |
| <b>NSF</b>     | National Standard Format                      |
| <b>OBRA</b>    | Omnibus Budget Reconciliation Act             |
| <b>OCNA</b>    | Other Carrier Name/Address                    |
| <b>OIG</b>     | Office of the Inspector General               |
| <b>OMB</b>     | Office of Management and Budget               |
| <b>OMHA</b>    | Office of Medicare Hearings and Appeals       |
| <b>PA</b>      | Policy Article, also Physician Assistant      |
| <b>PAR</b>     | Prior Authorization Request                   |
| <b>PCA</b>     | Progressive Corrective Action                 |
| <b>PDAC</b>    | Pricing, Data Analysis and Coding             |

|                    |  |
|--------------------|--|
| <b>PIM</b>         | Program Integrity Manual   |
| <b>PM</b>          | Program Memorandum   |
| <b>PMD</b>         | Power Mobility Device  |
| <b>POD</b>         | Proof of Delivery  |
| <b>POE</b>         | Provider Outreach and Education  |
| <b>PPS</b>         | Payment Prospective System   |
| <b>PSC</b>         | Program Safeguard Contractor   |
| <b>PTAN</b>        | Provider Transaction Access Number   |
| <b>PWK</b>         | Paperwork  |
| <b>QIC</b>         | Qualified Independent Contractor   |
| <b>RA</b>          | Remittance Advice  |
| <b>RAC (or RA)</b> | Recovery Audit Contractor (now called Recovery Auditor)                    |
| <b>RESNA</b>       | Rehabilitation Engineering & Assistive Technology Society of North America |
| <b>RRB</b>         | Railroad Retirement Board  |
| <b>SACU</b>        | Supplier Audit and Compliance Unit   |
| <b>SLM</b>         | Seat Lift Mechanism  |
| <b>SMRC</b>        | Supplemental Medical Review Contractor                                     |
| <b>SNF</b>         | Skilled Nursing Facility   |
| <b>SSA</b>         | Social Security Administration   |
| <b>SWO</b>         | Standard Written Order   |
| <b>TENS</b>        | Transcutaneous Electrical Nerve Stimulator                                 |
| <b>TIN</b>         | Tax Identification Number  |
| <b>TLSO</b>        | Thoracic-Lumbar-Sacral Orthosis  |
| <b>TPE</b>         | Targeted Probe and Educate   |
| <b>UMWA</b>        | United Mine Workers Association  |
| <b>UPIC</b>        | Unified Program Integrity Contractors                                      |
| <b>UPIN</b>        | Unique Physicians Identification Number                                    |

|             |                                   |
|-------------|-----------------------------------|
| <b>USC</b>  | United States Code                |
| <b>VA</b>   | Veteran's Administration          |
| <b>WC</b>   | Workers' Compensation             |
| <b>WOPD</b> | Written Order Prior to Delivery   |
| <b>ZPIC</b> | Zone Program Integrity Contractor |

## Level II HCPCS Codes

The following is a list of Level II HCPCS codes. The list includes the code descriptions, payment category (also known as “fee schedule category”—see Chapter 5 of this manual for information), and DME MAC Certificate of Medical Necessity (CMN) or DME MAC Information Form (DIF) number required where applicable. The appearance of a code below does not necessarily indicate that the item is covered by Medicare.

Although a CMN may not be required for certain supplies, a CMN may be required for the related piece of equipment. Please refer to the Documentation Requirements in the appropriate Local Coverage Determination (LCD) for more information regarding CMN requirements.

***NOTE: Effective with dates of service on or after January 1, 2023, CMNs/DIFs are no longer required to be submitted for HCPCS that require a CMN. Current CMN/DIF processing will remain for all CMNs that have an initial date before January 1, 2023, and will continue for the life of the CMN/DIF.***

Use the following hyperlinks for easy navigation to each HCPCS section:

[HCPCS A Codes](#)

[HCPCS B Codes](#)

[HCPCS E Codes](#)

[HCPCS G Codes](#)

[HCPCS J Codes](#)

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[HCPCS L Codes](#)

[HCPCS Q Codes](#)

[HCPCS V Codes](#)

**HCPCS A**

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The following chart contains definitions of the category numbers listed with the HCPCS codes below.

| Payment Category |                               |    |  |
|------------------|-------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits   |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps               |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs                |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                     |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                               |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified               |
|                  |                               | 15 | Nebulizer Drugs                        |
|                  |                               | 16 | Therapeutic Shoes for Diabetics        |
|                  |                               | 17 | Individual Consideration               |
|                  |                               | 18 | Epoetin (EPO)                          |
|                  |                               | 19 | Dialysis Supplies & Equipment          |
|                  |                               | 20 | Oral Antiemetic Drugs                  |
|                  |                               | 21 | Value Not Established                  |
|                  |                               | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| A4206 | Syringe with needle, sterile, 1 cc or less, (Updated Description 1/1/2008)       |          |                  |
| A4207 | Syringe with needle, sterile 2 cc, each  |          |                  |
| A4208 | Syringe with needle, sterile 3 cc, each  |          |                  |
| A4209 | Syringe with needle, sterile 5 cc or greater, each                               |          |                  |
| A4210 | Needle-free injection device, each   |          |                  |
| A4211 | Supplies for self-administered injections  |          |                  |
| A4212 | Non-coring needle or stylet with or without catheter                             |          |                  |
| A4213 | Syringe, sterile, 20 cc or greater, each (not valid for Medicare)                |          |                  |
| A4215 | Needle, Sterile, any size, each  |          |                  |
| A4216 | Sterile water, saline and/or dextrose, diluent/flush, 10 ml (Eff. date 1/1/2004) | 13       |                  |
| A4217 | Sterile water/saline 500 ml (Eff. Date 1/1/2004)                                 | 13       |                  |
| A4218 | Sterile saline or water, meter dose dispenser, 10 ml (Eff. Date 1/1/2006)        | 15       |                  |
| A4220 | Refill kit for implantable infusion pump   |          |                  |

|       |   |    |  |
|-------|---|----|--|
| A4221 | Supplies for maintenance of non-insulin drug infusion catheter, per week (list drugs separately) (Updated description 1/1/2017)   | 13 |  |
| A4222 | Infusion supplies for external drug infusion pump, per cassette or bag (list drugs separately)  | 13 |  |
| A4223 | Infusion supplies not used with external infusion pump, per cassette or bag (list drugs separately) (Eff. Date 1/1/2005)  |    |  |
| A4224 | Supplies for maintenance of insulin infusion catheter, per week (Eff. Date 1/1/2017)  | 13 |  |
| A4225 | Supplies for external insulin infusion pump, syringe type cartridge, sterile, each (Eff. Date 1/1/2017)   | 13 |  |
| A4226 | Supplies for maintenance of insulin infusion pump with dosage rate adjustment using therapeutic continuous glucose sensing, per week (Eff. Date 1/1/2020) (Deleted eff. 09/14/2020)                   | 21 |  |
| A4230 | Infusion set for external insulin pump, non needle cannula type (not valid for Medicare as of 1/1/2000)   | 13 |  |
| A4231 | Infusion set for external insulin pump, needle type (not valid for Medicare as of 1/1/2000)   | 13 |  |
| A4233 | Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each (Eff. Date 1/1/2006)  | 05 |  |
| A4234 | Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each (Eff. Date 1/1/2006)  | 05 |  |
| A4235 | Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each (Eff. Date 1/1/2006)   | 05 |  |
| A4236 | Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each (Eff. Date 1/1/2006)  | 05 |  |
| A4238 | Supply allowance for adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service (Eff. Date 04/01/2022, Revised 01/01/2023) | 13 |  |
| A4239 | Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (cgm), includes all supplies and accessories, 1 month supply = 1 unit of service (Eff. Date 01/01/2023)                 | 13 |  |
| A4244 | Alcohol or peroxide, per pint   | 13 |  |
| A4245 | Alcohol wipes, per box  |    |  |
| A4246 | Betadine or phisohex solution, per pint   |    |  |
| A4247 | Betadine or iodine swabs/wipes, per box   |    |  |

|       |   |    |
|-------|---|----|
| A4248 | Chlorhexidine containing antiseptic, 1 ml (Eff. Date 1/1/2004)  | 19 |
| A4250 | Urine test or reagent strips or tablets (100 tablets or strips)   |    |
| A4252 | Blood ketone test or reagent strip, each (Eff. Date 1/1/2008)   |    |
| A4253 | Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips  | 05 |
| A4255 | Platforms for home blood glucose monitor, 50 per box  | 13 |
| A4256 | Normal, low and high calibrator solution/chips  | 13 |
| A4257 | Replacement lens shield cartridge for use with laser skin piercing device, each (Eff. Date 1/1/2002)  | 13 |
| A4258 | Spring-powered device for lancet, each  | 13 |
| A4259 | Lancets, per box of 100   | 05 |
| A4261 | Cervical cap for contraceptive use  |    |
| A4262 | Temporary, absorbable lacrimal duct implant, each   |    |
| A4263 | Permanent, long term, non-dissolvable lacrimal duct implant, each   |    |
| A4265 | Paraffin, per pound   | 13 |
| A4270 | Disposable endoscope sheath, each   |    |
| A4271 | Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per month (Eff. Date 04/01/2024) Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests (Revised eff. 10/01/2024) |    |
| A4280 | Adhesive skin support attachment for use with external breast prosthesis, each implantable access catheter (venous, arterial, epidural or peritoneal), external access, (Eff. Date 1/1/2000)  | 04 |
| A4281 | Tubing for breast pump, replacement. (Eff. Date 01/01/2007)   |    |
| A4282 | Adapter for breast pump, replacement (Eff. Date 01/01/2007)   |    |
| A4283 | Cap for breast pump bottle, replacement (Eff. Date 01/01/2007)  |    |
| A4284 | Breast shield and splash protector for use with breast pump, replacement (Eff. Date 01/01/2007)   |    |
| A4285 | Polycarbonate bottle for use with breast pump, replacement (Eff. Date 01/01/2007)   |    |
| A4286 | Locking ring for breast pump, replacement (Eff. Date 01/01/2007)  |    |
| A4287 | Disposable collection and storage bag for breast milk, any size, any type, each (Eff. Date 01/01/2024)  |    |
| A4305 | Disposable drug delivery system, flow rate of 50 ml or greater per hour   |    |



|       |  |    |  |
|-------|--|----|--|
| A4306 | Disposable drug delivery system, flow rate less than 50 ml per hour  |    |  |
| A4310 | Insertion tray without drainage bag and without catheter (accessories only)  | 11 |  |
| A4311 | Insertion tray without drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.) | 11 |  |
| A4312 | Insertion tray without drainage bag with indwelling catheter, foley type, two-way, all silicone  | 11 |  |
| A4313 | Insertion tray without drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation   | 11 |  |
| A4314 | Insertion tray with drainage bag with indwelling catheter, foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)    | 11 |  |
| A4315 | Insertion tray with drainage bag with indwelling catheter, foley type, two-way, all silicone   | 11 |  |
| A4316 | Insertion tray with drainage bag with indwelling catheter, foley type, three-way, for continuous irrigation  | 11 |  |
| A4320 | Irrigation tray with bulb or piston syringe, any purpose   | 11 |  |
| A4321 | Therapeutic agent for urinary catheter irrigation  | 11 |  |
| A4322 | Irrigation syringe, bulb or piston, each   | 11 |  |
| A4326 | Male external catheter with integral collection chamber, any type, each  | 11 |  |
| A4327 | Female external urinary collection device; metal cup, each   | 11 |  |
| A4328 | Female external urinary collection device; pouch, each   | 11 |  |
| A4330 | Perianal fecal collection pouch with adhesive, each  | 11 |  |
| A4331 | Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each (Eff. Date 1/1/2001)               | 11 |  |
| A4332 | Lubricant, individual sterile packet, each (Eff. Date 1/1/2001)  | 11 |  |
| A4333 | Urinary catheter anchoring device, adhesive skin attachment, each (Eff. Date 1/1/2001)   | 11 |  |
| A4334 | Urinary catheter anchoring device, leg strap, each (Eff. Date 1/1/2001)  | 11 |  |
| A4335 | Incontinence supply; miscellaneous   | 14 |  |
| A4336 | Incontinence supply, urethral insert, any type, each (Eff. Date 1/1/2010)  | 11 |  |
| A4337 | Incontinence supply, rectal insert, any type, each   | 05 |  |

|       |   |    |
|-------|---|----|
| A4338 | Indwelling catheter; foley type, two-way latex with coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each                  | 11 |
| A4340 | Indwelling catheter; specialty type, (e.g., coude, mushroom, wing, etc.), each  | 11 |
| A4341 | Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each (Eff. Date 04/01/2023)                            | 11 |
| A4342 | Accessories for patient inserted indwelling intraurethral drainage device with valve, replacement only, each (Eff. Date 04/01/2023)             | 11 |
| A4344 | Indwelling catheter, foley type, two-way, all silicone or polyurethane, each (Revised 10/01/2023)   | 11 |
| A4346 | Indwelling catheter; foley type, three way for continuous irrigation, each  | 11 |
| A4349 | Male external catheter, with or without adhesive, disposable, each (Eff. Date 1/1/2005)   | 11 |
| A4351 | Intermittent urinary catheter; straight tip, with or without coating (teflon, silicone, silicone elastomer, or hydrophilic, etc.), each         | 11 |
| A4352 | Intermittent urinary catheter; coude (curved) tip, with or without coating (teflon, silicone, silicone elastomeric, or hydrophilic, etc.), each | 11 |
| A4353 | Intermittent urinary catheter, with insertion supplies  | 11 |
| A4354 | Insertion tray with drainage bag but without catheter   | 11 |
| A4355 | Irrigation tubing set for continuous bladder irrigation through a three-way indwelling foley catheter, each                                     | 11 |
| A4356 | External urethral clamp or compression device (not to be used for catheter clamp), each   | 11 |
| A4357 | Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each  | 11 |
| A4358 | Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each  | 11 |
| A4360 | Disposable external urethral clamp or compression device, with pad and /or pouch, each (Eff. Date 1/1/2010)                                     | 11 |
| A4361 | Ostomy faceplate, each  | 11 |
| A4362 | Skin barrier; solid, 4 x 4 or equivalent; each  | 11 |
| A4363 | Ostomy clamp, any type, replacement only, each (Eff. Date 1/1/2006)   | 11 |
| A4364 | Adhesive, liquid or equal, any type, per oz   | 11 |
| A4366 | Ostomy vent, any type, each (Eff. Date 1/1/2004)  | 11 |
| A4367 | Ostomy belt, each   | 11 |

|       |   |    |
|-------|---|----|
| A4368 | Ostomy filter, any type, each   | 11 |
| A4369 | Ostomy skin barrier, liquid (spray, brush, etc), per oz (Eff. Date 1/1/2000)  | 11 |
| A4371 | Ostomy skin barrier, powder, per oz (Eff. Date 1/1/2000)  | 11 |
| A4372 | Ostomy skin barrier, solid 4 x 4 or equivalent, standard wear, with built-in convexity, each (Eff. Date 1/1/2000)             | 11 |
| A4373 | Ostomy skin barrier, with flange (solid, flexible or accordion), with built-in convexity, any size, each (Eff. Date 1/1/2000) | 11 |
| A4375 | Ostomy pouch, drainable, with faceplate attached, plastic, each (Eff. Date 1/1/2000)  | 11 |
| A4376 | Ostomy pouch, drainable, with faceplate attached, rubber, each (Eff. Date 1/1/2000)   | 11 |
| A4377 | Ostomy pouch, drainable, for use on faceplate, plastic, each (Eff. Date 1/1/2000)   | 11 |
| A4378 | Ostomy pouch, drainable, for use on faceplate, rubber, each (Eff. Date 1/1/2000)  | 11 |
| A4379 | Ostomy pouch, urinary, with faceplate attached, plastic, each (Eff. Date 1/1/2000)  | 11 |
| A4380 | Ostomy pouch, urinary, with faceplate attached, rubber, each (Eff. Date 1/1/2000)   | 11 |
| A4381 | Ostomy pouch, urinary, for use on faceplate, plastic, each (Eff. Date 1/1/2000)   | 11 |
| A4382 | Ostomy pouch, urinary, for use on faceplate, heavy plastic, each (Eff. Date 1/1/2000)   | 11 |
| A4383 | Ostomy pouch, urinary, for use on faceplate, rubber, each (Eff. Date 1/1/2000)  | 11 |
| A4384 | Ostomy faceplate equivalent, silicone ring, each (Eff. Date 1/1/2000)   | 11 |
| A4385 | Ostomy skin barrier, solid 4 x 4 or equivalent, extended wear, without built-in convexity, each (Eff. Date 1/1/2000)          | 11 |
| A4387 | Ostomy pouch closed, with barrier attached, with built-in convexity (1 piece), each (Eff. Date 1/1/2000)                      | 11 |
| A4388 | Ostomy pouch, drainable, with extended wear barrier attached, (1 piece) (Eff. Date 1/1/2000)                                  | 11 |
| A4389 | Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each (Eff. Date 1/1/2000)                  | 11 |
| A4390 | Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each (Eff. Date 1/1/2000)    | 11 |

|       |  |    |
|-------|--|----|
| A4391 | Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each (Eff. Date 1/1/2000)   | 11 |
| A4392 | Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each (Eff. Date 1/1/2000)   | 11 |
| A4393 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each (Eff. Date 1/1/2000)   | 11 |
| A4394 | Ostomy deodorant, with or without lubricant, for use in ostomy pouch, per fluid ounce  | 11 |
| A4395 | Ostomy deodorant for use in ostomy pouch, solid, per tablet (Eff. Date 1/1/2000)   | 11 |
| A4396 | Ostomy belt with peristomal hernia support (Eff. Date 1/1/2001)  | 11 |
| A4397 | Irrigation supply; sleeve, each (Deleted eff. 12/31/2021)  | 11 |
| A4398 | Ostomy irrigation supply; bag, each  | 11 |
| A4399 | Ostomy irrigation supply; cone/catheter, with or without brush (Updated 01/01/2011)  | 11 |
| A4400 | Ostomy irrigation set (not valid for Medicare as of 9/30/1993)   | 11 |
| A4402 | Lubricant, per ounce   | 11 |
| A4404 | Ostomy ring, each  | 11 |
| A4405 | Ostomy skin barrier, non-pectin based, paste, per ounce (Eff. Date 1/1/2003)   | 04 |
| A4406 | Ostomy skin barrier, pectin based, paste, per ounce (Eff. Date 1/1/2003)   | 11 |
| A4407 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, 4 x 4 inches or smaller, each (Eff. Date 1/1/2003)     | 11 |
| A4408 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, with built-in convexity, larger than 4 x 4 inches, each (Eff. Date 1/1/2003)    | 11 |
| A4409 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, 4 x 4 inches or smaller, each (Eff. Date 1/1/2003)  | 11 |
| A4410 | Ostomy skin barrier, with flange (solid, flexible, or accordion), extended wear, without built-in convexity, larger than 4 x 4 inches, each (Eff. Date 1/1/2003) | 11 |
| A4411 | Ostomy skin barrier, solid 4 x4 or equivalent, extended wear, with built-in convexity, each (Eff. Date 1/1/2006)   | 11 |
| A4412 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), without filter, each (Eff. Date 1/1/2006)                               | 11 |

|       |   |    |
|-------|---|----|
| A4413 | Ostomy pouch, drainable, high output, for use on a barrier with flange (2 piece system), with filter, each (Eff. Date 1/1/2003)                           | 11 |
| A4414 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, 4 x 4 inches or smaller, each (Eff. Date 1/1/2003)          | 11 |
| A4415 | Ostomy skin barrier, with flange (solid, flexible, or accordion), without built-in convexity, larger than 4 x 4 inches, each (Eff. Date 1/1/2003)         | 11 |
| A4416 | Ostomy pouch, closed, with barrier attached, with filter (1 piece), each (Eff. Date 1/1/2004)   | 11 |
| A4417 | Ostomy pouch, closed, with barrier attached, with built-in convexity, with filter (1 piece), each (Eff. Date 1/1/2004)                                    | 11 |
| A4418 | Ostomy pouch, closed; without barrier attached, with filter (1 piece), each (Eff. Date 1/1/2004)  | 11 |
| A4419 | Ostomy pouch, closed; for use on barrier with non-locking flange, with filter (2 piece), each (Eff. Date 1/1/2004)  | 11 |
| A4420 | Ostomy pouch, closed; for use on barrier with locking flange (2 piece), each (Eff. Date 1/1/2004)   | 11 |
| A4421 | Ostomy supply; miscellaneous  | 14 |
| A4422 | Ostomy absorbent material (sheet/pad/crystal packet) for use in ostomy pouch to thicken liquid stomal output, each (Eff. Date 1/1/2003)                   | 11 |
| A4423 | Ostomy pouch, closed; for use on barrier with locking flange, with filter (2 piece), each (Eff. Date 1/1/2004)  | 11 |
| A4424 | Ostomy pouch, drainable, with barrier attached, with filter (1 piece), each (Eff. Date 1/1/2004)  | 11 |
| A4425 | Ostomy pouch, drainable; for use on barrier with non-locking flange, with filter (2 piece system), each (Eff. Date 1/1/2004)                              | 11 |
| A4426 | Ostomy pouch, drainable; for use on barrier with locking flange (2 piece system), each (Eff. Date 1/1/2004)   | 11 |
| A4427 | Ostomy pouch, drainable; for use on barrier with locking flange, with filter (2 piece system), each (Eff. Date 1/1/2004)                                  | 11 |
| A4428 | Ostomy pouch, urinary, with extended wear barrier attached, with faucet-type tap with valve (1 piece), each (Eff. Date 1/1/2004)                          | 11 |
| A4429 | Ostomy pouch, urinary, with barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each (Eff. Date 1/1/2004)               | 11 |
| A4430 | Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity, with faucet-type tap with valve (1 piece), each (Eff. Date 1/1/2004) | 11 |
| A4431 | Ostomy pouch, urinary; with barrier attached, with faucet-type tap with valve (1 piece), each (Eff. Date 1/1/2004)  | 11 |

|       |  |    |  |
|-------|--|----|--|
| A4432 | Ostomy pouch, urinary; for use on barrier with non locking flange, with faucet-type tap with valve (2 piece), each (Eff. Date 1/1/2004)        | 11 |  |
| A4433 | Ostomy pouch, urinary; for use on barrier with locking flange (2 piece), each (Eff. Date 1/1/2004)   | 11 |  |
| A4434 | Ostomy pouch, urinary; for use on barrier with locking flange, with faucet-type tap with valve (2 piece), each (Eff. Date 1/1/2004)            | 11 |  |
| A4435 | Ostomy pouch, drainable, high output, with extended wear barrier (one-piece system), with or without filter, each (Eff. Date 01/01/2013)       | 11 |  |
| A4436 | Irrigation supply; sleeve, reusable, per month (Eff. Date 01/01/2022)  |    |  |
| A4437 | Irrigation supply; sleeve, disposable, per month (Eff. Date 01/01/2022)  |    |  |
| A4450 | Tape, non-waterproof, per 18 square inches (Eff. Date 1/1/2003)  | 11 |  |
| A4452 | Tape, waterproof, per 18 square inches (Eff. Date 1/1/2003)  | 11 |  |
| A4453 | Rectal catheter for use with the manual pump-operated enema system, replacement only (Eff. Date 10/1/2021)                                     |    |  |
| A4455 | Adhesive remover or solvent (for tape, cement or other adhesive), per ounce  | 11 |  |
| A4456 | Adhesive remover, wipes, any type, each (Eff. Date 1/1/2010)   | 11 |  |
| A4457 | Enema tube, with or without adapter, any type, replacement only, each (Eff. Date 01/01/2024)   |    |  |
| A4458 | Enema bag with tubing, reusable (Eff. Date 1/1/2003)   | 11 |  |
| A4459 | Manual pump-operated enema system, includes balloon, catheter and all accessories, reusable, any type (Eff. Date 01/01/2015)                   | 11 |  |
| A4461 | Surgical dressing holder, non-reusable, each (Eff. date 1/1/2007)  | 12 |  |
| A4463 | Surgical dressing holder, reusable, each (Eff. date 1/1/2007)  | 12 |  |
| A4465 | Non-elastic binder for extremity   |    |  |
| A4466 | Garment belt, sleeve or other covering, elastic or similar stretchable material, any type, each (Effective 1/1/2010) (Deleted eff. 12/31/2016) |    |  |
| A4467 | Belt, strap, sleeve, garment, or covering, any type (Eff. Date 1/1/2017)   |    |  |
| A4468 | Exsufflation belt, includes all supplies and accessories (Eff. Date 01/01/2024)  |    |  |
| A4481 | Tracheostoma filter, any type, any size, each  | 11 |  |
| A4483 | Moisture exchanger, disposable, for use with invasive mechanical ventilation   | 11 |  |

|       |  |    |  |
|-------|--|----|--|
| A4490 | Surgical stockings above knee length, each   |    |  |
| A4495 | Surgical stockings thigh length, each  |    |  |
| A4500 | Surgical stockings below knee length, each   |    |  |
| A4510 | Surgical stockings full length, each   |    |  |
| A4520 | Incontinence Garment, any type, (e.g., brief, diaper), each (Eff. Date 1/1/2005)   |    |  |
| A4540 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm (Eff. Date 01/01/2024)                              |    |  |
| A4541 | Monthly supplies for use of device coded at e0733 (Eff. Date 01/01/2024)   | 13 |  |
| A4542 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist (Eff. Date 01/01/2024)                      | 13 |  |
| A4543 | Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month (Eff. Date 10/01/2024)                        |    |  |
| A4544 | Electrode for external lower extremity nerve stimulator for restless legs syndrome (Eff. Date 10/01/2024)  |    |  |
| A4545 | Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month (Eff. Date 10/01/2024) |    |  |
| A4553 | Non-disposable underpads, all sizes (Eff. Date 1/1/2017)   |    |  |
| A4554 | Disposable underpads, all sizes  |    |  |
| A4555 | Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only (Eff. Date 01/01/2014)                   | 13 |  |
| A4556 | Electrodes, (e.g., apnea monitor), per pair (not valid for Medicare as of 11/1/1996)   | 13 |  |
| A4557 | Lead wires, (e.g., apnea monitor), per pair  | 13 |  |
| A4558 | Conductive paste or gel (not valid for Medicare as of 11/1/1996)   | 13 |  |
| A4559 | Coupling gel or paste, for use with ultrasound device, per oz (Eff. date 1/1/2007)   |    |  |
| A4560 | Neuromuscular electrical stimulator (nmes), disposable, replacement only (Eff. Date 04/01/2023)  |    |  |
| A4575 | Topical hyperbaric oxygen chamber, disposable  |    |  |
| A4593 | Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, controller (Eff. Date 04/01/2024)                                       |    |  |
| A4594 | Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each (Eff. Date 04/01/2024)                                  |    |  |

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| A4595 | Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)   | 5  |
| A4596 | Cranial electrotherapy stimulation (ces) system supplies and accessories, per month (Eff. Date 10/01/2022)      | 13 |
| A4600 | Sleeve for intermittent limb compression device, replacement only, each   | 05 |
| A4601 | Lithium ion battery, rechargeable, for non-prosthetic use, replacement (Updated 01/01/2015)                     | 05 |
| A4602 | Replacement battery for external infusion pump owned by patient, lithium, 1.5 volt, each                        | 05 |
| A4604 | Tubing with integrated heating element for use with positive airway pressure device (Eff. Date 1/1/2006)        | 05 |
| A4605 | Tracheal suction catheter, closed system, each (Eff. Date 1/1/2005)   | 05 |
| A4606 | Oxygen probe for use with oximeter device, replacement (Eff. Date 1/1/2003)                                     | 17 |
| A4608 | Transtracheal oxygen catheter, each (Eff. Date 1/1/2001)  |    |
| A4611 | Battery, heavy duty; replacement for patient owned ventilator   | 05 |
| A4612 | Battery cables; replacement for patient-owned ventilator  | 05 |
| A4613 | Battery charger; replacement for patient-owned ventilator   | 05 |
| A4614 | Peak expiratory flow rate meter, hand held  |    |
| A4615 | Cannula, nasal  |    |
| A4616 | Tubing (oxygen), per foot   |    |
| A4617 | Mouth piece   |    |
| A4618 | Breathing circuits  | 05 |
| A4619 | Face tent   | 05 |
| A4620 | Variable concentration mask   |    |
| A4623 | Tracheostomy, inner cannula   | 11 |
| A4624 | Tracheal suction catheter, any type other than closed system, each  | 05 |
| A4625 | Tracheostomy care kit for new tracheostomy  | 11 |
| A4626 | Tracheostomy cleaning brush, each   | 11 |
| A4627 | Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler                               |    |
| A4628 | Oropharyngeal suction catheter, each Oral and/or oropharyngeal suction catheter, each (Revised eff. 04/01/2023) | 05 |
| A4629 | Tracheostomy care kit for established tracheostomy  | 11 |



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| A4630 | Replacement, batteries, medically necessary, transcutaneous electrical stimulator, owned by patient (not valid for Medicare as of 11/1/1996) | 05 |
| A4633 | Replacement bulb/lamp for ultraviolet light therapy system, each (Eff. Date 1/1/2003)  | 05 |
| A4634 | Replacement bulb for therapeutic light box, tabletop model (Eff. Date 1/1/2003)  | 05 |
| A4635 | Underarm pad, crutch, replacement, each  | 05 |
| A4636 | Replacement, handgrip, cane, crutch, or walker, each   | 05 |
| A4637 | Replacement tip, cane, crutch, walker, each.   | 05 |
| A4638 | Replacement battery for patient-owned ear pulse generator, each (Eff. Date 1/1/2004)   | 13 |
| A4639 | Replacement pad for infrared heating pad system, each (Eff. Date 1/1/2003)   | 01 |
| A4640 | Replacement pad for use with medically necessary alternating pressure pad owned by patient   | 05 |
| A4649 | Surgical supply; miscellaneous   | 14 |
| A4651 | Calibrated microcapillary tube, each (Eff. Date 1/1/2002)  | 19 |
| A4652 | Microcapillary tube sealant (Eff. Date 1/1/2002)   | 19 |
| A4653 | Peritoneal dialysis catheter anchoring device, belt, each (Eff. Date 1/1/2003)   | 19 |
| A4657 | Syringe, with or without needle, each (Eff. Date 1/1/2002)   | 19 |
| A4660 | Sphygmomanometer/blood pressure apparatus with cuff and stethoscope  | 19 |
| A4663 | Blood pressure cuff only   | 19 |
| A4670 | Automatic blood pressure monitor   |    |
| A4671 | Disposable cycler set used with cycler dialysis machine, each (Eff. Date 1/1/2004)   | 19 |
| A4672 | Drainage extension line, sterile, for dialysis, each (Eff. Date 1/1/2004)  | 19 |
| A4673 | Extension line with easy lock connectors, used with dialysis (Eff. Date 1/1/2004)  | 19 |
| A4674 | Chemicals/antiseptics solution used to clean/sterilize dialysis equipment, per 8 ounces (Eff. Date 1/1/2004)                                 | 19 |
| A4680 | Activated carbon filter for hemodialysis, each   | 19 |
| A4690 | Dialyzer (artificial kidneys), all types, all sizes, for hemodialysis, each  | 19 |

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| A4706 | Bicarbonate concentrate, solution, for hemodialysis, per gallon (Eff. Date 1/1/2002)  | 19 |
| A4707 | Bicarbonate concentrate, powder, for hemodialysis, per packet (Eff. Date 1/1/2002)  | 19 |
| A4708 | Acetate concentrate solution, for hemodialysis, per gallon (Eff. Date 1/1/2002)   | 19 |
| A4709 | Acid concentrate, solution, for hemodialysis, per gallon (Eff. Date 1/1/2002)   | 19 |
| A4714 | Treated water (deionized, distilled, or reverse osmosis) for peritoneal dialysis, per gallon  | 19 |
| A4719 | Y set tubing for peritoneal dialysis (Eff. Date 1/1/2002)   | 19 |
| A4720 | Dialysate solution, any concentration of dextrose, fluid volume greater than 249 cc, but less than or equal to 999 cc, for peritoneal dialysis (Eff. Date 1/1/2002)   | 19 |
| A4721 | Dialysate solution, any concentration of dextrose, fluid volume greater than 999 cc, but less than or equal to 1999 cc, for peritoneal dialysis (Eff. Date 1/1/2002)  | 19 |
| A4722 | Dialysate solution, any concentration of dextrose, fluid volume greater than 1999 cc, but less than or equal to 2999 cc, for peritoneal dialysis (Eff. Date 1/1/2002) | 19 |
| A4723 | Dialysate solution, any concentration of dextrose, fluid volume greater than 2999 cc, but less than or equal to 3999 cc, for peritoneal dialysis (Eff. Date 1/1/2002) | 19 |
| A4724 | Dialysate solution, any concentration of dextrose, fluid volume greater than 3999 cc, but less than or equal to 4999 cc, for peritoneal dialysis (Eff. Date 1/1/2002) | 19 |
| A4725 | Dialysate solution, any concentration of dextrose, fluid volume greater than 4999 cc, but less than or equal to 5999 cc, for peritoneal dialysis (Eff. Date 1/1/2002) | 19 |
| A4726 | Dialysate solution, any concentration of dextrose, fluid volume greater than 5999 cc, for peritoneal dialysis (Eff. Date 1/1/2002)                                    | 19 |
| A4728 | Dialysate solution, non-dextrose containing, 500 ml (Eff. Date 1/1/2004)  | 19 |
| A4730 | Fistula cannulation set for hemodialysis, each  | 19 |
| A4736 | Topical anesthetic, for dialysis, per gram (Eff. Date 1/1/2002)   | 19 |
| A4737 | Injectable anesthetic, for dialysis, per 10 ml (Eff. Date 1/1/2002)   | 19 |
| A4740 | Shunt accessory, for hemodialysis, any type, each   | 19 |
| A4750 | Blood tubing, arterial or venous, for hemodialysis, each  | 19 |
| A4755 | Blood tubing, arterial and venous combined, for hemodialysis, each  | 19 |

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| A4760 | Dialysate solution test kit, for peritoneal dialysis, any type, each  | 19 |
| A4765 | Dialysate concentrate, powder, additive for peritoneal dialysis, per packet                                     | 19 |
| A4766 | Dialysate concentrate, solution, additive for peritoneal dialysis, per 10 ml (Eff. Date 1/1/2002)               | 19 |
| A4770 | Blood collection tube, vacuum, for dialysis, per 50   | 19 |
| A4771 | Serum clotting time tube, for dialysis, per 50  | 19 |
| A4772 | Blood glucose test strips, for dialysis, per 50   | 19 |
| A4773 | Occult blood test strips, for dialysis, per 50  | 19 |
| A4774 | Ammonia test strips, for dialysis, per 50   |    |
| A4802 | Protamine sulfate, for hemodialysis, per 50 mg (Eff. Date 1/1/2002)   | 19 |
| A4860 | Disposable catheter tips for peritoneal dialysis, per 10  | 19 |
| A4870 | Plumbing and/or electrical work for home hemodialysis equipment   | 19 |
| A4890 | Contracts, repair and maintenance, for hemodialysis equipment   |    |
| A4911 | Drain bag/bottle, for dialysis, each (Eff. Date 1/1/2002)   | 19 |
| A4913 | Miscellaneous dialysis supplies, not otherwise specified  | 19 |
| A4918 | Venous pressure clamp, for hemodialysis, each   | 19 |
| A4927 | Gloves, non-sterile, per 100  | 19 |
| A4928 | Surgical mask, per 20 (Eff. Date 1/1/2002)  | 19 |
| A4929 | Tourniquet for dialysis, each (Eff. Date 1/1/2002)  | 19 |
| A4930 | Gloves, sterile, per pair (Eff. Date 1/1/2003)  | 19 |
| A4931 | Oral thermometer, reusable, any type, each (Eff. Date 1/1/2003)   | 19 |
| A4932 | Rectal thermometer, reusable, any type, each (Eff. Date 1/1/2003)   | 17 |
| A5051 | Ostomy pouch, closed; with barrier attached (1 piece), each   | 11 |
| A5052 | Ostomy pouch, closed; without barrier attached (1 piece), each  | 11 |
| A5053 | Ostomy pouch, closed; for use on faceplate, each  | 11 |
| A5054 | Ostomy pouch, closed; for use on barrier with flange (2 piece), each  | 11 |
| A5055 | Stoma cap   | 11 |
| A5056 | Ostomy pouch, drainable, with extended wear barrier attached, with filter, (1 piece), each (Eff. Date 1/1/2012) | 11 |

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| A5057 | Ostomy pouch, drainable, with extended wear barrier attached, with built in convexity, with filter, (1 piece), each (Eff. Date 1/1/2012)  | 11 |
| A5061 | Pouch, drainable; with barrier attached (1 piece), each   | 11 |
| A5062 | Ostomy pouch, drainable; without barrier attached (1 piece), each   | 11 |
| A5063 | Ostomy pouch, drainable; for use on barrier with flange (2 piece system), each  | 11 |
| A5071 | Ostomy pouch, urinary; with barrier attached (1 piece), each  | 11 |
| A5072 | Ostomy pouch, urinary; without barrier attached (1 piece), each   | 11 |
| A5073 | Ostomy pouch, urinary; for use on barrier with flange (2 piece), each   | 11 |
| A5081 | Stoma plug or seal, any type (Revised 01/01/2014)   | 11 |
| A5082 | Continent device; catheter for continent stoma  | 11 |
| A5083 | Continent device, stoma absorptive cover for continent stoma (Eff. Date 1/1/2008)   | 11 |
| A5093 | Ostomy accessory; convex insert   | 11 |
| A5102 | Bedside drainage bottle with or without tubing, rigid or expandable, each   | 11 |
| A5105 | Urinary suspensory with leg bag, with or without tube, each (Updated Description 1/1/2008)  | 11 |
| A5112 | Urinary drainage bag, leg or abdomen, latex, with or without tube, with straps, each (Updated 01/01/2011)   | 11 |
| A5113 | Leg strap; latex, replacement only, per set   | 11 |
| A5114 | Leg strap; foam or fabric, replacement only, per set  | 11 |
| A5120 | Skin Barrier, wipes or swabs, each (Eff. Date 1/1/2006)   | 11 |
| A5121 | Skin barrier; solid, 6 x 6 or equivalent, each  | 11 |
| A5122 | Skin barrier; solid, 8 x 8 or equivalent, each  | 11 |
| A5126 | Adhesive or non-adhesive; disk or foam pad  | 11 |
| A5131 | Appliance cleaner, incontinence and ostomy appliances, per 16 oz.   | 11 |
| A5200 | Percutaneous catheter/tube anchoring device, adhesive skin attachment   | 11 |
| A5500 | For diabetics only, fitting (including follow-up), custom preparation and supply of off-the-shelf depth-inlay shoe manufactured to accommodate multi-density insert(s), per shoe. | 16 |
| A5501 | For diabetics only, fitting (including follow-up), custom preparation and supply of shoe molded from cast(s) of patient's foot (custom molded shoe), per shoe                     | 16 |

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| A5503 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with roller or rigid rocker bottom, per shoe   | 16 |
| A5504 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe  | 16 |
| A5505 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe  | 16 |
| A5506 | For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with off-set heel(s), per shoe   | 16 |
| A5507 | For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe  | 16 |
| A5508 | For diabetics only, deluxe feature of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe (Eff. Date 1/1/2000)   | 16 |
| A5510 | For diabetics only, direct formed, compression molded to patient's foot without external heat source, multiple-density insert(s) prefabricated, per shoe (Eff. Date 1/1/2002)   | 16 |
| A5512 | For diabetics only, multiple density insert, direct formed, molded to foot after external heat source of 230 degrees fahrenheit or higher, total contact with patient's foot, including arch, base layer minimum of 1/4 inch material of shore a 35 durometer or 3/16 inch material of shore a 40 durometer (or higher), prefabricated, each (Eff. Date 1/1/2006)                               | 16 |
| A5513 | For diabetics only, multiple density insert, custom molded from model of patient's foot, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each (Eff. Date 1/1/2006, Revised 1/1/2019)   | 16 |
| A5514 | For diabetics only, multiple density insert, made by direct carving with cam technology from a rectified cad model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each (Eff. Date 1/1/2019) | 16 |
| A6000 | Non-contact wound warming wound cover for use with the non-contact wound warming device and warming card (Eff. Date 1/1/2002)   | 13 |
| A6010 | Collagen based wound filler, dry form, sterile, per gram of collagen (Eff. Date 1/1/2002, Updated eff. 1/1/2009)  | 12 |
| A6011 | Collagen based wound filler, gel/paste, per gram of collagen (Eff. Date 1/1/2003, Updated eff. 1/1/2011)  | 12 |

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| A6021 | Collagen dressing, sterile, size 16 sq. in. or less, each (Eff. Date 1/1/2001, Updated eff. 1/1/2013)  | 12 |
| A6022 | Collagen dressing, sterile, size more than 16 sq. in. but less than or equal to 48 sq. in., each (Eff. Date 1/1/2001, Updated eff. 1/1/2013)                             | 12 |
| A6023 | Collagen dressing, sterile, size more than 48 sq. in., each (Eff. Date 1/1/2001, Updated eff. 1/1/2013)  | 12 |
| A6024 | Collagen dressing wound filler, sterile, per 6 inches (Eff. Date 1/1/2001, Updated eff. 1/1/2009)  | 12 |
| A6025 | Gel sheet for dermal or epidermal application, (e.g., silicone, hydrogel, other), each (not valid for Medicare)  |    |
| A6154 | Wound pouch, each  | 12 |
| A6196 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size 16 sq. in. or less, each dressing (Updated eff. 1/1/2009)                                       | 12 |
| A6197 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., each dressing (Updated eff. 1/1/2009) | 12 |
| A6198 | Alginate or other fiber gelling dressing, wound cover, sterile, pad size more than 48 sq. in., each dressing (Updated eff. 1/1/2009)                                     | 17 |
| A6199 | Alginate or other fiber gelling dressing, wound filler, sterile, per 6 inches (Updated eff. 1/1/2009)  | 12 |
| A6203 | Composite dressing, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6204 | Composite dressing, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)    | 12 |
| A6205 | Composite dressing, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 17 |
| A6206 | Contact layer, sterile, 16 sq. in. or less, each dressing (Updated eff. 1/1/2009)  | 17 |
| A6207 | Contact layer, sterile, more than 16 sq. in. but less than or equal to 48 sq. in., each dressing (Updated eff. 1/1/2009)   | 12 |
| A6208 | Contact layer, sterile, more than 48 sq. in., each dressing (Updated eff. 1/1/2009)  | 17 |
| A6209 | Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6210 | Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6211 | Foam dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)                                       | 12 |

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| A6212 | Foam dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6213 | Foam dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)                                      | 17 |
| A6214 | Foam dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6215 | Foam dressing, wound filler, sterile, per gram (Updated eff. 1/1/2009)   | 17 |
| A6216 | Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing   | 12 |
| A6217 | Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing  | 12 |
| A6218 | Gauze, non-impregnated, non-sterile, pad size more than 48 sq. in., without adhesive border, each dressing   | 17 |
| A6219 | Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6220 | Gauze, non-impregnated, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6221 | Gauze, non-impregnated, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 17 |
| A6222 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |
| A6223 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009) | 12 |
| A6224 | Gauze, impregnated with other than water, normal saline, or hydrogel, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)                                       | 12 |
| A6228 | Gauze, impregnated, water or normal saline, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)   | 17 |
| A6229 | Gauze, impregnated, water or normal saline, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)                            | 12 |
| A6230 | Gauze, impregnated, water or normal saline, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)   | 17 |



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| A6231 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size 16 sq. in or less, each dressing (Eff. Date 1/1/2001, Updated eff. 1/1/2009)   | 12 |  |
| A6232 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size greater than 16 sq. in., but less than or equal to 48 sq. in., each dressing (Eff. Date 1/1/2001, Updated eff. 1/1/2009) | 12 |  |
| A6233 | Gauze, impregnated, hydrogel, for direct wound contact, sterile, pad size more than 48 sq. in., each dressing (Eff. Date 1/1/2001, Updated eff. 1/1/2009)  | 12 |  |
| A6234 | Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |  |
| A6235 | Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)                    | 12 |  |
| A6236 | Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border each dressing, (Updated eff. 1/1/2009)   | 12 |  |
| A6237 | Hydrocolloid dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |  |
| A6238 | Hydrocolloid dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)              | 12 |  |
| A6239 | Hydrocolloid dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)   | 17 |  |
| A6240 | Hydrocolloid dressing, wound filler, paste, sterile, per ounce (Updated eff. 1/1/2009)   | 12 |  |
| A6241 | Hydrocolloid dressing, wound filler, dry form, sterile, per gram (Updated eff. 1/1/2009)   | 12 |  |
| A6242 | Hydrogel dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |  |
| A6243 | Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)                         | 12 |  |
| A6244 | Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)   | 12 |  |
| A6245 | Hydrogel dressing, wound cover, sterile, pad size 16 sq. in or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |  |
| A6246 | Hydrogel dressing, wound cover, sterile, pad size more than 16 sq. in but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)                   | 12 |  |



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| A6247 | Hydrogel dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6248 | Hydrogel dressing, wound filler, gel, sterile, per fluid ounce (Updated eff. 1/1/2009)  | 12 |
| A6250 | Skin sealants, protectants, moisturizers, ointments, any type, any size   | 12 |
| A6251 | Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6252 | Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)       | 12 |
| A6253 | Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., without adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6254 | Specialty absorptive dressing, wound cover, sterile, pad size 16 sq. in. or less, with any size adhesive border, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6255 | Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009) | 12 |
| A6256 | Specialty absorptive dressing, wound cover, sterile, pad size more than 48 sq. in., with any size adhesive border, each dressing (Updated eff. 1/1/2009)                                      | 17 |
| A6257 | Transparent film, sterile, 16 sq. in. or less, each dressing (Updated eff. 1/1/2009)  | 12 |
| A6258 | Transparent film, sterile, more than 16 sq. in but less than or equal to 48 sq. in., each dressing (Updated eff. 1/1/2009)  | 12 |
| A6259 | Transparent film, sterile, more than 48 sq. in., each dressing (Updated eff. 1/1/2009)  | 12 |
| A6260 | Wound cleansers, sterile, any type, any size (Updated eff. 1/1/2009)  | 12 |
| A6261 | Wound filler, gel/paste, sterile, per fluid ounce, not otherwise specified (Updated eff. 1/1/2009)  | 14 |
| A6262 | Wound filler, dry form, per gram, not otherwise specified (Updated eff. 1/1/2011)   | 14 |
| A6266 | Gauze, impregnated, other than water. normal saline, or zinc paste, sterile, any width, per linear yard (Updated eff. 1/1/2009)   | 12 |
| A6402 | Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing  | 12 |

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| A6403 | Gauze, non-impregnated, sterile, pad size more than 16 sq. in. less than or equal to 48 sq. in., without adhesive border, each dressing   | 12 |  |
| A6404 | Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing  | 12 |  |
| A6407 | Packing strips, non-impregnated, sterile, up to 2 inches in width, per linear yard (Eff. Date 1/1/2004, (Updated eff. 1/1/2009)   | 12 |  |
| A6410 | Eye pad, sterile, each (Eff. Date 1/1/2003)   | 12 |  |
| A6411 | Eye pad, non-sterile, each (Eff. Date 1/1/2003)   | 12 |  |
| A6412 | Eye patch, occlusive, each (Eff. Date 1/1/2003)   | 12 |  |
| A6413 | Adhesive bandage, first-aid type, any size, each (Eff. Date 1/1/2008)   |    |  |
| A6441 | Padding bandage, non-elastic, non-woven/non-knitted, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6442 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width less than three inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6443 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6444 | Conforming bandage, non-elastic, knitted/woven, non-sterile, width greater than 5 inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6445 | Conforming bandage, non-elastic, knitted/woven, sterile, width less than three inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6446 | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6447 | Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to five inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6448 | Light compression bandage, elastic, knitted/woven, width less than three inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6449 | Light compression bandage, elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6450 | Light compression bandage, elastic, knitted/woven, width greater than or equal to five inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6451 | Moderate compression bandage, elastic, knitted/woven, load resistance of 1.25 to 1.34 foot pounds at 50% maximum stretch, width greater than or equal to three inches or less than five inches, per yard (Eff. Date 1/1/2004) | 12 |  |

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| A6452 | High compression bandage, elastic, knitted/woven, load resistance greater than or equal to 1.35 foot pounds at 50% maximum stretch, width greater than or equal to three inches and less than five inches per yard (Eff. Date 1/1/2004) | 12 |  |
| A6453 | Self-adherent bandage, elastic, non-knitted/non-woven, less than three inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6454 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)   | 12 |  |
| A6455 | Self-adherent bandage, elastic, non-knitted/non-woven, width greater than or equal to five inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6456 | Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per yard (Eff. Date 1/1/2004)  | 12 |  |
| A6457 | Tubular dressing with or without elastic, any width, per linear yard (Eff. Date 1/1/2006)   | 12 |  |
| A6501 | Compression Burn garment, bodysuit (head to foot), custom fabricated (Eff. Date 1/1/2003)   | 12 |  |
| A6502 | Compression Burn garment, chin strap, custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6503 | Compression Burn garment, facial hood, custom fabricated (Eff. Date 1/1/2003)   | 12 |  |
| A6504 | Compression Burn garment, glove to wrist, custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6505 | Compression Burn garment, glove to elbow, custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6506 | Compression Burn garment, glove to axilla, custom fabricated (Eff. Date 1/1/2003)   | 12 |  |
| A6507 | Compression Burn garment, foot to knee length, custom fabricated (Eff. Date 1/1/2003)   | 12 |  |
| A6508 | Compression Burn garment, foot to thigh length, custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6509 | Compression Burn garment, upper trunk to waist including arm openings (vest), custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6510 | Compression Burn garment, trunk, including arms down to leg openings (leotard), custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6511 | Compression Burn garment, lower trunk including leg openings (panty), custom fabricated (Eff. Date 1/1/2003)  | 12 |  |
| A6512 | Compression Burn garment, not otherwise classified (Eff. Date 1/1/2003)   | 12 |  |

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| A6513 | Compression burn mask, face and/or neck, plastic or equal, custom fabricated (Eff. Date 1/1/2006)                  | 12 |
| A6520 | Gradient compression garment, glove, padded, for nighttime use, each (Eff. Date 01/01/2024)                        | 22 |
| A6521 | Gradient compression garment, glove, padded, for nighttime use, custom, each (Eff. Date 01/01/2024)                | 22 |
| A6522 | Gradient compression garment, arm, padded, for nighttime use, each (Eff. Date 01/01/2024)                          | 22 |
| A6523 | Gradient compression garment, arm, padded, for nighttime use, custom, each (Eff. Date 01/01/2024)                  | 22 |
| A6524 | Gradient compression garment, lower leg and foot, padded, for nighttime use, each (Eff. Date 01/01/2024)           | 22 |
| A6525 | Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each (Eff. Date 01/01/2024)   | 22 |
| A6526 | Gradient compression garment, full leg and foot, padded, for nighttime use, each (Eff. Date 01/01/2024)            | 22 |
| A6527 | Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each (Eff. Date 01/01/2024)    | 22 |
| A6528 | Gradient compression garment, bra, for nighttime use, each (Eff. Date 01/01/2024)                                  | 22 |
| A6529 | Gradient compression garment, bra, for nighttime use, custom, each (Eff. Date 01/01/2024)                          | 22 |
| A6530 | Gradient compression stocking, below knee, 18-30 MMHG, each (Eff. Date 1/1/2006)                                   | 22 |
| A6531 | Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each (Revised eff. 01/01/2024) | 12 |
| A6532 | Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each (Revised eff. 01/01/2024) | 12 |
| A6533 | Gradient compression stocking, thigh length, 18-30 MMHG, each (Eff. Date 1/1/2006)                                 | 22 |
| A6534 | Gradient compression stocking, thigh length, 30-40 MMHG, each (Eff. Date 1/1/2006)                                 | 22 |
| A6535 | Gradient compression stocking, thigh length, 40 mmhg or greater, each (Revised eff. 01/01/2024)                    | 22 |
| A6536 | Gradient compression stocking, full length/chap style, 18-30 MMHG, each (Eff. Date 1/1/2006)                       | 22 |
| A6537 | Gradient compression stocking, full length/chap style, 30-40 MMHG, each (Eff. Date 1/1/2006)                       | 22 |

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| A6538 | Gradient compression stocking, full length/chap style, 40 mmhg or greater, each (Revised eff. 01/01/2024)                       | 22 |
| A6539 | Gradient compression stocking, waist length, 18-30 MMHG, each (Eff. Date 1/1/2006)  | 22 |
| A6540 | Gradient compression stocking, waist length, 30-40 MMHG, each (Eff. Date 1/1/2006)  | 22 |
| A6541 | Gradient compression stocking, waist length, 40 mmhg or greater, each (Revised eff. 01/01/2024)                                 | 22 |
| A6544 | Gradient compression stocking, garter belt (Eff. Date 1/1/2006)   | 12 |
| A6545 | Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, used as a surgical dressing, each (Revised eff. 01/01/2024)     | 12 |
| A6549 | Gradient compression garment, not otherwise specified (Revised eff. 01/01/2024)   | 22 |
| A6550 | Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories (Eff. Date 1/1/2004) | 13 |
| A6552 | Gradient compression stocking, below knee, 30-40 mmhg, each (Eff. Date 01/01/2024)  | 22 |
| A6553 | Gradient compression stocking, below knee, 30-40 mmhg, custom, each (Eff. Date 01/01/2024)                                      | 22 |
| A6554 | Gradient compression stocking, below knee, 40 mmhg or greater, each (Eff. Date 01/01/2024)                                      | 22 |
| A6555 | Gradient compression stocking, below knee, 40 mmhg or greater, custom, each (Eff. Date 01/01/2024)                              | 22 |
| A6556 | Gradient compression stocking, thigh length, 18-30 mmhg, custom, each (Eff. Date 01/01/2024)                                    | 22 |
| A6557 | Gradient compression stocking, thigh length, 30-40 mmhg, custom, each (Eff. Date 01/01/2024)                                    | 22 |
| A6558 | Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each (Eff. Date 01/01/2024)                            | 22 |
| A6559 | Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each (Eff. Date 01/01/2024)                          | 22 |
| A6560 | Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each (Eff. Date 01/01/2024)                          | 22 |
| A6561 | Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each (Eff. Date 01/01/2024)                  | 22 |
| A6562 | Gradient compression stocking, waist length, 18-30 mmhg, custom, each (Eff. Date 01/01/2024)                                    | 22 |
| A6563 | Gradient compression stocking, waist length, 30-40 mmhg, custom, each (Eff. Date 01/01/2024)                                    | 22 |

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| A6564 | Gradient compression stocking, waist length, 40 mmhg or greater, custom, each (Eff. Date 01/01/2024)  | 22 |
| A6565 | Gradient compression gauntlet, custom, each (Eff. Date 01/01/2024)                                    | 22 |
| A6566 | Gradient compression garment, neck/head, each (Eff. Date 01/01/2024)                                  | 22 |
| A6567 | Gradient compression garment, neck/head, custom, each (Eff. Date 01/01/2024)                          | 22 |
| A6568 | Gradient compression garment, torso and shoulder, each (Eff. Date 01/01/2024)                         | 22 |
| A6569 | Gradient compression garment, torso/shoulder, custom, each (Eff. Date 01/01/2024)                     | 22 |
| A6570 | Gradient compression garment, genital region, each (Eff. Date 01/01/2024)                             | 22 |
| A6571 | Gradient compression garment, genital region, custom, each (Eff. Date 01/01/2024)                     | 22 |
| A6572 | Gradient compression garment, toe caps, each (Eff. Date 01/01/2024)                                   | 22 |
| A6573 | Gradient compression garment, toe caps, custom, each (Eff. Date 01/01/2024)                           | 22 |
| A6574 | Gradient compression arm sleeve and glove combination, custom, each (Eff. Date 01/01/2024)            | 22 |
| A6575 | Gradient compression arm sleeve and glove combination, each (Eff. Date 01/01/2024)                    | 22 |
| A6576 | Gradient compression arm sleeve, custom, medium weight, each (Eff. Date 01/01/2024)                   | 22 |
| A6577 | Gradient compression arm sleeve, custom, heavy weight, each (Eff. Date 01/01/2024)                    | 22 |
| A6578 | Gradient compression arm sleeve, each (Eff. Date 01/01/2024)  | 22 |
| A6579 | Gradient compression glove, custom, medium weight, each (Eff. Date 01/01/2024)                        | 22 |
| A6580 | Gradient compression glove, custom, heavy weight, each (Eff. Date 01/01/2024)                         | 22 |
| A6581 | Gradient compression glove, each (Eff. Date 01/01/2024)   | 22 |
| A6582 | Gradient compression gauntlet, each (Eff. Date 01/01/2024)  | 22 |
| A6583 | Gradient compression wrap with adjustable straps, below knee, 30-50 mmhg, each (Eff. Date 01/01/2024) | 22 |
| A6584 | Gradient compression wrap with adjustable straps, not otherwise specified (Eff. Date 01/01/2024)      | 22 |

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| A6585 | Gradient pressure wrap with adjustable straps, above knee, each (Eff. Date 01/01/2024)   | 22 |
| A6586 | Gradient pressure wrap with adjustable straps, full leg, each (Eff. Date 01/01/2024)   | 22 |
| A6587 | Gradient pressure wrap with adjustable straps, foot, each (Eff. Date 01/01/2024)   | 22 |
| A6588 | Gradient pressure wrap with adjustable straps, arm, each (Eff. Date 01/01/2024)  | 22 |
| A6589 | Gradient pressure wrap with adjustable straps, bra, each (Eff. Date 01/01/2024)  | 22 |
| A6590 | External urinary catheters; disposable, with wicking material, for use with suction pump, per month (Eff. Date 04/01/2023)         |    |
| A6591 | External urinary catheter; non-disposable, for use with suction pump, per month (Eff. Date 04/01/2023)                             |    |
| A6593 | Accessory for gradient compression garment or wrap with adjustable straps, not-otherwise specified (Eff. Date 01/01/2024)          | 22 |
| A6594 | Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each (Eff. Date 01/01/2024)             | 22 |
| A6595 | Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each (Eff. Date 01/01/2024)             | 22 |
| A6596 | Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each (Eff. Date 01/01/2024)                   | 22 |
| A6597 | Gradient compression bandage roll, elastic long stretch, linear yard, any width, each (Eff. Date 01/01/2024)                       | 22 |
| A6598 | Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each (Eff. Date 01/01/2024)                 | 22 |
| A6599 | Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each (Eff. Date 01/01/2024)                | 22 |
| A6600 | Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each (Eff. Date 01/01/2024)            | 22 |
| A6601 | Gradient compression bandaging supply, high density foam pad, any size or shape, each (Eff. Date 01/01/2024)                       | 22 |
| A6602 | Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each (Eff. Date 01/01/2024) | 22 |
| A6603 | Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each (Eff. Date 01/01/2024)     | 22 |
| A6604 | Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each (Eff. Date 01/01/2024)        | 22 |



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| A6605 | Gradient compression bandaging supply, padded foam, per linear yard, any width, each (Eff. Date 01/01/2024)                                | 22 |  |
| A6606 | Gradient compression bandaging supply, padded textile, per linear yard, any width, each (Eff. Date 01/01/2024)                             | 22 |  |
| A6607 | Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each (Eff. Date 01/01/2024)        | 22 |  |
| A6608 | Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each (Eff. Date 01/01/2024) | 22 |  |
| A6609 | Gradient compression bandaging supply, not otherwise specified (Eff. Date 01/01/2024)  | 22 |  |
| A6610 | Gradient compression stocking, below knee, 18-30 mmhg, custom, each (Eff. Date 01/01/2024)   | 22 |  |
| A7000 | Canister, disposable, used with suction pump, each (Eff. Date 1/1/2000)  | 05 |  |
| A7001 | Canister, non-disposable, used with suction pump, each (Eff. Date 1/1/2000)  | 05 |  |
| A7002 | Tubing, used with suction pump, each (Eff. Date 1/1/2000)  | 05 |  |
| A7003 | Administration set, with small volume nonfiltered pneumatic nebulizer, disposable (Eff. Date 1/1/2000)                                     | 05 |  |
| A7004 | Small volume nonfiltered pneumatic nebulizer, disposable (Eff. Date 1/1/2000)  | 05 |  |
| A7005 | Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable (Eff. Date 1/1/2000)                                 | 05 |  |
| A7006 | Administration set, with small volume filtered pneumatic nebulizer (Eff. Date 1/1/2000)  | 05 |  |
| A7007 | Large volume nebulizer, disposable, unfilled, used with aerosol compressor (Eff. Date 1/1/2000)  | 05 |  |
| A7008 | Large volume nebulizer, disposable, prefilled, used with aerosol compressor (Eff. Date 1/1/2000)   | 05 |  |
| A7009 | Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer (Eff. Date 1/1/2000)   | 05 |  |
| A7010 | Corrugated tubing, disposable, used with large volume nebulizer, 100 feet (Eff. Date 1/1/2000)   | 05 |  |
| A7011 | Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet (Eff. Date 1/1/2000) (Deleted eff. 12/31/2015)                | 17 |  |
| A7012 | Water collection device, used with large volume nebulizer (Eff. Date 1/1/2000)   | 05 |  |



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| A7013 | Filter, disposable, used with aerosol compressor or ultrasonic generator (Eff. Date 1/1/2000, Updated 1/1/2011)   | 05 |
| A7014 | Filter, nondisposable, used with aerosol compressor or ultrasonic generator (Eff. Date 1/1/2000)  | 05 |
| A7015 | Aerosol mask, used with DME nebulizer (Eff. Date 1/1/2000)  | 05 |
| A7016 | Dome and mouthpiece, used with small volume ultrasonic nebulizer (Eff. Date 1/1/2000)   | 05 |
| A7017 | Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen (Eff. Date 1/1/2000)   | 05 |
| A7018 | Water, distilled, used with large volume nebulizer, 1000 ml (Eff. Date 1/1/2001)  | 13 |
| A7020 | Interface for cough stimulating device, includes all components, replacement only (Eff. Date 1/1/2011)  | 05 |
| A7021 | Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter) (Eff. Date 10/01/2024) |    |
| A7023 | Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical (Eff. Date 01/01/2024)  |    |
| A7025 | High frequency chest wall oscillation system vest, replacement for use with patient owned equipment, each (Eff. Date 1/1/2003)  | 01 |
| A7026 | High frequency chest wall oscillation system hose, replacement for use with patient owned equipment, each (Eff. Date 1/1/2003)  | 05 |
| A7027 | Combination oral/nasal mask, used with continuous positive airway pressure device, each (Eff. Date 1/1/2008)  | 05 |
| A7028 | Oral cushion for combination oral/nasal mask, replacement only, each (Eff. Date 1/1/2008)   | 05 |
| A7029 | Nasal pillows for combination oral/nasal mask, replacement only, pair (Eff. Date 1/1/2008)  | 05 |
| A7030 | Full face mask used with positive airway pressure device, each (Eff. Date 1/1/2003)   | 05 |
| A7031 | Face mask interface, replacement for full face mask, each (Eff. Date 1/1/2003)  | 05 |
| A7032 | Cushion for use on nasal mask interface, replacement only, each (Eff. Date 1/1/2003)  | 05 |
| A7033 | Pillow for use on nasal cannula type interface, replacement only, each (Eff. Date 1/1/2003)   | 05 |
| A7034 | Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap (Eff. Date 1/1/2003)   | 05 |

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| A7035 | Headgear used with positive airway pressure device (Eff. Date 1/1/2003)  | 05 |
| A7036 | Chinstrap used with positive airway pressure device (Eff. Date 1/1/2003)   | 05 |
| A7037 | Tubing used with positive airway pressure device (Eff. Date 1/1/2003)  | 05 |
| A7038 | Filter, disposable, used with positive airway pressure device (Eff. Date 1/1/2003)   | 05 |
| A7039 | Filter, non disposable, used with positive airway pressure device (Eff. Date 1/1/2003)   | 05 |
| A7044 | Oral interface used with positive airway pressure device, each (Eff. Date 1/1/2003)  | 05 |
| A7045 | Exhalation port with or without swivel used with accessories for positive airway devices, replacement only (Eff. Date 1/1/2005)                        | 05 |
| A7047 | Oral interface used with respiratory suction pump, each (Eff. Date 01/01/2014)   |    |
| A7049 | Expiratory positive airway pressure intranasal resistance valve (Eff. Date 04/01/2023)   |    |
| A7501 | Tracheostoma valve, including diaphragm, each (Eff. Date 1/1/2001)   | 11 |
| A7502 | Replacement diaphragm/faceplate for tracheostoma valve, each (Eff. Date 1/1/2001)  | 11 |
| A7503 | Filter holder or filter cap, reusable, for use in a trachostoma heat and moisture exchange, each (Eff. Date 1/1/2001)                                  | 11 |
| A7504 | Filter for use in a tracheostoma heat and moisture exchange system, each (Eff. Date 1/1/2001)  | 11 |
| A7505 | Housing, reusable without adhesive, for use in a heat and moisture exchange system and/or with a tracheostoma valve, each (Eff. Date 1/1/2001)         | 11 |
| A7506 | Adhesive disc for use in a heat and moisture exchange system and/or with trachostoma valve, any type each (Eff. Date 1/1/2001)                         | 11 |
| A7507 | Filter holder and integrated filter without adhesive, for use in a trachostoma heat and moisture exchange system, each (Eff. Date 1/1/2001)            | 11 |
| A7508 | Housing and integrated adhesive, for use in a trachestoma heat and moisture exchange system and/or with a tracheostma valve, each (Eff. Date 1/1/2001) | 11 |
| A7509 | Filter holder and integrated filter housing, and adhesive, for use as a tracheostoma heat and moisture exchange system, each (Eff. Date 1/1/2001)      | 11 |

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| A7520 | Tracheostomy/laryngectomy tube, non-cuffed, polyvinylchloride (PVC), silicone or equal, each (Eff. Date 1/1/2004)                     | 11 |  |
| A7521 | Tracheostomy/laryngectomy tube, cuffed, polyvinylchloride (PVC), silicone or equal, each (Eff. Date 1/1/2004)                         | 11 |  |
| A7522 | Tracheostomy/laryngectomy tube, stainless steel or equal (sterilizable and reusable), each (Eff. Date 1/1/2004)                       | 11 |  |
| A7523 | Tracheostomy shower protector, each (Eff. Date 1/1/2004)  | 11 |  |
| A7524 | Tracheostoma stent/stud/button, each (Eff. Date 1/1/2004)   | 11 |  |
| A7525 | Tracheostomy mask, each (Eff. Date 1/1/2004)  | 11 |  |
| A7526 | Tracheostomy tube collar/holder, each (Eff. Date 1/1/2004)  | 11 |  |
| A7527 | Tracheostomy/laryngectomy tube plug/stop, each (Eff. Date 1/1/2005)   | 11 |  |
| A8000 | Helmet, protective, soft, prefabricated, includes all components and accessories (Eff. Date 1/1/2007)                                 | 05 |  |
| A8001 | Helmet, protective, hard, prefabricated, includes all components and accessories (Eff. Date 1/1/2007)                                 | 05 |  |
| A8002 | Helmet, protective, soft, custom fabricated, includes all components and accessories (Eff. Date 1/1/2007)                             | 05 |  |
| A8003 | Helmet, protective, hard, custom fabricated, includes all components and accessories (Eff. Date 1/1/2007)                             | 05 |  |
| A8004 | Soft onterface for helmet, replacement only (Eff. Date 1/1/2007)  | 05 |  |
| A9156 | Oral mucoadhesive, any type (liquid, gel, paste, etc.), per 1 ml (Eff. Date 10/01/2023)   |    |  |
| A9268 | Programmer for transient, orally ingested capsule (Eff. Date 10/01/2023)  |    |  |
| A9269 | Programable, transient, orally ingested capsule, for use with external programmer, per month (Eff. Date 10/01/2023)                   |    |  |
| A9270 | Non-covered item or service   |    |  |
| A9272 | Wound suction, disposable, includes dressing, all accessories and components, any type, each (Eff. Date 1/1/2012, Revised 01/01/2014) |    |  |
| A9273 | Cold or hot fluid bottle, ice cap or collar, heat and/or cold wrap, any type (Eff. Date 1/1/2011, Revised 1/1/2019)                   |    |  |
| A9274 | External ambulatory insulin delivery system, disposable, each includes all supplies and accessories (Eff. Date 1/1/2008)              |    |  |
| A9275 | Home Blood Glucose disposable monitor, includes test strips (Eff. Date 1/1/2006)  |    |  |

|       |  |    |  |
|-------|--|----|--|
| A9276 | (Eff. Date 1/1/2008) (Invalid for Medicare submission effective 04/01/2022 through 12/31/2022) Sensor; invasive (e.g., subcutaneous), disposable, for use with non-durable medical equipment interstitial continuous glucose monitoring system, one unit = 1 day supply (Revised eff. 01/01/2023)  |    |  |
| A9277 | (Eff. Date 1/1/2008) (Invalid for Medicare submission effective 04/01/2022 through 12/31/2022) Transmitter; external, for use with non-durable medical equipment interstitial continuous glucose monitoring system (Revised eff. 01/01/2023)   |    |  |
| A9278 | Receiver (monitor); external, for use with interstitial continuous glucose monitoring system (Eff. Date 1/1/2008) (Invalid for Medicare submission effective 04/01/2022 through 12/31/2022) Receiver (monitor); external, for use with non-durable medical equipment interstitial continuous glucose monitoring system (Revised eff. 01/01/2023) |    |  |
| A9279 | Monitoring feature/device, stand-alone or integrated, any type, includes all accessories, components and electronics, not otherwise classified (Eff. Date 1/1/2007)  |    |  |
| A9280 | Alert or alarm device, not otherwise specified (Eff. Date 1/1/2004) (Deleted eff. 12/31/2003)  | 14 |  |
| A9281 | Reaching/grabbing device, any type, any length, each (Eff. Date 1/1/2006)  |    |  |
| A9282 | Wig, any type, each (Eff. Date 1/1/2006)   |    |  |
| A9283 | Foot pressure off loading/supportive device, any type, each (Eff. Date 1/1/2008)   |    |  |
| A9284 | Spirometer, non-electronic, includes all accessories (Eff. Date 1/1/2009)  |    |  |
| A9285 | Inversion/eversion correction device (Eff. Date 1/1/2017)  |    |  |
| A9286 | Hygienic item or device, disposable or non-disposable, any type, each (Eff. Date 1/1/2017)   |    |  |
| A9300 | Exercise equipment   |    |  |
| A9900 | Miscellaneous DME supply, accessory, and/or service of another HCPCS code (Eff. Date 1/1/2000)   | 17 |  |
| A9901 | DME delivery, set up, and/or dispensing service component of another HCPCS code (Eff. Date 1/1/2000)   |    |  |
| A9999 | Miscellaneous DME supply or accessory, not otherwise specified (Eff. Date 1/1/2004)  | 14 |  |

**HCPCS B**

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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| B4034 | Enteral feeding supply kit; syringe fed, per day, includes but is not limited to feeding/flushing syringe, administration set tubing, dressings, tape (Updated 1/1/2011) | 08       |                  |
| B4035 | Enteral feeding supply kit; pump fed, per day includes but is not limited to feeding/flushing syringe, administration set tubing, dressings, tape (Updated 1/1/2011)     | 08       |                  |
| B4036 | Enteral feeding supply kit; gravity fed, per day includes but is not limited to feeding/flushing syringe, administration set tubing, dressings, tape (Updated 1/1/2011)  | 08       |                  |
| B4081 | Nasogastric tubing with stylet   | 08       |                  |
| B4082 | Nasogastric tubing without stylet  | 08       |                  |
| B4083 | Stomach tube - levine type   | 08       |                  |
| B4087 | Gastrostomy/jejunostomy tube, standard, any material, any type, each (Eff. Date 1/1/2008)  |          |                  |
| B4088 | Gastrostomy/jejunostomy tube, low-profile, any material, any type, each (Eff. Date 1/1/2008)   |          |                  |
| B4100 | Food thickener, administered orally, per ounce (Eff. Date 1/1/2003)  |          |                  |
| B4102 | Enteral Formula, for adults, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit (Eff. Date 1/1/2005)   | 07       | 10.03B           |

|       |  |    |        |
|-------|--|----|--------|
| B4103 | Enteral Formula, for pediatrics, used to replace fluids and electrolytes (e.g., clear liquids), 500 ml = 1 unit (Eff. Date 1/1/2005)   | 07 | 10.03B |
| B4104 | Additive for enteral formula (e.g., fiber) (Eff. Date 1/1/2005)  | 07 |        |
| B4105 | In-line cartridge containing digestive enzyme(s) for enteral feeding, each (Eff. Date 1/1/2019)  | 07 |        |
| B4148 | Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape (Eff. Date 10/01/2023)  | 08 |        |
| B4149 | Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 100 unit (Eff. Date 1/1/2005)  | 07 | 10.03B |
| B4150 | Enteral Formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit   | 07 | 10.03B |
| B4152 | Enteral formula, nutritionally complete, calorically dense (equal to or greater than 1.5 KCL/ML) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit                                  | 07 | 10.03B |
| B4153 | Enteral Formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain) includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit   | 07 | 10.03B |
| B4154 | Enteral Formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/ or minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit               | 07 | 10.03B |
| B4155 | Enteral Formula, nutritionally incomplete/modular nutrients, includes specific nutrients, carbohydrates (e.g., glucose polymers), proteins/amino acids (e.g., glutamine, arginine), fat (e.g., medium chain triglycerides) or combination, administered through an enteral feeding tube, 100 calories = 1 unit | 07 | 10.03B |
| B4157 | Enteral Formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005)                           | 07 | 10.03B |
| B4158 | Enteral Formula, for pediatrics, nutritionally complete with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005)   | 07 | 10.03B |

|       |  |    |        |
|-------|--|----|--------|
| B4159 | Enteral Formula, for pediatrics, nutritionally complete soy based with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber and/or iron, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005)                                     | 07 | 10.03B |
| B4160 | Enteral Formula, for pediatrics, nutritionally complete calorically dense (equal to or greater than 0.7 KCAL/ ml) with intact nutrients includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005) | 07 | 10.03B |
| B4161 | Enteral Formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005)   | 07 | 10.03B |
| B4162 | Enteral Formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube, 100 calories = 1 unit (Eff. Date 1/1/2005)   | 07 | 10.03B |
| B4164 | Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml=1 unit) – home mix  | 07 | 10.03A |
| B4168 | Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) – home mix  | 07 | 10.03A |
| B4172 | Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml=1 unit) – home mix   | 07 | 10.03A |
| B4176 | Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml=1 unit) – home mix   | 07 | 10.03A |
| B4178 | Parenteral nutrition solution: amino acid, greater than 8.5% (500 ml=1 unit) – home mix  | 07 | 10.03A |
| B4180 | Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml=1 unit) – home mix   | 07 | 10.03A |
| B4185 | Parenteral nutrition solution, not otherwise specified, 10 grams lipids (Eff. Date 1/1/2006) (Revised 1/1/2020)  | 07 | 10.03A |
| B4187 | Omegaven, 10 grams lipids (Eff. Date 1/1/2020)   | 07 | 10.03A |
| B4189 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 10 to 51 grams of protein - premix  | 07 | 10.03A |
| B4193 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, 52 to 73 grams of protein - premix  | 07 | 10.03A |

|       |   |    |        |
|-------|---|----|--------|
| B4197 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, 74 to 100 grams of protein - premix                 | 07 | 10.03A |
| B4199 | Parenteral nutrition solution; compounded amino acid and carbohydrates with electrolytes, trace elements and vitamins, including preparation, any strength, over 100 grams of protein - premix                  | 07 | 10.03A |
| B4216 | Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) home mix per day  | 07 | 10.03A |
| B4220 | Parenteral nutrition supply kit; premix, per day  | 08 |        |
| B4222 | Parenteral nutrition supply kit; home mix, per day  | 08 |        |
| B4224 | Parenteral nutrition administration kit, per day  | 08 |        |
| B5000 | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal-aminosyn-rf, nephramine, renamine-premix      | 07 | 10.03A |
| B5100 | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic, heptamine-premix                           | 07 | 10.03A |
| B5200 | Parenteral nutrition solution compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress-branch chain amino acids-freamine-hbc-premix | 07 | 10.03A |
| B9000 | Enteral nutrition infusion pump - without alarm (Deleted eff. 12/31/2016)   | 09 | 10.03B |
| B9002 | Enteral nutrition infusion pump, any type (Updated description 1/1/2017)  | 09 | 10.03B |
| B9004 | Parenteral nutrition infusion pump, portable  | 09 | 10.03A |
| B9006 | Parenteral nutrition infusion pump, stationary  | 09 | 10.03A |
| B9998 | NOC for enteral supplies  | 08 |        |
| B9999 | NOC for parenteral supplies   | 08 |        |



**HCPCS E**

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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| E0100 | Cane, includes canes of all materials, adjustable or fixed, with tip   | 05       |                  |
| E0105 | Cane, quad or three prong, includes canes of all materials, adjustable or fixed, with tips                             | 05       |                  |
| E0110 | Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips | 05       |                  |
| E0111 | Crutch forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrip               | 05       |                  |
| E0112 | Crutches underarm, wood, adjustable or fixed, pair, with pads, tips and handgrips                                      | 05       |                  |
| E0113 | Crutch underarm, wood, adjustable or fixed, each, with pad, tip and handgrip   | 05       |                  |
| E0114 | Crutches underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips                           | 05       |                  |
| E0116 | Crutch, underarm, other than wood, adjustable or fixed, with pad, tip, handgrip, with or without shock absorber, each  | 05       |                  |
| E0117 | Crutch, underarm, articulating, spring assisted, each (Eff. Date 1/1/2003)   | 01       |                  |
| E0118 | Crutch substitute, lower leg platform, with or without wheels, each (Eff. Date 1/1/2004)                               | 05       |                  |
| E0130 | Walker, rigid (pickup), adjustable or fixed height   | 05       |                  |

|       |  |    |
|-------|--|----|
| E0135 | Walker, folding (pickup), adjustable or fixed height   | 05 |
| E0140 | Walker, with trunk support, adjustable or fixed height, any type (Eff. Date 1/1/2004)  | 01 |
| E0141 | Walker, rigid, wheeled, adjustable or fixed height   | 05 |
| E0143 | Walker, folding, wheeled, adjustable or fixed height   | 05 |
| E0144 | Walker, enclosed, four-sided framed, rigid or folding, wheeled with posterior seat (Eff. Date 1/1/2000)                      | 01 |
| E0147 | Walker, heavy duty, multiple braking system, variable wheel resistance   | 05 |
| E0148 | Walker, heavy duty, without wheels, rigid or folding, any type, each (Eff. Date 1/1/2001)                                    | 05 |
| E0149 | Walker, heavy duty, wheeled, rigid or folding, any type (Eff. Date 1/1/2001)   | 01 |
| E0152 | Walker, battery powered, wheeled, folding, adjustable or fixed height (Eff. Date 04/01/2024)                                 | 05 |
| E0153 | Platform attachment, forearm crutch, each  | 05 |
| E0154 | Platform attachment, walker, each  | 05 |
| E0155 | Wheel attachment, rigid pick-up walker, per pair   | 05 |
| E0156 | Seat attachment, walker  | 05 |
| E0157 | Crutch attachment, walker, each  | 05 |
| E0158 | Leg extensions for walker, per set of four (4)   | 05 |
| E0159 | Brake attachment for wheeled walker, replacement, each   | 05 |
| E0160 | Sitz type bath or equipment, portable, used with or without commode  | 05 |
| E0161 | Sitz type bath or equipment, portable, used with or without commode, with faucet attachment/s                                | 05 |
| E0162 | Sitz bath chair  | 05 |
| E0163 | Commode chair, stationary, with fixed arms   | 05 |
| E0165 | Commode chair, stationary, with detachable arms  | 01 |
| E0167 | Pail or pan for use with commode chair   | 05 |
| E0168 | Commode chair, extra wide and/or heavy duty, stationary or mobile, with or without arms, any type, each (Eff. Date 1/1/2001) | 05 |
| E0170 | Commode chair with integrated seat lift mechanism, electric, any type (Eff. Date 1/1/2006)                                   | 01 |

|       |   |    |  |
|-------|---|----|--|
| E0171 | Commode chair with integrated seat lift mechanism, non-electric, any type<br>(Eff. Date 1/1/2006)                 | 01 |  |
| E0172 | Seat lift mechanism placed over or on top of toilet, any type<br>(Eff. Date 1/1/2006)                             |    |  |
| E0175 | Foot rest, for use with commode chair, each   | 05 |  |
| E0181 | Powered pressure reducing mattress overlay/pad, alternating, with pump, includes heavy duty                       | 01 |  |
| E0182 | Pump for alternating pressure pad, for replacement only   | 01 |  |
| E0183 | Powered pressure reducing underlay/pad, alternating, with pump, includes heavy duty (Eff. Date 10/01/2022)        | 01 |  |
| E0184 | Dry pressure mattress   | 05 |  |
| E0185 | Gel or gel-like pressure pad for mattress, standard mattress length and width                                     | 05 |  |
| E0186 | Air pressure mattress   | 01 |  |
| E0187 | Water pressure mattress   | 01 |  |
| E0188 | Synthetic sheepskin pad   | 05 |  |
| E0189 | Lambswool sheepskin pad, any size   | 05 |  |
| E0190 | Positioning cushion/pillow/wedge, any shape or size, includes all components and accessories (Eff. Date 1/1/2004) | 05 |  |
| E0191 | Heel or elbow protector, each   | 05 |  |
| E0193 | Powered air flotation bed (low air loss therapy)  | 01 |  |
| E0194 | Air fluidized bed   | 01 |  |
| E0196 | Gel pressure mattress   | 01 |  |
| E0197 | Air pressure pad for mattress, standard mattress length and width   | 01 |  |
| E0198 | Water pressure pad for mattress, standard mattress length and width   | 01 |  |
| E0199 | Dry pressure pad for mattress, standard mattress length and width   | 05 |  |
| E0200 | Heat lamp, without stand (table model), includes bulb, or infrared element  | 05 |  |
| E0202 | Phototherapy (bilirubin) light with photometer  | 01 |  |
| E0203 | Therapeutic lightbox, minimum 10,000 LUX, table top model (Eff. Date 1/1/2003)                                    | 05 |  |
| E0205 | Heat lamp, with stand, includes bulb, or infrared element   | 05 |  |
| E0210 | Electric heat pad, standard   | 05 |  |

|       |   |    |
|-------|---|----|
| E0215 | Electric heat pad, moist  | 05 |
| E0217 | Water circulating heat pad with pump  | 05 |
| E0218 | Fluid circulating cold pad with pump, any type (Revised 1/1/2019)   | 01 |
| E0220 | Hot water bottle (Deleted eff. 12/31/2010)  | 05 |
| E0221 | Infrared heating pad system (Eff. Date 1/1/2002)  | 05 |
| E0225 | Hydrocollator unit, includes pads   | 05 |
| E0230 | Ice cap or collar (Deleted eff. 12/31/2010)   | 05 |
| E0231 | Non-contact wound warming device (temperature control unit, AC adapter and power cord) for use with warming card and wound cover (Eff. Date 1/1/2002) | 01 |
| E0232 | Warming card for use with the non-contact wound warming device and non-contact wound warming wound cover (Eff. Date 1/1/2002)                         | 13 |
| E0235 | Paraffin bath unit, portable (see medical supply code A4265 for paraffin)   | 01 |
| E0236 | Pump for water circulating pad  | 01 |
| E0238 | Non-electric heat pad, moist (Deleted eff. 12/31/2010)  | 05 |
| E0239 | Hydrocollator unit, portable  | 05 |
| E0240 | Bath/shower chair, with or without wheels, any size (Eff. Date 1/1/2004)  |    |
| E0241 | Bath tub wall rail, each  |    |
| E0242 | Bath tub rail, floor base   |    |
| E0243 | Toilet rail, each   |    |
| E0244 | Raised toilet seat  |    |
| E0245 | Tub stool or bench  |    |
| E0246 | Transfer tub rail attachment  |    |
| E0247 | Transfer bench for tub or toilet with or without commode opening (Eff. Date 1/1/2004)   | 05 |
| E0248 | Transfer bench, heavy duty, for tub or toilet with or without commode opening (Eff. Date 1/1/2004)  | 05 |
| E0249 | Pad for water circulating heat unit, for replacement only (Description Change 1/1/2010)   | 05 |
| E0250 | Hospital bed, fixed height, with any type side rails, with mattress   | 01 |
| E0251 | Hospital bed, fixed height, with any type side rails, without mattress  | 01 |

|       |  |    |  |
|-------|--|----|--|
| E0255 | Hospital bed, variable height, hi-lo, with any type side rails, with mattress                                | 01 |  |
| E0256 | Hospital bed, variable height, hi-lo, with any type side rails, without mattress                             | 01 |  |
| E0260 | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress              | 01 |  |
| E0261 | Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress           | 01 |  |
| E0265 | Hospital bed, total electric (head, foot and height adjustments), with any type rails, with mattress         | 01 |  |
| E0266 | Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress | 01 |  |
| E0270 | Hospital bed, institutional type includes: oscillating, circulating and stryker frame, with mattress         |    |  |
| E0271 | Mattress, innerspring  | 05 |  |
| E0272 | Mattress, foam rubber  | 05 |  |
| E0273 | Bed board  |    |  |
| E0274 | Over-bed table   |    |  |
| E0275 | Bed pan, standard, metal or plastic  | 05 |  |
| E0276 | Bed pan, fracture, metal or plastic  | 05 |  |
| E0277 | Powered pressure-reducing air mattress   | 01 |  |
| E0280 | Bed cradle, any type   | 05 |  |
| E0290 | Hospital bed, fixed height, without side rails, with mattress  | 01 |  |
| E0291 | Hospital bed, fixed height, without side rails, without mattress   | 01 |  |
| E0292 | Hospital bed, variable height, hi-lo, without side rails, with mattress                                      | 01 |  |
| E0293 | Hospital bed, variable height, hi-lo, without side rails, without mattress                                   | 01 |  |
| E0294 | Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress                    | 01 |  |
| E0295 | Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress                 | 01 |  |
| E0296 | Hospital bed, total electric (head, foot and height adjustments), without side rails, with mattress          | 01 |  |
| E0297 | Hospital bed, total electric (head, foot and height adjustments), without side rails, without mattress       | 01 |  |

|       |   |    |  |
|-------|---|----|--|
| E0300 | Pediatric crib, hospital grade, fully enclosed, with or without top enclosure (Eff. Date 1/1/2004) (Revised 01/01/2013)   | 01 |  |
| E0301 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, without mattress (Eff. Date 1/1/2004)           | 01 |  |
| E0302 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, without mattress (Eff. Date 1/1/2004)   | 01 |  |
| E0303 | Hospital bed, heavy duty, extra wide, with weight capacity greater than 350 pounds, but less than or equal to 600 pounds, with any type side rails, with mattress (Eff. Date 1/1/2004)              | 01 |  |
| E0304 | Hospital bed, extra heavy duty, extra wide, with weight capacity greater than 600 pounds, with any type side rails, with mattress (Eff. Date 1/1/2004)  | 01 |  |
| E0305 | Bed side rails, half length   | 01 |  |
| E0310 | Bed side rails, full length   | 05 |  |
| E0315 | Bed accessory: board, table, or support device, any type  |    |  |
| E0316 | Safety enclosure frame/canopy for use with hospital bed, any type (Eff. Date 1/1/2002)  | 01 |  |
| E0325 | Urinal; male, jug-type, any material  | 05 |  |
| E0326 | Urinal; female, jug-type, any material  | 05 |  |
| E0328 | Hospital bed, pediatric, manual, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress (Eff. Date 1/1/2008)                    | 01 |  |
| E0329 | Hospital bed, pediatric, electric or semi-electric, 360 degree side enclosures, top of headboard, footboard and side rails up to 24 inches above the spring, includes mattress (Eff. Date 1/1/2008) | 01 |  |
| E0350 | Control unit for electronic bowel irrigation/evacuation system  |    |  |
| E0352 | Disposable pack (water reservoir bag, speculum, valving mechanism and collection bag/box) for use with the electronic bowel irrigation/evacuation system  |    |  |
| E0370 | Air pressure elevator for heel  | 05 |  |
| E0371 | Nonpowered advanced pressure reducing overlay for mattress, standard mattress length and width  | 01 |  |
| E0372 | Powered air overlay for mattress, standard mattress length and width  | 01 |  |
| E0373 | Nonpowered advanced pressure reducing mattress  | 01 |  |

|       |   |    |       |
|-------|---|----|-------|
| E0424 | Stationary compressed gaseous oxygen system, rental; includes contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing  | 06 | 484.3 |
| E0425 | Stationary compressed gas system, purchase; includes regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing   | 06 |       |
| E0430 | Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing  | 06 |       |
| E0431 | Portable gaseous oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing  | 06 | 484.3 |
| E0433 | Portable liquid oxygen system, rental, home liqueifier used to fill portable liquid oxygen containers, includes portable containers, regulator, flowmeter, humidifier, cannula or mask and tubing, with or without supply reservoir and contents gauge (Eff. Date 1/1/2010) | 06 | 484.3 |
| E0434 | Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adaptor, contents gauge, cannula or mask, and tubing  | 06 | 484.3 |
| E0435 | Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing and refill adaptor   | 06 |       |
| E0439 | Stationary liquid oxygen system, rental; includes use of reservoir, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, & tubing  | 06 | 484.3 |
| E0440 | Stationary liquid oxygen system, purchase; includes use of reservoir, contents indicator, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing  | 06 |       |
| E0441 | Stationary oxygen contents, gaseous, 1 month's supply = 1 unit (Description change 1/1/2010)  | 06 | 484.3 |
| E0442 | Stationary oxygen contents, liquid, 1 month's supply = 1 unit (Description change 1/1/2010)   | 06 | 484.3 |
| E0443 | Portable oxygen contents, gaseous, 1 month's supply = 1 unit (Description change 1/1/2010)  | 06 | 484.3 |
| E0444 | Portable oxygen contents, liquid, 1 month's supply = 1 unit (Description change 1/1/2010)   | 06 | 484.3 |
| E0445 | Oximeter device for measuring blood oxygen levels non-invasively (Eff. Date 1/1/2003)   | 06 |       |
| E0446 | Topical oxygen delivery system, not otherwise specified, includes all supplies and accessories (Eff. Date 1/1/2011)   |    |       |
| E0447 | Portable oxygen contents, liquid, 1 month's supply = 1 unit, prescribed amount at rest or nighttime exceeds 4 liters per minute (lpm) (Eff. Date 1/1/2019)  | 06 |       |

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| E0450 | Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) (Deleted eff.12/31/2015)   | 02 |
| E0455 | Oxygen tent, excluding croup or pediatric tents  | 06 |
| E0457 | Chest shell (cuirass)  | 05 |
| E0459 | Chest wrap   | 01 |
| E0460 | Negative pressure ventilator; portable or stationary (Deleted eff. 12/31/2015)   | 02 |
| E0461 | Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface (e.g., mask) (Eff. Date 1/1/2003) (Deleted eff. 12/31/2015)  | 02 |
| E0462 | Rocking bed with or without side rails   | 01 |
| E0463 | Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface (e.g., tracheostomy tube) (Eff. Date 1/1/2005) (Deleted eff. 12/31/2015)   | 02 |
| E0464 | Pressure support ventilator, with volume control mode, may include pressure control mode, used with non-invasive interface (e.g., mask) (Eff. Date 1/1/2005) (Deleted eff. 12/31/2015)   | 02 |
| E0465 | Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube) (Eff. Date 1/1/2016)  | 02 |
| E0466 | Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell). (Eff. Date 1/1/2016)   | 02 |
| E0467 | Home ventilator, multi-function respiratory device, also performs any or all of the additional functions of oxygen concentration, drug nebulization, aspiration, and cough stimulation, includes all accessories, components and supplies for all functions (Eff. Date 1/1/2019) | 02 |
| E0468 | Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions (Eff. Date 04/01/2024)  | 02 |
| E0469 | Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (Eff. Date 10/01/2024)   | 01 |
| E0470 | Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (Eff. Date 1/1/2004)                               | 01 |
| E0471 | Respiratory assist device, bi-level pressure capability, with backup rate feature, used with noninvasive interface, e.g. nasal or facial mask (intermittent assist device with continuous positive airway pressure device) (Eff. Date 1/1/2004)                                  | 01 |



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| E0472 | Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface, e.g. tracheostomy tube (intermittent assist device with continuous positive airway pressure device) (Eff. Date 1/1/2004)             | 01 |  |
| E0480 | Percussor, electric or pneumatic, home model  | 01 |  |
| E0481 | Intrapulmonary percussive ventilation system and related accessories (not valid for Medicare) (Eff. Date 1/1/2002)  |    |  |
| E0482 | Cough stimulating device, alternating positive and negative airway pressure (Eff. Date 1/1/2002)  | 01 |  |
| E0483 | High frequency chest wall oscillation system, with full anterior and/or posterior thoracic region receiving simultaneous external oscillation, includes all accessories and supplies, each (Eff. Date 1/1/2003, Revised 1/1/2019, Revised 10/01/2022) | 01 |  |
| E0484 | Oscillatory positive expiratory pressure device, non-electric, any type, each (Eff. Date 1/1/2003)  | 05 |  |
| E0485 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 05 |  |
| E0486 | Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 05 |  |
| E0487 | Spirometer, electronic, includes all accessories (Eff. Date 1/1/2009)   |    |  |
| E0490 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote (Eff. Date 10/01/2023)   | 01 |  |
| E0491 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply (Eff. Date 10/01/2023)                      | 5  |  |
| E0492 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application (Eff. Date 01/01/2024)   |    |  |
| E0493 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply (Eff. Date 01/01/2024)                    |    |  |
| E0500 | IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source  | 02 |  |
| E0530 | Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type (Eff. Date 01/01/2024)  | 01 |  |

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|-------|---|----|
| E0550 | Humidifier, durable for extensive supplemental humidification during IPPB treatments or oxygen delivery   | 01 |
| E0555 | Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter       | 06 |
| E0560 | Humidifier, durable for supplemental humidification during IPPB treatment or oxygen delivery              | 05 |
| E0561 | Humidifier, non-heated, used with positive airway pressure device (Eff. Date 1/1/2004)                    | 05 |
| E0562 | Humidifier, heated, used with positive airway pressure device (Eff. Date 1/1/2004)                        | 05 |
| E0565 | Compressor, air power source for equipment which is not self-contained or cylinder driven                 | 01 |
| E0570 | Nebulizer, with compressor  | 01 |
| E0571 | Aerosol compressor, battery powered, for use with small volume nebulizer (Deleted eff. 06/31/2011)        | 01 |
| E0572 | Aerosol compressor, adjustment pressure, light duty for intermittent use (Eff. Date 1/1/2001)             | 01 |
| E0574 | Ultrasonic/electronic generator with small volume nebulizer (Eff. Date 1/1/2001)                          | 01 |
| E0575 | Nebulizer; ultrasonic, large volume (payment category changed eff. 1/1/2011)                              | 01 |
| E0580 | Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter       | 06 |
| E0585 | Nebulizer, with compressor and heater   | 01 |
| E0600 | Respiratory suction pump, home model, portable or stationary, electric (Eff. Date 1/1/2002)               | 01 |
| E0601 | Continuous positive airway pressure (cpap) device (Revised 01/01/2014)                                    | 01 |
| E0602 | Breast pump, manual, any type (Eff. Date 1/1/2002)  |    |
| E0603 | Breast pump, electric (AC and/or DC), any type (Eff. Date 1/1/2002)                                       |    |
| E0604 | Breast pump, hospital grade electric (AC and/or DC) any type (Updated Description 1/1/2008)               |    |
| E0605 | Vaporizer, room type  | 05 |
| E0606 | Postural drainage board   | 01 |
| E0607 | Home blood glucose monitor  | 05 |
| E0610 | Pacemaker monitor, self-contained, (checks battery depletion, includes audible and visible check systems) | 05 |

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|-------|---|----|--------|
| E0615 | Pacemaker monitor, self contained, checks battery depletion and other pacemaker components, includes digital/visible check systems                            | 05 |        |
| E0616 | Implantable cardiac event recorder with memory, activator and programmer (Eff. Date 1/1/2000)   |    |        |
| E0617 | External defibrillator with integrated electrocardiogram analysis (Eff. Date 1/1/2001)  |    |        |
| E0618 | Apnea monitor, without recording feature (Eff. Date 1/1/2003)   | 01 |        |
| E0619 | Apnea monitor, with recording feature (Eff. Date 1/1/2003)  | 01 |        |
| E0620 | Skin piercing device for collection of capillary blood, laser, each (Eff. Date 1/1/2002)  | 01 |        |
| E0621 | Sling or seat, patient lift, canvas or nylon  | 05 |        |
| E0625 | Patient lift, bathroom or toilet, not otherwise classified (not payable by Medicare) (Eff. Date 1/1/2005)   |    |        |
| E0627 | Seat lift mechanism, electric, any type (Updated description 1/1/2017)  | 05 | 07.03A |
| E0628 | Separate seat lift mechanism for use with patient owned furniture-electric (Deleted eff. 12/31/2016)  | 05 | 07.03A |
| E0629 | Seat lift mechanism, non-electric, any type (Updated description 1/1/2017)  | 05 | 07.03A |
| E0630 | Patient lift, hydraulic or mechanical, includes any seat, sling, strap(s) or pad(s) (Updated Description 1/1/2008)  | 01 |        |
| E0635 | Patient lift, electric with seat or sling   | 01 |        |
| E0636 | Multipositional patient support system, with integrated lift, patient accessible controls (Eff. Date 1/1/2003)  | 01 |        |
| E0637 | Combination sit to stand frame/table system, any size including pediatric, with seatlift feature, with or without wheels (Eff. Date 1/1/2012)                 | 05 |        |
| E0638 | Standing frame/table system, one position (e.g., upright, supine or prone stander), any size including pediatric, with or without wheels (Eff. Date 1/1/2012) | 05 |        |
| E0639 | Patient lift, moveable from room to room with disassembly and reassembly, includes all components/accessories (Eff. Date 1/1/2005)                            |    |        |
| E0640 | Patient lift, fixed system, includes all components/accessories (Eff. Date 1/1/2005)  | 01 |        |
| E0641 | Standing frame/table system, multi-position (e.g., three-way stander), any size including pediatric, with or without wheels (Eff. Date 1/1/2012)              | 01 |        |

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| E0642 | Standing frame/table system, mobile (dynamic stander), any size including pediatric (Eff. Date 1/1/2012)   |    |        |
| E0650 | Pneumatic compressor, non-segmental home model   | 05 | 04.04B |
| E0651 | Pneumatic compressor, segmental home model without calibrated gradient pressure  | 05 | 04.04B |
| E0652 | Pneumatic compressor, segmental home model with calibrated gradient pressure   | 05 | 04.04B |
| E0655 | Non-segmental pneumatic appliance for use with pneumatic compressor, half arm  | 05 | 04.04B |
| E0656 | Segmental pneumatic appliance for use with pneumatic compressor, trunk (Eff. Date 1/1/2009)  | 01 | 04.04B |
| E0657 | Segmental pneumatic appliance for use with pneumatic compressor, (Eff. Date 1/1/2009)  | 01 | 04.04B |
| E0660 | Non-segmental pneumatic appliance for use with pneumatic compressor, full leg  | 05 | 04.04B |
| E0665 | Non-segmental pneumatic appliance for use with pneumatic compressor, full arm  | 05 | 04.04B |
| E0666 | Non-segmental pneumatic appliance for use with pneumatic compressor, half leg  | 05 | 04.04B |
| E0667 | Segmental pneumatic appliance for use with pneumatic compressor, full leg  | 05 | 04.04B |
| E0668 | Segmental pneumatic appliance for use with pneumatic compressor, full arm  | 05 | 04.04B |
| E0669 | Segmental pneumatic appliance for use with pneumatic compressor, half leg  | 05 | 04.04B |
| E0670 | Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full legs and trunk (Eff. Date 1/1/2013)  | 05 | 04.04B |
| E0671 | Segmental gradient pressure pneumatic appliance, full leg  | 05 | 04.04B |
| E0672 | Segmental gradient pressure pneumatic appliance, full arm  | 05 | 04.04B |
| E0673 | Segmental gradient pressure pneumatic appliance, half leg  | 05 | 04.04B |
| E0675 | Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency (unilateral or bilateral system) (Eff. Date 1/1/2004) | 01 |        |
| E0676 | Intermittent limb compression device (includes all accessories), not otherwise classified (Eff. Date 1/1/2007)   |    |        |
| E0677 | Non-pneumatic sequential compression garment, trunk (Eff. Date 04/01/2023)   | 01 |        |

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| E0678 | Non-pneumatic sequential compression garment, full leg (Eff. Date 01/01/2024)   | 01 |        |
| E0679 | Non-pneumatic sequential compression garment, half leg (Eff. Date 01/01/2024)   | 01 |        |
| E0680 | Non-pneumatic compression controller with sequential calibrated gradient pressure (Eff. Date 01/01/2024)  | 01 |        |
| E0681 | Non-pneumatic compression controller without calibrated gradient pressure (Eff. Date 01/01/2024)  | 01 |        |
| E0682 | Non-pneumatic sequential compression garment, full arm (Eff. Date 01/01/2024)   | 01 |        |
| E0683 | Non-pneumatic, non-sequential, peristaltic wave compression pump (Eff. Date 10/01/2024)   | 01 |        |
| E0691 | Ultraviolet light therapy system panel, includes bulbs/lamps, timer and eye protection; treatment area 2 square feet or less (Eff. Date 1/1/2003) | 05 |        |
| E0692 | Ultraviolet light therapy system panel, includes bulb/lamps, timer and eye protection; 4 foot panel (Eff. Date 1/1/2003)                          | 05 |        |
| E0693 | Ultraviolet light therapy system panel, includes bulb/lamps, timer and eye protection; 6 foot panel (Eff. Date 1/1/2003)                          | 05 |        |
| E0694 | Ultraviolet multidirectional light therapy system in 6 foot cabinet, includes bulb/lamps, timer and eye protection (Eff. Date 1/1/2003)           | 05 |        |
| E0700 | Safety equipment, device or accessory, any type (Description change 1/1/2010)   |    |        |
| E0705 | Transfer device, any type, each (Updated Description 1/1/2008)  |    |        |
| E0710 | Restraints, any type (body, chest, wrist or ankle)  |    |        |
| E0711 | Upper extremity medical tubing/lines enclosure or covering device, restricts elbow range of motion (Eff. Date 04/01/2023)                         |    |        |
| E0715 | Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises (Eff. Date 10/01/2024)                                     |    |        |
| E0716 | Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises (Eff. Date 10/01/2024)        |    |        |
| E0720 | Transcutaneous Electrical Nerve Stimulation (TENS) device, two lead, localized stimulation  | 05 | 06.03B |
| E0721 | Transcutaneous electrical nerve stimulatory, stimulates nerves in the auricular region (Eff. Date 10/01/2024)                                     |    |        |
| E0730 | Transcutaneous Electrical Nerve Stimulation (TENS) device, four or more leads, for multiple nerve stimulation                                     | 05 | 06.03B |

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| E0731 | Form fitting conductive garment for delivery of TENS or NMES (with conductive fibers separated from the patient's skin by layers of fabric)  | 05 |        |
| E0732 | Cranial electrotherapy stimulation (ces) system, any type (Eff. Date 01/01/2024)   | 01 |        |
| E0733 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Eff. Date 01/01/2024)   | 01 |        |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist (Eff. Date 01/01/2024)   | 01 |        |
| E0735 | Non-invasive vagus nerve stimulator (Eff. Date 01/01/2024)   | 01 |        |
| E0736 | Transcutaneous tibial nerve stimulator (Eff. Date 04/01/2024)  | 01 |        |
| E0737 | Transcutaneous tibial nerve stimulator, controlled by phone application (Eff. Date 10/01/2024)   |    |        |
| E0738 | Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories (Eff. Date 04/01/2024)   | 01 |        |
| E0739 | Rehab system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors (Eff. Date 04/01/2024)<br>Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors (Revised eff. 10/01/2024) |    |        |
| E0740 | Non-implanted pelvic floor electrical stimulator, complete system (Updated description 1/1/2017)   | 01 |        |
| E0743 | External lower extremity nerve stimulator for restless legs syndrome, each (Eff. Date 10/01/2024)  | 01 |        |
| E0744 | Neuromuscular stimulator for scoliosis   | 01 |        |
| E0745 | Neuromuscular stimulator, electronic shock unit  | 01 |        |
| E0746 | Electromyography (EMG), biofeedback device   |    |        |
| E0747 | Osteogenesis stimulator, electrical, non-invasive, other than spinal applications  | 05 | 04.04C |
| E0748 | Osteogenesis stimulator, electrical, non-invasive, spinal applications   | 05 | 04.04C |
| E0755 | Electronic salivary reflex stimulator (intra-oral/non-invasive)  |    |        |
| E0760 | Ostogenesis stimulator, low intensity ultrasound, non-invasive   | 05 | 04.04C |
| E0761 | Non-thermal pulsed high frequency radiowaves, high peak power electromagnetic energy treatment device (Eff. Date 1/1/2003)   | 17 |        |
| E0762 | Transcutaneous electrical joint stimulation device system, includes all accessories (Eff. Date 1/1/2006)   | 01 |        |

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| E0764 | Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program (Eff. Date 1/1/2006, Updated Date 1/1/2009) | 01 |       |
| E0765 | FDA approver nerve stimulator, with replaceable batteries, for treatment of nausea and vomiting (Eff. Date 1/1/2001)   |    |       |
| E0766 | Electrical stimulation device used for cancer treatment, includes all accessories, any type (Eff. 01/01/2014)  |    |       |
| E0767 | Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories (Eff. Date 10/01/2024)  |    |       |
| E0769 | Electrical stimulation or electromagnetic wound treatment device, not otherwise classified (Eff. Date 1/1/2005)  |    |       |
| E0770 | Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified (Eff. Date 1/1/2009)  | 17 |       |
| E0776 | IV pole  | 05 | 09.03 |
| E0779 | Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater (Eff. Date 1/1/2000)   | 01 | 09.03 |
| E0780 | Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours (Eff. Date 1/1/2000)  | 05 | 09.03 |
| E0781 | Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient  | 01 | 09.03 |
| E0784 | External ambulatory infusion pump, insulin   | 01 | 09.03 |
| E0787 | External ambulatory infusion pump, insulin, dosage rate adjustment using therapeutic continuous glucose sensing (Eff. Date 1/1/2020) (Deleted eff. 09/14/2020)   | 21 |       |
| E0791 | Parenteral infusion pump, stationary, single or multi-channel  | 01 | 09.03 |
| E0830 | Ambulatory traction device, all types, each (Eff. Date 1/1/2001)   |    |       |
| E0840 | Traction frame, attached to headboard, cervical traction   | 05 |       |
| E0849 | Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible (Eff. Date 1/1/2005)  | 01 |       |
| E0850 | Traction stand, free standing, cervical traction   | 05 |       |
| E0855 | Cervical traction equipment not requiring additional stand or frame  | 01 |       |
| E0856 | Cervical traction device, with inflatable air bladder(s) (Eff. Date 1/1/2008) (Updated 01/01/2015)   | 01 |       |
| E0860 | Traction equipment, overdoor, cervical   | 05 |       |
| E0870 | Traction frame, attached to footboard, extremity traction, (e.g. buck's)   | 05 |       |

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| E0880 | Traction stand, free standing, extremity traction (Description change 10/01/2020)  | 05 |
| E0890 | Traction frame, attached to footboard, pelvic traction   | 05 |
| E0900 | Traction stand, free standing, pelvic traction, (e.g., buck's)   | 05 |
| E0910 | Trapeze bars, a/k/a patient helper, attached to bed, with grab bar   | 01 |
| E0911 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, attached to bed, with grab bar (Eff. Date 1/1/2006)        | 01 |
| E0912 | Trapeze bar, heavy duty, for patient weight capacity greater than 250 pounds, free standing, complete with grab bar (Eff. Date 1/1/2006) | 01 |
| E0920 | Fracture frame, attached to bed, includes weights  | 01 |
| E0930 | Fracture frame, free standing, includes weights  | 01 |
| E0935 | Continuous passive motion exercise device for use on knee only   | 02 |
| E0936 | Continuous passive motion exercise device for use other than knee (Eff. Date 1/1/2007)   |    |
| E0940 | Trapeze bar, free standing, complete with grab bar   | 01 |
| E0941 | Gravity assisted traction device, any type   | 01 |
| E0942 | Cervical head harness/halter   | 05 |
| E0944 | Pelvic belt/harness/boot   | 05 |
| E0945 | Extremity belt/harness   | 05 |
| E0946 | Fracture, frame, dual with cross bars, attached to bed, (e.g., balken, 4 poster)   | 01 |
| E0947 | Fracture frame, attachments for complex pelvic traction  | 05 |
| E0948 | Fracture frame, attachments for complex cervical traction  | 05 |
| E0950 | Wheelchair accessory, tray, each   | 05 |
| E0951 | Heel loop/holder, any type, with or without ankle strap, each  | 05 |
| E0952 | Toe loop/holder, any type, each  | 05 |
| E0953 | Wheelchair accessory, lateral thigh or knee support, any type including fixed mounting hardware, each (Eff. Date 01/01/2018)             | 05 |
| E0954 | Wheelchair accessory, foot box, any type, includes attachment and mounting hardware, each foot (Eff. Date 01/01/2018)                    | 05 |
| E0955 | Wheelchair accessory, headrest, cushioned, any type, including fixed mounting hardware, each (Eff. Date 1/1/2004)                        | 01 |
| E0956 | Wheelchair accessory, lateral trunk or hip support, any type, including fixed mounting hardware, each (Eff. Date 1/1/2004)               | 05 |



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| E0957 | Wheelchair accessory, medial thigh support, any type, including fixed mounting hardware, each (Eff. Date 1/1/2004)                           | 05 |  |
| E0958 | Manual wheelchair accessory, one-arm drive attachment, each (Eff. Date 1/1/2003)   | 01 |  |
| E0959 | Manual wheelchair accessory, adapter for amputee, each (Eff. Date 1/1/2004)  | 05 |  |
| E0960 | Wheelchair accessory, shoulder harness/straps or chest strap, including any type mounting hardware (Eff. Date 1/1/2004)                      | 05 |  |
| E0961 | Manual wheelchair accessory, wheel lock brake extension (handle), each (Eff. Date 1/1/2004)  | 05 |  |
| E0966 | Manual wheelchair accessory, headrest extension, each (Eff. Date 1/1/2004)   | 05 |  |
| E0967 | Manual wheelchair accessory, hand rim with projections, any type, replacement only, each (Eff. Date 1/1/2004) (Updated description 1/1/2017) | 05 |  |
| E0968 | Commode seat, wheelchair (Deleted eff. 1/1/1993)   | 01 |  |
| E0969 | Narrowing device, wheelchair (Deleted eff. 1/1/1993)   | 05 |  |
| E0971 | Manual Wheelchair accessory, anti-tipping device, each (Eff. Date 1/1/2003)  | 05 |  |
| E0973 | Wheelchair accessory, adjustable height, detachable armrest, complete assembly, each (Eff. Date 1/1/2004)                                    | 05 |  |
| E0974 | Manual wheelchair accessory, anti-rollback device, each (Eff. Date 1/1/2004)   | 05 |  |
| E0978 | Wheelchair accessory, positioning belt/safety belt/pelvic strap, each (Eff. Date 1/1/2004)   | 05 |  |
| E0981 | Wheelchair accessory, seat upholstery, replacement only, each (Eff. Date 1/1/2004)   | 05 |  |
| E0982 | Wheelchair accessory, back upholstery, replacement only, each (Eff. Date 1/1/2004)   | 05 |  |
| E0983 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, joystick control (Eff. Date 1/1/2004)        | 01 |  |
| E0984 | Manual wheelchair accessory, power add-on to convert manual wheelchair to motorized wheelchair, tiller control (Eff. Date 1/1/2004)          | 01 |  |
| E0985 | Wheelchair accessory, seat lift mechanism (Eff. Date 1/1/2004)   | 01 |  |
| E0986 | Manual wheelchair accessory, push-rim activated power assist system (Eff. Date 1/1/2004) (Updated 01/01/2015)                                | 01 |  |
| E0988 | Manual wheelchair accessory, lever-activated, wheel drive, pair (Eff. Date 01/01/2012)   | 01 |  |

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| E0990 | Wheelchair accessory, elevating leg rest, complete assembly, each (Eff. Date 1/1/2004)   | 05 |
| E0992 | Manual wheelchair accessory, solid seat insert (Eff. Date 1/1/2004)  | 05 |
| E0995 | Wheelchair accessory, calf rest/pad, replacement only, each (Eff. Date 1/1/2004) (Updated description 1/1/2017)  | 05 |
| E1002 | Wheelchair accessory, power seating system, tilt only (Eff. Date 1/1/2004)   | 01 |
| E1003 | Wheelchair accessory, power seating system, recline only, without shear reduction (Eff. Date 1/1/2004)   | 01 |
| E1004 | Wheelchair accessory, power seating system, recline only, with mechanical shear reduction (Eff. Date 1/1/2004)   | 01 |
| E1005 | Wheelchair accessory, power seating system, recline only, with power shear reduction (Eff. Date 1/1/2004)  | 01 |
| E1006 | Wheelchair accessory, power seating system, combination tilt and recline, without shear reduction (Eff. Date 1/1/2004)                                       | 01 |
| E1007 | Wheelchair accessory, power seating system, combination tilt and recline, with mechanical shear reduction (Eff. Date 1/1/2004)                               | 01 |
| E1008 | Wheelchair accessory, power seating system, combination tilt and recline, with power shear reduction (Eff. Date 1/1/2004)                                    | 01 |
| E1009 | Wheelchair accessory, addition to power seating system, mechanically linked leg elevation system, including pushrod and legrest, each (Eff. Date 1/1/2004)   | 05 |
| E1010 | Wheelchair accessory, addition to power seating system, power leg elevation system, including leg rest, pair (Eff. Date 1/1/2004)                            | 01 |
| E1011 | Modification to pediatric size wheelchair, width adjustment package (not to be dispensed with initial chair) (Eff. Date 1/1/2003)                            | 05 |
| E1012 | Wheelchair accessory, addition to power seating system, center mount power elevating leg rest/platform, complete system, any type, each (Eff. Date 1/1/2016) | 01 |
| E1014 | Reclining back, addition to pediatric size wheelchair (Eff. Date 1/1/2003)   | 01 |
| E1015 | Shock absorber for manual wheelchair, each (Eff. Date 1/1/2003)  | 05 |
| E1016 | Shock absorber for power wheelchair, each (Eff. Date 1/1/2003)   | 05 |
| E1017 | Heavy duty shock absorber for heavy duty or extra heavy duty manual wheelchair, each (Eff. Date 1/1/2003)  | 05 |
| E1018 | Heavy duty shock absorber for heavy duty or extra heavy duty power wheelchair, each (Eff. Date 1/1/2003)   | 05 |
| E1020 | Residual limb support system for wheelchair, any type (Eff. Date 1/1/2003) (Updated 01/01/2013)  | 01 |

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| E1028 | Wheelchair accessory, manual swingaway, retractable, or removable mounting hardware for joystick, other control interface or positioning accessory (Eff. Date 1/1/2004)                        | 01 |
| E1029 | Wheelchair accessory, ventilator tray, fixed (Eff. Date 1/1/2004)  | 01 |
| E1030 | Wheelchair accessory, ventilator tray, gimbaled (Eff. Date 1/1/2004)   | 01 |
| E1031 | Rollabout chair, any and all types with casters 5" or greater  | 01 |
| E1035 | Multi-positional patient transfer system, with integrated seat, operated by care giver, patient weight capacity up to and including 300 lbs (Eff. Date 1/1/2001) (Description Change 1/1/2010) | 01 |
| E1036 | Multi-positional patient transfer system, extra-wide, with integrated seat, operated by caregiver, patient weight capacity great than 300 lbs (Eff. Date 1/1/2010)                             | 01 |
| E1037 | Transport chair, pediatric size (Eff. Date 1/1/2003)   | 01 |
| E1038 | Transport chair, adult size, patient weight capacity up to and including 300 pounds (Eff. Date 1/1/2003)   | 01 |
| E1039 | Transport chair, adult size, heavy duty, patient weight capacity greater than 300 pounds (Eff. Date 1/1/2005)  | 01 |
| E1161 | Manual adult size wheelchair, includes tilt in space (Eff. Date 1/1/2003)  | 01 |
| E1225 | Wheelchair accessory, manual semi-reclining back, (recline greater than 15 degrees, but less than 80 degrees), each (Eff. Date 1/1/2004)   | 01 |
| E1226 | Wheelchair accessory, manual fully reclining back, (recline greater than 80 degrees), each (Eff. Date 1/1/2004)  | 05 |
| E1229 | Wheelchair pediatric size, not otherwise specified (Eff. Date 1/1/2005)  | 05 |
| E1231 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, with seating system (Eff. Date 1/1/2003)   | 05 |
| E1232 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, with seating system (Eff. Date 1/1/2003)   | 01 |
| E1233 | Wheelchair, pediatric size, tilt-in-space, rigid, adjustable, without seating system (Eff. Date 1/1/2003)  | 01 |
| E1234 | Wheelchair, pediatric size, tilt-in-space, folding, adjustable, without seating system (Eff. Date 1/1/2003)  | 01 |
| E1235 | Wheelchair, pediatric size, rigid, adjustable, with seating system (Eff. Date 1/1/2003)  | 01 |
| E1236 | Wheelchair, pediatric size, folding, adjustable, with seating system (Eff. Date 1/1/2003)  | 01 |

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| E1237 | Wheelchair, pediatric size, rigid, adjustable, without seating system (Eff. Date 1/1/2003)   | 01 |       |
| E1238 | Wheelchair, pediatric size, folding, adjustable, without seating system (Eff. Date 1/1/2003)   | 01 |       |
| E1239 | Power wheelchair, pediatric size, not otherwise specified (Eff. Date 1/1/2005)   | 01 |       |
| E1300 | Whirlpool, portable (overtub type)   |    |       |
| E1301 | Whirlpool tub, walk-in, portable (Eff. Date 01/01/2024)  |    |       |
| E1310 | Whirlpool, non-portable (built-in type)  | 05 |       |
| E1352 | Oxygen accessory, flow regulator capable of positive inspiratory pressure (Eff. Date 01/01/2014)   |    | 484.3 |
| E1353 | Regulator  |    | 484.3 |
| E1354 | Oxygen accessory, wheeled cart for portable cylinder or portable concentrator, any type, replacement only, each (Eff. Date 1/1/2009)   |    |       |
| E1355 | Stand/rack   |    |       |
| E1356 | Oxygen accessory, battery pack/cartridge, for portable concentrator, any type, replacement only, each (Eff. Date 1/1/2009)   |    |       |
| E1357 | Oxygen accessory, batter charger for portable concentrator, any type, replacement only, each (Eff. Date 1/1/2009)  |    |       |
| E1358 | Oxygen accessory, DC power adapter for portable concentrator, any type, replacement only, each (Eff. Date 1/1/2009)  |    |       |
| E1372 | Immersion external heater for nebulizer  | 05 |       |
| E1390 | Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater concentration at the prescribed flow rate (Eff. Date 1/1/2000)  | 06 | 484.3 |
| E1391 | Oxygen concentrator, dual delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate, each (Eff. Date 1/1/2004)   | 05 | 484.3 |
| E1392 | Portable oxygen concentrator, rental (Eff. Date 1/1/2006)  | 06 | 484.3 |
| E1399 | Durable medical equipment, miscellaneous   | 14 |       |
| E1405 | Oxygen and water vapor enriching system with heated delivery   | 06 | 484.3 |
| E1406 | Oxygen and water vapor enriching system without heated delivery  | 06 | 484.3 |
| E1500 | Centrifuge, for dialysis (Eff. Date 1/1/2002)  | 19 |       |
| E1510 | Kidney, dialysate delivery syst. kidney machine, pump recirculating, air removal syst, flowrate meter, power off, heater and temperature control with alarm, i.v. poles, pressure gauge, concentrate container | 19 |       |

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| E1520 | Heparin infusion pump for hemodialysis   | 19 |
| E1530 | Air bubble detector for hemodialysis, each, replacement                            | 19 |
| E1540 | Pressure alarm for hemodialysis, each, replacement                                 | 19 |
| E1550 | Bath conductivity meter for hemodialysis, each                                     | 19 |
| E1560 | Blood leak detector for hemodialysis, each, replacement                            | 19 |
| E1570 | Adjustable chair, for ESRD patients  | 19 |
| E1575 | Transducer protectors/fluid barriers, for hemodialysis, any size, per 10           | 19 |
| E1580 | Unipuncture control system for hemodialysis  | 19 |
| E1590 | Hemodialysis machine   | 19 |
| E1592 | Automatic intermittent peritoneal dialysis system                                  | 19 |
| E1594 | Cycler dialysis machine for peritoneal dialysis                                    | 19 |
| E1600 | Delivery and/or installation charges for hemodialysis equipment                    | 19 |
| E1610 | Reverse osmosis water purification system, for hemodialysis                        | 19 |
| E1615 | Deionizer water purification system, for hemodialysis                              | 19 |
| E1620 | Blood pump for hemodialysis, replacement   | 19 |
| E1625 | Water softening system, for hemodialysis   | 19 |
| E1629 | Tablo hemodialysis system for the billable dialysis service (Eff. Date 01/01/2022) | 19 |
| E1630 | Reciprocating peritoneal dialysis system   | 19 |
| E1632 | Wearable artificial kidney, each   | 19 |
| E1634 | Peritoneal dialysis clamps, each (Eff. Date 1/1/2004)                              | 19 |
| E1635 | Compact (portable) travel hemodialyzer system                                      | 19 |
| E1636 | Sorbent cartridges, for hemodialysis, per 10                                       | 19 |
| E1637 | Hemostats, each (Eff. Date 1/1/2002)   | 19 |
| E1639 | Scale, each (Eff. Date 1/1/2002)   | 19 |
| E1699 | Dialysis equipment, not otherwise specified  | 14 |
| E1700 | Jaw motion rehabilitation system   | 01 |
| E1701 | Replacement cushions for jaw motion rehabilitation system, pkg. of 6               | 13 |
| E1702 | Replacement measuring scales for jaw motion rehabilitation system, pkg. of 200     | 13 |

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| E1800 | Dynamic adjustable elbow extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)  | 01 |
| E1801 | Static progressive stretch elbow device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008) | 01 |
| E1802 | Dynamic adjustable forearm pronation/supination device, includes soft interface (Eff. Date 1/1/2003)  | 01 |
| E1803 | Dynamic adjustable elbow extension only device, includes soft interface material (Eff. Date 01/1/2025)  | 01 |
| E1804 | Dynamic adjustable elbow flexion only device, includes soft interface material (Eff. Date 1/1/2025)   | 01 |
| E1805 | Dynamic adjustable wrist extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)  | 01 |
| E1806 | Static progressive stretch wrist device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008) | 01 |
| E1807 | Dynamic adjustable wrist extension only device, includes soft interface material (Eff. Date 01/1/2025)  | 01 |
| E1808 | Dynamic adjustable wrist flexion only device, includes soft interface material (Eff. Date 01/1/2025)  | 01 |
| E1810 | Dynamic adjustable knee extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)   | 01 |
| E1811 | Static progressive stretch knee device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008)  | 01 |
| E1812 | Dynamic knee, extension/flexion device with active resistance control (Eff. Date 1/1/2006)  | 01 |
| E1813 | Dynamic adjustable knee extension only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1814 | Dynamic adjustable knee flexion only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1815 | Dynamic adjustable ankle extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)  | 01 |
| E1816 | Static progressive stretch ankle device, flexion and/or extension, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008) | 01 |

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| E1818 | Static progressive stretch forearm pronation / supination device, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008) | 01 |
| E1820 | Replacement soft interface material, dynamic adjustable extension/flexion device   | 05 |
| E1821 | Replacement soft interface material/cuffs for bi-directional static progressive stretch device (Eff. Date 1/1/2002)  | 05 |
| E1822 | Dynamic adjustable ankle extension only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1823 | Dynamic adjustable ankle flexion only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1825 | Dynamic adjustable finger extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)  | 01 |
| E1826 | Dynamic adjustable finger extension only device, includes soft interface material (Eff. Date 01/1/2025)  | 01 |
| E1827 | Dynamic adjustable finger flexion only device, includes soft interface material (Eff. Date 01/1/2025)  | 01 |
| E1828 | Dynamic adjustable toe extension only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1829 | Dynamic adjustable toe flexion only device, includes soft interface material (Eff. Date 01/1/2025)   | 01 |
| E1830 | Dynamic adjustable toe extension and flexion device, includes soft interface material (Rev. Eff. 1/1/2025)   | 01 |
| E1831 | Static progressive stretch toe device, extension and/or flexion, with or without range of motion adjustment, includes all components and accessories (Eff. Date 1/1/2011)            | 01 |
| E1840 | Dynamic adjustable shoulder flexion/abduction/rotation device, includes soft interface material (Eff. Date 1/1/2002)   | 01 |
| E1841 | Static progressive stretch shoulder device, with or without range of motion adjustment, includes all components and accessories (Updated Description 1/1/2008)                       | 01 |
| E1900 | Synthesized Speech Augmentative Comm. device with Dynamic Display (Deleted eff. 12/31/2001)  |    |
| E1902 | Communication board, non-electronic augmentation or alternative communication device (Eff. Date 1/1/2002)  |    |
| E1905 | Virtual reality cognitive behavioral therapy device (CBT), including pre-programmed therapy software (Eff. Date 04/01/2023) (Revised eff. 10/01/2023)                                | 01 |

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| E2000 | Gastric suction pump, home model, portable or stationary, electric (Eff. Date 1/1/2002)   | 01 |
| E2001 | Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system (Eff. Date 01/01/2024) Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system (Revised eff. 04/01/2024) | 01 |
| E2100 | Blood glucose monitor with integrated voice synthesizer (Eff. Date 1/1/2002)  | 05 |
| E2101 | Blood glucose monitor with integrated lancing/blood sample (Eff. Date 1/1/2002)   | 05 |
| E2102 | (Eff. Date 04/01/2022) Adjunctive, non-implanted continuous glucose monitor or receiver (Revised 01/01/2023)  | 05 |
| E2103 | Non-adjunctive, non-implanted continuous glucose monitor or receiver (Eff. Date 01/01/2023)   | 05 |
| E2104 | Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge (Eff. Date 04/01/2024)  |    |
| E2120 | Pulse generator system for the tympanic treatment of inner ear endolymphatic fluid (Eff. Date 1/1/2004)   | 01 |
| E2201 | Manual wheelchair accessory, nonstandard seat frame, width greater than or equal to 20 inches but less than 24 inches (Eff. Date 1/1/2004)  | 05 |
| E2202 | Manual wheelchair accessory, nonstandard seat frame width, 24-27 inches (Eff. Date 1/1/2004)  | 05 |
| E2203 | Manual wheelchair accessory, nonstandard seat frame depth, 20 to less than 22 inches (Eff. Date 1/1/2004)   | 05 |
| E2204 | Manual wheelchair accessory, nonstandard seat frame depth, 22 to 25 inches (Eff. Date 1/1/2004)   | 05 |
| E2205 | Manual wheelchair accessory, handrim without projections (includes ergonomic or contoured) any type, replacement only, each (Updated Description 1/1/2008)  | 05 |
| E2206 | Manual wheelchair accessory, wheel lock assembly, complete, replacement only, each (Eff. Date 1/1/2005) (Updated description 1/1/2017)  | 05 |
| E2207 | Wheelchair accessory, crutch and cane holder, each (Eff. Date 1/1/2006)   | 05 |
| E2208 | Wheelchair accessory, cylinder tank carrier, each (Eff. Date 1/1/2006)  | 05 |
| E2209 | Accessory, arm trough, with or without hand support, each (Eff. Date 1/1/2006)  | 05 |



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| E2210 | Wheelchair accessory, bearings, any type, replacement only, each (Eff. Date 1/1/2006)   | 05 |
| E2211 | Manual wheelchair accessory, pneumatic propulsion tire, any size, each (Eff. Date 1/1/2006)   | 05 |
| E2212 | Manual wheelchair accessory, tube for pneumatic propulsion tire, any size, each (Eff. Date 1/1/2006)  | 05 |
| E2213 | Manual wheelchair accessory, insert for pneumatic propulsion tire (removable) any type, any size, each (Eff. Date 1/1/2006)   | 05 |
| E2214 | Manual wheelchair accessory, pneumatic caster tire, any size each (Eff. Date 1/1/2006)  | 05 |
| E2215 | Manual wheelchair accessory, tube for pneumatic caster tire, any size each (Eff. Date 1/1/2006)   | 05 |
| E2216 | Manual wheelchair accessory, foam filled propulsion tire, any size, each (Eff. Date 1/1/2006)   | 05 |
| E2217 | Manual wheelchair accessory, foam filled caster tire, any size, each (Eff. Date 1/1/2006)   | 05 |
| E2218 | Manual wheelchair accessory, foam propulsion tire, any size, each (Eff. Date 1/1/2006)  | 05 |
| E2219 | Manual wheelchair accessory, foam caster tire, any size, each (Eff. Date 1/1/2006)  | 05 |
| E2220 | Manual wheelchair accessory, solid (rubber/plastic) propulsion tire, any size, replacement only, each (Eff. Date 1/1/2006) (Updated description 1/1/2017)                   | 05 |
| E2221 | Manual wheelchair accessory, solid (rubber/plastic) caster tire (removable), any size, replacement only, each (Eff. Date 1/1/2006) (Updated description 1/1/2017)           | 05 |
| E2222 | Manual wheelchair accessory, solid (rubber/plastic) caster tire with integrated wheel, any size, replacement only, each (Eff. Date 1/1/2006) (Updated description 1/1/2017) | 05 |
| E2224 | Manual wheelchair accessory, propulsion wheel excludes tire, any size, replacement only, each (Eff. Date 1/1/2006) (Updated description 1/1/2017)                           | 05 |
| E2225 | Manual wheelchair accessory, caster wheel excludes tire, any size, replacement only, each (Eff. Date 1/1/2006)  | 05 |
| E2226 | Manual wheelchair accessory, caster fork, any size, replacement only, each (Eff. Date 1/1/2006)   | 05 |
| E2227 | Manual wheelchair accessory, gear reduction drive wheel, each (Eff. Date 1/1/2008)  | 01 |
| E2228 | Manual wheelchair accessory, wheel braking system and lock, complete, each (Eff. Date 1/1/2008)   | 01 |

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| E2230 | Manual wheelchair accessory, manual standing system (Eff. Date 1/1/2009)  |    |  |
| E2231 | Manual wheelchair accessory, solid seat support base (replaces sling seat) includes any type mounting hardware (Eff. Date 1/1/2009)   | 05 |  |
| E2291 | Back, planar, for pediatric size wheelchair including fixed attaching hardware (Eff. Date 1/1/2005)   | 05 |  |
| E2292 | Seat, planar, for pediatric size wheelchair including fixed attaching hardware (Eff. Date 1/1/2005)   | 05 |  |
| E2293 | Back, contoured, for pediatric size wheelchair including fixed attaching hardware (Eff. Date 1/1/2005)  | 05 |  |
| E2294 | Seat, contoured, for pediatric size wheelchair including fixed attaching hardware (Eff. Date 1/1/2005)  | 05 |  |
| E2295 | Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame, allows coordinated movement of multiple positioning features (Eff. Date 1/1/2009)  | 05 |  |
| E2298 | Complex rehabilitative power wheelchair accessory, power seat elevation system, any type (Eff. Date 04/01/2024)   |    |  |
| E2300 | Wheelchair accessory, power seat elevation system, any type (Eff. Date 1/1/2004) (Revised 01/01/2014) (Deleted eff. 03/31/2024)   | 01 |  |
| E2301 | Wheelchair accessory, power standing system, any type (Eff. Date 1/1/2004) (Revised 01/01/2014)   |    |  |
| E2310 | Power wheelchair accessory, electronic connection between wheelchair controller and one power seating system motor, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware (Eff. Date 1/1/2004)          | 01 |  |
| E2311 | Power wheelchair accessory, electronic connection between wheelchair controller and two or more power seating system motors, including all related electronics, indicator feature, mechanical function selection switch, and fixed mounting hardware (Eff. Date 1/1/2004) | 01 |  |
| E2312 | Power wheelchair accessory, hand or chin control interface, mini-proportional remote joystick, proportional, including fixed mounting hardware (Eff. Date 1/1/2008)   | 01 |  |
| E2313 | Power wheelchair accessory, harness for upgrade to expandable controller, including all fasteners, connectors and mounting hardware, each (Eff. Date 1/1/2008)  | 01 |  |
| E2321 | Power wheelchair accessory, hand control interface, remote joystick, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware (Eff. Date 1/1/2004)   | 01 |  |
| E2322 | Power wheelchair accessory, hand control interface, multiple mechanical switches, nonproportional, including all related electronics, mechanical stop switch, and fixed mounting hardware (Eff. Date 1/1/2004)  | 01 |  |

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| E2323 | Power wheelchair accessory, specialty joystick handle for hand control interface, prefabricated (Eff. Date 1/1/2004)   | 05 |
| E2324 | Power wheelchair accessory, chin cup for chin control interface (Eff. Date 1/1/2004)   | 05 |
| E2325 | Power wheelchair accessory, sip and puff interface, nonproportional, including all related electronics, mechanical stop switch, and manual swingaway mounting hardware (Eff. Date 1/1/2004)  | 01 |
| E2326 | Power wheelchair accessory, breath tube kit for sip and puff interface (Eff. Date 1/1/2004)  | 01 |
| E2327 | Power wheelchair accessory, head control interface, mechanical, proportional, including all related electronics, mechanical direction change switch, and fixed mounting hardware (Eff. Date 1/1/2004)  | 01 |
| E2328 | Power wheelchair accessory, head control or extremity control interface, electronic, proportional, including all related electronics and fixed mounting hardware (Eff. Date 1/1/2004)  | 01 |
| E2329 | Power wheelchair accessory, head control interface, contact switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware (Eff. Date 1/1/2004)   | 01 |
| E2330 | Power wheelchair accessory, head control interface, proximity switch mechanism, nonproportional, including all related electronics, mechanical stop switch, mechanical direction change switch, head array, and fixed mounting hardware (Eff. Date 1/1/2004) | 01 |
| E2331 | Power wheelchair accessory, attendant control, proportional, including all related electronics and fixed mounting hardware (Eff. Date 1/1/2004)  | 05 |
| E2340 | Power wheelchair accessory, nonstandard seat frame width, 20-23 inches (Eff. Date 1/1/2004)  | 05 |
| E2341 | Power wheelchair accessory, nonstandard seat frame width, 24-27 inches (Eff. Date 1/1/2004)  | 05 |
| E2342 | Power wheelchair accessory, nonstandard seat frame depth, 20 or 21 inches (Eff. Date 1/1/2004)   | 05 |
| E2343 | Power wheelchair accessory, nonstandard seat frame depth, 22-25 inches (Eff. Date 1/1/2004)  | 05 |
| E2351 | Power wheelchair accessory, electronic interface to operate speech generating device using power wheelchair control interface (Eff. Date 1/1/2004)   | 05 |
| E2358 | Power wheelchair accessory, group 34 non-sealed lead acid battery, each (Eff. Date 01/01/2012)   | 05 |
| E2359 | Power wheelchair accessory, group 34 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) (Eff. Date 01/01/2012)   | 05 |

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| E2360 | Power wheelchair accessory, 22 NF non-sealed lead acid battery, each (Eff. Date 1/1/2004)   | 05 |
| E2361 | Power wheelchair accessory, 22 NF sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) (Eff. Date 1/1/2004)   | 05 |
| E2362 | Power wheelchair accessory, Group 24 non-sealed lead acid battery, each (Eff. Date 1/1/2004)  | 05 |
| E2363 | Power wheelchair accessory, Group 24 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) (Eff. Date 1/1/2004)  | 05 |
| E2364 | Power wheelchair accessory, U-1 non-sealed lead acid battery, each (Eff. Date 1/1/2004)   | 05 |
| E2365 | Power wheelchair accessory, U-1 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat) (Eff. Date 1/1/2004)   | 05 |
| E2366 | Power wheelchair accessory, battery charger, single mode, for use with only one battery type, sealed or non-sealed, each (Eff. Date 1/1/2004)   | 05 |
| E2367 | Power wheelchair accessory, battery charger, dual mode, for use with either battery type, sealed or non-sealed, each (Eff. Date 1/1/2004)   | 05 |
| E2368 | Power wheelchair component, drive wheel motor, replacement only (Eff. Date 1/1/2005) (updated 01/01/2013)   | 01 |
| E2369 | Power wheelchair component, drive wheel gear box, replacement only (Eff. Date 1/1/2005) (updated 01/01/2013)  | 01 |
| E2370 | Power wheelchair component, integrated drive wheel motor and gear box combination, replacement only (Eff. Date 1/1/2005) (updated 01/01/2013)   | 01 |
| E2371 | Power wheelchair accessory, group 27 sealed lead acid battery, each (e.g., gel cell, absorbed glassmat), each (Eff. Date 1/1/2006)  | 05 |
| E2372 | Power wheelchair accessory, group 27 non-sealed lead acid battery, each (Eff. Date 1/1/2006)  | 05 |
| E2373 | Power wheelchair accessory, hand or chin control interface, compact remote joystick, proportional, including fixed mounting hardware (Updated Description 1/1/2008)   | 01 |
| E2374 | Power Wheelchair Accessory, hand or chin control, interface, standard remote joystick (not including controller), proportional, including all related electronics and fixed mounting hardware, replacement only | 01 |
| E2375 | Power Wheelchair Accessory, non-expandable controller, including all related electronics and mounting hardware, replacement only (Eff. Date 1/1/2007)   | 01 |

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| E2376 | Power Wheelchair Accessory, expandable controller, including all related electronics and mounting hardware, replacement onl (Eff. Date 1/1/2007)                  | 01 |  |
| E2377 | Power Wheelchair Accessory, expandable controller, including all related electronics and mounting hardware, upgrade provided at intial issue (Eff. Date 1/1/2007) | 01 |  |
| E2378 | Power wheelchair component, actuator, replacement only  | 01 |  |
| E2381 | Power Wheelchair Accessory, Pneumatic Drive Wheel Tire, any size, replacement only, each (Eff. Date 1/1/2007)   | 05 |  |
| E2382 | Power Wheelchair Accessory, Tube for Pneumatic Drive Wheel Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2383 | Power Wheelchair Accessory, Insert for Pneumatic Drive Wheel Tire (removable), any type, any size, replacement only, each (Eff. Date 1/1/2007)                    | 05 |  |
| E2384 | Power Wheelchair Accessory, Pneumatic Caster Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2385 | Power Wheelchair Accessory, Tube for Pneumatic Caster Tire, any size, replacement only, each (Eff. Date 1/1/2007)   | 05 |  |
| E2386 | Power Wheelchair Accessory, Foam Filled Drive Wheel Tire, any size, replacement only, each (Eff. Date 1/1/2007)   | 05 |  |
| E2387 | Power Wheelchair Accessory, Foam Filled Caster Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2388 | Power Wheelchair Accessory, Foam Drive Wheel Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2389 | Power Wheelchair Accessory, Foam Caster Tire, any size, replacement only, each (Eff. Date 1/1/2007)   | 05 |  |
| E2390 | Power Wheelchair Accessory, Solid (Rubber/Plastic) Drive Wheel Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2391 | Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), any size, replacement only, each (Eff. Date 1/1/2007)                                 | 05 |  |
| E2392 | Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire, with intrgrated Wheel, any size, replacement only, each (Eff. Date 1/1/2007)                      | 05 |  |
| E2394 | Power Wheelchair Accessory, Drive Wheel excludes Tire, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |
| E2395 | Power Wheelchair Accessory, Caster Wheel excludes Tire, any size, replacement only, each (Eff. Date 1/1/2007)   | 05 |  |
| E2396 | Power Wheelchair Accessory, Caster Fork, any size, replacement only, each (Eff. Date 1/1/2007)  | 05 |  |

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|-------|---|----|
| E2397 | Power wheelchair accessory, lithium-based battery, each (Eff. Date 1/1/2008)  | 05 |
| E2398 | Wheelchair accessory, dynamic positioning hardware for back (Eff. Date 1/1/2020)  | 05 |
| E2402 | Negative pressure wound therapy electrical pump, stationary or portable (Eff. Date 1/1/2004)  | 01 |
| E2500 | Speech generating device, digitized speech, using pre-recorded messages, less than or equal to 8 minutes recording time (Eff. Date 1/1/2004)                              | 05 |
| E2502 | Speech generating device, digitized speech, using pre-recorded messages, greater than 8 minutes but less than or equal to 20 minutes recording time (Eff. Date 1/1/2004)  | 05 |
| E2504 | Speech generating device, digitized speech, using pre-recorded messages, greater than 20 minutes but less than or equal to 40 minutes recording time (Eff. Date 1/1/2004) | 05 |
| E2506 | Speech generating device, digitized speech, using pre-recorded messages, greater than 40 minutes recording time (Eff. Date 1/1/2004)                                      | 05 |
| E2508 | Speech generating device, synthesized speech, requiring message formulation by spelling and access by physical contact with the device (Eff. Date 1/1/2004)               | 05 |
| E2510 | Speech generating device, synthesized speech, permitting multiple methods of message formulation and multiple methods of device access (Eff. Date 1/1/2004)               | 05 |
| E2511 | Speech generating software program, for personal computer or personal digital assistant (Eff. Date 1/1/2004)  | 05 |
| E2512 | Accessory for speech generating device, mounting system (Eff. Date 1/1/2004)  | 05 |
| E2513 | Accessory for speech generating device, electromyographic sensor (Eff. Date 10/01/2024)   |    |
| E2599 | Accessory for speech generating device, not otherwise classified (Eff. Date 1/1/2004)   | 05 |
| E2601 | General use wheelchair seat cushion, width less than 22 inches, any depth (Eff. Date 1/1/2005)  | 05 |
| E2602 | General use wheelchair seat cushion, width 22 inches or greater, any depth (Eff. Date 1/1/2005)   | 05 |
| E2603 | Skin protection wheelchair seat cushion, width less than 22 inches, any depth (Eff. Date 1/1/2005)  | 05 |
| E2604 | Skin protection wheelchair seat cushion, width 22 inches or greater, any depth (Eff. Date 1/1/2005)   | 05 |

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|-------|---|----|
| E2605 | Positioning wheelchair seat cushion, width less than 22 inches, any depth (Eff. Date 1/1/2005)  | 05 |
| E2606 | Positioning wheelchair seat cushion, width 22 inches or greater, any depth (Eff. Date 1/1/2005)   | 05 |
| E2607 | Skin protection and positioning wheelchair seat cushion, width less than 22 inches, any depth (Eff. Date 1/1/2005)  | 05 |
| E2608 | Skin protection and positioning wheelchair seat cushion, width 22 inches or greater, any depth (Eff. Date 1/1/2005)   | 05 |
| E2609 | Custom fabricated wheelchair seat cushion, any size (Eff. Date 1/1/2005)  | 05 |
| E2610 | Wheelchair seat cushion, powered (Eff. Date 1/1/2005)   | 05 |
| E2611 | General use wheelchair back cushion, width less than 22 inches, any height, including any type mounting hardware (Eff. Date 1/1/2005)                                     | 05 |
| E2612 | General use wheelchair back cushion, width 22 inches or greater, any height, including any type mounting hardware (Eff. Date 1/1/2005)                                    | 05 |
| E2613 | Positioning wheelchair back cushion, posterior, width less than 22 inches, any height, including any type mounting hardware (Eff. Date 1/1/2005)                          | 05 |
| E2614 | Positioning wheelchair back cushion, posterior, width 22 inches or greater, any height, including any type mounting hardware (Eff. Date 1/1/2005)                         | 05 |
| E2615 | Positioning wheelchair back cushion, posterior-lateral, width less than 22 inches, any height, including mounting any type hardware (Eff. Date 1/1/2005)                  | 05 |
| E2616 | Positioning wheelchair back cushion, posterior-lateral, width 22 inches or greater, any height, including any type mounting hardware (Eff. Date 1/1/2005)                 | 05 |
| E2617 | Custom fabricated wheelchair back cushion, any size, including any type mounting hardware (Eff. Date 1/1/2005)  | 05 |
| E2619 | Replacement cover for wheelchair seat cushion or back cushion, each (Eff. Date 1/1/2005)  | 05 |
| E2620 | Positioning wheelchair back cushion, planar back with lateral supports, width less than 22 inches, any height, including any type mounting hardware (Eff. Date 1/1/2005)  | 05 |
| E2621 | Positioning wheelchair back cushion, planar back with lateral supports, width 22 inches or greater, any height, including any type mounting hardware (Eff. Date 1/1/2005) | 05 |
| E2622 | Skin Protection wheelchair seat cushion, adjustable, width less than 22 inches, any depth (Eff. Date 1/1/2011)  | 05 |



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|-------|---|----|--|
| E2623 | Skin protection wheelchair seat cushion, adjustable, width 22 inches or greater, any depth (Eff. Date 1/1/2011)   | 05 |  |
| E2624 | Skin protection and positioning wheelchair sea cushion, adjustable, width 22 inches or greater, any depth (Eff. Date 1/1/2011)  | 05 |  |
| E2625 | Skin protection and positioning wheelchair seat cushion, adjustable, width 22 inches or greater, any depth (Eff. Date 1/1/2011)   | 05 |  |
| E2626 | Wheelchair accessory, shoulder elbow, mobile arm support attached wheelchair, balanced, adjustable (Eff. Date 1/1/2012)   |    |  |
| E2627 | Wheelchair accessory, shoulder elbow, mobile arm support attached wheelchair, balanced, adjustable rancho type (Eff. Date 1/1/2012)   |    |  |
| E2628 | Wheelchair accessory, shoulder elbow, mobile arm support attached wheelchair, balanced, reclining (Eff. Date 1/1/2012)  |    |  |
| E2629 | Wheelchair accessory, shoulder elbow, mobile arm support attached wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints) (Eff. Date 1/1/2012)        |    |  |
| E2630 | Wheelchair accessory, shoulder elbow, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type suspension support (Eff. Date 1/1/2012) |    |  |
| E2631 | Wheelchair accessory, addition to mobile arm support, elevating proximal arm (Eff. Date 1/1/2012)   |    |  |
| E2632 | Wheelchair accessory, addition to mobile arm support, offset or lateral rocker arm with elastic balance control (Eff. Date 1/1/2012)  |    |  |
| E2633 | Wheelchair accessory, addition to mobile arm support, supinator (Eff. Date 1/1/2012)  |    |  |
| E3000 | Speech volume modulation system, any type, including all components and accessories (Eff. Date 01/01/2024)  | 01 |  |
| E3200 | Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only (Eff. Date 10/01/2024)                      |    |  |
| E8000 | Gait trainer, pediatric size, posterior support, includes all accessories and components (not payable by Medicare) (Eff. Date 1/1/2005)   |    |  |
| E8001 | Gait trainer, pediatric size, upright support, includes all accessories and components (not payable by Medicare) (Eff. Date 1/1/2005)   |    |  |
| E8002 | Gait trainer, pediatric size, anterior support, includes all accessories and components (not payable by Medicare) (Eff. Date 1/1/2005)  |    |  |



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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| G0068 | Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes (No longer valid for submission to DME MAC eff. 01/01/2021) |          |                  |
| G0069 | Professional services for the administration of subcutaneous immunotherapy or other subcutaneous infusion drug or biological for each infusion drug administration calendar day in the individual's home, each 15 minutes (No longer valid for submission to DME MAC eff. 01/01/2021)  |          |                  |
| G0070 | Professional services for the administration of intravenous chemotherapy or other intravenous highly complex drug or biological infusion for each infusion drug administration calendar day in the individual's home, each 15 minutes (No longer valid for submission to DME MAC eff. 01/01/2021)  |          |                  |
| G0333 | G0333 Pharmacy dispensing fee for inhalation drug(s); per 30-days as a beneficiary (Eff. Date 1/1/2006)  |          |                  |

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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description   | Category | CMN/DIF Required |
|-------|---|----------|------------------|
| J0120 | Injection, tetracycline, up to 250 mg   |          |                  |
| J0121 | Injection, omadacycline, 1 mg (Eff. Date 10/01/2019)  |          |                  |
| J0122 | Injection, eravacycline, 1 mg (Eff. Date 10/01/2019)  |          |                  |
| J0128 | Injection, abarelix, 10 mg (Eff. Date 1/1/2005) (Deleted eff. 12/31/2010)   |          |                  |
| J0129 | Injection, abatacept, 10 mg (Eff. Date 1/1/2007)  |          |                  |
| J0130 | Injection abciximab, 10 mg  |          |                  |
| J0131 | (Eff. Date 1/1/2012) Injection, acetaminophen, not otherwise specified, 10 mg (Revised 01/01/2023)  |          |                  |
| J0132 | Injection, acetylcysteine, 100 mg (01/01/2018)  |          |                  |
| J0133 | Injection, acyclovir, 5 mg (Eff. Date 1/1/2006)   |          |                  |
| J0134 | Injection, acetaminophen (fresenius kabi) not therapeutically equivalent to j0131, 10 mg (Eff. Date 01/01/2023) Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg (Revised eff. 07/01/2024) |          |                  |
| J0135 | Injection, adalimumab, 20 mg (Eff. Date 1/1/2005) (Deleted eff. 12/31/2024)   |          |                  |

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|-------|---|--|--|
| J0136 | Injection, acetaminophen (b braun) not therapeutically equivalent to j0131, 10 mg (Eff. Date 01/01/2023) Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg (Revised eff. 07/01/2024) |  |  |
| J0137 | Injection, acetaminophen (hikma) not therapeutically equivalent to j0131, 10 mg (Eff. Date 07/01/2023) Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg (Revised eff. 07/01/2024)     |  |  |
| J0138 | Injection, acetaminophen 10 mg and ibuprofen 3 mg (Eff. Date 10/01/2024)  |  |  |
| J0150 | Injection, adenosine for therapeutic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead used A9270) (Deleted eff. 12/31/2014)   |  |  |
| J0151 | Injection, adenosine for diagnostic use, 1 mg (not to be used to report any adenosine phosphate compounds, instead use A9270) (Eff. Date 01/01/2014) (Deleted eff. 12/31/2014)  |  |  |
| J0152 | Injection, adenosine for diagnostic use, 30 mg (not to be used to report any adenosine phosphate compounds; instead use A9270) (Deleted eff. 12/31/2013)  |  |  |
| J0153 | Injection, adenosine, 1 mg (not to be used to report any adenosine phosphate compounds) (Eff. Date 01/01/2015)  |  |  |
| J0170 | Injection, adrenalin, epinephrine, up to 1 ml ampule (Deleted eff. 12/31/2010)  |  |  |
| J0171 | Injection, Adrenalin, Epinephrine, 0.1 mg (Eff. Date 1/1/2011)  |  |  |
| J0172 | Injection, aducanumab-avwa, 2 mg (Eff. Date 01/01/2022)   |  |  |
| J0173 | Injection, epinephrine (belcher) not therapeutically equivalent to j0171, 0.1 mg (Eff. Date 01/01/2023) Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg (Revised eff, 07/01/2024)   |  |  |
| J0177 | Injection, aflibercept hd, 1 mg (Eff. Date 04/01/2024)  |  |  |
| J0178 | Injection, aflibercept, 1 mg (Eff. Date 01/01/2013)   |  |  |
| J0179 | Injection, brolocizumab-dbli, 1 mg (Eff. Date 1/1/2020)   |  |  |
| J0180 | Injection, agalsidase beta, 1 mg (Eff. Date 1/1/2005)   |  |  |
| J0184 | Injection, amisulpride, 1 mg (Eff. Date 01/01/2024)   |  |  |
| J0185 | Injection, aprepitant, 1 mg (Eff. Date 1/1/2019)  |  |  |
| J0190 | Injection, biperiden lactate, per 5 mg  |  |  |
| J0200 | Injection, alatrofloxacin mesylate, 100 mg (Eff. Date 1/1/2000)   |  |  |
| J0202 | Injection, alemtuzumab, 1 mg (Eff. Date 1/1/2016)   |  |  |

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|-------|---|----|--|
| J0205 | Injection, alglucerase, per 10 units  |    |  |
| J0206 | Injection, allopurinol sodium, 1 mg (Eff. Date 07/01/2023)  |    |  |
| J0207 | Injection, amifostine, 500 mg   |    |  |
| J0208 | Injection, sodium thiosulfate, 100 mg (Eff. Date 04/01/2023)<br>Injection, sodium thiosulfate (pedmark), 100 mg (Revised eff. 04/1/2024)  |    |  |
| J0209 | Injection, sodium thiosulfate (hope), 100 mg (Eff. Date 04/01/2024)   |    |  |
| J0210 | Injection, methyldopate HCL, up to 250 mg   |    |  |
| J0211 | Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote) (Eff. Date 07/01/2024)  |    |  |
| J0215 | Injection, alefacept, 0.5 mg (Eff. Date 1/1/2004)   | 10 |  |
| J0216 | Injection, alfentanil hydrochloride, 500 micrograms (Eff. Date 07/01/2023)  |    |  |
| J0217 | Injection, velmanase alfa-tycv, 1 mg (Eff. Date 01/01/2024)   |    |  |
| J0218 | Injection, olipudase alfa-rpcp, 1 mg (Eff. Date 04/01/2023)   |    |  |
| J0219 | Injection, avalglucosidase alfa-ngpt, 4 mg (Eff. Date 04/01/2022)   |    |  |
| J0220 | Injection, aglucosidase alfa, 10 mg, 10 mg, not otherwise specified (Eff. Date 1/1/2012)  |    |  |
| J0221 | Injection, Aglucosidase Alfa, (Lumizyme), 10 mg   |    |  |
| J0222 | Injection, Patisiran, 0.1 mg (Eff. Date 10/01/2019)   |    |  |
| J0223 | Injection, givosiran, 0.5 mg (Eff. Date 07/01/2020)   |    |  |
| J0224 | Injection, lumasiran, 0.5 mg (Eff. Date 07/01/2021)   |    |  |
| J0225 | Injection, vutrisiran, 1 mg (Eff. Date 01/01/2023)  |    |  |
| J0248 | Injection, remdesivir, 1 mg (Eff. Date 04/01/2022)  |    |  |
| J0256 | Injection, alpha 1 proteinase inhibitor (human) not otherwise specified, 10 mg (Eff. Date 1/1/2012)   |    |  |
| J0257 | Injection, alpha 1 proteinase inhibitor (human) (Glassia), 10 mg (Eff. date 1/1/2012)   |    |  |
| J0270 | Injection, alprostadil, 1.25 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) |    |  |
| J0275 | Alprostadil urethral suppository (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) |    |  |

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|-------|---|--|--|
| J0278 | Injection, amikacin sulfate, 100 mg (Eff. Date 1/1/2006)  |  |  |
| J0280 | Injection, aminophyllin, up to 250 mg   |  |  |
| J0282 | Injection, amiodarone hydrochloride, 30 mg (Eff. Date 1/1/2001)   |  |  |
| J0283 | Injection, amiodarone hydrochloride (nexterone), 30 mg (Eff. Date 01/01/2023)   |  |  |
| J0285 | Injection, amphotericin B 50 mg   |  |  |
| J0287 | Injection, amphotericin B lipid complex, 10 mg (Eff. Date 1/1/2003)   |  |  |
| J0288 | Injection, amphotericin B cholesteryl sulfate complex, 10 mg (Eff. Date 1/1/2003)   |  |  |
| J0289 | Injection, amphotericin B liposome, 10 mg (Eff. Date 1/1/2003)  |  |  |
| J0290 | Injection, ampicillin sodium, 500 mg  |  |  |
| J0291 | Injection, plazomicin, 5 mg (Eff. Date 10/01/2019)  |  |  |
| J0295 | Injection, ampicillin sodium/sulbactam sodium, per 1.5 gm   |  |  |
| J0300 | Injection, amobarbital, up to 125 mg  |  |  |
| J0330 | Injection, succinylcholine chloride, up to 20 mg  |  |  |
| J0348 | Injection, anidulafungin, 1 mg (Eff. Date 1/1/2007, Updated Eff. 1/1/2009)  |  |  |
| J0349 | Injection, rezafungin, 1 mg (Eff. Date 10/01/2023)  |  |  |
| J0350 | Injection, anistreplase, per 30 units   |  |  |
| J0360 | Injection, hydralazine HCL, up to 20 mg   |  |  |
| J0364 | njection, Apomorphine Hydrochloride, 1 mg (Eff. Date 1/1/2007)  |  |  |
| J0365 | Injection, aprotinin, 10, 000 KIU (Eff. Date 1/1/2006)  |  |  |
| J0380 | Injection, metaraminol bitartrate, per 10 mg  |  |  |
| J0390 | Injection, chloroquine hydrochloride, up to 250 mg  |  |  |
| J0391 | Injection, artesunate, 1 mg (Eff. Date 01/01/2024)  |  |  |
| J0395 | Injection, arbutamine HCL, 1 mg   |  |  |
| J0400 | Injection, aripiprazole, intramuscular, 0.25 mg- (Eff. Date 1/1/2008)   |  |  |
| J0401 | Injection, aripiprazole, extended release, 1 mg (Eff. Date 01/01/2014) Injection, aripiprazole (abilify maintena), 1 mg (Revised eff. 07/01/2024) |  |  |

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|-------|--|--|--|
| J0402 | Injection, aripiprazole (abilify asimtufii), 1 mg (Eff. Date 01/01/2024)   |  |  |
| J0456 | Injection, azithromycin, 500 mg (Eff. Date 1/1/2000)   |  |  |
| J0457 | Injection, aztreonam, 100 mg (Eff. Date 07/01/2023)  |  |  |
| J0461 | Injection, atropine sulfate, 0.01 mg (Eff. Date 1/1/2010)  |  |  |
| J0470 | Injection, dimercaprol, per 100 mg   |  |  |
| J0475 | Injection, baclofen, 10 mg   |  |  |
| J0476 | Injection, baclofen, 50 mcg for intrathecal trial  |  |  |
| J0480 | Injection, basiliximab, 20 mg (Eff. Date 1/1/2006)   |  |  |
| J0485 | Injection, belatacept, 1 mg (Eff. Date 01/01/2013)   |  |  |
| J0490 | Injection, belimumab, 10 mg (Eff. Date 1/1/2012)   |  |  |
| J0491 | Injection, anifrolumab-fnia, 1 mg (Eff. Date 04/01/2022)   |  |  |
| J0500 | Injection, dicyclomine HCL, up to 20 mg  |  |  |
| J0515 | Injection, benzotropine mesylate, per 1 mg   |  |  |
| J0517 | Injection, benralizumab, 1 mg (Eff. Date 1/1/2019)   |  |  |
| J0520 | Injection, bethanechol chloride, myotonachol or urecholine, up to 5 mg   |  |  |
| J0558 | Injection, Penicillin Benzathine and Penicillin Procaine, 100,000 units (Eff. Date 1/1/2011)                           |  |  |
| J0559 | Injection, penicillin g benzathine and pencillin g procaine, 2500 units (Eff. Date 1/1/2010) (Deleted eff. 12/31/2010) |  |  |
| J0560 | Injection, penicillin g benzathine, up to 600,000 units (Deleted eff. 12/31/2010)                                      |  |  |
| J0561 | Injection, penicillin g benzathine, 100,000 units (Eff. Date 1/1/2011, Updated 1/1/2011)                               |  |  |
| J0565 | Injection, bezlotoxumab, 10 mg (Eff. Date 01/01/2018)  |  |  |
| J0567 | Injection, cerliponase alfa, 1 mg (Eff. Date 1/1/2019)   |  |  |
| J0570 | Buprenorphine implant, 74.2 mg (Eff. Date 1/1/2017) (Deleted eff. 12/31/2024)  |  |  |
| J0571 | Buprenorphine, oral, 1 mg (Eff. Date 01/01/2015)   |  |  |
| J0572 | Buprenorphine/naloxone, oral, less than or equal to 3 mg buprenorphine (Eff. Date 01/01/2015)                          |  |  |

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|-------|---|--|--|
| J0573 | Buprenorphine/naloxone, oral, greater than 3 mg, but less than or equal to 6 mg buprenorphine (Eff. Date 01/01/2015) (Revised 1/1/2016) (Updated description 1/1/2017)                              |  |  |
| J0574 | Buprenorphine/naloxone, oral, greater than 6 mg, but less than or equal to 10 mg buprenorphine (Eff. Date 01/01/2015) (Revised 1/1/2016)  |  |  |
| J0575 | Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine (Eff. Date 01/01/2015) (Revised 1/1/2016)  |  |  |
| J0576 | Injection, buprenorphine extended-release (brixadi), 1 mg (Eff. Date 01/01/2024) (Deleted eff. 03/31/2024)  |  |  |
| J0577 | Injection, buprenorphine extended-release (brixadi), less than or equal to 7 days of therapy (Eff. Date 04/01/2024)   |  |  |
| J0578 | Injection, buprenorphine extended-release (brixadi), greater than 7 days and up to 28 days of therapy (Eff. Date 04/01/2024)  |  |  |
| J0580 | Injection, penicillin g benzathine, up to 2,400,000 units (Deleted eff. 12/31/2010)   |  |  |
| J0583 | Injection, bivalirudin, 1 mg  |  |  |
| J0584 | Injection, burosumab-twza 1 mg (Eff. Date 1/1/2019)   |  |  |
| J0585 | Injection, onabotulinumtoxina, 1 unit (Description change 1/1/2010)   |  |  |
| J0586 | Injection, abobotulinumtoxina, 5 units (Eff. Date 1/1/2010)   |  |  |
| J0587 | Injection, rimabotulinumtoxinb, 100 units (Eff. Date 1/1/2002) (Description change 1/1/2010)  |  |  |
| J0588 | Injection, Incobotulinumtoxin A, 1 unit (Eff. Date 1/1/2012)  |  |  |
| J0589 | Injection, daxibotulinumtoxina-lanm, 1 unit (Eff. Date 04/01/2024)  |  |  |
| J0591 | Injection, deoxycholic acid, 1 mg (Eff. Date 07/01/2020)  |  |  |
| J0592 | Injection, buprenorphine hydrochloride, 0.1 mg (Eff. Date 1/1/2003)   |  |  |
| J0593 | Injection, lanadelumab-flyo, 1 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered) (Eff. Date 10/01/2019) |  |  |
| J0594 | Injection, busulfan, 1 mg (Eff. Date 1/1/2007)  |  |  |
| J0595 | Injection, butorphanol, 1 mg  |  |  |
| J0596 | Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units (Eff. Date 1/1/2016)   |  |  |
| J0597 | Injection, C-1 Esterase Inhibitor (human), Berinert, 10 units (Eff. Date 1/1/2011)  |  |  |

|       |   |  |  |
|-------|---|--|--|
| J0598 | Injection, C-1 esterase inhibitor (human), 10 units (Eff. Date 1/1/2010, Updated 1/1/2011)  |  |  |
| J0599 | Injection, c-1 esterase inhibitor (human), (haegarda), 10 units (Eff. Date 1/1/2019)  |  |  |
| J0600 | Injection, edetate calcium disodium, up to 1000 mg  |  |  |
| J0601 | Sevelamer carbonate (renvela or therapeutically equivalent), oral, 20 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0602 | Sevelamer carbonate (renvela or therapeutically equivalent), oral, powder, 20 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0603 | Sevelamer hydrochloride (renagel or therapeutically equivalent), oral, 20 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0604 | Cinacalcet, oral, 1 mg, (for esrd on dialysis) (Eff. Date 01/01/2018)   |  |  |
| J0605 | Sucroferric oxyhydroxide, oral, 5 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0606 | Injection, etelcalcetide, 0.1 mg (Eff. Date 01/01/2018)   |  |  |
| J0607 | Lanthanum carbonate, oral, 5 mg (for esrd on dialysis) (Eff. Date 1/1/2025)   |  |  |
| J0608 | Lanthanum carbonate, oral, powder, 5 mg, not therapeutically equivalent to j0607 (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0609 | Ferric citrate, oral, 3 mg ferric iron, (for esrd on dialysis) (Eff. Date 1/1/2025)   |  |  |
| J0610 | Injection, calcium gluconate (fresenius kabi), per 10 ml (Revised 01/01/2023) (Deleted eff. 03/31/2023)   |  |  |
| J0611 | Injection, calcium gluconate (wg critical care), per 10 ml (Eff. Date 01/01/2023) (Deleted eff. 03/31/2023)   |  |  |
| J0612 | Injection, calcium gluconate (fresenius kabi), per 10 mg (Eff. Date 04/01/2023) Injection, calcium gluconate, not otherwise specified, 10 mg (Revised eff. 04/01/2024)                                      |  |  |
| J0613 | Injection, calcium gluconate (wg critical care), per 10 mg (Eff. Date 04/01/2023) Injection, calcium gluconate (wg critical care), not therapeutically equivalent to j0612, 10 mg (Revised eff. 04/01/2024) |  |  |
| J0615 | Calcium acetate, oral, 23 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0620 | Injection, calcium glycerophosphate and calcium lactate, per 10 ml  |  |  |
| J0630 | Injection, calcitonin salmon, up to 400 units   |  |  |
| J0636 | Injection, calcitriol, 0.1 mcg (Eff. Date 1/1/2003)   |  |  |
| J0637 | Injection, caspofungin acetate, 5 mg (Eff. Date 1/1/2003)   |  |  |



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| J0638        | Injection, Canakinumab, 1 mg (Eff. Date 1/1/2011)   |  |  |
| J0640        | Injection, leucovorin calcium, per 50 mg  |  |  |
| J0641        | Injection, levoleucovorin, not otherwise specified, 0.5 mg (Rev. Date 10/01/2019)   |  |  |
| J0642        | Injection, Levoleucovorin (khapzory), 0.5 mg (Eff. Date 10/01/2019)   |  |  |
| J0650        | Injection, levothyroxine sodium, not otherwise specified, 10 mcg (Eff. Date 04/01/2024)   |  |  |
| J0651        | Injection, levothyroxine sodium (fresenius kabi) not therapeutically equivalent to j0650, 10 mcg (Eff. Date 04/01/2024) Injection, levothyroxine sodium (fresenius kabi), not therapeutically equivalent to j0650, 10 mcg (Revised eff. 07/01/2024) |  |  |
| J0652        | Injection, levothyroxine sodium (hikma) not therapeutically equivalent to j0650, 10 mcg (Eff. Date 04/01/2024) Injection, levothyroxine sodium (hikma), not therapeutically equivalent to j0650, 10 mcg (Revised eff. 07/01/2024)                   |  |  |
| J0665        | Injection, bupivacaine, not otherwise specified, 0.5 mg (Eff. Date 07/01/2023)  |  |  |
| <b>J0666</b> | <b>Injection, bupivacaine liposome, 1 mg (Eff. Date 1/1/2025)</b>   |  |  |
| J0670        | Injection, mepivacaine hydrochloride, per 10 ml   |  |  |
| J0687        | Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg (Eff. Date 07/01/2024)  |  |  |
| J0688        | Injection, cefazolin sodium (hikma), not therapeutically equivalent to j0690, 500 mg (Eff. Date 01/01/2024)   |  |  |
| J0689        | Injection, cefazolin sodium (baxter), not therapeutically equivalent to j0690, 500 mg (Eff. Date 01/01/2023)  |  |  |
| J0690        | Injection, cefazolin sodium, 500 mg   |  |  |
| J0691        | Injection, lefamulin, 1 mg (Eff. Date 07/01/2020)   |  |  |
| J0692        | Injection, cefepime hydrochloride, 500 mg (Eff. Date 1/1/2002)  |  |  |
| J0693        | Injection, cefiderocol, 5 mg (Eff. Date 01/01/2021) (Deleted eff. 9/30/2021)  |  |  |
| J0694        | Injection, ceftioxin sodium, 1 gm   |  |  |
| J0695        | Injection, ceftolozane 50 mg and tazobactam 25 mg (Eff. Date 1/1/2016)  |  |  |
| J0696        | Injection, ceftriaxone sodium, per 250 mg   |  |  |
| J0697        | Injection, sterile cefuroxime sodium, per 750 mg  |  |  |
| J0698        | Injection, cefotaxime sodium, per gm  |  |  |

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| J0699 | Injection, cefiderocol, 10 mg (Eff. Date 10/1/2021)  |  |  |
| J0701 | Injection, cefepime hydrochloride (baxter), not therapeutically equivalent to maxipime, 500 mg (Eff. Date 01/01/2023)  |  |  |
| J0702 | Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg (Updated 1/1/2008)   |  |  |
| J0703 | Injection, cefepime hydrochloride (b braun), not therapeutically equivalent to maxipime, 500 mg (Eff. Date 01/01/2023)   |  |  |
| J0704 | Injection, betamethasone sodium phosphate, per 4 mg (Deleted eff. 12/31/2010)  |  |  |
| J0706 | Injection, caffeine citrate, 5 mg (Eff. Date 1/1/2002)   |  |  |
| J0710 | Injection, cephalirin sodium, up to 1 gm   |  |  |
| J0712 | Injection, Ceftaroline Fosamil, 10 mg (Eff. Date 1/1/2012)   |  |  |
| J0713 | Injection, ceftazidime, per 500 mg   |  |  |
| J0714 | Injection, ceftazidime and avibactam, 0.5 g/0.125 g (Eff. Date 1/1/2016)   |  |  |
| J0715 | Injection, ceftizoxime sodium, per 500 mg  |  |  |
| J0716 | Injection, centrurides immune f(ab)2, up to 120 milligrams (Eff. Date 01/01/2013)  |  |  |
| J0717 | Injection, certolizumab pegol, 1 mg (code may be used for medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Eff. Date 01/01/2014)                |  |  |
| J0718 | Injection, certolizumab pegol, 1 mg (Eff. Date 1/1/2010) (Deleted eff. 12/31/2013)   |  |  |
| J0720 | Injection, chloramphenicol sodium succinate, up to 1 gm  |  |  |
| J0725 | Injection, chorionic gonadotropin, per 1,000 usp units   |  |  |
| J0735 | Injection, clonidine hydrochloride, 1 mg   |  |  |
| J0736 | Injection, clindamycin phosphate, 300 mg (Eff. Date 07/01/2023)  |  |  |
| J0737 | Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg (Eff. Date 07/01/2023)  |  |  |
| J0739 | Injection, cabotegravir, 1 mg (Eff. Date 07/01/2022) Injection, cabotegravir, 1 mg, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment for hiv) (Revised eff. 01/02/2024) |  |  |
| J0740 | Injection, cidofovir, 375 mg   |  |  |
| J0741 | Injection, cabotegravir and rilpivirine, 2mg/3mg (Eff. Date 10/1/2021)   |  |  |

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| J0742 | Injection, imipenem 4 mg, cilastatin 4 mg and relebactam 2 mg (Eff. Date 07/01/2020)  |  |  |
| J0743 | Injection, cilastatin sodium; imipenem, per 250 mg  |  |  |
| J0744 | Injection, ciprofloxacin for intravenous infusion, 200 mg (Eff. Date 1/1/2002)  |  |  |
| J0745 | Injection, codeine phosphate, per 30 mg   |  |  |
| J0750 | Emtricitabine 200 mg and tenofovir disoproxil fumarate 300 mg, oral, fda approved prescription, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv) (Eff. Date 11/02/2023) |  |  |
| J0751 | Emtricitabine 200 mg and tenofovir alafenamide 25 mg, oral, fda approved prescription, only for use as pre-exposure prophylaxis (not for use as treatment of hiv) (Eff. Date 01/02/2024)              |  |  |
| J0760 | Injection, colchicine, per 1mg (Deleted eff. 12/31/2016)  |  |  |
| J0770 | Injection, colistimethate sodium, up to 150 mg  |  |  |
| J0775 | Injection, Collagenase, Clostridium Histolyticum 0.01 mg (Eff. Date 1/1/2011)   |  |  |
| J0780 | Injection, prochlorperazine, up to 10 mg  |  |  |
| J0791 | Injection, crizanlizumab-tmca, 5 mg (Eff. Date 07/01/2020)  |  |  |
| J0795 | Injection, corticorelin ovine triflutate, 1 microgram (Eff. Date 01/01/2006)  |  |  |
| J0799 | FDA approved prescription drug, only for use as hiv pre-exposure prophylaxis (not for use as treatment of hiv), not otherwise classified (Eff. Date 01/02/2024)                                       |  |  |
| J0800 | Injection, corticotropin, up to 40 units (Deleted eff. 09/30/2023)  |  |  |
| J0801 | Injection, corticotropin (acthar gel), up to 40 units (Eff. Date 10/01/2023)  |  |  |
| J0802 | Injection, corticotropin (ani), up to 40 units (Eff. Date 10/01/2023)   |  |  |
| J0833 | Injection, cosyntropin, not otherwside specified, 0.25 mg (Eff. Date 1/1/2010) (Deleted eff. 12/31/2018)  |  |  |
| J0834 | Injection, cosyntropin (cortrosym), 0.25 mg (Eff. Date 1/1/2010)  |  |  |
| J0840 | Injection, Crotalidae Polyvalent Immune Fab (Ovine), up to 1 gram (Eff. Date 1/1/2012)  |  |  |
| J0841 | Injection, crotalidae immune f(ab')2 (equine), 120 mg (Eff. Date 1/1/2019)  |  |  |

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| J0850 | Injection, cytomegalovirus immune globulin intravenous (human), per vial   |  |  |
| J0870 | Injection, imetelstat, 1 mg (Eff. Date 1/1/2025)   |  |  |
| J0872 | Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg (Eff. Date 07/01/2024)  |  |  |
| J0873 | Injection, daptomycin (xellia) not therapeutically equivalent to j0878, 1 mg (Eff. Date 01/01/2024) Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg (Revised eff. 07/01/2024) |  |  |
| J0874 | Injection, daptomycin (baxter), not therapeutically equivalent to j0878, 1 mg (Eff. Date 10/01/2023)   |  |  |
| J0875 | Injection, dalbavancin, 5mg (Eff. Date 1/1/2016)   |  |  |
| J0877 | Injection, daptomycin (hospira), not therapeutically equivalent to j0878, 1 mg (Eff. Date 01/01/2023)  |  |  |
| J0878 | Injection, daptomycin, 1 mg (Eff. Date 1/1/2005)   |  |  |
| J0879 | Injection, difelikefalin, 0.1 microgram, (for esrd on dialysis) (Eff. Date 04/01/2022)   |  |  |
| J0881 | Injection, darbepoetin alfa, 1 microgram (non-ESRD use) (Eff. Date 1/1/2006)   |  |  |
| J0882 | Injection, darbepoetin alfa, 1 microgram (for ESRD on dialysis) (Eff. Date 1/1/2006)   |  |  |
| J0883 | Injection, argatroban, 1 mg (for non-esrd use) (Eff. Date 1/1/2017)  |  |  |
| J0884 | Injection, argatroban, 1 mg (for esrd on dialysis) (Eff. Date 1/1/2017)  |  |  |
| J0885 | Injection, epoetin alfa, (for non-ESRD use), 1000 units (Eff. Date 1/1/2006)   |  |  |
| J0886 | Injection, epoetin alfa, 1000 units (for ESRD on dialysis) (Eff. Date 1/1/2006) (Deleted 1/1/2016)   |  |  |
| J0887 | Injection, epoetin beta, 1 microgram, (for esrd on dialysis) (Eff. Date 01/01/2015)  |  |  |
| J0888 | Injection, epoetin beta, 1 microgram, (for non esrd use) (Eff. Date 01/01/2015)  |  |  |
| J0889 | Daprodustat, oral, 1 mg, (for esrd on dialysis) (Eff. Date 10/01/2023)   |  |  |
| J0890 | Injection, peginesatide, 0. 1 mg (for esrd on dialysis) (Eff. Date 01/01/2013)   |  |  |
| J0891 | Injection, argatroban (accord), not therapeutically equivalent to j0883, 1 mg (for non-esrd use) (Eff. Date 01/01/2023)  |  |  |

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| J0892 | Injection, argatroban (accord), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis) (Eff. Date 01/01/2023)   |  |  |
| J0893 | Injection, decitabine (sun pharma) not therapeutically equivalent to j0894, 1 mg (Eff. Date 01/01/2023) Injection, decitabine (sun pharma), not therapeutically equivalent to j0894, 1 mg (Revised eff. 07/01/2024) |  |  |
| J0894 | Injection, decitabine, 1 mg (Eff. Date 1/1/2007)  |  |  |
| J0895 | Injection, deferoxamine mesylate, 500 mg per 5 cc   |  |  |
| J0896 | Injection, luspatercept-aamt, 0.25 mg (Eff. Date 07/01/2020)  |  |  |
| J0897 | Injection, Denosumab, 1 mg (Eff. Date 1/1/2012)   |  |  |
| J0898 | Injection, argatroban (auromedics), not therapeutically equivalent to j0883, 1 mg (for non-esrd use) (Eff. Date 01/01/2023)   |  |  |
| J0899 | Injection, argatroban (auromedics), not therapeutically equivalent to j0884, 1 mg (for esrd on dialysis) (Eff. Date 01/01/2023)   |  |  |
| J0900 | Injection, testosterone enanthate and estradiol valerate, up to 1 cc (Deleted eff. 12/31/2014)  |  |  |
| J0901 | Vadadustat, oral, 1 mg (for esrd on dialysis) (Eff. Date 1/1/2025)  |  |  |
| J0945 | Injection, brompheniramine maleate, per 10 mg   |  |  |
| J0970 | Injection, estradiol valerate, up to 40 mg (Deleted eff. 12/31/2010)  |  |  |
| J1000 | Injection, depo-estradiol cypionate, up to 5 mg   |  |  |
| J1010 | Injection, methylprednisolone acetate, 1 mg (Eff. Date 04/01/2024)  |  |  |
| J1020 | Injection, methylprednisolone acetate, 20 mg (Deleted eff. 03/31/2024)  |  |  |
| J1030 | Injection, methylprednisolone acetate, 40 mg (Deleted eff. 03/31/2024)  |  |  |
| J1040 | Injection, methylprednisolone acetate, 80 mg (Deleted eff. 03/31/2024)  |  |  |
| J1050 | Injection, medroxyprogesterone acetate, 1 mg (Eff. Date 1/1/2013)   |  |  |
| J1051 | Injection, medroxyprogesterone acetate, 50 mg (Eff. Date 1/1/2003) (Deleted eff. 12/31/2012)  |  |  |
| J1055 | Injection, medroxyprogesterone acetate for contraceptive use, 150 mg (Deleted Eff. 12/31/2012)  |  |  |
| J1056 | Injection, medroxyprogesterone acetate/estradiol cypionate, 5 mg/25 mg (Eff. Date 1/1/2002) (Deleted Eff. 12/31/2012)   |  |  |
| J1060 | Injection, testosterone cypionate and estradiol cypionate, up to 1 ml (Deleted eff. 12/31/2014)   |  |  |

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| J1070 | Injection, testosterone cypionate, up to 100 mg (Deleted eff. 12/31/2014) |  |  |
| J1071 | Injection, testosterone cypionate, 1 mg (Eff. Date 01/01/2015)            |  |  |
| J1080 | Injection, testosterone cypionate, 1 cc, 200 mg (Deleted eff. 12/31/2014) |  |  |
| J1094 | Injection, dexamethasone acetate, 1 mg (Eff. Date 1/1/2003)               |  |  |
| J1100 | Injection, dexamethosone sodium phosphate, 1 mg                           |  |  |
| J1105 | Dexmedetomidine, oral, 1 mcg (Eff. Date 01/01/2024)                       |  |  |
| J1110 | Injection, dihydroergotamine mesylate, per 1 mg                           |  |  |
| J1120 | Injection, acetazolamide sodium, up to 500 mg                             |  |  |
| J1130 | Injection, diclofenac sodium, 0.5 mg (Eff. Date 1/1/2017)                 |  |  |
| J1160 | Injection, digoxin, up to 0.5 mg  |  |  |
| J1162 | Injection, digoxin immune fab (ovine), per vial (Eff. Date 1/1/2006)      |  |  |
| J1165 | Injection, phenytoin sodium, per 50 mg                                    |  |  |
| J1170 | Injection, hydromorphone, up to 4 mg (Deleted eff. 09/30/2024)            |  |  |
| J1171 | Injection, hydromorphone, 0.1 mg (Eff. Date 10/01/2024)                   |  |  |
| J1180 | Injection, dyphylline, up to 500 mg                                       |  |  |
| J1190 | Injection, dexrazoxane hydrochloride, per 250 mg                          |  |  |
| J1200 | Injection, diphenhydramine HCL, up to 50 mg                               |  |  |
| J1201 | Injection, cetirizine hydrochloride, 0.5 mg (Eff. Date 07/01/2020)        |  |  |
| J1202 | Miglustat, oral, 65 mg (Eff. Date 04/01/2024)                             |  |  |
| J1203 | Injection, cipaglucoasidase alfa-atga, 5 mg (Eff. Date 04/01/2024)        |  |  |
| J1205 | Injection, chlorothiazide sodium, per 500 mg                              |  |  |
| J1212 | Injection, dmso, dimethyl sulfoxide, 50%, 50 ml                           |  |  |
| J1230 | Injection, methadone HCL, up to 10 mg                                     |  |  |
| J1240 | Injection, dimenhydrinate, up to 50 mg                                    |  |  |
| J1245 | Injection, dipyridamole, per 10 mg  |  |  |
| J1250 | Injection, dobutamine hydrochloride, per 250 mg                           |  |  |
| J1260 | Injection, dolasetron mesylate, 10 mg                                     |  |  |
| J1265 | Injection, dopamine HCL, 40 MG (Eff. Date 1/1/2006)                       |  |  |

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| J1267 | Injection, doripenem, 10 mg (Eff. Date 1/1/2009)   |  |  |
| J1270 | Injection, doxercalciferol, 1 mcg (Eff. Date 1/1/2002)   |  |  |
| J1290 | Injection, Ecallantide, 1 mg (Eff. Date 1/1/2011)  |  |  |
| J1300 | Injection, eculizumab, 10 mg (Eff. Date 1/1/2008)  |  |  |
| J1301 | Injection, edaravone, 1 mg (Eff. Date 1/1/2019)  |  |  |
| J1302 | Injection, sutimlimab-jome, 10 mg (Eff. Date 10/01/2022)   |  |  |
| J1303 | Injection, ravulizumab-cwvz, 10 mg (Eff. Date 10/01/2019)  |  |  |
| J1304 | Injection, tofersen, 1 mg (Eff. Date 01/01/2024)   |  |  |
| J1305 | Injection, evinacumab-dgnb, 5mg (Eff. Date 10/1/2021)  |  |  |
| J1306 | Injection, inclisiran, 1 mg (Eff. Date 07/01/2022)   |  |  |
| J1307 | Injection, crovalimab-akkz, 10 mg (Eff. Date 1/1/2025)   |  |  |
| J1320 | Injection, amitriptyline HCL, up to 20 mg  |  |  |
| J1322 | Injection, elosulfase alfa, 1mg (Eff. Date 01/01/2015)   |  |  |
| J1323 | Injection, elranatamab-bcmm, 1 mg (Eff. Date 04/01/2024)   |  |  |
| J1324 | Injection, enfuvirtide, 1 mg (Eff. Date 1/1/2007)  |  |  |
| J1325 | Injection, epoprostenol, 0.5 mg  |  |  |
| J1327 | Injection, eptifibatide, 5 mg (Eff. Date 1/1/2000)   |  |  |
| J1330 | Injection, ergonovine maleate, up to 0.2 mg  |  |  |
| J1335 | Injection, ertpenem sodium, 500 mg   |  |  |
| J1364 | Injection, erythromycin lactobionate, per 500 mg   |  |  |
| J1380 | Injection, estradiol valerate, up to 10 mg   |  |  |
| J1390 | Injection, estradiol valerate, up to 20 mg (Deleted eff. 12/31/2010)   |  |  |
| J1410 | Injection, estrogen conjugated, per 25 mg  |  |  |
| J1411 | Injection, etranacogene dezaparovec-drlb, per therapeutic dose (Eff. Date 04/01/2023)  |  |  |
| J1412 | Injection, valoctocogene roxaparovec-rvox, per ml, containing nominal 2 x 10 <sup>13</sup> vector genomes (Eff. Date 01/01/2024) |  |  |
| J1413 | Injection, delandistrogene moxeparovec-rokl, per therapeutic dose (Eff. Date 01/01/2024)   |  |  |
| J1414 | Injection, fidanacogene elaparovec-dzkt, per therapeutic dose (Eff. Date 1/1/2025)   |  |  |

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| J1426 | Injection, casimersen, 10 mg   |  |  |
| J1427 | Injection, viltolarsen, 10 mg (Eff. Date 04/01/2021)   |  |  |
| J1428 | Injection, eteplirsen, 10 mg (Eff. Date 01/01/2018)  |  |  |
| J1429 | Injection, golodirsen, 10 mg (Eff. Date 07/01/2020)  |  |  |
| J1430 | Injection, ethanolamine oleate, 100 MG (Eff. Date 1/1/2006)  |  |  |
| J1434 | Injection, fosaprepitant (focinvez), 1 mg (Eff. Date 04/01/2024)   |  |  |
| J1435 | Injection, estrone, per 1 mg   |  |  |
| J1436 | Injection, etidronate disodium, per 300 mg   |  |  |
| J1437 | Injection, ferric derisomaltose, 10 mg (Eff. Date 10/01/2020)  |  |  |
| J1438 | Injection, etanercept, 25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Eff. Date 1/1/2000) |  |  |
| J1439 | Injection, ferric carboxymaltose, 1 mg (Eff. Date 01/01/2015)  |  |  |
| J1440 | Injection, filgrastim (g-csf), 300 mcg (Deleted eff. 12/31/2013)   |  |  |
| J1441 | Injection, filgrastim (g-csf), 480 mcg (Deleted eff. 12/31/2013)   |  |  |
| J1442 | Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram (Eff. Date 01/01/2014) (Revised 1/1/2016)   |  |  |
| J1443 | Injection, ferric pyrophosphate citrate solution (triferic), 0.1 mg of iron (Eff. Date 1/1/2016) (Revised 10/1/2021)   |  |  |
| J1444 | Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron (Eff. Date 07/01/2019)  |  |  |
| J1445 | Injection, ferric pyrophosphate citrate solution (triferic avnu), 0.1 mg of iron (Eff. Date 10/1/2021)   |  |  |
| J1446 | Injection, tbo-filgrastim, 5 micrograms (Eff. Date 01/01/2014) (Deleted eff.12/31/2015)  |  |  |
| J1447 | Injection, tbo-filgrastim, 1 microgram (Eff. Date 1/1/2016)  |  |  |
| J1448 | Injection, trilaciclib, 1mg (Eff. Date 10/1/2021)  |  |  |
| J1449 | Injection, eflapegrastim-xnst, 0.1 mg (Eff. Date 04/01/2023)   |  |  |
| J1450 | Injection fluconazole, 200 mg (Eff. Date 1/1/2000)   |  |  |
| J1451 | Injection, fomepizole, 15 mg (Eff. Date 1/1/2006)  |  |  |
| J1452 | Injection, fomivirsen sodium, intraocular, 1.65 mg (Eff. Date 1/1/2001)  |  |  |
| J1453 | Injection, fosaprepitant, 1 mg (Eff. Date 1/1/2009)  |  |  |



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| J1454 | Injection, fosnetupitant 235 mg and palonosetron 0.25 mg (Eff Date 1/1/2019)                                   |  |  |
| J1455 | Injection, foscarnet sodium, per 1000 mg   |  |  |
| J1456 | Injection, fosaprepitant (teva), not therapeutically equivalent to j1453, 1 mg (Eff. Date 01/01/2023)          |  |  |
| J1457 | Injection, gallium nitrate, 1 mg (Eff. Date 1/1/2005)  |  |  |
| J1458 | Injection, galsulfase, 1 mg (Eff. date 1/1/2007)   |  |  |
| J1459 | Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg (Eff. Date 1/1/2009) |  |  |
| J1460 | Injection, gamma globulin, intramuscular, 1 cc   |  |  |
| J1470 | Injection, gamma globulin, intramuscular, 2 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1480 | Injection, gamma globulin, intramuscular, 3 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1490 | Injection, gamma globulin, intramuscular, 4 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1500 | Injection, gamma globulin, intramuscular, 5 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1510 | Injection, gamma globulin, intramuscular, 6 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1520 | Injection, gamma globulin, intramuscular, 7 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1530 | Injection, gamma globulin, intramuscular, 8 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1540 | Injection, gamma globulin, intramuscular, 9 cc (Deleted eff. 12/31/2010)                                       |  |  |
| J1550 | Injection, gamma globulin, intramuscular, 10 cc (Deleted eff. 12/31/2010)                                      |  |  |
| J1551 | Injection, immune globulin (cutaquist), 100 mg (Eff. Date 07/01/2022)  |  |  |
| J1552 | Injection, immune globulin (alyglo), 500 mg (Eff. Date 1/1/2025)   |  |  |
| J1554 | Injection, immune globulin (asceniv), 500 mg (Eff. Date 04/01/2021)  |  |  |
| J1555 | Injection, immune globulin (cuvitru), 100 mg (Eff. Date 01/01/2018)  |  |  |
| J1556 | Injection, immune globulin (bivigam), 500 mg (Eff. Date 01/01/2014)  |  |  |

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| J1557 | Injection, Immune Globulin, (Gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg (Eff. Date 1/1/2012)   |  |  |
| J1558 | Injection, immune globulin (xembify), 100 mg (Eff. Date 07/01/2020)   |  |  |
| J1559 | Injection, immune globulin (hizentra), 100 mg (Eff. Date 1/1/2011)  |  |  |
| J1560 | Injection, gamma globulin, intramuscular, over 10 cc  |  |  |
| J1561 | Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g. liquid), 500 mg (Eff. Date 1/1/2012) (updated 01/01/2013)   |  |  |
| J1562 | Injection, immune globulin (vivaglobin), 100 mg (Updated 1/1/2008)  |  |  |
| J1566 | Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg (Updated 1/1/2008)   |  |  |
| J1568 | Injection, immune globulin (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg (Eff. Date 1/1/2008)  |  |  |
| J1569 | Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg (Eff. Date 1/1/2008) (Updated 01/01/2013)   |  |  |
| J1570 | Injection, ganciclovir sodium, 500 mg   |  |  |
| J1571 | Injection, hepatitis b immune globulin (hepagam b), intramuscular, 0.5 ml (Eff. Date 1/1/2008)  |  |  |
| J1572 | Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg (Eff. Date 1/1/2008, Updated eff. 1/1/2009)  |  |  |
| J1573 | Injection, hepatitis b immune globulin (hepagam b), intravenous, 0.5 ml (Eff. Date 1/1/2008)  |  |  |
| J1574 | Injection, ganciclovir sodium (exela) not therapeutically equivalent to j1570, 500 mg (Eff. Date 01/01/2023) Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg (Revised eff. 07/01/2024) |  |  |
| J1575 | Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin (Eff. Date 1/1/2016)  |  |  |
| J1576 | Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg (Eff. Date 07/01/2023)  |  |  |
| J1580 | Injection, garamycin, gentamicin, up to 80 mg   |  |  |
| J1590 | Injection, gatifloxacin, 10 mg (Eff. Date 1/1/2002) (Deleted eff. 12/31/2016)   |  |  |
| J1595 | Injection, glatiramer acetate, 20 mg  |  |  |
| J1596 | Injection, glycopyrrolate, 0.1 mg (Eff. Date 01/01/2024)  |  |  |

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| J1597 | Injection, glycopyrrolate (glyrx-pf), 0.1 mg (Eff. Date 07/01/2024)  |  |  |
| J1598 | Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to j1596, 0.1 mg (Eff. Date 07/01/2024)             |  |  |
| J1599 | Injection, immune globulin, intravenous, non-lyophilized, (e.g., liquid), not otherwise specified, 500 mg (Eff. Date 1/1/2011) |  |  |
| J1600 | Injection, gold sodium thiomalate, up to 50 mg   |  |  |
| J1602 | Injection, golimumab, 1 mg, for intravenous use (Eff. Date 01/01/2014)   |  |  |
| J1610 | Injection, glucagon hydrochloride, per 1 mg  |  |  |
| J1611 | Injection, glucagon hydrochloride (fresenius kabi), not therapeutically equivalent to j1610, per 1 mg (Eff. Date 01/01/2023)   |  |  |
| J1620 | Injection, gonadorelin hydrochloride, per 100 mcg  |  |  |
| J1626 | Injection, granisetron hydrochloride, 100 mcg  |  |  |
| J1627 | Injection, granisetron, extended-release, 0.1 mg (Eff. Date 01/01/2018)  |  |  |
| J1628 | Injection, guselkumab, 1 mg (Eff. Date 1/1/2019)   |  |  |
| J1630 | Injection, haloperidol, up to 5 mg   |  |  |
| J1631 | Injection, haloperidol decanoate, per 50 mg  |  |  |
| J1632 | Injection, brexanolone, 1 mg (Eff. Date 10/01/2020)  |  |  |
| J1640 | Injection, hemin, 1 mg (Eff. Date 1/1/2006)  |  |  |
| J1642 | Injection, heparin sodium, (heparin lock flush), per 10 units  |  |  |
| J1643 | Injection, heparin sodium (pfizer), not therapeutically equivalent to j1644, per 1000 units (Eff. Date 01/01/2023)             |  |  |
| J1644 | Injection, heparin sodium, per 1000 units  |  |  |
| J1645 | Injection, dalteparin sodium, per 2500 I.U.  |  |  |
| J1650 | Injection, enoxaparin sodium, 10 mg  |  |  |
| J1652 | Injection, fondaparinux sodium, 0.5mg (Eff. Date 1/1/2003)   |  |  |
| J1655 | Injection, tinzaparin sodium, 1000 IU (Eff. Date 1/1/2002)   |  |  |
| J1670 | Injection, tetanus immune globulin, human, up to 250 units   |  |  |
| J1675 | Injection, histrelin acetate, 10 micrograms (Eff. Date 1/1/2006)   |  |  |
| J1680 | Injection, human fibrinogen concentrate, 100 mg (Eff. Date 1/1/2010) (Deleted eff. 06/30/2012)                                 |  |  |

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| J1700 | Injection, hydrocortisone acetate, up to 25 mg   |  |  |
| J1710 | Injection, hydrocortisone sodium phosphate, up to 50 mg  |  |  |
| J1720 | Injection, hydrocortisone sodium succinate, up to 100 mg   |  |  |
| J1725 | Injection, hydroxyprogesterone caproate, 1 mg (Eff. Date 1/1/2012) (Deleted eff. 06/30/2017)         |  |  |
| J1726 | Injection, hydroxyprogesterone caproate, (makena), 10 mg (Eff. Date 01/01/2018)                      |  |  |
| J1729 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg (Eff. Date 01/01/2018)       |  |  |
| J1730 | Injection, diazoxide, up to 300 mg   |  |  |
| J1738 | Injection, meloxicam, 1 mg (Eff. Date 10/01/2020)  |  |  |
| J1740 | Injection, Ibandronate Sodium, 1 mg (Eff. Date 1/1/2007)   |  |  |
| J1741 | Injection, ibuprofen, 100 mg (Eff, Date 1/1/2013)  |  |  |
| J1742 | Injection, ibutilide fumarate, 1 mg  |  |  |
| J1743 | Injection, idursulfase, 1 mg (Eff. Date 1/1/2008)  |  |  |
| J1744 | Injection, icatibant, 1 mg (Eff. Date 1/1/2013)  |  |  |
| J1745 | Injection infliximab, excludes biosimilar, 10 mg (Eff. Date 1/1/2000) (Updated description 1/1/2017) |  |  |
| J1746 | Injection, ibalizumab-uiyk, 10 mg (Eff. Date 1/1/2019)   |  |  |
| J1747 | Injection, spesolimab-sbzo, 1 mg (Eff. Date 04/01/2023)  |  |  |
| J1748 | Injection, infliximab-dyyb (zymfentra), 10 mg (Eff. Date 07/01/2024)                                 |  |  |
| J1749 | Injection, iloprost, 0.1 mcg (Eff. Date 10/01/2024)  |  |  |
| J1750 | Injection, iron dextran 50 mg (Eff. Date 1/1/2009)   |  |  |
| J1756 | Injection, iron sucrose, 1 mg (Eff. Date 1/1/2003)   |  |  |
| J1785 | Injection, imiglucerase, per unit (Deleted eff. 12/31/2010)  |  |  |
| J1786 | Injection, imiglucerase, 10 units (Eff. Date 1/1/2011)   |  |  |
| J1790 | Injection, droperidol, up to 5 mg  |  |  |
| J1800 | Injection, propranolol HCL, up to 1 mg   |  |  |
| J1805 | Injection, esmolol hydrochloride, 10 mg (Eff. Date 07/01/2023)                                       |  |  |

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| J1806 | Injection, esmolol hydrochloride (wg critical care) not therapeutically equivalent to j1805, 10 mg (Eff. Date 07/01/2023)<br>Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg (Revised eff. 07/01/2024) |  |  |
| J1810 | Injection, droperidol and fentanyl citrate, up to 2 ml ampule  |  |  |
| J1811 | Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units (Eff. Date 07/01/2023)  |  |  |
| J1812 | Insulin (fiasp), per 5 units (Eff. Date 07/01/2023)  |  |  |
| J1813 | Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units (Eff. Date 07/01/2023)  |  |  |
| J1814 | Insulin (lyumjev), per 5 units (Eff. Date 07/01/2023)  |  |  |
| J1815 | Injection, insulin, per 5 units (Eff. Date 1/1/2003)   |  |  |
| J1817 | Insulin for administration through DME (i.e., insulin pump) per 50 units (Eff. Date 1/1/2003)  |  |  |
| J1823 | Injection, inebilizumab-cdon, 1 mg (Eff. Date 01/01/2021)  |  |  |
| J1825 | Injection, interferon beta-1a, 33 mcg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered) (Deleted eff. 12/31/2010)   |  |  |
| J1826 | Injection, interferon beta-1a, 30 mcg (Eff. Date 1/1/2011)   |  |  |
| J1830 | Injection interferon beta-1b, 0.25 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)   |  |  |
| J1833 | Injection, isavuconazonium, 1 mg (Eff. Date 1/1/2016)  |  |  |
| J1835 | Injection, itroconazole, 50 mg (Eff. Date 1/1/2002)  |  |  |
| J1836 | Injection, metronidazole, 10 mg (Eff. Date 07/01/2023)   |  |  |
| J1840 | Injection, kanamycin sulfate, up to 500 mg (Deleted eff. 03/31/2024)   |  |  |
| J1850 | Injection, kanamycin sulfate, up to 75 mg (Deleted eff. 03/31/2024)  |  |  |
| J1885 | Injection, ketorolac tromethamine, per 15 mg   |  |  |
| J1890 | Injection, cephalothin sodium, up to 1 gram  |  |  |
| J1920 | Injection, labetalol hydrochloride, 5 mg (Eff. Date 07/01/2023)  |  |  |

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| J1921 | Injection, labetalol hydrochloride (hikma) not therapeutically equivalent to j1920, 5 mg (Eff. Date 07/01/2023) (Revised 10/01/2023) Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg (Revised eff. 07/01/2024) |  |  |
| J1930 | Injection, lanreotide, 1 mg (Eff. Date 1/1/2009)   |  |  |
| J1931 | Injection, laronidase, 0.1 mg (Eff. Date 1/1/2005)   |  |  |
| J1932 | Injection, lanreotide, (ciplá), 1 mg (Eff. Date 10/01/2022)  |  |  |
| J1939 | Injection, bumetanide, 0.5 mg (Eff. Date 01/01/2024)   |  |  |
| J1940 | Injection, furosemide, up to 20 mg   |  |  |
| J1941 | Injection, furosemide (furoscix), 20 mg (Eff. Date 07/01/2023)   |  |  |
| J1942 | Injection, aripiprazole lauroxil, 1 mg (Eff. Date 1/1/2017) (Deleted eff. 09/30/2019)  |  |  |
| J1943 | Injection, aripiprazole lauroxil, (aristada initio), 1 mg (Eff. Date 10/01/2019)   |  |  |
| J1944 | Injection, aripiprazole lauroxil, (aristada), 1 mg (Eff. Date 10/01/2019)  |  |  |
| J1945 | Injection, lepirudin, 50 mg (Eff. Date 1/1/2006)   |  |  |
| J1950 | Injection, leuprolide acetate (for depot suspension), per 3.75 mg  |  |  |
| J1951 | Injection, leuprolide acetate for depot suspension (fensolvi), 0.25 mg (Eff. Date 07/01/2021)  |  |  |
| J1952 | Leuprolide injectable, camcevi, 1 mg (Eff. Date 01/01/2022)  |  |  |
| J1953 | Injection, levetiracetam, 10 mg (Eff. Date 01/01/2009)   |  |  |
| J1954 | Injection, leuprolide acetate for depot suspension (ciplá), 7.5 mg (Eff. Date 01/01/2023) Injection, leuprolide acetate for depot suspension (lutrate), 7.5 mg (Revised 04/01/2023)  |  |  |
| J1955 | Injection, levocarnitine, per 1 gm   |  |  |
| J1956 | Injection, levofloxacin, 250 mg  |  |  |
| J1960 | Injection, levorphanol tartrate, up to 2 mg  |  |  |
| J1961 | Injection, lenacapavir, 1 mg (Eff. Date 07/01/2023)  |  |  |
| J1980 | Injection, hyoscyamine sulfate, up to 0.25 mg  |  |  |
| J1990 | Injection, chlordiazepoxide HCL, up to 100 mg  |  |  |
| J2001 | Injection, lidocaine HCL for intravenous infusion, 10 mg (Deleted eff. 09/30/2024)   |  |  |

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| J2002 | Injection, lidocaine hcl in 5% dextrose, 1 mg (Eff. Date 10/01/2024)  |  |  |
| J2003 | Injection, lidocaine hydrochloride, 1 mg (Eff. Date 10/01/2024)   |  |  |
| J2004 | Injection, lidocaine hcl with epinephrine, 1 mg (Eff. Date 10/01/2024)  |  |  |
| J2010 | Injection, lincomycin HCL, up to 300 mg   |  |  |
| J2020 | Injection, linezolid, 200 mg (Eff. Date 1/1/2002)   |  |  |
| J2021 | Injection, linezolid (hospira) not therapeutically equivalent to j2020, 200 mg (Eff. Date 01/01/2023) Injection, linezolid (hospira), not therapeutically equivalent to j2020, 200 mg (Revised eff. 07/01/2024)   |  |  |
| J2060 | Injection, lorazepam, 2 mg  |  |  |
| J2062 | Loxapine for inhalation, 1 mg (Eff. Date 1/1/2019)  |  |  |
| J2150 | Injection, mannitol, 25% in 50 ml   |  |  |
| J2170 | Injection, Mecasermin, 1 mg (Eff. date 1/1/2007)  |  |  |
| J2175 | Injection, meperidine hydrochloride, per 100 mg   |  |  |
| J2180 | Injection, meperidine and promethazine HCL, up to 50 mg   |  |  |
| J2182 | Injection, mepolizumab, 1 mg (Eff. Date 1/1/2017)   |  |  |
| J2183 | Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg (Eff. Date 07/01/2024)   |  |  |
| J2184 | Injection, meropenem (b. braun) not therapeutically equivalent to j2185, 100 mg (Eff. Date 01/01/2023) Injection, meropenem (b. braun), not therapeutically equivalent to j2185, 100 mg (Revised eff. 07/01/2024) |  |  |
| J2185 | Injection, meropenem, 100 mg  |  |  |
| J2186 | Injection, meropenem and vaborbactam, 10mg/10mg (20mg) (Eff. Date 1/1/2019)   |  |  |
| J2210 | Injection, methylergonovine maleate, up to 0.2 mg   |  |  |
| J2212 | Injection, methylnaltrexone, 0. 1 mg (Eff. Date 1/1/2013)   |  |  |
| J2246 | Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg (Eff. Date 07/01/2024)  |  |  |
| J2247 | Injection, micafungin sodium (par pharm) not thereapeutically equivalent to j2248, 1 mg (Eff. Date 01/01/2023)  |  |  |
| J2248 | Injection, micafungin sodium, 1 mg (Eff. Date 1/1/2007)   |  |  |
| J2249 | Injection, remimazolam, 1 mg (Eff. Date 07/01/2023)   |  |  |

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| J2250 | Injection, midazolam hydrochloride, per 1 mg   |  |  |
| J2251 | Injection, midazolam hydrochloride (wg critical care) not therapeutically equivalent to j2250, per 1 mg (Eff. Date 01/01/2023) Injection, midazolam hydrochloride (wg critical care), not therapeutically equivalent to j2250, per 1 mg (Revised eff. 07/01/2024) Injection, midazolam in 0.9% sodium chloride, intravenous, not therapeutically equivalent to j2250, 1 mg (Revised eff. 10/01/2024) |  |  |
| J2252 | Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to j2250, 1 mg (Eff. Date 10/01/2024)  |  |  |
| J2253 | Injection, midazolam (seizalam), 1 mg (Eff. Date 10/01/2024)   |  |  |
| J2260 | Injection, milrinone lactate, 5 mg   |  |  |
| J2265 | Injection Minocycline Hydrochloride, 1 mg (Eff. Date 1/1/2012)   |  |  |
| J2267 | Injection, mirikizumab-mrkz, 1 mg (Eff. Date 07/01/2024)   |  |  |
| J2270 | Injection, morphine sulfate, up to 10 mg   |  |  |
| J2271 | Injection, morphine sulfate, 100mg (Deleted eff. 12/31/2014)   |  |  |
| J2272 | Injection, morphine sulfate (fresenius kabi) not therapeutically equivalent to j2270, up to 10 mg (Eff. Date 01/01/2023) Injection, morphine sulfate (fresenius kabi), not therapeutically equivalent to j2270, up to 10 mg (Revised eff. 07/01/2024)  |  |  |
| J2274 | Injection, morphine sulfate, preservative-free for epidural or intrathecal use, 10 mg (Eff. Date 01/01/2015)   |  |  |
| J2275 | Injection, morphine sulfate (preservative-free sterile solution), per 10 mg (Deleted eff. 12/31/2014)  |  |  |
| J2277 | Injection, motixafortide, 0.25 mg (Eff. Date 04/01/2024)   |  |  |
| J2278 | Injection, ziconotide, 1 microgram (Eff. Date 1/1/2006)  |  |  |
| J2280 | Injection, moxifloxacin, 100 mg  |  |  |
| J2281 | Injection, moxifloxacin (fresenius kabi) not therapeutically equivalent to j2280, 100 mg (Eff. Date 01/01/2023) Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg (Revised eff. 07/01/2024)  |  |  |
| J2290 | Injection, nafcillin sodium, 20 mg (Eff. Date 1/1/2025)  |  |  |
| J2300 | Injection, nalbuphine hydrochloride, per 10 mg   |  |  |
| J2305 | Injection, nitroglycerin, 5 mg (Eff. Date 07/01/2023)  |  |  |
| J2310 | Injection, naloxone hydrochloride, per 1 mg  |  |  |
| J2311 | Injection, naloxone hydrochloride (zimhi), 1 mg (Eff. Date 01/01/2023)   |  |  |



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| J2315 | Injection, Naltrexone, Depot Foam, 1 mg (Eff. date 1/1/2007)                              |  |  |
| J2320 | Injection, nandrolone decanoate, up to 50 mg  |  |  |
| J2321 | Injection, nandrolone decanoate, up to 100 mg (Deleted eff. 12/31/2010)                   |  |  |
| J2322 | Injection, nandrolone decanoate, up to 200 mg (Deleted eff. 12/31/2010)                   |  |  |
| J2323 | Injection, natalizumab, 1 mg (Eff. Date 1/1/2008)   |  |  |
| J2325 | Injection, nesiritide, 0.1 mg (Eff. Date 1/1/2006)  |  |  |
| J2326 | Injection, nusinersen, 0.1 mg (Eff. Date 01/01/2018)                                      |  |  |
| J2327 | Injection, risankizumab-rzaa, intravenous, 1 mg (Eff. Date 01/01/2023)                    |  |  |
| J2329 | Injection, ublituximab-xiiy, 1mg (Eff. Date 07/01/2023)                                   |  |  |
| J2350 | Injection, ocrelizumab, 1 mg (Eff. Date 01/01/2018)                                       |  |  |
| J2353 | Injection, octreotide, depot form for intramuscular injection, 1 mg                       |  |  |
| J2354 | Injection, octreotide, non-depot form for subcutaneous or intravenous injection, 20 mcg   |  |  |
| J2355 | Injection, oprelvekin, 5 mg   |  |  |
| J2356 | Injection, tezepelumab-ekko, 1 mg (Eff. Date 07/01/2022)                                  |  |  |
| J2357 | Injection, omalizumab, 5 mg (Eff. Date 1/1/2005)  |  |  |
| J2358 | Injection, olanzapine, long-acting, 1 mg (Eff. Date 1/1/2011)                             |  |  |
| J2359 | Injection, olanzapine, 0.5 mg (Eff. Date 10/01/2023)                                      |  |  |
| J2360 | Injection, orphenadrine citrate, up to 60 mg  |  |  |
| J2370 | Injection, phenylephrine HCL, up to 1 ml (Deleted eff. 06/30/2023)                        |  |  |
| J2371 | Injection, phenylephrine hydrochloride, 20 micrograms (Eff. Date 07/01/2023)              |  |  |
| J2372 | Injection, phenylephrine hydrochloride (biorphen), 20 micrograms (Eff. Date 07/01/2023)   |  |  |
| J2373 | Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms (Eff. Date 07/01/2024) |  |  |
| J2400 | Injection, chloroprocaine hydrochloride, per 30 ml (Deleted eff. 12/31/2022)              |  |  |
| J2401 | Injection, chloroprocaine hydrochloride, per 1 mg (Eff. Date 01/01/2023)                  |  |  |

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| J2402 | Injection, chlorprocaine hydrochloride (clorotekal), per 1 mg (Eff. Date 01/01/2023)                                      |  |  |
| J2403 | Chlorprocaine hcl ophthalmic, 3% gel, 1 mg (Eff. Date 04/01/2023)   |  |  |
| J2404 | Injection, nicardipine, 0.1 mg (Eff. Date 01/01/2024)   |  |  |
| J2405 | Injection, ondansetron hydrochloride, per 1 mg  |  |  |
| J2406 | Injection, oritavancin (kimyrsa), 10 mg (Eff. Date 10/1/2021)   |  |  |
| J2407 | Injection, oritavancin (orbactiv), 10 mg (Eff. Date 1/1/2016) (Revised 10/1/2021)   |  |  |
| J2410 | Injection, oxymorphone HCL, up to 1 mg  |  |  |
| J2425 | Injection, palifermin, 50 micrograms (Eff. Date 1/1/2006)   |  |  |
| J2426 | Injection, paliperidone palmitate extended release (invega sustenna), 1 mg (Eff. Date 1/1/2011) (Revised eff. 07/01/2023) |  |  |
| J2427 | Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg (Eff. Date 07/01/2023)        |  |  |
| J2430 | Injection, pamidronate disodium, per 30 mg  |  |  |
| J2440 | Injection, papaverine HCL, up to 60 mg  |  |  |
| J2460 | Injection, oxytetracycline HCL, up to 50 mg   |  |  |
| J2468 | Injection, palonosetron hydrochloride (posfrea), 25 micrograms (Rev. Eff. 1/1/2025)                                       |  |  |
| J2469 | Injection, palonosetron HCL, 25 mcg (Eff. Date 1/1/2005)  |  |  |
| J2470 | Injection, pantoprazole sodium, 40 mg (Eff. Date 07/01/2024)  |  |  |
| J2471 | Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg (Eff. Date 07/01/2024)                    |  |  |
| J2472 | Injection, pantoprazole sodium in sodium chloride (baxter), 40 mg (Eff. Date 1/1/2025)                                    |  |  |
| J2501 | Injection, paricalcitol, 1 mcg (Eff. Date 1/1/2003)   |  |  |
| J2502 | Injection, pasireotide long acting, 1 mg (Eff. Date 1/1/2016)   |  |  |
| J2503 | Injection, pegaptanib sodium, 0.3 mg (Eff. Date 1/1/2006)   |  |  |
| J2504 | Injection, pegademase bovine, 25 IU (Eff. Date 1/1/2006)  |  |  |
| J2505 | Injection, pegfilgrastim, 6 mg (Deleted eff. 12/31/2021)  |  |  |
| J2506 | Injection, pegfilgrastim, excludes biosimilar, 0.5 mg (Eff. Date 01/01/2022)  |  |  |
| J2507 | Injection, Pegloticase, 1 mg (Eff. Date 1/1/2012)   |  |  |

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| J2508 | Injection, pegunigalsidase alfa-iwxj, 1 mg (Eff. Date 01/01/2024)   |    |  |
| J2510 | Injection, penicillin g procaine, aqueous, up to 600,000 units  |    |  |
| J2513 | Injection, pentastarch, 10% solutin, 100 ml (Eff. Date 1/1/2006)  |    |  |
| J2515 | Injection, pentobarbital sodium, per 50 mg  |    |  |
| J2540 | Injection, penicillin g potassium, up to 600,000 units  |    |  |
| J2543 | Injection, piperacillin sodium/tazobactam sodium, 1 gram/0.125 grams (1.125 grams) (Eff. Date 1/1/2000)   |    |  |
| J2545 | Pentamidine isethionate, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per 300 mg (Updated 1/1/2008)   | 15 |  |
| J2547 | Injection, peramivir, 1 mg (Eff. Date 1/1/2016)   |    |  |
| J2550 | Injection, promethazine HCL, up to 50 mg  |    |  |
| J2560 | Injection, phenobarbital sodium, up to 120 mg   |    |  |
| J2561 | Injection, phenobarbital sodium (sezaby), 1 mg (Eff. Date 07/01/2023)   |    |  |
| J2562 | Injection, plerixafor, 1 mg (Eff. Date 1/1/2010)  |    |  |
| J2590 | Injection, oxytocin, up to 10 units   |    |  |
| J2597 | Injection, desmopressin acetate, per 1 mcg  |    |  |
| J2598 | Injection, vasopressin, 1 unit (Eff. Date 07/01/2023)   |    |  |
| J2599 | Injection, vasopressin (american regent) not therapeutically equivalent to j2598, 1 unit (Eff. Date 07/01/2023) Injection, vasopressin (american regent), not therapeutically equivalent to j2598, 1 unit (Revised eff. 07/01/2024) |    |  |
| J2601 | Injection, vasopressin (baxter), 1 unit (Eff. Date 10/01/2024)  |    |  |
| J2650 | Injection, prednisolone acetate, up to 1 ml   |    |  |
| J2670 | Injection, tolazoline HCL, up to 25 mg  |    |  |
| J2675 | Injection, progesterone, per 50 mg  |    |  |
| J2679 | Injection, fluphenazine hcl, 1.25 mg (Eff. Date 01/01/2024)   |    |  |
| J2680 | Injection, fluphenazine decanoate, up to 25 mg  |    |  |
| J2690 | Injection, procainamide HCL, up to 1 gm   |    |  |
| J2700 | Injection, oxacillin sodium, up to 250 mg   |    |  |
| J2704 | Injection, propofol, 10 mg (Eff. Date 01/01/2015)   |    |  |
| J2710 | Injection, neostigmine methylsulfate, up to 0.5 mg  |    |  |

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| J2720 | Injection, protamine sulfate, per 10 mg   |  |  |
| J2724 | Injection, protein C concentrate, intravenous, human, 10iu (Eff. Date 1/1/2008)   |  |  |
| J2725 | Injection, protirelin, per 250 mcg  |  |  |
| J2730 | Injection, pralidoxime chloride, up to 1 gm   |  |  |
| J2760 | Injection, phentolamine mesylate, up to 5 mg  |  |  |
| J2765 | Injection, metoclopramide HCL, up to 10 mg  |  |  |
| J2770 | Injection, quinupristin/dalfopristim, 500 mg (150/350) (Eff. Date 1/1/2001)   |  |  |
| J2777 | Injection, faricimab-svoa, 0.1 mg (Eff. Date 10/01/2022)  |  |  |
| J2778 | Injection, ranibizumab, 0.1 mg (Eff. Date 1/1/2008)   |  |  |
| J2780 | Injection, ranitidine hydrochloride, 25 mg (Eff. Date 1/1/2000) (Deleted eff. 06/30/2024)                               |  |  |
| J2781 | Injection, pegcetacoplan, intravitreal, 1 mg (Eff. Date 10/01/2023)   |  |  |
| J2782 | Injection, avacincaptad pegol, 0.1 mg (Eff. Date 04/01/2024)  |  |  |
| J2783 | Injection, rasburicase, 0.5mg   |  |  |
| J2785 | Injection, regadenoson, 0.1 mg (Eff. Date 1/1/2009)   |  |  |
| J2786 | Injection, reslizumab, 1 mg (Eff. Date 1/1/2017)  |  |  |
| J2788 | Injection, rho d immune globulin, human, minidose, 50 micrograms (250 i.u.) (Eff. Date 1/1/2003, Updated eff. 1/1/2009) |  |  |
| J2790 | Injection, rho d immune globulin, human, full dose, 300 micrograms (1500 i.u.) (Updated eff. 1/1/2009)                  |  |  |
| J2791 | Injection, rho(d) immune globulin (human), (rhophylac), intramuscular or intravenous, 100 iu (Eff. Date 1/1/2008)       |  |  |
| J2792 | Injection, rho d immune globulin, intravenous, human, solvent detergent, 100 I.U.                                       |  |  |
| J2793 | Injection, riloncept, 1 mg (Eff. Date 1/1/2010)   |  |  |
| J2794 | Injection, risperidone (risperdal consta), 0.5 mg (Eff. Date 1/1/2005) (Revised 10/01/2019)                             |  |  |
| J2795 | Injection, ropivacaine hydrochloride, 1 mg (Eff. Date 1/1/2001)   |  |  |
| J2796 | Injection, romiplostim, 10 micrograms (Eff. Date 1/1/2010) (Deleted eff. 12/31/2024)                                    |  |  |
| J2797 | Injection, rolapitant, 0.5 mg (Eff Date 1/1/2019)   |  |  |

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| J2798 | Injection, risperidone, (perseris), 0.5 mg (Eff. Date 10/01/2019)   |  |    |
| J2799 | Injection, risperidone (uzedy), 1 mg (Eff. Date 01/01/2024)   |  |    |
| J2800 | Injection, methocarbamol, up to 10 ml   |  |    |
| J2801 | Injection, risperidone (rykindo), 0.5 mg (Eff. Date 04/01/2024)   |  |    |
| J2802 | Injection, romiplostim, 1 microgram (Eff. Date 1/1/2025)  |  |    |
| J2805 | Injection, sincalide, 5 micrograms (Eff. Date 1/1/2006)   |  |    |
| J2806 | Injection, sincalide (maia) not therapeutically equivalent to j2805, 5 micrograms (Eff. Date 07/01/2023) Injection, sincalide (maia), not therapeutically equivalent to j2805, 5 micrograms (Revised eff. 07/01/2024) (Deleted eff. 12/31/2024) |  |    |
| J2810 | Injection, theophylline, per 40 mg  |  |    |
| J2820 | Injection, sargramostim (gm-csf), 50 mcg  |  |    |
| J2840 | Injection, sebelipase alfa, 1 mg (Eff. Date 1/1/2017)   |  |    |
| J2850 | Injection, secretin, synthetic, human, 1 microgram (Eff. Date 1/1/2006)   |  |    |
| J2860 | Injection, siltuximab, 10 mg (Eff. Date 1/1/2016)   |  |    |
| J2910 | Injection, aurothioglucose, up to 50 mg   |  |    |
| J2916 | Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg (Eff. Date 1/1/2003)   |  |    |
| J2919 | Injection, methylprednisolone sodium succinate, 5 mg (Eff. Date 04/01/2024)   |  |    |
| J2920 | Injection, methylprednisolone sodium succinate, up to 40 mg (Deleted eff. 03/31/2024)   |  | 10 |
| J2930 | Injection, methylprednisolone sodium succinate, up to 125 mg (Deleted eff. 03/31/2024)  |  | 10 |
| J2940 | Injection, somatrem, 1 mg (Eff. Date 1/1/2002)  |  |    |
| J2941 | Injection, somatropin, 1 mg (Eff. Date 1/1/2002)  |  |    |
| J2950 | Injection, promazine HCL, up to 25 mg   |  |    |
| J2993 | Injection, reteplase, 18.1 mg (Eff. Date 1/1/2001)  |  |    |
| J2995 | Injection, streptokinase, per 250,000 I.U.  |  |    |
| J2997 | Injection, alteplase recombinant, 1 mg (Eff. Date 1/1/2001)   |  |    |
| J2998 | Injection, plasminogen, human-tvmh, 1 mg (Eff. Date 07/01/2022)   |  |    |
| J3000 | Injection, streptomycin, up to 1 gm   |  |    |

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| J3010 | Injection, fentanyl citrate, 0.1 mg  |  |  |
| J3030 | Injection, sumatriptan succinate, 6 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self administered)                    |  |  |
| J3031 | Injection, fremanezumab-vfrm, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered) (Eff. Date 10/01/2019) |  |  |
| J3032 | Injection, eptinezumab-jjmr, 1 mg (Eff. Date 10/01/2020)   |  |  |
| J3055 | Injection, talquetamab-tgvs, 0.25 mg (Eff. Date 04/01/2024)  |  |  |
| J3060 | Injection, taliglucerase alfa, 10 units (Eff. Date 01/01/2014)   |  |  |
| J3070 | Injection, pentazocine, 30 mg  |  |  |
| J3090 | Injection, tedizolid phosphate, 1 mg (Eff. Date 1/1/2016)  |  |  |
| J3095 | Injection, televancin, 10 mg (Eff. Date 1/1/2011)  |  |  |
| J3101 | Injection, tenecteplase, 1 mg (Eff. Date 1/1/2009)   |  |  |
| J3105 | Injection, terbutaline sulfate, up to 1 mg   |  |  |
| J3110 | Injection, teriparatide, 10 mcg (Eff. Date 1/1/2005)   |  |  |
| J3111 | Injection, romosozumab-aqqg, 1 mg (Eff. Date 10/01/2019)   |  |  |
| J3120 | Injection, testosterone enanthate, up to 100 mg (Deleted eff. 12/31/2014)  |  |  |
| J3121 | Injection, testosterone enanthate, 1 mg (Eff. Date 01/01/2015)   |  |  |
| J3130 | Injection, testosterone enanthate, up to 200 mg (Deleted eff. 12/31/2014)  |  |  |
| J3140 | Injection, testosterone suspension, up to 50 mg (Deleted eff. 12/31/2014)  |  |  |
| J3145 | Injection, testosterone undecanoate, 1 mg (Eff. Date 01/01/2015)   |  |  |
| J3150 | Injection, testosterone propionate, up to 100 mg (Deleted eff. 12/31/2014)   |  |  |
| J3230 | Injection, chlorpromazine HCL, up to 50 mg   |  |  |
| J3240 | Injection, thyrotropin alpha, 0.9 mg, provided in 1.1 mg vial  |  |  |
| J3241 | Injection, teprotumumab-trbw, 10 mg (Eff. Date 10/01/2020)   |  |  |
| J3243 | Injection, tigecycline, 1 mg (Eff. Date 1/1/2007)  |  |  |

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| J3244 | Injection, tigecycline (accord) not therapeutically equivalent to j3243, 1 mg (Eff. Date 01/01/2023) Injection, tigecycline (accord), not therapeutically equivalent to j3243, 1 mg (Revised eff. 07/01/2024) |  |  |
| J3245 | Injection, tildrakizumab, 1 mg (Eff. Date 1/1/2019)   |  |  |
| J3246 | Injection, Tirofiban HCL, 0.25 mg   |  |  |
| J3247 | Injection, secukinumab, intravenous, 1 mg (Eff. Date 07/01/2024)  |  |  |
| J3250 | Injection, trimethobenzamide HCL, up to 200 mg  |  |  |
| J3260 | Injection, tobramycin sulfate, up to 80 mg  |  |  |
| J3262 | Injection, tocilizumab, 1 mg (Eff. Date 1/1/2011)   |  |  |
| J3263 | Injection, toripalimab-tpzi, 1 mg (Eff. Date 07/01/2024)  |  |  |
| J3265 | Injection, torsemide, 10 mg/ml  |  |  |
| J3280 | Injection, thiethylperazine maleate, up to 10 mg  |  |  |
| J3285 | Injection, treprostinil, 1 mg (Eff. Date 1/1/2006)  |  |  |
| J3299 | Injection, triamcinolone acetonide (xipere), 1 mg (Eff. Date 07/01/2022)  |  |  |
| J3300 | Injection, triamcinolone acetonide, preservative free, 1 mg (Eff. Date 1/1/2009)  |  |  |
| J3301 | Injection, triamcinolone acetonide, not otherwise specified, 10 mg (Updated eff. 1/1/2009)  |  |  |
| J3302 | Injection, triamcinolone diacetate, per 5mg   |  |  |
| J3303 | Injection, triamcinolone hexacetonide, per 5mg  |  |  |
| J3304 | Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg (Eff. Date 1/1/2019)   |  |  |
| J3305 | Injection, trimetrexate glucuronate, per 25 mg  |  |  |
| J3310 | Injection, perphenazine, up to 5 mg   |  |  |
| J3315 | Injection, triptorelin pamoate, 3.75 mg (Eff. Date 1/1/2003)  |  |  |
| J3316 | Injection, triptorelin, extended-release, 3.75 mg (Eff. Date 1/1/2019)  |  |  |
| J3320 | Injection, spectinomycin dihydrochloride, up to 2 gm  |  |  |
| J3350 | Injection, urea, up to 40 gm  |  |  |
| J3355 | Injection, urofollitropin, 75 IU (Eff. Date 1/1/2006)   |  |  |
| J3357 | Ustekinumab, for subcutaneous injection, 1 (Eff. Date 1/1/2011) (Updated description 1/1/2017)  |  |  |

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| J3358 | Ustekinumab, for intravenous injection, 1 mg (Eff. Date 01/01/2018)   |  |  |
| J3360 | Injection, diazepam, up to 5 mg   |  |  |
| J3364 | Injection, urokinase, 5000 iu vial  |  |  |
| J3365 | Injection, IV, urokinase, 250,000 i.u. vial   |  |  |
| J3370 | Injection, vancomycin HCL, 500 mg   |  |  |
| J3371 | Injection, vancomycin hcl (mylan) not therapeutically equivalent to j3370, 500 mg (Eff. Date 01/01/2023) Injection, vancomycin hcl (mylan), not therapeutically equivalent to j3370, 500 mg (Revised eff. 07/01/2024)   |  |  |
| J3372 | Injection, vancomycin hcl (xellia) not therapeutically equivalent to j3370, 500 mg (Eff. Date 01/01/2023) Injection, vancomycin hcl (xellia), not therapeutically equivalent to j3370, 500 mg (Revised eff. 07/01/2024) |  |  |
| J3380 | Injection, vedolizumab, 1 mg (Eff. Date 1/1/2016) Injection, vedolizumab, intravenous, 1 mg (Revised eff. 04/01/2024)   |  |  |
| J3385 | Injection, velaglucerase alfa, 100 units (Eff. Date 1/1/2011)   |  |  |
| J3392 | Injection, exagamglogene autotemcel, per treatment (Eff. Date 1/1/2025)   |  |  |
| J3393 | Injection, betibeglogene autotemcel, per treatment (Eff. Date 07/01/2024)   |  |  |
| J3394 | Injection, lovetibeglogene autotemcel, per treatment (Eff. Date 07/01/2024)   |  |  |
| J3396 | Injection, verteporfin, 0.1 mg (Eff. Date 1/1/2005)   |  |  |
| J3397 | Injection, vestronidase alfa-vjvk, 1 mg (Eff. Date 1/1/2019)  |  |  |
| J3398 | Injection, voretigene neparvovec-rzyl, 1 billion vector genomes (Eff. Date 1/1/2019)  |  |  |
| J3399 | Injection, onasemnogene abeparvovec-xioi, per treatment, up to 5x10 <sup>15</sup> vector genomes (Eff. Date 07/01/2020)   |  |  |
| J3400 | Injection, triflupromazine HCL, up to 20 mg   |  |  |
| J3401 | Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 <sup>9</sup> pfu/ml vector genomes, per 0.1 ml (Eff. Date 01/01/2024)  |  |  |
| J3410 | Injection, hydroxyzine HCL, up to 25 mg   |  |  |
| J3411 | Injection, thiamine HCL, 100 mg   |  |  |
| J3415 | Injection, pyridoxine HCL, 100 mg   |  |  |
| J3420 | Injection, vitamin b-12 cyanocobalamin, up to 1000 mcg  |  |  |



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| J3424 | Injection, hydroxocobalamin, intravenous, 25 mg (Eff. Date 04/01/2024)   |    |  |
| J3425 | Injection, hydroxocobalamin, 10 mcg (Eff. Date 01/01/2024)<br>Injection, hydroxocobalamin, intramuscular, 10 mcg (Revised eff. 04/01/2024) |    |  |
| J3430 | Injection, phytonadione (vitamin k), per 1 mg  |    |  |
| J3465 | Injection, voriconazole, 10 mg   |    |  |
| J3470 | Injection, hyaluronidase, up to 150 units  |    |  |
| J3471 | Injection, hyaluronidase, ovine, preservative free, per 1 USP unit (up to 999 USP units) (Eff. Date 1/1/2006)                              |    |  |
| J3472 | Injection, hyaluronidase, ovine, preservative free, per 1000 USP units (Eff. Date 1/1/2006)  |    |  |
| J3473 | Injection, Hyaluronidase, Recombinant, 1 USP Unit (Eff. Date 1/1/2007)   |    |  |
| J3475 | Injection, magnesium sulfate, per 500 mg   |    |  |
| J3480 | Injection, potassium chloride, per 2 meq   |    |  |
| J3485 | Injection, zidovudine, 10 mg (Eff. Date 1/1/2001)  |    |  |
| J3486 | Injection, ziprasidone mesylate, 10 mg   |    |  |
| J3487 | Injection, zoledronic acid (zometa), 1 mg (Updated 1/1/2008) (Deleted eff. 06/30/2013)   |    |  |
| J3488 | Injection, zoledronic acid (reclast), 1 mg (Eff. Date 1/1/2008) (Deleted eff. 06/30/2013)  |    |  |
| J3489 | Injection, zoledronic acid, 1 mg   |    |  |
| J3490 | Unclassified drugs   | 14 |  |
| J3520 | Edetate disodium, per 150 mg   |    |  |
| J3530 | Nasal vaccine inhalation   |    |  |
| J3535 | Drug administered through a metered dose inhaler   |    |  |
| J3570 | Laetrile, amygdalin, vitamin b17   |    |  |
| J7030 | Infusion, normal saline solution, 1000 cc  |    |  |
| J7040 | Infusion, normal saline solution, sterile (500 ml=1 unit)  |    |  |
| J7042 | 5% dextrose/normal saline (500 ml = 1 unit)  |    |  |
| J7050 | Infusion, normal saline solution, 250 cc   |    |  |
| J7060 | 5% dextrose/water (500 ml = 1 unit)  |    |  |

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| J7070 | Infusion, d5w, 1000 cc   |    |  |
| J7100 | Infusion, dextran 40, 500 ml   |    |  |
| J7110 | Infusion, dextran 75, 500 ml   |    |  |
| J7120 | Ringers lactate infusion, up to 1000 cc  |    |  |
| J7121 | 5% dextrose in lactated ringers infusion, up to 1000 cc<br>(Eff. Date 1/1/2016)                                  |    |  |
| J7130 | Hypertonic saline solution, 50 or 100 meq, 20 cc vial<br>(Deleted eff. 12/31/11)                                 |    |  |
| J7131 | Hypertonic saline solution, 1 ml (Eff. Date 1/1/2012)  |    |  |
| J7165 | Injection, prothrombin complex concentrate, human-lans, per i.u.<br>of factor ix activity (Eff. Date 04/01/2024) |    |  |
| J7171 | Injection, adamts13, recombinant-krhn, 10 iu (Eff. Date<br>07/01/2024)   |    |  |
| J7340 | Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml<br>(Eff. Date 1/1/2016) (Updated description 1/1/2017)  |    |  |
| J7351 | Injection, bimatoprost, intracameral implant, 1 microgram (Eff.<br>Date 10/01/2020)                              |    |  |
| J7353 | Anacaulase-bcdb, 8.8% gel, 1 gram (Eff. Date 10/01/2023)   |    |  |
| J7354 | Cantharidin for topical administration, 0.7%, single unit dose<br>applicator (3.2 mg) (Eff. Date 04/01/2024)     |    |  |
| J7500 | Azathioprine, oral, 50 mg  | 10 |  |
| J7501 | Azathioprine, parenteral, 100 mg   | 10 |  |
| J7502 | Cyclosporine, oral, 100 mg (Eff. Date 1/1/2000)  | 10 |  |
| J7503 | Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg<br>(Eff. Date 1/1/2016)                               | 10 |  |
| J7504 | Lymphocyte immune globulin, antithymocyte globulin, equine,<br>parenteral, 250 mg                                | 10 |  |
| J7505 | Muromonab-cd3, parenteral, 5 mg  | 10 |  |
| J7506 | Prednisone, oral, per 5 mg (Deleted eff. 12/31/2015)   | 10 |  |
| J7507 | Tacrolimus, immediate release, oral, 1 mg (Revised 01/01/2014)   | 10 |  |
| J7508 | Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg<br>(Eff. Date 01/01/2014) (Revised 1/1/2016)           | 10 |  |
| J7509 | Methylprednisolone oral, per 4 mg  | 10 |  |
| J7510 | Prednisolone oral, per 5 mg  | 10 |  |

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| J7511 | Lymphocyte immune globulin, antithymocyte globulin, rabbit, parenteral 25 mg (Eff. Date 1/1/2002)  |    |  |
| J7512 | Prednisone, immediate release or delayed release, oral, 1 mg   | 10 |  |
| J7513 | Daclizumab, parenteral, 25 mg  | 10 |  |
| J7514 | <b>Mycophenolate mofetil (myhibbin), oral suspension, 100 mg (Eff. Date 1/1/2025)</b>  |    |  |
| J7515 | Cyclosporine, oral, 25 mg (Eff. Date 1/1/2000)   | 10 |  |
| J7516 | Cyclosporin, parenteral, 250 mg (Eff. Date 1/1/2000) Injection, cyclosporine, 250 mg (Revised eff. 04/01/2024)   | 10 |  |
| J7517 | Mycophenolate mofetil, oral, 250 mg (Eff. Date 1/1/2000)   | 10 |  |
| J7518 | Mycophenolic acid, oral, 180 mg (Eff. Date 1/1/2005)   | 10 |  |
| J7519 | Injection, mycophenolate mofetil, 10 mg (Eff. Date 10/01/2023)   | 10 |  |
| J7520 | Sirolimus, oral, 1 mg (Eff. Date 1/1/2001)   |    |  |
| J7525 | Tacrolimus, parenteral, 5 mg (Eff. Date 1/1/2001)  |    |  |
| J7527 | Everolimus, oral, 0.25 mg (Eff. Date 1/1/2013)   |    |  |
| J7599 | Immunosuppressive drug, not otherwise classified   | 10 |  |
| J7601 | <b>Ensifentrine, inhalation suspension, fda approved final product, non-compounded, administered through dme, unit dose form, 3 mg (Eff. Date 1/1/2025)</b>        |    |  |
| J7604 | Acetylcysteine, inhalation solution, compounded product, administered through dme, unit dose form, per gram (Eff. Date 1/1/2008)                                   | 15 |  |
| J7605 | Arformoterol, inhalation solution, fda approved final product, non-compounded, administered through dme, unit dose form, 15 micrograms (Eff. Date 1/1/2008)        | 15 |  |
| J7606 | Formoterol fumarate, inhalation solution, fda approved final product, non-compounded, administered through dme, unit dose form, 20 micrograms (Eff. Date 1/1/2009) | 15 |  |
| J7607 | Levalbuterol, inhalation solution, compounded product, administered through DME, Concentrated form, 0.5 mg (Eff. Date 1/1/2007)                                    | 15 |  |
| J7608 | Acetylcysteine, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per gram (Updated 1/1/2008)             | 15 |  |
| J7609 | Albuterol, inhalation solution, compounded product, administered through DME, unit dose, 1 mg (Eff. Date 1/1/2007)   | 15 |  |

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| J7610 | Albuterol, inhalation solution, compounded product, administered through DME, concentrated form, 1 mg (Eff. Date 1/1/2007)   | 15 |
| J7611 | Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 1 mg (Terminated on 6/30/2007) (Re-instated eff. 04/01/2008)      | 15 |
| J7612 | Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, 0.5 mg (Terminated on 6/30/2007) (Re-instated eff. 04/01/2008) | 15 |
| J7613 | Albuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 1 mg (Terminated on 6/30/2007) (Re-instated eff. 04/01/2008)              | 15 |
| J7614 | Levalbuterol, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, 0.5 mg (Terminated on 6/30/2007) (Re-instated eff. 04/01/2008)         | 15 |
| J7615 | Levalbuterol, inhalation solution, compounded product, administered through DME, unit dose, 0.5 mg (Eff. Date 1/1/2007)  | 15 |
| J7620 | Albuterol, up to 2.5 mg and ipratropium bromide, up to 0.5 mg, FDA-approved final product, non-compounded inhalation solution, administered through DME (Eff. Date 1/1/2006)               |    |
| J7622 | Beclomethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2002)  | 15 |
| J7624 | Betamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2002)   | 15 |
| J7626 | Budesonide inhalation solution, FDA-approved final product, non-compounded, administered through DME, unite dose form, up to 0.5 mg (Eff. Date 1/1/2002)                                   | 15 |
| J7627 | Budesonide, inhalation solution, compounded product, administered through DME, unit dose form, up to 0.5 mg (Eff. Date 1/1/2006)   | 15 |
| J7628 | Bitolterol mesylate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)  | 15 |
| J7629 | Bitolterol mesylate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)   | 15 |
| J7631 | Cromolyn sodium, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per 10 milligrams (Updated 1/1/2008)                           | 15 |
| J7632 | Cromolyn sodium, inhalation solution, compounded product, administered through dme, unit dose form, per 10 milligrams (Eff. Date 1/1/2008)   | 15 |

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| J7633 | Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 0.25 milligram (Eff. Date 1/1/2003)  | 15 |
| J7634 | Budesonide, inhalation solution, compounded product, administered through DME, concentrated form, per 0.25 milligram (Eff. Date 1/1/2007)                          | 15 |
| J7635 | Atropine, inhalation solution compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)                                  | 15 |
| J7636 | Atropine, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                                    | 15 |
| J7637 | Dexamethasone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)                            | 15 |
| J7638 | Dexamethasone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                               | 15 |
| J7639 | Dornase alfa, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, per milligram (Updated 1/1/2009)          | 15 |
| J7640 | Formoterol, inhalation solution, compounded product, administered through DME, unit dose form, 12 micrograms (Eff. Date 1/1/2006)                                  |    |
| J7641 | Flunisolide, inhalation solution, compounded product, administered through DME, unit dose, per milligram (Eff. Date 1/1/2002)                                      |    |
| J7642 | Glycopyrrolate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)                           | 15 |
| J7643 | Glycopyrrolate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                              | 15 |
| J7644 | Ipratropium bromide, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000) | 15 |
| J7645 | Ipratropium bromide, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2007)                         | 15 |
| J7647 | Isoetharine HCL, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2007)                          | 15 |

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| J7648 | Isoetharine HCL, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)   | 15 |
| J7649 | Isoetharine HCL, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)      | 15 |
| J7650 | Isoetharine HCL, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2007)                              | 15 |
| J7657 | Isoproterenol HCL, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2007)                         | 15 |
| J7658 | Isoproterenol HCL, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000) | 15 |
| J7659 | Isoproterenol HCL, inhalation solution. FDA-approved, non-compounded, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                  | 15 |
| J7660 | Isoproterenol HCL, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2007)                            | 15 |
| J7665 | Mannitol, administered through an inhaler, 5 mg (Eff. Date 1/1/2012)  | 15 |
| J7667 | Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per 10 milligrams (Eff. Date 1/1/2007)                | 15 |
| J7668 | Metaproterenol sulfate, inhalation solution, FDA-approved, non-compounded, administered through DME, concentrated form, per 10 milligrams (Eff. Date 1/1/2000)      | 15 |
| J7669 | Metaproterenol sulfate, inhalation solution, FDA-approved final product, administered through DME, unit dose form, per 10 milligrams (Eff. Date 1/1/2000)           | 15 |
| J7670 | Metaproterenol sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per 10 milligram (Eff. Date 1/1/2007)                    | 15 |
| J7674 | Methacholine chloride administered as inhalation solution through a nebulizer, per 1 mg (Eff. Date 1/1/2005)  |    |
| J7676 | Pentamidine isethionate, inhalation solution, compounded product, administered through dme, unit dose form, per 300 mg (Eff. Date 1/1/2008)                         | 15 |
| J7677 | Revefenacin inhalation solution, fda-approved final product, non-compounded, administered through DME, 1 microgram (Eff. Date 07/01/2019)                           |    |

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| J7680 | Terbutaline sulfate, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)                  | 15 |  |
| J7681 | Terbutaline sulfate, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                     | 15 |  |
| J7682 | Tobramycin, inhalation solution, FDA-approved final product, non-compounded, unit dose form, administered through DME, per 300 milligrams (Eff. Date 1/1/2000) | 15 |  |
| J7683 | Triamcinolone, inhalation solution, compounded product, administered through DME, concentrated form, per milligram (Eff. Date 1/1/2000)                        | 15 |  |
| J7684 | Triamcinolone, inhalation solution, compounded product, administered through DME, unit dose form, per milligram (Eff. Date 1/1/2000)                           | 15 |  |
| J7685 | Tobramycin, inhalation solution, compounded product, administered through DME. Unit dose form, per 300 milligrams (Eff. date 1/1/2007)                         | 15 |  |
| J7686 | Treprostinil, inhalation solution, FDA-Approved final product, non-compounded, administered through DME, unit does form, 1.74 mg (Eff. Date 1/1/2011)          | 15 |  |
| J7699 | NOC drugs, inhalation solution administered through DME  | 15 |  |
| J7799 | NOC drugs, other than inhalation drugs, administered through DME   | 14 |  |
| J7999 | Compounded drug, not otherwise classified (Eff. Date 1/1/2016)   | 14 |  |
| J8498 | Antiemetic drug, rectal/suppository, not otherwise specified (Eff. Date 1/1/2006)  |    |  |
| J8499 | Prescription drug, oral, non chemotherapeutic, NOS   |    |  |
| J8501 | Aprepitant, oral, 5 mg (Eff. Date 1/1/2005)  | 20 |  |
| J8510 | Busulfan; oral, 2 mg (Eff. Date 1/1/2000)  |    |  |
| J8515 | Cabergoline, oral, 0.25 mg (Eff. Date 1/1/2006)  |    |  |
| J8520 | Capecitabine, oral, 150 mg (Eff. Date 1/1/2000) (Deleted eff. 09/30/2024)  |    |  |
| J8521 | Capecitabine, oral, 500 mg (Eff. Date 1/1/2000) (Deleted eff. 09/30/2024)  |    |  |
| J8522 | Capecitabine, oral, 50 mg (Eff. Date 10/01/2024)   |    |  |
| J8530 | Cyclophosphamide; oral, 25 mg  | 10 |  |
| J8540 | Dexamethasone, oral, 0.25 mg (Eff. Date 1/1/2006)  |    |  |

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| J8541 | Dexamethasone (hemady), oral, 0.25 mg (Eff. Date 10/01/2024)  |    |  |
| J8560 | Etoposide; oral, 50 m   |    |  |
| J8562 | Fludarabine Phosphate, oral, 10 mg (Eff. Date 1/1/2011)   |    |  |
| J8565 | Gefitinib, oral, 250 mg (Eff. Date 1/1/2005)  |    |  |
| J8597 | Antiemetic drug, oral, not otherwise specified (Eff. Date 1/1/2006)   |    |  |
| J8600 | Melphalan; oral, 2 mg   |    |  |
| J8610 | Methotrexate; oral, 2.5 mg  | 10 |  |
| J8611 | Methotrexate (jylamvo), oral, 2.5 mg (Eff. Date 07/01/2024)   |    |  |
| J8612 | Methotrexate (xatmep), oral, 2.5 mg (Eff. Date 07/01/2024)  |    |  |
| J8650 | Nabilone, oral, 1mg (Eff. Date 1/1/2007)  | 20 |  |
| J8655 | Netupitant 300 mg and palonosetron 0.5 mg, oral (Revised 1/1/2019)  |    |  |
| J8670 | Rolapitant, oral, 1 mg (Eff. Date 1/1/2017)   | 20 |  |
| J8705 | Topotecan, oral, 0.25 mg (Eff. Date 1/1/2009)   |    |  |
| J8999 | Prescription drug, oral, chemotherapeutic, NOS  |    |  |
| J9000 | Injection, doxorubicin hydrochloride, 10 mg (Updated eff. 1/1/2009)   |    |  |
| J9001 | Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg (Eff. Date 1/1/2000, Updated eff. 1/1/2009, Discontinued eff. 07/01/2012) |    |  |
| J9002 | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg (Eff. Date 1/1/2013) (Discontinued eff. 07/01/2013)                             |    |  |
| J9010 | Injection, alemtuzumab, 10 mg (Eff. Date 1/1/2003, Updated eff. 1/1/2009) (Deleted eff. 12/31/2015)   |    |  |
| J9015 | Injection, aldesleukin, per single use vial (Updated eff. 1/1/2009)   |    |  |
| J9017 | Injection, arsenic trioxide, 1 mg (Eff. Date 1/1/2002, Updated eff. 1/1/2009)   |    |  |
| J9019 | Injection, asparaginase (erwinaze), 1,000 iu  |    |  |
| J9020 | Injection, asparaginase, not otherwise specified, 10,000 unit (Updated eff. 1/1/2013)   |    |  |
| J9021 | Injection, asparaginase, recombinant, (rylaze), 0.1 mg (Eff. Date 01/01/2022)   |    |  |
| J9022 | Injection, atezolizumab, 10 mg (Eff. Date 01/01/2018)   |    |  |
| J9023 | Injection, avelumab, 10 mg (Eff. Date 01/01/2018)   |    |  |



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| J9025 | Injection, azacitidine, 1 mg (Eff. Date 1/1/2006)   |  |  |
| J9026 | Injection, tarlatamab-dlle, 1 mg (Eff. Date 1/1/2025)   |  |  |
| J9027 | Injection, clofarabine, 1 mg (Eff. Date 1/1/2006)   |  |  |
| J9028 | Injection, nogapendekin alfa inbakicept-pmln, for intravesical use, 1 microgram (Eff. Date 1/1/2025)  |  |  |
| J9029 | Injection, nadofaragene firadenovec-vncg, per therapeutic dose (Eff. Date 07/01/2023) Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose (Revised 04/01/2024)                                   |  |  |
| J9030 | BCG live intravesical instillation, 1 mg (Eff. Date 07/01/2019)   |  |  |
| J9031 | Bcg (intravesical) per instillation (Deleted eff. 06/30/2019)   |  |  |
| J9032 | Injection, belinostat, 10 mg (Eff. Date 1/1/2016)   |  |  |
| J9033 | Injection, bendamustine hydrochloride, 1 mg (Rev. Eff. 1/1/2025)  |  |  |
| J9034 | Injection, bendamustine hcl (bendeka), 1 mg (Eff. Date 1/1/2017)  |  |  |
| J9035 | Injection, bevacizumab, 10 mg (Eff. Date 1/1/2005)  |  |  |
| J9036 | Injection, bendamustine hydrochloride, (Belrapzo/bendamustine), 1 mg (Eff. Date 07/01/2019)   |  |  |
| J9037 | Injection, belantamab mafodontin-blmf, 0.5 mg (Eff. Date 04/01/2021)  |  |  |
| J9039 | Injection, blinatumomab, 1 microgram (Eff. Date 1/1/2016)   |  |  |
| J9040 | Injection, bleomycin sulfate, 15 units (Updated eff. 1/1/2009)  |  |  |
| J9041 | (Eff. Date 1/1/2005, Revised 1/1/2019) Injection, bortezomib, 0.1 mg (Revised 01/01/2023)   |  |  |
| J9042 | Injection, brentuximab vedotin, 1 mg (Eff. Date 1/1/2013)   |  |  |
| J9043 | Injection, Cabazitaxel, 1 MG (Eff. Date 1/1/2012)   |  |  |
| J9044 | Injection, bortezomib, not otherwise specified, 0.1 mg (Eff. Date 1/1/2019) (Deleted eff. 12/31/2022)   |  |  |
| J9045 | Injection, carboplatin, 50 mg (Updated eff. 1/1/2009)   |  |  |
| J9046 | Injection, bortezomib, (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg (Eff. Date 01/01/2023) Injection, bortezomib (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg (Revised eff. 07/01/2024) |  |  |
| J9047 | Injection, carfilzomib, 1 mg (Eff. Date 01/01/2014)   |  |  |
| J9048 | Injection, bortezomib (fresenius kabi), not therapeutically equivalent to j9041, 0.1 mg (Eff. Date 01/01/2023)  |  |  |

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| J9049 | Injection, bortezomib (hospira), not therapeutically equivalent to j9041, 0.1 mg (Eff. Date 01/01/2023)   |  |  |
| J9050 | Injection, carmustine, 100 mg (Updated eff. 1/1/2009)   |  |  |
| J9051 | Injection, bortezomib (maia), not therapeutically equivalent to j9041, 0.1 mg (Eff. Date 10/01/2023)  |  |  |
| J9052 | Injection, carmustine (accord), not therapeutically equivalent to j9050, 100 mg (Eff. Date 01/01/2024)  |  |  |
| J9055 | Injection, cetuximab, 10 mg (Eff. Date 1/1/2005)  |  |  |
| J9056 | Injection, bendamustine hydrochloride (vivimusta), 1 mg (Eff. Date 07/01/2023)  |  |  |
| J9057 | Injection, copanlisib, 1 mg (Eff. Date 1/1/2019)  |  |  |
| J9058 | Injection, bendamustine hydrochloride (apotex), 1 mg (Eff. Date 07/01/2023) (Deleted eff. 12/31/2024)   |  |  |
| J9059 | Injection, bendamustine hydrochloride (baxter), 1 mg (Eff. Date 07/01/2023) (Deleted eff. 12/31/2024)   |  |  |
| J9060 | Injection, Cisplatin, powder or solution,10 mg (Updated Description 1/1/2011)   |  |  |
| J9061 | Injection, amivantamab-vmjw, 2 mg (Eff. Date 01/01/2022)  |  |  |
| J9062 | Cisplatin, 50 mg (Deleted eff. 12/31/2010)  |  |  |
| J9063 | Injection, mirvetuximab soravtansine-gynx, 1 mg (Eff. Date 07/01/2023)  |  |  |
| J9064 | Injection, cabazitaxel (sandoz), not therapeutically equivalent to j9043, 1 mg (Eff. Date 10/01/2023)   |  |  |
| J9065 | Injection, cladribine, per 1 mg   |  |  |
| J9070 | Cyclophosphamide, 100 mg (Deleted eff. 03/31/2024)  |  |  |
| J9071 | Injection, cyclophosphamide, (auromedics), 5 mg (Eff. Date 04/01/2022) Injection, cyclophosphamide (auromedics), 5 mg (Revised eff. 04/01/2024) |  |  |
| J9072 | Injection, cyclophosphamide (avyxa), 5 mg (Rev. Eff. 1/1/2025)  |  |  |
| J9073 | Injection, cyclophosphamide (ingenus), 5 mg (Eff. Date 04/01/2024)  |  |  |
| J9074 | Injection, cyclophosphamide (sandoz), 5 mg (Eff. Date 04/01/2024)   |  |  |
| J9075 | Injection, cyclophosphamide, not otherwise specified, 5 mg (Eff. Date 04/01/2024)   |  |  |
| J9076 | Injection, cyclophosphamide (baxter), 5 mg (Eff. Date 1/1/2025)   |  |  |

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| J9080 | Cyclophosphamide, 200 mg (Deleted eff. 12/31/2010)   |  |  |
| J9090 | Cyclophosphamide, 500 mg (Deleted eff. 12/31/2010)   |  |  |
| J9091 | Cyclophosphamide, 1.0 gram (Deleted eff. 12/31/2010)   |  |  |
| J9092 | Cyclophosphamide, 2.0 gram (Deleted eff. 12/31/2010)   |  |  |
| J9093 | Cyclophosphamide, lyophilized, 100 mg (Deleted eff. 12/31/2010)                                  |  |  |
| J9094 | Cyclophosphamide, lyophilized, 200 mg (Deleted eff. 12/31/2010)                                  |  |  |
| J9095 | Cyclophosphamide, lyophilized, 500 mg (Deleted eff. 12/31/2010)                                  |  |  |
| J9096 | Cyclophosphamide, lyophilized, 1.0 gram (Deleted eff. 12/31/2010)                                |  |  |
| J9097 | Cyclophosphamide, lyophilized, 2.0 gram (Deleted eff. 12/31/2010)                                |  |  |
| J9098 | Injection, cytarabine liposome, 10 mg (Updated Eff. 1/1/2009)                                    |  |  |
| J9100 | Injection, cytarabine, 100 mg (Updated eff. 1/1/2009)  |  |  |
| J9110 | Injection, cytarabine, 500 mg (Deleted eff. 12/31/2010)  |  |  |
| J9118 | Injection, calaspargase pegol-mknl, 10 units (Eff. Date 10/01/2019)                              |  |  |
| J9119 | Injection, cemiplimab-rwlc, 1 mg (Eff. Date 10/01/2019)  |  |  |
| J9120 | Injection, dactinomycin, 0.5 mg (Updated eff. 1/1/2009)  |  |  |
| J9130 | Dacarbazine, 100 mg  |  |  |
| J9140 | Dacarbazine, 200 mg (Deleted eff. 12/31/2010,)   |  |  |
| J9144 | Injection, daratumumab, 10 mg and hyaluronidase-fihj (Eff. Date 01/01/2021)                      |  |  |
| J9145 | Injection, daratumumab, 10 mg (Eff. Date 1/1/2017)   |  |  |
| J9150 | Injection, daunorubicin, 10 mg (Updated eff. 1/1/2009)   |  |  |
| J9151 | Injection, daunorubicin citrate, liposomal formulation, 10 mg (Updated eff. 1/1/2009)            |  |  |
| J9153 | Injection, liposomal, 1 mg daunorubicin and 2.27 mg cytarabine (Eff. Date 1/1/2019)              |  |  |
| J9155 | Injection, degarelix, 1 mg (Eff. Date 1/1/2010)  |  |  |
| J9160 | Injection, denileukin diftitox, 300 micrograms (Updated eff. 1/1/2009) (Deleted eff. 12/31/2023) |  |  |
| J9165 | Injection, diethylstilbestrol diphosphate, 250 mg (Updated eff. 1/1/2009)                        |  |  |

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| J9171 | Injection, docetaxel, 1 mg (Eff. Date 1/1/2010)  |  |  |
| J9172 | Injection, docetaxel (ingenus) not therapeutically equivalent to j9171, 1 mg (Eff. Date 01/01/2024) Injection, docetaxel (ingenus), not therapeutically equivalent to j9171, 1 mg (Revised eff. 07/01/2024) Injection, docetaxel (docivyx), 1 mg (Revised eff. 10/01/2024) |  |  |
| J9173 | Injection, durvalumab, 10 mg (Eff. Date 1/1/2019)  |  |  |
| J9175 | Injection, elliotts' B solution, 1 ml (Eff. Date 1/1/2006)   |  |  |
| J9176 | Injection, elotuzumab, 1 mg (Eff. Date 1/1/2017)   |  |  |
| J9177 | Injection, enfortumab vedotin-ejfv, 0.25 mg (Eff. Date 07/01/2020)   |  |  |
| J9178 | Injection, epirubicin HCL, 2 mg  |  |  |
| J9179 | Injection, Eribulin Mesylate, 0.1 mg (Eff. Date 1/1/2012)  |  |  |
| J9181 | Injection, etoposide, 10 mg (Updated eff. 1/1/2009)  |  |  |
| J9185 | Injection, fludarabine phosphate, 50 mg (Updated eff. 1/1/2009)  |  |  |
| J9190 | Injection, fluorouracil, 500 mg (Updated eff. 1/1/2009)  |  |  |
| J9196 | Injection, gemcitabine hydrochloride (accord), not therapeutically equivalent to J9201, 200 mg (Eff. Date 04/01/2023)  |  |  |
| J9198 | Injection, gemcitabine hydrochloride, (infugem), 100 mg (Eff. Date 07/01/2020)   |  |  |
| J9199 | Injection, gemcitabine hydrochloride (infugem), 200 mg (Eff. Date 1/1/2020) (Deleted eff. 06/30/2020)  |  |  |
| J9200 | Injection, floxuridine, 500 mg (Updated eff. 1/1/2009)   |  |  |
| J9201 | Injection, gemcitabine hydrochloride, not otherwise specified, 200 mg (Revised 1/1/2020)   |  |  |
| J9202 | Goserelin acetate implant, per 3.6 mg  |  |  |
| J9203 | Injection, gemtuzumab ozogamicin, 0.1 mg (Eff. Date 01/01/2018)  |  |  |
| J9204 | Injection, mogamulizumab-kpkc, 1 mg (Eff. Date 10/01/2019)   |  |  |
| J9205 | Injection, irinotecan liposome, 1 mg (Eff. Date 1/1/2017)  |  |  |
| J9206 | Irinotecan, 20 mg  |  |  |
| J9207 | Injection, ixabepilone, 1 mg (Eff. Date 1/1/2009)  |  |  |
| J9208 | Injection, ifosfamide, 1 gram (Updated eff. 1/1/2009)  |  |  |
| J9209 | Injection, mesna, 200 mg (Updated eff. 1/1/2009)   |  |  |
| J9210 | Injection, emapalumab-lzsg, 1 mg (Eff. Date 10/01/2019)  |  |  |

|       |   |  |  |
|-------|---|--|--|
| J9211 | Injection, idarubicin hydrochloride, 5 mg (Updated eff. 1/1/2009)   |  |  |
| J9212 | Injection, interferon alfacon-1, recombinant, 1 microgram (Updated eff. 1/1/2009)   |  |  |
| J9213 | Injection, interferon, alfa-2a, recombinant, 3 million units (Updated eff. 1/1/2009)  |  |  |
| J9214 | Injection, interferon, alfa-2b, recombinant, 1 million units (Updated eff. 1/1/2009)  |  |  |
| J9215 | Injection, interferon, alfa-n3, (human leukocyte derived), 250,000 iu (Updated eff. 1/1/2009)   |  |  |
| J9216 | Injection, interferon, gamma 1-b, 3 million units (Updated eff. 1/1/2009)   |  |  |
| J9217 | Leuprolide acetate (for depot suspension), 7.5 mg   |  |  |
| J9218 | Leuprolide acetate, per 1 mg  |  |  |
| J9223 | Injection, lurbinectedin, 0.1 mg (Eff. Date 01/01/2021)   |  |  |
| J9225 | Histrelin implant (vantas), 50 mg (Updated 1/1/2008)  |  |  |
| J9226 | Histrelin implant (supprelin la), 50 mg (Eff. Date 1/1/2008)  |  |  |
| J9227 | Injection, isatuximab-irfc, 10 mg (Eff. Date 10/01/2020)  |  |  |
| J9228 | Injection, Ipilimumab, 1 mg (Eff. Date 1/1/2012)  |  |  |
| J9229 | Injection, inotuzumab ozogamicin, 0.1 mg (Eff. Date 1/1/2019)   |  |  |
| J9230 | Injection, mechlorethamine hydrochloride, (nitrogen mustard), 10 mg (Updated eff. 1/1/2009)   |  |  |
| J9245 | Injection, melphalan hydrochloride, not otherwise specified, 50 mg (Updated eff. 07/01/2020)  |  |  |
| J9246 | Injection, melphalan (evomela), 1 mg (Eff. Date 07/01/2020)   |  |  |
| J9247 | Injection, melphalan flufenamide, 1mg (Eff. Date 10/1/2021)   |  |  |
| J9248 | Injection, melphalan (hepzato) 1 mg (Eff. Date 04/01/2024)  |  |  |
| J9249 | Injection, melphalan (apotex), 1 mg (Eff. Date 04/01/2024)  |  |  |
| J9250 | Methotrexate sodium, 5 mg (Deleted eff. 03/31/2024)   |  |  |
| J9255 | Injection, methotrexate (accord) not therapeutically equivalent to j9260, 50 mg (Eff. Date 01/01/2024)  |  |  |
| J9258 | Injection, paclitaxel protein-bound particles (teva) not therapeutically equivalent to j9264, 1 mg (Eff. Date 01/01/2024)<br>Injection, paclitaxel protein-bound particles (teva), not therapeutically equivalent to j9264, 1 mg (Revised eff. 07/01/2024)<br>(Deleted eff. 09/30/2024) |  |  |

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|-------|--|--|--|
| J9259 | Injection, paclitaxel protein-bound particles (american regent) not therapeutically equivalent to j9264, 1 mg (Eff. Date 07/01/2023)<br>Injection, paclitaxel protein-bound particles (american regent), not therapeutically equivalent to j9264, 1 mg (Revised eff. 07/01/2024)<br><b>(Deleted eff. 12/31/2024)</b> |  |  |
| J9260 | Methotrexate sodium, 50 mg Injection, methotrexate sodium, 50 mg (Revised eff. 04/01/2024)   |  |  |
| J9261 | Injection, nelarabine, 50 mg (Eff. date 1/1/2007)  |  |  |
| J9262 | Injection, omacetaxine mepesuccinate, 0.01 mg (Eff. Date 01/01/2014)   |  |  |
| J9263 | Injection, oxaliplatin, 0.5 mg   |  |  |
| J9264 | Injection, paclitaxel protein-bound particles, 1 mg (Eff. Date 1/1/2006)   |  |  |
| J9265 | Injection, paclitaxel, 30 mg (Updated eff. 1/1/2009) (Deleted eff. 12/31/2014)   |  |  |
| J9266 | Injection, pegaspargase, per single dose vial (Updated eff. 1/1/2009)  |  |  |
| J9267 | Injection, paclitaxel, 1 mg (Eff. Date 01/01/2015)   |  |  |
| J9268 | Injection, pentostatin, 10 mg (Updated eff. 1/1/2009)  |  |  |
| J9269 | Injection, tagraxofusp-erzs, 10 micrograms (Eff. Date 10/01/2019)  |  |  |
| J9270 | Injection, plicamycin, 2.5 mg (Updated eff. 1/1/2009)  |  |  |
| J9271 | Injection, pembrolizumab, 1 mg (Eff. Date 1/1/2016)  |  |  |
| J9272 | Injection, dostarlimab-gxly, 10 mg (Eff. Date 01/01/2022)  |  |  |
| J9273 | Injection, tisotumab vedotin-tftv, 1 mg (Eff. Date 04/01/2022)   |  |  |
| J9274 | Injection, tebentafusp-tebn, 1 microgram (Eff. Date 10/01/2022)  |  |  |
| J9280 | Injection, mitomycin, 5 mg (Updated 01/01/2013)  |  |  |
| J9281 | Mitomycin pyelocalyceal instillation, 1 mg (Eff. Date 01/01/2021)  |  |  |
| J9285 | Injection, olaratumab, 10 mg (Eff. Date 01/01/2018)  |  |  |
| J9286 | Injection, glofitamab-gxbm, 2.5 mg (Eff. Date 01/01/2024)  |  |  |
| J9290 | Mitomycin, 20 mg (Deleted eff. 12/31/2010)   |  |  |
| J9291 | Mitomycin, 40 mg (Deleted eff. 12/31/2010)   |  |  |
| J9292 | <b>Injection, pemetrexed (avyxa), not therapeutically equivalent to j9305, 10 mg (Eff. Date 1/1/2025)</b>  |  |  |
| J9293 | Injection, mitoxantrone hydrochloride, per 5 mg  |  |  |

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|-------|---|----|
| J9294 | Injection, pemetrexed (hospira) not therapeutically equivalent to J9305, 10 mg (Eff. Date 04/01/2023) Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg (Revised eff. 07/01/2024) |    |
| J9295 | Injection, necitumumab, 1 mg (Eff. Date 1/1/2017)   |    |
| J9296 | Injection, pemetrexed (accord) not therapeutically equivalent to J9305, 10 mg (Eff. Date 04/01/2023) Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg (Revised eff. 07/01/2024)   |    |
| J9297 | Injection, pemetrexed (sandoz), not therapeutically equivalent to J9305, 10 mg (Eff. Date 04/01/2023)   |    |
| J9298 | Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg (Eff. Date 10/01/2022)  |    |
| J9299 | Injection, nivolumab, 1 mg (Eff. Date 1/1/2016)   |    |
| J9300 | Injection, gemtuzumab ozogamicin, 5 mg (Eff. Date 1/1/2002, Updated eff. 1/1/2009) (Deleted eff. 12/31/2017)  |    |
| J9301 | Injection, gemtuzumab ozogamicin, 5 mg (Eff. Date 01/01/2015)   |    |
| J9302 | Injection, ofatumumab, 10 mg (Eff. Date 1/1/2011)   | 09 |
| J9303 | Injection, panitumumab, 10 mg (Eff. Date 1/1/2008)  |    |
| J9304 | Injection, pemetrexed (pemfexy), 10 mg (Eff. Date 10/01/2020)   |    |
| J9305 | Injection, pemetrexed, not otherwise specified, 10 mg (Description change 10/01/2020)   |    |
| J9306 | Injection, pertuzumab, 1 mg (Eff. Date 01/01/2014)  |    |
| J9307 | Injection, pralatrexate, 1 mg (Eff. Date 1/1/2011)  | 09 |
| J9308 | Injection, ramucirumab, 5 mg (Eff. Date 1/1/2016)   |    |
| J9309 | Injection, polatuzumab vedotin-piiq, 1 mg (Eff. Date 1/1/2020)  |    |
| J9310 | Injection, rituximab, 100 mg (Updated eff. 1/1/2009) (Deleted eff. 12/31/2018)  |    |
| J9311 | Injection, rituximab 10 mg and hyaluronidase (Eff. Date 1/1/2019)   |    |
| J9312 | Injection, rituximab, 10 mg (Eff. Date 1/1/2019)  |    |
| J9313 | Injection, moxetumomab pasudotox-tdfk, 0.01 mg (Eff. Date 10/01/2019)   |    |
| J9314 | Injection, pemetrexed (teva) not therapeutically equivalent to J9305, 10 mg (Eff. Date 01/01/2023) Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg (Revised eff. 07/01/2024)       |    |

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|-------|---|----|--|
| J9315 | Injection, romidepsin, 1 mg (Eff. Date 1/1/2011) (Deleted 9/30/2021)  | 09 |  |
| J9316 | Injection, pertuzumab, trastuzumab, and hyaluronidase-zzxf, per 10 mg (Eff. Date 01/01/2021)  |    |  |
| J9317 | Injection, sacituzumab govitecan-hziy, 2.5 mg (Eff. Date 01/01/2021)  |    |  |
| J9318 | Injection, romidepsin, non-lyophilized, 0.1 mg (Eff. Date 10/1/2021)  |    |  |
| J9319 | Injection, romidepsin, lyophilized, 0.1 mg (Eff. Date 10/1/2021)  |    |  |
| J9320 | Injection, streptozocin, 1 gram (Updated eff. 1/1/2009)   |    |  |
| J9321 | Injection, epcoritamab-bysp, 0.16 mg (Eff. Date 01/01/2024)   |    |  |
| J9322 | Injection, pemetrexed (bluepoint) not therapeutically equivalent to j9305, 10 mg (Eff. Date 07/01/2023) Injection, pemetrexed (bluepoint), not therapeutically equivalent to j9305, 10 mg (Revised eff. 07/01/2024) |    |  |
| J9323 | Injection, pemetrexed ditromethamine, 10 mg (Eff. Date 07/01/2023)  |    |  |
| J9324 | Injection, pemetrexed (pemrydi rtu), 10 mg (Eff. Date 01/01/2024)   |    |  |
| J9325 | Injection, talimogene laherparepvec, per 1 million plaque forming units (Eff. Date 1/1/2017)  |    |  |
| J9328 | Injection, temozolomide, 1 mg (Eff. Date 1/1/2010)  |    |  |
| J9329 | Injection, tislelizumab-jsgr, 1mg (Eff. Date 10/01/2024)  |    |  |
| J9330 | Injection, temsirolimus, 1 mg (Eff. Date 1/1/2009)  |    |  |
| J9331 | Injection, sirolimus protein-bound particles, 1 mg (Eff. Date 07/01/2022)   |    |  |
| J9332 | Injection, efgartigimod alfa-fcab, 2mg (Eff. Date 07/01/2022)   |    |  |
| J9333 | Injection, rozanolixizumab-noli, 1 mg (Eff. Date 01/01/2024)  |    |  |
| J9334 | Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Eff. Date 01/01/2024)  |    |  |
| J9340 | Injection, thiotepa, 15 mg (Updated eff. 1/1/2009)  |    |  |
| J9345 | Injection, retifanlimab-dlwr, 1 mg (Eff. Date 10/01/2023)   |    |  |
| J9347 | Injection, tremelimumab-actl, 1 mg (Eff. Date 07/01/2023)   |    |  |
| J9348 | Injection, naxitamab-gqgk, 1 mg (Eff. Date 07/01/2021)  |    |  |
| J9349 | Injection, tafasitamab-cxix, 2 mg (Eff. Date 04/01/2021)  |    |  |
| J9350 | Injection, mosunetuzumab-axgb, 1 mg (Eff. Date 07/01/2023)  |    |  |



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|-------|---|----|--|
| J9351 | Injection, topotecan, 0.1 mg (Eff. Date 1/1/2011)   | 09 |  |
| J9352 | Injection, trabectedin, 0.1 mg (Eff. Date 1/1/2017)   |    |  |
| J9353 | Injection, margetuximab-cmkb, 5 mg (Eff. Date 07/01/2021)   |    |  |
| J9354 | Injection, ado-trastuzumab emtansine, 1 mg (Eff. Date 01/01/2014)   |    |  |
| J9355 | Injection, trastuzumab, excludes biosimilar, 10 mg (Eff. Date 1/1/2000, Updated eff. 1/1/2009, Updated eff. 07/01/2019)   |    |  |
| J9356 | Injection, trastuzumab, 10 mg and Hyaluronidase-oysk (Eff. Date 07/01/2019)   |    |  |
| J9357 | Injection, valrubicin, intravesical, 200 mg (Eff. Date 1/1/2000, Updated eff. 1/1/2009)   |    |  |
| J9358 | Injection, fam-trastuzumab deruxtecan-nxki, 1 mg (Eff. Date 07/01/2020)   |    |  |
| J9359 | Injection, loncastuximab tesirine-lpyl, 0.075 mg (Eff. Date 04/01/2022)   |    |  |
| J9360 | Injection, vinblastine sulfate, 1 mg (Updated eff. 1/1/2009)  |    |  |
| J9361 | Injection, efbemalenograstim alfa-vuxw, 0.5 mg (Eff. Date 07/01/2024)   |    |  |
| J9370 | Vincristine sulfate, 1 mg   |    |  |
| J9371 | Injection, vincristine sulfate liposome, 1 mg (Eff. Date 01/01/2014) (Deleted eff. 06/30/2024)  |    |  |
| J9375 | Vincristine sulfate, 2 mg (Deleted eff. 12/31/2010)   |    |  |
| J9376 | Injection, pozelimab-bbfg, 1 mg (Eff. Date 04/01/2024)  |    |  |
| J9380 | Injection, teclistamab-cqyv, 0.5 mg (Eff. Date 07/01/2023)  |    |  |
| J9381 | Injection, teplizumab-mzwv, 5 mcg (Eff. Date 07/01/2023)  |    |  |
| J9390 | Injection, vinorelbine tartrate, 10 mg (Updated eff. 1/1/2009)  |    |  |
| J9393 | Injection, fulvestrant (teva) not therapeutically equivalent to j9395, 25 mg (Eff. Date 01/01/2023) Injection, fulvestrant (teva), not therapeutically equivalent to j9395, 25 mg (Revised eff. 07/01/2024) |    |  |
| J9394 | Injection, fulvestrant (fresenius kabi) not therapeutically equivalent to j9395, 25 mg (Eff. Date 01/01/2023)   |    |  |
| J9395 | Injection, fulvestrant, 25 mg   |    |  |
| J9400 | Injection, ziv-aflibercept, 1 mg (Eff. Date 01/01/2014)   |    |  |
| J9600 | Injection, porfimer sodium, 75 mg (Updated eff. 1/1/2009)   |    |  |

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| J9999   Not otherwise classified, antineoplastic drugs | 14 |
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**HCPCS K**

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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description   | Category | CMN/DIF Required |
|-------|---|----------|------------------|
| K0001 | Standard wheelchair   | 01       |                  |
| K0002 | Standard hemi (low seat) wheelchair   | 01       |                  |
| K0003 | Lightweight wheelchair  | 01       |                  |
| K0004 | High strength, lightweight wheelchair   | 01       |                  |
| K0005 | Ultralightweight wheelchair   | 05       |                  |
| K0006 | Heavy duty wheelchair   | 01       |                  |
| K0007 | Extra heavy duty wheelchair   | 01       |                  |
| K0008 | Custom manual wheelchair/base (Eff. Date 7/1/2013)  | 03       |                  |
| K0009 | Other manual wheelchair/base  | 01       |                  |
| K0010 | Standard - weight frame motorized/power wheelchair (invalid for new wheelchairs effective 11/15/2016)   | 01       |                  |
| K0011 | Standard - weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking (Invalid for new wheelchairs effective 11/15/2016) | 01       |                  |
| K0012 | Lightweight portable motorized/power wheelchair (Invalid for new wheelchairs effective 11/15/2016)  | 01       |                  |
| K0013 | Custom motorized/power wheelchair base (Eff. Date 7/1/2013)   | 03       |                  |

|       |  |       |
|-------|--|-------|
| K0014 | Other motorized/power wheelchair base (Invalid for new wheelchairs effective 11/15/2016)                                   | 01/14 |
| K0015 | Detachable, non-adjustable height armrest, replacement only, each (Updated description 1/1/2017)                           | 01    |
| K0017 | Detachable, adjustable height armrest, base, replacement only, each (Revised 1/1/2016)                                     | 05    |
| K0018 | Detachable, adjustable height armrest, upper portion, replacement only, each (Revised 1/1/2016)                            | 05    |
| K0019 | Arm pad, replacement only, each (Updated description 1/1/2017)   | 05    |
| K0020 | Fixed, adjustable height armrest, pair   | 05    |
| K0037 | High mount flip-up footrest, each (Updated description 1/1/2017, Revised 1/1/2019)   | 05    |
| K0038 | Leg strap, each  | 05    |
| K0039 | Leg strap, H style, each   | 05    |
| K0040 | Adjustable angle footplate, each   | 05    |
| K0041 | Large size footplate, each   | 05    |
| K0042 | Standard size footplate, replacement only, each (Updated description 1/1/2017)   | 05    |
| K0043 | Footrest, lower extension tube, replacement only, each (Updated description 1/1/2017)                                      | 05    |
| K0044 | Footrest, upper hanger bracket, replacement only, each (Updated description 1/1/2017)                                      | 05    |
| K0045 | Footrest, complete assembly, replacement only, each (Updated description 1/1/2017)   | 05    |
| K0046 | Elevating legrest, lower extension tube, replacement only, each (Updated description 1/1/2017)                             | 05    |
| K0047 | Elevating legrest, upper hanger bracket, replacement only, each (Updated description 1/1/2017)                             | 05    |
| K0050 | Ratchet assembly, replacement only (Updated description 1/1/2017)  | 05    |
| K0051 | Cam release assembly, footrest or legrest, replacement only, each (Updated description 1/1/2017)                           | 05    |
| K0052 | Swingaway, detachable footrests, replacement only, each (Updated description 1/1/2017)                                     | 05    |
| K0053 | Elevating footrests, articulating (telescoping), each  | 05    |
| K0056 | Seat height less than 17" or equal to or greater than 21" for a high strength, lightweight, or ultralightweight wheelchair | 05    |

|       |  |    |       |
|-------|--|----|-------|
| K0065 | Spoke protectors, each   | 05 |       |
| K0069 | Rear wheel assembly, complete, with solid tire, spokes or molded, replacement only, each (Updated description 1/1/2017)  | 05 |       |
| K0070 | Rear wheel assembly, complete, with pneumatic tire, spokes or molded, replacement only, each (Updated description 1/1/2017)  | 01 |       |
| K0071 | Front caster assembly, complete, with pneumatic tire, replacement only, each (Updated description 1/1/2017)  | 05 |       |
| K0072 | Front caster assembly, complete, with semi-pneumatic tire, replacement only, each (Updated description 1/1/2017)   | 05 |       |
| K0073 | Caster pin lock, each  | 05 |       |
| K0077 | Front caster assembly, complete, with solid tire, replacement only, each (Updated description 1/1/2017)  | 05 |       |
| K0098 | Drive belt for power wheelchair, replacement only (Updated description 1/1/2017)   | 05 |       |
| K0105 | IV hanger, each  | 05 |       |
| K0108 | Wheelchair component or accessory, not otherwise specified   | 14 |       |
| K0195 | Elevating leg rests, pair (for use with capped rental wheelchair base)   | 01 |       |
| K0455 | Infusion pump used for uninterrupted parenteral administration of medication, epoprostenol or treprostinil   | 02 | 09.03 |
| K0462 | Temporary replacement for patient owned equipment being repaired, any type   | 05 |       |
| K0552 | Supplies for external non-insulin drug infusion pump, syringe type cartridge, sterile, each (Eff. Date 04/01/2003) (Updated description 1/1/2017)  | 13 |       |
| K0553 | Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, <i>1 month supply = 1 unit of service</i> (Eff. Date 07/01/2017) (Deleted eff. 12/31/2022) | 13 |       |
| K0554 | Receiver (Monitor), dedicated, for use with therapeutic glucose continuous monitor system (Eff. Date 07/01/2017) (Deleted eff. 12/31/2022)   | 05 |       |
| K0601 | Replacement battery for external infusion pump owned by patient, silver oxide, 1.5 volt, each (Eff. Date 4/1/2003)   | 13 |       |
| K0602 | Replacement battery for external infusion pump owned by patient, silver oxide, 3 volt, each (Eff. Date 4/1/2003)   | 13 |       |
| K0603 | Replacement battery for external infusion pump owned by patient, alkaline, 1.5 volt, each (Eff. Date 4/1/2003)   | 13 |       |

|       |   |    |       |
|-------|---|----|-------|
| K0604 | Replacement battery for external infusion pump owned by patient, lithium, 3.6 volt, each (Eff. Date 4/1/2003)   | 13 |       |
| K0605 | Replacement battery for external infusion pump owned by patient, lithium, 4.5 volt, each (Eff. Date 4/1/2003)   | 13 |       |
| K0606 | Automatic external defibrillator, with integrated electrocardiogram analysis, garment type (Eff. Date 7/1/2003)   | 01 |       |
| K0607 | Replacement battery for automated external defibrillator, garment type only, each (Eff. Date 7/1/2003)  | 01 |       |
| K0608 | Replacement garment for use with automated external defibrillator, each (Eff. Date 7/1/2003)  | 05 |       |
| K0609 | Replacement electrodes for use with automated external defibrillator, garment type only, each (Eff. Date 7/1/2003)  | 13 |       |
| K0669 | Wheelchair accessory, wheelchair seat or back cushion, does not meet specific code criteria or no written coding verification from dne pdac (Eff. Date 07/01/2004, Updated eff. 1/1/2009)                           | 05 |       |
| K0672 | Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each (Eff. Date 04/01/2008)   | 04 |       |
| K0730 | Controlled dose inhalation drug delivery system (Eff. Date 04/01/2005)  | 01 |       |
| K0733 | Power wheelchair accessory, 12 or 24 amp hour sealed lead acid battery, each (e.g. gel cell, absorbed glassmat) (Eff. Date 07/01/06)  | 05 |       |
| K0738 | Portable Gaseous Oxygen System, Rental, Home Compression Used to fill Portable Oxygen Cylinders; includes Portable Containers, Regulator, Flowmeter, Humidifier, Cannula or Mask, and Tubing (Eff. date 10/01/2006) | 06 | 484.3 |
| K0739 | Repair or Nonroutine Service for Durable Medical Equipment Other than Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes (Eff. Date 04/01/2009)                                  |    |       |
| K0740 | Repair of Nonroutine Service for Oxygen Equipment Requiring the Skill of a Technician, Labor Component, Per 15 Minutes (Eff. Date 04/01/2009)   |    |       |
| K0743 | Suction pump, home model, portable, for use on wounds (Eff. Date 07/01/2011)  |    |       |
| K0744 | Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 square inches or less (Eff. Date 07/01/2011)   |    |       |
| K0745 | Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 square inches but less than or equal to 48 square inches (Eff. Date 07/01/2011)                                    |    |       |
| K0746 | Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 square inches (Eff. Date 07/01/2011)  |    |       |

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|-------|--|----|
| K0800 | Power operated vehicle, group 1 standard, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                                | 05 |
| K0801 | Power operated vehicle, group 1 heavy duty, patient weight capacity, 301 to 450 pounds (Eff. Date 10/01/2006)  | 05 |
| K0802 | Power operated vehicle, group 1 very heavy duty, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                                      | 05 |
| K0806 | Power operated vehicle, group 2 standard, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                                | 05 |
| K0807 | Power operated vehicle, group 2 heavy duty, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)   | 05 |
| K0808 | Power operated vehicle, group 2 very heavy duty, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                                      | 05 |
| K0812 | Power operated vehicle, not otherwise classified (Eff. Date 10/01/2006)  | 05 |
| K0813 | Power wheelchair, group 1 standard, portable, sling/solid seat and back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006) | 01 |
| K0814 | Power wheelchair, group 1 standard, portable, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)            | 01 |
| K0815 | Power wheelchair, group 1 standard, sling/solid seat and back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)           | 01 |
| K0816 | Power wheelchair, group 1 standard, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                      | 01 |
| K0820 | Power wheelchair, group 2 standard, portable, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)     | 01 |
| K0821 | Power wheelchair, group 2 standard, portable, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)            | 01 |
| K0822 | Power wheelchair, group 2 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)               | 01 |
| K0823 | Power wheelchair, group 2 standard, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                      | 01 |
| K0824 | Power wheelchair, group 2 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                          | 01 |
| K0825 | Power wheelchair, group 2 heavy duty, captains chair, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                                 | 01 |

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|-------|---|----|
| K0826 | Power wheelchair, group 2 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                              | 01 |
| K0827 | Power wheelchair, group 2 very heavy duty, captains chair, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                                     | 01 |
| K0828 | Power wheelchair, group 2 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)                            | 01 |
| K0829 | Power wheelchair, group 2 extra heavy duty, captains chair, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)                                   | 01 |
| K0830 | Power wheelchair, group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)         | 01 |
| K0831 | Power wheelchair, group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                | 01 |
| K0835 | Power wheelchair, group 2 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)   | 01 |
| K0836 | Power wheelchair, group 2 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)          | 01 |
| K0837 | Power wheelchair, group 2 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)              | 01 |
| K0838 | Power wheelchair, group 2 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                     | 01 |
| K0839 | Power wheelchair, group 2 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)         | 01 |
| K0840 | Power wheelchair, group 2 extra heavy duty, single power option, sling/solid seat/back, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)       | 01 |
| K0841 | Power wheelchair, group 2 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006) | 01 |
| K0842 | Power wheelchair, group 2 standard, multiple power option, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)        | 01 |
| K0843 | Power wheelchair, group 2 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)            | 01 |



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|-------|---|----|
| K0848 | Power wheelchair, group 3 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                        | 01 |
| K0849 | Power wheelchair, group 3 standard, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                               | 01 |
| K0850 | Power wheelchair, group 3 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                                   | 01 |
| K0851 | Power wheelchair, group 3 heavy duty, captains chair, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)  | 01 |
| K0852 | Power wheelchair, group 3 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                              | 01 |
| K0853 | Power wheelchair, group 3 very heavy duty, captains chair, patient weight capacity, 451 to 600 pounds (Eff. Date 10/01/2006)                                    | 01 |
| K0854 | Power wheelchair, group 3 extra heavy duty, sling/solid seat/back, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)                            | 01 |
| K0855 | Power wheelchair, group 3 extra heavy duty, captains chair, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)                                   | 01 |
| K0856 | Power wheelchair, group 3 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)   | 01 |
| K0857 | Power wheelchair, group 3 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)          | 01 |
| K0858 | Power wheelchair, group 3 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)              | 01 |
| K0859 | Power wheelchair, group 3 heavy duty, single power option, captains chair, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                     | 01 |
| K0860 | Power wheelchair, group 3 very heavy duty, single power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)         | 01 |
| K0861 | Power wheelchair, group 3 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006) | 01 |
| K0862 | Power wheelchair, group 3 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)            | 01 |
| K0863 | Power wheelchair, group 3 very heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)       | 01 |

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|-------|--|----|
| K0864 | Power wheelchair, group 3 extra heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 601 pounds or more (Eff. Date 10/01/2006)      | 01 |
| K0868 | Power wheelchair, group 4 standard, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                         | 01 |
| K0869 | Power wheelchair, group 4 standard, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                                | 01 |
| K0870 | Power wheelchair, group 4 heavy duty, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)                                    | 01 |
| K0871 | Power wheelchair, group 4 very heavy duty, sling/solid seat/back, patient weight capacity 451 to 600 pounds (Eff. Date 10/01/2006)                               | 01 |
| K0877 | Power wheelchair, group 4 standard, single power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)    | 01 |
| K0878 | Power wheelchair, group 4 standard, single power option, captains chair, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)           | 01 |
| K0879 | Power wheelchair, group 4 heavy duty, single power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)               | 01 |
| K0880 | Power wheelchair, group 4 very heavy duty, single power option, sling/solid seat/back, patient weight 451 to 600 pounds (Eff. Date 10/01/2006)                   | 01 |
| K0884 | Power wheelchair, group 4 standard, multiple power option, sling/solid seat/back, patient weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)  | 01 |
| K0885 | Power wheelchair, group 4 standard, multiple power option, captains chair, weight capacity up to and including 300 pounds (Eff. Date 10/01/2006)                 | 01 |
| K0886 | Power wheelchair, group 4 heavy duty, multiple power option, sling/solid seat/back, patient weight capacity 301 to 450 pounds (Eff. Date 10/01/2006)             | 01 |
| K0890 | Power wheelchair, group 5 pediatric, single power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds (Eff. Date 10/01/2006)   | 01 |
| K0891 | Power wheelchair, group 5 pediatric, multiple power option, sling/solid seat/back, patient weight capacity up to and including 125 pounds (Eff. Date 10/01/2006) | 01 |
| K0898 | Power wheelchair, not otherwise classified (Eff. Date 10/01/2006)  | 01 |

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|-------|---|----|
| K0899 | Power mobility device, not coded by dme pdac or does not meet criteria (Eff. Date 10/01/2006, Updated eff. 1/1/2009)  | 01 |
| K0900 | Custom Durable Medical Equipment, Other than Wheelchair (Eff. Date 7/1/2013)  | 03 |
| K0901 | Knee orthosis (KO), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Eff. Date 10/01/2014) (Deleted eff. 12/31/2016)  | 04 |
| K0902 | Knee orthosis (KO), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Eff. Date 10/01/2014) (Deleted eff. 12/31/2016)  | 04 |
| K0903 | For diabetics only, multiple density insert, made by direct carving with CAM technology from a rectified CAD model created from a digitized scan of the patient, total contact with patient's foot, including arch, base layer minimum of 3/16 inch material of shore a 35 durometer (or higher), includes arch filler and other shaping material, custom fabricated, each (Eff. Date 04/01/2018) (Deleted eff. 12/31/2018) | 16 |
| K1001 | Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type (Eff. Date 1/1/2020) (Revised eff. 04/01/2023) (Deleted eff. 12/31/2023)  | 01 |
| K1002 | Cranial electrotherapy stimulation (ces) system, any type (Eff. Date 1/1/2020, Revised 10/01/2022) (Deleted eff. 12/31/2023)  | 01 |
| K1003 | Whirlpool tub, walk-in, portable (Eff. Date 1/1/2020) (Deleted eff. 12/31/2023)   |    |
| K1004 | Low frequency ultrasonic diathermy treatment device for home use (Eff. Date 01/01/2020) (Revised 10/01/2023)  |    |
| K1005 | Disposable collection and storage bag for breast milk, any size, any type, each (Eff. Date 1/1/2020) (Deleted eff. 12/31/2023)  |    |
| K1006 | Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system (Eff. Date 10/01/2020) (Revised eff. 04/01/2023) (Deleted eff. 12/31/2023)  | 01 |
| K1007 | Bilateral hip, knee, ankle, foot device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors (Eff. Date 10/01/2020)   | 04 |
| K1009 | Speech volume modulation system, any type, including all components and accessories (Eff. Date 10/01/2020) (Deleted eff. 12/31/2023)  | 01 |

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|-------|---|----|--|
| K1010 | Indwelling intraurethral drainage device with valve, patient inserted, replacement only, each (Eff. Date 10/01/2020) (Deleted eff. 03/31/2021)  |    |  |
| K1011 | Activation device for intraurethral drainage device with valve, replacement only, each (Eff. Date 10/01/2020) (Deleted eff. 03/31/2021)   |    |  |
| K1012 | Charger and base station for intraurethral activation device, replacement only (Eff. Date 10/01/2020) (Deleted eff. 03/31/2021)   |    |  |
| K1013 | Enema tube, with or without adapter, any type, replacement only, each (Eff. Date 4/1/2021) (Revised 10/1/2021) (Deleted eff. 12/31/2023)  |    |  |
| K1014 | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)                                     | 04 |  |
| K1015 | Foot, adductus positioning device, adjustable (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)  |    |  |
| K1016 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)  | 01 |  |
| K1017 | Monthly supplies for use of device coded at K1016 (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)  | 13 |  |
| K1018 | External upper limb tremor stimulator of the peripheral nerves of the wrist (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)  | 01 |  |
| K1019 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist (Revised 04/01/2023) (Deleted eff. 12/31/2023)   |    |  |
| K1020 | Non-invasive vagus nerve stimulator (Eff. Date 04/01/2021) (Deleted eff. 12/31/2023)  | 01 |  |
| K1021 | Exsufflation belt, includes all supplies and accessories (Eff. Date 10/1/2021) (Deleted eff. 12/31/2023)  |    |  |
| K1022 | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type (Eff. Date 10/1/2021) (Deleted eff. 12/31/2023) | 04 |  |
| K1023 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm (Eff. Date 10/1/2021) (Deleted eff. 12/31/2023)  |    |  |
| K1024 | Non-pneumatic compression controller with sequential calibrated gradient pressure (Eff. Date 10/1/2021) (Deleted eff. 12/31/2023)   | 01 |  |
| K1025 | Non-pneumatic sequential compression garment, full arm (Eff. Date 10/1/2021) (Deleted eff. 12/31/2023)  | 01 |  |

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|-------|--|----|--|
| K1026 | Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical (Eff. Date 10/01/2021) (Deleted eff. 12/31/2023)   |    |  |
| K1027 | Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment (Eff. Date 10/1/2021)   |    |  |
| K1028 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application (Eff. Date 04/01/2022) (Revised 10/01/2023) (Deleted eff. 12/31/2023)                     |    |  |
| K1029 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply (Eff. Date 04/01/2022) (Deleted eff. 12/31/2023) |    |  |
| K1031 | Non-pneumatic compression controller without calibrated gradient pressure (Eff. Date 04/01/2022) (Deleted eff. 12/31/2023)   | 01 |  |
| K1032 | Non-pneumatic sequential compression garment, full leg (Eff. Date 04/01/2022) (Deleted eff. 12/31/2023)  | 01 |  |
| K1033 | Non-pneumatic sequential compression garment, half leg (Eff. Date 04/01/2022) (Deleted eff. 12/31/2023)  | 01 |  |
| K1036 | Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month (Eff. Date 10/01/2023)  |    |  |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility (Eff. Date 04/01/2024)   |    |  |

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| Payment Category |                               |    |  |
|------------------|-------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits   |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps               |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs                |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                     |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                               |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified               |
|                  |                               | 15 | Nebulizer Drugs                        |
|                  |                               | 16 | Therapeutic Shoes for Diabetics        |
|                  |                               | 17 | Individual Consideration               |
|                  |                               | 18 | Epoetin (EPO)                          |
|                  |                               | 19 | Dialysis Supplies & Equipment          |
|                  |                               | 20 | Oral Antiemetic Drugs                  |
|                  |                               | 21 | Value Not Established                  |
|                  |                               | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| L0112 | Cranial cervical orthosis, congenital torticollis type, with or without soft interface material, adjustable range of motion joint, custom fabricated (Eff. Date 1/1/2004)        | 04       |                  |
| L0113 | Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2009) | 04       |                  |
| L0120 | Cervical, flexible, non-adjustable, prefabricated, off-the-shelf (foam collar) (Revised 01/01/2014)  | 04       |                  |
| L0130 | Cervical, flexible, thermoplastic collar, molded to patient  | 04       |                  |
| L0140 | Cervical, semi-rigid, adjustable (plastic collar)  | 04       |                  |
| L0150 | Cervical, semi-rigid, adjustable molded chin cup (plastic collar with mandibular/occipital piece)  | 04       |                  |
| L0160 | Cervical, semi-rigid, wire frame occipital/mandibular support, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04       |                  |
| L0170 | Cervical, collar, molded to patient model  | 04       |                  |
| L0172 | Cervical, collar, semi-rigid thermoplastic foam, two-piece, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04       |                  |
| L0174 | Cervical, collar, semi-rigid, thermoplastic foam, two piece with thoracic extension, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04       |                  |
| L0180 | Cervical, multiple post collar, occipital/mandibular supports, adjustable  | 04       |                  |

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|-------|---|----|
| L0190 | Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars (somi, guilford, taylor types)  | 04 |
| L0200 | Cervical, multiple post collar, occipital/mandibular supports, adjustable cervical bars, and thoracic extension   | 04 |
| L0220 | Thoracic, rib belt, custom fabricated   |    |
| L0430 | Spinal Orthosis, anterior-posterior-lateral control, with interface material, custom fitted (DeWall Posture Protector only) (Eff. Date 1/1/2005) (Deleted eff. 11/16/2012)  | 04 |
| L0450 | Tlso, flexible, provides trunk support, upper thoracic region, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf (Eff. Date 1/1/2003, Revised 01/01/2014)  | 04 |
| L0452 | TLSO, flexible, provides trunk support, upper thoracic region, produces intracavitary pressures to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, custom fabricated (Eff. Date 1/1/2003)  | 04 |
| L0454 | Tlso flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014)   | 04 |
| L0455 | Tlso, flexible, provides trunk support, extends from sacrococcygeal junction to above t-9 vertebra, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks with rigid stays or panel(s), includes shoulder straps and closures, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L0456 | Tlso, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014) | 04 |
| L0457 | Tlso, flexible, provides trunk support, thoracic region, rigid posterior panel and soft anterior apron, extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, restricts gross trunk motion in the sagittal plane, produces intracavitary pressure to reduce load on the intervertebral disks, includes straps and closures, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |



|       |   |    |
|-------|---|----|
| L0458 | TLSO, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)  | 04 |
| L0460 | Tlso, triplanar control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014) | 04 |
| L0462 | TLSO, triplanar control, modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in the sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closure, includes straps and clsoures, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)   | 04 |
| L0464 | TLSO, triplanar control, modular segmented spinal system, four rigid plastic shells, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to the sternal notch, soft liner, restricts gross trunk motion in sagittal, coronal, and transverse planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)  | 04 |
| L0466 | Tlso, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014)  | 04 |
| L0467 | Tlso, sagittal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, restricts gross trunk motion in sagittal plane, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |



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|-------|---|----|
| L0468 | Tlso, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal, and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014) | 04 |
| L0469 | Tlso, sagittal-coronal control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction over scapulae, lateral strength provided by pelvic, thoracic, and lateral frame pieces, restricts gross trunk motion in sagittal and coronal planes, produces intracavitary pressure to reduce load on intervertebral disks, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L0470 | TLSO, triplanar control, rigid posterior frame and flexible soft anterior apron with straps, closures and padding, extends from sacrococcygeal junction to scapula, lateral strength provided by pelvic, thoracic, and lateral frame pieces, rotational strength provided by subclavicular extensions, restricts gross trunk motion in sagittal, coronal, and transverse planes, produces intracavitary pressure to reduce load on the intervertebral disks, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)                | 04 |
| L0472 | TLSO, triplanar control, hyperextension, rigid anterior and lateral frame extends from syphysis pubis to sternal notch with two anterior components (one pubic and one sternal), posterior and lateral pads with straps and closures, limits spinal flexion, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes fitting and shaping the frame, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)  | 04 |
| L0480 | TLSO, triplanar control, one piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junctuin and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated (Eff. Date 1/1/2003)   | 04 |
| L0482 | TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posteror extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated (Eff. Date 1/1/2003)  | 04 |

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| L0484 | <p>TLSO, triplanar control, two piece rigid plastic shell without interface liner, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam mode, custom fabricated (Eff. Date 1/1/2003)</p>                             | 04 |
| L0486 | <p>TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, lateral strength is enhanced by overlapping plastic, restricts gross trunk motion in the sagittal, coronal, and transverse planes, includes a carved plaster or Cad-Cam model, custom fabricated (Eff. Date 1/1/2003)</p>                                    | 04 |
| L0488 | <p>TLSO, triplanar control, one piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from scarococcygeal junction and terminates just inferior to scapular spine, anterior extends from symphysis pubis to sternal notch, anterior or posterior opening, restricts gross trunk motion in the sagittal, coronal, and transverse planes, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)</p>   | 04 |
| L0490 | <p>TLSO, sagittal-coronal control, one piece rigid plastic shell, with overlapping reinforced anterior, with multiple straps and closures, posterior extends from sacrococcygeal junction and terminates at or before the T-9 vertebra, anterior extends from symphysis pubis to xiphoid, anterior opening, restricts gross trunk motion in sagittal and coronal planes, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2003)</p>  | 04 |
| L0491 | <p>TLSO, sagittal-coronal control, modular segmented spinal system, two rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated includes fitting and adjustment (Eff. Date 1/1/2006)</p>    | 04 |
| L0492 | <p>TLSO, sagittal-coronal control., modular segmented spinal system, three rigid plastic shells, posterior extends from the sacrococcygeal junction and terminates just inferior to the scapular spine, anterior extends from the symphysis pubis to the xiphoid, soft liner, restricts gross trunk motion in the sagittal and coronal planes, lateral strength is provided by overlapping plastic and stabilizing closures, includes straps and closures, prefabricated includes fitting and adjustment (Eff. Date 1/1/2006)</p> | 04 |

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| L0621 | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 1/1/2006, Revised 01/01/2014)  | 04 |
| L0622 | Sacroiliac orthosis, flexible, provides pelvic-sacral support, reduces motion above the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)   | 04 |
| L0623 | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels over the sacrum and abdomen, reduces motion about the sacroiliac joint, includes straps, closures, may include pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 1/1/2006, Revised 01/01/2014)   | 04 |
| L0624 | Sacroiliac orthosis, provides pelvic-sacral support, with rigid or semi-rigid panels places over the sacrum and abdomen, reduces motion above the sacroiliac joint, include straps, closures, may includes pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)   | 04 |
| L0625 | Lumbar orthosis, flexible, provides lumbar support, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include pendulous abdomen design, shoulder straps, stays, prefabricated, off-the-shelf (Eff. Date 1/1/2006, Revised 01/01/2014)  | 04 |
| L0626 | Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014)     | 04 |
| L0627 | Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014) | 04 |
| L0628 | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 1/1/2006, Revised 01/01/2014)   | 04 |

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| L0629 | Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include stays, shoulder straps, pendulous abdomen design, custom prefabricated (Eff. Date 1/1/2006)   | 04 |
| L0630 | Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014)  | 04 |
| L0631 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014)  | 04 |
| L0632 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)   | 04 |
| L0633 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014) | 04 |
| L0634 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)  | 04 |

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| L0635 | Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panel(s), lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L0636 | Lumbar-sacral orthosis, sagittal-coronal control, lumbar flexion, rigid posterior frame/panels, lateral articulating design to flex the lumbar spine, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, anterior panel, pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)  | 04 |
| L0637 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014)  | 04 |
| L0638 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panels, posterior extends from sacrococcygeal junction to T-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)   | 04 |
| L0639 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2006, Revised 01/01/2014) | 04 |
| L0640 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to T-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, custom fabricated (Eff. Date 1/1/2006)  | 04 |

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| L0641 | Lumbar orthosis, sagittal control, with rigid posterior panel(s), posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L0642 | Lumbar orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from L-1 to below L-5 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L0643 | Lumbar-sacral orthosis, sagittal control, with rigid posterior panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L0648 | Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L0649 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panels, produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, stays, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L0650 | Lumbar-sacral orthosis, sagittal-coronal control, with rigid anterior and posterior frame/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, lateral strength provided by rigid lateral frame/panel(s), produces intracavitary pressure to reduce load on intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L0651 | Lumbar-sacral orthosis, sagittal-coronal control, rigid shell(s)/panel(s), posterior extends from sacrococcygeal junction to t-9 vertebra, anterior extends from symphysis pubis to xyphoid, produces intracavitary pressure to reduce load on the intervertebral discs, overall strength is provided by overlapping rigid material and stabilizing closures, includes straps, closures, may include soft interface, pendulous abdomen design, prefabricated, off-the-shelf (Eff. Date 01/01/2014) | 04 |
| L0700 | Cervical-thoracic-lumbar-sacral-orthoses (CTLSO), anterior-posterior-lateral control, molded to patient model, (minerva type)  | 04 |

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| L0710 | CTLISO, anterior-posterior-lateral-control, molded to patient model, with interface material, (minerva type)  | 04 |
| L0810 | Halo procedure, cervical halo incorporated into jacket vest   | 04 |
| L0820 | Halo procedure, cervical halo incorporated into plaster body jacket   | 04 |
| L0830 | Halo procedure, cervical halo incorporated into milwaukee type orthosis   | 04 |
| L0859 | Addition to halo procedure, magnetic resonance image compatible systems, rings and pins, any material (Eff. Date 1/1/2006)  | 04 |
| L0861 | Addition to halo procedure, replacement liner/interface material (Eff. Date 1/1/2004)   | 04 |
| L0970 | TLSO, corset front  | 04 |
| L0972 | LSO, corset front   | 04 |
| L0974 | TLSO, full corset   | 04 |
| L0976 | LSO, full corset  | 04 |
| L0978 | Axillary crutch extension   | 04 |
| L0980 | Peroneal straps, prefabricated, off-the-shelf, pair (Revised 01/01/2014)  | 04 |
| L0982 | Stocking supporter grips, prefabricated, off-the-shelf, set of four (4) (Revised 01/01/2014)  | 04 |
| L0984 | Protective body sock, prefabricated, off-the-shelf, each (Revised 01/01/2014)   | 04 |
| L0999 | Addition to spinal orthosis, not otherwise specified  | 14 |
| L1000 | Cervical-thoracic-lumbar-sacral orthosis (CTLISO) (milwaukee), inclusive of furnishing initial orthosis, including model  | 04 |
| L1001 | Cervical thoracic lumbar sacral orthosis, immobilizer, infant size, prefabricated. Includes fitting and adjustment (Eff. Date 1/1/2007)   | 04 |
| L1005 | Tension based scoliosis orthosis and accessory pads, includes fitting and adjustment (Eff. Date 1/1/2002)   | 04 |
| L1006 | Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 10/01/2024) | 04 |
| L1010 | Addition to cervical-thoracic-lumbar-sacral orthosis (CTLISO) or scoliosis orthosis, axilla sling   | 04 |
| L1020 | Addition to CTLISO or scoliosis orthosis, kyphosis pad  | 04 |



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| L1025 | Addition to CTLSO or scoliosis orthosis, kyphosis pad, floating   | 04 |
| L1030 | Addition to CTLSO or scoliosis orthosis, lumbar bolster pad   | 04 |
| L1040 | Addition to CTLSO or scoliosis orthosis, lumbar or lumbar rib pad   | 04 |
| L1050 | Addition to CTLSO or scoliosis orthosis, sternal pad  | 04 |
| L1060 | Addition to CTLSO or scoliosis orthosis, thoracic pad   | 04 |
| L1070 | Addition to CTLSO or scoliosis orthosis, trapezius sling  | 04 |
| L1080 | Addition to CTLSO or scoliosis orthosis, outrigger  | 04 |
| L1085 | Addition to CTLSO or scoliosis orthosis, outrigger, bilateral with vertical extensions  | 04 |
| L1090 | Addition to CTLSO or scoliosis orthosis, lumbar sling   | 04 |
| L1100 | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather  | 04 |
| L1110 | Addition to CTLSO or scoliosis orthosis, ring flange, plastic or leather, molded to patient model   | 04 |
| L1120 | Addition to CTLSO, scoliosis orthosis, cover for upright, each  | 04 |
| L1200 | Thoracic-lumbar-sacral-orthosis (TLSO), inclusive of furnishing initial orthosis only   | 04 |
| L1210 | Addition to TLSO, (low profile), lateral thoracic extension   | 04 |
| L1220 | Addition to TLSO, (low profile), anterior thoracic extension  | 04 |
| L1230 | Addition to TLSO, (low profile), milwaukee type superstructure  | 04 |
| L1240 | Addition to TLSO, (low profile), lumbar derotation pad  | 04 |
| L1250 | Addition to TLSO, (low profile), anterior asis pad  | 04 |
| L1260 | Addition to TLSO, (low profile), anterior thoracic derotation pad   | 04 |
| L1270 | Addition to TLSO, (low profile), abdominal pad  | 04 |
| L1280 | Addition to TLSO, (low profile), rib gusset (elastic), each   | 04 |
| L1290 | Addition to TLSO, (low profile), lateral trochanteric pad   | 04 |
| L1300 | Other scoliosis procedure, body jacket molded to patient model  | 04 |
| L1310 | Other scoliosis procedure, post-operative body jacket   | 04 |
| L1320 | Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated (Eff. Date 04/1/2024) | 04 |
| L1499 | Spinal orthosis, not otherwise specified  | 14 |



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| L1500 | Thoracic-hip-knee-ankle orthosis (THKAO), mobility frame (newington, parapodium types) (Deleted eff. 12/31/11)   | 04 |
| L1510 | THKAO, standing frame, with or without tray and accessories (Deleted eff. 12/31/11)  | 04 |
| L1520 | THKAO, swivel walker (Deleted eff. 12/31/11)   | 04 |
| L1600 | Hip orthosis, abduction control of hip joints, flexible, frejka type with cover, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)   | 04 |
| L1610 | Hip orthosis, abduction control of hip joints, flexible, (frejka cover only), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)  | 04 |
| L1620 | Hip orthosis, abduction control of hip joints, flexible, (pavlik harness), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)   | 04 |
| L1630 | Hip Orthosis, abduction control of hip joints, semi-flexible (von rosen type), custom fabricated   | 04 |
| L1640 | Hip Orthosis, abduction control of hip joints, static, pelvic band or spreader bar, thigh cuffs, custom fabricated   | 04 |
| L1650 | HO, abduction control of hip joints, static, adjustable, (ilfled type), perfabriacted, includes fitting and adjustment   | 04 |
| L1652 | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, any type (Eff. Date 1/1/2003) Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised eff. 10/01/2024) | 04 |
| L1653 | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, off the shelf (Eff. Date 10/01/2024)   | 04 |
| L1660 | HO, abduction control of hip joints, static, plastic, perfabriacted, includes fitting and adjustment   | 04 |
| L1680 | HO, abduction control of hip joints, dynamic, pelvic control, adjustable hip motion control, thigh cuffs (rancho hip action type), custom-fabricated   | 04 |
| L1681 | Hip orthosis, bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction control of hip joint, postoperative hip abduction type, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 10/01/2023)   | 04 |

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| L1685 | HO, abduction control of hip joint, post-operative hip abduction type, custom fabricated   | 04 |
| L1686 | HO, abduction control of hip joint, post-operative hip abduction type, perfabriacted, includes fitting and adjustment  | 04 |
| L1690 | Combination, bilateral, lumbo-sacral, hip, femur orthosis providing adduction and internal rotation control, perfabriacted, includes fitting and adjustment  | 04 |
| L1700 | Legg perthes orthosis, (toronto type), custom fabricated   | 04 |
| L1710 | Legg perthes orthosis, (newington type), custom fabricated   | 04 |
| L1720 | Legg perthes orthosis, trilateral, (tachdijan type), custom fabricated   | 04 |
| L1730 | Legg perthes orthosis, (scottish rite type), custom fabricated   | 04 |
| L1755 | Legg perthes orthosis, (patten bottom type), custom fabricated   | 04 |
| L1810 | Knee orthosis, elastic with joints, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)  | 04 |
| L1812 | Knee orthosis, elastic with joints, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L1820 | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, includes fitting and adjustment<br>Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised eff. 10/01/2024) | 04 |
| L1821 | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, off the shelf (Eff. Date 10/01/2024)  | 04 |
| L1830 | Knee orthosis, immobilizer, canvas longitudinal, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04 |
| L1831 | Knee orthosis, locking knee joint(s), positional orthosis, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2004)   | 04 |
| L1832 | Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)   | 04 |
| L1833 | Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf (Eff. Date 01/01/2014)   | 04 |
| L1834 | Knee orthosis, without knee joint, rigid, custom fabricated  | 04 |
| L1836 | Knee orthosis, rigid, without joint(s), includes soft interface material, prefabricated, off-the-shelf (Eff. Date 1/1/2003, Rev. 01/01/2014)   | 04 |

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| L1840 | Knee orthosis, derotation, medial-lateral, anterior cruciate ligament, custom abricated   | 04 |
| L1843 | Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014) | 04 |
| L1844 | Knee Orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated   | 04 |
| L1845 | Knee orthosis, double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014) | 04 |
| L1846 | Knee Orthosis, double upright, thigh and calf, with adjustable flexion and extension joint, (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, custom fabricated  | 04 |
| L1847 | Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)  | 04 |
| L1848 | Knee orthosis, double upright with adjustable joint, with inflatable air support chamber(s), prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L1850 | Knee orthosis, swedish type, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |
| L1851 | Knee orthosis (ko), single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Eff. Date 1/1/2017)  | 04 |
| L1852 | Knee orthosis (ko), double upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf (Eff. Date 1/1/2017)  | 04 |
| L1860 | Knee orthosis, modification of supracondylar prosthetic socket, custom abricated (SK)   | 04 |
| L1900 | Ankle foot orthosis (AFO), spring wire, dorsiflexion assist calf band, custom abricated   | 04 |
| L1902 | Ankle orthosis, ankle gauntlet or similar, with or without joints, prefabricated, off-the-shelf (Revised 01/01/2016)  | 04 |

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| L1904 | Ankle orthosis, ankle gauntlet or similar, with or without joints, custom fabricated (Revised 01/01/2016)   | 04 |
| L1906 | Ankle foot orthosis, multiligamentous ankle support, prefabricated, off-the-shelf (Revised 01/01/2014) (Updated description 1/1/2017)   | 04 |
| L1907 | Ankle orthosis, supramalleolar with straps, with or without interface/pads, custom fabricated (Eff. Date 1/1/2004, Revised 01/01/2014)  | 04 |
| L1910 | Ankle foot orthosis, posterior, single bar, clasp attachment to shoe counter, prefabricated, includes fitting and adjustment  | 04 |
| L1920 | Ankle foot orthosis, single upright with static or adjustable stop (phelps or perlstein type), custom fabricated  | 04 |
| L1930 | Ankle-foot orthosis, plastic or other material, prefabricated, includes fitting and adjustment  | 04 |
| L1932 | AFO, rigid anterior tibial section, total carbon fiber or equal material, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2005)   | 04 |
| L1940 | Ankle foot orthosis, plastic or other material, custom fabricated   | 04 |
| L1945 | Ankle foot orthosis, plastic, rigid anterior tibial section (floor reaction), custom fabricated   | 04 |
| L1950 | Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic, custom fabricated  | 04 |
| L1951 | Ankle foot orthosis, spiral, (institute of rehabilitative medicine type), plastic or other material, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2004)  | 04 |
| L1960 | Ankle foot orthosis, posterior solid ankle, plastic, custom fabricated  | 04 |
| L1970 | Ankle foot orthosis, plastic, with ankle joint, custom fabricated   | 04 |
| L1971 | Ankle foot orthosis, plastic or other material with ankle joint, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2004)  | 04 |
| L1980 | Ankle foot orthosis, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar 'bk' orthosis), custom fabricated  | 04 |
| L1990 | Ankle foot orthosis, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar 'bk' orthosis), custom fabricated  | 04 |
| L2000 | Knee ankle foot orthosis (KAFO), single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'ak' orthosis), custom fabricated   | 04 |
| L2005 | Knee ankle foot orthosis, any material, single or double upright, stance control, automatic lock and swing phase release, any type activation, includes ankle joint, any type, custom fabricated (Eff. Date 1/1/2012) | 04 |

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| L2006 | Knee ankle foot device, any material, single or double upright, swing and/or stance phase microprocessor control with adjustability, includes all components (e.g., sensors, batteries, charger), any type activation, with or without ankle joint(s), custom fabricated (Eff. Date 1/1/2020) | 04 |  |
| L2010 | Knee ankle foot orthosis, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar 'ak' orthosis), without knee joint, custom fabricated   | 04 |  |
| L2020 | Knee ankle foot orthosis, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar 'ak' orthosis), custom fabricated  | 04 |  |
| L2030 | Knee ankle foot orthosis, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar 'ak' orthosis), without knee joint, custom fabricated  | 04 |  |
| L2034 | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, medial lateral rotation control, with or without free motion ankle, custom fabricated (Eff. Date 1/1/2006)  | 04 |  |
| L2035 | Knee ankle foot orthosis, full plastic, static (pediatric size), without free motion ankle, prefabricated, includes fitting and adjustment  | 04 |  |
| L2036 | Knee ankle foot orthosis, full plastic, dougle upright, with or without free motion knee, with or without free motion ankle, custom fabricated  | 04 |  |
| L2037 | Knee ankle foot orthosis, full plastic, single upright, with or without free motion knee, with or without free motion ankle, custom fabricated  | 04 |  |
| L2038 | Knee ankle foot orthosis, full plastic, with or without free motion knee, multi-axis ankle, custom fabricated   | 04 |  |
| L2040 | Hip knee ankle foot orthosis (HKAFO) torsion control, bilateral rotation straps, pelvic band/belt, custom fabricated  | 04 |  |
| L2050 | Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, hip joint, pelvic band/belt, custom fabricated   | 04 |  |
| L2060 | Hip knee ankle foot orthosis, torsion control, bilateral torsion cables, ball bearing hip joint, pelvic band/ belt, custom fabricated   | 04 |  |
| L2070 | Hip knee ankle foot orthosis, torsion control, unilateral rotation straps, pelvic band/belt, custom fabricated  | 04 |  |
| L2080 | Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, hip joint, pelvic band/belt, custom fabricated   | 04 |  |
| L2090 | Hip knee ankle foot orthosis, torsion control, unilateral torsion cable, ball bearing hip joint, pelvic band/ belt, custom fabricated   | 04 |  |
| L2106 | Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, custom fabricated   | 04 |  |
| L2108 | Ankle foot orthosis, fracture orthosis, tibial fracture cast orthosis, custom fabricated  | 04 |  |

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| L2112 | Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, soft, prefabricated, includes fitting and adjustment                              | 04 |
| L2114 | Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, semi-rigid, prefabricated, includes fitting and adjustment                        | 04 |
| L2116 | Ankle foot orthosis, fracture orthosis, tibial fracture orthosis, rigid, prefabricated, includes fitting and adjustment                             | 04 |
| L2126 | Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, custom fabricated                 | 04 |
| L2128 | Knee ankle foot orthosis, fracture orthosis, femoral fracture cast orthosis, custom fabricated  | 04 |
| L2132 | KAFO, fracture orthosis, femoral fracture cast orthosis, soft, prefabricated, includes fitting and adjustment                                       | 04 |
| L2134 | KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid, prefabricated, includes fitting and adjustment                                 | 04 |
| L2136 | KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, prefabricated, includes fitting and adjustment                                      | 04 |
| L2180 | Addition to lower extremity fracture orthosis, plastic shoe insert with ankle joints  | 04 |
| L2182 | Addition to lower extremity fracture orthosis, drop lock knee joint   | 04 |
| L2184 | Addition to lower extremity fracture orthosis, limited motion knee joint  | 04 |
| L2186 | Addition to lower extremity fracture orthosis, adjustable motion knee joint, lerman type  | 04 |
| L2188 | Addition to lower extremity fracture orthosis, quadrilateral brim   | 04 |
| L2190 | Addition to lower extremity fracture orthosis, waist belt   | 04 |
| L2192 | Addition to lower extremity fracture orthosis, hip joint, pelvic band, thigh flange, and pelvic belt  | 04 |
| L2200 | Addition to lower extremity, limited ankle motion, each joint   | 04 |
| L2210 | Addition to lower extremity, dorsiflexion assist (plantar flexion resist), each joint   | 04 |
| L2220 | Addition to lower extremity, dorsiflexion and plantar flexion assist/resist, each joint   | 04 |
| L2230 | Addition to lower extremity, split flat caliper stirrups and plate attachment   | 04 |
| L2232 | Addition to lower extremity orthosis, rocker bottom for total contact ankle foot orthosis, for custom fabricated orthosis only (Eff. Date 1/1/2005) | 04 |
| L2240 | Addition to lower extremity, round caliper and plate attachment   | 04 |

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| L2250 | Addition to lower extremity, foot plate, molded to patient model, stirrup attachment   | 04 |
| L2260 | Addition to lower extremity, reinforced solid stirrup (scott-craig type)   | 04 |
| L2265 | Addition to lower extremity, long tongue stirrup   | 04 |
| L2270 | Addition to lower extremity, varus/valgus correction ('t') strap, padded/lined or malleolus pad                                      | 04 |
| L2275 | Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined   | 04 |
| L2280 | Addition to lower extremity, molded inner boot   | 04 |
| L2300 | Addition to lower extremity, abduction bar (bilateral hip involvement), jointed, adjustable  | 04 |
| L2310 | Addition to lower extremity, abduction bar-straight  | 04 |
| L2320 | Addition to lower extremity, non-molded lacer, for custom fabricated orthosis only   | 04 |
| L2330 | Addition to lower extremity, lacer molded to patient model, for custom fabricated orthosis only                                      | 04 |
| L2335 | Addition to lower extremity, anterior swing band   | 04 |
| L2340 | Addition to lower extremity, pre-tibial shell, molded to patient model   | 04 |
| L2350 | Addition to lower extremity, prosthetic type, (bk) socket, molded to patient model, (used for 'ptb' 'AFO' orthoses)                  | 04 |
| L2360 | Addition to lower extremity, extended steel shank  | 04 |
| L2370 | Addition to lower extremity, patten bottom   | 04 |
| L2375 | Addition to lower extremity, torsion control, ankle joint and half solid stirrup   | 04 |
| L2380 | Addition to lower extremity, torsion control, straight knee joint, each joint  | 04 |
| L2385 | Addition to lower extremity, straight knee joint, heavy duty, each joint   | 04 |
| L2387 | Addition to lower extremity, polycentric knee joint, for custom fabricated knee ankle foot orthosis, each joint (Eff. Date 1/1/2006) | 04 |
| L2390 | Addition to lower extremity, offset knee joint, each joint   | 04 |
| L2395 | Addition to lower extremity, offset knee joint, heavy duty, each joint   | 04 |
| L2397 | Addition to lower extremity orthosis, suspension sleeve  | 04 |
| L2405 | Addition to knee joint, drop lock, each  | 04 |



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| L2415 | Addition to knee lock with integrated release mechanism (bail, cable, or equal), any material, each joint         | 04 |
| L2425 | Addition to knee joint, disc or dial lock for adjustable knee flexion, each joint                                 | 04 |
| L2430 | Addition to knee joint, ratchet lock for active and progressive knee extension, each joint                        | 04 |
| L2492 | Addition to knee joint, lift loop for drop lock ring  |    |
| L2500 | Addition to lower extremity, thigh/weight bearing, gluteal/ ischial weight bearing, ring                          | 04 |
| L2510 | Addition to lower extremity, thigh/weight bearing, quadri- lateral brim, molded to patient model                  | 04 |
| L2520 | Addition to lower extremity, thigh/weight bearing, quadri- lateral brim, custom fitted                            | 04 |
| L2525 | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow m-l brim molded to patient model    | 04 |
| L2526 | Addition to lower extremity, thigh/weight bearing, ischial containment/narrow m-l brim, custom fitted             | 04 |
| L2530 | Addition to lower extremity, thigh-weight bearing, lacer, non-molded  | 04 |
| L2540 | Addition to lower extremity, thigh/weight bearing, lacer, molded to patient model                                 | 04 |
| L2550 | Addition to lower extremity, thigh/weight bearing, high roll cuff   | 04 |
| L2570 | Addition to lower extremity, pelvic control, hip joint, clevis type two position joint, each                      | 04 |
| L2580 | Addition to lower extremity, pelvic control, pelvic sling   | 04 |
| L2600 | Addition to lower extremity, pelvic control, hip joint, clevis type, or thrust bearing, free, each                | 04 |
| L2610 | Addition to lower extremity, pelvic control, hip joint, clevis or thrust bearing, lock, each                      | 04 |
| L2620 | Addition to lower extremity, pelvic control, hip joint, heavy duty, each  | 04 |
| L2622 | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, each                                  | 04 |
| L2624 | Addition to lower extremity, pelvic control, hip joint, adjustable flexion, extension, abduction control, each    | 04 |
| L2627 | Addition to lower extremity, pelvic control, plastic, molded to patient model, reciprocating hip joint and cables | 04 |
| L2628 | Addition to lower extremity, pelvic control, metal frame, reciprocating hip joint and cables                      | 04 |



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| L2630 | Addition to lower extremity, pelvic control, band and belt, unilateral   | 04 |
| L2640 | Addition to lower extremity, pelvic control, band and belt, bilateral  | 04 |
| L2650 | Addition to lower extremity, pelvic and thoracic control, gluteal pad, each  | 04 |
| L2660 | Addition to lower extremity, thoracic control, thoracic band   | 04 |
| L2670 | Addition to lower extremity, thoracic control, paraspinal uprights   | 04 |
| L2680 | Addition to lower extremity, thoracic control, lateral support uprights  | 04 |
| L2750 | Addition to lower extremity orthosis, plating chrome or nickel, per bar  | 04 |
| L2755 | Addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, per segment, for custom fabricated orthosis only | 04 |
| L2760 | Addition to lower extremity orthosis, extension, per extension, per bar (for lineal adjustment for growth)   | 04 |
| L2768 | Orthotic side bar disconnect device, per bar   | 04 |
| L2780 | Addition to lower extremity orthosis, non-corrosive finish, per bar  | 04 |
| L2785 | Addition to lower extremity orthosis, drop lock retainer, each   | 04 |
| L2795 | Addition to lower extremity orthosis, knee control, full kneecap   | 04 |
| L2800 | Addition to lower extremity orthosis, knee control, knee cap, medial or lateral pull, for use with custom fabricated orthosis only                                   | 04 |
| L2810 | Addition to lower extremity orthosis, knee control, condylar pad   | 04 |
| L2820 | Addition to lower extremity orthosis, soft interface for molded plastic, below knee section  | 04 |
| L2830 | Addition to lower extremity orthosis, soft interface for molded plastic, above knee section  | 04 |
| L2840 | Addition to lower extremity orthosis, tibial length sock, fracture or equal, each  | 04 |
| L2850 | Addition to lower extremity orthosis, femoral length sock, fracture or equal, each   | 04 |
| L2861 | Addition to lower extremity joint, knee or ankle, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each (Eff. Date 1/1/2010)      | 04 |
| L2999 | Lower extremity orthoses, not otherwise specified  | 14 |
| L3000 | Foot, insert, removable, molded to patient model, 'ucb' type, berkeley shell, each   | 04 |
| L3001 | Foot, insert, removable, molded to patient model, spenco, each   | 04 |

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| L3002 | Foot, insert, removable, molded to patient model, plastazote or equal, each  | 04 |
| L3003 | Foot, insert, removable, molded to patient model, silicone gel, each   | 04 |
| L3010 | Foot, insert, removable, molded to patient model, longitudinal arch support, each  | 04 |
| L3020 | Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each  | 04 |
| L3030 | Foot, insert, removable, formed to patient foot, each  | 04 |
| L3031 | Foot, insert/plate, removable, addition to lower extremity orthosis, high strength, lightweight material, all hybrid lamination/prepreg composite, each (Eff. Date 1/1/2004) | 04 |
| L3040 | Foot, arch support, removable, premolded, longitudinal, each   | 04 |
| L3050 | Foot, arch support, removable, premolded, metatarsal, each   | 04 |
| L3060 | Foot, arch support, removable, premolded, longitudinal/ metatarsal, each   | 04 |
| L3070 | Foot, arch support, non-removable attached to shoe, longitudinal, each   | 04 |
| L3080 | Foot, arch support, non-removable attached to shoe, metatarsal, each   | 04 |
| L3090 | Foot, arch support, non-removable attached to shoe, longitudinal/metatarsal, each  | 04 |
| L3100 | Hallus-valgus night dynamic splint, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |
| L3140 | Foot, abduction rotation bar, including shoes  | 04 |
| L3150 | Foot, abduction rotation bar, without shoes  | 04 |
| L3160 | Foot, adjustable shoe-styled positioning device  | 04 |
| L3161 | Foot, adductus positioning device, adjustable (Eff. Date 01/01/2024)   |    |
| L3170 | Foot, plastic, silicone or equal, heel stabilizer, prafabricated, off-the-shelf, each (revised 01/01/2014)   | 04 |
| L3201 | Orthopedic shoe, oxford with supinator or pronator, infant   | 04 |
| L3202 | Orthopedic shoe, oxford with supinator or pronator, child  | 04 |
| L3203 | Orthopedic shoe, oxford with supinator or pronator, junior   | 04 |
| L3204 | Orthopedic shoe, hightop with supinator or pronator, infant  | 04 |
| L3206 | Orthopedic shoe, hightop with supinator or pronator, child   | 04 |

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| L3207 | Orthopedic shoe, hightop with supinator or pronator, junior                               | 04 |
| L3208 | Surgical boot, each, infant   | 04 |
| L3209 | Surgical boot, each, child  | 04 |
| L3211 | Surgical boot, each, junior   | 04 |
| L3212 | Benesch boot, pair, infant  | 04 |
| L3213 | Benesch boot, pair, child   | 04 |
| L3214 | Benesch boot, pair, junior  | 04 |
| L3215 | Orthopedic footwear, ladies shoe, oxford, each  | 04 |
| L3216 | Orthopedic footwear, ladies shoe, depth inlay, each                                       | 04 |
| L3217 | Orthopedic footwear, ladies shoe, hightop, depth inlay, each                              | 04 |
| L3219 | Orthopedic footwear, mens shoe, oxford, each  | 04 |
| L3221 | Orthopedic footwear, mens shoe, depth inlay, each   | 04 |
| L3222 | Orthopedic footwear, mens shoe, hightop, depth inlay, each                                | 04 |
| L3224 | Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis) | 04 |
| L3225 | Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)   | 04 |
| L3230 | Orthopedic footwear, custom shoe, depth inlay, each                                       | 04 |
| L3250 | Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each      | 04 |
| L3251 | Foot, shoe molded to patient model, silicone shoe, each                                   | 04 |
| L3252 | Foot, shoe molded to patient model, plastazote (or similar), custom fabricated, each      | 04 |
| L3253 | Foot, molded shoe plastazote (or similar) custom fitted, each                             | 04 |
| L3254 | Non-standard size or width  | 04 |
| L3255 | Non-standard size or length   | 04 |
| L3257 | Orthopedic footwear, additional charge for split size                                     | 04 |
| L3260 | Surgical boot/shoe, each  | 04 |
| L3265 | Plastazote sandal, each   | 04 |
| L3300 | Lift, elevation, heel, tapered to metatarsals, per inch                                   | 04 |
| L3310 | Lift, elevation, heel and sole, neoprene, per inch  | 04 |

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| L3320 | Lift, elevation, heel and sole, cork, per inch              | 04 |
| L3330 | Lift, elevation, metal extension (skate)                    | 04 |
| L3332 | Lift, elevation, inside shoe, tapered, up to one-half inch  | 04 |
| L3334 | Lift, elevation, heel, per inch                             | 04 |
| L3340 | Heel wedge, sach  | 04 |
| L3350 | Heel wedge  | 04 |
| L3360 | Sole wedge, outside sole                                    | 04 |
| L3370 | Sole wedge, between sole                                    | 04 |
| L3380 | Clubfoot wedge  | 04 |
| L3390 | Outflare wedge  | 04 |
| L3400 | Metatarsal bar wedge, rocker                                | 04 |
| L3410 | Metatarsal bar wedge, between sole                          | 04 |
| L3420 | Full sole and heel wedge, between sole                      | 04 |
| L3430 | Heel, counter, plastic reinforced                           | 04 |
| L3440 | Heel, counter, leather reinforced                           | 04 |
| L3450 | Heel, sach cushion type                                     | 04 |
| L3455 | Heel, new leather, standard                                 | 04 |
| L3460 | Heel, new rubber, standard                                  | 04 |
| L3465 | Heel, thomas with wedge                                     | 04 |
| L3470 | Heel, thomas extended to ball                               | 04 |
| L3480 | Heel, pad and depression for spur                           | 04 |
| L3485 | Heel, pad, removable for spur                               | 04 |
| L3500 | Orthopedic shoe addition, insole, leather                   | 04 |
| L3510 | Orthopedic shoe addition, insole, rubber                    | 04 |
| L3520 | Orthopedic shoe addition, insole, felt covered with leather | 04 |
| L3530 | Orthopedic shoe addition, sole, half                        | 04 |
| L3540 | Orthopedic shoe addition, sole, full                        | 04 |
| L3550 | Orthopedic shoe addition, toe tap standard                  | 04 |

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| L3560 | Orthopedic shoe addition, toe tap, horseshoe  | 04 |
| L3570 | Orthopedic shoe addition, special extension to instep (leather with eyelets)  | 04 |
| L3580 | Orthopedic shoe addition, convert instep to velcro closure  | 04 |
| L3590 | Orthopedic shoe addition, convert firm shoe counter to soft counter   | 04 |
| L3595 | Orthopedic shoe addition, march bar   | 04 |
| L3600 | Transfer of an orthosis from one shoe to another, caliper plate, existing   | 04 |
| L3610 | Transfer of an orthosis from one shoe to another, caliper plate, new  | 04 |
| L3620 | Transfer of an orthosis from one shoe to another, solid stirrup, existing   | 04 |
| L3630 | Transfer of an orthosis from one shoe to another, solid stirrup, new  | 04 |
| L3640 | Transfer of an orthosis from one shoe to another, dennis browne splint (riveton), both shoes  | 04 |
| L3649 | Orthopedic shoe, modification, addition or transfer, not otherwise specified  | 14 |
| L3650 | Shoulder orthosis, figure of eight design abduction restrainer, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04 |
| L3660 | Shoulder orthosis, figure of eight design abduction restrainer, canvas and webbing, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04 |
| L3670 | Shoulder orthosis, acromio/clavicular (canvas and webbing type), prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |
| L3671 | Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006, Updated 1/1/2011)   | 04 |
| L3672 | Shoulder orthosis, abduction positioning (airplane design), thoracic components and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Deleted eff. 12/31/2010)   | 04 |
| L3673 | Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, includes nontorsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006) (Deleted eff. 12/31/2010) | 04 |
| L3674 | Shoulder orthosis, abduction positioning (airplane design), thoracic component and support bar, with or without non-torsion joint/turnbuckle, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2011)                   | 04 |
| L3675 | Shoulder orthosis, vest type abduction restrainer, canvas webbing type or equal, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |

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| L3677 | Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2002, Rev. 01/01/2014) | 04 |
| L3678 | Shoulder orthosis, shoulder joint design, without joints, may include soft interface, straps, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L3702 | Elbow orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |
| L3710 | Elbow orthosis, elastic with metal joints, prefabricated, off-the-shelf (revised 01/01/2014)   | 04 |
| L3720 | Elbow orthosis, double upright with forearm/arm cuffs, free motion custom fabricated   | 04 |
| L3730 | Elbow orthosis, double upright with forearm/arm cuffs, extension/flexion assist, custom fabricated   | 04 |
| L3740 | Elbow orthosis, double upright with forearm/arm cuffs, adjustable position lock with active control, custom fabricated   | 04 |
| L3760 | Elbow orthosis (eo), with adjustable position locking joint(s), prefabricated, item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2018)   | 04 |
| L3761 | Elbow orthosis (eo), with adjustable position locking joint(s), prefabricated, off-the-shelf (Eff. Date 01/01/2018)  | 04 |
| L3762 | Elbow orthosis, rigid, without joints, includes soft interface material, prefabricated, off-the-shelf (Eff. Date 1/1/2003, Revised 01/01/2014)   | 04 |
| L3763 | Elbow wrist hand orthosis, rigid, without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L3764 | Elbow wrist hand orthosis, includes one or more nontorsion joints, elastic bands, tumbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |
| L3765 | Elbow wrist hand finger orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |
| L3766 | Elbow wrist hand finger orthosis, includes one or more nontorsion joints, elastic bands, tumbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |

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| L3806 | Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, custom fabricated, includes fitting and adjustment (Updated 1/1/2008)   | 04 |
| L3807 | Wrist hand finger orthosis, without joint(s), prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2000, Revised 01/01/2014)  | 04 |
| L3808 | Wrist hand finger orthosis, rigid without joints, may include soft interface material, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2007)   | 04 |
| L3809 | Wrist hand finger orthosis, without joint(s), prefabricated, off-the-shelf, any type (Eff. Date 01/01/2014)  | 04 |
| L3891 | Addition to upper extremity joint, wrist or elbow, concentric adjustable torsion style mechanism for custom fabricated orthotics only, each (Eff. Date 1/1/2010)   | 04 |
| L3900 | Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, wrist or finger driven, custom fabricated  | 04 |
| L3901 | Wrist hand finger orthosis, dynamic flexor hinge, reciprocal wrist extension/flexion, finger flexion/extension, cable driven, custom fabricated  | 04 |
| L3904 | Wrist hand finger orthosis, external powered, electric, custom fabricated  | 04 |
| L3905 | Wrist hand orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L3906 | Wrist hand orthosis, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment  | 04 |
| L3908 | Wrist hand orthosis, wrist extension control cock-up, non molded, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |
| L3912 | Hand finger orthosis (hfo), flexion glove with elastic finger control, prefabricated, off-the-shelf (Revised 01/01/2014)   | 04 |
| L3913 | Hand finger orthosis, without joint, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L3915 | Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. date 1/1/2007, Revised 01/01/2014) | 04 |

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| L3916 | Wrist hand orthosis, includes one or more nontorsion joint(s), elastic bands, turnbuckles, may include soft interface, straps, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L3917 | Hand orthosis, metacarpal fracture orthosis, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2004, Revised 01/01/2014)   | 04 |
| L3918 | Hand orthosis, metacarpal fracture orthosis, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L3919 | Hand orthosis, without joint, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |
| L3921 | Hand finger orthosis, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |
| L3923 | Hand finger orthosis, without joints, may include soft interface, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2001, Revised 01/01/2014)  | 04 |
| L3924 | Hand finger orthosis, without joints, may include soft interface, straps, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L3925 | Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), non torsion joint/spring, extension/flexion, may include soft interface material, prefabricated, off-the-shelf (Eff. Date 1/1/2008, Revised 01/01/2014)  | 04 |
| L3927 | Finger orthosis, proximal interphalangeal (pip)/distal interphalangeal (dip), without joint/spring, extension/flexion (e.g., static or ring type), may include soft interface material, prefabricated, off-the-shelf (Eff. Date 1/1/2008, Revised 01/01/2014)  | 04 |
| L3929 | Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2008, Revised 01/01/2014) | 04 |
| L3930 | Hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   | 04 |
| L3931 | Wrist hand finger orthosis, includes one or more nontorsion joint(s), turnbuckles, elastic bands/springs, may include soft interface material, straps, prefabricated, includes fitting and adjustment (Eff. Date 1/1/2008)   | 04 |
| L3933 | Finger orthosis, without joints, may includes soft interface, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |



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| L3935 | Finger orthosis, nontorsion joint, may include soft interface, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L3956 | Addition of joint to upper extremity orthosis, any material; per joint   | 04 |
| L3960 | Shoulder-elbow-wrist-hand orthosis, (SEWHO), abduction positioning, airplane design, prefabricated, included fitting and adjustment  | 04 |
| L3961 | Shoulder elbow wrist hand orthosis, should cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |
| L3962 | Shoulder elbow wrist hand orthosis, abduction positioning, erb's palsey design, prefabricated, included fitting and adjustment   | 04 |
| L3964 | Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable, prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)   | 05 |
| L3965 | Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, adjustable rancho type, prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)   | 05 |
| L3966 | Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, reclining, prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)  | 05 |
| L3967 | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006) | 04 |
| L3968 | Shoulder elbow orthosis, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints), prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)                | 05 |
| L3969 | Shoulder elbow orthosis, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support, prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)        | 05 |
| L3970 | SEO, addition to mobile arm support, elevating proximal arm (Deleted eff. 12/31/11)  | 05 |
| L3971 | Shoulder elbow wrist hand orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)     | 04 |
| L3972 | SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control (Deleted eff. 12/31/11)   | 05 |

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| L3973 | Shoulder elbow wrist hand orthosis, abduction positioning (airplane design) thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)        | 04 |  |
| L3974 | SEO, addition to mobile arm support, supinator (Deleted eff. 12/31/11)   | 05 |  |
| L3975 | Shoulder elbow wrist hand orthosis, shoulder cap design, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)   | 04 |  |
| L3976 | Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design), thoracic component and support bar, without joints, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |  |
| L3977 | Shoulder elbow wrist hand finger orthosis, shoulder cap design, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)  | 04 |  |
| L3978 | Shoulder elbow wrist hand finger orthosis, abduction positioning (airplane design) thoracic component and support bar, includes one or more nontorsion joints, elastic bands, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006) | 04 |  |
| L3980 | Upper extremity fracture orthosis, humeral, prefabricated, included fitting and adjustment   | 04 |  |
| L3981 | Upper extremity fracture orthosis, humeral, prefabricated, includes shoulder cap design, with or without joints, forearm section, may include soft interface, straps, includes fitting and adjustments   | 04 |  |
| L3982 | Upper extremity fracture orthosis, radius/ulnar, prefabricated, included fitting and adjustment  | 04 |  |
| L3984 | Upper extremity fracture orthosis, wrist, prefabricated, included fitting and adjustment   | 04 |  |
| L3995 | Addition to upper extremity orthosis, sock, fracture or equal, each  | 04 |  |
| L3999 | Upper limb orthosis, not otherwise specified   | 14 |  |
| L4000 | Replace girdle for spinal orthosis (CTLSO or SO)   | 04 |  |
| L4002 | Replacement strap, any orthosis, includes all components, any length, any type (Eff. Date 1/1/2005)  | 04 |  |
| L4010 | Replace trilateral socket brim   | 04 |  |

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| L4020 | Replace quadrilateral socket brim, molded to patient model  | 04 |
| L4030 | Replace quadrilateral socket brim, custom fitted  | 04 |
| L4040 | Replace molded thigh lacer, for custom fabricated orthosis only   | 04 |
| L4045 | Replace non-molded thigh lacer, for custom fabricated orthosis only   | 04 |
| L4050 | Replace molded calf lacer, for custom fabricated orthosis only  | 04 |
| L4055 | Replace non-molded calf lacer, for custom fabricated orthosis only  | 04 |
| L4060 | Replace high roll cuff  | 04 |
| L4070 | Replace proximal and distal upright for KAFO  | 04 |
| L4080 | Replace metal bands KAFO, proximal thigh  | 04 |
| L4090 | Replace metal bands KAFO-AFO, calf or distal thigh  | 04 |
| L4100 | Replace leather cuff KAFO, proximal thigh   | 04 |
| L4110 | Replace leather cuff KAFO-AFO, calf or distal thigh   | 04 |
| L4130 | Replace pretibial shell   | 04 |
| L4205 | Repair of orthotic device, labor component, per 15 minutes  | 04 |
| L4210 | Repair of orthotic device, repair or replace minor parts  | 04 |
| L4350 | Ankle control orthosis, stirrup style, rigid, includes any type interface (e.g., pneumatic, gel), prefabricated, off-the-shelf (Rev. 01/01/2014)  | 04 |
| L4360 | Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014)        | 04 |
| L4361 | Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L4370 | Pneumatic full leg splint, prefabricated, off-the-shelf (Rev.01/01/2014)  | 04 |
| L4380 | Pneumatic knee splint, prefabricated, included fitting and adjustment (Deleted eff. 12/31/11)   | 04 |
| L4386 | Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Eff. Date 1/1/2003, Rev. 01/01/2014) | 04 |
| L4387 | Walking boot, non-pneumatic, with or without joints, with or without interface material, prefabricated, off-the-shelf (Eff. Date 01/01/2014)  | 04 |
| L4392 | Replacement soft interface material, static AFO   | 04 |

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| L4394 | Replace soft interface material, foot drop splint  | 04 |
| L4396 | Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise (Revised 01/01/2014) | 04 |
| L4397 | Static or dynamic ankle foot orthosis, including soft interface material, adjustable for fit, for positioning, may be used for minimal ambulation, prefabricated, off-the-shelf (Eff. Date 01/01/2014)   |    |
| L4398 | Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf (Revised 01/01/2014)  | 04 |
| L4631 | Ankle Foot orthosis, walking boot type, varus/valgus correction, rocker bottom, anterior tibial shell, soft interface, custom arch support, plastic or other material includes straps and closures, custom fabricated (Eff. Date 1/1/2011)   | 04 |
| L5000 | Partial foot, shoe insert with longitudinal arch, toe filler   | 04 |
| L5010 | Partial foot, molded socket, ankle height, with toe filler   | 04 |
| L5020 | Partial foot, molded socket, tibial tubercle height, with toe filler   | 04 |
| L5050 | Ankle, symes, molded socket, sach foot   | 04 |
| L5060 | Ankle, symes, metal frame, molded leather socket, articulated ankle/foot   | 04 |
| L5100 | Below knee, molded socket, shin, sach foot   | 04 |
| L5105 | Below knee, plastic socket, joints and thigh lacer, sach foot  | 04 |
| L5150 | Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot   | 04 |
| L5160 | Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin, sach foot  | 04 |
| L5200 | Above knee, molded socket, single axis constant friction knee, shin, sach foot   | 04 |
| L5210 | Above knee, short prosthesis, no knee joint ('stubbies'), with foot blocks, no ankle joints, each  | 04 |
| L5220 | Above knee, short prosthesis, no knee joint ('stubbies'), with articulated ankle/foot, dynamically aligned, each   | 04 |
| L5230 | Above knee, for proximal femoral focal deficiency, constant friction knee, shin, sach foot   | 04 |
| L5250 | Hip disarticulation, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot  | 04 |

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| L5270 | Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, sach foot   | 04 |
| L5280 | Hemipelvectomy, canadian type; molded socket, hip joint, single axis constant friction knee, shin, sach foot  | 04 |
| L5301 | Below knee, molded socket, shin, sach foot, endoskeletal system (Eff. Date 1/1/2002)  | 04 |
| L5311 | Knee disarticulation (or through knee), molded socket, external knee joints, shin, sach foot, endoskeletal system (Deleted eff. 12/31/11)   | 04 |
| L5312 | Knee disarticulation (or through knee), molded socket, single axis knee, pylon, sach foot, endoskeletal system (Eff. Date 1/1/2012)   |    |
| L5321 | Above knee, molded socket, open end, sach foot, endoskeletal system, single axis knee (Eff. Date 1/1/2002)  | 04 |
| L5331 | Hip disarticulation, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot (Eff. Date 1/1/2002)   | 04 |
| L5341 | Hemipelvectomy, canadian type, molded socket, endoskeletal system, hip joint, single axis knee, sach foot (Eff. Date 1/1/2002)  | 04 |
| L5400 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee  | 04 |
| L5410 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, below knee, each additional cast change and realignment               | 04 |
| L5420 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension and one cast change 'ak' or knee disarticulation                       | 04 |
| L5430 | Immediate post surgical or early fitting, application of initial rigid dressing, incl. fitting, alignment and suspension, 'ak' or knee disarticulation, each additional cast change and realignment | 04 |
| L5450 | Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, below knee  | 04 |
| L5460 | Immediate post surgical or early fitting, application of non-weight bearing rigid dressing, above knee  | 04 |
| L5500 | Initial, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, plaster socket, direct formed  | 04 |
| L5505 | Initial, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, plaster socket, direct formed   | 04 |
| L5510 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, plaster socket, molded to model  | 04 |
| L5520 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, direct formed  | 04 |

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| L5530 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model                             | 04 |
| L5535 | Preparatory, below knee 'ptb' type socket, non-alignable system, no cover, sach foot, prefabricated, adjustable open end socket                                  | 04 |
| L5540 | Preparatory, below knee 'ptb' type socket, non-alignable system, pylon, no cover, sach foot, laminated socket, molded to model                                   | 04 |
| L5560 | Preparatory, above knee- knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, plaster socket, molded to model           | 04 |
| L5570 | Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, direct formed    | 04 |
| L5580 | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon, no cover, sach foot, thermoplastic or equal, molded to model   | 04 |
| L5585 | Preparatory, above knee - knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, sach foot, prefabricated adjustable open end socket | 04 |
| L5590 | Preparatory, above knee - knee disarticulation ischial level socket, non-alignable system, pylon no cover, sach foot, laminated socket, molded to model          | 04 |
| L5595 | Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, sach foot, thermoplastic or equal, molded to patient model                                     | 04 |
| L5600 | Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, sach foot, laminated socket, molded to patient model   | 04 |
| L5610 | Addition to lower extremity, endoskeletal system, above knee, hydracadence system  | 04 |
| L5611 | Addition to lower extremity, endoskeletal system, above knee - knee disarticulation, 4 bar linkage, with friction swing phase control                            | 04 |
| L5613 | Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage, with hydraulic swing phase control                             | 04 |
| L5614 | Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4 bar linkage, with pneumatic swing phase control                              | 04 |
| L5615 | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control (Eff. Date 01/01/2024)                                | 04 |
| L5616 | Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control   | 04 |
| L5617 | Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each   | 04 |
| L5618 | Addition to lower extremity, test socket, symes  | 04 |

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| L5620 | Addition to lower extremity, test socket, below knee                                    | 04 |
| L5622 | Addition to lower extremity, test socket, knee disarticulation                          | 04 |
| L5624 | Addition to lower extremity, test socket, above knee                                    | 04 |
| L5626 | Addition to lower extremity, test socket, hip disarticulation                           | 04 |
| L5628 | Addition to lower extremity, test socket, hemipelvectomy                                | 04 |
| L5629 | Addition to lower extremity, below knee, acrylic socket                                 | 04 |
| L5630 | Addition to lower extremity, symes type, expandable wall socket                         | 04 |
| L5631 | Addition to lower extremity, above knee or knee disarticulation, acrylic socket         | 04 |
| L5632 | Addition to lower extremity, symes type, 'ptb' brim design socket                       | 04 |
| L5634 | Addition to lower extremity, symes type, posterior opening (canadian) socket            | 04 |
| L5636 | Addition to lower extremity, symes type, medial opening socket                          | 04 |
| L5637 | Addition to lower extremity, below knee, total contact                                  | 04 |
| L5638 | Addition to lower extremity, below knee, leather socket                                 | 04 |
| L5639 | Addition to lower extremity, below knee, wood socket                                    | 04 |
| L5640 | Addition to lower extremity, knee disarticulation, leather socket                       | 04 |
| L5642 | Addition to lower extremity, above knee, leather socket                                 | 04 |
| L5643 | Addition to lower extremity, hip disarticulation, flexible inner socket, external frame | 04 |
| L5644 | Addition to lower extremity, above knee, wood socket                                    | 04 |
| L5645 | Addition to lower extremity, below knee, flexible inner socket, external frame          | 04 |
| L5646 | Addition to lower extremity, below knee, air, fluid, gel or equal, cushion socket       | 04 |
| L5647 | Addition to lower extremity, below knee suction socket                                  | 04 |
| L5648 | Addition to lower extremity, above knee, air, fluid, gel or equal, cushion socket       |    |
| L5649 | Addition to lower extremity, ischial containment/narrow m-l socket                      | 04 |
| L5650 | Additions to lower extremity, total contact, above knee or knee disarticulation socket  | 04 |
| L5651 | Addition to lower extremity, above knee, flexible inner socket, external frame          | 04 |

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| L5652 | Addition to lower extremity, suction suspension, above knee or knee disarticulation socket   | 04 |
| L5653 | Addition to lower extremity, knee disarticulation, expandable wall socket  | 04 |
| L5654 | Addition to lower extremity, socket insert, symes, (kemblo, pelite, aliplast, plastazote or equal)   | 04 |
| L5655 | Addition to lower extremity, socket insert, below knee (kemblo, pelite, aliplast, plastazote or equal)   | 04 |
| L5656 | Addition to lower extremity, socket insert, knee disarticulation (kemblo, pelite, aliplast, plastazote or equal)   | 04 |
| L5658 | Addition to lower extremity, socket insert, above knee (kemblo, pelite, aliplast, plastazote or equal)   | 04 |
| L5661 | Addition to lower extremity, socket insert, multi-durometer symes  | 04 |
| L5665 | Addition to lower extremity, socket insert, multi-durometer, below knee  | 04 |
| L5666 | Addition to lower extremity, below knee, cuff suspension   | 04 |
| L5668 | Addition to lower extremity, below knee, molded distal cushion   | 04 |
| L5670 | Addition to lower extremity, below knee, molded supracondylar suspension ('pts' or similar)  | 04 |
| L5671 | Addition to lower extremity, below knee/above knee suspension locking mechanism (shuttle, lanyard or equal), excludes socket insert (Eff. Date 1/1/2002)   | 04 |
| L5672 | Addition to lower extremity, below knee, removable medial brim suspension  | 04 |
| L5673 | Addition to lower extremity, below knee/above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism (Eff. Date 1/1/2004)      | 04 |
| L5676 | Additions to lower extremity, below knee, knee joints, single axis, pair   | 04 |
| L5677 | Additions to lower extremity, below knee, knee joints, polycentric, pair   | 04 |
| L5678 | Additions to lower extremity, below knee, joint covers, pair   |    |
| L5679 | Addition to lower extremity, below knee/ above knee, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism (Eff. Date 1/1/2004) | 04 |
| L5680 | Addition to lower extremity, below knee, thigh lacer, nonmolded  | 04 |



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| L5681 | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) (Eff. Date 1/1/2004)            | 04 |  |
| L5682 | Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded   | 04 |  |
| L5683 | Addition to lower extremity, below knee/above knee, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L5673 or L5679) (Eff. Date 1/1/2004) | 04 |  |
| L5684 | Addition to lower extremity, below knee, fork strap   | 04 |  |
| L5685 | Addition to lower extremity prosthesis, below knee, suspension/sealing sleeve, with or without valve, any material, each (Eff. Date 1/1/2005)   | 04 |  |
| L5686 | Addition to lower extremity, below knee, back check (extension control)   | 04 |  |
| L5688 | Addition to lower extremity, below knee, waist belt, webbing  | 04 |  |
| L5690 | Addition to lower extremity, below knee, waist belt, padded and lined   | 04 |  |
| L5692 | Addition to lower extremity, above knee, pelvic control belt, light   | 04 |  |
| L5694 | Addition to lower extremity, above knee, pelvic control belt, padded and lined  | 04 |  |
| L5695 | Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each   | 04 |  |
| L5696 | Addition to lower extremity, above knee or knee disarticulation, pelvic joint   | 04 |  |
| L5697 | Addition to lower extremity, above knee or knee disarticulation, pelvic band  | 04 |  |
| L5698 | Addition to lower extremity, above knee or knee disarticulation, silesian bandage   | 04 |  |
| L5699 | All lower extremity prostheses, shoulder harness  | 04 |  |
| L5700 | Replacement, socket, below knee, molded to patient model  | 04 |  |
| L5701 | Replacement, socket, above knee/knee disarticulation, including attachment plate, molded to patient model   | 04 |  |
| L5702 | Replacement, socket, hip disarticulation, including hip joint, molded to patient model  | 04 |  |

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| L5703 | Ankle, symes, molded to patient model, socket without solid ankle cushion heel (sach) foot, replacement only (Eff. Date 1/1/2006)               | 04 |
| L5704 | Custom shaped protective cover, below knee  | 04 |
| L5705 | Custom shaped protective cover, above knee  | 04 |
| L5706 | Custom shaped protective cover, knee disarticulation  | 04 |
| L5707 | Custom shaped protective cover, hip disarticulation   | 04 |
| L5710 | Addition, exoskeletal knee-shin system, single axis, manual lock  | 04 |
| L5711 | Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material  | 04 |
| L5712 | Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)                                      | 04 |
| L5714 | Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control  | 04 |
| L5716 | Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock   | 04 |
| L5718 | Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control  | 04 |
| L5722 | Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control   | 04 |
| L5724 | Addition, exoskeletal knee-shin system, single axis, fluid swing phase control  | 04 |
| L5726 | Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control  | 04 |
| L5728 | Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control   | 04 |
| L5780 | Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control  | 04 |
| L5781 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system (Eff. Date 1/1/2003)             | 04 |
| L5782 | Addition to lower limb prosthesis, vacuum pump, residual limb volume management and moisture evacuation system, heavy duty (Eff. Date 1/1/2003) | 04 |
| L5783 | Addition to lower extremity, user adjustable, mechanical, residual limb volume management system (Eff. Date 04/01/2024)                         | 04 |
| L5785 | Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)  | 04 |

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| L5790 | Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)  | 04 |
| L5795 | Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)                                     | 04 |
| L5810 | Addition, endoskeletal knee-shin system, single axis, manual lock   | 04 |
| L5811 | Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material   | 04 |
| L5812 | Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)                                   | 04 |
| L5814 | Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock                             | 04 |
| L5816 | Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock  | 04 |
| L5818 | Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control  | 04 |
| L5822 | Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control  | 04 |
| L5824 | Addition, endoskeletal knee-shin system, single axis, fluid swing phase control   | 04 |
| L5826 | Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame                       | 04 |
| L5828 | Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control  | 04 |
| L5830 | Addition, endoskeletal knee-shin system, single axis, pneumatic/ swing phase control  | 04 |
| L5840 | Addition, endoskeletal knee/shin system, 4-bar linkage or multiaxial, pneumatic swing phase control   | 04 |
| L5841 | Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control (Eff. Date 04/01/2024)                        | 04 |
| L5845 | Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable  | 04 |
| L5848 | Addition to endoskeletal, knee-shin system, hydraulic stance extension, dampening feature, with or without adjustability (Eff. Date 1/1/2003) | 04 |
| L5850 | Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist   | 04 |
| L5855 | Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist   | 04 |

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| L5856 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing and stance phase, includes electronic sensor (s), any type (Eff. Date 1/1/2005) | 04 |
| L5857 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, microprocessor control feature, swing phase only, includes electronic sensor (s), any type (Eff. Date 1/1/2005)       | 04 |
| L5858 | Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type (Eff. Date 1/1/2006)       | 04 |
| L5859 | Addition to lower extremity prosthesis, endoskeletal knee-shin system, powered and programmable flexion/extension assist control, includes any type motor(s) (Eff. Date 1/1/2013)            | 04 |
| L5910 | Addition, endoskeletal system, below knee, alignable system  | 04 |
| L5920 | Addition, endoskeletal system, above knee or hip disarticulation, alignable system   | 04 |
| L5925 | Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual lock  | 04 |
| L5926 | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type (Eff. Date 01/01/2024)                       | 04 |
| L5930 | Addition, endoskeletal system, high activity knee control frame  | 04 |
| L5940 | Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)  | 04 |
| L5950 | Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)  | 04 |
| L5960 | Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)   | 04 |
| L5961 | Addition, endoskeletal system, polycentric hip joint, pneumatic or hydraulic control, rotation control, with or without flexion and/or extension control (Eff. Date 1/1/2011)                | 04 |
| L5962 | Addition, endoskeletal system, below knee, flexible protective outer surface covering system   | 04 |
| L5964 | Addition, endoskeletal system, above knee, flexible protective outer surface covering system   | 04 |
| L5966 | Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system  | 04 |
| L5968 | Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature   | 04 |

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| L5969 | Addition, endoskeletal ankle-foot or ankle system, power assist, includes any type motor(s) (Eff. Date 01/01/2014)   | 04 |
| L5970 | All lower extremity prostheses, foot, external keel, sach foot   | 04 |
| L5971 | All lower extremity prosthesis, solid ankle cushion heel (sach) foot, replacement only (Eff. Date 1/1/2006)  | 04 |
| L5972 | All lower extremity prostheses, foot, flexible keel (Updated 01/01/2013)   | 04 |
| L5973 | Endoskeletal ankle foot system, microprocessor controlled feature, dorsiflexion and/or plantar flexion control, includes power source (Eff. Date 1/1/2010) | 04 |
| L5974 | All lower extremity prostheses, foot, single axis ankle/foot   | 04 |
| L5975 | All lower extremity prosthesis, combination single axis ankle and flexible keel foot   | 04 |
| L5976 | All lower extremity prostheses, energy storing foot (seattle carbon copy ii or equal)  | 04 |
| L5978 | All lower extremity prostheses, foot, multiaxial ankle/foot  | 04 |
| L5979 | All lower extremity prostheses, multi-iaxial ankle, dynamic response foot, one piece system  | 04 |
| L5980 | All lower extremity prostheses, flex foot system   | 04 |
| L5981 | All lower extremity prostheses, flex-walk system or equal  | 04 |
| L5982 | All exoskeletal lower extremity prostheses, axial rotation unit  | 04 |
| L5984 | All endoskeletal lower extremity prosthesis, axial rotation unit, with or without adjustability  | 04 |
| L5985 | All endoskeletal lower extremity protheses, dynamic prosthetic pylon   | 04 |
| L5986 | All lower extremity prostheses, multi-axial rotation unit ('mcp' or equal)   | 04 |
| L5987 | All lower extremity prosthesis, shank foot system with vertical loading pylon  | 04 |
| L5988 | Addition to lower limb prosthesis, vertical shock reducing pylon feature   | 04 |
| L5990 | Addition to lower extremity prosthesis, user adjustable heel height (Eff. Date 1/1/2002)   | 04 |
| L5991 | Addition to lower extremity prostheses, osseointegrated external prosthetic connector (Eff. Date 10/01/2023)   | 04 |
| L5999 | Lower extremity prosthesis, not otherwise specified  | 14 |
| L6000 | Partial hand, thumb remaining (Eff. Date 1/1/2012)   | 04 |

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| L6010 | Partial hand, little and/or ring finger remaining (Eff. Date 1/1/2012)   | 04 |
| L6020 | Partial hand, no finger remaining (Eff. Date 1/1/2012)   | 04 |
| L6025 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device (Eff. Date 1/1/2003) (Deleted eff. 12/31/2014) | 04 |
| L6026 | Transcarpal/metacarpal or partial hand disarticulation prosthesis, external power, self-suspended, inner socket with removable forearm section, electrodes and cables, two batteries, charger, myoelectric control of terminal device, excludes terminal device(s)                   | 04 |
| L6050 | Wrist disarticulation, molded socket, flexible elbow hinges, triceps pad   | 04 |
| L6055 | Wrist disarticulation, molded socket with expandable interface, flexible elbow hinges, triceps pad   | 04 |
| L6100 | Below elbow, molded socket, flexible elbow hinge, triceps pad  | 04 |
| L6110 | Below elbow, molded socket, (muenster or northwestern suspension types)  | 04 |
| L6120 | Below elbow, molded double wall split socket, step-up hinges, half cuff  | 04 |
| L6130 | Below elbow, molded double wall split socket, stump activated locking hinge, half cuff   | 04 |
| L6200 | Elbow disarticulation, molded socket, outside locking hinge, forearm   | 04 |
| L6205 | Elbow disarticulation, molded socket with expandable interface, outside locking hinges, forearm  | 04 |
| L6250 | Above elbow, molded double wall socket, internal locking elbow, forearm  | 04 |
| L6300 | Shoulder disarticulation, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm   | 04 |
| L6310 | Shoulder disarticulation, passive restoration (complete prosthesis)  | 04 |
| L6320 | Shoulder disarticulation, passive restoration (shoulder cap only)  | 04 |
| L6350 | Interscapular thoracic, molded socket, shoulder bulkhead, humeral section, internal locking elbow, forearm   | 04 |
| L6360 | Interscapular thoracic, passive restoration (complete prosthesis)  | 04 |
| L6370 | Interscapular thoracic, passive restoration (shoulder cap only)  | 04 |
| L6380 | Immediate post surgical or early fitting, application of initial rigid dressing, including fitting alignment and suspension of components, and one cast change, wrist disarticulation or below elbow   | 04 |

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| L6382 | Immediate post surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, elbow disarticulation or above elbow                                       | 04 |  |
| L6384 | Immediate post surgical or early fitting, application of initial rigid dressing including fitting alignment and suspension of components, and one cast change, shoulder disarticulation or interscapular thoracic                         | 04 |  |
| L6386 | Immediate post surgical or early fitting, each additional cast change and realignment   | 04 |  |
| L6388 | Immediate post surgical or early fitting, application of rigid dressing only  | 04 |  |
| L6400 | Below elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping   |    |  |
| L6450 | Elbow disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping   | 04 |  |
| L6500 | Above elbow, molded socket, endoskeletal system, including soft prosthetic tissue shaping   | 04 |  |
| L6550 | Shoulder disarticulation, molded socket, endoskeletal system, including soft prosthetic tissue shaping  | 04 |  |
| L6570 | Interscapular thoracic, molded socket, endoskeletal system, including soft prosthetic tissue shaping  | 04 |  |
| L6580 | Preparatory, wrist disarticulation or below elbow, single wall plastic socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, bowden cable control, usmc or equal pylon, no cover, molded to patient model | 04 |  |
| L6582 | Preparatory, wrist disarticulation or below elbow, single wall socket, friction wrist, flexible elbow hinges, figure of eight harness, humeral cuff, bowden cable control, usmc or equal pylon, no cover, direct formed                   | 04 |  |
| L6584 | Preparatory, elbow disarticulation or above elbow, single wall plastic socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, usmc or equal pylon, no cover, molded to patient model                    | 04 |  |
| L6586 | Preparatory, elbow disarticulation or above elbow, single wall socket, friction wrist, locking elbow, figure of eight harness, fair lead cable control, usmc or equal pylon, no cover, direct formed                                      | 04 |  |
| L6588 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall plastic socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, usmc or equal pylon, no cover, molded to patient model  | 04 |  |
| L6590 | Preparatory, shoulder disarticulation or interscapular thoracic, single wall socket, shoulder joint, locking elbow, friction wrist, chest strap, fair lead cable control, usmc or equal pylon, no cover, direct formed                    | 04 |  |

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| L6600 | Upper extremity additions, polycentric hinge, pair   | 04 |
| L6605 | Upper extremity additions, single pivot hinge, pair  | 04 |
| L6610 | Upper extremity additions, flexible metal hinge, pair  | 04 |
| L6611 | Addition to upper extremity prosthesis, external powered, additional switch, any type (Eff. date 1/1/2007)   | 04 |
| L6615 | Upper extremity addition, disconnect locking wrist unit  | 04 |
| L6616 | Upper extremity addition, additional disconnect insert for locking wrist unit, each  | 04 |
| L6620 | Upper extremity addition, flexion/extension wrist unit, with or without friction   | 04 |
| L6621 | Upper extremity prosthesis addition, flexion/extension wrist with or without friction, for use with external powered terminal device (Eff. Date 1/1/2006)                                    | 04 |
| L6623 | Upper extremity addition, spring assisted rotational wrist unit with latch release   | 04 |
| L6624 | Upper extremity addition, flexion/extension and rotation wrist unit (Eff. Date 1/1/2007)   | 04 |
| L6625 | Upper extremity addition, rotation wrist unit with cable lock  | 04 |
| L6628 | Upper extremity addition, quick disconnect hook adapter, otto bock or equal  | 04 |
| L6629 | Upper extremity addition, quick disconnect lamination collar with coupling piece, otto bock or equal   | 04 |
| L6630 | Upper extremity addition, stainless steel, any wrist   | 04 |
| L6632 | Upper extremity addition, latex suspension sleeve, each  | 04 |
| L6635 | Upper extremity addition, lift assist for elbow  | 04 |
| L6637 | Upper extremity addition, nudge control elbow lock   | 04 |
| L6638 | Upper extremity addition to prosthesis, electric locking feature, only for use with manually powered elbow (Eff. Date 1/1/2003)  | 04 |
| L6640 | Upper extremity additions, shoulder abduction joint, pair  | 04 |
| L6641 | Upper extremity addition, excursion amplifier, pulley type   | 04 |
| L6642 | Upper extremity addition, excursion amplifier, lever type  | 04 |
| L6645 | Upper extremity addition, shoulder flexion-abduction joint, each   | 04 |
| L6646 | Upper extremity addition, shoulder joint, multipositional locking, flexion, adjustable abduction friction control, for use with body powered or external powered system (Eff. Date 1/1/2003) | 04 |



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| L6647 | Upper extremity addition, shoulder lock mechanism, body powered actuator (Eff. Date 1/1/2003)                               | 04 |
| L6648 | Upper extremity addition, shoulder lock mechanism, external powered actuator (Eff. Date 1/1/2003)                           | 04 |
| L6650 | Upper extremity addition, shoulder universal joint, each  | 04 |
| L6655 | Upper extremity addition, standard control cable, extra   | 04 |
| L6660 | Upper extremity addition, heavy duty control cable  | 04 |
| L6665 | Upper extremity addition, teflon, or equal, cable lining  | 04 |
| L6670 | Upper extremity addition, hook to hand, cable adapter   | 04 |
| L6672 | Upper extremity addition, harness, chest or shoulder, saddle type   | 04 |
| L6675 | Upper extremity addition, harness, (e.g., figure of eight type), single cable design  | 04 |
| L6676 | Upper extremity addition, harness, (e.g., figure of eight type), dual cable design  | 04 |
| L6677 | Upper extremity addition, harness, triple control, simultaneous operation of terminal device and elbow (Eff. Date 1/1/2006) | 04 |
| L6680 | Upper extremity addition, test socket, wrist disarticulation or below elbow   | 04 |
| L6682 | Upper extremity addition, test socket, elbow disarticulation or above elbow   | 04 |
| L6684 | Upper extremity addition, test socket, shoulder disarticulation or interscapular thoracic                                   | 04 |
| L6686 | Upper extremity addition, suction socket  | 04 |
| L6687 | Upper extremity addition, frame type socket, below elbow or wrist disarticulation   | 04 |
| L6688 | Upper extremity addition, frame type socket, above elbow or elbow disarticulation   | 04 |
| L6689 | Upper extremity addition, frame type socket, shoulder disarticulation   | 04 |
| L6690 | Upper extremity addition, frame type socket, interscapular-thoracic   | 04 |
| L6691 | Upper extremity addition, removable insert, each  | 04 |
| L6692 | Upper extremity addition, silicone gel insert or equal, each  | 04 |
| L6693 | Upper extremity addition, locking elbow, forearm counterbalance   | 04 |

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| L6694 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, for use with locking mechanism (Eff. Date 1/1/2005)   | 04 |
| L6695 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated from existing mold or prefabricated, socket insert, silicone gel, elastomeric or equal, not for use with locking mechanism (Eff. Date 1/1/2005)   | 04 |
| L6696 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) (Eff. Date 1/1/2005)            | 04 |
| L6697 | Addition to upper extremity prosthesis, below elbow/above elbow, custom fabricated socket insert for other than congenital or atypical traumatic amputee, silicone gel, elastomeric or equal, for use with or without locking mechanism, initial only (for other than initial, use code L6694 or L6695) (Eff. Date 1/1/2005) | 04 |
| L6698 | Addition to upper extremity prosthesis, below elbow/above elbow, lock mechanism, excludes socket insert (Eff. Date 1/1/2005)   | 04 |
| L6703 | Terminal device, passive hand/mitt, any material, ant size (Eff. date 1/1/2007)  | 04 |
| L6704 | Terminal device, sport/recreation/work attachment, any material, any size (Eff. date 1/1/2007)   | 04 |
| L6706 | Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined (Eff. Date 1/1/2007)  | 04 |
| L6707 | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined (Eff. Date 1/1/2007)  | 04 |
| L6708 | Terminal device, hand, mechanical, voluntary opening, any material, any size (Eff. Date 1/1/2007)  | 04 |
| L6709 | Terminal device, hand, mechanical, voluntary closing, any material, any size (Eff. Date 1/1/2007)  | 04 |
| L6711 | Terminal device, hook, mechanical, voluntary opening, any material, any size, lined or unlined, pediatric (Eff. Date 1/1/2009)   | 04 |
| L6712 | Terminal device, hook, mechanical, voluntary closing, any material, any size, lined or unlined, pediatric (Eff. Date 1/1/2009)   | 04 |
| L6713 | Terminal device, hand, mechanical, voluntary opening, any material, any size, pediatric (Eff. Date 1/1/2009)   | 04 |
| L6714 | Terminal device, hand, mechanical, voluntary closing, any material, any size, pediatric (Eff. Date 1/1/2009)   | 04 |
| L6715 | Terminal device, multiple articulating digit. Includes motor(s), initial issue or replacement (Eff. Date 1/1/2012)   | 04 |

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| L6721 | Terminal device, hook or hand, heavy duty, mechanical, voluntary opening, any material, any size, lined or unlined (Eff. Date 1/1/2009)   | 04 |
| L6722 | Terminal device, hook or hand, heavy duty, mechanical, voluntary closing, any material, any size, lined or unlined (Eff. Date 1/1/2009)   | 04 |
| L6805 | Addition to terminal device, modifier wrist unit  | 04 |
| L6810 | Addition to terminal device, precision pinch device   | 04 |
| L6880 | Electric hand, switch or myoelectric controlled, independently articulating digits, any grasp pattern or combination or grasp patterns, includes motor(s) (Eff. Date 1/1/2012)                              | 04 |
| L6881 | Automatic grasp feature, addition to upper limb electric prosthetic terminal device (Eff. Date 1/1/2002)  | 04 |
| L6882 | Microprocessor control feature, addition to upper limb prosthetic terminal device (Eff. Date 1/1/2002)  | 04 |
| L6883 | Replacement socket, below elbow/wrist disarticulation, molded to patient model, for use with or without external power (Eff. Date 1/1/2006)   | 04 |
| L6884 | Replacement socket, above elbow/elbow disarticulation, molded to patient model, for use with or without external power (Eff. Date 1/1/2006)   | 04 |
| L6885 | Replacement socket, shoulder disarticulation/interscapular thoracic, molded to patient model, for use with or without external power (Eff. Date 1/1/2006)   | 04 |
| L6890 | Addition to upper extremity prosthesis, glove for terminal device, any material, prefabricated, includes fitting and adjustment   | 04 |
| L6895 | Addition to upper extremity prosthesis, glove for terminal device, any material, custom fabricated  | 04 |
| L6900 | Hand restoration (casts, shading and measurements included), partial hand, with glove, thumb or one finger remaining  | 04 |
| L6905 | Hand restoration (casts, shading and measurements included), partial hand, with glove, multiple fingers remaining   | 04 |
| L6910 | Hand restoration (casts, shading and measurements included), partial hand, with glove, no fingers remaining   | 04 |
| L6915 | Hand restoration (shading, and measurements included), replacement glove for above  | 04 |
| L6920 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal, switch, cables, two batteries and one charger, switch control of terminal device           | 04 |
| L6925 | Wrist disarticulation, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | 04 |

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| L6930 | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device   | 04 |
| L6935 | Below elbow, external power, self-suspended inner socket, removable forearm shell, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device  | 04 |
| L6940 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device  | 04 |
| L6945 | Elbow disarticulation, external power, molded inner socket, removable humeral shell, outside locking hinges, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device                                 | 04 |
| L6950 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device  | 04 |
| L6955 | Above elbow, external power, molded inner socket, removable humeral shell, internal locking elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device   | 04 |
| L6960 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device          | 04 |
| L6965 | Shoulder disarticulation, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal      | 04 |
| L6970 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal switch, cables, two batteries and one charger, switch control of terminal device            | 04 |
| L6975 | Interscapular-thoracic, external power, molded inner socket, removable shoulder shell, shoulder bulkhead, humeral section, mechanical elbow, forearm, otto bock or equal electrodes, cables, two batteries and one charger, myoelectronic control of terminal device | 04 |
| L7007 | Electric hand, switchor myoelectric controlled, adult (Eff. date 1/1/2007)   | 04 |
| L7008 | Electric hand, switchor myoelectric controlled, pediatric (Eff. date 1/1/2007)   | 04 |
| L7009 | Electric hand, switchor myoelectric controlled, adult (Eff. date 1/1/2007)   | 04 |

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| L7040 | Prehensile actuator, switch controlled   | 04 |
| L7045 | Electronic hook, switch or myoelectric controlled, pediatric   | 04 |
| L7170 | Electronic elbow, hosmer or equal, switch controlled   | 04 |
| L7180 | Electronic elbow, microprocessor sequential control of elbow and terminal device   | 04 |
| L7181 | Electronic elbow, microprocessor simultaneous control of elbow and terminal device (Eff. Date 1/1/2005)  | 04 |
| L7185 | Electronic elbow, adolescent, variety village or equal, switch controlled  | 04 |
| L7186 | Electronic elbow, child, variety village or equal, switch controlled   | 04 |
| L7190 | Electronic elbow, adolescent, variety village or equal, myoelectronically controlled   | 04 |
| L7191 | Electronic elbow, child, variety village or equal, myoelectronically controlled  | 04 |
| L7259 | Electronic wrist rotator, any type (Eff. Date 01/01/2015)  | 04 |
| L7260 | Electronic wrist rotator, otto bock or equal (Deleted eff. 12/31/2014)   | 04 |
| L7261 | Electronic wrist rotator, for Utah arm (Deleted eff. 12/31/2014)   | 04 |
| L7266 | Servo control, steeper or equal (Deleted eff. 12/31/2011)  | 04 |
| L7272 | Analogue control, unb or equal (Deleted eff. 12/31/2011)   | 04 |
| L7274 | Proportional control, 6-12 volt, liberty, Utah or equal (Deleted eff. 12/31/2011)  | 04 |
| L7360 | Six volt battery, each (Updated 1/1/2008)  | 04 |
| L7362 | Battery charger, six volt, each (Updated 1/1/2008)   | 04 |
| L7364 | Twelve volt battery, each (Updated 1/1/2008)   | 04 |
| L7366 | Twelve volt battery, each (Updated 1/1/2008)   | 04 |
| L7367 | Lithium ion battery, rechargeable, replacement (Eff. Date 01/01/2003)  | 04 |
| L7368 | Lithium ion battery charger, replacement only (Eff. Date 1/1/2012)   | 04 |
| L7400 | Addition to upper extremity prosthesis, below elbow/wrist disarticulation<br>ultralight material (titanium, carbon fiber, or equal) (Eff. Date 1/1/2006) | 04 |
| L7401 | Addition to upper extremity prosthesis, above elbow disarticulation, ultralight material (titanium, carbon fiber, or equal) (Eff. Date 1/1/2006)         | 04 |

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| L7402 | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, ultralight material (titanium, carbon fiber or equal) (Eff. Date 1/1/2006) | 04 |
| L7403 | Addition to upper extremity prosthesis, below elbow/wrist disarticulation, acrylic material (Eff. Date 1/1/2006)  | 04 |
| L7404 | Addition to upper extremity prosthesis, above elbow disarticulation, acrylic material (Eff. Date 1/1/2006)  | 04 |
| L7405 | Addition to upper extremity prosthesis, shoulder disarticulation/interscapular thoracic, acrylic material (Eff. Date 1/1/2006)                                      | 04 |
| L7499 | Upper extremity prosthesis, not otherwise specified   | 14 |
| L7500 | Repair of prosthetic device, hourly rate (excludes v5335 repair of oral or laryngeal prosthesis or artificial larynx) (Deleted eff. 12/31/2011)                     | 04 |
| L7510 | Repair of prosthetic device, repair or replace minor parts  | 04 |
| L7520 | Repair prosthetic device, labor component, per 15 minutes   | 04 |
| L7600 | Prosthesis donning sleeve, any material, each (Eff. Date 1/1/2006)  | 04 |
| L7700 | Gasket or seal, for use with prosthetic socket insert, any type, each (Eff. Date 01/01/2018)  | 04 |
| L7900 | Vacuum erection system  | 04 |
| L7902 | Tension ring, for vacuum erection device, any type, replacement only, each (Eff. Date 1/1/2013)   | 04 |
| L8000 | Breast prosthesis, mastectomy bra, without integrated breast prosthesis form, any size, any type (Updated 01/01/2013)   | 04 |
| L8001 | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, unilateral, any size, any type (Eff. Date 1/1/2002) (Updated 01/01/2013)                 | 04 |
| L8002 | Breast prosthesis, mastectomy bra, with integrated breast prosthesis form, bilateral any size, any type (Eff. Date 1/1/2002) (Updated 01/01/2013)                   | 04 |
| L8010 | Breast prosthesis, mastectomy sleeve  | 04 |
| L8015 | External breast prosthesis garment, with mastectomy form, post mastectomy   | 04 |
| L8020 | Breast prosthesis, mastectomy form  | 04 |
| L8030 | Breast prosthesis, silicone or equal, without integral adhesive (Description change 1/1/2010)   | 04 |

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| L8031 | Breast prosthesis, silicone or equal, with integral adhesive (Eff. Date 1/1/2010)   | 04 |
| L8032 | Nipple prosthesis, prefabricated, reusable, any type, each (Eff. Date 1/1/2010) (Revised 1/1/2020)  | 04 |
| L8033 | Nipple prosthesis, custom fabricated, reusable, any material, any type, each (Eff. Date 1/1/2020)   | 04 |
| L8035 | Custom breast prosthesis, post mastectomy, molded to patient model  | 04 |
| L8039 | Breast prosthesis, not otherwise specified  | 14 |
| L8040 | Nasal prosthesis, provided by a non-physician (Eff. Date 1/1/2001)  | 04 |
| L8041 | Midfacial prosthesis, provided by a non-physician (Eff. Date 1/1/2001)  | 04 |
| L8042 | Orbital prosthesis, provided by a non-physician (Eff. Date 1/1/2001)  | 04 |
| L8043 | Upper facial prosthesis, provided by a non-physician (Eff. Date 1/1/2001)   | 04 |
| L8044 | Hemi-facial prosthesis, provided by a non-physician (Eff. Date 1/1/2001)  | 04 |
| L8045 | Auricular prosthesis, provided by a non-physician (Eff. Date 1/1/2001)  | 04 |
| L8046 | Partial facial prosthesis, provided by a non-physician (Eff. Date 1/1/2001)   | 04 |
| L8047 | Nasal septal prosthesis, provided by a non-physician (Eff. Date 1/1/2001)   | 04 |
| L8048 | Unspecified maxillofacial prosthesis, by report, provided by a non-physician (Eff. Date 1/1/2001)   | 04 |
| L8049 | Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a non-physician (Eff. Date 1/1/2001) | 04 |
| L8300 | Truss, single with standard pad   | 04 |
| L8310 | Truss, double with standard pads  | 04 |
| L8320 | Truss, addition to standard pad, water pad  | 04 |
| L8330 | Truss, addition to standard pad, scrotal pad  | 04 |
| L8400 | Prosthetic sheath, below knee, each   | 04 |
| L8410 | Prosthetic sheath, above knee, each   | 04 |
| L8415 | Prosthetic sheath, upper limb, each   | 04 |
| L8417 | Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each   | 04 |

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| L8420 | Prosthetic sock, multiple ply, below knee, each   | 04 |
| L8430 | Prosthetic sock, multiple ply, above knee, each   | 04 |
| L8435 | Prosthetic sock, multiple ply, upper limb, each   | 04 |
| L8440 | Prosthetic shrinker, below knee, each   | 04 |
| L8460 | Prosthetic shrinker, above knee, each   | 04 |
| L8465 | Prosthetic shrinker, upper limb, each   | 04 |
| L8470 | Prosthetic sock, single ply, fitting, below knee, each  | 04 |
| L8480 | Prosthetic sock, single ply, fitting, above knee, each  | 04 |
| L8485 | Prosthetic sock, single ply, fitting, upper limb, each  | 04 |
| L8499 | Unlisted procedure for miscellaneous prosthetic services  | 14 |
| L8500 | Artificial larynx, any type   | 04 |
| L8501 | Tracheostomy speaking valve   | 04 |
| L8505 | Artificial larynx replacement battery/accessory, any type (Eff. Date 1/1/2002)  | 04 |
| L8507 | Tracheo-esophageal voice prosthesis, patient inserted, any type, each (Eff. Date 1/1/2002)  | 04 |
| L8509 | Tracheo-esophageal voice prosthesis, inserted by a licensed health care provider, any type (Eff. Date 1/1/2002)   | 04 |
| L8510 | Voice amplifier (Eff. Date 1/1/2002)  | 04 |
| L8511 | Insert for indwelling tracheoesophageal prosthesis, with or without valve, replacement only, each (Eff. Date 1/1/2004)  | 04 |
| L8512 | Gelatin capsules or equivalent, for use with tracheoesophageal voice prosthesis, replacement only, per 10 (Eff. Date 1/1/2004)  | 04 |
| L8513 | Cleaning device used with tracheoesophageal voice prosthesis, pipet, brush or equal, replacement only, each (Eff. Date 1/1/2004)  | 04 |
| L8514 | Tracheoesophageal puncture dilator, replacement only, each (Eff. Date 1/1/2004)   | 04 |
| L8515 | Gelatin capsule application device for use with tracheoesophageal voice prosthesis, each (Eff. Date 1/1/2005)   | 04 |
| L8701 | Elbow, wrist, hand device, powered, with single or double upright(s), any type joint(s), includes microprocessor, sensors, all components and accessories (Description change 10/01/2020)         | 04 |
| L8702 | Elbow, wrist, hand, finger device, powered, with single or double upright(s), any type joint(s), includes microprocessor, sensors, all components and accessories (Description change 10/01/2020) | 04 |



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| L8720 | External lower extremity sensory prosthetic device, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg (Rev. Eff. 1/1/2025) | 04 |  |
| L8721 | Receptor sole for use with l8720, replacement, each (Eff. Date 10/01/2024)  | 04 |  |
| L9900 | Orthotic and prosthetic supply, accessory, and/or service component of another HCPCS L code   | 04 |  |

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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| Q0090 | Levonorgestrel-Releasing Intrauterine Contraceptive System (SKYLA), 13.5 mg (Eff. Date 07/01/2013) (Deleted eff. 12/31/2013)   |          |                  |
| Q0155 | Dronabinol (syndros), 0.1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Eff. Date 1/1/2025)   |          |                  |
| Q0161 | Chlorpromazine hydrochloride, 5 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Eff. Date 2014) |          |                  |
| Q0162 | Ondansetron 1mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Eff. Date 1/1/2012)                | 20       |                  |
| Q0163 | Diphenhydramine hydrochloride, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen                     | 20       |                  |
| Q0164 | Prochlorperazine maleate, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen                      | 20       |                  |

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|-------|--|----|--|
| Q0165 | Prochlorperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013)     | 20 |  |
| Q0166 | Granisetron hydrochloride, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen                               | 20 |  |
| Q0167 | Dronabinol, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen  | 20 |  |
| Q0168 | Dronabinol, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013)                    | 20 |  |
| Q0169 | Promethazine hydrochloride, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen                           | 20 |  |
| Q0170 | Promethazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013)   | 20 |  |
| Q0171 | Chlorpromazine hydrochloride, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013) | 20 |  |
| Q0172 | Chlorpromazine hydrochloride, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013) | 20 |  |
| Q0173 | Trimethobenzamide hydrochloride, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen                       | 20 |  |
| Q0174 | Thiethylperazine maleate, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen                               | 20 |  |
| Q0175 | Perphenazine, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen  | 20 |  |

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| Q0176 | Perphenazine, 8mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013)                         | 20 |  |
| Q0177 | Hydroxyzine pamoate, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen  | 20 |  |
| Q0178 | Hydroxyzine pamoate, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Deleted eff. 12/31/2013)                | 20 |  |
| Q0179 | Ondansetron hydrochloride 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen (Discontinued Deleted eff. 12/31/11) | 20 |  |
| Q0180 | Dolasetron mesylate, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen   | 20 |  |
| Q0181 | Unspecified oral dosage form, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen   | 20 |  |
| Q0184 | Dermal tissue, of human origin, with or without other bioengineered or processed elements, with metabolically active elements, per square centimeter   |    |  |
| Q0478 | Power adapter for use with electric or electric/pneumatic ventricular assist device, vehicle type (Eff. Date 1/1/2011)   |    |  |
| Q0479 | Power module for use with electric or electric/pneumatic ventricular assist device, replacement only (Eff. Date 1/1/2011)  |    |  |
| Q0499 | Belt/Vest/Bag for use to carry external peripheral components of any type ventricular assist device, replacement only (Eff. Date 10/1/05, Updated 1/1/2011)  |    |  |
| Q0510 | Pharmacy Supply fee for initial immunosuppressive drug(s), first month following implant (Eff. Date 1/1/2006)  |    |  |
| Q0511 | Pharmacy Supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s); for the first prescription in a 30 -day period (Eff. Date 1/1/2006)   |    |  |
| Q0512 | Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s): for a subsequent prescription in a 30-day period (Eff. Date 1/1/2006)   |    |  |

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|-------|---|--|--|
| Q0513 | Pharmacy dispensing fee for inhalation drug(s); per 30 days (Eff. Date 1/1/2006)  |  |  |
| Q0514 | Pharmacy dispensing fee for inhalation drug(s): per 90 days (Eff. Date 1/1/2006)  |  |  |
| Q0516 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 30-days (Eff. Date 01/02/2024) (Deleted eff. 12/31/2024)       |  |  |
| Q0517 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 60-days (Eff. Date 01/02/2024) (Deleted eff. 12/31/2024)       |  |  |
| Q0518 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription oral drug, per 90-days (Eff. Date 01/02/2024) (Deleted eff. 12/31/2024)       |  |  |
| Q0519 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days (Eff. Date 09/15/2024) (Deleted eff. 12/31/2024) |  |  |
| Q0520 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription injectable drug, per 30-days (Eff. Date 09/15/2024) (Deleted eff. 12/31/2024) |  |  |
| Q0521 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription (Eff. Date 1/1/2025)  |  |  |
| Q2009 | Injection, fosphenytoin, 50 mg phenytoin equivalent (Description change 1/1/2010)   |  |  |
| Q2025 | Fludarabine phosphate, oral, 1 mg (Eff. Date 07/01/2010) (Deleted eff. 12/31/2010)  |  |  |
| Q2045 | Inejction, human fibrinogen concentrate, 1 mg (Eff. Date 07/01/2012) (Deleted eff. 12/31/2012)  |  |  |
| Q2046 | Inection, aflibercept, 1 mg (Eff. Date 07/01/2012) (Deleted eff. 12/31/2012)  |  |  |
| Q2047 | Injection, peginesatide, 0.1 mg (for ESRD on dialysis) (Eff. Date 07/01/2012) (Deleted eff. 12/31/2012)   |  |  |
| Q2048 | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg (Eff. Date 07/01/2012) (Deleted eff. 12/31/2012)  |  |  |
| Q2049 | Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg (Eff. Date 07/01/2012)   |  |  |
| Q2050 | Injection, Doxorubicin Hydrochloride, Liposomal, Not Otherwise Specified, 10 mg (Eff. Date 07/01/2013)  |  |  |
| Q2051 | Injection, Zoledronic Acid, not otherwise specified, 1 mg (Eff. Date 07/01/2013) (Deleted eff. 12/31/2013)  |  |  |

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|-------|---|----|--|
| Q2052 | Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig) (Revised eff. 01/01/2024)                                 |    |  |
| Q4074 | Iloprost, inhalation solution, fda-approved final product, non-compounded, administered through dme, unit dose form, up to 20 micrograms                                    | 15 |  |
| Q4081 | Injection, Epoetin alfa, 100 units (for ESRD on Dialysis) (Eff. Date 1/1/2007)  | 18 |  |
| Q5101 | Injection, filgrastim-sndz, biosimilar, (zarxio), 1 microgram (Eff. Date 03/06/2015) (Revised Date 04/01/2018)  |    |  |
| Q5102 | Injection, Infliximab, Biosimilar, 10 mg (Eff. Date 04/05/2016) (Deleted eff. 03/31/2018)   |    |  |
| Q5103 | Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg (Eff. Date 04/01/2018)   |    |  |
| Q5104 | Injection, infliximab-abda, biosimilar, (renflexis), 10 mg (Eff. Date 04/01/2018)   |    |  |
| Q5105 | Injection, epoetin alfa, biosimilar, (Retacrit) (for esrd on dialysis), 100 units (Eff. date 07/01/2018)  |    |  |
| Q5106 | Injection, epoetin alfa-epbx, biosimilar, (retacrit) (for non-esrd use), 1000 units (Eff. date 07/01/2018) (Revised 1/1/2020)   |    |  |
| Q5107 | Injection, bevacizumab-awwb, biosimilar, (mvasi), 10 mg (Eff. Date 1/1/2019)  |    |  |
| Q5108 | Injection, pegfilgrastim-jmdb, biosimilar, (fulphila), 0.5 mg (Eff. Date 07/12/2018) Injection, pegfilgrastim-jmdb (fulphila), biosimilar, 0.5 mg (Revised eff. 04/01/2023) |    |  |
| Q5109 | Injection, infliximab-qbtx, biosimilar, (ixifi), 10 mg (Eff. Date 1/1/2019)   |    |  |
| Q5110 | Injection, filgrastim-aafi, biosimilar, (nivestym), 1 microgram (Eff. Date 10/01/2018)  |    |  |
| Q5111 | Injection, pegfilgrastim-cbqv, biosimilar, (udenyca), 0.5 mg (Eff. Date 1/1/2019) Injection, pegfilgrastim-cbqv (udenyca), biosimilar, 0.5 mg (Revised eff. 04/01/2023)     |    |  |
| Q5112 | Injection, trastuzumab-dttb, biosimilar, (Ontruzant), 10 mg (Eff. Date 07/01/2019)  |    |  |
| Q5113 | Injection, trastuzumab-pkrb, biosimilar, (Herzuma), 10 mg (Eff. Date 07/01/2019)  |    |  |
| Q5114 | Injection, Trastuzumab-dkst, biosimilar, (Ogivri), 10 mg (Eff. Date 07/01/2019)   |    |  |
| Q5115 | Injection, rituximab-abbs, biosimilar, (Truxima), 10 mg (Eff. Date 07/01/2019)  |    |  |

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| Q5116 | Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg (Eff. Date 10/01/2019)  |  |  |
| Q5117 | Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg (Eff. Date 10/01/2019)   |  |  |
| Q5118 | Injection, bevacizumab-bvzr, biosimilar, (Zirabev), 10 mg (Eff. Date 10/01/2019)  |  |  |
| Q5119 | Injection, rituximab-pvvr, biosimilar, (ruxience), 10 mg (Eff. Date 07/01/2020)   |  |  |
| Q5120 | Injection, pegfilgrastim-bmez, biosimilar, (ziextenzo), 0.5 mg (Eff. Date 07/01/2020) Injection, pegfilgrastim-bmez (ziextenzo), biosimilar, 0.5 mg (Revised eff. 04/01/2023) |  |  |
| Q5121 | Injection, infliximab-axxq, biosimilar, (avsola), 10 mg (Eff. Date 07/01/2020)  |  |  |
| Q5122 | Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg (Eff. Date 01/01/2021) Injection, pegfilgrastim-apgf (nyvepria), biosimilar, 0.5 mg (Revised 04/01/2023)        |  |  |
| Q5123 | Injection, rituximab-arrx, biosimilar, (riabni), 10 mg (Eff. Date 07/01/2021)   |  |  |
| Q5131 | Injection, adalimumab-aacf (idacio), biosimilar, 20 mg (Eff. Date 07/01/2023) (Deleted eff. 12/31/2024)   |  |  |
| Q5132 | Injection, adalimumab-afzb (abrilada), biosimilar, 10 mg (Eff. Date 01/01/2024) (Deleted eff. 12/31/2024)   |  |  |
| Q5133 | Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg (Eff. Date 04/01/2024)  |  |  |
| Q5134 | Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg (Eff. Date 04/01/2024)   |  |  |
| Q5135 | Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg (Eff. Date 10/01/2024)   |  |  |
| Q5136 | Injection, denosumab-bbdz (jubonti/wyost), biosimilar, 1 mg (Eff. Date 10/01/2024)  |  |  |
| Q5137 | Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg (Eff. Date 07/01/2024)  |  |  |
| Q5138 | Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg (Eff. Date 07/01/2024)   |  |  |
| Q5139 | Injection, eculizumab-aeeb (bkemv), biosimilar, 10 mg (Eff. Date 1/1/2025)  |  |  |
| Q5140 | Injection, adalimumab-fkjp, biosimilar, 1 mg (Eff. Date 1/1/2025)   |  |  |
| Q5141 | Injection, adalimumab-aaty, biosimilar, 1 mg (Eff. Date 1/1/2025)   |  |  |

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|-------|---|----|--|
| Q5142 | Injection, adalimumab-ryvk biosimilar, 1 mg (Eff. Date 1/1/2025)  |    |  |
| Q5143 | Injection, adalimumab-adbm, biosimilar, 1 mg (Eff. Date 1/1/2025)   |    |  |
| Q5144 | Injection, adalimumab-aacf (idacio), biosimilar, 1 mg (Eff. Date 1/1/2025)  |    |  |
| Q5145 | Injection, adalimumab-afzb (abrilada), biosimilar, 1 mg (Eff. Date 1/1/2025)  |    |  |
| Q5146 | Injection, trastuzumab-strf (hercessi), biosimilar, 10 mg (Eff. Date 1/1/2025)  |    |  |
| Q9977 | Compounded Drug, Not Otherwise Classified (Eff. Date 07/01/15) (Deleted eff. 12/31/2015)                                      | 14 |  |
| Q9978 | Netupitant 300 mg and Palonosetron 0.5 mg, oral (Eff. Date 07/01/15) (Deleted eff.12/31/2015)                                 | 20 |  |
| Q9979 | Injection, Alemtuzumab, 1 mg (Deleted eff.12/31/2015)   |    |  |
| Q9981 | Rolapitant, Oral, 1mg (Eff. Date 07/01/2016) (Deleted eff. 12/31/2016)  | 20 |  |
| Q9985 | Injection, hydroxyprogesterone caproate, not otherwise specified, 10 mg (Eff. Date 07/01/2017) (Deleted eff. 12/31/2017)      |    |  |
| Q9986 | Injection, hydroxyprogesterone caproate (Makena), 10 mg (Eff. Date 07/01/2017) (Deleted eff. 12/31/2017)                      |    |  |
| Q9989 | Ustekinumab, for Intravenous Injection, 1 mg (Eff. Date 07/01/2017) (Deleted eff. 12/31/2017)                                 |    |  |
| Q9991 | Injection, buprenorphine extended-release (sublocade), less than or equal to 100 mg (Eff. Date 07/01/2018)                    |    |  |
| Q9992 | Injection, buprenorphine extended-release (sublocade), greater than 100 mg (Eff. Date 07/01/2018)                             |    |  |
| Q9993 | Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg (Eff. Date 07/01/2018) |    |  |
| Q9994 | In-line cartridge containing digestive enzyme(s) for enteral feeding, each (Eff. Date 07/01/2018) (Deleted eff. 12/31/2018)   |    |  |
| Q9995 | Injection, emicizumab-kxwh, 0.5 mg (Eff. Date 07/01/2018)   |    |  |



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| Payment Category |                               |    |                                      |    |  |
|------------------|-------------------------------|----|--------------------------------------|----|--|
| 1                | Capped Rental                 | 8  | Parenteral/Enteral Supplies and Kits | 15 | Nebulizer Drugs                        |
| 2                | Freq. & Substantial Serv. DME | 9  | Parenteral/Enteral Pumps             | 16 | Therapeutic Shoes for Diabetics        |
| 3                | Customized DMEPOS             | 10 | Immunosuppressive Drugs              | 17 | Individual Consideration               |
| 4                | Prosthetics/Orthotics         | 11 | Ostomy, Trach., & Urologicals        | 18 | Epoetin (EPO)                          |
| 5                | Inexp. & Routinely Purch. DME | 12 | Surgical Dressings                   | 19 | Dialysis Supplies & Equipment          |
| 6                | Oxygen and Oxygen Equipment   | 13 | Supplies                             | 20 | Oral Antiemetic Drugs                  |
| 7                | Parenteral/Enteral Nutrients  | 14 | Not Otherwise Classified             | 21 | Value Not Established                  |
|                  |                               |    |                                      | 22 | Lymphedema Compression Treatment Items |

| Code  | Description  | Category | CMN/DIF Required |
|-------|--|----------|------------------|
| V2020 | Frames, purchases  | 04       |                  |
| V2025 | Deluxe frame   | 04       |                  |
| V2100 | Sphere, single vision, plano to plus or minus 4.00, per lens   | 04       |                  |
| V2101 | Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens   | 04       |                  |
| V2102 | Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens  | 04       |                  |
| V2103 | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens                | 04       |                  |
| V2104 | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens               | 04       |                  |
| V2105 | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens               | 04       |                  |
| V2106 | Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens                  | 04       |                  |
| V2107 | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, .12 to 2.00d cylinder, per lens    | 04       |                  |
| V2108 | Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens | 04       |                  |
| V2109 | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens  | 04       |                  |

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|-------|---|----|
| V2110 | Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens                    | 04 |
| V2111 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens   | 04 |
| V2112 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens | 04 |
| V2113 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens  | 04 |
| V2114 | Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens   | 04 |
| V2115 | Lenticular, (myodisc), per lens, single vision  | 04 |
| V2118 | Aniseikonic lens, single vision   | 04 |
| V2121 | Lenticular lens, per lens, single (Eff. Date 1/1/2004)  | 04 |
| V2199 | Not otherwise classified, single vision lens  | 04 |
| V2200 | Sphere, bifocal, plano to plus or minus 4.00d, per lens   | 04 |
| V2201 | Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens  | 04 |
| V2202 | Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens   | 04 |
| V2203 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens                       | 04 |
| V2204 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens                      | 04 |
| V2205 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens                      | 04 |
| V2206 | Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens                         | 04 |
| V2207 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens          | 04 |
| V2208 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens         | 04 |
| V2209 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens         | 04 |
| V2210 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens            | 04 |
| V2211 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens         | 04 |
| V2212 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens       | 04 |

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|       | sphere, 2.25 to 4.00d cylinder, per lens  |    |  |
| V2213 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens  | 04 |  |
| V2214 | Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens   | 04 |  |
| V2215 | Lenticular (myodisc), per lens, bifocal   | 04 |  |
| V2218 | Aniseikonic, per lens, bifocal  | 04 |  |
| V2219 | Bifocal seg width over 28 mm  | 04 |  |
| V2220 | Bifocal add over 3.25d  | 04 |  |
| V2221 | Lenticular lens, per lens, bifocal (Eff. Date 1/1/2004)   | 04 |  |
| V2299 | Specialty bifocal (by report)   | 04 |  |
| V2300 | Sphere, trifocal, plano to plus or minus 4.00d, per lens  | 04 |  |
| V2301 | Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d, per lens   | 04 |  |
| V2302 | Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00, per lens   | 04 |  |
| V2303 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, .12-2.00d cylinder, per lens                   | 04 |  |
| V2304 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25-4.00d cylinder, per lens                  | 04 |  |
| V2305 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00 cylinder, per lens                | 04 |  |
| V2306 | Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens                  | 04 |  |
| V2307 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, .12 to 2.00d cylinder, per lens   | 04 |  |
| V2308 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens  | 04 |  |
| V2309 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens  | 04 |  |
| V2310 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens     | 04 |  |
| V2311 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, .25 to 2.25d cylinder, per lens  | 04 |  |
| V2312 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens | 04 |  |
| V2313 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d  | 04 |  |

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|       | sphere, 4.25 to 6.00d cylinder, per lens   |    |  |
| V2314 | Spherocylinder, trifocal, sphere over plus or minus 12 .00d, per lens                        | 04 |  |
| V2315 | Lenticular, (myodisc), per lens, trifocal  | 04 |  |
| V2318 | Aniseikonic lens, trifocal   | 04 |  |
| V2319 | Trifocal seg width over 28 mm  | 04 |  |
| V2320 | Trifocal add over 3.25d  | 04 |  |
| V2321 | Lenticular lens, per lens, trifocal (Eff. Date 1/1/2004)                                     | 04 |  |
| V2399 | Specialty trifocal (by report)   | 04 |  |
| V2410 | Variable asphericity lens, single vision, full field, glass or plastic, per lens             | 04 |  |
| V2430 | Variable asphericity lens, bifocal, full field, glass or plastic, per lens                   | 04 |  |
| V2499 | Variable sphericity lens, other type   | 04 |  |
| V2500 | Contact lens, PMMA, spherical, per lens  | 04 |  |
| V2501 | Contact lens, PMMA, toric or prism ballast, per lens   | 04 |  |
| V2502 | Contact lens, PMMA, bifocal, per lens  | 04 |  |
| V2503 | Contact lens, PMMA, color vision deficiency, per lens  | 04 |  |
| V2510 | Contact lens, gas permeable, spherical, per lens   | 04 |  |
| V2511 | Contact lens, gas permeable, toric, prism ballast, per lens                                  | 04 |  |
| V2512 | Contact lens, gas permeable, bifocal, per lens   | 04 |  |
| V2513 | Contact lens, gas permeable, extended wear, per lens   | 04 |  |
| V2520 | Contact lens, hydrophilic, spherical, per lens   | 04 |  |
| V2521 | Contact lens, hydrophilic, toric, or prism ballast, per lens                                 | 04 |  |
| V2522 | Contact lens, hydrophilic, bifocal, per lens   | 04 |  |
| V2523 | Contact lens, hydrophilic, extended wear, per lens   | 04 |  |
| V2524 | Contact lens, hydrophilic, spherical, photochromic additive, per lens (Eff. Date 10/01/2020) | 04 |  |
| V2525 | Contact lens, hydrophilic, dual focus, per lens (Eff. Date 04/01/2022)                       |    |  |
| V2526 | Contact lens, hydrophilic, with blue-violet filter, per lens (Eff. Date 10/01/2023)          |    |  |
| V2530 | Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)  | 04 |  |

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| V2531 | Contact lens, scleral, gas permeable, per lens (for contact lens modification, see 92325)  | 04 |
| V2599 | Contact lens, other type   | 04 |
| V2600 | Hand held low vision aids and other nonspectacle mounted aids  | 04 |
| V2610 | Single lens spectacle mounted low vision aids  | 04 |
| V2615 | Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens system | 04 |
| V2623 | Prosthetic eye, plastic, custom  | 04 |
| V2624 | Polishing/resurfacing of ocular prosthesis   | 04 |
| V2625 | Enlargement of ocular prosthesis   | 04 |
| V2626 | Reduction of ocular prosthesis   | 04 |
| V2627 | Scleral cover shell  | 04 |
| V2628 | Fabrication and fitting of ocular conformer  | 04 |
| V2629 | Prosthetic eye, other type   | 04 |
| V2630 | Anterior chamber intraocular lens  | 04 |
| V2631 | Iris supported intraocular lens  | 04 |
| V2632 | Posterior chamber intraocular lens   | 04 |
| V2700 | Balance lens, per lens   | 04 |
| V2702 | Deluxe lens feature (Eff. Date 1/1/2005)   | 04 |
| V2710 | Slab off prism, glass or plastic, per lens   | 04 |
| V2715 | Prism, per lens  | 04 |
| V2718 | Press-on lens, fresnell prism, per lens  | 04 |
| V2730 | Special base curve, glass or plastic, per lens   | 04 |
| V2744 | Tint, photochromatic, per lens   | 04 |
| V2745 | Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens (Eff. Date 1/1/2004)       | 04 |
| V2750 | Anti-reflective coating, per lens  | 04 |
| V2755 | U-V lens, per lens   | 04 |
| V2756 | Eye glass case (Eff. Date 1/1/2004)  | 04 |
| V2760 | Scratch resistant coating, per lens  | 04 |

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| V2761 | Mirror coating, any type, solid, gradient or equal, any lens material, per lens (Eff. Date 1/1/2004)   | 04 |
| V2762 | Polarization, any lens material, per lens (Eff. Date 1/1/2004)   | 04 |
| V2770 | Occluder lens, per lens  | 04 |
| V2780 | Oversize lens, per lens  | 04 |
| V2781 | Progressive lens, per lens   | 04 |
| V2782 | Lens index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens (Eff. Date 1/1/2004)                                   | 04 |
| V2783 | Lens index greater than or equal to 1.66 plastic or greater than or equal to 1.80 glass, excludes polycarbonate, per lens (Eff. Date 1/1/2004) | 04 |
| V2784 | Lens, polycarbonate or equal, any index, per lens (Eff. Date 1/1/2004)   | 04 |
| V2785 | Processing, preserving and transporting corneal tissue   | 04 |
| V2786 | Specialty occupational multifocal lens, per lens (Eff. Date 1/1/2004)  | 04 |
| V2797 | Vision supply, accessory and/or services component of another HCPCS vision code (Eff. Date 1/1/2004)   | 04 |
| V2799 | Vision item or service, miscellaneous (Updated 01/01/2015)   | 04 |
| V5336 | Repair/modification of augmentative communicative system or device (excludes adaptive hearing aid)   | 14 |