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DME MAC JURISDICTION C SUPPLIER MANUAL
WINTER 2023 UPDATE

We IMPACT lives.

January 2023

Dear Supplier:

The Winter 2023 version of the *DME MAC Jurisdiction C Supplier Manual* has been released. Please read the updated manual carefully. The *DME MAC Jurisdiction C 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 in order to ensure that you are using the most recent version. You can find the latest version of the Supplier Manual on our website at http://www.cgsmedicare.com/jc/pubs/supman/index.html.

Please be sure to visit the "News" page on our website (https://www.cgsmedicare.com/jc/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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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

WINTER 2023

DME MAC Jurisdiction C

SUPPLIER MANUAL

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CMS
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Welcome

Welcome to the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction C Supplier Manual. This manual is provided for suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) who serve beneficiaries in Jurisdiction C. 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 C 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/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html (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 C. Jurisdiction C includes Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia.

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 C 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 2023 is $226. 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.

Our Interactive Voice Response (IVR) Unit (which can be reached at 1.866.238.9650) is available to determine current deductible status for a beneficiary. Please see Chapter 13 of this manual for more information about the IVR.

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 may contact the DME MAC Jurisdiction C IVR at 1.866.238.9650 to determine eligibility. Please see Chapter 13 of this manual for more information about the IVR.

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 HICN/MBI is missing or incorrect.

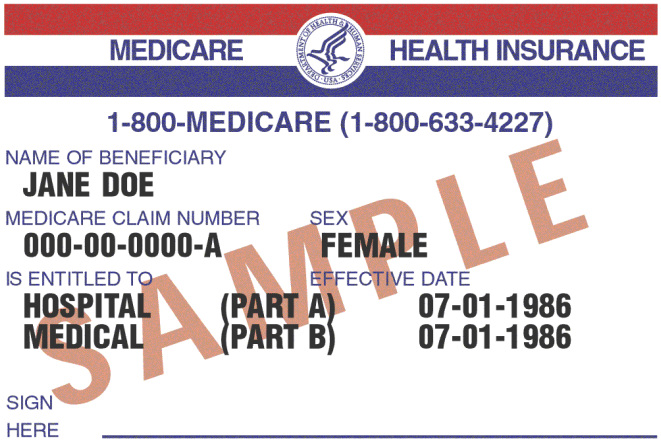
For additional information about the new Medicare Card and MBI, visit https://www.cms.gov/medicare/new-medicare-card/index.html.

7. The Medicare Card

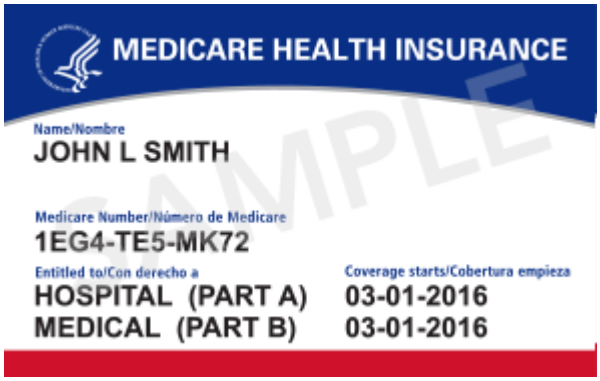
A Medicare card is issued to every person who is entitled to Medicare benefits. This card identifies the Medicare beneficiary and includes the following information:

- 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:



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



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/medicare/new-medicare-card/nmc-home.html.

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 C.

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

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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 http://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

2. National Provider Enrolment (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.

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). With regards to DMEPOS enrollment, you should submit the EFT when initially enrolling or submitting an application for an additional location. Suppliers must list the proper Medicare contractor and ensure the form has the original signature of the authorized or delegated official. Also, suppliers should submit a separate form for each Medicare contractor where it submits claims.

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

The NPE contractor's role is to simply verify the form is complete and to ensure the agreement is signed properly. Once verified, the NPE contractor will send the agreements to the appropriate DME MAC for processing. After receiving and verifying that your EFT application is complete, the DME MAC has 30 days from the date of receipt to process the application.

Again, you should only submit the CMS-588 to the NPE contractor when submitting the CMS 855S for initial enrollment or when enrolling an additional location. The NPE contractor does not enroll suppliers into the EFT program. If you need to make changes to existing EFT information, you can either update your EFT information in PECOS (https://pecos.cms.hhs.gov/) or submit your changes to the following address:

CGS
Attn: EFT-DME
PO Box 20010
Nashville, TN 37202

Note: If you are a re-enrolling supplier and not already enrolled to receive payments through electronic fund transfer, you must submit the CMS-588 form.

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 Enrolment (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 Enrolment (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 in the event that 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 DME MAC receives updated EFT banking information on a valid CMS 588 form. You can avoid this situation by immediately notifying the DME MAC 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 address below. The CMS 588 form is available on the DME MAC Jurisdiction C website at http://www.cgsmedicare.com/jc/forms.

CGS
Attn: EFT-DME
PO Box 20010
Nashville, TN 37202

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 http://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

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 requirements, along with a list of the accreditation organizations and guidance regarding the DMEPOS Quality Standards for DMEPOS suppliers, is located in the Downloads section of the CMS DMEPOS Accreditation webpage at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/DMEPOSAccreditation.html.

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.

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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), the Certificate of Medical Necessity (CMN) (if applicable), the DME MAC Information Form (DIF) (if applicable), information from the treating practitioner concerning the beneficiary's diagnosis[1], 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.

[1] 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.

Please see Chapter 4 of this manual for information regarding CMNs and DIFs. 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 5*; 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 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 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)
    - 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, or on the CMN (completed prior to 1/1/2023), 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.

Signature and date stamps are not allowed. 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.

A prescription is not considered as part of the medical record. Medical information intended to demonstrate compliance with coverage criteria may be included on the 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 it 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; or
- 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, or on the CMN (completed prior to 1/1/2023), 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 information on a supplier-prepared statement or practitioner's attestation (if applicable).

Supplier-produced records, even if signed by the treating practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.

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
- A properly completed CMN or DIF obtained prior to DOS 1/1/2023, with an appropriate length of need specified
- 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 services provided/ordered/certified be authenticated by the persons responsible for the care of the beneficiary in accordance with Medicare's policies. For example, if the practitioner's authenticated documentation corroborates the nurse's unsigned note, and the practitioner was the responsible party per Medicare's payment

policy, medical reviewers would consider signature requirements to have been met. The method used shall be a handwritten or electronic signature. Stamped signatures are not acceptable.

The *Medicare Program Integrity Manual* notes several exceptions to normal signature requirements, as listed below:

EXCEPTION 1: Facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

EXCEPTION 2: There are some circumstances for which an order does not need to be signed. For example, orders for some clinical diagnostic tests are not required to be signed. The rules in 42 CFR §410 and Pub.100-02 Chapter 15, §80.6.1 state that if the order for the clinical diagnostic test is unsigned, there must be medical documentation (e.g., a progress note) by the treating practitioner that they intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

EXCEPTION 3: Other regulations and the CMS' instructions regarding conditions of payment related to signatures (such as timeliness standards for particular benefits) take precedence. For medical review purposes, if the relevant regulation, NCD, LCD, and CMS manuals are silent on whether the signature needs to be legible or present and the signature is illegible/missing, the reviewer shall follow the guidelines listed in the *Medicare Program Integrity Manual*, Chapter 3, to discern the identity and credentials (e.g., MD, RN, etc.) of the signator. In cases where the relevant regulation, NCD, LCD, and CMS manuals have specific signature requirements, those signature requirements take precedence.

EXCEPTION 4: CMS would permit use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of their inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

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 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 approaching exhaustion, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, you must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. 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 prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request 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 their 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 either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between you and the beneficiary. The refill request 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.
- Date of refill request.
- For consumable supplies, i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.)—you must assess the quantity of each item that the beneficiary still has remaining, to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.

- For non-consumable supplies, i.e., those more durable items that are not used up but may need periodic replacement (e.g., positive airway pressure and respiratory assist devices' supplies)—you must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. You must document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).

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

Note: Some policies may require additional documentation. Refer to the appropriate LCD and related Policy Article for guidance.

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 Supplier Clearinghouse 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 either 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 either 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. 06/30/2023). Other forms will be considered invalid. The ABN form CMS-R-131 (Exp. 06/30/2023) 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. 06/30/2023) 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. When making review determinations, only entries that comply with the widely accepted Recordkeeping Principles described below will be considered. Entries that do not comply with the principles listed below will not be considered, even if such exclusion will lead to claim denial. For example, undated or unsigned entries handwritten in the margin of a document will not be considered.

Recordkeeping Principles

Both paper record and electronic health record documents containing amendments, corrections or addenda must:

1. Clearly and permanently identify any amendment, correction or delayed entry as such, and
2. Clearly indicate the date and author of any amendment, correction or delayed entry, and
3. Clearly identify all original content, without deletion.

Paper Medical Records—Corrections are generally accomplished by:

1. Using a single line strike through so the original content is still readable, and
2. The author of the alteration must sign and date the revision.

Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name. For example, the initials match the first and last name of the practitioner documented elsewhere in the medical records including typed or written identifying information.

Electronic Health Records (EHR): Records sourced from electronic systems containing amendments, corrections, or delayed entries must:

a) Distinctly identify any amendment, correction or delayed entry, and
b) Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

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 new Certificate of Medical Necessity (CMN) and/or 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 or capped rental items 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, oxygen equipment, or inexpensive or routinely purchased rental items.

A treating practitioner's order and/or new CMN (prior to DOS 1/1/2023), 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)
    c. CMN or DIF information
- 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/jc/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 10th 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 an in-person practitioner-beneficiary encounter (*the in-person visit and medical examination together are often referred to as the "face-to-face" encounter)*. 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.

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/jc/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
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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 http://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 by 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 PO2 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) No change in HCPCS	initial	1
2	Break in service > 60 days (no change in medical condition) No change in HCPCS	none	1
3	Break in service < 60 days (change in medical condition) No change in HCPCS	none	1
4	Break in service < 60 days (no change in medical condition) No change in HCPCS	none	1
5	Break in service > 60 days (change in medical condition) 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) 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) 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) 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

	HCPCS 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

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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*:

RR	Rental
NU	Purchase of new equipment. Only use if new equipment was delivered.
UE	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*:

RR	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*:

RR	Rental
KH	First rental month
KI	Second and third rental months
KJ	Fourth to the fifteenth months
BR	Beneficiary has elected to rent
BP	Beneficiary has elected to purchase

BU	Beneficiary has not informed supplier of decision after 30 days
MS	Maintenance and Servicing
NU	New Equipment
UE	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: http://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 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.

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:

BR	Beneficiary has elected to rent
BP	Beneficiary has elected to purchase
BU	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:

MS	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

elected 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.

QE	Use if the prescribed amount of oxygen is **less** than 1 LPM.
QF	Use if the prescribed amount of oxygen **exceeds** 4 LPM and portable oxygen is prescribed.
QG	Use if the prescribed amount of oxygen is **greater** than 4 LPM.
QH	Use if an oxygen conserving device is being used with an oxygen delivery system.
RR	Rental
MS	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 36th payment, you may bill on a monthly basis for furnishing oxygen contents (stationary and/or portable), but only in accordance with the following chart:

Equipment Furnished in Month 36	Monthly Contents Payment after Stationary Cap
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 36th month of continuous use of the stationary oxygen equipment begins on March 11th and ends on April 10th, you may begin billing for monthly oxygen contents that the beneficiary will use after the cap on April 11th.

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 11th and the beneficiary only uses 15 tanks from April 11th through May 10th and 15 tanks from May 11th through June 10th, you may bill for contents on April 11th and again on May 11th for contents delivered on April 11th 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. New initial Certificate of Medical Necessity (CMN)
    a. Repeat blood gas testing is not required. Enter the most recent qualifying value and test date. This test does not have to be within 30 days prior to the Initial Date. It could be the test result reported on the most recent prior CMN.
    b. There is no requirement for a physician visit that is specifically related to the completion of the CMN for replacement equipment.
3. Medical necessity documentation as outlined in the Oxygen LCD

Be sure to review the entire Oxygen LCD 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, 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 if and submit it to the DME MAC at the time that FFS coverage begins. 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 1.866.238.9650 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/jc/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.

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.

Type of Equipment	Part Being Repaired/Replaced	Allowed Units of Service (UOS)
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.

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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 PO2 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 (http://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 20010, 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 Health Insurance Claim Number (HICN) or Medicare Beneficiary ID (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 – Check the appropriate box for the patient’s marital status and whether employed or a student.

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 – This field is not required.

Item 9c – This field is not required.

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 "MCD" followed by the patient's Medicaid number.

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 Medicare Set-Aside Arrangements (WCMSA)
- 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;
- 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, diskette, 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 31st 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.

To sign up for EFT, you or your authorized representative* must complete the Authorization for Electronic Funds Transfer agreement form which can be downloaded from our website at http://www.cgsmedicare.com/jc/forms/index.html or the CMS website at http://www.cms.gov/cmsforms/downloads/CMS588.pdf. When completing the form, be sure to indicate the DME MAC Jurisdiction for which you are requesting EFT (Jurisdiction B or Jurisdiction C).

NOTE: The EFT form must be mailed in with original signatures and banking information. Faxes/copies are not accepted.

Once we receive the request, we will conduct testing with your bank. During the testing process, a bank transaction with a payment will be initiated and forwarded to the routing and account number provided on the authorization agreement received by CGS. The testing process normally takes ten business days to complete. Once the testing process is successful, the account will be activated for EFT. Deposits made to your account will transpire within 48 hours after the claim has been through the adjudication process and has reached the mandated payment floor.

**An authorized representative is an appointed official of the entity (including, but not limited to, officer, director, manager, general partner, etc.) who has been given the legal authority by the entity to enroll it in the Medicare DMEPOS supplier program, to make changes and/or updates to the*

entity's status in the DMEPOS program, and to commit the entity to fully abide by the laws, rules, and regulations of the Medicare DMEPOS program. A written appointment or delegation of authority is required to be on file with the National Provider Enrollment (NPE) contractors for all other than officers of the company and general partners. The person(s) granted the authority of authorized representative must sign the appointment as well to ensure that their signature is on file with the NPE Contractor.

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:

01	Pharmacy
04	Homeless Shelter
12	Home
13	Assisted Living Facility
14	Group Home
16	Temporary Lodging
33	Custodial Care Facility
54	Intermediate Care Facility/Individuals with Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
65	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

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, 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: http://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 http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html. **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" (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 http://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.

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 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.

Upgrade Situation	ABN Required	Required Modifier(s)	DME MAC Payment	Beneficiary Pays for Upgrade
1. Physician orders upgrade:				
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
2. Patient requests upgrade:				
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
3. Supplier provides upgrade for supplier convenience:				
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 (https://www.cgsmedicare.com/jc/forms/pdf/pwk_coversheet.pdf), available on our website at http://www.cgsmedicare.com/jc/forms/.

- 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.

For additional information, refer to MLN Matters Article MM7041 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7041.pdf and/or MLN Matters Article MM7306 at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM7306.pdf.

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 C 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 http://www.cms.gov/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 C 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 http://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
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 http://www.ngscedi.com/ under "Resource Materials." 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 http://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: http://cgsmedicare.com/jc/claims/sub/subclm.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 http://www.cgsmedicare.com/jc/claims/csi/csi.html.

Note that myCGS, the Jurisdiction C web portal, offers all the functionality you will find in CSI, plus much more. We encourage all Jurisdiction C 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 http://www.cgsmedicare.com/jc/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 http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/HETSHelp/index.html.

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 http://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 http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/AccesstoDataApplication/index.html.

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 http://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 DMEPOS benefit categories, the 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 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/jc/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, §§50.5.1-50.6 &110-140
CMS Manual System, Pub. 100-03, *Medicare National Determinations Manual*, Chapter 1, §180

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 leg, arm, 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

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 21st 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. Infusion pumps and other administration supplies are not covered 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*
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 C website, listed under Local Coverage Determinations (https://www.cgsmedicare.com/jc/coverage/LCDinfo.html).

Major Sections of an LCD

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 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

**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 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 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 other 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/jc.

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/jc/coverage/LCDinfo.html.

New LCD Request Process

The New LCD Request process is a mechanism by which interested parties within a contractor's jurisdiction can request the development of a new LCD. This process is different from the LCD Reconsideration Process.

Informal Meeting (Optional):

The process for requesting a New LCD may begin with an informal meeting in which interested parties (in the DME MAC's jurisdiction) can request to informally discuss potential New LCD Requests. These meetings are permitted but **not** required, are for educational purposes only, and allow requestors the opportunity to communicate with the DME MACs via conference call before submitting a formal LCD request. During these meetings, the requirements for valid LCD requests are reviewed. Requests for these optional, informal meetings may be submitted via email to LCDReconJC@cgsadmin.com. In the request for an informal discussion, requestors should include the following information:

1. Include the following in the subject line of the email: "Request for New LCD Call – [**Topic for New LCD**]"
2. Several options for dates and times for a call
3. Teleconference number with enough lines to accommodate a minimum of 30 participants
4. Agenda and presentation documents, including requestor participants and titles, submitted one (1) week in advance of the call
5. Summary information (1-2 paragraphs, maximum) for the LCD request

Request Submission Criteria (Required):

Following the voluntary informal discussion, should the requestor wish to continue with submission of a formal new LCD request, a valid request must include all of 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
    - 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 Medicare benefit category.

4. Identify the language that 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 that addresses the relevance, usefulness, clinical health outcomes, or the medical benefits of the item or service in the Medicare-eligible population.

7. Must include information that fully explains the design, purpose, and/or method, as appropriate, of using the item or service for which the request is made.

The DME MACs prefer that formal new LCD requests be submitted in the format of a letter (PDF). Please ensure that the formal request letter (PDF) you submit is 508-compliant. Requests should not contain beneficiary protected health information (PHI) or personally identifiable information (PII).

The level of evidence required for LCD development may be found in the CMS *Program Integrity Manual*, Chapter 13.

The DME MAC 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.

***How to Submit New LCD Requests**:*

For your convenience, CGS has prepared forms that you may fill out and submit with your request. These forms are optional; however, they will assist you in ensuring the requirements for a complete request are met.

Informal Teleconference request form:
https://www.cgsmedicare.com/pdf/dme/jc_request_for_informal_call.pdf

LCD request form: https://www.cgsmedicare.com/pdf/dme/jc_new_lcd_request.pdf

New LCD requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Below lists pertinent information for each of the three methods:

1. **Email (Preferred Method)**: LCDReconJC@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 LCDReconJC@cgsadmin.com for alternative methods for submitting large electronic files or if you have difficulty submitting a new LCD request.

2. **Fax:** 615.664.5955
   - Please address your fax cover sheet to DME New LCD – **[Topic for New LCD]** – Attn: Dr. Robert Hoover
3. **Mail:**

   CGS Administrators, LLC
   Attn: Robert D. Hoover, Jr., MD, MPH, FACP
   DME LCD Reconsiderations
   26 Century Blvd STE ST610
   Nashville, TN 37214-3685

***Next Steps*:**

The DME MAC will review 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 the DME MAC determines that the request is not valid, the requestor will be notified in writing that the request is not valid and the rationale for this decision will be provided.

If the request is valid, the DME MAC 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 that the request is valid is simply an acknowledgement to the requestor of the receipt of a complete, valid request. The DME MAC's request response does not convey that a determination has been made or the likelihood of coverage, or non-coverage, within a defined period of time 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, the DME MAC 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. New LCD requests that contain beneficiary PHI and/or PII will be redacted by the DME MACs before inclusion in the proposed LCD.

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/jc/coverage/lcd_request_process.html.

LCD Reconsideration Process

The LCD Reconsideration process is a method by which interested parties can request a revision to an active LCD. The reconsideration process is available for final, effective LCDs only. The entire LCD or any part of it is subject to reconsideration.

Informal Meeting (Optional):

Prior to submitting a formal request for LCD Reconsideration, interested parties are encouraged to schedule an informal conference call to review the requirements for a valid LCD Reconsideration request. Request for a conference call may be submitted via email to LCDReconJC@cgsadmin.com. In the request for an informal discussion, requestors should include the following information:

1. Include in the subject line of the email: "Request for LCD Reconsideration Call – **[Title of LCD]**"
2. Several options for dates and times for a call
3. Teleconference number with enough lines to accommodate a minimum of 30 participants
4. Agenda and presentation documents, including the requestor's participants and titles, submitted one (1) week in advance of the call
5. Summary information (1-2 paragraphs, maximum) for the reconsideration request.

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 of 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 be added to or deleted from an LCD.
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 DME MACs prefer that formal LCD Reconsideration requests be submitted in the format of a letter (PDF). Please ensure that the formal request letter (PDF) you submit is 508-compliant. Requests should not contain beneficiary protected health information (PHI) or personally identifiable information (PII).

The level of evidence required for LCD reconsideration is the same as that required for new/revised LCD development (see *Program Integrity Manual*, Chapter 13).

The DME MAC 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.

The DME MAC 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 http://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.

How to Submit LCD Reconsideration Requests:

For your convenience, CGS has prepared forms that you may fill out and submit with your request. These forms are optional; however, they will assist you in ensuring the requirements for a complete request are met.

Informal Teleconference Request form:
https://www.cgsmedicare.com/pdf/dme/jc_request_for_informal_call.pdf

LCD Reconsideration Request form:
https://www.cgsmedicare.com/pdf/dme/jc_lcd_reconsideration_request.pdf

LCD Reconsideration requests may be sent via one of three methods: email (preferred), fax, or hard copy by mail. Below lists pertinent information for each of the three methods:

1. **Email (Preferred Method):** LCDReconJC@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 LCDReconJC@cgsadmin.com for alternative methods for submitting large electronic files or if you have difficulty submitting an LCD Reconsideration request.
2. **Fax:** 615.664.5955
   - Please address your fax cover sheet to DME LCD Reconsideration – Attn: Dr. Robert Hoover.
   - Note: This fax line is for the LCD reconsideration process described above. This is not the fax line for appealing individual claims (Redeterminations).
3. **Mail:**

   CGS Administrators, LLC
   Attn: Robert D. Hoover, Jr., MD, MPH, FACP
   DME LCD Reconsiderations
   26 Century Blvd STE ST610
   Nashville, TN 37214-3685

Next Steps

The DME MAC will review 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 the DME MAC determines that the request is not valid, the requestor will be notified in writing that the request is not valid and the rationale for this decision will be provided.

If the request is valid, the DME MAC 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 that the request is valid is simply an acknowledgement to the requestor of the receipt of a complete, valid request. The DME MAC's request response does not convey that a determination has been made or the likelihood of coverage, or non-coverage, within a defined period of time 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, the DME MACs will follow the process detailed in the Centers for Medicare & Medicaid Services (CMS) *Program Integrity Manual* (Internet-only manual 100-08), 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. LCD reconsideration requests that contain beneficiary PHI and/or PII will be redacted by the DME MACs before inclusion in the proposed LCD.

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 LCD Reconsideration process, please see CGS' LCD Reconsideration Process webpage at https://cgsmedicare.com/jc/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* (Internet-only Manual 100-08) Chapter 13.

For up-to-date information on LCDs under reconsideration or development, please see CGS' LCD Tracking webpage at https://www.cgsmedicare.com/jc/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 ADMC 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 C website. You can access and fill out the form online at https://www.cgsmedicare.com/jc/forms/pdf/JC_ADMC_request_form.pdf.

ADMC requests may be submitted by the following methods:

1. **Fax**: 615.782.4647
2. **Mail:**

   CGS
   Attn: ADMC
   P.O. Box 20010
   Nashville, TN 37202

3. **Electronically:**

   - MyCGS Web Portal: https://mycgsportal.com/mycgs

- esMD: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD

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 C.
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 2nd request, but no new information was submitted.
7. The place of service is a hospital or skilled nursing facility.
8. 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.
9. A faxing error has occurred which resulted in missing, blackened, partial and/or incomplete documentation.
10. A duplicate request is submitted.
11. A request is submitted for an advance determination on previously denied accessories and/or additional accessories when the base was previously approved.
12. The item that is being submitted for advanced determination is NOT a wheelchair.
13. 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 **in-person examination**. The treating practitioner must conduct an in-person examination of the beneficiary 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.

4. **Attestation of "no financial involvement."** The PMD LCD requires a signed and dated affirmation from the supplier that the licensed/certified medical professional (LCMP) performing the specialty evaluation has no financial relationship with the supplier. CGS will also accept an attestation of no financial relationship from the LCMP 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 licensed/certified medical professional's (LCMP's) evaluation identifying the ATP and his/her employer. The RESNA website is 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)

5. 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 an LCMP, the ADMC request must also include the report of the in-person examination with 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, & §6.7.3 & Chapter 5, §5.3
CMS Manual System, Pub. 100-04, *Medicare Program Integrity 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) 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 orthoses HCPCS codes L0648, L0650, L1832, L1833, and L1851, and **only** for **acute situations** or when furnishing these items under a **Competitive Bidding Program (CBP)**. Please see the “Braces (Orthotics)” section, as well as the “Orthoses Prior Authorization – What Suppliers Need to Know” page at: https://cgsmedicare.com/jc/mr/orth_whattoknow.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
- 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.

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/jc/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/jc/mr/pdf/prior_authorization_coversheet.pdf.

Requesters/submitters have the option to submit a prior authorization request via esMD (indicate document/content type 8.4), fax, myCGS Web Portal, 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. **Fax:** 615.664.5960
2. **Mail:**

   CGS – **JUR C** DME Medical Review – Prior Authorization
   PO Box 24890
   Nashville, TN 37202-4890

3. **Electronically:**
   - myCGS Web Portal: https://mycgsportal.com/mycgs
   - esMD: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD

Power Mobility Devices (PMDs)

Power Wheelchairs (PWCs)

As a condition of payment, Medicare requires a prior authorization for the following PWC HCPCS codes for all states and territories.

HCPCS Code	Type of Base
K0813–K0816	Group 1 Power Wheelchair

K0820–K0829	Group 2 Power Wheelchair
K0835–K0840	Group 2 Single Power Option Power Wheelchair
K0841–K0843	Group 2 Multiple Power Option Power Wheelchair
K0848–K0855	Group 3 Power Wheelchair, No Power Option
K0856–K0860	Group 3 Single Power Option Power Wheelchair
K0861–K0864	Group 3 Multiple Power Option Power Wheelchair

NOTE: This review is for the wheelchair base only. Accessories will not be reviewed.

The LCD states that for these 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 base, should also be submitted as part of the prior authorization request.

The Condition of Payment Prior Authorization Request for a PWC HCPCS code must include the following documentation:

- WOPD for the PWC base
- SWO for related options/accessories, if applicable
- Treating practitioner's face-to-face encounter
- Specialty evaluation performed by an LCMP 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, 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
- 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 PWC prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester within 10 business days (excluding federal holidays). 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. If the DME MAC exceeds the 10-business day (postmarked) requirement of the initial submission, the request is not automatically affirmed.

Resubmission:

For a resubmitted PWC 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 10 business days of receipt of the resubmission. 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 10 business days (excluding federal holidays) 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) of receipt of all applicable Medicare required documentation.

An affirmative prior authorization determination for the PWC HCPCS code is only valid for items delivered within six months following the date of the determination.

Power Operated Vehicles (POVs)

As a condition of payment, Medicare requires a prior authorization for the following POV HCPCS codes for all states and territories on the effective dates in the table below.

The DME MACs began accepting prior authorization requests nationwide on March 30, 2022, for items furnished on or after April 13, 2022.

HCPCS Code	Code Description	Effective Date
K0800	Power Operated Vehicle, Group 1 Standard, Patient Weight Capacity Up to And Including 300 Pounds	Nationwide: 4/13/22
K0801	Power Operated Vehicle, Group 1 Heavy Duty, Patient Weight Capacity, 301 to 450 Pounds	Nationwide: 4/13/22
K0802	Power Operated Vehicle, Group 1 Very Heavy Duty, Patient Weight Capacity 451	Nationwide: 4/13/22

	to 600 Pounds	
*K0806	Power Operated Vehicle, Group 2 Standard, Patient Weight Capacity Up to And Including 300 Pounds	Nationwide: 4/13/22
*K0807	Power Operated Vehicle, Group 2 Heavy Duty, Patient Weight Capacity 301 to 450 Pounds	Nationwide: 4/13/22
*K0808	Power Operated Vehicle, Group 2 Very Heavy Duty, Patient Weight Capacity 451 to 600 Pounds	Nationwide: 4/13/22

*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 Condition of Payment Prior Authorization Request for a POV 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 a POV prior authorization request(s), the DME MAC will be required to make the decision(s) and notify each requester within 10 business days (excluding federal holidays). 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. If the DME MAC exceeds the 10-business day (postmarked) requirement of the initial submission, the request is not automatically affirmed.

Resubmission:

For a resubmitted POV 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 10 business days of receipt of the resubmission. 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 10 business days (excluding federal holidays) 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) of receipt of all applicable Medicare required documentation.

An affirmative prior authorization determination for the POV HCPCS code is only valid for items delivered within six months following the date of the determination.

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 (excluding federal holidays). 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. If the DME MAC exceeds the five-business day (postmarked) 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 of receipt of the resubmission. 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 (excluding federal holidays) 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) 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 10 business days (excluding federal holidays). 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. If the DME MAC exceeds the 10-business day (postmarked) 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 10 business days of receipt of the resubmission. 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 10 business days (excluding federal holidays) 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) of receipt of all applicable Medicare required documentation. For expedited review requests, utilize fax, esMD, or the myCGS Web Portal 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 the states and territories for the effective dates listed in the table below.

The DME MACs began accepting prior authorization requests for New York, Illinois, Florida, and California on March 30, 2022, for items furnished on or after April 13, 2022.

The DME MACs began accepting prior authorization requests for Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington on June 28, 2022, for items furnished on or after July 12, 2022.

The DME MACs began accepting prior authorization requests for all remaining states and territories on September 26, 2022, for items furnished on or after October 10, 2022.

The following brace HCPCS codes are subject to the Required Prior Authorization program:

HCPCS Code	Code Description	Effective Date, States and Territories
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	NY, IL, FL, and CA: 4/13/22 MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA: 7/12/22 Nationwide: 10/10/22
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	NY, IL, FL, and CA: 4/13/22 MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA: 7/12/22 Nationwide: 10/10/22
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	NY, IL, FL, and CA: 4/13/22 MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA: 7/12/22 Nationwide: 10/10/22

	Expertise	
L1833	Knee Orthosis, Adjustable Knee Joints (Unicentric or Polycentric), Positional Orthosis, Rigid Support, Prefabricated, Off-The Shelf	NY, IL, FL, and CA: 4/13/22 MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA: 7/12/22 Nationwide: 10/10/22
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	NY, IL, FL, and CA: 4/13/22 MD, PA, NJ, MI, OH, KY, TX, NC, GA, MO, AZ, and WA: 7/12/22 Nationwide: 10/10/22

Exceptions to claims submitted for HCPCS codes L0648, L0650, L1832, L1833, and L1851 that may otherwise be subject to prior authorization requirements are:

- **Acute situations** when the need for certain patients to receive an orthoses item, and when the two-day expedited review would delay care and risk the health or life of the beneficiary. Prior authorization requirements are suspended for HCPCS codes L0648, L0650, L1832, L1833, and L1851 furnished under these circumstances. Claims for these HCPCS codes are to be billed using modifier ST and will not undergo prior authorization. These claims will instead be subject to 100% prepayment review.

- Suppliers furnishing these items under a **Competitive Bidding Program (CBP)** exception [as described in 42 CFR 414.404(b)] with claims billed using modifiers KV, J5, or J4 would convey that the DMEPOS item is needed immediately. Ten percent of claims submitted using the KV, J5, or J4 modifiers for HCPCS L0648, L0650, L1833, and L1851 will be subject to 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 (excluding federal holidays). 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. If the DME MAC exceeds the five-

business day (postmarked) 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 of receipt of the resubmission. 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 (excluding federal holidays) 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) of receipt of all applicable Medicare required documentation. For expedited review requests, utilize fax, esMD, or the myCGS Web Portal 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 or supplies required for the effective use of DME or prosthetic devices
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) 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)(16) 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

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 21st 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 http://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.

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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2. Accident/Injury Insurance
3. Other Government-Sponsored Health Plans
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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/jc/forms/pdf/JC_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(B)

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, items10a, 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
1. Medicare primary payment is $375 x 80%= $300 2. Primary allowed of $500 is the higher allowed amount 3. Primary allowed minus primary paid is $500 - $400 = $100 4. The lower of Step 1 or 3 is $100. (This claim will pay $100)	

Example 2:

Submitted Charge	$300
Unmet Medicare Deductible	$0
Medicare Allowed	$250
Primary Allowed	$200
Primary Paid	$160
1. Medicare primary payment is $250 x 80%= $200 2. Medicare allowed of $250 is the higher allowed amount 3. Medicare allowed minus primary paid is $250 - $160 = $90 4. The lower of Step 1 or 3 is $90. (This claim will pay $90)	

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

1. Medicare primary payment is $120 - $100 (deductible) x 80%= $16
2. Primary allowed of $150 is the higher allowed amount
3. Primary allowed minus primary paid is $150 - $120 = $30
4. The lower of Step 1 or 3 is $16. (This claim will pay $16)

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.

Example 2:

Submitted Charge	$200
Unmet Medicare Deductible	$0
Medicare Allowed	$120
Unmet Primary Deductible	$150
Primary Allowable	$150
Primary Paid	$0

1. Medicare primary payment is $120 x 80% = $96
2. Primary allowed of $150 is the higher allowed amount
3. Primary allowed minus primary paid is $150 - 0 = $150
4. The lower of Step 1 or 3 is $96. (This claim will pay $96)

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 $24 for this claim. The Medicare deductible is satisfied by this claim.

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 x 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 C
PO Box 955152
St. Louis, MO 63195-5152

9. Benefits Coordination & Recovery Center (BCRC)

CMS Manual System, Pub. 100-05, *Medicare Secondary Payer Manual*, Chapter 4, §§10.1-2

The Centers for Medicare & Medicaid Services (CMS) has established a centralized Coordination of Benefits (COB) operation by consolidating under a single contractor, the 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 BCRC 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 BCRC 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 BCRC. 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 BCRC. 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 BCRC. 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 BCRC 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 BCRC. 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 BCRC

BCRC 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 BCRC is available on the CMS website at https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/ProviderServices/index.html.

Chapter 12 Contents

1. Overpayments and Refunds
2. Overpayment Offsets
3. Referral of Delinquent Debt
4. Extended Repayment Schedule
5. Overpayment Appeals

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, the Voluntary Overpayment Refund form (see below) must be completed and returned 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/jc/forms or by following the link below:

   Voluntary Overpayment Refund Form
   (https://www.cgsmedicare.com/jc/forms/pdf/jc_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 C
   PO Box 955152
   St. Louis, MO 63195-5152

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, complete the Overpayment Recovery Request Form and submit it to CGS through fax or mail to the fax number or mailing address on the Overpayment Recovery Request Form.

The Overpayment Recovery Request form is available on our website at https://www.cgsmedicare.com/jc/forms or by following the link below:

Overpayment Recovery Request Form
(https://www.cgsmedicare.com/jc/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 complete the form “Offset Request” located below and fax to 1.615.782.4477 or mail to CGS JC DME MAC, PO Box 20010, 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/jc/forms or by following the link below:

Offset Request Form (https://www.cgsmedicare.com/jc/forms/pdf/jc_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

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.

3. 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 input the debt into the Debt Collection System (DCS) 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.

4. 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. 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)

2. A completed *Extended Repayment Schedule Checklist*.

   Sole Proprietor Checklist (https://www.cgsmedicare.com/ers/sole_ers_checklist_re.pdf)

   Other Entity Checklist (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. 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.

5. 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

1. Telephone Inquiries
2. Written Inquiries
3. myCGS—The Jurisdiction C Web Portal
4. Provider Outreach and Education (POE) Department
5. Reopenings for Minor Errors and Omissions
6. Appeals
7. Redeterminations
8. Reconsiderations
9. Administrative Law Judge (ALJ)
10. Departmental Appeals Board Review
11. Federal Court Review

1. 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 C. The IVR is available by calling 1.866.238.9650. 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, 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)
- Skilled Nursing Facility (SNF)/inpatient hospital stay information
- Hospice information
- 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/jc/help/ivr.html. For an abbreviated version, refer to the IVR flow chart at https://www.cgsmedicare.com/jc/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 1.866.270.4909 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–5 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 12 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 C 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 1.866.813.7878)
- Answer questions about supplier enrollment (please call the National Supplier Clearinghouse 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 a Customer Support, you should take the following steps:

- Consult your Remittance Advice (RA)
- Consult the Claim Denial Resolution Tool (https://cgsmedicare.com/medicare_dynamic/jc/claim_denial_resolution_tool.asp) 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 Service, 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.

2. 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 letterhead should contain all practice location addresses (if you have multiple practice locations) and at least one of the addresses should match the practice location address on file. Including this information will allow us to respond more specifically to the inquiry. You must also include your name and phone number. 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 C
PO Box 20010
Nashville, TN 37202
ATTN: Correspondence Department

Email inquiries may be submitted through our website at https://www.cgsmedicare.com/jc/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.

3. myCGS—The Jurisdiction C Web Portal

The myCGS portal is a Web-based application developed by CGS that is available to DMEPOS suppliers who serve beneficiaries in Jurisdiction C. 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 ADMC 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.

For a complete listing of all that myCGS has to offer and information about how to register, visit our website at http://www.cgsmedicare.com/jc/mycgs.

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/jc/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_c/jc_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 in filing the claim, which, in turn, caused the claim to be denied. 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 can request a reopening for minor errors or omissions either by telephone or in writing. You have one year to request a reopening from the date on your Remittance Advice (RA). 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 C
ATTN: Clerical Error Reopening Department
PO Box 20010
Nashville, TN 37202

You may also send written requests for a reopening with an underpayment via fax to 615.782.4649.

Written reopening requests should be made using the Medicare Reopening Request form (https://www.cgsmedicare.com/pdf/dme_reopening.pdf) available on our website at https://www.cgsmedicare.com/jc/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 and signature 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, 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)
- Claims denied for medical necessity
- Corrected PTANs
- Recoupment requests which should be submitted to overpayment recovery

NOTE: For information regarding COVID-19, visit https://www.cgsmedicare.com/jc/covid-19.html.

Telephone Reopenings

The DME MAC telephone reopening number is 1.866.813.7878. The line is available Monday–Friday, 7 am–5 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.

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, 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
   - Addition, change, and/or removal of KX, GA, GY and/or GZ modifiers
   - Inquiries on the status of a claim(s)
   - Inquiries related to denial of payment based on entitlement
   - Questions that are general in nature and not claim specific
   - 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. Wait to call the telephone reopening line until you receive your Remittance Advice (RA). No action can be taken until a final claim determination is issued.
4. Consult this *Supplier Manual* and applicable medical policy guidelines before calling. Failure to have appropriate information available when you call the telephone reopening line may result in an unfavorable decision.
5. Questions about the status of a claim or general Medicare payment and coding should not be directed through the telephone reopening line. You can obtain a claim status report through the Interactive Voice Response (IVR) unit or by using Claim Status Inquiry (CSI). See Chapter 8 of this manual for information about CSI.
6. 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.

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 C 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, 2023, at least $180 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 before January 1, 2023, at least $1,760 remains in controversy. For requests filed on or after January 1, 2023, at least $1,850 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. The appeal will be dismissed if the person requesting is not a proper party. 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/jc/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/jc/forms/index.html) of our website or at the following link:

Medicare DME Redetermination Request Form
(https://www.cgsmedicare.com/pdf/dme_redetermination.pdf) (375K) 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; 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 615.782.4630.
- If you prefer to mail your request, send your redetermination to:

  CGS
  DME MAC Jurisdiction C
  PO Box 20009
  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/jc/forms/pdf/jc_separator_sheet.pdf), which is available on the Forms page (https://www.cgsmedicare.com/jc/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/jc/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 claim control number (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 overpayment demand letter (the official demand letter that is issued by CGS, containing the total amount of the overpayment, information on where to send payment, and appeal rights)
- 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.
- Submit one redetermination request per demand letter.

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 Local Coverage Determination(s) and/or supplier bulletins on our website at https://www.cgsmedicare.com/jc/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

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

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 C Reconsideration Request Form located on the CGS website at https://www.cgsmedicare.com/jc/forms/pdf/JC_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

Requests can also be submitted via the QIC Appeals Portal at https://qicappeals.cms.gov

The DME MACs must be notified of the effectuation by the QIC. The DME MACs cannot accept copies of the decision letters from suppliers, beneficiaries, or representatives in order 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 $180 or more for requests filed on or after January 1, 2023, 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 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 $1,760 or more for requests filed before January 1, 2023, or $1,850 or more for more for requests filed on or after January 1, 2023, you may request a court review of the decision. The complaint must be filed with a United States District Court.

Chapter 14 Contents

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3. Procedures for Handling Fraud and Abuse Situations
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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 Contractors (UPICs)

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), Part C (Medicare Advantage health plans), Part D (prescription drug plans) and coordination of Medicare-Medicaid data matches (Medi-Medi). UPICs are divided into five zones across the country, two of which cover the states that encompass DME MAC Jurisdiction C.

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.

The two UPICs which service DME MAC Jurisdiction C are as follows:

Qlarant

Beginning April 1, 2018, Qlarant, is the UPIC responsible for the following states:

- Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas

SafeGuard Services, LLC

Beginning June 1, 2018, SafeGuard Services, LLC is the UPIC responsible for the following states/territories:

- Alabama, Georgia, Florida, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, U.S. Virgin Islands, and West Virginia

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 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 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.

5. UPIC Contact Information

You may contact the appropriate UPIC using the information below:

Qlarant

Unified Program Integrity Contractor (Southwest)

Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas

Website: http://www.qlarant.com/

SafeGuard Services, LLC

Unified Program Integrity Contractor (Southeast)

Alabama, Georgia, Florida, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, U.S. Virgin Islands, and West Virginia

Website: http://www.Safeguard-ServicesLLC.com

Chapter 15 Contents

Introduction
1. Durable Medical Equipment Medicare Administrative Contractors
2. Jurisdiction C 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 C Resources

Advance Determination of Medicare Coverage (ADMC)
CGS
ATTN: ADMC
PO Box 20010
Nashville, TN 37202
Fax: 1.615.782.4647

Common Electronic Data Interchange
National Government Services
Phone: 1.866.311.9184
Email address: ngs.cedihelpdesk@anthem.com
Website: https://www.ngscedi.com

Correspondence
CGS
DME MAC Jurisdiction C
PO Box 20010
Nashville, TN 37202

Prior Authorization Requests
CGS – DME Medical Review – Prior Authorization
PO Box 24890
Nashville, TN 37202-4890
Fax: 1.615.664.5960

Provider Outreach and Education (POE)
CGS
DME MAC Jurisdiction C
PO Box 20010
Nashville, TN 37202
ATTN: POE Department

Refund Checks
CGS
JC DME MAC
PO Box 955152
St. Louis, MO 63195-5152

Unified Program Integrity Contractor (UPIC) (Southwest)
Qlarant
Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas
Website: http://www.qlarant.com/

Unified Program Integrity Contractor (UPIC) (Southeast)
SafeGuard Services, LLC
Alabama, Georgia, Florida, North Carolina, Puerto Rico, South Carolina, Tennessee, Virginia, U.S. Virgin Islands, and West Virginia
Website: http://www.safeguard-servicesllc.com/

Appeals and Reopenings

Clerical Error Reopenings
CGS
DME MAC Jurisdiction C
PO Box 20010
Nashville, TN 37202
For a reopening with an underpayment, fax to: 1.615.782.4649
For a reopening with an overpayment, fax to: 1.615.782.4477
Telephone Reopenings: 1.866.813.7878

Redeterminations
CGS
ATTN: Redetermination Department
PO Box 20009
Nashville, TN 37202
Fax: 1.615.782.4630

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

Requests can also be submitted via the QIC Appeals Portal at https://qicappeals.cms.gov

Administrative Law Judge (ALJ)
Requests for ALJ hearings must be filed to the Office of Medicare Hearings and Appeals (OMHA) at to 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 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 C website is available at https://www.cgsmedicare.com/jc. From the Jurisdiction C website, you can access a variety of resources, including the *DME MAC Jurisdiction C 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/overview-and-quick-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:

99	MODIFIER OVERFLOW (EFFECTIVE DATE 7/1/2003)
A1	DRESSING FOR ONE WOUND (EFFECTIVE DATE 1/1/2003)
A2	DRESSING FOR TWO WOUNDS (EFFECTIVE DATE 1/1/2003)
A3	DRESSING FOR THREE WOUNDS (EFFECTIVE DATE 1/1/2003)
A4	DRESSING FOR FOUR WOUNDS (EFFECTIVE DATE 1/1/2003)
A5	DRESSING FOR FIVE WOUNDS (EFFECTIVE DATE 1/1/2003)
A6	DRESSING FOR SIX WOUNDS (EFFECTIVE DATE 1/1/2003)
A7	DRESSING FOR SEVEN WOUNDS (EFFECTIVE DATE 1/1/2003)
A8	DRESSING FOR EIGHT WOUNDS (EFFECTIVE DATE 1/1/2003)
A9	DRESSING FOR NINE OR MORE WOUNDS (EFFECTIVE DATE 1/1/2003)
AU	ITEM FURNISHED IN CONJUNCTION WITH A UROLOGICAL, OSTOMY, OR TRACHEOSTOMY SUPPLY (EFFECTIVE DATE 1/1/2003)
AV	ITEM FURNISHED IN CONJUNCTION WITH A PROSTHETIC DEVICE, PROSTHETIC OR ORTHOTIC (EFFECTIVE DATE 1/1/2003)
AW	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)

F6	RIGHT HAND, SECOND DIGIT (EFFECTIVE DATE 01/01/1995)
F7	RIGHT HAND, THIRD DIGIT (EFFECTIVE DATE 01/01/1995)
F8	RIGHT HAND, FOURTH DIGIT (EFFECTIVE DATE 01/01/1995)
F9	RIGHT HAND, FIFTH DIGIT (EFFECTIVE DATE 01/01/1995)
FA	LEFT HAND, THUMB (EFFECTIVE DATE 01/01/1995)
FC	PARTIAL CREDIT RECEIVED FOR REPLACED DEVICE (EFFECTIVE DATE 1/1/2008)
GA	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, INDIVIDUAL CASE (EFFECTIVE 10/02/1995)
GD	UNITS OF SERVICE EXCEEDS MEDICALLY UNLIKELY EDIT VALUE AND REPRESENTS REASONABLE AND NECESSARY SERVICES (END DATE 12/31/2019)
GK	REASONABLE AND NECESSARY ITEM/SERVICE ASSOCIATED WITH A GA OR GZ MODIFIER (UPDATED 1/1/2008)
GL	MEDICALLY UNNECESSARY UPGRADE PROVIDED INSTEAD OF NON-UPGRADED ITEM, NO CHARGE, NO ADVANCE BENEFICIARY NOTICE (ABN) (UPDATED 1/1/2008)
GU	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYER POLICY, ROUTINE NOTICE (EFFECTIVE 01/01/2011)
GW	SERVICE NOT RELATED TO THE HOSPICE PATIENT'S TERMINAL CONDITION
GX	NOTICE OF LIABILITY ISSUED, VOLUNTARY UNDER PAYER POLICY (EFFECTIVE 4/1/2010)
GY	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)
GZ	ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE OR NECESSARY. (EFFECTIVE 1/1/2002)
J4	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED BY A HOSPITAL UPON DISCHARGE (EFFECTIVE 01/01/2010)
J5	DMEPOS COMP BID FUR BY PT/OT (EFFECTIVE 10/01/2020)
JA	ADMINISTERED INTRAVENOUSLY (EFFECTIVE DATE 01/01/2007)
JB	ADMINISTERED SUBCUTANEOUSLY (EFFECTIVE DATE 01/01/2007)
JW	DRUG AMOUNT DISCARDED/NOT ADMINISTERED TO ANY PATIENT (EFFECTIVE 01/01/2003)
JZ	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 THOUGH 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
KO	SINGLE DRUG UNIT DOSE FORMULATION
KP	FIRST DRUG OF A MULTIPLE DRUG UNIT DOSE FORMULATION

KQ	SECOND OR SUBSEQUENT DRUG OF A MULTIPLE DRUG UNIT DOSE FORMULATION
KR	RENTAL ITEM, BILLING FOR PARTIAL MONTH
KS	GLUCOSE MONITOR SUPPLY FOR DIABETIC BENEFICIARY NOT TREATED WITH INSULIN
KT	BENEFICIARY RESIDES IN A COMPETITIVE BIDDING AREA AND TRAVELS OUTSIDE THAT COMPETITIVE BIDDING AREA AND RECEIVES A COMPETITIVE BID ITEM (UPDATED 04/01/2008)
KU	CR9520 UNADJUSTED FEE SCHEDULE (EFFECTIVE DATE 07/01/2007; DESCRIPTION CHANGE EFFECTIVE 01/01/2016))
KV	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM THAT IS FURNISHED AS PART OF A PROFESSIONAL SERVICE (EFFECTIVE DATE 1/1/2008)
KW	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 4 (EFFECTIVE DATE 1/1/2008)
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET (EFFECTIVE DATE 7/1/2002)
KY	DMEPOS ITEM SUBJECT TO DMEPOS COMPETITIVE BIDDING PROGRAM NUMBER 5 (EFFECTIVE DATE 1/1/2008)
LT	LEFT SIDE (USED TO IDENTIFY ITEM PROVIDED FOR THE LEFT SIDE OF THE BODY)
M2	MEDICARE SECONDARY PAYER (MSP) (EFFECTIVE DATE 01/01/2007)
MS	SIX MONTH MAINTENANCE AND SERVICING FEE FOR REASONABLE AND NECESSARY PARTS AND LABOR WHICH ARE NOT COVERED UNDER ANY MANUFACTURER OR SUPPLIER WARRANTY
NB	NEBULIZER SYSTEM, ANY TYPE, FDA-CLEARED FOR USE WITH SPECIFIC DRUG (EFFECTIVE 01/01/2011)
NR	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)
NU	NEW DURABLE MEDICAL EQUIPMENT PURCHASE
PD	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)
PL	PROGRESSIVE ADDITION LENSES (EFFECTIVE DATE 01/01/89)
Q0	INVESTIGATIONAL CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY (EFFECTIVE DATE 1/1/2008)
Q1	ROUTINE CLINICAL SERVICE PROVIDED IN A CLINICAL RESEARCH STUDY THAT IS IN AN APPROVED CLINICAL RESEARCH STUDY (EFFECTIVE DATE 1/1/2008)
Q2	DEMONSTRATION PROCEDURE/SERVICE (UPDATED DESCRIPTION 01/01/2017)
QA	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)

QB	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)
QE	PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS LESS THAN 1 LITER PER MINUTE (LPM) (UPDATED DESCRIPTION 04/01/2018)
QF	PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST EXCEEDS 4 LITERS PER MINUTE (LPM) AND PORTABLE OXYGEN IS PRESCRIBED (UPDATED DESCRIPTION 04/01/2018)
QG	PRESCRIBED AMOUNT OF STATIONARY OXYGEN WHILE AT REST IS GREATER THAN 4 LITERS PER MINUTE (LPM) (UPDATED DESCRIPTION 04/01/2018)
QH	OXYGEN CONSERVING DEVICE IS BEING USED WITH AN OXYGEN DELIVERY SYSTEM
QJ	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)
QQ	CLAIM SUBMITTED WITH A WRITTEN STATEMENT OF INTENT
QR	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)
RA	REPLACEMENT OF A DME, ORTHOTIC OR PROSTHETIC ITEM (EFFECTIVE 01/01/2011)
RB	REPLACEMENT OF A PART OF A DME, ORTHOTIC OR PROSTHETIC ITEM FURNISHED AS PART OF A REPAIR (EFFECTIVE 01/01/2011)
RD	DRUG PROVIDED TO BENEFICIARY, BUT NOT ADMINISTERED “INCIDENT-TO” (EFFECTIVE 01/01/2004)
RE	FURNISHED IN FULL COMPLIANCE WITH FDA-MANDATED RISK EVALUATION AND MITIGATION STRATEGY (REMS) (EFFECTIVE 01/01/2009)
RR	RENTAL (USE THE 'RR' MODIFIER WHEN DME IS TO BE RENTED)
RT	RIGHT SIDE (USED TO IDENTIFY PROCEDURES PERFORMED ON THE RIGHT SIDE OF THE BODY)
SC	MEDICALLY NECESSARY SERVICE OR SUPPLY (EFFECTIVE DATE 01/01/2001)
ST	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)
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 C 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/jc/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 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 C DME MAC by calling 1.866.270.4909 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://cgsmedicare.com/medicare_dynamic/jc/claim_denial_resolution_tool.asp.

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.

PR	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: • Patient's deductible or coinsurance, • The patient assumed financial responsibility for a service not considered reasonable and necessary, • Cost of therapy or psychiatric services after the coverage limit had been reached, • A charge denied as a result of the patient's failure to supply primary payer or other information, • Where a patient is responsible for payment of excess non-assigned physician charges. **Charges that have not been paid by Medicare and/or are not included in a PR group are:** • Late filing penalty (reason code B4), • Excess charges on an assigned claim (reason code 42), • Excess charges attributable to rebundled services (reason code B15), • Charges denied as a result of the failure to submit necessary information by a provider who accepts assignment, • 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. **Providers may be subject to penalties if they bill a patient for charges not identified with the PR group code.**
CO	Contractual obligations. This includes any amounts for which the provider is financially liable, such as: • Participation agreement violations, • Assignment amount violations, • Excess charges by a managed care plan provider, • Late filing penalties, • Gramm-Rudman reductions, • Medical necessity denials/reductions. **The patient may not be billed for these amounts.**
OA	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

Acronyms and Abbreviations

AARP	American Association of Retired Persons
ABG	Arterial Blood Gas
ABN	Advance Beneficiary Notice
ACA	Affordable Care Act
ADMC	Advance Determination of Medicare Coverage
ADS	Automated Development Letter
ADR	Additional Documentation Request
ALJ	Administrative Law Judge
AMA	American Medical Association
ANSI	American National Standard Institute
ASCA	Administrative Simplification Compliance Act
AWP	Average Wholesale Pricing
BBA	Balanced Budget Act
BCRC	Benefits Coordination & Recovery Center
BIPA	Benefits Improvement and Protection Act of 2000
CBA	Competitive Bidding Area
CBIC	Competitive Bidding Implementation Contractor
CCN	Claim Control Number
CEDI	Common Electronic Data Interchange
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMN	Certificate of Medical Necessity
CMR	Comprehensive Medical Review
CMS	Centers for Medicare and Medicaid Services

CNS	Clinical Nurse Specialist
COB	Coordination of Benefits
CPAP	Continuous Positive Airway Pressure
CPI	Consumer Price Index
CSI	Claim Status Inquiry
CSR	Customer Service Representative
CSS	Chronic Stable State
CWF	Common Working File
DCN	Document Control Number
DHHS	Department of Health and Human Services
DIF	DME MAC Information Form
DME	Durable Medical Equipment
DME MAC	Durable Medical Equipment Medicare Administrative Contractor
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DO	Doctor of Osteopathy
DOJ	Department of Justice
DOS	Date of Service
DPM	Doctor of Podiatric Medicine
DRA	Deficit Reduction Act of 2005
DWO	Detailed Written Order
DWOPD	Detailed Written Order Prior to Delivery
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
e.g.	For example
EGHP	Employer Group Health Plan
EIN	Employer Identification Number
EMC	Electronic Media Claims

EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ERL	Electronic Receipt Listing
ERA	Electronic Remittance Advice
esMD	Electronic Submission of Medical Documentation
ESRD	End Stage Renal Disease
FCN	Financial Control Number
FDA	Food and Drug Administration
Fed Reg	Federal Register
FFS	Fee-for-Service
FOIA	Freedom of Information Act
FTF	Face To Face
GHP	Group Health Plan
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Health and Human Services
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act
HME	Home Medical Equipment
HMO	Health Maintenance Organization
HO	Hearing Officer
IIC	Inflation-Indexed Charge
IOL	Intraocular lens
IPPB	Intermittent Positive Pressure Breathing
IRP	Inexpensive or Other Routinely Purchased
IV	Intravenous
IVR	Interactive Voice Response
LCD	Local Coverage Determination
LCL	Lowest Charge Level

LGHP	Large Group Health Plan
LSO	Lumbar Sacral Orthosis
MD	Medical Director
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MEDPARD	Medicare Participating Suppliers Directory
MHO	Medicare Hearing Officer
MMA	Medicare Modernization Act (of 1999)
MS	Maintenance and Servicing
MSE	Metropolitan Statistical Area
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
NCD	National Coverage Determination
NDC	National Drug Code
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NPE	National Provider Enrollment
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NSC	National Supplier Clearinghouse
NSF	National Standard Format
OBRA	Omnibus Budget Reconciliation Act
OCNA	Other Carrier Name/Address
OIG	Office of the Inspector General
OMB	Office of Management and Budget
OMHA	Office of Medicare Hearings and Appeals
PA	Policy Article, also Physician Assistance
PAR	Prior Authorization Request

PCA	Progressive Corrective Action
PDAC	Pricing, Data Analysis and Coding
PIM	Program Integrity Manual
PM	Program Memorandum
PMD	Power Mobility Device
POD	Proof of Delivery
POE	Provider Outreach and Education
PPS	Payment Prospective System
PSC	Program Safeguard Contractor
PTAN	Provider Transaction Access Number
PWK	Paperwork
QIC	Qualified Independent Contractor
RA	Remittance Advice
RAC (or RA)	Recovery Audit Contractor (now called Recovery Auditor)
RESNA	Rehabilitation Engineering & Assistive Technology Society of North America
RRB	Railroad Retirement Board
SACU	Supplier Audit and Compliance Unit
SLM	Seat Lift Mechanism
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
SSA	Social Security Administration
TENS	Transcutaneous Electrical Nerve Stimulator
TIN	Tax Identification Number
TLSO	Thoracic-Lumbar-Sacral Orthosis
UMWA	United Mine Workers Association
UPIC	Unified Program Integrity Contractors
UPIN	Unique Physicians Identification Number
USC	United States Code
VA	Veteran's Administration
WC	Workers' Compensation
WOPD	Written Order Prior to Delivery
ZPIC	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

HCPCS K Codes

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	**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 Nutriets	**14**	Not Otherwise Classified	**21**	Value Not Established

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		
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)		
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	
A4344	Indwelling catheter, foley type, two-way, all silicone, each	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 than4 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	
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)		
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)		
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)		
A4575	Topical hyperbaric oxygen chamber, disposable		
A4595	Electrical stimulator supplies, 2 lead, per month, (e.g., TENS, NMES)	13	
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	05	
A4629	Tracheostomy care kit for established tracheostomy	11	
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	
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	
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	
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	
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 contract 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	
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	
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	
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	
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	
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	
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	
A6513	Compression burn mask, face and/or neck, plastic or equal, custom fabricated (Eff. Date 1/1/2006)	12	
A6530	Gradient compression stocking, below knee, 18-30 MMHG, each (Eff. Date 1/1/2006)	12	
A6531	Gradient compression stocking, below knee, 30-40 MMHG, each (Eff. Date 1/1/2006)	12	
A6532	Gradient compression stocking, below knee, 40-50 MMHG, each (Eff. Date 1/1/2006)	12	

A6533	Gradient compression stocking, thigh length, 18-30 MMHG, each (Eff. Date 1/1/2006)	12	
A6534	Gradient compression stocking, thigh length, 30-40 MMHG, each (Eff. Date 1/1/2006)	12	
A6535	Gradient compression stocking, thigh length, 40-50 MMHG, each (Eff. Date 1/1/2006)	12	
A6536	Gradient compression stocking, full length/chap style, 18-30 MMHG, each (Eff. Date 1/1/2006)	12	
A6537	Gradient compression stocking, full length/chap style, 30-40 MMHG, each (Eff. Date 1/1/2006)	12	
A6538	Gradient compression stocking, full length/chap style, 40-50 MMHG, each (Eff. Date 1/1/2006)	12	
A6539	Gradient compression stocking, waist length, 18-30 MMHG, each (Eff. Date 1/1/2006)	12	
A6540	Gradient compression stocking, waist length, 30-40 MMHG, each (Eff. Date 1/1/2006)	12	
A6541	Gradient compression stocking, waist length, 40-50 MMHG, each (Eff. Date 1/1/2006)	12	
A6544	Gradient compression stocking, garter belt (Eff. Date 1/1/2006)	12	
A6545	Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each (Eff. Date 1/1/2009)	12	
A6549	Gradient compression stocking/sleeve, not otherwise specified (Eff. Date 1/1/2006) (Description Change 1/1/2010)	12	
A6550	Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories (Eff. Date 1/1/2004)	13	
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	
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	
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 chess 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	
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)		
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	
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	
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 electromics, 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	

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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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

Code	Description	Category	CMN/DIF Required
B4034	Enteral feeding supply kit; syringe fed, per day, includes but is not limited to feedling/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	
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, hepatamine-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	

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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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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	
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 (Eff. Date 1/1/2006)	01	
E0172	Seat lift mechanism placed over or on top of toilet, any type (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	
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	
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	
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)		
E0500	IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	02	
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	UItrasonic/eletronic 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	
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	
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)		
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)		
E0720	Transcutaneous Electrical Nerve Stimulation (TENS) device, two lead, localized stimulation	05	06.03B
E0730	Transcutaneous Electrical Nerve Stimulation (TENS) device, four or more leads, for multiple nerve stimulation	05	06.03B
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	
E0740	Non-implanted pelvic floor electrical stimulator, complete system (Updated description 1/1/2017)	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	
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)		
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	
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	
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	
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	
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	
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)		
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	
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 peritioneal 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	
E1800	Dynamic adjustable elbow extension/flexion device, includes soft interface material	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	
E1805	Dynamic adjustable wrist extension/flexion device, includes soft interface material	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	
E1810	Dynamic adjustable knee extension/flexion device, includes soft interface material	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	
E1815	Dynamic adjustable ankle extension/flexion device, or equal	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	
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	
E1825	Dynamic adjustable finger extension/flexion device, includes soft interface material	01	
E1830	Dynamic adjustable toe extension/flexion device, includes soft interface material	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)		
E2000	Gastric suction pump, home model, portable or stationary, electric (Eff. Date 1/1/2002)	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	
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	
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	
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	

E2300	Wheelchair accessory, power seat elevation system, any type (Eff. Date 1/1/2004) (Revised 01/01/2014)	05	
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	
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	
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, stabdard 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	
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	
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	
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	
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	
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)		
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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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)		
J0135	Injection, adalimumab, 20 mg (Eff. Date 1/1/2005)		
J0136	Injection, acetaminophen (b braun) not therapeutically equivalent to j0131, 10 mg (Eff. Date 01/01/2023)		
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)		
J0178	Injection, aflibercept, 1 mg (Eff. Date 01/01/2013)		
J0179	Injection, brolucizumab-dbll, 1 mg (Eff. Date 1/1/2020)		
J0180	Injection, agalsidase beta, 1 mg (Eff. Date 1/1/2005)		
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)		
J0205	Injection, alglucerase, per 10 units		
J0207	Injection, amifostine, 500 mg		
J0210	Injection, methyldopate HCL, up to 250 mg		
J0215	Injection, alefacept, 0.5 mg (Eff. Date 1/1/2004)	10	
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)		
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)		
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		
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)		
J0456	Injection, azithromycin, 500 mg (Eff. Date 1/1/2000)		
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, benztropine 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)		
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)		
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)		
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)		
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		

J0604	Cinacalcet, oral, 1 mg, (for esrd on dialysis) (Eff. Date 01/01/2018)		
J0606	Injection, etelcalcetide, 0.1 mg (Eff. Date 01/01/2018)		
J0610	Injection, calcium gluconate (fresenius kabi), per 10 ml (Revised 01/01/2023)		
J0611	Injection, calcium gluconate (wg critical care), per 10 ml (Eff. Date 01/01/2023)		
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)		
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)		
J0670	Injection, mepivacaine hydrochloride, per 10 ml		
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, cefoxitin 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		
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, cephapirin 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, centruroides 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		
J0739	Injection, cabotegravir, 1 mg (Eff. Date 07/01/2022)		
J0740	Injection, cidofovir, 375 mg		
J0741	Injection, cabotegravir and rilpivirine, 2mg/3mg (Eff. Date 10/1/2021)		
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		
J0760	Injection, colchicine, per 1mg (Deleted eff. 12/31/2016)		

J0770	Injection, colistimethate sodium, up to 150 mg		
J0775	Injection, Collagenase, Closrtridium 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)		
J0800	Injection, corticotropin, up to 40 units		
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)		
J0850	Injection, cytomegalovirus immune globulin intravenous (human), per vial		
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)		
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)		
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)		
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)		
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		
J1020	Injection, methylprednisolone acetate, 20 mg		
J1030	Injection, methylprednisolone acetate, 40 mg		
J1040	Injection, methylprednisolone acetate, 80 mg		
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)		

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		
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		
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)		
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)		
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)		
J1305	Injection, evinacumab-dgnb, 5mg (Eff. Date 10/1/2021)		
J1306	Injection, inclisiran, 1 mg (Eff. Date 07/01/2022)		
J1320	Injection, amitriptyline HCL, up to 20 mg		
J1322	Injection, elosulfase alfa, 1mg (Eff. Date 01/01/2015)		
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		
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)		
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)		
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)		
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 (cutaquig), 100 mg (Eff. Date 07/01/2022)		
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)		
J1557	Injection, Immune Globulin, (Gammaplex), intravenous, non-lypholized (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)		
J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immunoglobulin (Eff. Date 1/1/2016)		
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		
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		
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)		
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)		
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		
J1810	Injection, droperidol and fentanyl citrate, up to 2 ml ampule		
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)		
J1840	Injection, kanamycin sulfate, up to 500 mg		
J1850	Injection, kanamycin sulfate, up to 75 mg		
J1885	Injection, ketorolac tromethamine, per 15 mg		
J1890	Injection, cephalothin sodium, up to 1 gram		
J1930	Injection, lanreotide, 1 mg (Eff. Date 1/1/2009)		
J1931	Injection, laronidase, 0.1 mg (Eff. Date 1/1/2005)		
J1932	Injection, lanreotide, (cipla), 1 mg (Eff. Date 10/01/2022)		
J1940	Injection, furosemide, up to 20 mg		
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		
J1955	Injection, levocarnitine, per 1 gm		
J1956	Injection, levofloxacin, 250 mg		
J1960	Injection, levorphanol tartrate, up to 2 mg		
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		
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)		
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)		
J2184	Injection, meropenem (b. braun) not therapeutically equivalent to j2185, 100 mg (Eff. Date 01/01/2023)		
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)		
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)		
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)		
J2260	Injection, milrinone lactate, 5 mg		
J2265	Injection Minocycline Hydrochloride, 1 mg (Eff. Date 1/1/2012)		
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)		
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)		
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)		
J2300	Injection, nalbuphine hydrochloride, per 10 mg		
J2310	Injection, naloxone hydrochloride, per 1 mg		
J2311	Injection, naloxone hydrochloride (zimhi), 1 mg (Eff. Date 01/01/2023)		
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)		
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)		
J2360	Injection, orphenadrine citrate, up to 60 mg		
J2370	Injection, phenylephrine HCL, up to 1 ml		
J2400	Injection, chloroprocaine hydrochloride, per 30 ml (Deleted eff. 12/31/2022)		
J2401	Injection, chloroprocaine hydrochloride, per 1 mg (Eff. Date 01/01/2023)		
J2402	Injection, chloroprocaine hydrochloride (clorotekal), per 1 mg (Eff. Date 01/01/2023)		
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, 1 mg (Eff. Date 1/1/2011)		
J2430	Injection, pamidronate disodium, per 30 mg		
J2440	Injection, papaverine HCL, up to 60 mg		
J2460	Injection, oxytetracycline HCL, up to 50 mg		
J2469	Injection, palonosetron HCL, 25 mcg (Eff. Date 1/1/2005)		
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)		
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		
J2562	Injection, plerixafor, 1 mg (Eff. Date 1/1/2010)		
J2590	Injection, oxytocin, up to 10 units		
J2597	Injection, desmopressin acetate, per 1 mcg		
J2650	Injection, prednisolone acetate, up to 1 ml		
J2670	Injection, tolazoline HCL, up to 25 mg		
J2675	Injection, progesterone, per 50 mg		
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		
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)		
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, rilonacept, 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)		
J2797	Injection, rolapitant, 0.5 mg (Eff Date 1/1/2019)		
J2798	Injection, risperidone, (perseris), 0.5 mg (Eff. Date 10/01/2019)		
J2800	Injection, methocarbamol, up to 10 ml		
J2805	Injection, sincalide, 5 micrograms (Eff. Date 1/1/2006)		
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)		
J2920	Injection, methylprednisolone sodium succinate, up to 40 mg	10	
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg	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		
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)		
J3060	Injection, taliglucerace 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)		
J3244	Injection, tigecycline (accord) not therapeutically equivalent to j3243, 1 mg (Eff. Date 01/01/2023)		
J3245	Injection, tildrakizumab, 1 mg (Eff. Date 1/1/2019)		
J3246	Injection, Tirofiban HCL, 0.25 mg		
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)		
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)		
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)		
J3372	Injection, vancomycin hcl (xellia) not therapeutically equivalent to j3370, 500 mg (Eff. Date 01/01/2023)		
J3380	Injection, vedolizumab, 1 mg (Eff. Date 1/1/2016)		
J3385	Injection, velaglucerase alfa, 100 units (Eff. Date 1/1/2011)		
J3396	Injection, verteporfin, 0.1 mg (Eff. Date 1/1/2005)		
J3397	Injection, vestronidase alfa-vjbk, 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 5x10^15 vector genomes (Eff. Date 07/01/2020)		
J3400	Injection, triflupromazine HCL, up to 20 mg		
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		
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)		
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 (Eff. Date 1/1/2016)		

J7130	Hypertonic saline solution, 50 or 100 meq, 20 cc vial (Deleted eff. 12/31/11)		
J7131	Hypertonic saline solution, 1 ml (Eff. Date 1/1/2012)		
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml (Eff. Date 1/1/2016) (Updated description 1/1/2017)		
J7351	Injection, bimatoprost, intracameral implant, 1 microgram (Eff. Date 10/01/2020)		
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 (Eff. Date 1/1/2016)	10	
J7504	Lymphocyte immune globulin, antithymocyte globulin, equine, 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 (Eff. Date 01/01/2014) (Revised 1/1/2016)	10	
J7509	Methylprednisolone oral, per 4 mg	10	
J7510	Prednisolone oral, per 5 mg	10	
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	
J7515	Cyclosporine, oral, 25 mg (Eff. Date 1/1/2000)	10	
J7516	Cyclosporin, parenteral, 250 mg (Eff. Date 1/1/2000)	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	
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	

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	
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	
J7633	Budesonide, inhalation solution, FDA-approved final product, non-compounded, administered throught DME, concentrated form, per 0.25 milligram (Eff. Date 1/1/2003)	15	
J7634	Budesonide, inhalation solution, compounded product, administered throught 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	Formorterol, 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	
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)		
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)		
J8521	Capecitabine, oral, 500 mg (Eff. Date 1/1/2000)		
J8530	Cyclophosphamide; oral, 25 mg	10	
J8540	Dexamethasone, oral, 0.25 mg (Eff. Date 1/1/2006)		
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	
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)		
J9025	Injection, azacitidine, 1 mg (Eff. Date 1/1/2006)		
J9027	Injection, clofarabine, 1 mg (Eff. Date 1/1/2006)		
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 hcl (treanda), 1 mg (Eff. Date 1/1/2009) (Updated description 1/1/2017)		
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)		
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)		
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)		
J9055	Injection, cetuximab, 10 mg (Eff. Date 1/1/2005)		
J9057	Injection, copanlisib, 1 mg (Eff. Date 1/1/2019)		
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)		
J9065	Injection, cladribine, per 1 mg		
J9070	Cyclophosphamide, 100 mg		
J9071	Injection, cyclophosphamide, (auromedics), 5 mg (Eff. Date 04/01/2022)		
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)		
J9165	Injection, diethylstilbestrol diphosphate, 250 mg (Updated eff. 1/1/2009)		
J9171	Injection, docetaxel, 1 mg (Eff. Date 1/1/2010)		
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)		
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)		
J9250	Methotrexate sodium, 5 mg		
J9260	Methotrexate sodium, 50 mg		
J9261	Injection, nelarabine, 50 mg (Eff. date 1/1/2007)		
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg (Eff. Date 01/01/2014)		
J9263	Injection, oxaliplatine, 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)		
J9290	Mitomycin, 20 mg (Deleted eff. 12/31/2010)		
J9291	Mitomycin, 40 mg (Deleted eff. 12/31/2010)		
J9293	Injection, mitoxantrone hydrochloride, per 5 mg		
J9295	Injection, necitumumab, 1 mg (Eff. Date 1/1/2017)		

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)		
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)		
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)		

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)		
J9340	Injection, thiotepa, 15 mg (Updated eff. 1/1/2009)		
J9348	Injection, naxitamab-gqgk, 1 mg (Eff. Date 07/01/2021)		
J9349	Injection, tafasitamab-cxix, 2 mg (Eff. Date 04/01/2021)		
J9350	Injection, topotecan, 4 mg (Updated eff. 1/1/2009) (Deleted eff. 12/31/10)		
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)		
J9370	Vincristine sulfate, 1 mg		
J9371	Injection, vincristine sulfate liposome, 1 mg (Eff. Date 01/01/2014)		
J9375	Vincristine sulfate, 2 mg (Deleted eff. 12/31/2010)		
J9380	Vincristine sulfate, 5 mg (Deleted eff. 12/31/2010)		
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)		
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)		
J9999	Not otherwise classified, antineoplastic drugs	14	

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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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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, *1 month supply = 1 unit of service* (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 dme 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 Poratble 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)		
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 capactiy 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	
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	
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	
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	
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)		
K1002	Cranial electrotherapy stimulation (ces) system, any type (Eff. Date 1/1/2020, Revised 10/01/2022)	01	
K1003	Whirlpool tub, walk-in, portable (Eff. Date 1/1/2020)		
K1004	Low frequency ultrasonic diathermy treatment device for home use, includes all components and accessories (Eff. Date 01/01/2020)		
K1005	Disposable collection and storage bag for breast milk, any size, any type, each (Eff. Date 1/1/2020)		
K1006	Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system (Eff. Date 10/01/2020)		

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)		
K1009	Speech volume modulation system, any type, including all components and accessories (Eff. Date 10/01/2020)	01	
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)		
K1014	Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control (Eff. Date 04/01/2021)	04	
K1015	Foot, adductus positioning device, adjustable (Eff. Date 04/01/2021)		
K1016	Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve (Eff. Date 04/01/2021)	01	
K1017	Monthly supplies for use of device coded at K1016 (Eff. Date 04/01/2021)	13	
K1018	External upper limb tremor stimulator of the peripheral nerves of the wrist (Eff. Date 04/01/2021)	01	
K1019	Replacement supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist (Eff. Date 04/01/2021, Revised 10/01/2022)		
K1020	Non-invasive vagus nerve stimulator (Eff. Date 04/01/2021)	01	
K1021	Exsufflation belt, includes all supplies and accessories (Eff. Date 10/1/2021		
K1022	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type (Eff. Date 10/1/2021)	04	
K1023	Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm (Eff. Date 10/1/2021)		

K1024	Non-pneumatic compression controller with sequential calibrated gradient pressure (Eff. Date 10/1/2021)	01	
K1025	Non-pneumatic sequential compression garment, full arm (Eff. Date 10/1/2021)	01	
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 for the reduction of snoring and obstructive sleep apnea, controlled by phone application (Eff. Date 04/01/2022)		
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)		
K1031	Non-pneumatic compression controller without calibrated gradient pressure (Eff. Date 04/01/2022)	01	
K1032	Non-pneumatic sequential compression garment, full leg (Eff. Date 04/01/2022)	01	
K1033	Non-pneumatic sequential compression garment, half leg (Eff. Date 04/01/2022)	01	

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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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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	
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	

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 plastric 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	

L0484	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)	04	
L0486	TLSO, triplanar control, two piece rigid plastic shell with interface liner, multiple straps and closures, posterior extends from sacrococcygel 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)	04	
L0488	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)	04	
L0490	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)	04	
L0491	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)	04	
L0492	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)	04	

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	

L0629	Lumbar-sacral orthosis, flexible, provides lumbo-sacral support, posterior extends from sacococcygeal 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 juntion 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 juntion 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	

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 juntion 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 juntion 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 juntion 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 juntion 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	

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	

L0710	CTLSO, 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 (CTLSO) (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	
L1010	Addition to cervical-thoracic-lumbar-sacral orthosis (CTLSO) or scoliosis orthosis, axilla sling	04	
L1020	Addition to CTLSO or scoliosis orthosis, kyphosis pad	04	
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	
L1499	Spinal orthosis, not otherwise specified	14	
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 inidividual 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)	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	
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	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	
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	
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, prefabriacted, 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, perfabricated, 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	
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	
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, perfabricated, includes fitting and adjustment	04	
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid, perfabricated, 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	
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	
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	
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	
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	
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	
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	
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	
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	
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, turnbuckles, 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, turnbuckles, may include soft interface, straps, custom fabricated, includes fitting and adjustment (Eff. Date 1/1/2006)	04	
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	
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	
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	
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	
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	
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	
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 supension, '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	
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	
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	
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	
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	
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	
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	
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)	04	
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	
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	
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	
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 conrol (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	
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. Date1/1/2010)	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, mult-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	
L5999	Lower extremity prosthesis, not otherwise specified	14	
L6000	Partial hand, thumb remaining (Eff. Date 1/1/2012)	04	
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	
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	
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 our 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	
L6647	Upper extremity addition, shoulder lock mechanism, body powered actuator (Eff. Date 1/1/2003)	04	
L6648	Upper extremity addition, shoulder lock mechanism, external powred 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	
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, anu 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	
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	
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	
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 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	
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	
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 prothesis, 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	
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)	01	
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)	01	
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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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)		
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	
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	
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)		
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)		
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)		
Q2052	Services, supplies and accessories used in the home under the medicare intravenous immune globulin (ivig) demonstration (Eff. Date 04/01/2014)		
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)		
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)		
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)		
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)		
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)		
Q5123	Injection, rituximab-arrx, biosimilar, (riabni), 10 mg (Eff. Date 07/01/2021)		
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 Nutriets	14	Not Otherwise Classified	21	Value Not Established

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	
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere	04	

	over 6.00d cylinder, per lens		
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, 2.25 to 4.00d cylinder, per lens	04	

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 sphere, 4.25 to 6.00d cylinder, per lens	04	

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)		
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see 92325)	04	
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	
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	