PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
PART A DURABLE MEDICAL EQUIPMENT

General Information for the billing of Durable Medical Equipment (DME) to the Medicare Part A Intermediary

The purpose of these policies is to assist in the correct billing of DME to the Part A Intermediary when appropriate.

These policies have been adapted from the Durable Medical Equipment Regional Carrier (DMERC) policies but should not be confused with those policies. These policies apply to the Medicare Part A billing procedures and should not be used with the Durable Medical Equipment Regional Carrier (DMERC) billing procedures.

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. For the items addressed in these local medical review policies, "reasonable and necessary" is defined by the criteria following the coverage and payment rules of each policy.

Bill Types

Home Health 32x, 33x, 34x,

Skilled Nursing Facilities 21x, 22x, 23x

Comprehensive Outpatient Rehabilitation Facilities 75x

Revenue Codes

Home Health: 0274, 0291, 0294, 0600, 0601, 0602, 0603, 0604, 0946

Skilled Nursing Facilities: 0270, 0272, 0291, 0946

Comprehensive Outpatient Rehabilitation Facilities: 0290, 0291, 0292, 0293, 0946

Note: Revenue code 0946 is only used when billing HCPCS code E0194, air fluidized bed.

Modifiers

When modifiers are listed in a policy they will be required with the claim submission.

Certificates of Medical Necessity (CMNs)/ Physician Orders

When a certificate of medical necessity is required it does not have to be submitted with the claim. However the CMN and /or physician's order must document the medical necessity of the item being ordered.

Documentation (with the same information as CMN) must be kept on file by the provider and be available to the Intermediary upon request.

Documentation Required

All documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

HCPCS codes

The true and correct HCPCS code should be used at all times. Only use miscellaneous HCPCS codes when absolutely necessary, as these codes will require detailed documentation of name, model and manufacturer of the product as well as the medical necessity of the item. Claims for these items may be subject to manual review.

Skilled Nursing Facilities

Consolidated billing requires that services provided by individuals or companies other than the employees of the SNF must be billed to the Intermediary on the HCFA-1450 for Medicare beneficiaries under both Part A and Part B including those services provided by vendors for the following items or services:

- orthotics/prosthetics
- ostomy/colostomy supplies
- sterile dressings/surgical dressings and supplies
- enteral/parenteral nutrition and supplies

If you have any questions concerning this Durable Medical Equipment Manual, please contact the Medicare Part A Customer Service Center at ***(803) 736-4730*** *(for South Carolina Part A; and Southeast, Southwest and Midwest RHHI providers) or* ***(727) 773-9225*** *(for Gulf Coast RHHI providers).*

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS

PART A DURABLE MEDICAL EQUIPMENT POLICY LIST

Ankle-Foot Orthotics

Canes and Crutches

Cold Therapy

Commodes

Continuous Positive Airway Pressure system (CPAP)

External Breast Prostheses

External Infusion Pumps

Eye Prosthesis

Facial Prostheses

Home Blood Glucose Monitors and Related Supplies

Hospital Beds – Fixed Height

Hospital Beds – Variable Height

Hospital Beds – Semi Electric

Hospital Beds – Total Electric

Immunosuppressive Drugs

Lower Limb Prostheses

Nebulizers

Orthopedic Footwear

Osteogenesis Stimulators

Ostomy Supplies

Oxygen and Oxygen Equipment

General Parenteral/Enteral Nutrition Therapy Information

Parenteral Nutrition

Enteral Nutrition

Patient Lifts

Pneumatic Compression Devices (Used for Lymphedema)

Power Operated Vehicles (POVs)

Pressure Reducing Support Surfaces-Group 1

Pressure Reducing Support Surfaces-Group 2

Pressure Reducing Support Surfaces-Group 3

Recumbent Ankle Positioning Splints

Refractive Lenses

Repairs

Seat Lift Mechanisms

Spinal Orthoses, TLSO and LSO

Suction Pumps

Therapeutic Shoes for Diabetics

Tracheostomy Care Supplies

Transcutaneous Electrical Nerve Stimulators (TENS)

Trapeze Bars and Other Bed Accessories

Urological Supplies

Walkers

Manual Wheelchair Base

Motorized/Power Wheelchair Base

Wheelchair Options/Accessories

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Ankle-Foot/Knee-Ankle-Foot Orthotics

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

L1900	AFO, spring wire, dorsiflexion assist calf band
L1920	AFO, single upright with static or adjustable stop (Phelps or Perlstein type)
L1930	AFO, plastic
L1940	AFO, molded to patient model, plastic
L1960	AFO, posterior solid ankle, molded to patient model, plastic
L1980	AFO, single upright free plantar dorsiflexion, solid stirrup, calf band/cuff (single bar “BK” orthosis)
L1990	AFO, double upright free plantar dorsiflexion, solid stirrup, calf band/cuff (double bar “BK” orthosis)
L2000	KAFO, single upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar “AK” orthosis)
L2010	KAFO, single upright, free ankle, solid stirrup, thigh and calf bands/cuffs (single bar “AK” orthosis), without knee joint
L2020	KAFO, double upright, free knee, free ankle, solid stirrup, thigh and calf bands/cuffs (double bar “AK” orthosis)
L2030	KAFO, double upright, free ankle, solid stirrup, thigh and calf bands/cuffs, (double bar “AK” orthosis), without knee joint

L2036	KAFO, full plastic, double upright, free knee, molded to patient model
L2037	KAFO, full plastic, single upright, free knee, molded to patient model
L2038	KAFO, full plastic, without knee joint, multi-axis ankle, molded to patient model (Lively orthosis or equal)
L2102	AFO, fracture orthosis, tibial fracture cast orthosis, plaster type casting material casting material, molded to patient
L2104	AFO, fracture orthosis, tibial fracture cast orthosis, synthetic type casting material, molded to patient
L2106	AFO, fracture orthosis, tibial fracture cast orthosis, thermoplastic type casting material, molded to patient
L2108	AFO, fracture orthosis, tibial fracture cast orthosis, molded to patient model
L2112	AFO, fracture orthosis, tibial fracture orthosis, soft
L2114	AFO, fracture orthosis, tibial fracture orthosis, semi-rigid
L2116	AFO, fracture orthosis, tibial fracture orthosis, rigid
L2122	KAFO, fracture orthosis, femoral fracture cast orthosis, plaster type casting material, molded to patient
L2124	KAFO, fracture orthosis, femoral fracture cast orthosis, synthetic type casting material, molded to patient
L2126	KAFO, fracture orthosis, femoral fracture cast orthosis, thermoplastic type casting material, molded to patient

L2128	KAFO, fracture orthosis, femoral fracture cast orthosis, molded to patient model
L2132	KAFO, fracture orthosis, femoral fracture cast orthosis, soft
L2134	KAFO, fracture orthosis, femoral fracture cast orthosis, semi-rigid
L2136	KAFO, fracture orthosis, femoral fracture cast orthosis, rigid
L3215	Orthopedic footwear, woman's shoes, oxford
L3219	Orthopedic footwear, man's shoes, oxford
L4110	Replace leather cuff KAFO-AFO, calf or distal thigh

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

DEFINITIONS

1. A custom molded (molded-to-patient model) ankle-foot orthosis (AFO), codes L1940, L1960, involves taking a mold of a patient and fabricating an AFO from that mold. This device is constructed for only one patient and is not generic in design.
2. A custom-fitted AFO, code L1930, is an AFO manufactured in generic sizes, which is subsequently modified to fit the patient.

INDICATIONS

1. Ankle-foot orthoses are medically necessary for patients with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.
2. Knee-ankle-foot orthoses are covered for patients for whom an ankle-foot orthosis is covered and for whom additional knee stability is required.
3. Orthoses that are molded-to-patient model are covered when one of the following criteria is met:

a. Failure to fit a custom fitted AFO to the patient, or

b. The condition necessitating the orthosis is expected to be permanent or of long-standing duration (more than 6 months), or

c. There is a need to control the knee, ankle or foot in more than one plane, or

d. The patient has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury

e. A healing fracture lacking normal anatomical integrity or anthropometric proportions

COVERAGE AND PAYMENT RULES

1. If the criteria for a molded-to-patient model AFO (L1940, L1960) are not met, but the criteria for a custom fitted AFO (L1930) is met, payment is based on the least costly alternative, L1930.
2. Shoes are covered only when they are an integral part of a covered orthosis. Since the orthoses represented by codes L1940 and L1960 fit inside of shoes, the shoes are non-covered.
3. Separate payment is allowed for shoes when used as an integral part of codes L1900, L1920, L 1980, L1990, L2000, L2010, L2020, L2030. Shoes should be billed using either code L3215 or code L3219. Payment for covered shoes billed under other shoe codes will be based on the least costly alternative, L3215 or L3219.
4. Replacement, repair or adjustment of the orthosis (including a new shoe attached to the orthosis to replace a worn one) is a covered service when required by excessive wear or by a change in the patient’s condition and ordered by a physician.

CODING GUIDELINES

1. A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I Code	***Column II Code***
L1990	L4110

2. Fitting and measurement for an orthotic device, or casting for the purpose of fitting and measurement of an orthotic device, is included in the allowance for the purchase or replacement of the device. Separate charges are not allowed.

DOCUMENTATION REQUIRED

1. A physician’s order for the item that has been completed, signed, and dated by the ordering physician must be kept on file in the patient’s medical record.
2. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Canes and Crutches

HCPCS CODES

E0100	Cane, includes canes of all materials, adjustable or fixed, with tip
E0105	Cane, quad or three prong, includes canes of all materials, adjustable or fixed with tips
E0110	Crutches, forearm, includes crutches of various materials, adjustable or fixed, pair, complete with tips and handgrips
E0111	Crutch, forearm, includes crutches of various materials, adjustable or fixed, each, with tip and handgrips
E0112	Crutches, underarm, wood adjustable or fixed, pair, with pads, tips and handgrips
E0113	Crutch, underarm, wood adjustable or fixed, each, with pad, tip and handgrip
E0114	Crutches, underarm, other than wood, adjustable or fixed, pair, with pads, tips and handgrips
E0116	Crutches underarm, other than wood, adjustable or fixed, each, with pads, tip and handgrip
A9270	Non-covered item or service

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9, 60-3

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

Subject: **CANES AND CRUTCHES**

INDICATIONS

Canes (E0100, E0105) and crutches (E0110-E0116) are covered when prescribed by a physician for a patient with a condition causing impaired ambulation and when there is a potential for ambulation.

COVERAGE AND PAYMENT RULES

A white cane for a blind person is non-covered since it is a “self-help” item. Use code A9270 for this item.

DOCUMENTATION REQUIRED

1. An order for canes and crutches which is reviewed, signed, and dated by the ordering physician must be kept on file in the patient’s medical record. The medical records must contain information that supports the medical necessity of the item ordered.
2. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Cold Therapy

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0218	Water circulating cold pad with pump
A9270	Non-covered item or service

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

DEFINITIONS

Code E0218 describes a device that has an electric pump that circulates cold water through a pad.

COVERAGE AND PAYMENT RULES

A water circulating cold pad with pump (E0218) will be denied as not medically necessary. Other non-DME cooling devices (see ***CODING GUIDELINES***) will be denied as non-covered.

CODING GUIDELINES

1. A device in which ice water is put in a reservoir and then circulated through a pad by means of gravity is not considered durable medical equipment (DME).
2. Other devices (not all-inclusive) which are also not considered to be DME are:
    a. single use packs which generate cold temperature by a chemical reaction;
    b. packs which contain gel or other material which can be repeatedly frozen;
    c. simple containers into which ice water can be placed.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

3. All of these types of devices must be coded A9270 if claims are submitted to the Intermediary.
4. A provider wanting a coding determination for a particular product should contact the Medicare Part A Service Center.

DOCUMENTATION REQUIRED

1. An order for the device that is signed and dated by the ordering physician must be kept on file in the patient's medical record.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Commodes

HCPCS CODES

E0163	Commode chair, stationary, with fixed arms
E0164	Commode chair, mobile, with fixed arms
E0165	Commode chair, stationary, with detachable arms
E0166	Commode chair, mobile, with detachable arms
E0167	Pail or pan for use with commode chair
E0175	Foot rest for commode chair, each
K0457	Extra-wide/heavy-duty commode chair, each

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-9

DEFINITION

Extra-wide/heavy-duty commodes are defined as those that have a width ≥ 23 inches and are capable of supporting patients who weigh 300 pounds or more.

INDICATIONS

A commode is covered when the patient is incapable of utilizing regular toilet facilities.

COVERAGE AND PAYMENT RULES

1. The patient must be confined to a single room or to one level of his/her home environment. This means that leaving this environment is medically contraindicated or that the patient is physically incapable of doing so.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

2. When there are no toilet facilities anywhere in the home, it would be an appropriate setting for a commode.
3. Coverage would be provided if a patient's medical condition confines him/her to a single level and there is no toilet facility on that level.
4. Detachable arms (E0165) are covered when used to facilitate transferring the patient or if the patient has a body configuration that requires extra width.
5. A footrest (E0175) is non-covered because it is not medical in nature.
6. A mobile commode chair (E0164, E0166) is not medically necessary. Payment is based on the least costly alternative stationary commode.
7. An extra-wide/heavy-duty commode chair (K0457) is covered when the patient's weight is 300 pounds or more.

CODING GUIDELINES

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I:	**Column II:**
E0163	E0167
E0164	E0167
E0165	E0167
E0166	E0167
K0457	E0167

DOCUMENTATION REQUIRED

1. An order for the commode that is reviewed, signed, and dated by the ordering physician must be kept on file in the patient's medical record.
2. The medical records must contain information that supports the medical necessity of the item ordered.
3. For a heavy-duty, extra-wide commode chair, the patient's medical record must document a weight of 300 pounds or more.
4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Continuous Positive Airway Pressure System (CPAP)

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0601	Continuous positive airway pressure (CPAP)device
K0183	Nasal application device used with positive airway pressure device
K0184	Nasal pillows/seals, replacement for nasal application device, pair
K0185	Headgear used with positive airway pressure device
K0186	Chin strap used with positive airway pressure device
K0187	Tubing used with positive airway pressure device
K0188	Filter, disposable, used with positive airway pressure device
K0189	Filter, non-disposable, used with positive airway pressure device
K0193	Continuous positive airway pressure (CPAP) device, with humidifier
K0194	Intermittent assist device with continuous positive airway pressure (CPAP)with humidifier
K0268	Humidifier, non-heated, used with positive airway pressure (CPAP)device

Subject: **CONTINUOUS POSITIVE AIRWAY PRESSURE SYSTEM (CPAP)**

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-17

DEFINITIONS

1. CPAP is a noninvasive provision of air pressure, through a nose mask and flow generator system, through the nostrils to prevent collapse of the oropharyngeal walls during sleep.
2. Code E0601 has a single delivered pressure.

INDICATIONS

CPAP is covered for patients with a diagnosis of obstructive sleep apnea with documentation of at least 30 episodes of apnea, each lasting a minimum of 10 seconds, during a minimum of six-seven hours of recorded sleep. CPAP is covered when used in adult patients with moderate or severe obstructive sleep apnea, as defined above, for whom surgery is a likely alternative to CPAP.

COVERAGE AND PAYMENT RULES

Payment for CPAP (E0601) includes payment for the provision of all necessary accessories, i.e., mask, tubing or cannula. Separate charges for replacement of masks, tubing, or cannula or for respiratory equipment maintenance services are not covered since they are included in the rental payment for CPAP.

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or a physician’s order that has been completed, signed, and dated by the ordering physician must be kept on file in the patient’s medical record and be available to the Intermediary upon request. The CMN for CPAP is DMERC 03.
2. Copies of the patient’s sleep lab evaluation, including polysomnogram, pulmonary function tests, and oxygen saturations must be retained in the patient’s medical records.
3. Separate reimbursement will be allowed by the Intermediary for a humidifier, as long as the CPAP device is covered. Providers who bill for this equipment for existing CPAP patients should submit their claims using HCPCS code E0601 for the CPAP (if appropriate) and HCPCS code K0268 for the humidifier. The humidifier billed for an existing CPAP patient, after the initial issue of the CPAP , can be reimbursed as a purchase. Rentals can be reimbursed up to the purchase allowance. Code K0193 (CPAP with humidifier) is used only for newly

placed CPAPs with humidifier. HCPCS code K0268 requires a pricing modifier: NU, UE or RR.

4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

Note: Effective with dates of service on and after January 1, 1994, accessories used with CPAPs should be billed separately, whether the item is rented or purchased. The eligible accessories are:

K0183	Nasal application device, used with positive airway pressure device
K0184	Nasal pillows/seals, replacement for nasal application device, pair
K0185	Headgear, used with positive airway pressure device
K0186	Chin strap, used with positive airway pressure device
K0187	Tubing, used with positive airway pressure device
K0188	Filter, disposable, used with positive airway pressure device

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

External Breast Prostheses

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

L8000	Breast prosthesis, mastectomy bra
L8010	Breast prosthesis, mastectomy sleeve
L8015	External breast prosthesis garment, with mastectomy form, post-mastectomy
L8020	Breast prosthesis, mastectomy form
L8030	Breast prosthesis, silicone or equal
L8035	Custom breast prosthesis, post-mastectomy, molded to patient model
L8039	Breast prosthesis, not otherwise classified
K0400	Adhesive skin support attachment for use with external breast prosthesis, each

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

COVERAGE AND PAYMENT RULES

1. A breast prosthesis is covered for a patient who has had a mastectomy.
2. A mastectomy sleeve (L8010) is denied as non-covered, since it does not meet the definition of prosthesis.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

CODING GUIDELINES

1. The right (RT) and left (LT) modifiers should be used with these codes. When the same code for two breast prostheses are billed for both breasts on the same date, the items (RT and LT) should be entered on the same line of the claim form using the RTLT modifier and two units of service.
2. Custom breast prosthesis, post-mastectomy, molded to patient model (L8035) will be paid at the least costly medically appropriate alternative (L8030).

DOCUMENTATION REQUIRED

1. An order for the breast prosthesis, which shows the type of prosthesis, and that is signed and dated by the treating physician.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

External Infusion Pumps

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

Equipment:

E0781	Ambulatory infusion pump, single or multiple channels, with administrative equipment, worn by patient
E0782	Infusion pump, implantable, non-programmable
E0791	Parenteral infusion pump, stationary, single or multi-channel
E0776	IV pole
E1399	Durable medical equipment, miscellaneous
K0284	External infusion pump, mechanical, reusable, for extended drug infusion
K0417	External infusion pump, mechanical, reusable, for short term drug infusion
K0455	Infusion pump used for uninterrupted administration of epoprostenol

Supplies:

A4221	Supplies for maintenance of a drug infusion catheter, per week (list drug separately)
A4222	Supplies for external drug infusion pump, per cassette or bag (list drug separately
A4305	Disposable drug delivery system, flow rate of 50 ml or greater per hour

A4306	Disposable drug delivery system, flow rate of 5 ml or less per hour
A9270	Non-covered item or service

Drugs:

J0285	Injection, amphotericin B, 50 mg
J0286	Injection, amphotericin B, any lipid formulation, 50 mg
J0895	Injection, deferoxamine mesylate, 500 mg per 5 cc
J1170	Injection, hydromorphone, up to 4 mg
J1250	Injection, dobutamine HCl, per 250 mg
J1325	Injection, epoprostenol, 0.5 mg
J1455	Injection, foscarnet sodium, per 1000 mg
J1570	Injection, ganciclovir sodium, 500 mg
J2175	Injection, meperidine, per 100 mg
J2260	Injection, milrinone lactate, per 5 ml
J2270	Injection, morphine sulfate, up to 10 mg
J2271	Injection, morphine sulfate, 100 mg
J2275	Injection, morphine sulfate (preservative-free sterile solution), per 10 mg
J3010	Injection, fentanyl citrate, up to 2 ml
J7799	NOC drugs, other than inhalation drugs, administered through DME
J9000	Doxorubicin HCL, 10 mg
J9040	Bleomycin sulfate, 15 units
J9065	Injection, cladribine, per 1 mg

J9100	Cytarabine, 100 mg
J9110	Cytarabine, 500 mg
J9190	Fluorouracil, 500 mg
J9200	Floxuridine, 500 mg
J9360	Vinblastine sulfate, 1 mg
J9370	Vincristine sulfate, 1 mg
J9375	Vincristine sulfate, 2 mg
J9380	Vincristine sulfate, 5 mg

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-14

DEFINITIONS

1. An ambulatory infusion pump (E0781) is an electrical device that is used to deliver solutions containing parenteral medication under pressure at a regulated flow rate. It is small, portable and designed to be carried by the patient.
2. A stationary infusion pump (E0791) is an electrical device that serves the same purpose as an ambulatory pump but is larger and typically mounted on a pole.
3. An infusion controller (E1399) is an electrical device that regulates the flow of parenteral solutions under gravity pressure.
4. A reusable mechanical infusion pump (K0284) is a device used to deliver solutions containing parenteral medication under pressure at a constant flow rate determined by the tubing with which it is used. It is small, portable and designed to be carried by the patient. It must be capable of a single infusion cycle of at least eight hours.
5. Code K0417 describes a mechanical infusion pump which is similar to a K0284 pump, but that is only capable of a single infusion cycle of less than eight hours.
6. A disposable drug delivery system (A4305, A4306) is a device used to deliver solutions containing parenteral medication under pressure generated from the elastic properties of the container. It is

commonly called an elastomeric infusion pump. Code K0455 describes an ambulatory electrical infusion pump that is used for the administration of epoprostenol.

7. Code A4221 includes dressings for the catheter site and flush solutions not directly related to drug infusion. The catheter site may be a peripheral intravenous line, a peripherally inserted central catheter (PICC), a centrally inserted intravenous line with either an external or subcutaneous port, or an epidural catheter.
8. Code A4222 includes the cassette or bag, diluting solutions, tubing and other administration supplies, port cap changes, compounding charges, and preparation charges.

COVERAGE AND PAYMENT RULES

1. An infusion pump is indicated for the administration of parenteral medication in the home setting when both of the following criteria are met:
    a. parenteral administration of the medication in the home is reasonable and necessary
    b. an infusion pump is necessary to safely administer the medication
2. An external infusion pump is covered for the following indications:
    a. in the administration of deferoxamine for the treatment of chronic iron overload
    b. chemotherapy for the treatment of primary hepatocellular carcinoma or colorectal cancer where this disease is un-resectable or where the patient refuses surgical excision of the tumor
    c. morphine when used in the treatment of intractable pain caused by cancer
3. Additional uses of an infusion pump are covered for the administration of parenteral medication in the home setting if the patient meets criteria a., b., and c. (below) ***or*** a., d., and e. (below):
    - **Criteria:**
        a. Parenteral administration of the medication in the home is reasonable and necessary.
        b. The drug is administered by a prolonged infusion of at least eight hours because of proven improved clinical efficacy.
        c. The therapeutic regimen is proven or generally accepted to have significant advantages over:
            - Intermittent bolus administration regimens or

- Infusions lasting less than eight hours

d. The drug is administered by intermittent infusion (each episode of infusion lasting less than eight hours) which does not require the patient to return to the physician's office prior to the beginning of each infusion.

e. Systemic toxicity or adverse effects of the drug is unavoidable without infusing it at a strictly controlled rate as indicated in the Physicians Desk Reference, American Medical Association's Drug Evaluations, or the U. S. Pharmacopoeia Drug Information.

4. The criteria for additional uses of infusion pumps as described in a. and b. above are met in the following situations:

a. administration of cladribine, fluorouracil, cytarabine, bleomycin, floxuridine, doxorubicin, vincristine or vinblastine by continuous infusion over at least eight hours when the regimen is proven or generally accepted to have significant advantages over intermittent administration regimens. This does not apply to primary hepatocellular carcinoma or liver metastases from colorectal carcinoma.

b. Administration of narcotic analgesics (except meperidine) in place of morphine to a patient with intractable pain caused by cancer that has not responded to an adequate oral/transdermal therapeutic regimen and/or cannot tolerate oral/transdermal narcotic analgesics.

c. Administration of the following anti-fungal or anti-viral drugs: foscarnet, amphotericin B, acyclovir, and ganciclovir.

d. Administration of parenteral inotropic therapy, using the drugs dobutamine, milrinone and/or dopamine for patients with congestive heart failure and depressed cardiac function if a patient has all of the following conditions:

1. Dyspnea at rest despite treatment with maximum or near maximum tolerated doses of digitoxin, a loop diuretic, and an angiotensin converting enzyme inhibitor or another vasodilator (e.g., hydralazine or isosorbide dinitrate), used simultaneously (unless allergic or intolerant), and

2. Doses are within the following ranges (lower doses will be covered only if part of a weaning or tapering protocol from higher dose levels):

- Dobutamine 2.5 – 10 mcg/kg/min
- Milrinone 0.375 – 0.750 mcg/kg/min
- Dopamine < 2 mcg/kg/min, and

3. Invasive hemodynamic studies performed within six months prior to the initiation of home inotropic therapy show (a) cardiac index (CI) is less than or equal to 2.2 liters/min/meter squared and/or pulmonary capillary wedge pressure (PCWP) is greater than or equal to 20 mm Hg before inotrope infusion on maximum medical management and (b) at least a 20% increase in Cl and/or at least a 20% decrease in PCWP during inotrope infusion at the dose initially prescribed for home infusion.
4. An improvement in patient well being, (less dyspnea, improved diuresis, improved renal function and/or reduction in weight) with the absence of dyspnea at rest at the time of discharge and the capability of outpatient evaluation by the prescribing physician at least monthly, and
5. In the case of continuous infusion, there is documented deterioration in clinical status when the drug(s) is tapered or discontinued under observation in a hospital, or

   In the case of intermittent infusions, there is documentation of repeated hospitalizations for congestive heart failure despite maximum medical management, and
6. Any life threatening arrhythmia is controlled prior to hospital discharge and there is no need for routine electrocardiographic monitoring at home, and
7. The patient is maintained on the lower practical dose and efforts to decrease the dose of the drug(s) or the frequency/duration of infusion are documented during the first three months of therapy, and
8. The patient’s cardiac symptoms, vital signs, weight, lab values, and response to therapy are routinely assessed and documented in the patient’s medical record.
9. Administration of parenteral epoprostenol sodium for patients with primary pulmonary hypertension (PPH) is the patient meets ***all*** of the following criteria:
   a. PPH is evidenced by a mean pulmonary artery pressure of greater than 25 mm Hg at rest, or greater than 30 mm Hg with exercise, in the absence of left-sided cardiac valvular disease, myocardial disease, congenital heart disease, and any clinically important respiratory, connective-tissue or chronic thromboembolic diseases, and
   b. The patient has significant symptoms from the PPH (i.e., dyspnea on exertion, and variably, fatigability, angina, ***or*** syncope), and

c. A clinical trial or oral calcium channel blocking agents has been conducted or considered prior to long term commitment to chronic intravenous epoprostenol therapy.

5. External infusion pumps and related drugs and supplies will be denied as not medically necessary when these criteria are not met. When an infusion pump is covered, the medication necessitating the use of the pump and necessary supplies are also covered. When a pump has been purchased by the Medicare program, other insurer, or the patient, or the rental cap has been reached, the medication necessitating the use of the pump, and supplies are covered as long as the coverage criteria for the pump are met.
6. Injectable drugs administered in a physician's office, whether with or without a pump, must be billed to the local Carrier and not the Intermediary. Drugs put into an infusion pump in the physician's office for use in the patient's home must be billed to the Intermediary if the pump is billed to the Intermediary.
7. Medicare only pays for one pump for administering epoprostenol (K0455); the provider is responsible for ensuring that there is an appropriate and acceptable contingency plan to address any emergency situations or mechanical failures of the equipment. A second pump provided as a backup will be denied as not medically necessary.
8. Disposable drug delivery systems, including elastomeric infusion pumps (A4305, A4306) are non-covered devices because they do not meet the Medicare definition of durable medical equipment. Medication and supplies used with disposable drug delivery systems are also non-covered items.
9. An external infusion pump and related medication and supplies will be denied as not medically necessary in the home setting in the following situations:
    a. Heparin for the treatment of thromboembolic disease and/or pulmonary embolism
    b. Insulin for the treatment of diabetes mellitus
10. An infusion controller device (E1399) is not medically necessary.
11. An IV pole (E0776) is covered only when a stationary infusion pump (E0791) is covered. It is considered not medically necessary if it is billed with an ambulatory infusion pump (E0781).
12. Supplies for the maintenance of a parenteral drug infusion catheter (A4221) are covered during the period of covered use of an infusion pump. They are also covered for the weeks in between covered infusion pump use, not to exceed four weeks per episode. More than one unit of service per week is not separately allowed.
13. Supplies used with an external infusion pump, K0111, are covered. Allowance is based on the number of cassettes or bags prepared. For

intermittent infusions, no more than one cassette or bag is covered for each dose of medication. For continuous infusion, the concentration of the drug and the size of the cassette or bag should be maximized to result in the fewest cassettes or bags in keeping with good pharmacologic and medical practice. Medications and supplies that are dispensed but not used for completely unforeseen circumstances (e.g., emergency admission to hospital, drug toxicity, etc.) are covered. Providers are expected to anticipate changing needs for drugs (e.g., planned hospital admissions, drug level testing with possible dosage change, etc.) in their drug and supply preparation and delivery schedule.

14. The Intermediary does not process claims for implantable infusion pumps or medications and supplies used in conjunction with implantable infusion pumps. Claims for these items must be submitted to the local carrier.

CODING GUIDELINES

1. Supplies (including dressings) used in conjunction with a durable infusion pump (E0781, E0791, K0284, K0455) are included in codes A4221 or A4222. Other codes should not be used for the separate billing of these supplies.

2. Use codes A4221 and A4222 only for supplies related to durable infusion pumps. Charges for supplies for non-covered infusion therapy via disposable pump or without a pump may be billed under code A9270.

3. Medication used in a durable infusion pump should be coded using the appropriate HCPCS codes. If the medication does not have a distinct code, then use the unclassified drug code J7799. Do not use code J9999. If there is no distinct HCPCS code for the drug billed, and the drug is not administered via an infusion pump, use code A9270.

4. A new code has been established for any formulation of Amphotericin B lipid complex:

J0286	Injection, Amphotericin B, any lipid formulation, 50 mg

The new code is effective for claims with dates of service on/after January 1, 1999. Currently, there are three liposomal preparations of Amphotericin B being manufactured. They are:

   a. Abelcet

   b. Amphotec

   c. AmBisome

5. Use code J2275 only for morphine sulfate that is labeled “preservative free”. Morphine sulfate that is not labeled “preservative free” must be coded J2270.

6. For disposable drug delivery systems (e.g., elastomeric) with a flow rate of more than 5 ml per hour and less than 50 ml per hour, use code A9270.

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file by the provider. The CMN for external infusion pumps is DMERC 09.
2. If a patient begins using an infusion for one drug and subsequently the drug is changed or another drug is added, a revised CMN and/or physician's order must be submitted for use of the pump with the new or additional drug. In the case of an additional drug, all drugs for which the pump is used should be included on the revised CMN and/or physician's order.
3. If an inotropic drug is ordered, a copy of the order (prescription and documentation from the ordering physician) including information relating to each of the criteria ("d.1." through "d.8.") defined in ***COVERAGE AND PAYMENT RULES*** should be documented in the patient's medical record. This must include the before and after inotropic drug infusion values defined in "d.3." A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to collect this information may not be completed by the provider or by anyone in a financial relationship with the provider. If coverage criteria stated in the policy are not met, documentation in the patient's medical record should include a copy of a letter from the physician giving details of the patient's history (e.g., dates of past hospitalization for heart failure, prior use of parenteral inotropics and the results, etc.). If invasive hemodynamic studies were not performed, the documentation in the patient's medical record should include a letter from the attending physician explaining the rationale for not performing the tests accompanied by any other documentation deemed appropriate to explain this exception. This information is to be available to the Intermediary upon request.
4. Initial claims for J0286 must be submitted with a statement obtained by the provider from the physician indicating why the liposomal form of Amphotericin B is needed for a particular patient. If the documentation is not submitted or does not support the medical necessity of the need for this form of the drug for the particular patient, coverage will be based on the least costly medically appropriate alternative, standard Amphotericin B (J0285).
5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

NOTE: A new code has been established for the standard form of Amphotericin B. K0453 was the appropriate code used for billing standard Amphotericin B. Effective for claims with dates of service on/after January 1, 1999, a new J code has been established.

J0285 – Injection, Amphotericin B, up to 5 mg

Claims for code K0453 will not be valid for claim submission to the Intermediary if ***both of these apply:***

- The date of service is on or after January 1, 1999
- The claim is received on or after April 1, 1999.

HOME PARENTERAL INOTROPIC THERAPY, DATA COLLECTION FORM

Patient's Name_____

HIC #_____

Information below may not be completed by the supplier nor anyone in a financial relationship with the supplier.

1. Results of invasive hemodynamic monitoring:

	Cardiac Index	Wedge Pressure	Date
Before inotrope infusion	_____	_____	_____
On inotrope infusion	_____	_____	_____

Drug _____ Dose_____ mcg/kg/min

2. Cardiac medications (digoxin, diuretics, vasodilators) immediately prior to inotrope infusion (list name, dose, frequency):_____

_____

_____

3. Does this represent maximum tolerated doses of these medications?_____

4. Breathing status (check one in each column)	Prior to inotrope infusion	At time of discharge
No dyspnea on exertion	_____	_____
Dyspnea on moderate exertion	_____	_____
Dyspnea on mild exertion	_____	_____
Dyspnea at rest	_____	_____

5. Initial home prescription: Drug_____ Dose_____mcg/kg/min

_____hrs/day days/week (or every day)

6. If continuous infusion is prescribed, have attempts to discontinue inotrope infusion in the hospital failed?
7. If intermittent infusion is prescribed, have there been repeated hospitalizations for heart failure during which parenteral inotropes were required?
8. Is the patient capable of going to the physician for outpatient evaluation?
9. Is routine electrocardiographic monitoring required in the home?
10. The above statements and any additional explanations included separately are true and accurate and there is documentation present in the patient's medical record to support these statements.

Physician Signature:_____ Date:_____

Physician name Printed/Typed:_____ UPIN #:_____

363 Physician Specialty:_____

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Eye Prosthesis

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

V2623	Prosthetic eye, plastic, custom
V2624	Polishing/resurfacing of ocular prosthesis
V2625	Enlargement of ocular prosthesis
V2626	Reduction of ocular prosthesis
V2627	Scleral cover shell
V2628	Fabrication and fitting of ocular conformer
V2629	Prosthetic eye, other type

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

INDICATIONS

An eye prosthesis is indicated for a patient with absence of an eye due to trauma or surgical removal.

COVERAGE AND PAYMENT RULES

1. Polishing and resurfacing is covered on a yearly basis.
2. Replacement is covered every five (5) years unless documentation supports medical necessity of more frequent replacement.
3. One enlargement (V2625) or reduction (V2626) of the prosthesis is covered without documentation. Additional enlargements or reductions are rarely medically necessary and are therefore covered only when accompanied by documentation that supports medical necessity.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

DOCUMENTATION REQUIRED

1. An order for the eye prosthesis that is reviewed, signed, and dated by the ordering physician must be kept on file by the provider. The medical records must contain information that supports the medical necessity of the item ordered.
2. The ocularist's documentation of the necessity for replacement prosthesis would be appropriate documentation for that claim if the replacement were necessitated by other than medical reasons.
3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Facial Prostheses

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A6265	Tape, all types, per 18 sq. in.
K0440	Nasal prosthesis, provided by a non-physician
K0441	Midfacial prosthesis, provided by a non-physician
K0442	Orbital prosthesis, provided by a non-physician
K0443	Upper facial prosthesis, provided by a non-physician
K0444	Hemi-facial prosthesis, provided by a non-physician
K0445	Auricular prosthesis, provided by a non-physician
K0446	Partial facial prosthesis, provided by a non-physician
K0447	Nasal septal prosthesis, provided by a non-physician
K0448	Unspecified maxillofacial prosthesis, by report, provided by a non-physician
K0449	Repair or modification of maxillofacial prosthesis, labor component, 15 minute increments, provided by a non-physician

K0450	Adhesive liquid, for use with facial prosthesis only, per ounce
K0451	Adhesive remover, wipes, for use with facial prosthesis, per box of 50
V2623	Prosthetic eye, plastic, custom
V2629	Prosthetic eye, other type

HCPCS MODIFIERS

KM	Replacement of facial prosthesis, including new impression/moulage
KN	Replacement of facial prosthesis, using previous master model

BENEFIT CATEGORY

Durable Medical Equipment

DEFINITIONS

1. A nasal prosthesis (K0440) is a removable superficial prosthesis that restores all or part of the nose. It may include the nasal septum.
2. A mid-facial prosthesis (K0441) is a removable superficial prosthesis that restores all or part of the nose ***plus*** significant adjacent facial tissue/structures, but does not include the orbit or any intra-oral maxillary component. Adjacent facial tissue/structures include one or more of the following: soft tissue of the cheek, upper lip or forehead.
3. An orbital prosthesis (K0442) is a removable superficial prosthesis that restores the eyelids and the hard and soft tissue of the orbit. It also may include the eyebrow. This code does ***not*** include the ocular prosthesis component.
4. An upper facial prosthesis (K0443) is a removable superficial prosthesis that restores all or part of the nose ***plus*** the orbit ***plus*** significant adjacent facial tissue/structures, but does not include any intra-oral maxillary component. This code does not include the ocular prosthesis component.
5. An auricular prosthesis (K0445) is a removable superficial prosthesis that restores all or part of the ear.

6. A partial facial prosthesis (K0446) is a removable prosthesis that occludes a hole in the nasal septum, but does not include superficial nasal tissue.
7. Code V2623 describes an ocular prosthesis that is custom fabricated.

COVERAGE AND PAYMENT RULES

1. A facial prosthesis is covered when there is loss or absence of facial tissue due to disease, trauma, surgery or a congenital defect.
2. Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis are covered. Other skin care products related to the prosthesis, including but not limited to cosmetics, skin cream, cleansers, etc., are non-covered.
3. The following services and items are included in the allowance for a facial prosthesis and, therefore, are not separately billable to, or payable by, Medicare under the prosthetic device benefit:
    a. evaluation of the patient
    b. pre-operative planning
    c. cost of materials
    d. labor involved in the fabrication and fitting of the prosthesis
    e. modifications to the prosthesis made at the time of delivery of the prosthesis, or within 90 days thereafter
    f. repair due to normal wear or tear within 90 days of delivery, ***or***
    g. follow-up visits within 90 days of delivery of the prosthesis
4. Modifications to a prosthesis are separately payable when they occur more than 90 days after delivery of the prosthesis and are required because of a change in the patient’s condition.
5. Repairs are covered when there has been accidental damage to or extensive wear on the prosthesis that can be repaired. If the expense for repairs exceeds the estimated expense for a replacement prosthesis, no payments can be made for the amount of the excess.
6. Follow-up visits which occur more than 90 days after delivery and which do not involve modification or repair of the prosthesis are non-covered services.
7. Replacement of a facial prosthesis is covered in cases of loss or irreparable damage or wear, or when required because of a change in the patient’s condition that cannot be accommodated by modification of the existing prosthesis. When replacement involves a new impression/moulage rather than use of a previous master model, the reason for the new impression/moulage must be documented clearly in the patient’s medical records and be available to the Intermediary on request.

8. Claims for facial prostheses billed by a skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency are submitted to the Intermediary. Claims for facial prostheses from ***physicians*** are submitted to the local Carrier. Claims for facial prostheses provided in an outpatient hospital facility are submitted to the local Intermediary. Facial prostheses provided in an in-patient hospital setting are included in the payment made to the hospital. Implanted prosthesis-anchoring components should be billed to the Intermediary.
9. If an ocular prosthesis is dispensed to the patient as an integral part of a facial prosthesis, the ocular prosthesis component must be billed by the provider of the facial prosthesis (for information on ocular prostheses not part of the orbital prostheses, refer to the medical policy on eye prostheses).

CODING GUIDELINES

1. When a replacement prosthesis is fabricated starting with a new impression/moulage, the KM modifier should be added to the code. When a replacement prosthesis is fabricated using a previous master model, the KN modifier should be added to the code.
2. Covered modifications or repairs are billed using code K0449 for the labor components and code K0448 for any materials used. Time reported using code K0449 should be only for laboratory modification/repair time, and associated prosthetic evaluation used only for services after 90 days from the date of delivery of the prosthesis. Evaluation not associated with repair or modification is non-covered and should not be coded as K0449.
3. Adhesives, adhesive remover and tape used in conjunction with a facial prosthesis should be billed using codes K0450, A4455, K0451 or K0265. The unit of service is specified for each code. For tape, one unit of service is 18 square inches. Therefore, a roll of tape ½″ x 3 yds. would be 3 units; 1″ x 3 yds. would be 6 units. Other skin care products related to the prosthesis generally should not be billed to the Intermediary, but if they are billed at the beneficiary's request, code A9270 (non-covered item or service) should be used.
4. When a new ocular prosthesis component which is used to attach it to a bone-anchored implant, or to an internal prosthesis (e.g., maxillary obturator), that component should be billed separately using code K0448. This code should ***not*** be used for implanted prosthesis-anchoring components.
5. Code K0448 also is used for a facial prosthesis that is not described by a specific code (K0440-K0447).
6. Code V2629 also is used for a facial prosthesis that is ***not*** custom fabricated (i.e., stock prosthesis).

7. When a prosthesis is needed for adjacent facial regions, a single code must be used to bill for the item whenever possible. For example, if a defect involves the nose and orbit, this should be billed using the hemi-facial prosthesis code and ***not*** separate codes for the orbit and nose. This applies even if the prosthesis is fabricated in two separate parts.
8. The right (RT) and left (LT) modifiers should be used with facial prosthesis codes when applicable. If bilateral prostheses using the same code are billed on the same date of service, the code should be entered on a single claims line, using the LT/RT modifiers, and billed with 2 units of service.

DOCUMENTATION REQUIRED

1. An order for the initial prosthesis and/or related supplies that is signed and dated by the ordering physician must be kept on file by the prosthetist/provider. A separate physician order is not required for subsequent modification, repairs or replacement of a facial prosthesis. A new order is required when different supplies are ordered.
2. When codes A4455, K0265 or K0451 are billed for supplies used in conjunction with a facial prosthesis, ICD-9-CM diagnosis code V43.89 also should be included on each claim.
3. A photograph of the prosthesis and a photograph of the patient without the prosthesis must be retained in the patient’s medical record and be available to the Intermediary upon request.
4. When code K0450 is billed, a complete description and a drawing/copy of photograph of the item provided and the medical necessity must be documented in the patient’s medical records and made available to the Intermediary upon request.
5. When code V2629 is billed, a complete description of the item must be documented in the patient’s medical record and made available to the Intermediary upon request.
6. When claims for replacement, repair or modification of a facial prosthesis are billed, a complete description of the repair or modification must be documented in the patient’s medical record and made available to the Intermediary upon request.
7. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

MODIFIERS

The following listed modifiers are frequently used to identify the service/charges billed for Prosthetics and Orthotics:

CC	Procedure code change Used by the Carrier when the procedure code submitted was changed either for administrative reasons or because an incorrect procedure code was filed. Do not use this modifier when filing your claims to Palmetto GBA
GA	Advance notice of possible medical necessity denial on file
K0	Lower limb 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 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, stair 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 traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.

K4	Lower extremity prosthesis functional Level 4 Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress or energy levels. Typical of the prosthetic demands of the child, active adult or athlete
LT	Left side of the body Left side (used to identify procedures performed on the LEFT side of the body)
RP	DME, orthotic and prosthetic device, repair or replacement Charges are for the device due to: loss, irreparable damage or wear, or a change in the patient's condition. Replacement and repair, RP may be used to indicate replacement of DME, orthotic, and prosthetic devices that have been in use for some time. The claim shows the code for the part, followed by the RP modifier and the charge for this part.
RT	Right side of the body Right side (used to identify procedures performed o the RIGHT side of the body).
ZX	Specific requirements found in the ***DOCUMENTATION REQUIRED*** section of the medical policy have been met, and evidence of this is available in the patient's medical records.
ZY	Potentially non-covered item or service billed for denial or at the beneficiary-s request (not to be used for medical necessity denials).

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Home Blood Glucose Monitors and Related Supplies

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0607	Home Blood Glucose Monitor
E0609	Blood Glucose Monitor with Special Features (e.g., voice synthesizers, automatic timers, etc.)

BENEFIT CATEGORY

Durable Medical Equipment

ACCESSORIES/SUPPLIES:

A4244	Alcohol or peroxide, per pint
A4245	Alcohol wipes, per box
A4246	Betadine or pHisohex solution, per pint
A4247	Betadine or iodine swabs/wipes, per box
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips
A4254	Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each
A4255	Platforms for home blood glucose monitor, 50 per box
A4256	Normal, low and high calibrator solution/chips
A4258	Spring-powered device for lancet, each

A4259	Lancets, per box of 100

HCPCS MODIFIERS

KS	Glucose monitor supply for diabetic beneficiary not treated by insulin
ZX	Specific requirements found in the ***DOCUMENTATION REQUIRED*** section of this policy have been met and evidence of this is available in the patient's medical records

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-11 (addresses insulin-treated diabetics)

Program Memorandum B98-26 (addresses non-insulin-treated diabetics)

DEFINITIONS

1. Insulin-treated means that the patient is receiving insulin ***injections*** to treat their diabetes. Insulin does not exist in an oral form and therefore patients taking oral medication to treat their diabetes are ***not*** insulin-treated.
2. A severe visual impairment is defined as a best-corrected visual acuity of 20/200 or worse.
3. A ***renewal*** of an order is the writing of a new order by the treating physician. A ***refill*** of an order is the actual dispensing of the item to the beneficiary based on an existing valid order.
4. Code A4256 describes control solutions containing high, normal, and low concentrations of glucose that can be applied to test strips to check the integrity of the test strips. This code does ***not*** describe the strip or chip which is included in a vial of test strips and which calibrates the glucose monitor of that particular vial of test strips.

COVERAGE AND PAYMENT RULES

1. For any item to be covered by Medicare, it must be reasonable and necessary for the treatment of illness or injury or to improve the functioning of a malformed body member. The determination of medical necessity for the items addressed by this policy will be based on the information contained in this section.
2. Home blood glucose monitors are covered for patients who are diabetics and who can better control their blood glucose levels by

checking these levels and appropriately contacting their attending physician for advice and treatment.

3. To be eligible for coverage, the patient must meet the following basic criteria:
    a. the patient has diabetes (ICD-9-CM codes 250.00-250.93) which is being treated by a physician; and
    b. the glucose monitor and related accessories and supplies have been ordered by the physician who is treating the patient's diabetes; and
    c. the patient (or the patient's caregiver) has successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancets; and
    d. the patient (or the patient's caregiver) is capable of using the test results to assure the patient's appropriate glycemic control; and
    e. the device is designed for home use.
4. For all glucose monitors and related accessories and supplies, if the basic coverage criteria (3.a.-3.e.) are not met, the items will be denied as not medically necessary.
5. Blood glucose monitors with such features as voice synthesizers and specially designed arrangements of supplies and materials to enable the visually-impaired to use the equipment without assistance (E0609) are covered when the basic coverage criteria (3.a.-3.e.) are met, and the patient's physician certifies that he or she has a visual impairment severe enough to require use of this special monitoring system.
6. If an E0609 glucose monitor is provided and basic coverage criteria (3.a.-3.e.) are met but the additional criterion is not met, payment will be based on the allowance for the least costly medically appropriate alternative, E0607.
7. Lancets (A4259), blood glucose test reagent strips (A4253), glucose control solutions (A4256), and spring powered devices for lancets (A4258) are covered for patient's for whom the glucose monitor is covered. More than one spring powered device (A4258) per 6 months will rarely be medically necessary.
8. The quantity of test strips (A4253) and lancets (A4259) that are covered depends on the usual medical needs of the diabetic patient according to the following guidelines:
    a. for a patient who is ***not*** currently being treated with insulin injections, up to 100 test strips and 100 lancets every 3 months are covered if criteria i., ii, and iii. (below) are met:

b. for a patient who ***is*** currently being treated with insulin injections, up to 100 test strips and 100 lancets every month are covered if criteria i., ii., and iii. (below) are met:

c. for a patient who is ***not*** currently being treated with insulin injections, more than 100 test strips and 100 lancets every 3 months are covered if criteria (3.a)-(3e) are met:

d. for a patient who ***is*** currently being treated with insulin injections, more than 100 test strips and 100 lancets every month are covered if criteria (3.a)-(3.e) are met:

i. the coverage criteria 2a.-2e. (above) are met; and

ii. the provider of the test strips and lancets maintains in it records the order from the treating physician; and

iii. the beneficiary has nearly exhausted the supply of test strips and lancets that have been previously dispensed

iv. the provider has ordered a frequency of testing that exceeds the utilization guidelines and has documented in the patient's medical record the specific reason for the additional strips for that particular patient.

v. The provider has seen the patient and has evaluated their diabetes control within 6 months prior to ordering quantities of strips and lancets that exceed the utilization guidelines.

vi. If refills of quantities of supplies that exceed the utilization guidelines are dispensed, there must be documentation in the provider's records (e.g., a specific narrative statement that adequately documents the frequency at which the patient is actually testing or a copy of the beneficiary's log) or in the provider's records (e.g., a copy of the beneficiary's log) that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed. If the patient is regularly using quantities of supplies that exceed the utilization guidelines, new documentation must be present at least every 6 months.

9. If criteria 8.d.i.-8.d.iii are not met, all testing supplies will be denied as not medically necessary. If quantities of test strips or lancets that exceed the utilization guidelines are provided and criteria 8.d.iv.-8.d.vi. are not met, the amount in excess will be denied as not medically necessary.

10. A provider should not dispense more than a 3-month supply of test strips and/or lancets at a time.

11. Alcohol or peroxide (A4244, A4245), Betadine of pHisohex (A4246, A4247) are non-covered since these items are not required for the proper functioning of the device.
12. Urine test reagent strips or tablets (A4250) are non-covered since they are not used with a glucose monitor.

CODING GUIDELINES

1. For glucose test strips (A4253), 1 unit of service = 50 strips. For lancets (A4259), 1 unit of service = 100 lancets.
2. Blood glucose test or reagent strips that use a visual reading and are not used in a glucose monitor must be coded A9270 (non-covered item or service). Do not use code A4253 for these items.
3. In the following table, a Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

E0607	A4254, A4256, A4258
E0609	A4254, A4256, A4258

DOCUMENTATION REQUIRED

1. The provider must have an original order that is signed and dated by the physician who is treating the patient's diabetes. For supplies, the order must list the items that are to be dispensed and the frequency of testing. A narrative diagnosis and/or ICD-9-CM diagnosis code must be present on each order for a glucose monitor or related accessory or supply. The order must also include a statement indicating whether the patient is being treated with insulin injections. The provider is required to have a new ***written*** order from the treating physician every 6 months. The renewal of the order must also contain the information specified above.
2. The ICD-9-CM diagnosis code describing the condition that necessitates glucose testing must be included on each claim for the monitor, accessories, and supplies.
3. If the order indicates that the patient is being treated with insulin injections, the ZX modifier must be added to the code for the monitor and each related supply on every claim submitted. The ZX modifier must ***not*** be used for a patient who is ***not*** treated with insulin injections.
4. If the order indicates that the patient is ***not*** being treated with insulin injections, the KS modifier must be added to the code for the monitor and supplies on each claim submitted.
5. Additional documentation requirements apply to:

a. a diabetic patient who is ***not*** insulin-treated (KS modifier present) and whose prescribed frequency of testing is more often than once per day, ***or***

b. a diabetic patient who ***is*** insulin-treated (ZX modifier present) and whose prescribed frequency of testing is more often than three times per day.

6. When refills for quantities of supplies that exceed the utilization guidelines are dispensed, the documentation as described in 8.d.i.-8.d.vi. section, must be available to the Intermediary upon request.

7. The medical necessity for E0609 must be documented by a narrative statement from the physician that includes the patient's visual acuity.

8. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Hospital Beds-Fixed Height

HCPCS CODES

E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-18

DEFINITIONS

A fixed height hospital bed is one with manual head and leg elevation adjustments but no height adjustment.

An ordinary bed is one that is typically sold as furniture. It consists of a frame, box spring and mattress. It is a fixed height and has no head or leg elevation adjustments. An ordinary bed will accommodate most transfers to a chair, wheelchair or standing position. If needed, it can almost always be adapted to accommodate these transfers. The need for a particular bed height would rarely by itself justify the need for a hospital bed.

INDICATIONS

A fixed height bed is covered if ***one or more*** of the following indications are met:

1. A patient who requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
2. A patient who requires the head of the bed to be elevated more than thirty degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or

wedges must have been tried and failed to achieve the desired clinical outcome.

3. A patient who requires traction equipment which can only be attached to a hospital bed.

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file by the provider. The CMN for hospital beds is DMERC 01.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Hospital Beds-Variable Height

HCPCS CODES

E0255	Hospital bed, variable height (hi-lo), with any type side rails, with mattress
E0256	Hospital bed, variable height (hi-lo), with any type side rails, without mattress
E0292	Hospital bed, variable height (hi-lo), without side rails, with mattress
E0293	Hospital bed, variable height (hi-lo), without side rails, without mattress

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-18

DEFINITION

A variable height hospital bed is one with manual height adjustment and with manual head and leg elevation adjustments.

INDICATIONS

A variable height bed is covered if ***one*** of the following indications is met:

1. A patient who requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
2. A patient who requires the head of the bed to be elevated more than thirty degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed.
3. A patient who requires traction equipment that can only be attached to a hospital bed ***and*** the patient requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

Subject: **HOSPITAL BEDS-VARIABLE HEIGHT**

COVERAGE AND PAYMENT RULES

If the documentation does not support the medical necessity of a variable height bed but does support the necessity for a fixed height bed, payment will be based on the allowance for the least costly alternative.

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed, and dated by the ordering physician must be kept on file by the provider. The CMN for hospital beds is DMERC 01.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Hospital Beds-Semi-Electric

HCPCS CODES

E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
K0456	Hospital bed, heavy-duty, extra-wide, with any type side rails, with mattress

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-18

DEFINITIONS

1. A semi-electric bed is one with manual height adjustment and with electric head and leg elevation adjustments.
2. A heavy-duty, extra-wide hospital bed is a hospital bed that is capable of supporting a patient that weighs more than 350 pounds but less than or equal to 600 pounds.

INDICATIONS

1. A semi-electric bed is covered if ***one*** of the following indications are met:

a. A patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.

b. A patient requires the head of the bed to be elevated more than thirty degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Pillows or wedges must have been tried and failed to achieve the desired clinical outcome.

c. A patient requires traction equipment that can only be attached to a hospital bed ***and*** the patient requires frequent changes in body position and/or has an immediate need for a change in body position.

2. A heavy-duty, extra-wide hospital bed is covered when the patient's weight is 350 pounds or more but less than 600 pounds.

COVERAGE AND PAYMENT RULES

1. If the documentation does not support the medical necessity of a semi-electric bed but does support the necessity of a lower level bed, payment will be based on the allowance for the least costly alternative.

2. If the documentation does not support the medical necessity for a heavy-duty, extra-wide hospital bed (K0456) but does show medical necessity for a lower level bed, the least costly alternative will be paid (HCPCS Code E0260).

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file by the provider. The CMN for hospital beds is DMERC 01.

2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Hospital Beds-Total Electric

HCPCS CODES

E0265	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, with mattress
E0266	Hospital bed, total electric (head, foot and height adjustments), with any type side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustment), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustment), without side rails, without mattress

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-18

DEFINITION

A total electric bed is one with electric height adjustment and with electric head and leg elevation adjustments.

COVERAGE AND PAYMENT RULES

1. An electric bed height adjustment feature is not covered; it is a convenience feature.
2. If the documentation supports a lower level bed, payment is based on the allowance for the least costly alternative.
3. If E0265-E0297 is billed it will be paid the same as E0260-E0295 comparatively.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file by the provider. The CMN for hospital beds is DMERC 01.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Immunosuppressive Drugs

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

J2920	Injection, methylprednisolone sodium succinate, up to 40 mg
J2930	Injection, methylprednisolone sodium succinate, up to 125 mg
J7503	Cyclosporine, parenteral, per 50 mg
J7505	Monoclonal antibodies, parenteral, 5 mg
J7506	Prednisone, oral, per 5 mg
J7507	Tacrolimus, oral, per 1 mg
J7508	Tacrolimus, oral, per 5 mg
J7509	Methylprednisolone, oral, per 4 mg
J7510	Prednisolone, oral, per 5 mg
J7513	Daclizumab, parenteral, 25 mg
J7599	Immunosuppressive drug, not otherwise classified
J8530	Cyclophosphamide, oral, 25 mg
J8610	Methotrexate, oral, 2.5 mg
K0119	Azathioprine, oral, tab, 50 mg
K0120	Azathioprine, parenteral, 100 mg
K0121	Cyclosporine, oral, 25 mg
K0123	Lymphocyte immune globulin, antithymocyte globulin, parenteral, 250 mg
K0412	Mycophenolate mofetil, oral, 250 mg

K0418 Cyclosporine, oral, per 100 mg

BENEFIT CATEGORY

Immunosuppressive Drugs

COVERAGE AND PAYMENT RULES

1. Prescription drugs used in immunosuppressive therapy are covered if ***all*** of the following criteria are met:
   a. The drugs are prescribed following a kidney, heart, liver, bone marrow/stem cell, lung or heart/lung transplant which met Medicare coverage criteria in effect at the time (e.g., approved facility for kidney, heart, liver, lung, or heart/lung transplant; national and/or local medical necessity criteria etc.);
   b. The drugs are furnished during the benefit period specified below;
   c. The drugs are medically necessary to prevent or treat rejection of an organ transplant in the particular patient;
   d. The patient was enrolled in Medicare Part A at the time that the drugs were dispensed.
2. The benefit period for coverage of immunosuppressive drugs is determined by the date that the beneficiary is discharged from a hospital following a covered transplant. For beneficiaries discharged on or before 7/31/93, coverage is limited to one year from the date of discharge. Table 1 gives examples of the phased-in benefit period for patients discharged between 8/1/93 and 7/1/95. For all patients discharged on or after 7/1/95 following a covered transplant, coverage of immunosuppressive drugs is limited to 36 months.
3. If criteria a is met, the transplant is considered a “covered transplant’ for purposes of this policy whether payment for the transplant was made by Medicare or by another insurer.
4. If criterion a, b or d (above) are not met, the drug(s) will be denied as non-covered. If criterion a, b and d are met but criterion c is not met, the drug(s) will be denied as not medically necessary.
5. The dosage, frequency and route of administration of the immunosuppressive drugs must conform with generally accepted medical practice.
6. Parenteral cyclosporine (J7503), anti-thymocyte globulin (K0123), monoclonal antibodies (J7505) and Daclizumab (J7513) are not safely administered in the home setting and therefore they will be denied as not medically necessary in that setting.

7. Coverage of ***parenteral*** azathioprine (K0120) or methylprednisolone (J2920, J2930) is limited to those situations in which the medication cannot be tolerated or absorbed if taken orally and is self-administered by the patient. There is no coverage under the immunosuppressive drug benefit for supplies used in conjunction with the administration of parenteral immunosuppressive drugs.
8. The quantity of immunosuppressive drugs dispensed must be limited to a 30-day supply. Prescriptions may be refillable.

CODING GUIDELINES

1. Codes J7501, J7502 and J7504 are not valid for claims submitted to the Intermediary.
2. Code J7599 should be used for immunosuppressive drugs that do not have a specific J or K code.
3. For all immunosuppressive drugs, the number of units billed must accurately reflect the definition of one unit of service in each code narrative. For example, if fifty 10 mg prednisone tablets are dispensed, bill J7506, 100 units (1 unit of J7506 = 5 mg). If fifty 2.5 mg prednisone tablets are dispensed, bill J7506, 25 units.

DOCUMENTATION REQUIRED

1. A prescription (order) for the drugs that has been signed and dated by the ordering physician must be kept on file by the provider. A new prescription would be needed if there were a change in dose or frequency of administration.
2. If code J7599 is billed, the claim must list the name of the drug, the dosage strength, number dispensed and administration instructions.
3. If a transplant was paid in full by a primary insurer other than Medicare, documentation of the transplant must be of the type Medicare covers. The provider must also submit documentation of payment by the primary insurer.
4. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

TABLE 1

Phased-In Consecutive Benefit Periods For Immunosuppressive Drug Therapy

This table gives examples of the phased-in benefit periods using a discharge date of the first day of each month.

Discharge Date	Coverage Period Ends	Total Months of Coverage
8/1/93	8/31/94	13
9/1/93	10/31/94	14
10/1/93	12/31/94	15
11/1/93	2/28/95	16
12/1/93	4/30/95	17
1/1/94	6/30/95	18
2/1/94	8/31/95	19
3/1/94	10/31/95	20
4/1/94	12/31/95	21
5/1/94	2/29/96	22
6/1/94	4/30/96	23
7/1/94	6/30/96	24
8/1/94	8/31/96	25
9/1/94	10/31/96	26
10/1/94	12/31/96	27
11/1/94	2/28/97	28
12/1/94	4/30/97	29
1/1/95	6/30/97	30
2/1/95	8/31/97	31
3/1/95	10/31/97	32

4/1/95	12/31/97	33
5/1/95	2/28/98	34
6/1/95	4/30/98	35
7/1/95	6/30/98	36

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Lower Limb Prostheses

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

L5000	Partial foot, shoe insert with longitudinal arch, toe filler
L5010	Partial foot, molded socket, ankle height, with toe filler
L5020	Partial foot, molded socket, tibial tubercle height, with toe filler
L5050	Ankle, Symes, molded socket, SACH foot
L5060	Ankle, Symes, metal frame, molded leather socket, articulated ankle/foot
L5100	Below knee, molded socket, shin, SACH foot
L5105	Below knee, plastic socket, joints and thigh lacer, SACH foot
L5150	Knee disarticulation (or through knee), molded socket, external knee joints, shin, SACH foot
L5160	Knee disarticulation (or through knee), molded socket, bent knee configuration, external knee joints, shin SACH foot
L5200	Above knee, molded socket, single axis constant friction knee, shin, SACH foot
L5210	Above knee, short prosthesis, no knee joint (“stubbies”), with foot blocks, no ankle joints, each
L5220	Above knee, short prosthesis, no knee joint (“stubbies”), with articulated ankle/foot, dynamically aligned, each

L5230	Above knee, for proximal femoral focal deficiency, constant friction knee, shin, SACH foot
L5250	Hip disarticulation, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5270	Hip disarticulation, tilt table type; molded socket, locking hip joint, single axis constant friction knee, shin, SACH foot
L5280	Hemipelvectomy, Canadian type; molded socket, hip joint, single axis constant friction knee, shin, SACH foot
L5300	Below knee, molded socket, SACH foot, endoskeletal system, including soft cover and finishing
L5310	Knee disarticulation (or through knee), molded socket, SACH foot endoskeletal system, including soft cover and finishing
L5320	Above knee, molded socket, open end, SACH foot, endoskeletal system, single axis knee, including soft cover and finishing
L5330	Hip disarticulation, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5340	Hemipelvectomy, Canadian type; molded socket, endoskeletal system, hip joint, single axis knee, SACH foot, including soft cover and finishing
L5400	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment, suspension, and one cast change, below knee
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

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
L5430	Immediate post surgical or early fitting, application of initial rigid dressing, including fitting, alignment and suspension, 'AK' or knee disarticulation, each additional cast change and realignment
L5450	Immediate post surgical or early fitting, application of non weight bearing rigid dressing, below knee
L5460	Immediate post surgical or early fitting, application of non weight bearing rigid dressing, above knee
L5500	Initial, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed
L5505	Initial, above knee – knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, direct formed
L5510	Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5520	Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5530	Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5535	Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, prefabricated, adjustable open end socket
L5540	Preparatory, below knee 'PTB' type socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model

L5560	Preparatory, above knee- knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, plaster socket, molded to model
L5570	Preparatory, above knee- knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, direct formed
L5580	Preparatory, above knee- knee disarticulation ischial level socket, non-alignable system, pylon, no cover, SACH foot, thermoplastic or equal, molded to model
L5585	Preparatory, above knee- knee disarticulation, ischial level socket, non-alignable system, pylon, no cover, SACH foot, prefabricated adjustable open end socket
L5590	Preparatory, above knee- knee disarticulation ischial level socket, non-alignable system, pylon, no cover, SACH foot, laminated socket, molded to model
L5595	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, thermoplastic or equal, molded to patient model
L5600	Preparatory, hip disarticulation-hemipelvectomy, pylon, no cover, SACH foot, laminated socket, molded to patient model
L5610	Addition to lower extremity, endoskeletal system, above knee, hydracadence system
L5611	Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4 bar linkage with friction swing phase control
L5613	Addition to lower extremity, endoskeletal system, above knee-knee disarticulation, 4-bar linkage, with hydraulic swing phase control
L5614	Addition to lower extremity, exoskeletal system, above knee-knee disarticulation, 4-bar linkage with pneumatic swing phase control

L5616	Addition to lower extremity, endoskeletal system, above knee, universal multiplex system, friction swing phase control
L5617	Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each
L5618	Addition to lower extremity, test socket, Symes
L5620	Addition to lower extremity, test socket, below knee
L5622	Addition to lower extremity, test socket, knee disarticulation
L5624	Addition to lower extremity, test socket, above knee
L5626	Addition to lower extremity, test socket, hip disarticulation
L5628	Addition to lower extremity, test socket, hemipelvectomy
L5629	Addition to lower extremity, below knee, acrylic socket
L5630	Addition to lower extremity, Symes type, expandable wall socket
L5631	Addition to lower extremity, above knee or knee disarticulation, acrylic socket
L5632	Addition to lower extremity, Symes type, 'PTB' brim design socket
L5634	Addition to lower extremity, Symes type, posterior opening (Canadian) socket
L5636	Addition to lower extremity, Symes type, medial opening socket
L5637	Addition to lower extremity, below knee, total contact

L5638	Addition to lower extremity, below knee, leather socket
L5639	Addition to lower extremity, below knee, wood socket
L5640	Addition to lower extremity, knee disarticulation, leather socket
L5642	Addition to lower extremity, above knee, leather socket
L5643	Addition to lower extremity, hip disarticulation, flexible inner socket, external frame
L5644	Addition to lower extremity, above knee, wood socket
L5645	Addition to lower extremity, below knee, flexible inner socket, external frame
L5646	Addition to lower extremity, below knee, air cushion socket
L5647	Addition to lower extremity, below knee suction socket
L5648	Addition to lower extremity, above knee, air cushion socket
L5649	Addition to lower extremity, ischial containment/narrow M-L socket
L5650	Addition to lower extremity, total contact, above knee or knee disarticulation socket
L5651	Addition to lower extremity, above knee, flexible inner socket, external frame
L5652	Addition to lower extremity, suction suspension, above knee or knee disarticulation socket
L5653	Addition to lower extremity, knee disarticulation, expandable wall socket

L5654	Addition to lower extremity, socket insert, Symes, (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5655	Addition to lower extremity, socket insert, below knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5656	Addition to lower extremity, socket insert, knee disarticulation (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5658	Addition to lower extremity, socket inset, above knee (Kemblo, Pelite, Aliplast, Plastazote or equal)
L5660	Addition to lower extremity, socket insert, Symes, silicone gel or equal
L5661	Addition to lower extremity, socket insert, multidurometer Symes
L5662	Addition to lower extremity, socket insert, below knee, silicone gel or equal
L5663	Addition to lower extremity, socket insert, knee disarticulation, silicone gel or equal
L5664	Addition to lower extremity, socket insert, above knee, silicone gel or equal
L5665	Addition to lower extremity, socket insert, multi durometer, below knee
L5666	Addition to lower extremity, below knee, cuff suspension
L5667	Addition to lower extremity, below knee/above knee, socket insert, suction suspension, with locking mechanism
L5668	Addition to lower extremity, below knee, molded distal cushion
L5669	Addition to lower extremity, below knee/above knee, socket insert, suction suspension without locking mechanism

L5670	Addition to lower extremity, below knee, molded supracondylar suspension ('PTS' or similar)
L5672	Addition to lower extremity, below knee, removable medial brim suspension
L5674	Addition to lower extremity, below knee, latex sleeve suspension or equal, each
L5675	Addition to lower extremity, below knee, latex sleeve suspension or equal, heavy duty, each
L5676	Additions to lower extremity, below knee, knee joints, single axis, pair
L5677	Additions to lower extremity, below knee, knee joints, polycentric, pair
L5678	Additions to lower extremity, below knee, joint covers, pair
L5680	Addition to lower extremity, below knee, thigh lacer, non-molded
L5682	Addition to lower extremity, below knee, thigh lacer, gluteal/ischial, molded
L5684	Addition to lower extremity, below knee, fork strap
L5686	Addition to lower extremity, below knee, back check (extension control)
L5688	Addition to lower extremity, below knee, waist belt, webbing
L5690	Addition to lower extremity, below knee, waist belt, padded and lined
L5692	Addition to lower extremity, above knee, pelvic control belt, light
L5694	Addition to lower extremity, above knee, pelvic control belt, padded and lined

L5695	Addition to lower extremity, above knee, pelvic control, sleeve suspension, neoprene or equal, each
L5696	Addition to lower extremity, above knee or knee disarticulation, pelvic joint
L5697	Addition to lower extremity, above knee or knee disarticulation, pelvic band
L5698	Addition to lower extremity, above knee or knee disarticulation, Silesian bandage
L5699	All lower extremity prostheses, shoulder harness
L5700	Replacement, socket, below knee, molded to patient model
L5701	Replacement, socket, above knee/knee disarticulation including attachment plate, molded to patient model
L5702	Replacement, socket, hip disarticulation, including hip joint, molded to patient model
L5704	Replacement, custom shaped protective cover, below knee
L5705	Replacement, custom shaped protective cover, above knee
L5706	Replacement, custom shaped protective cover knee disarticulation
L5707	Replacement, custom shaped protective cover, hip disarticulation
L5710	Addition, exoskeletal knee-shin system, single axis, manual lock
L5711	Additions exoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5712	Addition, exoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)

L5714	Addition, exoskeletal knee-shin system, single axis, variable friction swing phase control
L5716	Addition, exoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5718	Addition, exoskeletal knee-shin system, polycentric, friction swing and stance phase control
L5722	Addition, exoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5724	Addition, exoskeletal knee-shin system, single axis, fluid swing phase control
L5726	Addition, exoskeletal knee-shin system, single axis, external joints fluid swing phase control
L5728	Addition, exoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5780	Addition, exoskeletal knee-shin system, single axis, pneumatic/hydra pneumatic swing phase control
L5785	Addition, exoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5790	Addition, exoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5795	Addition, exoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5810	Addition, endoskeletal knee-shin system, single axis, manual lock
L5811	Addition, endoskeletal knee-shin system, single axis, manual lock, ultra-light material
L5812	Addition, endoskeletal knee-shin system, single axis, friction swing and stance phase control (safety knee)

L5814	Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control, mechanical stance phase lock
L5816	Addition, endoskeletal knee-shin system, polycentric, mechanical stance phase lock
L5818	Addition, endoskeletal knee-shin system, polycentric, friction swing, and stance phase control
L5822	Addition, endoskeletal knee-shin system, single axis, pneumatic swing, friction stance phase control
L5824	Addition, endoskeletal knee-shin system, single axis, fluid swing phase control
L5826	Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control with miniature high activity frame
L5828	Addition, endoskeletal knee-shin system, single axis, fluid swing and stance phase control
L5830	Addition, endoskeletal knee-shin system, single axis, 4-bar linkage or multiaxial, pneumatic swing phase control
L5840	Addition, endoskeletal knee-shin system, 4-bar linkage or multiaxial, pneumatic swing phase control
L5845	Addition, endoskeletal, knee-shin system, stance flexion feature, adjustable
L5846	Addition, endoskeletal, knee-shin system, microprocessor control feature, swing phase only
L5850	Addition, endoskeletal system, above knee or hip disarticulation, knee extension assist
L5855	Addition, endoskeletal system, hip disarticulation, mechanical hip extension assist

L5910	Addition, endoskeletal system, below knee, alignable system
L5920	Addition, endoskeletal system, above knee or hip disarticulation, alignable system
L5925	Addition, endoskeletal system, above knee, knee disarticulation or hip disarticulation, manual
L5930	Addition, endoskeletal system, high activity knee control frame
L5940	Addition, endoskeletal system, below knee, ultra-light material (titanium, carbon fiber or equal)
L5950	Addition, endoskeletal system, above knee, ultra-light material (titanium, carbon fiber or equal)
L5960	Addition, endoskeletal system, hip disarticulation, ultra-light material (titanium, carbon fiber or equal)
L5962	Addition, endoskeletal system, below knee flexible protective out surface covering system
L5964	Addition, endoskeletal system, above knee flexible protective outer surface covering system
L5966	Addition, endoskeletal system, hip disarticulation, flexible protective outer surface covering system
L5968	All lower extremity prosthesis, ankle, multiaxial shock absorbing system
L5970	All lower extremity prostheses, foot, external keel, SACH foot
L5972	All lower extremity prostheses, flexible keel foot (Safe, Sten, Bock dynamic or equal)
L5974	All lower extremity prostheses, foot, single axis ankle/foot

L5975	All lower extremity prosthesis, combination single axis ankle and flexible keel foot
L5976	All lower extremity prostheses, energy storing foot (Seattle Carbon Copy II or equal)
L5978	All lower extremity prostheses, foot, multiaxial ankle/foot
L5979	All lower extremity prostheses, multiaxial ankle/foot, dynamic response
L5980	All lower extremity prostheses, flex foot system
L5981	All lower extremity prostheses, flex-walk system or equal
L5982	All exoskeletal lower extremity prostheses, axial rotation unit
L5984	All endoskeletal lower extremity prostheses, axial rotation unit
L5985	All endoskeletal lower extremity prostheses, dynamic prosthetic pylon
L5986	All lower extremity prostheses, multi-axial rotation unit (“MCP” or equal)
L5987	All lower extremity prostheses, shank foot sytem with vertical loading pylon
L5988	All lower extremity prosthesis, combination vertical shock and multiaxial rotation/torsional force reducing pylon
L5999	Lower extremity prosthesis, not otherwise specified
L7510	Repair of prosthetic device, repair or replace minor parts
L7520	Repair prosthetic device, labor component, per 15 minutes
L8400	Prosthetic sheath, below knee, each

L8410	Prosthetic sheath, above knee, each
L8417	Prosthetic sheath/sock, including a gel cushion layer, below knee or above knee, each
L8420	Prosthetic sock, multiple ply, below knee, each
L8430	Prosthetic sock, multiple ply, above knee, each
L8440	Prosthetic shrinker, below knee, each
L8460	Prosthetic shrinker, above knee, each
L8470	Stump sock, single ply, fitting, below knee, each
L8480	Stump sock, single ply, fitting, above knee, each
L8490	Addition to prosthetic sheath/sock, air seal suction retention system

6

LEVEL II MODIFIERS

KO	Lower limb 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 traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
K4	Lower extremity prosthesis functional Level 4 – Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

BENEFIT CATEGORY

Durable Medical Equipment

DEFINITIONS

1. A **functional level** is a measurement of the capacity and potential of the patient to accomplish his/her expected, post-rehabilitation, daily function. The functional classification is used by the Intermediary to establish the medical necessity only of prosthetic knees, feet and ankles.

2. An **adjustment** is any modification to the prosthesis due to a change in the patient's condition or to improve the function of the prosthesis.
3. A **repair** is a restoration of the prosthesis to correct problems due to wear or damage.
4. A **replacement** is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

COVERAGE AND PAYMENT RULES

1. A lower limb prosthesis is covered when the patient:
   a. will reach or maintain a defined functional state within a reasonable period of time; ***and***
   b. is motivated to ambulate
2. **Functional Levels**

   A determination of the medical necessity for certain components/additions to the prosthesis is based on the patient's potential functional abilities. Potential functional ability is based on the reasonable expectations of the prosthetist, and ordering physician, considering factors including, but not limited to:
   a. the patient's past history (including prior prosthetic use if applicable)
   b. the patient's current condition including the status of the residual limb and the nature of other medical problems and
   c. the patient's desire to ambulate.
3. Clinical assessments of patient rehabilitation potential should be based on the following classification levels:

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
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
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

Level 3	Has the ability or potential for ambulation with variable cadence. Typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
Level 4	Has the ability or potential for prosthetic ambulation that exceeds basic ambulation skills, exhibiting high impact, stress, or energy levels. Typical of the prosthetic demands of the child, active adult, or athlete.

4. The medical records should document the patient's current functional capabilities ***and*** his/her expected functional potential, including an explanation for the difference, if that is the case. The Intermediary recognizes within the functional classification hierarchy that bilateral amputees often cannot be strictly bound by functional level classifications.

GENERAL

1. Prostheses are covered when furnished incident to physicians' services or on a physician's order. Accessories (e.g., stump stockings for the residual limb, harness - including replacements) are also covered when these appliances aid in or are essential to the effective use of the artificial limb.
2. The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable to Medicare under the prosthetic benefit:
    a. evaluation of the residual limb and gait
    b. fitting of the prosthesis
    c. cost of base component parts and labor contained in HCPCS base codes
    d. repairs due to normal wear or tear within 90 days of delivery
    e. adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments ***are not*** necessitated by changes in the residual limb or the patient's functional abilities.
3. Any prosthesis or prosthetic component provided in an inpatient hospital setting should be submitted to the Intermediary on the inpatient bill.

4. When an initial below knee prosthesis (L5500) or a preparatory below knee prosthesis (L5510-L5530, L5540) prostheses is provided, prosthetic substitutions and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5629, L5638, L5639, L5646, L5647, L5667, L5669, L5785, L5962, and L5980 which will be denied as not medically necessary. When a below knee preparatory prefabricated prosthesis (L5535) is provided prosthetic substitutions and/or additions of procedures are covered in accordance with the functional level assessment except for codes L5620, L5629, L5645, L5667, L5669, L5670, and L5676 which will be denied as not medically necessary.
5. When an above knee initial prosthesis (L5505) or an above knee preparatory (L5560-L5580, L5590-L5600) prostheses is provided, prosthetic substitution and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5610, L5631, L5640, L5642, L5644, L5648, L5980, and L5710-L5780, L5790-L5795 which will be denied as not medically necessary. When an above knee preparatory prefabricated prosthesis (L5585) is provided, prosthetic substitution and/or additions of procedures and components are covered in accordance with the functional level assessment except for codes L5624, L5631, L5648, L5651, L5652, L5964, and L5966 which will be denied as not medically necessary.
6. In the following sections, the determination of coverage for selected prostheses and components with respect to potential functional levels represents the usual case. Exceptions will be considered in an individual case if additional documentation is included which justifies the medical necessity. Prostheses will be denied as not medically necessary if the patient’s potential functional level is “0”.

Feet

1. A determination of the type of foot for the prosthesis will be made by the prescribing physician and/or the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a SACH foot. Prosthetic feet are considered for coverage based upon functional classification.
    a. external keel, SACH foot (L5970) or single axis ankle/foot (L5974) are covered for patients with a functional **Level 1** or above.
    b. Flexible-keel foot (L5972) and multiaxial ankle/foot (L5978) candidates are expected to demonstrate a functional **Level 2** or greater functional needs.
    c. Flex foot system (L5980), Energy storing foot (L5976), multiaxial ankle/foot, dynamic response (L5979), or flex-walk system or equal (L5981) are covered for patients with a functional **Level 3** or above.

2. Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic or design feature of a given type of foot. This information must be retained the patient's medical records and available to the Intermediary upon request.

Knees

1. A determination of the type of knee for the prosthesis will be made by the prescribing physician and/or the prosthetist based upon the functional needs of the patient. Basic lower extremity prostheses include a single axis, constant friction knee. Prosthetic knees are considered for coverage based upon functional classification.
    a. fluid and pneumatic knees (L5610, L5613, L5614, L5722-L5780, L5822-L5840) are covered for patients with a functional **Level 3** or above.
    b. other knee systems (L5611, L5616, L5710-L5718, L5810-L5818) are covered for patients with a functional **Level 1** or above.
2. Coverage is extended only if there is sufficient clinical documentation of functional need for the technologic design feature of a given type of knee. This information must be retained in the patient's medical records and available to the Intermediary upon request.

Ankles

Axial rotation units (L5982-L5986) are covered for patients with a functional **Level 2** or above.

Sockets

1. Test (diagnostic) sockets for Immediate (L5400-L5460) prostheses are not medically necessary.
2. No more than 2 test (diagnostic) sockets for an individual prosthesis are medically necessary without additional documentation.
3. No more than two of the same socket inserts (L5654-L5665) are allowed per individual prosthesis at the same time.
4. Socket replacements are considered medically necessary if there is adequate documentation of functional and/or physiological need. The Intermediary recognizes that there are situations where the explanation includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.

ADJUSTMENT, REPAIRS, AND COMPONENT REPLACEMENT

1. Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis, is non-covered. Adjustments to a prosthesis required by wear or by change in the patient's condition are covered under the initial physician's order for the prosthesis for the life of the prosthesis.
2. Repairs to a prosthesis are covered when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payments can be made for the amount of the excess. Maintenance that may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist is covered as a repair.
3. Replacement of a prosthesis or prosthetic component is covered in cases of loss or irreparable damage or wear or when required because of a change in the patient's condition. Expenses for replacement of a prosthesis or prosthetic components required because of loss or irreparable damage may be reimbursed without a physician's order when it is determined that the prosthesis as originally ordered still fills the patient's medical needs. However, claims involving replacement of a prosthesis or major component (foot, ankle, knee, socket) necessitated by wear or a change in the patient's condition must be supported by a new physician's order. When the Intermediary determines that malicious damage, culpable neglect or wrongful disposition of the prosthesis has occurred, investigation will be undertaken to determine whether it is unreasonable to make program payment under the circumstances.

CODING GUIDELINES

1. ***Adjustments*** and ***repairs*** are billed as a labor charge using HCPCS code L7520 (one unit of service representing 15 minutes of labor time). Documentation should exist in the patient's medical records indicating the precise adjustments and/or repairs performed and actual time involved. The time reported for L7520 should only be for laboratory repair time and associated prosthetic evaluation. Evaluation not associated with repair or adjustment is non-covered and should not be coded with L7520. The time for patient evaluation, gait instruction, and other general education should not be reported with code L7520.
2. The L7510 code is used to bill for any "minor" materials (those without HCPCS definitions) used to achieve the adjustment and/or repair.
3. ***Replacement*** of components (except sockets and covers) is billed using the base code for the component with the addition of the **RP** modifier. Socket and cover replacement procedures are identified by the codes L5700 to L5707. Since these codes are defined as a replacement, the modifier **RP** should not be used. The submitted charge for replacements

reflects both the cost of the component and the labor associated with the removal, replacement, and finishing of that component. Labor associated with replacement should not be reported using code L7520.

4. The right (RT) and left (LT) modifiers should be used with prosthesis codes. When the same code for prostheses, sockets, or components for bilateral amputees are billed on the same date of service, the items (RT and LT) will be entered on the same line of the claim using the LTRT modifier and billed with 2 units of service.

DOCUMENTATION REQUIRED

1. An order for the prosthesis including all components which is signed and dated by the ordering physician must be kept on file by the provider. Adjustments and repairs of prostheses and prosthetic components are covered under this original order. Claims involving replacement of a prosthesis or major component (foot, ankle, knee, socket) necessitated by wear or a change in the patient's condition must be supported by a new physician's order. If replacement of a prosthesis or prosthetic component is required because of loss or irreparable damage, reimbursement may be made without a new physician's order if it is determined that the prosthesis as originally ordered, considering the time since it was furnished, still fills the patient's medical need.
2. 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.
3. When replacement of the entire prosthesis or socket is billed, the claim must be accompanied by an explanation of the medical necessity of the replacement. The Intermediary recognizes that there are situations where the explanation includes but is not limited to: changes in the residual limb; functional need changes; or irreparable damage or wear/tear due to excessive patient weight or prosthetic demands of very active amputees.
4. When submitting a prosthetic claim to the Intermediary, the billed code for knees, feet and ankles (HCPCS codes L5610-L5616, L5710-L5780, L5810-L5840, L5970-L5986) components must be submitted with modifiers K0-K4, indicating the expected patient functional level. This expectation of functional ability information must be clearly documented and retained in the prosthetist's records.
5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Nebulizers

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

EQUIPMENT

E0565	Compressor, air power source, for equipment which is not self-contained or cylinder driven
E0570	Nebulizer with compressor
E0575	Nebulizer, ultrasonic
E0585	Nebulizer, with compressor and heater
E1375*	Nebulizer, portable with small compressor, with limited flow
K0269	Aerosol compressor, adjustable pressure, light duty for intermittent use
K0270	Ultrasonic generator with small volume ultrasonic nebulizer
K0501	Aerosol compressor, battery powered, for use with small volume nebulizer

*This code is not valid for claims as of the effective date of this policy

ACCESSORIES

A4619	Face tent
A4621	Tracheostomy mask or collar
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1372	Immersion external heater for nebulizer

K0168	Administration set, small volume nonfiltered pneumatic nebulizer, disposable
K0169	Small volume nonfiltered pneumatic nebulizer, disposable
K0170	Administration set, small volume nonfiltered pneumatic nebulizer, non-disposable
K0171	Administration set, small volume filtered pneumatic nebulizer
K0172	Large volume nebulizer, disposable, unfilled, used with aerosol compressor
K0173	Large volume nebulizer, disposable, prefilled, used with aerosol compressor
K0174	Reservoir bottle, non-disposable, used with large volume ultrasonic nebulizer
K0175	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet
K0176	Corrugated tubing, non-disposable, used with large volume nebulizer, 10 feet
K0177	Water collection device, used with large volume nebulizer
K0178	Filter, disposable, used with aerosol compressor
K0179	Filter, non-disposable, used with aerosol compressor or ultrasonic generator
K0180	Aerosol mask, used with DME nebulizer
K0181	Dome and mouthpiece, used with small volume ultrasonic nebulizer
K0530	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen

12 ***INHALATION DRUGS***

J2545	Pentamidine isethionate, inhalation solution, per 300 mg, administered through DME
J7051	Sterile saline or water, up to 5 cc
J7699	NOC drugs, inhalation solution administered through DME
K0182	Water, distilled, used with large volume nebulizer, 1000 ml
K0283	Saline solution, per 10 ml, metered dose dispenser, for use with inhalation drugs
K0503	Acetylcysteine, inhalation solution administered through DME, unit dose form, per gram
K0504	Albuterol, inhalation solution administered through DME, concentrated form, per milligram
K0505	Albuterol, inhalation solution administered through DME, unit dose form, per milligram
K0506	Atropine, administered through DME, concentrated form, per milligram
K0507	Atropine, inhalation solution administered through DME, unit dose form, per milligram
K0508	Bitolterol mesylate, inhalation solution administered through DME, concentrated form, per milligram
K0509	Bitolterol mesylate, inhalation solution administered through DME, unit dose from, per milligram
K0511	Cromolyn sodium, inhalation solution administered through DME, unit dose form, per 10 milligrams

K0512	Dexamethasone, inhalation solution administered through DME, concentrated form, per milligram
K0513	Dexamethasone, inhalation solution administered through; DME, unit dose form, per milligram
K0514	Dornase alpha, inhalation solution administered through DME, unit dose form, per milligram
K0515	Glycopyrrolate, inhalation solution administered through DME, concentrated form, per milligram
K0516	Glycopyrrolate, inhalation solution administered through DME, unit dose form, per milligram
K0518	Ipratropium bromide, inhalation solution administered through DME, unit dose form, per milligram
K0519	Isoetharine HCL, inhalation solution administered through DME, concentrated form, per milligram
K0520	Isoetharine HCL, inhalation solution administered through DME, unit dose form, per milligram
K0521	Isoproterenol HCL, inhalation solution administered through DME, concentrated form, per milligram
K0522	Isoproterenol HCL, inhalation solution administered through DME, unit dose form, per milligram
K0523	Metaproterenol sulfate, inhalation solution administered through DME, concentrated form, per 10 milligrams

K0524	Metaproterenol sulfate, inhalation solution administered through DME, unit dose form, per 10 milligrams
K0525	Terbutaline sulfate, inhalation solution administered through DME, concentrated form, per milligram
K0526	Terbutaline sulfate, inhalation solution administered through DME, unit dose form, per milligram
K0527	Triamcinolone, inhalation solution administered through DME, concentrated form, per milligram
K0528	Triamcinolone, inhalation solution administered through DME, unit dose form, per milligram
K0529	Sterile water or sterile saline, 1000 ml, used with large volume nebulizer
Q0132	Dispensing fee for covered drug administered through DME nebulizer

HCPCS MODIFIERS

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

REFERENCE

HCFA Pub. 6, Coverage Issues Manual, 60-9

DEFINITIONS

Equipment:

1. In this policy, the actual equipment (i.e., electrical device) will generally be referred to as either a compressor (when nebulization of

liquid is achieved by means of air flow) or as a generator (when nebulization of liquid is achieved by means of ultrasonic vibrations). The term nebulizer is generally used for the actual chamber in which the nebulization of liquid occurs and is an accessory to the equipment. The nebulizer is attached to an aerosol compressor or an ultrasonic generator in order to achieve a functioning delivery system for aerosol therapy.

2. Code E0565 describes an aerosol compressor that can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation.
3. A nebulizer with compressor (E0570) is an aerosol compressor that delivers a fixed, low pressure and is used with a small volume nebulizer. It is only AC powered.
4. A portable compressor (K0501) is an aerosol compressor that delivers a fixed, low pressure and is used with a small volume nebulizer. It must have battery or DC power capability and may have an AC power option.
5. A light duty adjustable pressure compressor (K0269) is a pneumatic aerosol compressor which can be set for pressures above 30 psi at a flow of 6-8 L/m, but is capable only of intermittent operation.
6. Code K0270 describes an ultrasonic generator used with a small volume chamber for medication delivery that is capable only of intermittent operation.
7. Code E0575 describes a large volume ultrasonic nebulizer system which is used for medication and humidification delivery, and which is capable of continuous operation.

Accessories:

1. Code K0168, K0170, and K0171 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code K0171 includes a filter.
2. Code K0169 includes only the lid, jar and baffles.
3. Code K0177 describes a device to collect water condensation that is placed in line with the corrugated tubing used with a large volume nebulizer.

Inhalation drugs:

1. Unit dose form of an inhalation drug or a combination of drugs is one in which the medication is ***dispensed to a patient:***

   a. in a bottle/vial/ampule that contains the dose usually used for a single inhalation treatment; ***and***

   b. in a concentration that is dilute enough that it may be administered to a patient without adding any separate diluent

2. Concentrated form of a drug used for inhalation is one in which the drug is ***dispensed to a patient*** in a concentration that requires that a separate diluent (usually saline) be added to the nebulizer when the drug is administered to a patient

COVERAGE AND PAYMENT RULES

1. A small volume nebulizer (K0168, K0169, K0170) and related compressor (E0570, K0501) are covered when:
    a. it is medically necessary to administer beta-adrenergics, anticholinergics, corticosteroids, and cromolyn for the management of obstructive pulmonary disease (ICD-9-CM codes 491.0-505); ***or***
    b. it is medically necessary to administer gentamicin, tobramycin, amikacin, or dornase alfa to a patient with cystic fibrosis (ICD-9-CM code 277.00); ***or***
    c. it is medically necessary to administer pentamidine to patients with HIV (ICD-9-CM code 042); ***or***
    d. it is medically necessary to administer mucolytics (other than dornase alpha) for persistent thick or tenacious pulmonary secretions (ICD-9-CM code 786.4)
2. Use of inhalation drugs, other than those listed above, will be denied as not medically necessary.
3. For criterion (a) to be met, the physician must have considered use of a metered dose inhaler (MDI) with and without a reservoir or spacer device and decided that, for medical reasons, it was not sufficient for the administration of needed inhalation drugs. The reason for requiring a small volume nebulizer and related compressor/generator instead of or in addition to an MDI must be documented in the patient’s medical record and be available to the Intermediary on request.
4. If none of the drugs used with a nebulizer are covered, the nebulizer and its accessories/supplies will be denied as not medically necessary.
5. A large volume nebulizer (K0530), related compressor (E0565 or K0269), and water or saline (K0182 or K0529) are covered when it is medically necessary to deliver humidity to a patient with thick, tenacious secretions, who has cystic fibrosis (ICD-9-CM code 277.00), bronchiectasis (ICD-9-CM code 494 or 748.61), or a tracheostomy (ICD-9-CM code V44.0 or V55.0). Combination code E0585 will be covered for the same indications.

6. An E0565 or K0269 compressor and filtered nebulizer (K0171) are covered when it is medically necessary to administer pentamidine to patients with HIV (ICD-9-CM code 042).
7. If a large volume nebulizer, related compressor/generator, and water or saline are used predominantly to provide room humidification it will be denied as non-covered.
8. Because there is no ***proven*** medical benefit to nebulizing particles to diameters smaller than achievable with a pneumatic model, when a small volume ultrasonic nebulizer (K0270) is ordered, it will be reimbursed at the least costly alternative of a pneumatic compressor (E0570).
9. A large volume ultrasonic nebulizer (E0575) offers no proven clinical advantage over a pneumatic compressor. However, since code E0575 is in a different payment category than pneumatic compressors, payment for a least costly alternate cannot be made. Therefore, when an E0575 nebulizer is provided, it will be denied as not medically necessary as will any related accessories and supplies.
10. A battery powered compressor (K0501) is rarely medically necessary. If this compressor is provided without accompanying documentation which justifies its medical necessity, and the coverage criteria for code E0570 are met, payment will be based on the allowance for the least costly medically acceptable alternative, E0570.
11. Other uses of compressors/generators will be considered individually on a case by case basis, to determine their medical necessity.

Accessories:

1. A large volume pneumatic nebulizer (E0580) and water or saline (K0182 or K0529) are not separately payable and should not be separately billed when used for patients with rented home oxygen equipment.
2. Disposable large volume nebulizers (K0172 and K0173) are non-covered under the DME benefit because they are convenience items. A nondisposable unfilled nebulizer (K0530 or E0585) filled with water or saline (K0182, K0529) by the patient/caregiver is an acceptable alternative.
3. Kits and concentrates for use in cleaning respiratory equipment will be denied as non-covered.
4. Accessories are separately payable if the related aerosol compressor and the individual accessories are medically necessary.
5. The following table lists the compressor/generator that is related to the accessories described.

Note: Other than the compressor/generator/accessory combinations listed below are considered medically unnecessary.

Compressor/ Generator	**Related Accessories**
E0565	A4619, A4621, K0530, E1372, K0171, K0175, K0176, K0177, K0179, K0180
E0570	A4621, K0168, K0169, K0170, K0171, K0178, K0180
E0585	A4619, A4621, K0171, K0175, K0176, K0177, K0179, K0180
K0269	K0171, K0179
K0270	K0179, K0181
K0501	A4621, K0168, K0169, K0170, K0171, K0178, K0180

6. This array of accessories represents all possible combinations but it may not be appropriate to bill any or all of them for one device.

7. The following table lists the usual maximum frequency of replacement for accessories. Claims for more than the usual maximum replacement amount will be denied as not medically necessary unless there is documentation in the medical records that justifies a larger quantity in the individual case.

Accessories	**Usual Maximum Replacement**
A4619	One/month
A4621	One/month
K0530	One/3 years
E1372	One/3 years
K0168	Two/month
K0169	Two/month (in addition to K0168)
K0170	One/6 months
K0171	One/month
K0175	One unit (100 ft.)/2 months
K0176	One year
K0177	Two/month
K0178	Two/month
K0179	One/3 months
K0180	One/month
K0181	Two/year

INHALATION DRUGS AND SOLUTIONS:

1. For all inhalation drugs and solutions, claims for dispensed quantities greater than would be reasonable based on usual suggested dosing guidelines will be denied as not medically necessary unless there is documentation in the medical records justifying these unexpected quantities. The pharmacist is responsible for assessing how much inhalation solution a patient is actually using. Considering this information, the pharmacist is responsible for assuring that the patient usually has no more than one month’s supply on hand at any time.
2. The following table represents the maximum milligrams/month of inhalation drugs that would be reasonably billed for each nebulized drug. Claims for more than these amounts of drugs will be denied as

not medically necessary unless there is documentation in the medical records that justifies a larger amount in the individual case.

Inhalation Drugs	**Maximum Mg/Month**
Acetylcysteine	up to 74 grams/month
Albuterol sulfate	up to 465 mg/month
Atropine	up to 186 mg/month
Bitolterol	up to 434 mg/month
Cromolyn sodium	up to 2480 mg/month (248 units/month)
Dornase alpha	up to up to 78 mg/month
Glycopyrrolate	up to 75 mg/month
Ipratropium bromide	up to 90 mg/month
Isoetharine	up to 930 mg/month
Isoproterenol	up to 450 mg/month
Metaproterenol	up to 2800 mg/month (280 units/month)
Pentamidine	up to 300 mg/month
Terbutaline	up to 186 mg/month
Sterile saline or water, up to 5cc/unit (J7051)	up to 186 units/month
Saline solution, metered dose,10 ml/unit (K0283)	up to 60 units/month
Distilled water, sterile water or sterile saline in large volume nebulizer (K0529)	up to 18 liters/month

3. When a “concentrated form” of an inhalation drug is dispensed, separate saline solution (J7051 or K0283) used to dilute it will be

separately reimbursed. Saline dispensed for the dilution of concentrated nebulizer drugs must be billed on the same claim as the drug(s) being diluted. If the unit dose form of the drug is dispensed, separate saline solution (J7051 or K0283) will be denied as not medically necessary. Water or saline in 1000 ml quantities (K0182 or K0529) are not appropriate for use by patients to dilute inhalation drugs and will therefore be denied as not medically necessary if used for this purpose. These codes are only medically necessary when used in a large volume nebulizer (K0530 or E0585).

4. Albuterol, bitolterol, epinephrine, isoetharine, isoproterenol, metaproterenol, and terbutaline are all bronchodilators with beta-adrenergic stimulatory effect. It would rarely be medically necessary for a patient to be using more than one of these at a time. The use of more than one of these drugs at the same time will be denied as not medically necessary without documentation of medical necessity.

5. Ipratropium bromide, atropine, and glycopyrrolate are all anticholinergics. It would rarely be medically necessary for a patient to be using any more than one of these at a time. The use of more than one of these drugs at the same time will be denied as not medically necessary without documentation of medical necessity.

6. Dornase alpha is covered for patients with cystic fibrosis (ICD-9-CM 277.00) who have a history of 2 respiratory infections requiring parenteral antibiotics during the year prior to initiation of dornase alpha ***and*** have a forced vital capacity equal to or greater than 40% of predicted value.

7. Because of the difference in preparation costs, the allowance per mg for a single drug dispensed as a unit dose formulation (e.g., K0505KO) will be higher than the allowance per mg for the same drug dispensed in a concentrated form (e.g., K0504). However, if multiple inhalation drugs are dispensed in a single container, only one of the drugs (i.e., the drug billed with the KP modifier) will be reimbursed at the higher allowance, whereas the other drug(s)(i.e., those billed with the KQ modifier) will be reimbursed at the same allowance as the concentrate (see ***CODING GUIDELINES*** for explanation f the KO, KP, and KQ modifiers).

CODING GUIDELINES

1. The billing unit for most inhalation drugs is ***per milligram*** (mg) of the drug dispensed. The billing unit of K0511, K0523 and K0524 is ***per 10 milligrams*** (10 mg) of the drug dispensed. The billing unit of K0503 is per gram (gm) of the drug dispensed. The billing unit of J2545 is per 300 milligrams (300 mg) of the drug dispensed.

2. When inhalation drugs are dispensed as a single drug formulation, the coding of a unit dose form or a concentrated form (see ***DEFINITIONS***

section) is determined by ***the formulation of the drug as it is dispensed to the patient.*** If a pharmacist takes a concentrated form of a single inhalation drug (e.g. 0.5% albuterol) and dilutes it to a ready-to-use concentration (e.g. 0.083% albuterol) which is then dispensed to the patient in single-dose bottles/vials/ampules, the inhalation solution is billed as the unit dose form, ***not*** the concentrated form.

3. When there is a single drug in a unit dose container, the KO modifier is added to the unit dose form code. When two or more drugs are combined by a pharmacist and dispensed to the patient in the same unit dose container, all of the drugs are billed using the unit dose form code. However, the KP modifier is added to ***only one*** of the unit dose form codes and the KQ modifier is added to the other unit dose code(s). When two or more drugs are combined, the use of the KP and KQ modifiers should result in a combination that yields the lower cost to the beneficiary.

4. Whenever a unit dose form code is billed, it must have either a KO, KP, or KQ modifier. If a unit dose code does not have one of these modifiers, it will be denied as an invalid code. The KO, KP, and KQ modifiers are not used with the concentrated form codes.

5. The concentration of the drug in the dispensed solution can be converted to mg or gm as follows:

   A solution with a labeled concentration of 1% has ten (10) mg of drug in each milliliter (ml) of solution. Therefore, a 0.083% albuterol solution has 0.83 mg of albuterol in each ml of solution. Since albuterol 0.083% solution typically comes in a 3 ml vial/ampule, each vial/ampule contains 2.5 mg of albuterol (3 x .83 = 2.5). If a pharmacist provides 120 ampules of 0.083% albuterol solution each containing 3 ml, the billed units of service would be 300 (2.5 x 120) units (1 unit = 1 mg) of code K0505KO. ***One*** unit of Q0132 would be billed, which would represent the dispensing fee for the albuterol for the entire month.

6. When billing unit dose solutions which combine two or more drugs in a single container, each drug must be listed on a separate claim line. For example, if a pharmacist provides 120 ampules of a solution containing a combination of 2.5 mg of albuterol and 20 mg of cromolyn in each 3 ml ampule, the pharmacist would bill K0505KQ 300 units for the albuterol (2.5 mg x 120 doses = 300) (1 unit = 1 mg) and K0511KP (unit dose cromolyn) 240 units (20 mg/amp) 10 mg/unit x 120 = 240) (1 unit = 10 mg) for the cromolyn. ***One*** unit of Q0132 would be billed which represents the dispensing fee for the combined solution for the entire month. There should be no separate billing for saline diluent. Providers should note that the correct concentration figure must be used to determine the number of mg of drug dispensed. For example, if a pharmacist takes 0.5 ml of a concentrated 0.5% albuterol solution

and dilutes it with 2.5 ml of saline to give a 3 ml unit dose solution which is dispensed to the patient, each vial contains 2.5 mg of albuterol (0.5 ml x 5.0 mg/ml = 2.5 mg) ***not*** 15 mg (3 x 5.0).

7. When a drug is provided in a concentration that is dilute enough that it may be administered to a patient without adding any separate diluent in a multidose container, use code J7699.
8. Code J7699 is also used for an inhalation drug administered by a nebulizer that does not have a ***valid*** specific J or K code. If two or more drugs are combined in the same unit dose container, bill specific J or K codes when possible and J7699 only for individual drugs which do not have a specific J or K code. Claims for drugs that are incorrectly coded J7699 instead of the appropriate specific J or K codes will denied for invalid coding.
9. Code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (K0530), and immersion heater (E1372) are provided at the same time. If all three items were not provided initially, the separate codes for the components would be used for billing. Code K0530 is billed for a durable, bottle type nebulizer when it is used with a K0269 compressor or a separately billed E0565 compressor. Code K0530 would not be separately billed when an E0585 system was also being billed. Code E0580 (nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flow meter) describes the same piece of equipment as K0530, but should only be billed when this type of nebulizer is used with a beneficiary-owned oxygen system.
10. Codes K0503-K0529 are valid for dates of service on or after 4/1/97.
11. Codes K0269, K0501 and K0530 are valid for dates of service on or after 4/1/97.
12. Code E1375 (nebulizer, portable with small compressor, with limited flow) is not valid for claim submission to the Intermediary. Use code E0570 or K0501 instead.
13. Code A4323 (sterile saline irrigation solution, 1000 ml) is not valid for saline solutions used with nebulizers.
14. Code XX001 (sterile saline) should not be billed to the Intermediary. Use code J7051.

DOCUMENTATION REQUIRED

1. An order for all equipment, accessories, drugs, and other supplies related to nebulizer therapy must be signed and dated by the ordering physician and kept on file by the provider. The order for any drug must clearly specify the type of solution to be dispensed to the patient and the administration instructions for that solution. The type of solution is described by a combination of:

   a. the name of the drug and the concentration of the drug in the dispensed solution and the volume of solution in each container (e.g. albuterol 0.083% 3 ml; or albuterol 0.5% 20 ml; or cromolyn 20 mg/2ml) ***or***

   b. the name of the drug and the number of milligrams/grams of drug in the dispensed solution ***and*** the volume of solution in that container (e.g. albuterol 1.25 mg in 3 ml saline; or albuterol 2.5 mg and cromolyn 20 mg in 3 ml saline)

2. Administration instructions must specify the amount of solution ***and*** frequency of use (e.g. 3 ml qid and prn-max 6 doses/24 hr; or one ampule q 4 hr prn; or 0.5 ml diluted with saline to 3.0 ml tid and prn.
3. A new order is required if there is a change in the type of solution dispensed or the administration instructions.
4. For all inhalation drugs, a new order is required with each certification/recertification even if the prescription has not changed.
5. An ICD-9-CM code describing the condition that necessitates nebulizer therapy must be included on each claim for equipment, accessories and/or drugs.
6. The patient’s medical record must contain information that supports the medical necessity for all equipment, accessories, drugs, and other supplies that are ordered. Except for the situations described below, this information does not have to be submitted with the claim but should be available to the Intermediary upon request.
7. Documentation for K0501 and the need for the battery feature must be in the patient’s medical records and submitted to the Intermediary upon request.
8. When billing for quantities of nebulized inhalation drugs or nebulizer accessories and supplies greater than those described in the policy as the usual maximum amount, the rationale should be documented in the patient’s medical records and submitted to the Intermediary upon request.
9. When billing for nebulized inhalation drugs or nebulizer accessories and the related compressor/generator is not billed on the same claim, indicate on the claim the HCPCS codes of the compressor/generator with which the drugs or accessories are used.
10. If more than one beta-adrenergic or more than one anticholinergic inhalation drug is billed during the same month, the rationale should be documented in the patient’s records and submitted to the Intermediary upon request.

11. When code E1399 is billed for miscellaneous equipment or accessories, the documentation in the patient's records should include a clear description of the item including the manufacturer, the model name/number if applicable, and the medical necessity of the item for that patient.
12. When code J7699 is billed for miscellaneous inhalation drugs, the claim must be accompanied by the detailed order information described above, a clear statement of the number of ampules/bottles of solution dispensed, and documentation of the medical necessity of the drug for that patient.
13. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Orthopedic Footwear

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

L3000	Foot, insert, removable, molded to patient model, “UCB” type, Berkeley shell, each
L3001	Foot, insert, removable, molded to patient model, Spenco, each
L3002	Foot, insert, removable, molded to patient model, plastazote or equal, each
L3003	Foot, insert, removable, molded to patient model, silicone gel, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/metatarsal support, each
L3030	Foot, insert, removable, formed to patient foot, each
L3040	Foot, arch support, removable, pre-molded, longitudinal, each
L3050	Foot, arch support, removable, pre-molded, metatarsal, each
L3060	Foot, arch support, removable, pre-molded longitudinal/metatarsal, each
L3070	Foot, arch support, non-removable, attached to shoe, longitudinal, each
L3080	Foot, arch support, non-removable, attached to shoe, metatarsal, each

L3090	Foot, arch support, non-removable, attached to shoe longitudinal/metatarsal, each
L3100	Hallus-Valgus night dynamic splint
L3140	Foot, abduction rotation bar, including shoes
L3150	Foot, abduction rotation bar, without shoes
L3160	Foot, adjustable shoe styled positioning device
L3170	Foot, plastic heel stabilizer
L3201	Orthopedic shoe, oxford with supinator or pronator, infant
L3202	Orthopedic shoe, oxford with supinator or pronator, child
L3203	Orthopedic shoe, oxford with supinator or pronator, junior
L3204	Orthopedic shoe, hightop with supinator or pronator, infant
L3206	Orthopedic shoe, hightop with supinator or pronator, child
L3207	Orthopedic shoe, hightop with supinator or pronator, junior
L3208	Surgical boot, each, infant
L3209	Surgical boot, each, child
L3211	Surgical boot, each, junior
L3212	Benesch boot, pair, infant
L3213	Benesch boot, pair, child
L3214	Benesch boot, pair, junior
L3215	Orthopedic footwear, woman’s shoes, oxford

L3216	Orthopedic footwear, woman’s shoes, depth inlay
L3217	Orthopedic footwear, woman’s shoes, high top, depth inlay
L3218	Orthopedic footwear, woman’s surgical boot, each
L3219	Orthopedic footwear, man’s shoes, oxford
L3221	Orthopedic footwear, man’s shoes, depth inlay
L3222	Orthopedic footwear, man’s shoes, hightop, depth inlay
L3223	Orthopedic footwear, man’s surgical boot, each
L3224	Orthopedic footwear, woman’s shoe, oxford, used as an integral part of a brace (orthosis)
L3225	Orthopedic footwear, man’s shoe, oxford, used as an integral part of a brace (orthosis)
L3230	Orthopedic footwear, custom shoes, depth inlay
L3250	Orthopedic footwear, custom molded shoe, removable inner mold, prosthetic shoe, each
L3251	Foot, shoe molded to patient model, silicone shoe, each
L3252	Foot, shoe molded to patient model, Plastazote (or similar), custom fabricated, each
L3253	Foot, molded shoe Plastazote (or similar) custom fitted, each
L3254	Non-standard size or width
L3255	Non-standard size or length
L3257	Orthopedic footwear, additional charge for split size
L3260	Ambulatory surgical boot, each

L3265	Plastazote sandal, each
L3300	Lift, elevation, heel, tapered to metatarsals, per inch
L3310	Lift, elevation, heel and sole, neoprene, per inch
L3320	Lift, elevation, heel and sole, cork, per inch
L3330	Lift, elevation, metal extension (skate)
L3332	Lift, elevation, inside shoe, tapered, up to one-half inch
L3334	Lift, elevation, heel, per inch
L3340	Heel wedge, SACH
L3350	Heel wedge
L3360	Sole wedge, outside sole
L3370	Sole wedge, between sole
L3380	Clubfoot wedge
L3390	Outflare wedge
L3400	Metatarsal bar wedge, rocker
L3410	Metatarsal bar wedge, between sole
L3420	Full sole and heel wedge, between sole
L3430	Heel, counter, plastic reinforced
L3440	Heel, counter, leather reinforced
L3450	Heel, SACH cushion type
L3455	Heel, new leather, standard
L3460	Heel, new rubber, standard
L3465	Heel, Thomas with wedge

L3470	Heel, Thomas extended to ball
L3480	Heel, pad and depression for spur
L3485	Heel, pad, removable for spur
L3500	Orthopedic shoe addition, insole, leather
L3510	Orthopedic shoe addition, insole, rubber
L3520	Orthopedic shoe addition, insole, felt covered with leather
L3530	Orthopedic shoe addition, sole, half
L3540	Orthopedic shoe addition, sole, full
L3550	Orthopedic shoe addition, toe tap, standard
L3560	Orthopedic shoe addition, toe tap, horseshoe
L3570	Orthopedic shoe addition, special extension to instep (leather with eyelets)
L3580	Orthopedic shoe addition, convert instep to velcro closure
L3590	Orthopedic shoe addition, convert firm shoe counter to soft counter
L3595	Orthopedic shoe addition, March bar
L3600	Transfer of an orthosis from one shoe to another, caliper plate, existing
L3610	Transfer of an orthosis from one shoe to another, caliper plate, new
L3620	Transfer of an orthosis from one shoe to another, solid stirrup, existing
L3630	Transfer of an orthosis from one shoe to another, solid stirrup, new
L3640	Transfer of an orthosis from one shoe to another, Dennis Browne splint (Riveton), both shoes

L3649	Orthopedic shoe, modification, addition or transfer, not otherwise specified

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 70-3

COVERAGE AND PAYMENT RULES

1. Shoes, inserts, and modifications are covered in limited circumstances. They are covered in selected patients with diabetes for the prevention or treatment of diabetic foot ulcers. However, different codes (A5500-A5507) are used for footwear provided under this benefit. See the medical policy on Therapeutic Shoes for Diabetics for details.
2. Shoes are also covered if they are an integral part of a covered leg brace described by codes L1900, L1920, L1980-L2030, L2050, L2060, L2080, or L2090. Oxford shoes (L3215, L3219, L3224, L3225-see ***CODING GUIDELINES***) are covered in these situations. Other shoes, e.g., high top, depth inlay or custom for non-diabetics, etc. (L3216, L3217, L3221, L3222, L3230, L3251-L3253, L3649-see ***CODING GUIDELINES***), are also covered if they are an integral part of a covered brace and if they are medically necessary for the proper functioning of the brace. Heel replacements (L3455, L3460), sole replacements (L3530, L3540), and shoe transfers (L3600-L3640) involving shoes on a covered brace are also covered. Inserts and other shoe modifications (L3000-L3170, L3300-L3450, L3550-L3595) are covered if they are on a shoe that is an integral part of a brace and if they are medically necessary for the proper functioning of the brace. Shoes and related modifications, inserts, heel/sole replacements or shoe transfers billed without a ZX modifier will be denied as non-covered (see ***DOCUMENTATION REQUIRED*** for definition of ZX modifier).
3. According to a national policy determination, a shoe and related modifications, inserts, and heel/sole replacements, are covered only when the shoe is an integral part of a brace. A matching shoe that is not attached to the brace and items related to that shoe should not be billed with a ZX modifier and will be denied as non-covered.
4. Shoes which are billed separately (i.e., not as part of a brace) will be denied as non-covered even if they are later incorporated into a brace. A ZX modifier may not be used in this situation.
5. Prosthetic shoes (L3250) are covered if they are an integral part of a prosthesis for patients with a partial foot (ICD-9-CM diagnosis codes 895.0-896.3, 755.31, 755.39). Shoes are denied as non-covered

when they are put on over a partial foot or other lower extremity prosthesis (L5010-L5600).

6. With the exception of the situations described above, orthopedic footwear billed using codes L3000-L3649 will be denied as non-covered.

CODING GUIDELINES

1. For dates of service on or after 1/1/95: Oxford shoes that are an integral part of a brace are billed using codes L3224 or L3225 with a ZX modifier. For these codes, one unit of service is each shoe. Oxford shoes that are not part of a leg brace are billed with codes L3215 or L3219 without a ZX modifier. Other shoes (e.g., high top, depth inlay or custom shoes for non-diabetics, etc.) that are an integral part of a brace are billed using code L3649 with a ZX modifier. Other shoes that are not an integral part of a brace are billed using codes L3216, L3217, L3221, L3222, L3230, L3251-L3253 without a ZX modifier.
2. Depth-inlay or custom molded shoes for diabetics (A5500-A5501) and related inserts and modifications (A5502-A5507) are billed using these A codes whether the shoe is an integral part of a brace or not (see policy on Therapeutic Shoes for Diabetics for coverage, documentation, and additional coding guidelines).
3. The right (RT) and left (LT) modifiers should be used with footwear codes. When bilateral items are provided on the same date of service, bill both on the same claim line using the LTRT modifier and 2 units of service.

DOCUMENTATION REQUIRED

1. An order for the shoe and related modifications and inserts must be signed and dated by the ordering physician and kept on file by the provider. The physician must see to it that the patient’s medical record contains information which supports the medical necessity of the item ordered. An order is not required for a heel or sole replacement or transfer of a shoe to a brace.
2. When billing for a shoe that is an integral part of a leg brace or for related modifications, inserts, heel/sole replacements or shoe transfer, a ZX modifier should be added to the code. If the shoe or related item is not an integral part of a leg brace, the ZX modifier may not be used (the ZX modifier indicates that “The specified coverage criteria in the medical policy are met and documentation is available in the patient’s medical records”).
3. When billing for prosthetic shoes, a diagnosis code defining the medical condition must be entered on the claim.

4. When code L3649 with a ZX modifier is billed, the claim must include a narrative description of the item provided as well as a brief statement of the medical necessity for the item.
5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Osteogenesis Stimulators

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0747	Osteogenesis stimulator, electrical, non-invasive, other than spinal applications
E0748	Osteogenesis stimulator, electrical, non-invasive, spinal applications
E0760	Osteogenesis stimulator, low intensity ultrasound, non-invasive

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 35-48

DEFINITIONS

1. An electrical osteogenesis stimulator is a device that provides electrical stimulation to augment bone repair. A non-invasive electrical stimulator is characterized by an external power source, which is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.
2. An ultrasonic osteogenesis stimulator is a non-invasive device that emits low intensity, pulsed ultrasound in an attempt to accelerate the healing time of a fracture.
3. A multilevel spinal fusion is one that involves three or more vertebrae (e.g., L3-L5, L4-S1, etc).

COVERAGE AND PAYMENT RULES

1. A non-spinal electrical osteogenesis stimulator (E0747) is covered ***only*** if any of the following criteria are met:
    a. Nonunion of a long bone fracture after six or more months have elapsed without healing of the fracture, or

   b. Failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery, or

   c. Congenital pseudarthrosis.

2. A spinal electrical osteogenesis stimulator (E0748) is covered only if any of the following criteria are met:

   a. Failed spinal fusion where a minimum of nine months has elapsed since the last surgery, or

   b. Following a multilevel spinal fusion surgery, or

   c. Following spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.

3. An electrical osteogenesis stimulator will be denied as not medically necessary if none of the above criteria are met.

4. An ultrasonic osteogenesis stimulator (E0760) will be denied as not medically necessary.

5. The Intermediary does not process claims for an invasive osteogenesis stimulator when used in a Skilled Nursing Facility or Home Health Agency.

DOCUMENTATION REQUIRED

1. For electrical osteogenesis stimulators, an order for the item that has been signed and dated by the treating physician and/or a Certificate of Medical Necessity (CMN) which has been signed and dated by the ordering physician must be kept on file by the provider and made available to the Intermediary upon request. The CMN for osteogenesis stimulators is HCFA Form 847.

2. When a claim for a spinal electrical osteogenesis stimulator is submitted with a version .02 CMN, additional documentation is required in the following situations. If it is ordered following a multilevel spinal fusion, the claim must include the date of the surgery and level of the fusion. If it is ordered when thee is a history of a previously failed spinal fusion, the claim must include the date and level of the previous fusion and that fact that the fusion failed. This information must be documented in the patient’s medical record and made available to the Intermediary upon request.

3. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

1 ***SUBJECT***

2 Ostomy Supplies

3 ***HCPCS CODES***

A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
A4361	Ostomy faceplate, each
A4362	Skin barrier; solid, 4 x 4 or equivalent, each
A4363	Skin barrier; liquid (spray, brush, etc.) powder or paste; per ounce
A4364	Adhesive for ostomy or catheter; liquid (spray, brush, etc.), cement, powder or paste; any combination (e.g., silicone, latex, etc.); per ounce
A4367	Ostomy belt
A4397	Irrigation supply; sleeve, each
A4398	Irrigation supply; bag, each
A4399	Irrigation supply; cone/catheter, including brush
A4400	Ostomy irrigation set
A4402	Lubricant, per ounce
A4404	Ostomy ring, each
A4421	Ostomy supply, miscellaneous
A4454	Tape, all types, all sizes
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce

A5051	Pouch, closed; with barrier attached (1 piece)
A5052	Pouch, closed; without barrier attached (1 piece)
A5053	Pouch, closed; for use on faceplate
A5054	Pouch, closed; for use on barrier with flange (2 piece)
A5055	Stoma cap
A5061	Pouch, drainable; with barrier attached (1 piece)
A5062	Pouch, drainable; without barrier attached (1 piece)
A5063	Pouch drainable; for use on barrier with flange (2 piece system)
A5064	Pouch, drainable; with faceplate attached; plastic or rubber
A5065	Pouch, drainable; for use on faceplate; plastic or rubber
A5071	Pouch, urinary; with barrier attached (1 piece)
A5072	Pouch, urinary; without barrier attached (1 piece)
A5073	Pouch, urinary; for use on barrier with flange (2 piece)
A5074	Pouch, urinary; with faceplate attached; plastic or rubber
A5075	Pouch, urinary; for use on faceplate; plastic or rubber
A5081	Continent device; plug for continent stoma

A5082	Continent device; catheter for continent stoma
A5093	Ostomy accessory; convex insert
A5102	Bedside drainage bottle, with or without tubing, rigid or expandable, each
A5119	Skin barrier; wipes, box per 50
A5121	Skin barrier; solid, 6 x 6 or equivalent, each
A5122	Skin barrier; solid, 8 x 8 or equivalent, each
A5123	Skin barrier; with flange (solid, flexible or accordion), any size, each
A5126	Adhesive; disk or foam pad
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 ounces
A5149	Incontinence/ostomy supply; miscellaneous
A6216	Gauze, non-impregnated, pad size 16 sq. in. or less, without adhesive border, each dressing
A6217	Gauze, non-impregnated, pad size more than 16 sq. in. but less than or equal to 48 sq. in., without adhesive border, each dressing
A6218	Gauze, non-impregnated, pad size more than 48 sq., in., without adhesive border, each dressing
A9270	Non-covered item or service
K0137	Skin barrier; liquid (spray, brush, etc.) per oz.
K0138	Skin barrier; paste, per oz.
K0139	Skin barrier; powder, per oz.

XX007	Adhesive remover wipes, 50 per box
XX008	Ostomy filters, any type, each

BENEFIT CATEGORY

Prosthetic devices

DEFINITION

An ostomy is a surgically created opening (stoma) to divert urine, feces or ileal contents outside the body.

INDICATIONS

Ostomy supplies are covered for use on patients with an ostomy as described above.

COVERAGE AND PAYMENT RULES

1. The quantity of ostomy supplies needed by a patient is determined to a great extent by the type of ostomy, its location, its construction, and the condition of the skin surface surrounding the stoma. There will be variation according to individual patient need. The table below lists the maximum number of items/units of service that are usually medically necessary. The actual quantity needed by a particular patient may be more or less than the amount listed depending on the factors that affect the frequency of barrier and pouch change. The medical necessity for use of a greater quantity of supplies than the amount listed must be well documented in the patient's medical record and may be requested by the Intermediary.

NOTE: The number listed in the table refers to the number of units of service provided. For example: for K0138, 4 per month represents two 2 ounce tubes (4 ounces) since the unit of service for K0138 is one ounce.

28 ***USUAL MAXIMUM QUANTITY OF SUPPLIES***

CODE	***#/month***	***#/6 month***
A4361		3
A4362	10	
A4364	4	
K0137	2	
K0138	4	
K0139		10
A4367		2
A4397	1	
A4398		2
A4399		1
A4402	4	
A4404	10	
A4454	2	
A4455	16	
A5051	31	
A5052	31	
A5053	31	
A5054	31	
A5055	31	
A5061	10	
A5062	10	

A5063	10	
A5064	10	
A5065	10	
A5071	10	
A5072	10	
A5073	10	
A5074	10	
A5075	10	
A5081	31	
A5082	1	
A5093	10	
A5102		3
A5119		4
A5121	10	
A5122	6	
A54123	10	
A5126	10	
A5131	1	
K0216	60	
K0217	60	
K0218	60	

2. There is seldom medical necessity for closed colostomy or ileostomy pouches (A5051-A5054) rather than drainable pouches (A5061-A5065). The medical necessity of a closed pouch must be well documented in the patient’s medical record and the record may be requested by the

Intermediary. When a liquid barrier is necessary, either liquid or spray (K0137) or individual wipes (A5119) would be appropriate. The use of both would not be medically necessary.

3. Patients with continent stomas may use the following means to prevent/manage drainage (no more than one type of supply would be medically necessary on a given day):
    a. stomas cap (A5055)
    b. stoma plug (A5081)
    c. gauze pads (K0216-K0218)
4. Patients with urinary ostomies may use either a bag (A4357) or bottle (A5102) for drainage at night. It is not medically necessary to have both. When a drainage bag is used with urinary ostomies, more than one per month would rarely be medically necessary.
5. Codes A5051-A5054 and A5061-A5065 are appropriately used with a colostomy (V44.3) or ileostomy (V44.2). Codes A5071-A5075 are appropriately used with a urinary ostomy (V44.6). Use for other conditions will be denied as not medically necessary.
6. Replacement of an irrigation cone/catheter every 3 months would be covered. This would be billed either using code A4398 if the irrigation bag were replaced at the same time or using code A4399 if just the cone/catheter were being replaced.
7. A pouch cover should be coded A9270 and will be denied as a non-covered item.
8. Provision of ostomy supplies should be limited to a one month supply for a patient in a nursing facility and a 3 month supply for a patient at home.

CODING GUIDELINES

1. Code A4400 for an irrigation kit is not valid for claims submitted to the Intermediary. Necessary components should be billed by individual codes A4367, A4397, A4398. Note that the code for the irrigation bag (A4398) includes an irrigation cone/catheter (A4399) and a brush.
2. Code A4363 is not valid for claims submitted to the Intermediary; code K0137, K0138 or K0139 should be used instead for ostomy supplies.
3. Code A5149 is not valid for claims submitted to the Intermediary; code A4421 should be used instead for ostomy supplies.
4. Code A4402: 1 unit of service is 1 ounce
5. Code A4454: 1 unit of service is 1 roll
6. Code A4455: 1 unit of service is 1 ounce of liquid or spray

7. In the following table, a Column II code is included in the allowance for the corresponding Column I code when provided at the same time:

Column 1	**Column II**
A5064	A4361, A5065
A5074	A4361, A5075

DOCUMENTATION REQUIRED

1. An order for ostomy supplies may be initiated by the physician or the enterostomal therapist. The order must include the type of supplies ordered and the approximate quantity to be used per unit of time. An ICD-9-CM diagnosis code describing the type of ostomy (V44.2, V44.3 or V44.6) should be included on the initial order to a provider. A new order is required if there is a change in the quantity of the supply used per unit time.
2. The provider must enter the diagnosis code for the ostomy on each claim submitted for ostomy supplies. If there is more than one ostomy, enter the appropriate codes. If there are two ostomies of the same type (e.g., two urinary ostomies), enter the diagnosis code twice.
3. If the Intermediary requests justification for the quantity of supplies billed, the information submitted should include the quantity of the supply to be used per unit of time and an explanation of why the patient requires more supplies than usual.
4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

OSTOMY SUPPLY CODES

1. New codes have been established for ostomy solid-skin barriers that are extended wear and/or have built-in convexity. The codes are:

K0279	Skin barrier, with flange (solid, flexible, or accordian), extended wear, with built-in convexity, any size, each
K0429	Skin barrier, solid, 4 x 4 or equivalent, extended wear, without built-in convexity, each
K0430	Skin barrier, with flange (solid, flexible or accordian), extended wear, without built-in convexity, any size, each

K0431	Pouch, closed, with standard wear barrier attached, with built-in convexity (1 piece), each
K0432	Pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece), each
K0433	Pouch, drainable, with standard wear barrier attached, with built-in convexity (1 piece), each
K0434	Pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each
K0435	Pouch, urinary, with extended wear barrier attached, without built-in convexity (1 piece), each
K0436	Pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each
K0437	Pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each

2. The following codes' narrative has been revised by adding the term"standard wear."

K0277	Skin barrier; solid, 4 x 4 or equivalent, standard wear with built-in convexity, each
K0278	Skin barrier; with flange (solid, flexible or accordian), standard wear with built-in convexity, any size, each

3. Attachment 1 provides definitions of extended wear barriers, barriers with built-in convexity and other terms in the codes. At present, the only products that should be coded as extended wear barriers are the Durahesive barrier by ConvaTec and the Flextend barrier by Hollister. If a supplier or manufacturer thinks another product qualifies as an extended wear barrier, they should contact the SADMERC for a coding determination.

4. Attachment 2 lists all solid barrier codes so that providers can see the choices within each group of codes. The barriers in codes A4362, A5123,A5051, A5061 and A5071 are standard wear barriers without built-in convexity.

5. New codes have been established for ostomy pouches with attached faceplates, ostomy pouches for use on a faceplate, and a faceplate equivalent. The codes are:

K0419	Pouch, drainable, with faceplate attached, plastic, each
K0420	Pouch, drainable, with faceplate attached, rubber, each
K0421	Pouch, drainable, for use on faceplate, plastic, each
K0422	Pouch, drainable, for use on faceplate, rubber, each
K0423	Pouch, urinary, with faceplate attached, plastic, each
K0424	Pouch, urinary, with faceplate attached, rubber, each
K0425	Pouch, urinary, for use on faceplate, plastic, each
K0426	Pouch, urinary, for use on faceplate, heavy plastic, each
K0427	Pouch, urinary, for use on faceplate, rubber, each
K0428	Ostomy faceplate equivalent, silicone ring, each

6. Attachment 3 lists products that would be appropriately billed using the new codes. Inquiries concerning the coding of items not on the list should be directed to the Part A Service Center. For products not on the list, providers should use their knowledge of the product and the definitions listed below to determine the correct code until a determination is published in a future Intermediary Advisory. It should be noted that there are no products manufactured by Coloplast, ConvaTec or Hollister that would be billed using these codes.

OSTOMY DEODORANT

New codes have been established for ostomy deodorants. They are:

K0438	Ostomy deodorant for use in ostomy pouch, liquid, per fluid ounce
K0439	Ostomy deodorant for use in ostomy pouch, solid, per tablet

Attachment #1:

Definitions

1. A solid barrier (wafer) is an interface between the patient's skin and the pouching system which is made of a pectin-based or karaya material, has measurable thickness and an adhesive property. There are distinct codes for barriers with built-in convexity compared to flat barriers. There also are distinct codes for extended wear compared to standard wear barriers.
2. A barrier with built-in convexity is one in which an outward curve is achieved by plastic embedded in the barrier.
3. An extended wear barrier is a pectin-based barrier with special additives which achieve a stronger adhesive seal, resist breakdown by urine or ileal effluent and permit longer wear time between changes.
4. A pouch "with barrier attached" is one in which a solid barrier is part of a one-piece pouch system. There are distinct codes for one-piece pouches with convex barriers and extended wear barriers.
5. A pouch "without barrier attached" is a pouch with or without a thin adhesive coating that is applied directly to the skin or to a separate barrier.
6. A faceplate is a solid interface between the patient's skin and the pouch. It usually is made of plastic, rubber or encased metal. It does not have an adhesive property and there is no pectin-based or karaya material that is an integral part of a faceplate. It can be taken off the skin and reattached repeatedly. It is held on by means of a separate adhesive and/or an elastic belt. The clips for attaching the belt are usually a part of the faceplate. There is no coding distinction between flat and convex faceplates.
7. A pouch "with faceplate attached" or "for use on a faceplate" is generally rubber or heavy plastic. It is drainable, cleanable and reusable for periods of weeks to months, depending on the product.

Attachment #2

OSTOMY BARRIER CODES

A4362	Skin barrier, solid, 4 x 4 or equivalent, each
A5051	Pouch, closed, with barrier attached (1 piece)
A5061	Pouch, drainable, with barrier attached (1 piece)
A5071	Pouch, urinary, with barrier attached (1 piece)
A5123	Skin barrier, with flange (solid, flexible or accordian), any size, each
K0277	Skin barrier, solid, 4 x 4 or equivalent, standard wear with built-in convexity, each
K0278	Skin barrier, with flange (solid, flexible or accordian), standard wear, with built-in convexity, any size, each
K0279	Skin barrier, with flange (solid, flexible or accordian),extended wear, with built-in convexity, any size, each
K0429	Skin barrier, solid, 4 x 4 or equivalent, extended wear, without built-in convexity, each
K0430	Skin barrier, with flange (solid, flexible or accordian), extended wear, without built-in convexity, any size, each
K0431	Pouch, closed, with standard wear barrier attached, with built-in convexity (1 piece), each
K0432	Pouch, drainable, with extended wear barrier attached, without built-in convexity (1 piece), each

K0433	Pouch, drainable, with standard wear barrier attached, with built-in convexity (1 piece), each
K0434	Pouch, drainable, with extended wear barrier attached with built-in convexity (1 piece), each
K0435	Pouch, urinary, with extended wear barrier attached, without built-in convexity (1 piece), each
K0436	Pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each
K0437	Pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each

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Attachment #3

HCPCS CODE	***DESCRIPTION***	
	Manufacturer	***Brand Name/Number***
K0419	*Pouch, drainable, with faceplate attached, plastic, each*	
	Marlen	OPV 4001 SI 2001
K0420	*Pouch, drainable, with faceplate attached, rubber, each*	
	Atlantic Perma-Type	O-dor-less Rubber Ileostomy/Colostomy Pouch with flange Colostomy/Ileostomy Appliance with disc
K0421	*Pouch, drainable, for use on faceplate, plastic, each*	
	Marlen	GR-22 MDW-10 XTL-MDW-20 ZK-18
	Perma-Type	Permettes
	Smith & Nephew	Feather-Lite Odorproof Ileostomy Pouch Feather-Lite Vinyl Ileostomy Pouch
	Torbot	Colostomy/Ileostomy Opaque Plastic Pouch Colostomy/Ileostomy Transparent Plastic Pouch
	VPI	Colostomy Ileostomy
K0422	*Pouch, drainable, for use on faceplate, rubber, each*	

K0422 (cont.)	Atlantic	O-dor-less Ileostomy Pouch White Rubber Drainable Pouch
	Gricks	Rubber Ileo Pouch
	Marlen	Ileostomy MP-2
	Perma-Type	Colostomy/Ileostomy Appliance Pouch with apron Colostomy/Ileostomy Synthetic Pouch with apron
	Torbot	Colostomy/Ileostomy Rubber Pouch
K0423	*Pouch, urinary, with faceplate attached, plastic, each*	
	Marlen	SU 3001
K0424	*Pouch, urinary, with faceplate attached, rubber, each*	
	Perma-Type Torbot	Ileal Bladder Appliance with disc Rubber Urostomy Pouch with flange
K0425	Pouch, urinary, for use on faceplate, plastic, each	
	Marlen	EZD-36 MAF-12 XTL-EZS-24
	Smith & Nephew	Feather-Lite Dri-Flo Urinary Pouch Feather-Lite Urinary Pouch
	Torbot	Urinary Opaque Plastic Pouch Urinary Transparent Plastic Pouch

K0426	*Pouch, urinary, for use on faceplate, heavy plastic, each*	
K0426 (cont.)	Atlantic Gricks	White Rubber Pouch Rubber Urinary Pouch
K0427	*Pouch, urinary, for use on faceplate, rubber, each*	
	Marlen	MU3R
	Perma-Type	Urinary Appliance Pouch with apron Urinary Synthetic Pouch with apron
	Torbot	Urinary Rubber Pouch
	VPI	Urostomy
K0428	*Ostomy faceplate equivalent, silicone ring, each*	
	VPI	O-ring Seal

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Oxygen and Oxygen Equipment

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0424	Stationary compressed gaseous oxygen system, rental; includes contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask & tubing; 1 unit = 50 cubic ft.
E0431	Portable gaseous oxygen system, rental; includes regulator, flowmeter, humidifier, cannula or mask and tubing
E0434	Portable liquid oxygen system, rental; includes portable container, supply reservoir, humidifier, flowmeter, refill adapter, contents gauge, cannula or mask, and tubing
E0439	Stationary liquid oxygen system, rental; includes use of reservoir, contents (per unit), regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing; 1 unit = 10 lbs.
E0441	Oxygen contents, gaseous, per unit (for use with owned gaseous stationary systems or when both a stationary and portable gaseous system are owned; 1 unit = 50 cubic ft.)
E0442	Oxygen contents, liquid, per unit (for use with owned liquid stationary systems or when both a stationary and portable liquid system are owned; 1 unit = 10 lbs.)
E0443	Portable oxygen contents, gaseous, per unit (for use only with portable gaseous systems when no stationary gas or liquid system is used; 1 unit = 5 cubic ft.)

E0444	Portable oxygen contents, liquid, per unit (for use only with portable liquid systems when no stationary gas or liquid system is used; 1 unit = 1 lb.)
E0455	Oxygen tent, excluding croup or pediatric tents
E0555	Humidifier, durable, glass or autoclavable plastic bottle type, for use with regulator or flowmeter
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter
E1353	Regulator
E1355	Stand/rack
E1400	Oxygen concentrator, manufacturer specified maximum flow rate does not exceed 2 liters per minute, at 85 percent or greater concentration.
E1401	Oxygen concentrator, manufacturer specified maximum flow rate greater than 2 liters per minute, does not exceed 3 liters per minute, at 85 percent or greater concentration
E1402	Oxygen concentrator, manufacturer specified maximum flow rate greater than 3 liters per minute, does not exceed 4 liters per minute, at 85 percent or greater concentration
E1403	Oxygen concentrator, manufacturer specified maximum flow rate greater than 4 liters per minute, does not exceed 5 liters per minute, at 85 percent or greater concentration
E1404	Oxygen concentrator, manufacturer specified maximum flow rate greater than 5 liters per minute, at 85 percent or greater concentration

E1405	Oxygen and water vapor enriching system with heated delivery
E1406	Oxygen and water vapor enriching system without heated delivery

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-4

DEFINITIONS

1. Oxygen and oxygen equipment, as DME, includes the oxygen contents, the system for furnishing it, the vessels that store it, and the tubing and administration sets that allow the safe delivery of oxygen in the home.

INDICATIONS

Medicare coverage of home oxygen therapy is available only for patients with significant hypoxemia in the chronic stable state provided ***all*** of the following conditions are met:

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

COVERAGE AND PAYMENT RULES

Medicare coverage of oxygen therapy is not available for the following conditions for which oxygen is not medically necessary:

1. Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood and there are other preferred treatments.
2. Dyspnea without cor pulmonale or evidence of hypoxemia.
3. Severe peripheral vascular disease resulting in clinically evident desaturation in one or more extremities. There is no evidence that increased P02 will improve the oxygenation of tissues with impaired circulation.
4. Terminal illnesses that do not affect the respiratory system.

Covered Blood Gas Values

1. Group 1 Coverage is provided for patients with significant hypoxemia evidenced by any of the following:
    a. An arterial P02 at or below 55 mm Hg, or arterial oxygen saturation at or below 88 percent, taken at rest. When a P02 of greater than 55 mm Hg. is submitted, the service will be denied as not medically necessary unless "Group II" criteria are met.
    b. An arterial P02 at or below 55 mm Hg, or an arterial oxygen saturation at or below 88 percent taken during sleep for a patient who demonstrates an arterial P02 at or above 56 mm Hg, or an arterial oxygen saturation at or above 89 percent, while awake, or a greater than normal fall in oxygen level during sleep (a decrease in arterial P02 more than 10 mm Hg, or a decrease in arterial oxygen saturation more than 5 percent) associated with symptoms or signs reasonable attributable to hypoxemia, (e.g., cor pulmonale, "P" pulmonale on EKG, documented pulmonary hypertension and erythrocytosis). In either of these cases, coverage is provided only for nocturnal use of oxygen.
    c. An arterial P02 at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent, taken during activity for a patient who demonstrates an arterial P02 at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent, during the day while at rest. In this case, supplemental oxygen is provided for during exercise if it is documented that the use of oxygen improves the hypoxemia that was demonstrated during exercise when the patient was breathing room air.
2. Group II-Coverage is available for patients whose arterial P02 is 56 to 59 mm Hg or whose arterial blood oxygen saturation is 89 percent if any of the following are documented:

a. Dependent edema suggesting congestive heart failure

b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale of EKG (P wave greater than 3 mm in standard leads II, III, or AVF); OR

c. Erythrocythemia with a hematocrit greater than 56 percent.

3. Group III-In processing claims for home oxygen therapy, Medicare must presume that home use of oxygen is not medically necessary for patients with arterial P02 levels at or above 60 mm Hg, or arterial blood oxygen saturation at or above 90 percent.

PORTABLE OXYGEN SYSTEMS

Medicare coverage of a portable oxygen system alone or to complement a stationary oxygen system may be allowed if the patient is mobile within the home.

Respiratory Therapists

1. Respiratory therapists' services are ***not*** covered under the provisions for coverage of oxygen services under the Part A Durable Medical Equipment (DME) benefit as outlined above. The DME benefit provides for coverage of home use of oxygen and oxygen equipment, but does not include a professional component in the delivery of such services.

2. Initial claims for oxygen therapy must also include the results of a blood gas study that has been ordered and evaluated by the ordering, or consulting, physician. This will usually be in the form of a measurement of the partial pressure of oxygen (PO2) in arterial blood. A measurement of pulse arterial oxygen saturation will also be acceptable when ordered and evaluated by the physician.

3. When a patient's initial certification for oxygen **is** approved based on an arterial P02 of 56 mm Hg or greater or an oxygen saturation of 89 percent of greater, retesting between the 61st and 90th day of home oxygen therapy is required in order to establish continued medical necessity.

4. The conditions under which the laboratory tests are performed must be specified in writing and documented in the patient’s medical records and made available to the Intermediary upon request. Examples of this documentation may include: at rest, while sleeping, while exercising, on room air, or, if while on oxygen, the amount, body position during testing, and similar information necessary for interpreting the evidence.

5. Spare tanks of oxygen or emergency oxygen inhalators are denied as medically unnecessary since these items are precautionary and not therapeutic in nature.

CODING GUIDELINES

N/A

DOCUMENTATION REQUIRED

1. The Certification of Medical Necessity (CMN) for home oxygen is HCFA 484 (5/97) form. This form is used for initial certification, recertification, and changes in the oxygen prescription. This form and/or an order must be filled out, signed and dated by the ordering physician. The documentation must kept on file by the provider and made available to the Intermediary upon request.
2. Recertification is required 1 to 3 months after initial certification (i.e., with the fourth month's claim) in patients:
    a. with PO2 on certification greater than 55, or
    b. in whom the physician's initial estimate of length of need for oxygen was 1 to 3 months.
3. For those patients for whom recertification at three months is not required, recertification will be required by 12 months after initial certification (i.e., by the thirteenth month's claim). Once one recertification establishes the medical necessity for continued use of home oxygen, subsequent recertification will not be routinely required. However, a HCFA 484 (5/97) form or an order from the physician that is signed and dated should be kept on file in the patient's medical records (and made available to the Intermediary upon request) whenever there is a change in the oxygen prescription (e.g., increase or decrease in oxygen flow rate, different equipment, etc.) or if there is a change of the ordering physician. In addition, the Intermediary may require subsequent recertification in individual cases.
4. Initial certification and 3 month recertification required because of initial PO2 of 56 mm Hg or greater or oxygen saturation of 89 percent or greater must include the results of a recently performed arterial blood gas (ABG) or oximetry test (see ***COVERAGE AND PAYMENT RULES***). For other recertification, retesting is not required, but the results of the most recent ABG or oximetry test representing the patient's chronic stable state must be included on the form or in the patient's medical records.
5. Documentation must be furnished on the HCFA 484 (5/97) form or on an order from the physician that is signed and dated, and must consist of arterial blood gas values or oxygen saturation levels obtained from tests conducted on oxygen at a flow rate of four liters per minute (LPM). Test results should be indicated in Item 3A of the HCFA

484 (5/97) form with notation in Item 3C that testing was conducted on a four liter per minute flow rate of oxygen, or on an order from the physician that is signed and dated, or in the units field of the UB92.

6. Claims received with the following modifiers will not be approved for additional payment when the supporting documentation as described on the previous page is not included on the HCFA 484 (5/97) form:

   QF Flow rate exceeds 4LPM, with a portable system

   QG Flow rate exceeds 4LPM, without a portable system

7. Additionally, patients receiving oxygen from a stationary unit at a flow rate greater than four liters per minute and also receiving portable oxygen will be reimbursed on the portable component or for the higher flow rate, whichever is greater, but not both.

8. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

Transtracheal Catheters

1. The use of home oxygen equipment is covered under the Part A benefit of the Medicare program. Catheters used in the administration of transtracheal oxygen are also covered as DME supplies in those cases in which they are medically necessary for the patient to receive home oxygen treatment.

2. Medicare's payment rules for home use of oxygen are governed by sections 1834(a)(5) and (9) of the Social Security Act. These sections require that Medicare pay for home use of stationary oxygen with a single monthly payment amount that includes the oxygen equipment and all necessary supplies. The law does not permit separate payment for any additional items (such as masks, tubing, humidity jars, or transtracheal catheters) used in furnishing oxygen to a patient. The monthly payment amount already includes an allowance for such devices. Therefore, for Medicare to pay a separate amount for such devices would result in duplicate payments since the price of these items has already been included in the base for the fee schedule payment amount for home oxygen therapy.

3. Because the fee schedule amount for home oxygen includes an allowance for all necessary supplies, providers are obligated, without additional payment, to provide transtracheal catheters (including replacements as often as medically necessary) to Medicare recipients when ordered by a physician for purposes of home oxygen. When the attending physician specifies delivery through a transtracheal catheter in Item 5 of the HCFA 484 (5/97) form (as indicated in HCFA Pub. 14-3, Medicare Carrier Manual at §3312.A.10), the oxygen equipment provided by the supplier must conform fully to what has been prescribed in order to be covered.

4. Medicare participating providers have agreed to accept the Medicare approved amount as total payment for covered services for oxygen therapy in the home. The same is true for non-participating providers who agree to take assignment in a particular case. These providers are prohibited from charging Medicare recipients a separate amount for the catheter in the administration of oxygen. They are allowed to charge only for the annual deductible that the recipient has not met, and for the coinsurance, which is the remaining 20 percent of the approved amount, if applicable.

200 **Oxygen Billing Tips**

201 The following chart has been provided as a quick reference to help
202 providers determine what oxygen items may be billed separately.

If Type of System Is:	Can Stationary Equipment Be Billed?	Can Stationary Contents Be Billed?	Can Portable Equipment Be Billed?	Can Portable Contents Be Billed?
A. Situation: Beneficiary Uses a Stationary System Only:				
1. Rents Stationary System				
Concentrator	Yes	No	No	No
Gaseous	Yes	No	No	No
Liquid	Yes	No	No	No
2. Owns Stationary System				
Concentrator	No	No	No	No
Gaseous	No	Yes	No	No
Liquid	No	Yes	No	No
B. Situation: Beneficiary Uses Both a Stationary and a Portable				
1. Rents Stationary/Rents Portable:				
Concentrator	Yes	No	Yes	No
Gaseous	Yes	No	Yes	No
Liquid	Yes	No	Yes	No
2. Rents Stationary/Owns Portable:				
Concentrator	Yes	No	No	No
Gaseous	Yes	No	No	No

Liquid	Yes	No	No	No
Owns Stationary/Owns Portable				
Concentrator	No	No	No	Yes
Gaseous	No	Yes	No	No
Liquid	No	Yes	No	No
Owns Stationary/Rents Portable				
Concentrator	No	No	Yes	Yes
Gaseous	No	Yes	Yes	No
Liquid	No	Yes	Yes	No
C. Situation: Beneficiary Uses a Portable System Only				
Rents Portable System:				
Gaseous	No	No	Yes	Yes
Liquid	No	No	Yes	Yes
Owns Portable System:				
Gaseous	No	No	No	Yes
Liquid	No	No	No	yes

HOW TO COMPLETE THE HCFA 484 (5/97) FORM

Identifying Information: The patient's name, address, and Medicare provider number and the nature of the certification (initial, revised, or renewed) must be entered on all certifications. The provider-identifying information is required on all initial certifications and encouraged on later certifications.

Item 1.

Diagnosis and Clinical Findings: For convenience, several diagnoses that result in the need for oxygen are listed in the form. An additional diagnosis that pertains to the order for oxygen should be entered in the

other block with its appropriate code. Item 1 is required in all initial certifications and recertifications.

All pertinent diagnoses and clinical findings prompting the oxygen prescription should be entered, particularly for patients whose arterial P02 is at, or above, 56 mm Hg or whose arterial blood oxygen saturation is at, or above, 89 percent.

Item 2a.

Date Patient Last Examined: Enter the month, day, and year of the most recent patient examination on all certifications. On initial claims, this date should be within a month of both the date oxygen was prescribed (Item 2b) and the date of the most recent arterial blood gas or oximetry test (Item 3a). When the physician last examined the patient more than one month prior to the order for home oxygen of the most recent testing, Medicare will research to determine whether future examinations or tests have been scheduled.

On recertification, the date last examined should be within 90 days prior to the date of the revised certifications or prior recertification.

Item 2b.

Home Oxygen Prescribed: The date of the current oxygen prescription should be entered. In a revision or recertification, the date of the most recent prescription should be entered, preferably within 90 days of the date of recertification.

On recertifications, do not enter the date you originally prescribed the oxygen, examined the patient or tested the patient in Items 2a, 2b and 3a.

We will suspend payment for any period beyond the last month of anticipated need (from information on the prior certification) or the last month covered by the prior prescription (whichever is earlier) until an acceptable renewal prescription is received. The provider and beneficiary will be advised of any suspension and asked for their assistance in obtaining a current prescription for home oxygen if the beneficiary's circumstances warrant.

Item 2c.

Estimated Length of Need: When oxygen is first ordered, it may be unclear whether the patient's need for it will be short or long-term. The provider must complete one of the blocks taking into consideration the diagnosis, prognosis, test results and the anticipated results of optimum therapy in stabilizing the patient.

Item 3a.

Conditions and Results of Pertinent Tests: Coverage for home oxygen cannot be authorized until the attending physician certifies the extent of hypoxemia and the need for oxygen as evidenced by the results of recent arterial blood gas and/or oxygen saturation tests on the patient is more likely to be stabilized.

The preferred evidence of hypoxemia is the result of a recent arterial blood gas test conducted at room air. If two or more tests have been conducted while the beneficiary was hospitalized, greater weight is given to the test results which establish the need for it only in limited circumstances, such as while sleeping or exercising.

Coverage of home oxygen will be determined in light of the patient's circumstances at the time of the qualifying test(s). For example, continuous use (24 hours a day) of oxygen cannot be approved if qualifying test results establish the need for it only in limited circumstances, such as while sleeping or exercising.

When the patient's P02 level exceeds 59 mm Hg or the arterial blood saturation exceeds 89 percent at rest at room air, the physician must supplement the completed HCFA-484 (5/97) form and/or physician’s order by submitting additional evidence justifying the oxygen prescription, including a statement of the more conservative types of therapy that have been tried and have not successfully treated the patient's hypoxemia.

Item 3b.

Physician/Provider Performing Tests: Qualifying tests must be conducted by a 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 on initial claims or when accompanying recertification. The prohibition does not extend to the results of tests conducted by a hospital that is a certified provider of such services that may also furnish home oxygen therapy to the patient directly or through an associated organization.

Item 3c.

Testing Under Conditions Other Than Room Air: The most reliable test for hypoxemia is arterial blood gas tests conducted at room air. The physician must, therefore, explain if the testing was conducted other than at room air.

Item 4.

Oxygen Flow Rate: A specific flow rate, either continuously or for a lessor period of daily use, must be entered. "PRN" prescriptions are unacceptable. If the prescribed flow rate is to vary with particular activities (e.g., 2 liters per minute at rest, but 3 liters per minute while exercising), physicians should make this distinction when completing this item.

Item 5.

Oxygen Equipment Prescribed: This item is completed only if a particular form of delivery has been prescribed by the physician. In this case, the specific form of delivery or supply ordered must be indicated. To be covered, the equipment supplied must fully conform to that prescribed.

Item 6.

Explanation of Need for Ambulatory or Portable Equipment: When ambulatory or portable equipment has been prescribed in lieu of, or in addition to, a stationary system, an explanation is required. Since oxygen equipment is covered under the Part A DME provisions, the necessity for the portable or ambulatory equipment in the patient's home must be documented. The certification must, therefore, show that the patient's amount and frequency of ambulation, exercise regimen, or other activities regularly undertaken in and about the home could not be met by a stationary system alone. Examples of acceptable explanations include: "Patient must ambulate between the 50 foot limits of stationary equipment delivery tubing daily to meet personal needs" or "Patient regularly engages in an exercise program or other physical activity in and around the home that requires the availability and use of ambulatory or portable equipment."

Once information on the HCFA 484 (5/97) form and/or physician's orders establishes the necessity for portable or ambulatory oxygen equipment in and about the home, use outside the home will be paid as well.

Attending Physician's Signature and Identification

A legible, handwritten signature must be on each form.

A Facsimile or Stamped Signature Is Not Acceptable

The signature must be dated to show reasonable pertinence to the date of oxygen prescription and date(s) of relevant testing. The full name, address, telephone number and identification number of the attending physician is required to allow verification that the prescribing physician is authorized to order Medicare services and to otherwise facilitate claims development. For all initial or revised certifications, or recertification, the identification number to be used is the Medicare Provider Identification Number.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

General Parenteral/Enteral Nutrition Therapy Information

CHANGE OF PEN SUPPLIER

If a beneficiary changes PEN providers during the course of treatment, payment made to the previous provider or to the beneficiary can impact reimbursement to the new provider. The following rules have been established for those providers who obtain new business from beneficiaries already receiving Parenteral or Enteral Nutritional therapy.

PUMPS AND POLES

If the pump or pole was purchased and Medicare provided purchase benefits, the equipment is owned by the beneficiary. No additional Medicare benefits will be provided for rental or purchase of items already owned by the beneficiary. In addition, if the beneficiary sells or discards the owned equipment, future rental or purchase of the same equipment is the responsibility of the beneficiary. If the patient is renting the pump or pole and a rental payment has been made for the month in which a change of provider occurs, another rental payment will not be made within the same month to the new provider. The patient is expected to be allowed to continue to use the equipment for the duration of that month.

NUTRIENTS AND SUPPLIES

Nutrients and supplies are usually provided in quantities sufficient to meet the patient's nutritional needs for a period of one month. When a change in provider occurs before the end of the one-month period, overlapping or duplicate services rendered by the new provider may occur. The nutrients and supplies provided by the previous provider are owned by the beneficiary and should be used to meet his or her nutritional requirements for the remaining portion of the month.

Example: When a patient is transferred from one nursing facility to another, the remaining nutrients, supplies and equipment already paid for by Medicare should be transferred with the patient. The former nursing facility does not own these items or services.

CERTIFICATE OF MEDICAL NECESSITY (CMN) AND RECERTIFICATION

If a change in PEN provider occurs, a new initial CMN and/or physician's order should not be submitted by the new provider. CMNs and any recertification provided by the previous provider are acceptable for the new provider's claims. However, it is the responsibility of the new provider to obtain the necessary information prior to claim submission.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

PARENTERAL AND ENTERAL NUTRITION (PEN) INFUSION PUMP RENTAL LIMITATIONS

1. A period of medical need ends when Parenteral and Enteral Nutrients are not medically necessary for two consecutive months. Voluntary non-billing and institutional care to two or more months does not affect the 15-month period. We will resume calculating the 15-month period when the patient is released from the hospital. You cannot file for an entire month's rental when the patient is hospitalized during the month. Medicare may request documentation verifying a break in medical need of two months or more before we will approve an additional 15-month rental period.
2. A new 15-month period does not begin when the patient changes suppliers. The new supplier is entitled to the balance remaining on the 15-month rental period. Providers must continue supplying the patient with a pump after the 15-month rental is completed, as long as the pump is medically necessary.
3. The patient (or responsible party) decides whether to rent or purchase the pump. Medicare will not cover the purchase of a pump that has met the 15-month rental limit unless the ordering physician switches the prescription between Parenteral and Enteral Nutrients.
4. The total rental payments will be subtracted from the reasonable charge when a pump is purchased before the 15-month rental period is met. Medicare will not continue rental payments after the pump is purchased. In addition, Palmetto Government Benefits Administrators reserves the right to request written authorization from the patient for a pump purchase.
5. The following modifiers must be used on claims for PEN pumps:

KH	Initial claim, purchase or first month rental, capped rental items and/or PEN pumps
KI	Second or third month rental, capped rental items and/or PEN pumps
KJ	Months four to fifteen, capped rental items and/or PEN pumps

6. Medicare will allow maintenance and servicing payments once the 15-month rental period is completed. The maintenance charge will equal one-half month's rental. Use modifier "MS" with the appropriate pump procedure code when filing a claim for the maintenance charge. Medicare will pay maintenance for Enteral Nutrition pumps every six months and every three months for Parenteral Nutrition pumps; if the maintenance or service actually was provided.

BLENDERIZED FORMULAS

1. Justification for use and higher reimbursement of blenderized formulas must be indicated on the CMN and/or documented in the patient's medical record. Blenderized formulas (B4151) will be reimbursed at the Category I (B4150) rate in the absence of medical justification.
2. A higher reimbursement rate will be made only when:
    a. the beneficiary has demonstrated an intolerance to semisynthetic formulas, ***or***
    b. the attending physician submits documentation, which may include hospital or other medical records, demonstrating medically justifiable contraindications to semi-synthetics.

PATIENTS RECEIVING LESS THAN 20 OR MORE THAN 35 CALORIES/Kg

Most patients require between 20 and 35 caloris/kg per day to maintain weight and strength. If a patient falls outside this range, the certification should document the medical reason why. The calculation for determining the patient's intake of calories/kg takes the patient's weight into consideration. This formula is provided on page

NUTRIENTS OTHER THAN BLENDERIZED, SEMI-SYNTHETICS OR CATEGORY II FORMULAS

If a patient has been prescribed an Enteral Nutrition formula in Categories III-VI, justification for use of these formulas must be indicated on the CMN. The physician must indicate what medical reason necessitates the need for the higher level nutrient or why the patient could not be maintained on the Category I Semi-synthetic nutrient.

SKILLED NURSING FACILITY (SNF) PATIENTS

1. The Skilled Nursing Facility (SNF) has the option to furnish PEN nutrients and supplies directly or through an outside provider (pharmacy, manufacturer, etc.).
2. If the SNF chooses to have an outside provider furnish the PEN supplies and nutrients, the SNF will bill the Intermediary for Medicare beneficiaries, if they are covered under Medicare Part A. If they have Medicare Part B coverage ***only***, the SNF may bill the DMERC.
3. If the SNF chooses to furnish the nutrients and supplies ***directly***, the following distinction must be made:
    a. when the Medicare beneficiary is an inpatient with Medicare Part A coverage, the SNF bills the Medicare Part A Intermediary on a reasonable cost basis. Parenteral Nutrition therapy is classified as ancillary service, and

Enteral Nutrition therapy is classified as routine dietary cost for Medicare reporting purposes.

b. when the Medicare beneficiary is in a long-term facility with Medicare Part B coverage only, the SNF bills Part A using bill type 22x.

HOSPITAL INPATIENTS

1. When a patient is in the hospital as an inpatient covered under Medicare Part A, the PEN therapy for that stay is reimbursed under the DRG payment rate by the Medicare Part A Intermediary.
2. When a hospital supplies PEN therapy to an inpatient who is not covered by Medicare Part A and meets the criteria for coverage under the prosthetic device benefit under Medicare Part B, the claim with all necessary documentation must be sent by the hospital to the DMERC. It must be indicated that the beneficiary is not covered under Medicare Part A Hospital Plan.

SPECIAL PEN BILLING INSTRUCTION FOR REPORTING "DAYS", "GRAMS OF PROTEIN" OR "UNITS"

Reporting Units of PEN Formulas

1. For all nutrients and solutions billed, the date range for the Dates of Service should always correspond to the actual number of days billed. If the data does not match, we will check for a change in orders. If a revision certification and/or physician's order is not attached, your claim will be denied for either a revised certification form or to verify the number of units billed. All Enteral Nutrient codes are established in 100 calories increments, therefore, they must be billed and processed in 100 calories increments – one unit for every 100 calories supplied.
2. For Enteral Nutrients, always indicate the number of units supplied. Calculate as follows:

Number of Calories Prescribed ÷ 100 x Number of Days Billed = Number of Units

Example: Prescribed calories –

1500 per day for 30 days (one month)

1500 Calories ÷ 100 x 30 Days = 450 Units

Monthly Units = 450

3. If a physician orders more than one nutrient in the same category, the charges must be combined with the caloric units for these nutrients on one line. Each nutrient and the calories per day must be listed separately on the certification form.

Example: The certification indicates Osmolite at 750 calories per day and Ensure at 750 calories per day. Both nutrients are in the same category and should be coded as B4150, combined and submitted as follows:

1500 Calories ÷ 100 x 30 Days = 450 Units

01/01/92-01/31/92	B4150	450

4. For TPN solutions, always indicate the number of days infused.

Calculating Calories/Kg

To determine if a patient is receiving less than 20 calories/Kg or more than 35 calories/Kg, the following calculations must be done. If the patient's intake falls outside this range, an explanation should be documented on the CMN form. The patient's weight in pounds must be converted to kilograms by dividing the weight in pounds by 2.2 (the number of kilograms in one pound):

Weight (lbs) ÷ 2.2 = Weight in Kilograms

Then the prescribed number of calories per day should be divided by the patient's weight in kilograms. This indicates the number of calories/Kg the patient is infusing:

Prescribed Calories ÷ Weight (Kg) = Calories/Kg

PEN SUPPLY AND ADMINISTRATION KITS

Payment for supply and administration kits are based on a per diem rate. The total number of actual days used should be entered in units field of the UB92 or in the Days/Units field for EMC transmission.

PUMPS AND INTRAVENOUS (IV) POLES

The number of units for pump and IV pole is always "1" if billing for a one month period. If billing for a service charge that is less than your usual and customary charge, use modifier-52 with the appropriate procedure code.

ENTERAL NUTRITION TUBES

For Enteral Nutrition tubes, show the actual number of tubes provided.

REPORTING PARENTERAL NUTRITION GRAMS OF PROTEIN

Pre-mixed solutions, grams of protein or amino acid per day must be reported on the certification form. To convert volume and concentration to grams of protein, the following formula must be used:

Milliliters of Solution ÷ 100 x Concentration = Grams of Protein

Fractions of a gram are always rounded up to the next whole gram.

Example: Prescription is for Travasol 8.5%, 750 ml per day –

750 ml ÷ 8.5 – 63.75 Rounded to 64 Grams of Protein per Day

The grams of amino acid determines which procedure code will be used to bill the TPN solution.

REPORTING UNITS OF LIPIDS

For proper payment of lipids, use the following formula:

Milliliters of Lipids x Number of Infusions (Of Lipids)

During Billing Period ÷ 500

Note: Lipids are billed by number of units – 500 ml of lipids = 1 unit.

Example: Prescription is for 400 ml of lipids, three times/week and billed for a 31 day month.

400 ml x 13 Infusions ÷500 = 10 Units

SPECIAL PARENTERAL NUTRITION SOLUTIONS

Unlike the method of reporting units as days for other pre-mixed solutions, units for special solutions (codes B5000, B5100 and B5200) are reported in the remarks field on page 7 of the UB92 as grams per day multiplied by number of days.

Example: Prescription is for Nephramine 5.4%, 250 ml per day and billed for the month of April 1996.

250 ÷ 100 x 5.4 = 13.5 Rounded to 14 x 30 Days = 420 Units

Date	Place	Code	Charge	Units
04/01/92-04/30/92	12	B5000	$3,500.00	420

Note: Medicare will only pay for a one-month supply at a time.

Note: Span dates (i.e., a span of time between the "from" and "to" dates of service) are required when billing for enteral nutrition formulae, parenteral solutions and all supply kits.

Note: Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

INTRA-PERITONEAL NUTRITION

The Intermediary's policy on Parenteral Nutrition defines parenteral nutrition as the provision of nutritional requirements ***intravenously***. When billing nutrients, supplies or pumps that are used for ***intra-peritoneal nutrition*** (sometimes associated with peritoneal dialysis), use HCPCS code B9999 (Not Otherwise Classified for parenteral supplies). Do not use the specific B codes for parenteral nutrients based on protein content, etc., when nutrients are used in this fashion.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Parenteral Nutrition

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

B4164	Parenteral nutrition solution: carbohydrates (dextrose), 50% or less (500 ml = 1 unit) – home mix
B4168	Parenteral nutrition solution; amino acid, 3.5%, (500 ml = 1 unit) – home mix
B4172	Parenteral nutrition solution; amino acid, 5.5% through 7%, (500 ml = 1 unit) – home mix
B4176	Parenteral nutrition solution; amino acid, 7% through 8.5%, (500 ml = 1 unit) – home mix
B4178	Parenteral nutrition solution, amino acid, greater than 8.5%, (500 ml = 1 unit) – home mix
B4180	Parenteral nutrition solution; carbohydrates (dextrose), greater than 50% (500 ml = 1 unit) – home mix
B4184	Parenteral nutrition solution; lipids, 10% with administration set (500 ml = 1 unit)
B4186	Parenteral nutrition solution, lipids, 20% with administration set (500 ml = 1 unit)
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

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
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
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
B4216	Parenteral nutrition; additives (vitamins, trace elements, heparin, electrolytes) home mix per day
B4220	Parenteral nutrition supply kit; premix, per day
B4222	Parenteral nutrition supply kit; home mix, per day
B4224	Parenteral nutrition administration kit, per day
B5000	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, renal – premix
B5100	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, hepatic – premix
B5200	Parenteral nutrition solution: compounded amino acid and carbohydrates with electrolytes, trace elements, and vitamins, including preparation, any strength, stress (branch chain amino acids) – premix

B9004	Parenteral nutrition infusion pump, portable
B9006	Parenteral nutrition infusion pump, stationary
B9999	NOC for parenteral supplies
E0776	IV pole

HCPCS MODIFIER

XA	IV pole is used in conjunction with parenteral or enteral nutrition

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 65-10

DEFINITIONS

Parenteral nutrition is the provision of nutritional requirements intravenously.

COVERAGE AND PAYMENT RULES

Parenteral nutrition is covered for a patient with permanent, severe pathology of the alimentary tract which does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the patient's general condition.

General

1. The patient must have a permanent impairment. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgement of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Parenteral nutrition will be denied as non-covered in situations involving temporary impairments.
2. The patient must have:
    a. a condition involving the small intestine and/or its exocrine glands which significantly impairs the absorption of nutrients, ***or***

   b. disease of the stomach and/or intestine which is a motility disorder and impairs the ability of nutrients to be transported through the GI system. There must be objective evidence supporting the clinical diagnosis.

3. Parenteral nutrition is non-covered for the patient with a functioning gastrointestinal tract whose need for parenteral nutrition is only due to:

   a. a swallowing disorder

   b. a temporary defect in gastric emptying such as a metabolic or electrolyte disorder

   c. a psychological disorder impairing food intake such as depression

   d. a metabolic disorder inducing anorexia such as cancer

   e. a physical disorder impairing food intake such as the dyspnea of severe pulmonary or cardiac disease

   f. a side effect of a medication

   g. renal failure and/or dialysis

4. In order to cover intradialytic parenteral nutrition (IDPN), documentation must be clear and precise to verify that the patient suffers from a permanently impaired gastrointestinal tract and that there is insufficient absorption of nutrients to maintain adequate strength and weight. Records should document that the patient cannot be maintained on oral or enteral feedings and that due to severe pathology of the alimentary tract, the patient must be intravenously infused with nutrients. Infusions must be vital to the nutritional stability of the patient and not supplemental to a deficient diet or deficiencies caused by dialysis. Physical signs, symptoms and test results indicating severe pathology of the alimentary tract must be clearly evident in any documentation submitted. Patients receiving IDPN must meet the parenteral nutrition coverage criteria listed below.

5. Maintenance of weight and strength commensurate with the patient's overall health status must require intravenous nutrition and must not be possible utilizing all of the following approaches:

   a. modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long chain triglycerides, substitution with medium chain triglycerides, provision of protein as peptides or amino acids, etc.), ***and***

   b. utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad-spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility, etc.).

6. Parenteral nutrition is covered in any of the following situations:

a. the patient has undergone recent (within the past 3 months) massive small bowel resection leaving ≤ 5 feet of small bowel beyond the ligament of Treitz

b. the patient has a short bowel syndrome that is severe enough that the patient has net gastrointestinal fluid and electrolyte malabsorption such that on an oral intake of 2.5-3 liters/day the enteral losses exceed 50% of the oral/enteral intake and the urine output is < 1 liter/day

c. the patient requires bowel rest for at least 3 months and is receiving intravenously 20-35 cal/kg/day for treatment of symptomatic pancreatitis with/without pancreatic pseudocyst, severe exacerbation of regional enteritis, or a proximal enterocutaneous fistula where tube feeding distal to the fistula isn't possible

d. the patient has complete mechanical small bowel obstruction where surgery is not an option

e. the patient is significantly malnourished (10% weight loss over 3 months or less and serum albumin ≤ 3.4 gm/Dl) and has very severe fat malabsorption (fecal fat exceeds 50% of oral/enteral intake o a diet of at least 50 gm of fat/day as measured by a standard 72 hour fecal fat test)

f. the patient is significantly malnourished (10% weight loss over 3 months or less and serum albumin ≤ 3.4 gm/Dl)) and has a severe motility disturbance of the small intestine and/or stomach which is unresponsive to prokinetic medication and is demonstrated either:

- scintigraphically (solid meal gastric emptying study demonstrates that the isotope fails to reach the right colon by 6 hours following ingestion), ***or***
- radiographically (barium or radiopaque pellets fail to reach the right colon by 6 hours following administration).

Note: These studies must be performed when the patient is not acutely ill and is not on any medication that would decrease bowel motility.

Note: Unresponsiveness to prokinetic medication is defined as the presence of daily symptoms of nausea and vomiting while taking maximal doses.

7. For criteria a-f above, the conditions are deemed to be severe enough that the patient would not be able to maintain weight and strength on only oral intake or tube enteral nutrition.

8. Patients who do not meet criteria 6.a.-6.f. above must meet criteria 5.a. and 5.b. above (modification of diet and pharmacologic intervention) ***plus*** criteria 8.a. and 8.b. below:

a. the patient is malnourished (10% weight loss over 3 months or less and serum albumin ≤ 3.4 gm/Dl), ***and***

b. a disease and clinical condition hs been documented as being present and it has not responded to altering the manner of delivery of appropriate nutrients (e.g., slow infusion of nutrients through a tube with the tip located in the stomach or jejunum).

9. The following are some examples of moderate abnormalities which would require a failed trial of tube enteral nutrition before parenteral nutrition would be covered:

a. moderate fat malabsorption (fecal fat exceeds 25% of oral/enteral intake on a diet of at least 50 gm of fat/day as measured by a standard 72 hour fecal fat test)

b. diagnosis of malabsorption with objective confirmation by methods other than 72 hour fecal fat test (e.g., Sudan stain of stool, d-xylose test, etc.)

c. gastroparesis which has been demonstrated:

- radiographically or scintigraphically as described in 6.f. above with the isotope or pellets failing to reach the jejunum in 3-6 hours, ***or***
- by manometric motility studies with results consistent with an abnormal gastric emptying, and which is unresponsive to prokinetic medication
- a small bowel motility disturbance which is unresponsive to prokinetic medication, demonstrated with a gastric to right colon transit time between 3-6 hours
- small bowel resection leaving < 5 feet of small bowel beyond the ligament of Treitz
- short bowel resection leaving > 5 feet of small bowel beyond the ligament of Treitz
- short bowel syndrome that is not severe (as defined in 6.b.
- mild to moderate exacerbation of regional enteritis, or an enterocutaneous fistula
- partial mechanical small bowel obstruction where surgery is not an option

Note: Definition of a Tube Trial –

A concerted effort must be made to place a tube. For gastroparesis, tube placement must be post-pylorus, preferably in the jejunum. Use of a double lumen tube should be considered. Placement of the tube in the

jejunum must be objectively verified by radiographic studies or fluoroscopy. Placement via endoscopy or open surgical procedure would also verify location of the tube, however they are not required.

10. A trial with enteral nutrition must be made, with appropriate attention to dilution, rate, and alternative formulas to address side effects of diarrhea.

11. Examples of a failed tube trial would be:

    a. a person who has had documented placement of a tube in the post-pyloric area continues to have problems with vomiting and on radiographic recheck the tube has returned to the stomach

    b. after an attempt of sufficient time (5-6 hours) to get a tube into the jejunum, the tube does not progress and remains in the stomach or duodenum. An attempt of enteral tube feeding with a very slow drip was made. It was initially tolerated well but vomiting occurred when the rate was increased.

    c. after placement of the tube in the jejunum and 1-2 days of enteral tube feeding, the person has vomiting and distension.

    d. a tube is placed appropriately and remains in place. Enteral nutrition is initiated and the concentration and rate are increased gradually. Over the course of 3-4 weeks, attempts to increase the rate and/or concentration and/or to alter the formula to reach the targeted intake are unsuccessful, with increase in diarrhea, bloating or other limiting symptoms, and the person is unable to meet the needed nutritional goals (stabilize at desired weight or gain weight as needed).

12. Parenteral nutrition can be covered in a patient with the ability to obtain partial nutrition from oral intake or a combination of oral/enteral (or even oral/enteral/parenteral) intake as long as the following criteria are met:

    a. a permanent condition of the alimentary tract is present which has been deemed to require parenteral therapy because of its severity (criteria 6.a.-6.f., ***or***

        - a permanent condition of the alimentary tract is present which is unresponsive to standard medical management (criterion 8.h.), ***and***

    b. the person is unable to maintain weight and strength (criterion 8.g.).

13. parenteral nutrition would usually be non-covered for patients who do not meet these criteria but will be considered on an individual case basis if detailed documentation is submitted.

14. The medical necessity of continued parenteral nutrition must be recertified 6 months after the initial claim. Patients covered under criteria 6.a. or 6.b. should have documentation that adequate small

bowel adaptation had not occurred which would permit tube enteral or oral feedings. Patients covered under 6.c. should have documentation of worsening of their underlying condition during attempts to resume oral feedings. Patients covered under 6.d. should have documentation of the persistence of their condition. Patients covered under 6.e., 6.f., 8.g., 8.h. should have documentation that sufficient improvement of their underlying condition had not occurred which would permit discontinuation of parenteral nutrition. Coverage for these patients would be continued if the treatment had been effective as evidenced by an improvement of weight and/or serum albumin. If there had been no improvement, subsequent claims will be denied unless the physician clearly documents the medical necessity for continued parenteral nutrition and any changes to the therapeutic regimen that are planned – e.g., an increase in the quantity of parenteral nutrients provided.

15. If the coverage requirements for parenteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

16. No more than one month’s supply of parenteral nutrients, equipment or supplies is allowed for one month’s prospective billing. Claims submitted retroactively, however, may include multiple months.

17. The ordering physician is expected to see the patient within 30 days prior to the initial certification or required recertification (but not revised certifications). If the physician does not see the patient within this time frame, he/she must document the reason why and describe what other monitoring methods were used to evaluate the patient’s parenteral nutrition needs.

18. Parenteral nutrition provided by a skilled nursing facility (SNF) to a Part A covered patient is billed by the SNF to the Intermediary. No payment from Part B is available to a SNF when the SNF furnishes parenteral nutrition services to a beneficiary in a stay covered by Part A. Furthermore, if a beneficiary is ***not*** covered by Part A, parenteral nutrition is eligible for coverage under Part B and is billed to the Intermediary using a 22x bill type, regardless of whether it is furnished by a SNF or an outside supplier.

Nutrients

1. Parenteral nutrition solutions containing little or no amino acids and/or carbohydrates would be covered only in situations A, B, or D (above).

2. A total daily caloric intake (parenteral, enteral and oral) of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight. The ordering physician must document in the medical record the medical necessity for a caloric intake outside this range in an individual patient. This information must be available to the Intermediary on request.

3. The ordering physician must document the medical necessity for protein orders outside of the range of 0.8-1.5 gm/kg/day, dextrose concentration less than 10%, or lipid use greater than 15 units of a 20% solution or 30 units of a 10% solution per month.
4. Special parenteral formulas (B5000-B5200) are rarely medically necessary. If the medical necessity for these formulas is not substantiated, payment will be made for the medically appropriate formula.

Equipment and Supplies

1. Infusion pumps (B9004-B9006) are covered for patients in whom parenteral nutrition is covered. Only one pump (stationary or portable) will be covered at any one time. Additional pumps will be denied as not medically necessary.
2. When parenteral nutrition is administered in a outpatient facility, the pump used for its administration and IV pole will be denied as not separately payable. The pump and pole are not considered as rentals to a single patient but rather as items of equipment used for multiple patients.
3. If the coverage requirements for parenteral nutrition are met, one supply kit (B4220 or B4222) and one administration kit will be covered for each day that parenteral nutrition is administered, if such kits are medically necessary and used.

RELATED CLINICAL INFORMATION

When nutritional support other than the oral route is needed, tube enteral nutrition is usually preferable to parenteral nutrition for the following reasons:

a. in a fluid restricted patient, tube enteral nutrition permits delivery of all necessary nutrients in a more concentrated volume than parenteral nutrition
b. tube enteral nutrition allows for safer home delivery of nutrients.

CODING GUIDELINES

1. when home mix parenteral nutrition solutions are used, the component carbohydrates (B4164, B4180), amino acids (B4168-B4178), additives (B4216) and lipids (B4184, B4186) are all separately billable.
2. When premix parenteral nutrition solutions are used (B4189-B4199, B5000-B5200) there must be no separate billing for the carbohydrates, amino acids or additives (vitamins, trace elements, heparin, electrolytes). However, lipids are separately billable with premix solutions.

3. When an IV pole (E0776) is used in conjunction with parenteral nutrition, the XA modifier should be added to the code.
4. When codes B4189-B4199, one unit of service represents one day's supply of protein and carbohydrate regardless of the fluid volume and/or the number of bags. For example, if 60 grams of protein are administered per day in two bags of a premix solution each containing 30 grams of amino acids, correct coding is one (1) unit of B4193, ***not*** two units of B4189.
5. For codes B5000-B5200, one unit of service is one gram of amino acid.
6. Parenteral nutrition solutions containing less than 10 grams of protein per day are coded using the miscellaneous code B9999.

DOCUMENTATION REQUIRED

1. The CMN for parenteral nutrition may be completed by someone other than the ordering physician. The person completing the information on the form may not be the provider. However the CMN must be reviewed for the accuracy of the information and signed and dated by the ordering physician to indicate agreement. the CMN for parenteral nutrition is DMERC 10.
2. Additional documentation must be included with the first claim for parenteral nutrition. The type of documentation relates to which situation (6.a.-6.e., 8g., 8.h.) in ***COVERAGE AND PAYMENT RULES***, generally serves as the basis for coverage. For situations 6.a.-6.d., the documentation should include copies of the operative report and/or hospital discharge summary and/or x-ray reports and/or physician letter that document the condition and the necessity for parenteral therapy. For situations 6.e. and 8.h. (when appropriate), include the results of the fecal fat test and dates of the test. For situations 6.f. and 6.h. (when appropriate), include a copy of the report of the small bowel motility study and a list of medications that the patient was on at the time of the test. For situations 6.e., 6.f., 8.g. and 8.h., include results of serum albumin and date of test (within 1 week prior to initiation of parenteral nutrition, PN) and a copy of a nutritional assessment by a physician, dietitian or other qualified professional within 1 week prior to initiation of PN, to include the following information:
    a. current weight with date and weight 1-3 months prior to initiation of PN
    b. estimated daily calorie intake during the prior month and by what route (e.g., oral, tube)
    c. statement of whether there were caloric losses from vomiting or diarrhea and whether these estimated losses are reflected in the calorie count

d. description of any dietary modifications made or supplements tried during the prior month (e.g., low fat, extra medium chain triglycerides, etc.)

3. For situations described in 8.h., include a statement from the physician, copies of objective studies, and excerpts of the medical record giving the following information:

   a. specific etiology for the gastroparesis, small bowel dysmotility, or malabsorption

   b. a detailed description of the trial of tube enteral nutrition including the beginning and ending dates of the trial, duration of time that the tube was in place, the type and size of tube, the location of tip of the tube, the name of the enteral nutrient, the quantity, concentration, and rate of administration, and the results

   c. a copy of the x-ray report or procedure report documenting placement of the tube in the jejunum

   d. prokinetic medications used, dosage, and dates of use

   e. non-dietary treatment given during prior month directed at etiology of malabsorption (e.g., antibiotic for bacterial overgrowth)

   f. any medications used that might impair GI tolerance to enteral feedings (e.g., anticholinergics, opiates, tricyclics, phenothiazines, etc.) or that might interfere with test results (e.g., mineral oil, etc.) and a statement explaining the need for these medications.

4. Any other information that supports the medical necessity for parenteral nutrition may also be included.

5. For the Initial Certification and for Revised Certifications or Recertification involving a change in the order, there must be additional documentation to support the medical necessity of the following orders, if applicable:

   a. the need for special nutrients (B5000-B5200)

   b. the need for dextrose concentration less than 10%

   c. the need for lipids more than 15 units of a 20% solution or 30 units of a 10% solution per month

6. After the initial certification of parenteral nutrition items, recertification is required every 30 days for skilled nursing facilities and every 62 days for home health agencies and comprehensive outpatient rehabilitation facilities, documenting the patient’s continued need for therapy.

7. The Recertification must include a physician’s statement describing the continued need for parenteral nutrition. For situations 6.e., 6.f., 8.g., 8.h., the Recertification must include the results of the

most recent serum albumin (within 2 weeks of recertification) and the patient's most recent weight with the date of each. If the results indicate malnutrition, there should be a physician's statement describing the continued need for parenteral nutrition and any changes to the therapeutic regimen that are planned.

8. When code B9999 is billed, the claim must include a clear description of the item, the quantity provided, and the medical necessity of the item for the patient.
9. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

385 **ENTERAL NUTRIENTS PRODUCT CLASSIFICATION**

Category	Product Name	HCPCS Code
1	AMTF	B4150
	Attain L.S.	
	Attain K.D.S.	
	Boost	
	Enfamil	
	Ensure	
	Ensure HN	
	Ensure High Protein	
	Ensure Powder	
	Ensure with Fiber	
	Entera	
	Entera Isotonic	
	Entera Isotonic Fiber	
	Entralife HN	
	Entralife HN Fiber	
	Entralife HN-2	
	Entrition HN	
	Fiberlan	
	Fibersource	
	Fibersource HN	
	Fortison	
	Flytrol	

Hearty Balance

Introlite

Isocal

Isocal HN

Isocal II

Isofiber

Isolan

Isomil

Isosource

Isosource HN

Jevity

Jevity Plus

Kindercal

Lonalac

Meritene

Naturite

Nitrolan

NuBasics

NuBasics with Fiber

NuBasics VHP

Nutrapak

Nutramigen

Nutren 1.0

Nutren 1.0 with Fiber

Nutren Junior

Nutren Junior Fiber

Nutren VHP

Nutri-Drink

Nutrilan

Nutrition

Osmolite

Osmolite HN Plus

Osmolite HN

Pediasure

Pediasure with Fiber

Portagen

Pro-Peptide for Kids

ProBalance

Promote

Promote with Fiber

Resource

Resource Diabetic

Resource for Kids

Similac with Iron

Susta II

Sustacal

Sustacal Basic

Sustacal Fiber

	Ultracal	
	Compleat-B	
	Compleat-B modified	
	Complete Pediatric	
	ProSobee	
II	Comply	B4152
	Deliver 2.0	
	Ensure Plus	
	Ensure Plus HN	
	Entrition 1.5	
	IsoSource 1.5	
	Isotera Isotonic	
	Lipisorb	
	Magnacal Renal	
	Naturite Plus	
	Newtrition 1.5	
	NuBasics 2.0 Complete	
	NuBasics Plus	
	Nutren 2.0	
	Nutri-Drink Plus	
	NutriAssist 1.5	
	Nutrition Plus	
	Nutrivent	
	Resource Plus	

	Respalor	
	Sustacal Plus	
	Twocal HN	
	Ultralan	
III	Accupepha	B4153
	Criticare HN	
	Isotein	
	L-Emental	
	L-Emental Pediatric	
	Neocate Infant Formula	
	Neocate One + Liquid	
	Neocate One + Powder	
	Neocate One Powder	
	Peptical	
	Reabilan	
	Travasorb HN	
	Vital HN	
	Vivonex Pediatric	
IV	Accupep HPF	B4154
	Advera	
	Alitraq	
	AminAid	
	Choice DM	
	Citrotein	

Crucial

Diabetisource

Entera OPD

Fulfil

Peptamen VHP

Peptamin Junior

Perative

Pregestimil

Pro-Peptide

Pro-Peptide VHN

Protain XL

Provide

Pulmocare

Reabilan HN

Renalcal

Replete

Glucerna

Gluco-Pro

Hepatic Aid

Impact

Impact 1.5

Impact with Fiber

Immun-Aid

Isosource VHN

	L-Emental Hepatic	
	L-Emental Plus	
	Lipisorb	
	Nepro	
	Novasource Renal	
	NutriHep	
	Nutrivent	
	Peptamen	
	Replete with Fiber	
	SLD	
	SandoSource Peptide	
	Stresstain	
	Suplena (Replena)	
	Traumacal	
	Travasorb MCT	
	Travasorb Renal	
	Vivonex Plus	
	Vivonex T.E.N.	
V	Casec	B4155
	Elementra	
	Fibrad	
	MCT Oil	
	Microlipid	
	Moducal	

	Polycose	
	ProSource	
	Promix	
	ProMod	
	Propac Plus	
	ProSource Protein Supplement	
	Ross Carbohydrate Free	
	Sumacal	
VI	Tolerex	B4156
	Travasorb STD Powder	

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Note: Parenteral Nutrition supply kits and their components are generally considered all-inclusive items necessary to administer therapy for a one month period. Payment will not be made to providers or beneficiaries for additional components billed separately. Items in the different kits include, but are not limited to:

B4220	**B4222**	**B4224**
Supplies – Pre-Mix	**Supplies – Home mix**	**Admin. Kit**
Gloves	Containers	AdminSets/Leur
Tape/Wipes	Gloves	Containers
Alcohol Wipes	Destruclip	Lock and Iso. Alcohol
Micron Filter	Acetone	2 or 3-way Connectors
Providone Iodine	Iso. Alcohol	Clamps
Acetone	Providone Iodine	Pump Cassettes
Scrub	Scrub	Extension Sets
Providone Iodine	Providone Swabs	Ointment
Providone Sticks	Providone Sticks	
Gauze Sponges	Gauze Sponges	
Heparin Flush	Heparin Flush	
Micropore Tape	Injection Caps	
Plastic Tape	Micropore Tape	
Injection Caps	Plastic Tape	
Syringes	Needles	
Needles	Syringes	
Keto-diastix	Keto-diastix	
Destruclip		

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Enteral Nutrition

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

B4034	Enteral feeding supply kit; syringe, per day
B4035	Enteral feeding supply kit; pump fed, per day
B4036	Enteral feeding supply kit; gravity fed, per day
B4081	Nasogastric tubing with stylet
B4082	Nasogastric tubing without stylet
B4083	Stomach tube-levine type
B4084	Gastrostomy/jejunostomy tubing
B4085	Gastrostomy tube, silicone with sliding ring, each
B4150	Enteral formulae; category I, semi-synthetic intact protein/protein isolates, 100 calories=1 unit
B4151	Enteral formulae; category I: natural intact protein/protein isolates, 100 calories=1 unit
B4152	Enteral formulae; category II: intact protein/protein isolates (calorically dense), 100 calories=1 unit
B4153	Enteral formulae; category III: hydrolized protein/amino acids, 100 calories =1 unit

B4154	Enteral formulae; category IV: defined formula for special metabolic need, 100 calories=1 unit
B4155	Enteral formulae; category V: modular components (protein, carbohydrates, fat), 100 calories=1 unit
B4156	Enteral formulae; category VI: standardized nutrients, 100 calories=1 unit
B9000	Enteral nutrition infusion pump-without alarm
B9002	Enteral nutrition infusion pump-with alarm
B9998	NOC for enteral supplies
E0776	IV pole

HCPCS MODIFIERS

XA	IV pole used in conjunction with parenteral or enteral nutrition
ZY	Potentially non-covered item or service billed for denial or at beneficiary's request (not to be used for medical necessity denials)

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 65-10

DEFINITION

Enteral nutrition is the provision of nutritional requirements through a tube into the stomach or small intestine.

COVERAGE AND PAYMENT RULES

General:

1. Enteral nutrition is covered for a patient who has:

    a. permanent non-function or disease of the structures that normally permit food to reach the small bowel, ***or***

    b. disease of the small bowel which impairs digestion and absorption of an oral diet

    either of which requires tube feeding to provide sufficient nutrients to maintain weight and strength commensurate with the patient's overall health status. The patient must have a permanent impairment. Permanence does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the judgement of the attending physician, substantiated in the medical record, is that the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Enteral nutrition will be denied as non-covered in situations involving temporary impairments.

2. The patient's condition could be either anatomic (e.g., obstruction due to head and neck cancer to reconstructive surgery, etc.) or due to a motility disorder (e.g., severe dysphagia following a stroke, etc.). Enteral nutrition is non-covered for patients with a functioning gastrointestinal tract whose need for enteral nutrition is due to reasons such as anorexia or nausea associated with mood disorder, end-stage disease, etc.

3. The patient must require tube feedings to maintain weight and strength commensurate with the patient's overall health status. Adequate nutrition must not be possible by dietary adjustment and/or oral supplements. Coverage is possible for patients with partial impairment- e.g., a patient with dysphagia who can swallow small amounts of food or a patient with Crohn's disease who requires prolonged infusion of enteral nutrients to overcome a problem with absorption.

4. Enteral nutrition products that are administered orally and related supplies are non-covered.

5. If the coverage requirements for enteral nutrition are met, medically necessary nutrients, administration supplies, and equipment are covered.

6. No more than one month's supply of enteral nutrients, equipment or supplies is allowed for one month's prospective billing. Claims submitted retroactively, however, may include multiple months.

7. The ordering physician is expected to see the patient within 30 days prior to the initial certification. If the physician did not see the patient within this timeframe, he/she must document the reason why

and describe what other monitoring methods were used to evaluate the patient's enteral nutrition needs.

8. Enteral nutrition provided by a skilled nursing facility (SNF) to a Part A covered patient is billed by the SNF to the Intermediary. No payment from Part B is available to a SNF when the SNF furnishes enteral services to a beneficiary in a stay covered by Part A. If a beneficiary is not covered by Part A, enteral nutrition is eligible for coverage under Part B and should be billed to the Intermediary regardless of whether it is furnished by a SNF or an outside supplier.

Nutrients:

1. Enteral formulas consisting of semi-synthetic intact protein/protein isolates (B4150) are appropriate for the majority of patients requiring enteral nutrition. Formulas consisting of natural intact protein/protein isolates, code B4151, are covered for patients with an allergy or intolerance to semi-synthetic formulae (B4150). Calorically dense formulas (B4152) are covered if they are ordered and are medically necessary. The medical necessity for special enteral formulas B4151, B4153-B4156) will need to be justified in each patient. If the medical necessity for these formulas is not substantiated, payment will be based on the allowance for the least costly alternative, code B4150.
2. Baby food and other regular grocery products that can be blenderized and used with the enteral system will be denied as non-covered.
3. A total daily calorie intake of 20-35 cal/kg/day is considered sufficient to achieve or maintain appropriate body weight in most patients. The ordering physician must document the medical necessity for a caloric intake outside this range in an individual patient. This information must be available to the Intermediary on request.

Equipment and Supplies:

1. Enteral nutrition may be administered by syringe, gravity or pump. Some enteral patients may experience complications associated with syringe or gravity method of administration. If a pump (B9000-B9002) is ordered, there must be documentation accompanying the Certificate of Medical Necessity (CMN) and/or physician's order to justify its use (e.g., gravity feeding is not satisfactory due to reflux and/or aspiration, severe diarrhea, dumping syndrome, administration rate less than 100 ml/hr, blood glucose fluctuations, circulatory overload, jejunostomy tube used for feeding). If the medical necessity of the pump is not documented, the pump will be denied as not medically necessary.
2. The feeding supply kit (B4034-B4036) must correspond to the method of administration. If a pump supply kit (B4035) is ordered and the medical necessity of the pump is not documented, payment will be based on the allowance for the least costly alternative B4036.

3. More than three nasogastric tubes (B4081-B4083), or one gastrostomy or jejunostomy tube (B4084, B4085) every three months is rarely medically necessary.

CODING GUIDELINES

1. When enteral nutrition is covered, dressings used in conjunction with a gastrostomy or enterostomy tube are included in the supply kit code (B4034-B4036) and should not be billed separately using dressing codes.
2. Categories of enteral nutrition are based on the composition and source of ingredients in each enteral nutrient product. Only those products included in the Product Classification List published by the DMERCs may be billed using code B4154 or B4155. If a manufacturer or provider thinks that another product meets the definition of this code, they should contact Medicare Part A Service Center.
3. When an IV pole (E0776) is used for enteral nutrition administered by gravity or a pump the XA modifier should be added to the code.

DOCUMENTATION REQUIRED

1. With initial claims for enteral nutrition formulas and pumps, a Certificate of Medical Necessity (CMN) and/or physician's order must be on file and made available to the Intermediary upon request. Section B of the CMN for enteral nutrition may be completed by someone other than the treating physician, so long as it is not anyone in a financial relationship with the provider. However, the CMN must be reviewed for the accuracy of the information and signed and dated by the treating physician to indicate agreement. The CMN for enteral nutrition is HCFA Form 853.
2. A new order for enteral nutrients is required when:
    a. a formula billed with a different code which has not been previously ordered, ***or***
    b. enteral nutrition services are resumed after they have not been required for two consecutive months.
3. A new order for a pump (B9000 or B9002) is required if enteral nutrition services involving use of a pump are resumed after they have not been required to two consecutive months. An order is also required for a pump if a patient receiving enteral nutrition by the syringe or gravity method is changed to administration using a pump (in this latter situation, a new order is required for the nutrient which indicates the change to the pump method of administration-Question #13 on the CMN).
4. In addition to the reason listed above, a new order ***is*** required when, for a formula that has been previously ordered:
    a. the number of calories per day is changed, ***or***

b. number of days per week administered is changed, ***or***

c. the method of administration (syringe, gravity, pump) changes, ***or***

d. route of administration is changed from tube feedings to oral feedings (if billing for denial), ***or***

e. if a Category IV or V enteral nutrient being provided is changed.

5. The initial date listed in Section A of a Revised CMN and/or the new physician's order for codes B4154 or B4155 must match the initial date on the certification record for code B4154 or B4155 which has been set up by the Intermediary.

6. Regularly scheduled re-certifications are required every 30 days for Skilled Nursing Facilities and every 62 days for Home Health Agencies and Comprehensive Outpatient Rehabilitation Facilities. A re-certification and/or physician's order is required if the physician indicates a length of need of less than lifetime on the CMN and subsequently orders a greater length of need. Re-certification may also be requested on an individual basis at the discretion of the Intermediary.

7. The Initial Certification and/or physician's order must be accompanied by adequate documentation to support the medical necessity of the following orders, if applicable:

   a. the need for special nutrients (B4151, B4153-B4156)

   b. the need for a pump

8. Each claim submitted with code B4154 or B4155 must include the product name of the nutrient that is provided.

9. If two Category IV or two Category V nutrients are being provided at the same time, they should be billed on a single claim line with the units of service reflecting the total calories of both nutrients.

10. If a provider is billing for items that are non-covered, this must be indicated on the claim. The recommended way of doing this is to add the ZY modifier to the code. If ZY is used, a brief description of the reason for non-coverage should be included (e.g., B4150ZY-nutrient given orally; no tube).

11. When a certification is required, the certification must include a copy of the CMN and/or physician's order and be available to the Intermediary upon request.

12. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

188 **ENTERAL NUTRITION PRODUCT CLASSIFICATION**

189 **Category I – HCPCS Code: B4150**

AMTF	Newtrition (flavor)
Attain L.S.	Newtrition Isofiber
Attain K.D.S.	Newtrition Isotonic
Boost	Nitrolan
Enfamil	NuBasics
Ensure	NuBasics with Fiber
Ensure HN	NuBasics VHP
Ensure High Protein	Nutrapak
Ensure Powder	Nutramigen
Ensure with Fiber	Nutren 1.0
Entera	Nutren 1.0 with Fiber
Entera Isotonic	Nutren Junior
Entera Isotonic Fiber	Nutren Junior Fiber
Entralife HN	Nutren VHP
Entralife HN Fiber	Nutri-Drink
Entralife HN-2	Nutrilan
Entrition HN	Nutrition
Fiberlan	Osmolite
Fibersource	Osmolite HN Plus
Fibersource HN	Osomolite HN
Fortison	Pediasure
Glytrol	Pediasure with Fiber

Hearty Balance	Portagen
Isocal	Pro-Peptide for Kids
Isocal HN	ProBalance
Isofiber	Promote
Isolan	Promote with Fiber
Isomil	Resource
Isosource	Resource Diabetic
Isosource HN	Resource for Kids
Jevity	Similac with Iron
Jevity Plus	Susta II
Kindercal	Sustacal
Lonalac	Sustacal Basic
Meritene	Sustacal Fiber
Naturite	Ultracal

Category I – HCPCS Code: B4151

Compleat-B	ProSobee
Complete Pediatric	

Category II – HCPCS Code: B4152

Comply	NuBasics Plus
Deliver 2.0	Nutren 1.5
Ensure Plus	Nutren 2.0
Ensure Plus HN	Nutri-Drink Plus

Entrition 1.5	NutriAssist 1.5
Deliver 2.0	Nutrition Plus
IsoSource 1.5	Nutrivent
Isotera Isotonic	Resource Plus
Lipisorb	Respalor
Magnacal Renal	Sustacal Plus
Naturite Plus	Twocal HN
Newtrition 1.5	Ultralan
NuBasics 2.0 Complete	

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Category III – HCPCS Code: B4153

Accupepha	Peptical
L-Emental	Reabilan
L-Emental Pediatric	Travasorb HN
Neocate Infant Formula	Vital HN
Neocate One + Powder	Vivonex Pediatric
Neocate One Powder	

Category IV – HCPCS Code: B4154

Accupep HPF	Nutrivent
Advera	Peptamen
Alitraq	Peptamen VHP
AminAid	Peptamin Junior
Choice DM	Perative
Citrotein	Pregestimil
Crucial	Pro-Peptide
Diabetisource	Pro-Peptide VHN
Entera OPD	Protain XL
Fulfil	Provide
Glucerna	Pulmocare
Gluco-Pro	Reabilan HN
Hepatic Aid	Renalcal
Impact	Replete
Impact 1.5	Replete with Fiber

Impact with Fiber	SLD
Immun-Aid	SandoSource Peptide
Isosource VHN	Stresstein
L-Emental Hepatic	Suplena (Replena)
L-Emental Plus	Traumacal
Lipisorb	Travasorb MCT
Nepro	Travasorb Renal
Novasource Renal	Vivonex Plus
NutriHep	Vivonex T.E.N.

Category V – HCPCS Code: B4155

Casec	ProSource
Elementra	Promix
Fibrad	ProMod
MCT Oil	Propac Plus
Microlipid	ProSource Protein Supplement
Moducal	Ross Carbohydrate Free
Polycose	Sumacal

Category VI – HCPCS Code: B4156

Tolerex	Vivonex STD Powder

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Patient Lifts

HCPCS CODES

E0621	Sling or seat patient lift, canvas or nylon
E0625	Patient lift, Kartop, bathroom or toilet
E0630	Patient lift, hydraulic, with seat or sling
E0635	Patient lift, electric, with seat or sling

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9

INDICATIONS

A lift is covered if transfer between bed and a chair, wheelchair, or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined.

COVERAGE AND PAYMENT RULES

1. Code E0625 is denied as a convenience item, consistent with CIM 60-9.
2. An electric lift mechanism, E0635, is not covered; it is a convenience feature. When code E0635 is billed and if coverage criteria for patient lift are met, payment is based on the least costly alternative, E0630.
3. Code E0621, Sling or Seat for patient lift is covered as an accessory when ordered as a replacement for the original equipment item. The usual payment rules for accessory items apply to this code.

CODING GUIDELINES

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time:

Column I	**Column II**
E0630	E0621
E0635	E0621

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file by the provider and made available to the Intermediary upon request.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Pneumatic Compression Devices (Used For Lymphedema)

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0650	Pneumatic compressor, non-segmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor, half arm
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance full arm

Subject: **PNEUMATIC COMPRESSION DEVICES (USED FOR LYMPHEDEMA)**

E0673	Segmental gradient pressure pneumatic appliance, half leg

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-16

DEFINITIONS

1. In this policy, the terms pneumatic compression device and lymphedema pump are considered to be the same.
2. A non-segmented pneumatic compressor (E0650) is a device that has a single outflow port on the compressor. The fact that the air from the single tube may be transmitted to a sleeve/appliance with multiple compartments or segments (E0671-E0673) does not affect the coding of the compressor.
3. A segmented pneumatic compressor (E0651, E0652) is a device that has multiple outflow ports on the compressor which lead to distinct segments on the appliance which inflate sequentially. A segmented device without calibrated gradient pressure (E0651) is one in which either (a) the same pressure is present in each segment ***or*** (b) there is a predetermined pressure gradient in successive segments but no ability to individually set or adjust pressures in each of several segments. In an E0651 device the pressure is usually set by a single control on the distal segment. A segmented device with ***calibrated*** gradient pressure (E0652) is characterized by a manual control on at least three outflow ports that can deliver an individually determined pressure to each segmental unit. The fact that the tubing and/or appliance are capable of achieving a pressure gradient does not classify the compressor as E0652 because this is not a ***calibrated*** gradient pressure.
4. Segmental gradient pressure pneumatic appliances (E0671-E0673) are appliances/sleeves which are used with a non-segmented pneumatic compressor (E0650) but which achieve a pressure gradient through the design of the tubing and/or air chambers.

COVERAGE AND PAYMENT RULES

1. A pneumatic compression device is covered only for the treatment of refractory lymphedema involving one or more limbs. This condition is a relatively uncommon medical problem. Causes of lymphedema include:
    a. radical surgical procedures with removal of regional groups of lymph nodes (e.g., after radical mastectomy)
    b. post-radiation fibrosis
    c. spread of malignant tumors to regional lymph nodes with lymphatic obstruction
    d. scarring of lymphatic channels

e. onset of puberty (Milroy's Disease) ***and***

f. congenital anomalies

2. Pneumatic compression devices are only covered as a treatment of last resort, i.e., other less intensive treatments must have been tried first and found inadequate. Such treatments would include leg or arm elevation and ***custom fabricated*** gradient pressure stockings or sleeves.

3. Pneumatic compression devices may be covered only when prescribed by a physician and when they are used with appropriate physician oversight, i.e., physician evaluation of the patient's condition to determine medical necessity of the device, suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.

4. For patients in whom the cause of the lymphedema is scarring of the lymphatic channels (i.e., those with generalized, refractory edema from venous insufficiency which is complicated by recurrent cellulitis), a pneumatic compression device with be covered only if ***all*** of the following criteria have been met:

   a. there is significant ulceration of the lower extremity(ies)

   b. the patient has received repeated, standard treatment from a physician using such methods as a compression bandage system or its equivalent

   c. the ulcer(s) have failed to heal after 6 months of ***continuous*** treatment.

5. When a pneumatic compression device is covered, a non-segmented device (E0650) or segmented device without manual control of the pressure in each chamber (E0651) is generally sufficient to meet the clinical needs of the patient.

6. A non-segmented compressor (E0650) with a segmented appliance/sleeve (E0671-E0673) is considered functionally equivalent to an E0651 compressor with a segmented appliance/sleeve (E0667-E0669).

7. When a segmented device with manual control of the pressure in each chamber (E0652) is ordered and provided, payment will be based on the allowance for the least costly medically appropriate alternative, E0651, unless there is clear documentation of medical necessity in the individual case.

8. Full payment for code E0652 will be made only when there is a painful focal lesion (e.g., significant sensitive skin scar or contracture of the extremity) which requires a reduction in pressure over the affected segment that can only be provided by an E0652 device. There must be documentation that an E0651 device or its equivalent had been tried and had caused significant symptoms that were improved with this use of an E0652 device.

CODING GUIDELINES

1. A non-segmented pneumatic compressor (E0650) is used with appliances/sleeves coded by E0655-E0666 or E0671-E0673. Segmented pneumatic compressors (E0651 or E0652) are used with appliances/sleeves coded by E0667-E0669.
2. When a foot or hand segment is used in conjunction with a leg or arm appliance respectively, there should be no separate bill for this segment. It is considered included in the code for the leg or arm appliance.

DOCUMENTATION REQUIRED

1. An order and/or Certificate of Medical necessity (CMN) for the compressor and the appliance that has been filled out, signed and dated by the treating physician must be kept on file by the provider and made available to the Intermediary upon request. The CMN for pneumatic compression devices/lymphedema pumps is HCFA form 846.
2. If the patient has venous stasis ulcers, documentation supporting the medical necessity for the device should include a signed and dated statement from the ordering physician indicating:
    a. the location and size of venous stasis ulcer(s)
    b. how long each ulcer has been continuously present
    c. whether the patient has been treated with regular compression bandaging for the past 6 months
    d. whether the patient has been treated with ***custom fabricated*** gradient pressure stockings/sleeves, approximately when, and the results
    e. other treatment for the venous stasis ulcer(s) during the past 6 months, and
    f. whether the patient has been seen regularly by a physician for treatment of venous stasis ulcer(s) during the past 6 months.
3. If E0652 is billed, additional documentation supporting the medical necessity for this device should include a signed and dated statement from the ordering physician indicating:
    a. whether the patient has been treated with ***custom fabricated*** gradient pressure stockings/sleeves, approximately when, and the results,
    b. the treatment plan including the pressure in each chamber, and the frequency and duration of each treatment episode,
    c. the location, size and etiology of the painful focal lesion which necessitates the use of this pump,
    d. whether a segmented compressor without calibrated gradient pressure (E0651) or a non-segmented compressor (E0650) with a

segmented appliance (E0671-E0673) had been tried and the results,

e. why the features of the system that was provided are needed for this patient,

f. the name, model number, and manufacturer of the device.

4. Questions pertaining to medical necessity on any form used to gather the above information may not be completed by the provider or anyone in a financial relationship with the provider. The information on the form must be supported by documentation in the patient's medical record and be available to the Intermediary upon request.

5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

PNEUMATIC COMPRESSION DEVICES/LYMPHEDEMA PUMPS PRODUCT CLASSIFICATION

Manufacturer/Brand Name	*Model Name/Number*	*HCPCS Code*
Advantage	2100	E0652
Bio Compressions Systems/Sequential Circulator	2000 2004	E0651
	3000 3001 3004	E0652
Camp	GCS 2000	E0652
Chattanooga	PresSsion PreSsion 4328 CGS	E0651
	PresSsion 4330 VGS	E0652
	4320 4322	E0650
Gaymar	Sof-Press	E0651
Huntleigh	Flowplus (AC330) Flowtron	E0650

	Flowpress (AC300) Lumphatron Lymphatron (AC340**	E0651
	Lymphatron Trio (AC350)	E0652
Jobst/Extremity Pump	Clinical Model System 7000	E0650
	System 7500 (II)	E0651
Kendall	Home Rx (5550)	E0651
MedComp	MC 3 Gradient Sequential	E0651
	MC 5 Gradient Sequential	E0652
Mego Afek/Lymph Press	103A 201A-Mini	E0651
	103M 201-M	E0652
Talley/Hemaflow 2 Pump	Intermittent	E0650
	Sequential	E0651
Talley/Multicom	100 200	E0650
	300	E0651
	300G 500* (1993 and 1994 model)	E0652
Talley/Multipulse	1000	E0652
Thera-Con	Thera-Flow	E0652

	651 series	E0651
Wright Linear Pump	Pro 52*** AutoPro 52*** Pro Lite 52	E0652
	Solo 50	E0650
	Solo 51	E0651

*Talley/Multicom model 1992 or before, E0651

**This model has been discontinued, effective December 1995

***Wright Linear Pump II is now Pro 52, and Wright Linear Pump IV is now AutoPro 52. These name changes are effective December 1996.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Power Operated Vehicles (POVs)

HCPCS CODES

E1230	Power Operated Vehicle (3- or 4-wheel non-highway), specify brand name and model number

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-5, 60-9

INDICATIONS

A power operated vehicle (POV) is covered when ***all*** of the following criteria are met:

1. The patient's condition is such that a wheelchair is required for the patient to get around in the home
2. The patient is unable to operate a manual wheelchair
3. The patient is capable of safely operating the controls for the POV
4. The patient can transfer safely in and out of the POV and has adequate trunk stability to be able to safely ride in the POV

COVERAGE AND PAYMENT RULES

1. Most POV's are ordered for patients who are capable of ambulation within the home but require a power vehicle for movement outside the home. POVs will be denied as not medically necessary in these circumstances
2. A POV that is beneficial primarily in allowing the patient to perform leisure or recreational activities will be denied as not medically necessary
3. If a POV is covered, a wheelchair provided at the same time will usually be denied as not medically necessary
4. A POV is usually covered only if it is ordered by a physician who is one of the following specialties: Physical Medicine, Orthopedic Surgery, Neurology, or Rheumatology. When such a specialist is not reasonably accessible, e.g., more than one day's round trip from the

beneficiary's home, or the patient's condition precludes such travel, a prescription from the beneficiary's physician may be acceptable

CODING GUIDELINES

Code E1230 should be used only for POV's that can be operated inside the home. Vehicles that because of their size and/or other features are generally intended for use outdoors are not eligible for coverage.

DOCUMENTATION REQUIRED

1. A certificate of medical necessity (CMN) and/or an order must be filled out, signed and dated by the ordering physician and kept on file by the provider. The CMN for POV's is DMERC 07.
2. An order for power operated vehicles signed and dated by the physician must be received by the provider prior to delivery of the item. A CMN for the item that has been reviewed, signed and dated by the ordering physician may be substituted for the order if returned to the provider prior to the delivery. Otherwise, the prior completed order and/or the completed CMN must be kept on file by the provider.
3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Pressure Reducing Support Surfaces-Group 1

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

A4640	Replacement pad for use with medically necessary alternating pressure pad owned by patient
A9270	Non-covered item or service
E0180	Pressure pad, alternating with pump
E0181	Pressure pad, alternating with pump, heavy duty
E0182	Pump for alternating pressure pad
E0184	Dry pressure mattress
E0185	Gel or gel-like pressure pad for mattress, standard mattress length and width
E0186	Air pressure mattress
E0187	Water pressure mattress
E0196	Gel pressure mattress
E0197	Air pressure pad for mattress, standard mattress length and width
E0198	Water pressure pad for mattress, standard mattress length and width
E0199	Dry pressure pad for mattress, standard mattress length and width
E1399	Durable medical equipment, miscellaneous

HCPCS MODIFIER

ZX	Specific requirements found in the Documentation section of the medical policy have been met and evidence of this is available in the patient's medical records.

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9

DEFINITIONS

1. Codes E0185 and E0197-E0199 termed "pressure pad for mattress" describe non-powered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.
2. A gel/gel-like mattress overlay (E0185) is characterized by a gel or gel-like layer with a height of 2" or greater.
3. An air mattress overlay (E0197) is characterized by interconnected air cells having a cell height of 3" or greater that are inflated with an air pump.
4. A water mattress overlay (E0198) is characterized by a filled height of 3" or greater.
5. A foam mattress overlay (E0199) is characterized by ***all*** of the following:
    a. base thickness of 2" or greater and peak height of 3" or greater if it is a convoluted overlay (e.g., eggcrate) or an overall height of at least 3" if it is a non-convoluted overlay
    b. foam with a density and other qualities that provide adequate pressure reduction
    c. durable, waterproof cover
6. Codes E0184, E0186, E0187 and E0196 describe non-powered pressure reducing mattresses.
7. A foam mattress (E0184) is characterized by ***all*** of the following:
    a. foam height of 5" or greater
    b. foam with a density and other qualities that provide adequate pressure reduction
    c. durable, waterproof cover

d. can be placed directly on a hospital bed frame

8. An air, water or gel mattress (E0186, E0197, E0196) is characterized by ***all*** of the following:

   a. height of 5" or greater of the air, water, or gel layer (respectively)

   b. durable, waterproof cover

   c. can be placed directly on a hospital bed frame

9. Codes E0180, E0181, E0182 and A4640 describe powered pressure reducing mattress overlay systems (alternating pressure or low air loss). They are characterized by ***all*** of the following:

   a. an air pump or blower which provides either sequential inflation and deflation of air cells or a low interface pressure throughout the overlay

   b. inflated cell height of the air cells through which air is being circulated is 2.5 " or greater

   c. height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out

10. The staging of pressure ulcers used in this policy is as follows:

Stage I	non-blanchable erythema of intact skin
Stage II	partial thickness skin loss involving epidermis and/or dermis
Stage III	full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
Stage IV	full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures

11. Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the patient’s bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than 30 degrees), and in the sidelying position.

COVERAGE AND PAYMENT RULES

1. A Group 1 mattress overlay or mattress (E0180-E0187, E0196-E0199, A4640) is covered if the patient meets the following:
    - Criterion a., ***or***
    - Criteria b. or c. ***and*** at least one of criteria d.-g.:
        a. completely immobile-i.e., patient cannot make changes in body position without assistance
        b. limited mobility-i.e., patient cannot independently make changes in body position significant enough to alleviate pressure
        c. any stage pressure ulcer on the trunk or pelvis
        d. impaired nutritional status
        e. fecal or urinary incontinence
        f. altered sensory perception
        g. compromised circulatory status
2. When the coverage criteria for a group 1 overlay or mattress are not met, a claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case. A Group I Support Surface billed without a ZX modifier (see ***DOCUMENTATION REQUIRED***) will usually be denied as not medically necessary.
3. A foam overlay or mattress that does not have a waterproof cover is not considered durable and will be denied as non-covered.
4. The support surface provided for the patient should be one in which the patient does not “bottom out” (see ***DEFINITIONS***, #11)
5. A support surface which does not meet the characteristics specified in the ***DEFINITIONS*** section of the support surface policies will usually be denied as not medically necessary (see ***CODING GUIDELINES*** and ***DOCUMENTATION REQUIRED*** sections concerning billing E1399).
6. A Product Classification list has been provided with this policy.

RELATED CLINICAL INFORMATION

Patients needing pressure reducing support surfaces should have a care plan which has been established by the patient’s physician, which is documented in the patient’s medical records, and which generally should include the following:

1. Education of the patient and caregiver on the prevention and/or management of pressure ulcers
2. Regular assessment by a nurse, physician, or other licensed healthcare practitioner
3. Appropriate turning and positioning
4. Appropriate wound care (for a stage II, III, or IV ulcer)
5. Appropriate management of moisture/incontinence
6. Nutritional assessment and intervention consistent with the overall plan of care

CODING GUIDELINES

1. A foam overlay or mattress that does not have a waterproof cover should be coded using A9270. Other Group 1 support surfaces that do not meet the characteristics specified in the ***DEFINITION*** section should be coded using code E1399.
2. Alternating pressure mattress overlays or low air loss mattress overlays are coded using codes E0180, E0181, E0182 and A4640
3. Code A4640 or E0182 should only be billed when they are provided as replacement components for a patient-owned powered pressure-reducing mattress overlay system (E0180 or E0181).
4. A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I	**Column II**
E0180	A4640
	E0182
E0181	A4640
	E0182

5. Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0180 or E0181), ***not*** as a powered mattress (E0277).

DOCUMENTATION REQUIRED

1. An order for the overlay or mattress that is signed and dated by the ordering physician must be kept on file by the provider. The written order must be obtained prior to the delivery of the item.
2. The provider must obtain information concerning which, if any, of criteria 1.a.-1.g. in ***COVERAGE AND PAYMENT RULES*** the patient meets in a signed and dated statement from the ordering physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to collect this information may not be completed by the provider or anyone in a financial relationship with the provider. This statement must be supported by information in the patient's medical record that would be available to the Intermediary on request.
3. If the coverage and payment rules are met, the ZX modifier should be added to the code. The ZX modifier should only be used when the requirements are met.
4. If a support surface is billed using code E1399, the claim must include the following information:
   a. manufacturer and brand name of product
   b. what support surface group (1, 2, or 3) the provider considers it to be
   c. why it doesn't fall into an existing code
   d. why it is necessary for that patient
   e. the ZX modifier should also be added if the requirements for use are met.
5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

Statement of Ordering Physician

Group 1 Support Surfaces

Patient name:_____

HIC #_____

Cost information (to be completed by the provider):

Provider's charge_____

Medicare fee schedule allowance_____

The information below may not be completed by the provider:

Indicate which of the following conditions describe the patient (circle all that apply):

1) **Completely immobile – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure**

2) **Limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure**

3) **Any pressure ulcer on the trunk or pelvis**

4) **Impaired nutritional status**

5) **Fecal or urinary incontinence**

6) **Altered sensory perception**

7) **Compromised circulatory status**

Estimated length of need (# of months):_____**(99=lifetime)**

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Physician name (printed or typed):_____

Physician signature:_____

Physician UPIN:_____

Date signed:_____

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PRODUCT NAME	MFG NAME	HCPCS CODE
ACS Comfort Gel Plus	ACS	E0185
ACS Gel Foam Overlay	ACS	E1399
Action Full Mattress Pad No. 6301-03	Action Medical	E0185
Action Professional No. 6100/6200	Action Medical	E1399
Action Professional No. 6300	Action Medical	E0185
Action Shear Reduction Pad No. 6304	Action Medical	E1399
Advantage Gel Foam Overlay 1000	Brewer Medical	E1399
Advantage Gel Foam Overlay 2000	Brewer Medical	E1399
Advantage Gel Foam Overlay 3000	Brewer Medical	E1399
Aero-Pulse Deluxe	Dermal Mgmt. Sys.	E0180
Air-O-Ease	Mason Medical	E0197
Air Soft Antidecubitus Mattress	Turnsoft	E0184
Anatomical Mattress Overlay with Heel-Ease	Anatomic Concepts	E0199
BASE Bellows Flotation/Double	Talley	E0186
BASE Bellows Flotation/Single	Talley	E0197

Biocomfort Gel Foam Overlay	BioCompression Systems	E0199
Biocomfort Gel Pad	BioCompression Systems	E0185
BioCompression Low Air Loss Pressure Pad Overlay	BioCompression Systems	E0180
BioCompression Standard Double Pad Mattress with Airloss	BioCompression Systems	E0180
BioCompression Standard Double Pad Mattress without Airloss	BioCompression Systems	E0180
BioCompression Standard Pressure Pad Overlay	BioCompression Systems	E0180
Biotherapy Advanced Pressure Relief System	Bioclinic	E0180
Bye-Bye Decubiti Pneumatic Mattress Unit	Ken McRight Supplies	E0197
Carital Air Floatation System	ECP Distributors	E0186
Comfort ET Specialty Mattress	Anatomic Concepts	E0184
Comfort Infection Control Mattress	Anatomic Concepts	E0184
Comfort Pressure Relief Mattress	Anatomic Concepts	E0184
Comfort Spectrum 317	Lumex	E0184
Comfort Zone One	Sports Med	E0199
Conforma I or II Mattress Overlay	Anatomic Concepts	E0199

Conforma I or II Replacement Mattress	Anatomic Concepts	E0184
Critical Care with Heel-Ease Mattress	Anatomic Concepts	E0184
De Cube Therapeutic Mattress	Comfortex	E0184
Decubi Care	Gate City Bed	E0184
Duro - Matic APP & Pump	Duro-Med Industries	E0180
Dyna Soft System	Grant	E0180
Flexcell	Zephyr Therapeutics	E0186
Flo Care Pressure Relief Mattress	Flo Care	E0187
Foamatt	ProBed Medical	E0184
Freedom Bed	ProBed Medical	A9270
Gel-Lite Mattress Overlay	KAP Industries	E1399
Gel-U-Sleep 3 (three) inch	Mason Medical	E0185
Gel-U-Sleep 5 (five) inch	Mason Medical	E0184
Gel Flotation Mattress	Family Medical	E0184
Gel Foam Overlay	BioCompression Systems	E0199
Gel Medex	Chattanooga Group	E0199
Gel T Mattress Overlay	Spann-America	E0199
GelRestx 3 inch Overlay	Compression Systems, Inc.	E0199
GelRestxII Gel Mattress Overlay	Compression Systems, Inc.	E0199

Geo Matt	Spann-America	E0199
Geo Mattress HC	Spann-America	E0184
Heelcare Cushion	Gaymar	E1399
Hydro-Ease I	Mason Medical	E0198
Hydro-Ease II	Mason Medical	E0185
ISIS Mattress	Atlantis Medical	E1399
Isotonic Pressure Reduction Mattress	Bergad Mattress	E0184
Laser I Powered Overlay	Mason Medical	E0180
Lotus Air 3780 Mattress Overlay	Lotus	E0197
Lotus Air 3787 Mattress Overlay	Lotus	E0197
Lotus DU 4072 Mattress Overlay	Lotus	E0197
Lotus GL 3666 Mattress Overlay	Lotus	E0185
Lotus GLPX 3666 Mattress Overlay	Lotus	E0185
Lotus HM 3666 Mattress Overlay	Lotus	E0198
Lotus HMX Mattress Overlay	Lotus	E0198
Lotus MD 3677 Mattress Overlay	Lotus	E0198
Lotus MDGL 3677 Mattress Overlay	Lotus	E0185
Lotus PXM 3666 Mattress Overlay	Lotus	E0198

Luxury Adjustable Bed	Golden Technologies	A9270
Overgel	ProBed Medical	E0199
Pillo-Pump APS	Gaymar	E0181
Plexus P100 Pressure Pad with Pump	Plexus Medical	E0180
Pneu-Air	Cardio Systems	E0181
Pressure Cradle Mattress	PreMed Inc.	E0186
Pressure Guard Custom Care	Spann-America	E0186
Pressure Guard I	Spann-America	E0184
Pressure Guard II	Spann-America	E0186
Pressure Guard Select	Spann-America	E0186
Pro-Turn	Cardio Systems	E0181
Pro 2000 MRS	Cardio Systems	E0181
Pulsair Large Cell 100	Talley	E0180
Pulsair LX Pump	Talley	E0182
Pulsair Mattress Pad (Replacement)	Talley	A4640
Pulsair Ripple Bed	Talley	E0180
Royal Medical Mattress Pad	Royal Medical	E0199
Self Adjusting Mattress (SAM)	Atlantis Medical	E0186
Series II and III AP Pump and Pad	Mason Medical	E0180

Sierra 3"	Mason Medical	E0185
Sierra 5"	Mason Medical	E0184
Sof-Care Plus Companion System	Gaymar	E0197
Sof Form Trizone Mattress Overlay	Talley	E0197
Sofflex Mattress **(Re-Review)**	Crown Therapeutics	E0197
Span + Guard Pressure Reducing Mattress Overlay	Spann-America	E0199
Spenco Bed Pad	Spenco	E0199
Tempur-Med Mattress	Tempur-Pedic	E0184
Tempur-Med Overlay	Tempur-Pedic	E0199
Top Guard II	Gaymar	E0184
Top Guard II Plus	Gaymar	E0184
Turnsoft System	Turnsoft Inc.	E1399
Ulti-Mat II	Hudson Medical	E0199
Ultra Float	Ultra Float, Inc.	E0187
Ultra Gel Mat	Hudson Industries	E0185
Ultra Med Alpha X Cell	Huntleigh Healthcare	E0180
Unitek Tri-Laminate	Mason Medical	E0184
Vari-Zone II	Mason Medical	E0199
Waffle Expansion Control Mattress	EHOB	E0197
Z-Gel Mattress Overlay	Zephyr	E0199

Zaam Mattress	Atlantis Medical	E0186

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Pressure Reducing Support Surfaces-Group 2

HCPCS CODES

E0193	Powered air flotation bed (low air loss therapy)
E0277	Alternating pressure mattress
E0371	Non-powered, advanced pressure-reducing overlay for mattress, standard mattress length and width
E0372	Powered air overlay for mattress
E0373	Non-powered, advanced pressure-reducing mattress
E1399	Durable medical equipment, miscellaneous

HCPCS MODIFIER

ZX	Specific requirements found in the ***Documentation Required*** section of this policy have been met and documentation of this is in the patient's medical records.

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9

DEFINITIONS

1. Code E0277 describes a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by ***all*** of the following:

    a. an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress

   b. inflated cell height of the air cells through which air is being circulated is 5" or greater

   c. height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out

   d. a surface designed to reduce friction and shear

   e. can be placed directly on a hospital bed frame

2. Code E0193 describes a semi-electric or total electric hospital bed with a fully integrated powered pressure-reducing mattress that has all the characteristics defined above.

3. Code E0371 describes an advanced non-powered pressure reducing mattress overlay which is characterized by ***all*** of the following:

   a. height and design of individual cells which provide significantly more pressure reduction than a Group 1 overlay and prevent bottoming out

   b. total height of 3" or greater

   c. a surface designed to reduce friction and shear

   d. documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

4. Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) which is characterized by ***all*** of the following:

   a. an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the overlay

   b. inflated cell height of the air cells through which air is being circulated is 3.5" or greater

   c. height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure to provide adequate patient lift, reduce pressure and prevent bottoming out

   d. a surface designed to reduce friction and shear

5. Code E0373 describes an advanced non-powered pressure reducing mattress which is characterized by ***all*** of the following:

   a. height and design of individual cells which provide significantly more pressure reduction than a Group 1 mattress and prevent bottoming out

   b. total height of 5" or greater

c. a surface designed to reduce friction and shear

d. documented evidence to substantiate that the product is effective for the treatment of conditions described by the coverage criteria for Group 2 support surfaces

e. can be placed directly on a hospital bed frame

f. the staging of pressure ulcers used in this policy is as follows:

Stage I	Non-blanchable erythema of intact skin
Stage II	Partial thickness skin loss involving epidermis and/or dermis
Stage III	Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia
Stage IV	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone or supporting structures

Note: Bottoming out is the finding that an outstretched hand can readily palpate a bony prominence (coccyx or lateral trochanter) when it is placed palm up beneath the undersurface of the mattress or overlay and in an area under the bony prominence. This bottoming out criterion should be tested with the patient in the supine position with their head flat, in the supine position with their head slightly elevated (no more than thirty degrees), and in the sidelying position.

COVERAGE AND PAYMENT RULES

1. A Group 2 Support Surface is covered if the patient meets:

- Criterion a and b and c, ***or***
- Criterion d, ***or***
- Criterion e and f

a. multiple stage II pressure ulcers located on the trunk or pelvis

b. patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate Group 1 Support Surface

c. the ulcers have worsened or remained the same over the past month

d. large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis

e. recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past sixty days)

f. the patient has been on a Group 2 or 3 Support Surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past thirty days)

2. The comprehensive ulcer treatment described in “a.” above should generally include:

   a. education of the patient and caregiver on the prevention and/or management of pressure ulcers

   b. regular assessment by a nurse, physician, or other licensed healthcare practitioner (usually at least weekly for a patient with an ulcer)

   c. appropriate turning and positioning

   d. appropriate wound care (for a stage II, III, or IV ulcer)

   e. appropriate management of moisture/incontinence

   f. nutritional assessment and intervention consistent with the overall plan of care

3. If the patient is on a Group 2 Support Surface, there should be a care plan established by the physician that includes the above elements. The support surface provided for the patient should be one in which the patient does not “bottom out” (see ***Note:*** in ***DEFINITIONS*** section).

4. When a Group 2 Support Surface is covered following a myocutaneous flap or skin graft, coverage generally is limited to sixty days from the date of surgery.

5. When the stated coverage criteria for a group 2 mattress or bed are not met, a claim will be denied as not being medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case. A Group 2 Support Surface billed without ZX modifier (see ***DOCUMENTATION REQUIRED***) will usually be denied as not medically necessary.

6. A support surface which does not meet the characteristics specified in the ***DEFINITIONS*** section will usually be denied as not medically necessary (see ***CODING GUIDELINES*** and ***DOCUMENTATION REQUIRED*** concerning billing of E1399).

7. Continued use of a Group 2 Support Surface is covered until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that:

a. other aspects of the care plan are being modified to promote healing, ***or***

b. the use of the Group 2 Support Surface is medically necessary for wound management

8. Appropriate use of the ZX modifier (see ***DOCUMENTAION REQUIRED***) is the responsibility of the provider billing the Intermediary. The provider should maintain adequate communication on an ongoing basis with the clinician providing the wound care in order to accurately determine that use of the ZX modifier still reflects the clinical conditions which meet the criteria for coverage of a Group 2 Support Surface, and that adequate documentation exists in the medical record reflecting these conditions. Such documentation should not be submitted with a claim but should be available for review if requested by the Intermediary.

9. In cases where a Group 2 product is inappropriate, a Group 1 or 3 Support Surface could be covered if coverage criteria for that group are met.

CODING GUIDELINES

1. The ***only*** products that may be coded and billed using code E0371 or E0373 are those products for which a written coding determination specifying the use of these codes has been made by the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC).

2. Group 2 Support Surfaces which do not meet the characteristics specified in the ***DEFINITIONS*** section should be coded using code E1399.

3. Either alternating pressure mattresses or low air loss mattresses are coded using code E0277.

4. Products containing multiple components are categorized according to the clinically predominant component (usually the topmost layer of a multi-layer product). For example, a product with 3" powered air cells on top of a 3" foam base would be coded as a powered overlay (code E0180 or E0181) ***not*** as a powered mattress (E0277).

5. A Product Classification list is provided with this policy.

DOCUMENTATION REQUIRED

1. An order for the mattress or bed that is signed and dated by the ordering physician must be kept on file by the provider. The written order must be obtained prior to the delivery of the item.
2. The provider must obtain information concerning which, if any, of criteria a-f listed in the ***COVERAGE AND PAYMENT RULES*** section of this policy the patient meets. This information should be documented in a signed and dated statement from the physician. A suggested form for collecting this information is attached. Questions pertaining to medical necessity on any form used to obtain this information may not be completed by the provider or anyone in a financial relationship with the provider. This statement must be supported by information in the patient's medical record that would be available to the Intermediary upon request.
3. When the initial claim for a Group 2 Support Surface is received, if it meets the criteria specified in situation (a), (b) or (c) in the Coverage and Payment Rules section, the ZX modifier should be added to the code on the initial claim. On subsequent claims for situations (a) and (b), the ZX modifier should be added to the code until the ulcer is healed. Once the ulcer has healed, the ZX modifier should not be used. On subsequent claims for situation (c), the ZX modifier may only be added to claims with dates of service within 60 days of the surgery.
4. The ZX modifier ***may only be used when these requirements are met.*** If the requirements for the modifier are not met, the provider can document in the patient's medical records additional information to justify coverage but the ZX modifier should not be used.
5. If a support surface is billed using code E1399, the claim must include ***all*** of the following information:
    a. manufacturer and brand name of product
    b. what support surface group (1, 2, 3) the supplier considers it to be
    c. why it doesn't fall into an existing code
    d. why it is necessary for that patient
6. If the provider considers the Support Surface to be a Group 2 Surface, the ZX modifier should also be added if the requirements for its use are met.
7. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

Statement of Ordering Physician
Group 2 Support Surfaces

Patient Name:_____

HIC #:_____

Cost information (to be completed by the provider):

Provider's charge_____

Medicare fee schedule allowance_____

The information below may not be completed by the provider or anyone in a financial relationship with the provider:

Circle **Y** for Yes, **N** for No, **D** for Does Not Apply, unless otherwise noted.

Y	**N**	**D**	Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?
Y	**N**	**D**	Has the patient been on a comprehensive ulcer treatment program for at least the past month that has included the use of an alternating pressure or low air loss overlay which is less than 3.5", or a non-powered pressure reducing overlay or mattress?
1	**2**	**3**	Over the past month, the patient's ulcer(s) has/have: 1-improved 2-remained the same, or 3-worsened?
Y	**N**	**D**	Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?
Y	**N**	**D**	Has the patient had a recent (within the past sixty days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery:_____
Y	**N**	**D**	Was the patient on an alternating pressure or low air loss mattress or bed or an air-fluidized bed immediately prior to a recent (within the past thirty days) discharge from a hospital or nursing facility?

Estimated length of need (#of months):_____(99=lifetime)

Physician's name (printed or typed):_____

Physician's signature:_____

Physician's UPIN:_____

Date signed:_____

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PRODUCT NAME	MANUFACTURER	HCPCS
Aero-One Plus AP Therapy System	Thera-Con Medical	E0277
Aeromat MRS 2500 LAL Therapy	Integrated Therapy	E0277
Air-Medex I	Chattanooga Group	E0277
Air Express	Plexus Medical	E0372
Airflo Plus	Gaymar	E1399
AIRies Mattress System	Lumex	E0277
Akrotech 4000	Lumex	E0277
Akrotech 4000T	Lumex	E0277
Alta Dyne APM	Lumex	E0277
Altair	Lumex	E0277
APM	Invacare	E0277
APM 400 Mattress	SportsMed	E0277
APM 450 Overlay	SportsMed	E0372
Aprema II	Mellen Air Mfg.	E0277
BariatRIK Bed: Equi-Tron Bed Frame	RIK Medical	E1399
BariatRIK Bed: RIK Mattress	RIK Medical	E0373
BariatRIK Bed: Side Rail Pads, Border Pads, Positioning Aids	RIK Medical	A9270
BASE Bellows Sequential Mattress	Talley	E0277

BASE Deep Cell 1000	Talley	E0277
BASE Large Cell 500 and 600	Talley	E0277
Bazooka System	Innovative Med Systems	E0277
Bio MedX	BioClinic	E0277
Bio Therapy APM	BioClinic	E0277
BioCompression Deluxe Standard Mattress with Low Airloss	BioCompression Systems	E0277
BioCompression Deluxe Standard Mattress without Low Airloss	BioCompression Systems	E0277
BioCompression Standard Mattress with Airloss	BioCompression Systems	E0277
BioCompression Standard Mattress without Airloss	BioCompression Systems	E0277
Biologics 800 Air-Lift Bed	MW Wound Care Mgrs.	E1399
BioTherapy Plus	BioClinic	E0372
Clini-Care	Gaymar	E0372
Clini-Dyne Lateral Rotation Therapy Mattress	Gaymar	E0277
Comfort Care Low Airloss Bed	Cardio Systems	E0193
DMS 2500 Dynamic Mattress System	Stryker Patient Care	E1399
Dyna Guard APM	Spann-America	E0277
Falcon FX 8000 Powerloft System	Mason Medical	E0277
Huntleigh DFS System	Huntleigh	E0277

Lotus LA4072 Mattress Overlay	Lotus Healthcare	E0372
LM 500 Mattress	SportsMed	E0277
LM 550 Overlay	SportsMed	E0372
LumexAir	Lumex	E0277
Mark I Overlay	Volkner	E0372
Mark II Mattress	Volkner	E0277
Masonair LS3000	Masonair	E0277
Masonair LS6000	Masonair	E0277
Masonair LS7000	Masonair	E0277
MC-5000	Master Care	E0277
MC-8000	Master Care	E0277
Med Air 300	Medifloat	E0277
Med Air 500	Medifloat	E0277
Med Air 500-T	Medifloat	E0277
Med Air 700	Medifloat	E0277
MicroAir 3500S	Invacare	E0277
MicroAir PUP	Invacare	E0372
MicroAir Turn Q Plus	Invacare	E0277
Orthoderm Convertible I HC	BioClinic	E0277
Orthoderm Convertible II	BioClinic	E0277
Oscillair 1000	Talley	E0277
PAL Lowered Air Loss System	Gaymar	E0372

Pegasus Airwave	Pegasus	E0277
Phoenix PX 115 Powerloft Alternating Air Floatation Mattress System	Mason Medical	E1399
Phoenix PX 115 Powerloft Series II Alternating Mattress System	Mason Medical	E0277
Plexus Air Express	Plexus Medical	E0372
Plexus P 2000	Plexus Medical	E0277
Plexus P200 Overlay	Plexus Medical	E0372
Pneu Care Dynamics	Cardio Systems	E0277
Pneu Care Plus	Cardio Systems	E0277
Pneu Care Plus Pulse	Cardio Systems	E0277
Pressure Guard IV	Spann-America	E0277
Pressure Guard Turn Select	Spann-America	E0277
Pro Aire Portable Rotation System	BioClinic	E0277
Rem-Air Powered Low Air Loss Mattress System	Mellen Air Mfg.	E0277
Restx System 1000	Compression Systems	E0277
Restx System 2000	Compression Systems	E0277
Restx System 3000	Compression Systems	E0277
RIK Fluid Mattress	RIK	E0373
RIK Fluid Overlay	RIK	E0371
ROHO Dry Flotation Overlay	ROHO	E0371
Silkair Low Airloss	Hill-Rom, Inc.	E0277

Sof-Matt	Gaymar	E0277
Sof Mat DSM	Gaymar	E0277
Sof Mat KSM	Gaymar	E0277
Sof Mat QSM	Gaymar	E0277
SPR Plus	Gaymar	E0372
SPR Plus II	Gaymar	E0372
StarMatt	Star Cushion Products	E0371
Synergy Dynamic	Cardio Systems	E0277
Synergy Pulse	Cardio Systems	E0277
Thera-Air Low Airloss Therapy System	Thera-Con	E0277
TheraKair Mattress	KCI	E0277
Turn Q LTM	Invacare	E0277
Volkner Turning System/Lamellar	James Consolidated	E1399

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Pressure Reducing Support Surfaces-Group 3

HCPCS CODES

E0194	Air-fluidized bed

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-19

DEFINITIONS

1. An air-fluidized bed is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid.
2. The staging of pressure ulcers used in this policy is as follows:

Stage I	Non-blanchable erythema of intact skin
Stage II	Partial thickness skin loss involving epidermis and/or dermis
Stage III	Full thickness skin loss involving damage or necrosis of subcutaneous tissues that may extend down to, but not through, underlying fascia
Stage IV	Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures

COVERAGE AND PAYMENT RULES

An air-fluidized bed is covered only if ***all*** of the following criteria are met:

1. The patient has a Stage III (full thickness tissue loss) or Stage IV (deep tissue destruction) pressure sore

2. The patient is bedridden or chair bound as a result of severely limited mobility
3. In the absence of an air-fluidized bed, the patient would require institutionalization
4. The air-fluidized bed is ordered in writing by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after conservative treatment has been tried without success
    - Treatment should generally include:
        a. education of the patient and caregiver on the prevention and/or management of pressure ulcers
        b. assessment by a physician, nurse, or other licensed healthcare practitioner at least weekly
        c. appropriate turning and positioning
        d. use of a Group 2 Support Surface, if appropriate
        e. appropriate wound care
        f. appropriate management of moisture/incontinence
        g. nutritional assessment and intervention consistent with the overall plan of care
            - The patient must generally have been on the conservative treatment program for at least one month prior to use of the air-fluidized bed with worsening or no improvement of the ulcer. The evaluation generally must be performed within a week prior to initiation of therapy with the air-fluidized bed.
5. A trained adult caregiver is available to assist the patient with activities of daily living, fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air-fluidized bed system and its problems such as leakage.
6. A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis or with each plan of care recertification (62 days) for Home Health.
7. All other alternative equipment has been considered and ruled out.
8. An air-fluidized bed will be denied as not medically necessary under any of the following circumstances:
    a. The patient has coexisting pulmonary disease (the lack of firm back support makes coughing ineffective and dry air inhalation thickens pulmonary secretions)

b. The patient requires treatment with wet soaks or moist wound dressings that are not protected with an impervious covering such as plastic wrap or other occlusive material

c. The caregiver is unwilling or unable to provide the type of care required by the patient on an air-fluidized bed

d. Structural support is inadequate to support the weight of the air-fluidized bed system (it generally weighs 1600 pounds or more)

e. Electrical system is insufficient for the anticipated increase in energy consumption

f. Other known contraindications exist

9. Payment is not included for the caregiver or for architectural adjustments such as electrical or structural improvement.

10. The medical necessity of an air-fluidized bed must be recertified every month or every 62 days for Home Health. Continued use of an air-fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that:

a. other aspects of the care plan are being modified to promote healing, ***or***

b. the use of the bed is medically necessary for wound management

11. If the stated coverage criteria for an air-fluidized bed are not met, the claim will be denied as not medically necessary unless there is clear documentation which justifies the medical necessity for the item in the individual case.

CODING GUIDELINES

N/A

DOCUMENTATION REQUIRED

1. An order for the bed which has been signed and dated by the attending physician who is caring for the patient’s wounds must be documented in the patient’s medical records and be available to the Intermediary upon request. The written order must be obtained prior to the delivery of the air-fluidized bed.

2. A certificate of medical necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file in the patient’s medical records and made available to the Intermediary upon request. The CMN for air-fluidized beds is DMERC 01. If the answer to Question 15 of the CMN is “yes”, the physician must provide additional information about the prior conservative treatment which should include information about the duration of treatment, wound care (including products used and frequency of change), pressure reducing surfaces used within the last

month and/or considered and ruled out (including an explanation of why it was anticipated they would not be effective), and nutritional support. The documentation of the comprehensive assessment should include information on the location of the ulcers, nutritional status, moisture control and other pressure ulcer risk factors as well as the date of the assessment and identification of the person performing the assessment. If the ulcer is less than 8-sq. cm surface area and/or it is on an area other than the posterior trunk or pelvis, there would need to be detailed documentation of why alternative treatment/equipment would not be effective.

3. The medical necessity for the bed must be recertified on a monthly basis or every 62 days for Home Health. The documentation must include a revised CMN or an order to continue use of the bed. If the answer to Question 22 (CMN) indicates worsening or no improvement, documentation must describe any changes in the treatment regimen which have been made or are planned.

4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Recumbent Ankle Positioning Splints

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

L4392	Replace soft interface material, ankle contracture splint
L4394	Replace soft interface material, foot drop splint contracture
L4396	Ankle contracture splint
L4398	Foot drop splint, recumbent positioning device

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 14-3, Medicare Carrier Manual, 2130

DEFINITIONS

1. An ankle contracture splint (L4396) is a prefabricated splint which has all of the following characteristics:
   a. ability to adjust the lower leg-foot angle between 0 degrees and 45 degrees plantar flexion
   b. designed primarily for use in a recumbent patient
   c. structural design which reduces pressure on the heel, and
   d. soft interface
2. A foot drop splint (L4398) is a prefabricated splint which has all of the following characteristics:
   a. ability to maintain the foot perpendicular to the lower leg
   b. designed primarily for use in a recumbent patient
   c. structural design which significantly reduces pressure on the heel, and

d. soft interface

3. Foot drop is a condition in which there is weakness and/or lack of use of the muscles that dorsiflex the ankle but there is the ability to bring the ankle to 0 degrees by passive range of motion. Ankle flexion contracture is a condition in which there is shortening of the muscles and/or tendons that plantarflex the ankle with the resulting inability to bring the ankle to 0 degrees by passive range of motion (0 degrees ankle position is when the foot is perpendicular to the lower leg).

INDICATIONS

An ankle contracture splint (L4396) is covered if ***all*** of the following criteria are met:

1. plantar flexion contracture of the ankle (ICD-9 CM diagnosis code 718.47) with maximal dorsiflexion on passive range of motion testing of at least 10 degrees
2. reasonable expectation of the ability to correct the contracture
3. contracture is interfering or expected to interfere significantly with the patient’s functional abilities, and
4. used as a component of a therapy program which includes active stretching of the involved muscles and/or tendons

COVERAGE AND PAYMENT RULES

1. If an ankle contracture splint (L4396) is used for the treatment of a plantar flexion contracture, the pretreatment passive range of motion must be measured with a goniometer and documented in the medical record. There must be documentation of an appropriate stretching program carried out by professional staff (in a nursing facility) or caregiver (at home). An ankle contracture splint is not medically necessary if the contracture is fixed.
2. An ankle contracture splint is not medically necessary for a patient with a foot drop but without an ankle flexion contracture.
3. A foot drop splint (L4398) is not medically necessary for the prevention of an ankle flexion contracture in a patient with foot drop. A foot drop splint is non-covered when it is used for prevention or treatment of a heel pressure sore because for these indications it is not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.
4. These splints must be ordered by the patient’s attending physician or a consulting physician for the condition resulting in the need for the splint.
5. If code L4396 is covered, a replacement liner (L4392) is covered as long as the patient continues to meet indications and other coverage

rules for the splint. Coverage of additional replacement liners is limited to a maximum of one (1) per 6 months.

CODING GUIDELINES

The right (RT) and left (LT) modifiers must be used.

DOCUMENTATION REQUIRED

1. An order for the splint that is signed and dated by the ordering physician must be kept on file by the provider and made available to the Intermediary upon request. The medical records must contain information that supports the medical necessity of the item ordered.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Refractive Lenses

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

Frames

V2020	Frames, purchases
V2025	Deluxe frame

Spectacle Lenses

V2100	Sphere, single vision, plano to plus or minus 4.00d, per lens
V2101	Sphere, single vision, plus or minus 4.12 to plus or minus 7.00d, per lens
V2102	Sphere, single vision, plus or minus 7.12 to plus or minus 20.00d, per lens
V2103	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 0.12 to 2.00d cylinder, per lens
V2104	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2105	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2106	Spherocylinder, single vision, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2107	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00 sphere, 0.12 to 2.00d cylinder, per lens

V2108	Spherocylinder, single vision, plus or minus 4.25d to plus or minus 7.00d sphere, 2.12 to 4.00D cylinder, per lens
V2109	Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2110	Spherocylinder, single vision, plus or minus 4.25 to 7.00d sphere, over 6.00d cylinder, per lens
V2111	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2112	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25d to 4.00d cylinder, per lens
V2113	Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2114	Spherocylinder, single vision, sphere over plus or minus 12.00d, per lens
V2115	Lenticular (myodisc), per lens, single vision
V2116	Lenticular lens, nonaspheric, per lens, single vision
V2117	Lenticular, aspheric, per lens, single vision
V2118	Aniseikonic lens, single vision
V2199	Not otherwise classified, single vision lens
V2200	Sphere, bifocal, plano to plus or minus 4.00d, per lens
V2201	Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00d, per lens
V2202	Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00d, per lens

V2203	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, .12 to 2.00d cylinder, per lens
V2204	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 2.12 to 4.00d cylinder, per lens
V2205	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2206	Spherocylinder, bifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2207	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2208	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2209	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens
V2210	Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2211	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2212	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2213	Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2214	Spherocylinder, bifocal, sphere over plus or minus 12.00d, per lens
V2215	Lenticular (myodisc), per lens, bifocal

V2216	Lenticular, nonaspheric, per lens, bifocal
V2217	Lenticular, aspheric lens, bifocal
V2218	Aniseikonic, per lens, bifocal
V2219	Bifocal seg width over 28mm
V2220	Bifocal add over 3.25d
V2299	Specialty bifocal (by report)
V2300	Sphere, trifocal, plano to plus or minus 4.00d, per lens
V2301	Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00d per lens
V2302	Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00d, per lens
V2303	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 0.12-2.00d cylinder, per lens
V2304	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 2.25-4.00d cylinder, per lens
V2305	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, 4.25 to 6.00d cylinder, per lens
V2306	Spherocylinder, trifocal, plano to plus or minus 4.00d sphere, over 6.00d cylinder, per lens
V2307	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 0.12 to 2.00d cylinder, per lens
V2308	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 2.12 to 4.00d cylinder, per lens
V2309	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, 4.25 to 6.00d cylinder, per lens

V2310	Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00d sphere, over 6.00d cylinder, per lens
V2311	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 0.25 to 2.25d cylinder, per lens
V2312	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 2.25 to 4.00d cylinder, per lens
V2313	Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00d sphere, 4.25 to 6.00d cylinder, per lens
V2314	Spherocylinder, trifocal, sphere over plus or minus 12.00d, per lens
V2315	Lenticular, (myodisc), per lens, trifocal
V2316	Lenticular nonaspheric, per lens, trifocal
V2317	Lenticular, aspheric lens, trifocal
V2318	Aniseikonic lens, trifocal
V2319	Trifocal seg width over 28 mm
V2320	Trifocal add over 3.25d
V2399	Specialty trifocal (by report)
V2410	Variable asphericity lens, single vision, full field, glass or plastic, per lens
V2430	Variable asphericity lens, bifocal, full field, glass or plastic, per lens
V2499	Variable sphericity lens, other type
V2500	Contact lens, PMMA, spherical, per lens
V2501	Contact lens, PMMA, toric or prism ballast, per lens
V2502	Contact lens, PMMA, bifocal, per lens

V2503	Contact lens, PMMA, color vision deficiency, per lens
V2510	Contact lens, gas permeable, spherical, per lens
V2511	Contact lens, gas permeable, toric, prism ballast, per lens
V2512	Contact lens, gas permeable, bifocal, per lens
V2513	Contact lens, gas permeable, extended wear, per lens
V2520	Contact lens, hydrophilic, spherical, per lens
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens
V2522	Contact lens, hydrophilic, bifocal, per lens
V2523	Contact lens, hydrophilic, extended wear, per lens
V2530	Contact lens, scleral, gas impermeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2531	Contact lens, scleral, gas permeable, per lens (for contact lens modification, see CPT Level I code 92325)
V2599	Contact lens, other type

Low Vision Aids

V2600	Hand held low vision aids and other nonspectacle mounted aids
V2610	Single lens spectacle mounted low vision aids
V2615	Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopes and compound microscopic lens system

Miscellaneous

V2700	Balance lens, per lens
V2710	Slab off prism, glass or plastic, per lens
V2715	Prism, per lens
V2718	Press-on lens, Fresnell prism, per lens
V2730	Special base curve, glass or plastic, per lens
V2740	Tint, plastic, rose 1 or 2 per lens
V2741	Tint, plastic, other than rose 1 or 2, per lens
V2742	Tint, glass rose 1 or 2, per lens
V2743	Tint, glass other than rose 1 or 2, per lens
V2744	Tint, photochromatic, per lens
V2750	Anti-reflective coating, per lens
V2755	U-V lens, per lens
V2760	Scratch resistant coating, per lens
V2770	Occluder lens, per lens
V2780	Oversize lens, per lens
V2781	Progressive lens, per lens
V2799	Vision service, miscellaneous

BENEFIT CATEGORY

Prosthetic Device

DEFINITIONS

1. Aphakia is the absence of the lens of the eye.
2. Pseudophakia is an eye in which the natural lens has been replaced with an artificial intra-ocular lens (IOL).

3. Photochromatic lenses are those in which the degree of tint changes in response to changes in ambient light.

COVERAGE AND PAYMENT RULES

1. Refractive lenses are covered when they are medically necessary to restore the vision normally provided by the natural lens of the eye of an individual lacking the organic lens because of surgical removal or congenital absence. Covered diagnoses are limited to pseudophakia (ICD-9-CM V43.1), aphakia (ICD-9-CM 379.31), and congential aphakia (ICD-9-CM 743.35). Lenses provided for other diagnoses will be denied as non-covered.
2. After each cataract surgery with insertion of an intraocular lens (ICD-9-CM V43.1), coverage is limited to one pair of eyeglasses or contact lenses. Replacement glasses and lenses are non-covered. If a beneficiary has a cataract extraction with IOL insertion in one eye, subsequently has a cataract extraction with IOL insertion in the other eye, and does not receive eyeglasses or cataract lenses between the two surgical procedures, Medicare covers only one pair of eyeglasses or contact lenses after the second surgery. If a beneficiary has a pair of eyeglasses, has a cataract extraction with IOL insertion, and receives only new lenses but not new frames after the surgery, the benefit would not cover new frames at a later date (unless it follows subsequent cataract extraction in the other eye).
3. Tints (V2740-V2744), anti-reflective coating (V2750), U-V lenses (V2755), or oversize lenses (V2780) are covered when they are medically necessary for the individual patient and the medical necessity is documented by the treating physician. When these features are provided as a patient preference item they should be billed as non-covered with a condition code 20. Tinted lenses used as sunglasses that are provided to an aphakic patient in addition to regular prosthetic lenses will be denied as not medically necessary. Tinted lenses used as sunglasses which are prescribed to a pseudophakic patient in addition to regular prosthetic lenses will be denied as non-covered.
4. For patients who are aphakic who do not have an IOL (ICD-9-CM 379.31, 743.35), the following lenses or combinations of lenses are covered when determined to be medically necessary:
    a. bifocal lenses in frames
    b. lenses in frames for far vision and lenses in frames for near vision
    c. when a contact lens(es) for far vision is prescribed (including cases of binocular and monocular aphakia), payment will be made for the contact lens(es), and lenses in frames to be worn when the contacts have been removed.
5. Refractive lenses are covered even though the surgical removal of the natural lens occurred before Medicare entitlement.

6. Scratch resistant coating (V2760) and progressive lenses (V2781) are non-covered as a deluxe item.
7. Only standard frames (V2020) are covered. Additional charges for deluxe frames (V2025) are non-covered.
8. When hydrophilic soft contact lenses (V2520-V2523) are used as a corneal dressing, they are denied as non-covered because in this situation they do not meet the definition of a prosthetic device. However, if these lenses are used for refraction and meet the coverage criteria described above, they are covered.
9. Contact lens cleaning solution and normal saline for contact lenses are non-covered.
10. Low vision aids are non-covered items. These aids are used to maximize residual vision rather than replace “all or part of an internal body organ” and therefore do not meet the definition of a prosthetic device.

CODING GUIDELINES

1. Appropriate modifiers (RT and LT) must be used with the procedure code(s) on the claim.
2. When lenses are provided bilaterally and the same code is used for both lenses, bill both on the same claim line using the LTRT modifier and two units of service.
3. Codes V2100-V2218, V2299-V2318, V2399-V2499, V2700 and V2770 describe specific eyeglass lenses. Only one of these codes may be billed for each lens provided.
4. Codes V2219, V2220, V2319, V2320, V2710-V2760 and V2781 describe add-on features of lenses. They are billed in addition to codes for the basic lens.
5. Code V2744 is used for any type of photochromatic lens, either glass or plastic.
6. When billing claims for deluxe frames, use code V2020 for the cost of standard frames and a second line item using code V2025 for the difference between the charges for the deluxe frames and the standard frames.
7. When billing claims for progressive lens, use the appropriate code for the standard bifocal (V2200-V2299) or trifocal (V2300-V2399) lens and a second line item using code V2781 for the difference between the charge for the progressive lens and the standard lens.

DOCUMENTATION REQUIRED

1. An order for the lens(es) which is signed and dated by the ordering physician must be kept on file by the provider. The order must include the ICD-9-CM diagnosis code for the condition necessitating

the lens(es) (if the ordering physician is also the provider, the prescription is an integral part of the patient's record).

2. If aphakia is the result of the removal of a previously implanted lens, the date of the surgical removal of the lens must be documented in the patient's medical record.

3. Tints (V2740-V2744), anti-reflective coating (V2750, U-V lenses (V2755) or oversized lenses (V2780), if they are specifically ordered by the physician and are not a patient preference item only, the ZX modifier should be added to the codes. The ZX modifier may only be used when the requirement is met. When the ZX modifier is billed, documentation to support the medical necessity of the lens feature must be available to the Intermediary upon request.

4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

NOTES:

1. This policy allows coverage for only one pair of contacts ***or*** one pair of frames and lenses for patients undergoing cataract extraction with the insertion of intraocular lenses (IOLs) [pseudophakia, ICD-9-CM V43.1]. In order to more accurately adjudicate claims, it will be necessary to document the date(s) of cataract surgery on a claim. ***Claims without dates of cataract surgery will be denied for lack of sufficient documentation.***

2. It is sometimes necessary to remove an IOL because of complications, rendering the patient aphakic in the affected eye (ICD-9-CM 379.31). However, Medicare files may indicate the patient is pseudophakic rather than aphakic, due to information furnished on prior claims. ***Claims for patients who have undergone IOL removal require documentation of the IOL removal to allow payment for subsequent refractive lenses.***

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Repairs

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E1340	Repair or non-routine service for durable medical equipment requiring the skill of a technician, labor component, per 15 minutes

BENEFIT CATEGORY

Durable Medical Equipment

DEFINITIONS

1. This code is used for services not covered by other codes or combination of codes in reference to the repairs of durable medical equipment.
2. This policy does not apply to the maintenance and servicing or the replacement of durable medical equipment.

COVERAGE AND PAYMENT RULES

1. Under the circumstances specified below, payment may be made for repair of medically required Durable Medical Equipment which the beneficiary owns or is purchasing, including equipment which had been in use before the user enrolled in Part A of the program. Since renters of equipment usually recover from the rental charge the expenses they incur in maintaining in working order the equipment they rent out, separately itemized charges for repair of rented equipment are not covered, except for the lease of rental dialysis equipment.
2. Repairs to equipment that a beneficiary is purchasing or already 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.

DOCUMENTATION REQUIRED

1. The claim must be accompanied by a statement that the patient owns the equipment, description of the nature and medical necessity of the repair, and an itemization of the parts and labor time involved.
2. Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced. If replacing a part that has not been assigned a specific HCPCS code, use a miscellaneous HCPCS code (E1399, or K0108 for wheelchair parts) to bill each part, and include the make, model number, part number and manufacturer of the product.
3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Seat Lift Mechanisms

HCPCS CODES

E0627	Seat lift mechanism incorporated into a combination lift-chair mechanism
E0628	Separate seat lift mechanism for use with patient owned furniture - electric
E0629	Separate seat lift mechanism for use with patient owned furniture - non-electric

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-8

INDICATIONS

A seat lift mechanism is covered if ***all*** of the following criteria are met:

1. The patient must have severe arthritis of the hip or knee or have a severe neuromuscular disease
2. The seat lift mechanism must be a part of the physician’s course of treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient’s condition
3. The patient must be completely incapable of standing up from any chair in his/her home (the fact that a patient has difficulty or is even incapable of getting up from a chair, particularly a low chair, is not sufficient justification for a seat lift mechanism. Almost all patients who are capable of ambulating can get out of an ordinary chair if the seat height is appropriate and the chair has arms)
4. Once standing, the patient must have the ability to ambulate

Subject: **SEAT LIFT MECHANISMS**

COVERAGE AND PAYMENT RULES

1. Coverage of seat lift mechanisms is limited to those types which operate smoothly, can be controlled by the patient, and effectively assist a patient in standing up and sitting down without other assistance. Excluded from coverage is the type of lift that operates by spring release mechanism with a sudden, catapult-like motion and jolts the patient from a seated to a standing position.
2. Coverage is limited to the seat lift mechanism, even if it is incorporated into a chair (E0627). Payment for a seat lift mechanism incorporated into a chair (E0627) is based on the allowance for the least costly alternative (E0628, E0629).
3. The physician ordering the seat lift mechanism must be the attending physician or a consulting physician for the disease or condition resulting in the need for a seat lift. The physician's record must document that all appropriate therapeutic modalities (e.g., medication, physical therapy) have been tried and failed to enable the patient to transfer from a chair to a standing position.

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician prior to the date of delivery, must be kept on file by the provider. The CMN for the seat lift mechanism is DMERC 07.
2. An order for seat lift mechanisms signed and dated by the physician must be received by the provider prior to delivery of the item. A CMN for the item that has been reviewed, signed and dated by the ordering physician may be substituted for the order if returned to the provider prior to the delivery. Otherwise, the prior completed order and/or the completed CMN must be kept on file by the provider and made available to the Intermediary upon request.
3. Documentation requirements must be kept on file in the patient’s medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

Approved by: ***Harry Feliciano, M.D., M.P.H.*** *Initials:*

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Spinal Orthoses, TLSO and LSO

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

K0112	Trunk support device, vest type, with inner frame, prefabricated
K0113	Trunk support device, vest type, without inner frame, prefabricated
L0300	TLSO, flexible (dorso-lumbar surgical support), custom fitted
L0310	TLSO, flexible, (dorso-lumbar surgical support), custom fabricated
L0315	TLSO, flexible (dorso-lumbar surgical support), elastic type, with rigid posterior panel
L0317	TLSO, flexible (dorso-lumbar surgical support), hyperextension, elastic type, with rigid posterior panel
L0320	TLSO, anterior-posterior control (Taylor type), with apron front
L0330	TLSO, anterior-posterior-lateral control (Knight-Taylor type), with apron front
L0340	TLSO, anterior-posterior-lateral-rotary control (Arnold, Magnuson, Steindler types), with apron front
L0350	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, custom fitted
L0360	TLSO, anterior-posterior-lateral-rotary control, flexion compression jacket, molded to patient model

L0370	TLSO, anterior-posterior-lateral-rotary control, hyperextension (Jewett, Lennox, Baker, Cash types)
L0380	TLSO, anterior-posterior-lateral-rotary control, with extensions
L0390	TLSO, anterior-posterior-lateral control, molded to patient model
L0400	TLSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0410	TLSO, anterior-posterior-lateral control, two-piece construction, molded to patient model
L0420	TLSO, anterior-posterior-lateral control, two piece construction, molded to patient model, with interface material
L0430	TLSO, anterior-posterior-lateral control, with interface material custom-fitted
L0440	TLSO, anterior-posterior-lateral control, with overlapping front section, spring steel front, custom-fitted
L0500	LSO, flexible, (lumbo-sacral surgical support)
L0510	LSO, flexible, (lumbo-sacral surgical support), custom fabricated
L0515	LSO, flexible, (lumbo-sacral surgical support) elastic type, with rigid posterior panel
L0520	LSO, anterior-posterior lateral control (Knight, Wilcox types), with apron front
L0530	LSO, anterior-posterior control (Macausland type), with apron front
L0540	LSO, lumbar flexion (Williams flexion type)

L0550	LSO, anterior-posterior-lateral control, molded to patient model
L0560	LSO, anterior-posterior-lateral control, molded to patient model, with interface material
L0565	LSO, anterior-posterior-lateral control, custom-fitted

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

DEFINITIONS

1. Code K0112 describes a prefabricated orthosis with the following characteristics:
    a. plastic frame which is padded and covered with cloth, or other material
    b. designed to be worn on top of clothing
    c. primarily intended to assist in maintaining upright trunk posture in patients in wheelchairs
    d. capable of being worn by an ambulatory patient – i.e., not attached to a wheelchair
    e. limited degree of custom fitting/molding possible
2. Code K0113 describes a prefabricated device with the following characteristics:
    a. foam shape covered with cloth or other material
    b. designed to be worn on top of clothing
    c. primarily intended to assist in maintain upright trunk posture in patients in wheelchairs
    d. capable of being worn by an ambulatory patient – i.e., not attached to a wheelchair
3. Thoracic-lumbar-sacral orthoses (TLSO) described by codes L0300-L0440 and lumbar-sacral orthoses (LSO) described by codes L0500-L0565 have the following characteristics:
    a. used to immobilize the specified areas of the spine
    b. intimate fit and generally designed to be worn under clothing

c. not specifically designed for patients in wheelchairs

4. In addition to 3.a. and 3.b. (above), the body jacket type orthoses (L0390-L0440, L0550-L0565) are characterized by a rigid plastic shell that encircles the trunk and provides a high degree of immobility.

5. A custom fitted orthosis is one which is manufactured in quantity (i.e., prefabricated) without a specific patient in mind. A custom fitted orthosis is trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific patient. An orthosis that is assembled from prefabricated components is considered custom fitted. Any orthosis that does not meet the definition of a custom fabricated orthosis is considered custom fitted.

6. A custom fabricated orthosis is one which is individually made for a specific patient starting with basic materials including, but not limited to, plastic, metal, leather, or cloth in the form of sheets, bars, etc. It involves substantial work such as cutting, bending, molding, sawing, etc. It may involve the incorporation of some prefabricated components. It involves more than trimming, bending, or making other modifications to a substantially prefabricated item. A molded-to-patient-model orthosis is a particular type of custom fabricated orthosis in which an impression of the specific body part is made (usually by means of a plaster cast) and this impression is then used to make a positive model (usually of plaster) of the body part. The orthosis is then molded on this positive model.

COVERAGE AND PAYMENT RULES

1. Thoracic-lumbar-sacral orthoses (L0300-L0440) and lumbar-sacral orthoses (L0500-L0565) are covered when they are ordered by a physician to reduce pain by restricting mobility of the trunk, to facilitate healing following an injury to and/or a surgical procedure on the spine or related soft tissues, or to otherwise support weak spinal muscles and/or a deformed spine.

2. Trunk support devices described by code K0112 are considered not medically necessary. These devices are not generally accepted as being reasonable and necessary to provide trunk support to patients in wheelchairs. An adequate seating system would allow the patient to function appropriately in the wheelchair.

3. Items described by code K0113 will be denied as non-covered because they do not meet the definition of a brace – i.e., they are not rigid or semi-rigid devices.

CODING GUIDELINES

1. Devices which are described by codes K0112 or K0113 should not be billed using other spinal orthosis codes (L0300-L0440, L0500-L1499).

2. Codes L0310, L0320-L0340, L0360-L0420, L0510 and L0520-L0560 describe ***custom fabricated*** orthoses. These codes must not be used for prefabricated/custom fitted orthoses.
3. A provider or physician wanting to know which code to use to describe a particular product should contact the Medicare Part A Service Center.

DOCUMENTATION REQUIRED

1. An order for the orthosis which is signed and dated by the treating physician and which clearly describes the type of orthosis ordered must be kept on file by the provider and made available to the Intermediary upon request.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Suction Pumps

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0600	Suction pump, home model, portable
E1399	Durable medical equipment, miscellaneous
A4214	Sterile saline or water, 30 cc vial
A4323	Sterile saline irrigation solution, 1000 ml
A4624	Tracheal suction catheter, any type, each
A4628	Oropharyngeal suction catheter, each
K0190	Canister, disposable, used with suction pump
K0191	Canister, non-disposable, used with suction pump
K0192	Tubing, used with suction pump

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9

DEFINITION

A portable home model suction pump is a lightweight, compact, electric aspirator designed for upper respiratory oral pharyngeal and tracheal suction for use in the home. Use of the device does not require technical or professional supervision.

COVERAGE AND PAYMENT RULES

1. Use of a home model suction machine is covered for patients who have difficulty raising and clearing secretions secondary to:

a. cancer or surgery of the throat or mouth

b. dysfunction of the swallowing muscles

c. unconsciousness or obtunded state

d. tracheostomy (ICD-9-CM V44.0 or V55.0)

2. When a suction pump is covered, tracheal suction catheters (A4624) are separately payable supplies. In most cases, in the home setting, ***sterile*** catheters are medically necessary only for tracheostomy suctioning. Three suction catheters per day are covered for medically necessary tracheostomy suctioning, unless additional documentation is provided. When a tracheal suction catheter is used in the oropharynx, which is not sterile, the catheter can be reused if properly cleansed and/or disinfected. In this situation the medical necessity for more than three catheters (A4624) per week would require additional documentation.
3. Sterile saline solution (A4214, A4323) is covered and separately payable when used to clear a suction catheter after tracheostomy suctioning. It is not usually medically necessary for oropharyngeal suctioning. Saline used for tracheal lavage is a non-covered supply.
4. Tracheal suction catheters (A4624) and sterile saline used for suctioning (A4214, A4323) are considered supplies for durable medical equipment. Therefore, when supplied to beneficiaries in nursing facilities, Place of Service Codes 31 and 32, they will be denied as non-covered.
5. Supplies (A4628, K0190-K0192) are covered and are separately payable when they are medically necessary and used with a medically necessary suction pump in a covered setting.
6. When a suction pump is used for tracheal suctioning, other supplies (e.g., cups, basins, gloves, solutions, etc.) are included in the tracheal care kit code, A4625 (refer to the Tracheostomy Care Supplies policy for details). When a suction pump is used for oropharyngeal suctioning, these other supplies are not medically necessary.

CODING GUIDELINES

Code E0600 would not be used for a suction pump used with nasogastric tubes. This would be coded E1399.

DOCUMENTATION REQUIRED

1. An order for the item, which has been signed and dated by the ordering physician, must be kept on file by the provider.
2. When billing HCPCS code A4624 for patients with a tracheostomy, ICD-9-CM codes V44.0, V55.0 or 519.00-519.09 should be entered on the claim form.

3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Therapeutic Shoes for Diabetics

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

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
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
A5502	For diabetics only, multiple density insert(s), per shoe
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
A5504	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with wedge(s), per shoe
A5505	For diabetics only, modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe with metatarsal bar, per shoe
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

A5507	For diabetics only, not otherwise specified modification (including fitting) of off-the-shelf depth-inlay shoe or custom-molded shoe, per shoe
K0401	For diabetics only, deluxe feature of off-the-shelf depth inlay shoe or custom-molded shoe, per shoe

HCPCS MODIFIER

ZX	Specific requirements found in the documentation section of the medical policy have been met and evidence of this is available in the provider's record

BENEFIT CATEGORY

Durable Medical Equipment

DEFINITIONS

1. A depth shoe (A5500) is one that:
    a. has a full length, heel-to-toe filler that when removed provides a minimum of 3/16″ of additional depth used to accommodate custom-molded or customized inserts;
    b. is made from leather or other suitable material of equal quality;
    c. has some form of shoe closure; and
    d. is available in full and half sizes with a minimum of three widths so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent (the American last sizing schedule is the numerical shoe sizing system used for shoes in the United States). This includes a shoe with or without an internally seamless toe.
2. A custom-molded shoe(A5501) is one that:
    a. is constructed over a positive model of the patient's foot
    b. is made from leather or other suitable material of equal quality
    c. has removable inserts that can be altered or replaced as the patient's condition warrants, and
    d. has some form of shoe closure

This includes a shoe with or without an internally seamless toe.

3. An insert (A5502) is a total contact, multiple density, removable inlay that is directly molded to the patient's foot or a model of the patient's foot and that is made of a suitable material with regard to the patient's condition.
4. Rigid rocker bottoms (A5503) are exterior elevations with apex position for 51 percent to 75 percent distance measured from the back end of the heel. The apex is a narrowed or pointed end of an anatomical structure. The apex must be positioned behind the metatarsal heads and tapering off sharply to the front tip of the sole. Apex height helps to eliminate pressure at the metatarsal heads. Rigidity is ensured by the steel in the shoe. The heel of the shoe tapers off in the back in order to cause the heel to strike in the middle of the heel.
5. Roller bottoms (sole or bar) (A5503) are the same as rocker bottoms, but the heel is tapered from the apex to the front tip of the sole.
6. Wedges (posting) (A5504) are either of hind foot, fore foot, or both and may be in the middle or to the side. The function is to shift or transfer weight bearing upon standing or during ambulation to the opposite side for added support, stabilization, equalized weight distribution, or balance.
7. Metatarsal bars (A5505) are exterior bars which are placed behind the metatarsal heads in order to remove pressure from the metatarsal heads. The bars are of various shapes, heights, and construction depending on the exact purpose.
8. Offset heel (A5506) is a heel flanged at its base either in the middle, to the side, or a combination, that is then extended upward to the shoe in order to stabilize extreme positions of the hind foot.
9. A deluxe feature (K0401) does not contribute to the therapeutic function of the shoe. It may include, but is not limited to style, color, or type of leather.
10. The ***ordering physician*** actually writes the order for the therapeutic shoe, modifications and inserts. The prescribing physician may be a podiatrist, M.D., or D.O.
11. The ***provider*** is the person or entity that actually furnishes the shoe, modification, and/or insert to the beneficiary and that bills Medicare. The provider may be a podiatrist, pedorthist, orthotist, prosthetist, or other qualified individual. The ***prescribing physician*** may be the provider. The ***certifying physician*** may ***only*** be the provider if the certifying physician is practicing in a defined rural area or a defined health professional shortage area.

COVERAGE AND PAYMENT RULES

1. Diabetic shoes, inserts and/or modifications to the shoes are covered if the following criteria are met:
   a. The patient has diabetes mellitus (ICD-9-CM diagnosis codes 250.00-250.93); and
   b. The patient has one or more of the following conditions:
      - Previous amputation of the other foot, or part of either foot, or
      - History of previous foot ulceration of either foot, or
      - History of pre-ulcerative calluses of either foot, or
      - Peripheral neuropathy with evidence of callus formation of either foot, or
      - Foot deformity of either foot, or
      - Poor circulation in either foot; and
      - The certifying physician who is managing the patient's systemic diabetes condition has certified that indications a. and b. are met and that he/she is treating the patient under a comprehensive plan of care for his/her diabetes and that the patient needs diabetic shoes.
2. For patients meeting these criteria, coverage is limited to one of the following within one calendar year:
   a. one pair of custom-molded shoes (A5501) (which includes inserts provided with these shoes) and two additional pairs of inserts (A5502); or
   b. One pair of depth shoes (A5500) and three pairs of inserts (A5502) (not including the non-customized removable inserts provided with such shoes).
3. Separate inserts may be covered and dispensed independently of diabetic shoes if the provider of the shoes verifies in writing that the patient has appropriate footwear into which the insert can be placed. This footwear must meet the definitions found in the policy for depth shoes or custom-molded shoes. In addition, the inserts furnished must fully meet the definition of an insert set forth in this policy. Inserts that will be used in non-covered shoes are non-covered.
4. A custom-molded shoe (A5501) is covered when the patient has a foot deformity which cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the providers records and may be requested by the Intermediary. If there

is insufficient justification for a custom-molded shoe but the general coverage criteria are met, payment will be based on the allowance for the least costly medically appropriate alternative, A5500.

5. A modification of a custom molded or depth shoe will be covered as a substitute for an insert. Although not intended as a comprehensive list, the following are the most common shoe modification:
   a. rigid rocker bottoms (A5503)
   b. roller bottoms (A5503)
   c. wedges (A5504)
   d. metatarsal bars (A5505)
   e. offset heels (A5506)
6. Other modifications to diabetic shoes (A5507) include, but are not limited to flared heels and inserts for missing toes.
7. Deluxe features of diabetic shoes (K0401) will be denied as non-covered.
8. Shoes, inserts, and/or modifications that are provided to patients who do not meet the coverage criteria will be denied as non-covered.
9. When codes are billed without a ZX modifier (see ***DOCUMENTATION REQUIRED***), they will be denied as non-covered.
10. The particular type of footwear (shoes, inserts, modifications) which is necessary must be prescribed by a podiatrist or other qualified physician, knowledgeable in the fitting of diabetic shoes and inserts.
11. The footwear must be fitted and furnished by a podiatrist or other qualified individual such as a pedorthist, orthotist or prosthetist.
12. The certifying physician (i.e., the physician who manages the systemic diabetic condition) may not furnish the footwear unless he/she practices in a defined rural area or a defined health professional shortage area. The prescribing physician (podiatrist or other qualified physician) can be the supplier (i.e., the one who furnishes the footwear).
13. There is no separate payment for the fitting of the shoes, inserts or modifications or for the certification of need or prescription of the footwear. Unrelated evaluation and management services by the physician are processed by the local carrier.

CODING GUIDELINES

1. Code A5507 is only to be used for not otherwise specified therapeutic modifications to the shoe. Deluxe features must be coded using code K0401.
2. Codes for inserts or modification (A5502-A5507) may only be used for items related to diabetic shoes(A5500, A5501). They should not be used for items related to footwear (L3215-L3253). Inserts and modifications used with L coded footwear must be coded using L codes (L3000-L3649).
3. When a single shoe, insert or modification is provided, the appropriate modifier, right (RT) or left (LT), must be used. If a pair is provided, report as two (2) units of service on the claim – the RT or LT modifiers should not be used.

DOCUMENTATION REQUIRED

1. An order for the shoes, inserts or modifications which has been signed and dated by the prescribing physician must be kept on file by the provider. If the prescribing physician is the provider, a separate order is not required, but the item provided must be clearly noted in the patient's record.
2. A new order is not required for the replacement of an insert or modification within one year of the order on file. However, the providers records should document the reason for the replacement
3. A new order is required for the replacement of any shoe.
4. A new order is required for the replacement of an insert or modification more than one year from the most recent order on file.
5. The provider must obtain a signed statement and/or order from the certifying physician specifying that the patient has diabetes mellitus, has one of conditions listed in ***COVERAGE AND PAYMENT RULES*** – section 1.b. of this policy, is being treated under a comprehensive plan of care for his/her diabetes, and needs diabetic shoes. The Statement of Certifying Physician for Therapeutic Shoes developed by the DMERC is recommended. This statement may be completed by the prescribing physician or provider but must be reviewed for accuracy of the information and signed by the certifying physician to indicate agreement.
6. A new Certification Statement and/or order is required for a shoe, insert modification provided more than one year from the most recent Certification Statement on file.
7. If the provider has a current signed statement of file that indicates that the coverage criteria described above have been met, then a ZX modifier must be added to the code.

8. A diagnosis code for diabetes (ICD-9-CM code 250.00-250.93) should be entered on the claim.
9. If code A5507 is submitted, the claim must contain a narrative description of the modification or feature provided.
10. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Tracheostomy Care Supplies

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

A4625	Tracheostomy care kit for a new tracheostomy
A4626	Tracheostomy cleaning brush, each
A4629	Tracheostomy care kit for established tracheostomy

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual

DEFINITIONS

1. A tracheostomy care or cleaning starter kit (A4625) contains the following:
    a. plastic tray
    b. basin
    c. pair of sterile gloves
    d. tube brush
    e. pipe cleaners
    f. pre-cut tracheostomy dressing
    g. roll of gauze
    h. 4″ x4″ sponges
    i. cotton tip applicators
    j. twill tape
2. A tracheostomy care kit for an established tracheostomy (A4629) contains the following:

a. tube brush
b. pipe cleaners
c. cotton tip applicators
d. twill tape
e. 4″ x 4″ sponges

COVERAGE AND PAYMENT RULES

1. A tracheostomy care kit is covered for a patient following an open surgical tracheostomy that has been open or is expected to remain open for at least three months.
2. A tracheostomy care or cleaning starter kit (A4625) is covered for the first two weeks following an open surgical tracheostomy. Beginning two weeks post-operatively, code A4625 is no longer medically necessary and if that code is billed, payment is based on the least costly alternative, code A4629.
3. One tracheostomy care kit (A4625, A4629) per day is considered necessary for routine care of a tracheostomy. Claims for additional kits for non-routine tracheostomy care must be accompanied by substantiating documentation.
4. For information on tracheal suction catheters and related supplies, see the ***SUCTION PUMP*** policy.

CODING GUIDELINES

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I	***Column II***
A4625	A4626
A4629	A4626

DOCUMENTATION REQUIRED

1. An order for tracheostomy care supplies, which is signed and dated by the ordering physician, must be kept on file in the patient's record and be available to the Intermediary upon request.
2. When billing for more than one tracheostomy care kit (A4625, A4629) per day, documentation explaining the medical necessity for the greater amount must be in the patient's medical records and made available to the Intermediary upon request.
3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Transcutaneous Electrical Nerve Stimulators (TENS)

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

E0720	TENS, two lead, localized stimulation
E0730	TENS, four lead, larger area/multiple nerve stimulation
E0731	Form fitting conductive garment for delivery of tens or NMES (with conductive fibers separated from the patient's skin by layers of fabric)
A4556	Electrodes, (e.g., apnea monitor)
A4557	Lead wires, (e.g., apnea monitor)
A4558	Conductive paste or gel
A4595	TENS supplies, 2 lead, per month
A4630	Replacement batteries for medically necessary TENS (Transcutaneous Electrical Nerve Stimulator owned by patient

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCES

HCFA Pub. 6, Coverage Issues Manual 35-46, 45-19, 45-25, 60-20

SUBJECT: **TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)**

DEFINITION

A Transcutaneous Electrical Nerve Stimulator (TENS) (E0720, E0730) is a device which utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. A TENS unit must be distinguished from other electrical stimulators (e.g., neuromuscular stimulators) which are used to directly stimulate muscles and/or motor nerves. A TENS supply allowance (A4595) includes electrodes (any type), conductive paste or gel (if needed, depending on the type of electrode), tape or other adhesive (if needed, depending on the type of electrode), adhesive remover, skin preparation materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if rechargeable batteries are used).

COVERAGE AND PAYMENT RULES

A Transcutaneous Electrical Nerve Stimulator (TENS) is covered for the treatment of patients with chronic, intractable pain or acute post-operative pain who meet the coverage rules listed below:

1. When a TENS unit is used for acute post-operative pain, the medical necessity is usually limited to 30 days from the day of surgery. Payment for more than one month is determined by individual consideration based upon supportive documentation provided by the ordering physician. Payment will be made only as a rental. A TENS unit will be denied as not medically necessary for acute pain (less than three months duration) other than post-operative pain.
2. For chronic pain, the medical record must document the location of the pain, the duration of time the patient has had the pain, and the presumed etiology of the pain. The pain must have been present for at least three months. Other appropriate treatment modalities must have been tried and failed, and the medical record must document what treatment modalities have been used (including the names and dosage of medication), the length of time that each type of treatment was used, and the results.
3. The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit are not considered to be medically necessary are (not all-inclusive): headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain.
4. When used for the treatment of chronic, intractable pain, the TENS unit must be used by the patient on a trail basis for a minimum of one month (30 days), but not to exceed two months. The trail period will be paid as a rental. The trial period must be monitored by the ordering physician to determine the effectiveness of the TENS unit in modulating the pain. For coverage of a purchase, the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long

period of time. The physician's records must document a reevaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results.

5. A 4 lead TENS unit may be used with either 2 leads or 4 leads, depending on the characteristics of the patient's pain. If it is ordered for use with 4 leads, the medical record must document why 2 leads are insufficient to meet the patients needs.

6. During the rental of a TENS unit, supplies for the unit are included in the rental allowance; there is no additional allowance for electrodes, lead wires, batteries, etc. If a TENS unit (E0720 or E0730) is purchased, the allowance includes lead wires and one month's supply of electrodes, conductive paste or gel (if needed), and batteries.

7. Separate allowance will be made for replacement supplies when they are medically necessary and are used with a TENS unit that has been purchased and/or approved by Medicare. If 2 TENS leads are medically necessary, then a maximum of one unit of Code A4595 would be allowed per month; if 4 TENS leads are necessary, a maximum of two units per month would be allowed. If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

8. There should be no billing and there will be no separate allowance for replacement electrodes (A4556), conductive paste or gel (A4558), replacement batteries (A4630), or a battery charger used with a TENS unit.

9. Replacement of lead wires (A4557) will be covered when they are inoperative due to damage and the TENS unit is still medically necessary. Replacement more often than every 12 months would rarely be medically necessary.

10. Other supplies, including but not limited to the following, will be separately allowed: adapters (snap, banana, alligator, tab, button, clip), belt clips, adhesive remover, additional connecting cable for lead wires, carrying pouches, or covers.

11. A conductive garment (E0731) used with a TENS unit is rarely medically necessary, but may be covered if all of the following conditions are met:

    a. it has been prescribed by a physician for use in delivering covered TENS treatment; ***and***

    b. one of the medical indications outlined below is met:

        - the patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; ***or***

- the patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; ***or***
- the patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; ***or***
- the patient requires electrical stimulation beneath a cast to treat chronic intractable pain

12. A conductive garment is not covered for use with a TENS device during the trial period unless:

    a. the patient has a documented skin problem prior to the start of the trial period; ***and***

    b. the item is medically necessary for the patient

    c. The physician ordering the TENS unit could be the physician or a consulting physician for the disease or condition resulting in the need for the TENS unit

CODING GUIDELINES

1. Codes A4556, A4558, and A4630 are not valid for supplies used with a TENS unit; A4595 should be used instead.
2. For code A4557, one unit of service is for lead wires going to two electrodes. If all the lead wires of a 4 lead TENS unit needed to be replaced, billing would be for two units of service.

DOCUMENTATION REQUIRED

1. An order for the TENS unit and related supplies, which has been signed and dated by the ordering physician and/or Certificate of Medical Necessity (CMN), which has been completed, signed and dated by the ordering physician, must be kept on file by the provider. The CMN for TENS is HCFA form 848. The written order for a TENS unit must be obtained prior to delivery.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

Notes:

1. A claim for code E0731 must be accompanied by the brand name and model number of the conductive garment, and a detailed statement justifying the medical necessity of the garment for the patient.
2. When a TENS unit is prescribed for chronic pain, once the physician has re-evaluated the patient after the trial period, a new order and (separate) CMN must be completed and included in the patient's medical record. The initial date needed on this order and CMN must

indicate the date of the TENS purchase and should not overlap the dates of the trial period.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Trapeze Bars and Other Bed Accessories

HCPCS CODES

Accessories

E0271	Mattress, innerspring
E0272	Mattress, foam rubber
E0273	Bed board
E0274	Over-bed table
E0280	Bed cradle, any type
E0305	Bed side rails, half length
E0310	Bed side rails, full length
E0315	Bed accessories: boards or tables, or any type support device
E0910	Trapeze bars (also known as Patient Helper), attached to bed, with grab bar
E0940	Trapeze bar, free standing, complete with grab bar

Hospital Beds

E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0251	Hospital bed, fixed height, with any type side rails, without mattress
E0255	Hospital bed, variable height (Hi-Lo), with any type side rails, with mattress
E0256	Hospital bed, variable height (Hi-Lo), with any type side rails, without mattress

E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0261	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress
E0290	Hospital bed, fixed height, without side rails, with mattress
E0291	Hospital bed, fixed height, without side rails, without mattress
E0292	Hospital bed, variable height (Hi-Lo), without side rails, with mattress
E0293	Hospital bed, variable height (Hi-Lo), without side rails, without mattress
E0294	Hospital bed, semi-electric (head and foot adjustment), without side rails, with mattress
E0295	Hospital bed, semi-electric (head and foot adjustment), without side rails, without mattress
E0296	Hospital bed, total electric (head, foot and height adjustment), without side rails, with mattress
E0297	Hospital bed, total electric (head, foot and height adjustment), without side rails, without mattress

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-9, 60-18

INDICATIONS

1. A trapeze bar is covered when a patient needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

2. A bed cradle is covered for a patient with acute gouty arthritis (ICD-9-CM code 274.0) or burns (ICD-9-CM codes 942.00-943.59, 945.00-945.59) when it is necessary to prevent contact with the bed coverings.

COVERAGE AND PAYMENT RULES

1. An "attachable" trapeze bar (E0910) is non-covered when used on a non-hospital bed.
2. A trapeze bar (E0910) is covered when it is either an integral part of or used on a hospital bed, and it has been determined that both the hospital bed and the trapeze bar are medically necessary.
3. When "free standing" trapeze equipment (E0940) is prescribed, it must meet the same criteria as the attached equipment and the patient must not rent or own a hospital bed.
4. A bed cradle (E0280) is covered when used for the indications above. Other uses of a bed cradle are usually not medically necessary.
5. Side rails (E0305, E0310) are covered when they are an integral part of, or an accessory to, a hospital bed.
6. A bed board (E0273, E0315) is non-covered since it is a convenience item and not medically necessary.
7. An over-bed table (E0274, E0315) is non-covered since it is a convenience item and not medically necessary.
8. A mattress innerspring (E0271) or mattress, foam rubber (E0272) is covered as a replacement mattress for a hospital bed owned by the patient.

CODING GUIDELINES

When mattresses or bed side rails are billed at the same time as hospital beds without these items, use the single code that combines these items:

E0271, E0272: Mattress, Innerspring-Foam Rubber

- When combined with E0251, pay as E0250
- When combined with E0291, pay as E0290
- When combined with E0293, pay as E0292
- When combined with E0295, pay as E0294
- When combined with E0297, pay as E0296

E0305, E0310: Bed Side Rails, Half Length-Full Length

- When combined with E0290, pay as E0250
- When combined with E0291, pay as E0251

- When combined with E0292, pay as E0255
- When combined with E0293, pay as E0256
- When combined with E0294, pay as E0260
- When combined with E0295, pay as E0261

DOCUMENTATION REQUIRED

1. A Certificate of Medical Necessity (CMN) and/or an order that has been completed, signed and dated by the ordering physician must be kept on file in the patient's medical record.
2. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Urological Supplies

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

A4310	Insertion tray without drainage bag and without catheter (accessories only)
A4311	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4312	Insertion tray without drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4313	Insertion tray without drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation
A4314	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.)
A4315	Insertion tray with drainage bag with indwelling catheter, Foley type, two-way, all silicone
A4316	Insertion tray with drainage bag with indwelling catheter, Foley type, three-way, for continuous irrigation
A4320	Irrigation tray with bulb or piston syringe, any purpose
A4321	Therapeutic agent for urinary catheter irrigation
A4322	Irrigation syringe, bulb or piston, each

A4323	Sterile saline irrigation solution, 1000 ml
A4326	Male external catheter specialty type, (e.g., inflatable, faceplate, etc.), each
A4327	Female external urinary collection device, meatal cup, each
A4328	Female external urinary collection device, pouch, each
A4329	External catheter starter set, male/female, includes catheters/urinary collectin device bag/pouch and accessories (tubing, clamps, etc.), seven day supply
A4335	Incontinence supply; miscellaneous
A4338	Indwelling catheter; Foley type; two-way latex with coating (teflon, silicone, silicone elastomer or hydrophilic, etc.), each
A4340	Indwelling catheter; specialty type (e.g., coude, mushroom wing, etc.), each
A4344	Indwelling catheter; Foley type, two-way, all silicone, each
A4346	Indwelling catheter; Foley type, three-way for continuous irrigation, each
A4347	Male external catheter with or without adhesive, with or without anti-reflux device; per dozen
A4351	Intermittent urinary catheter; straight tip, each
A4352	Intermittent urinary catheter; Coude (curved) tip, each
A4353	Intermittent urinary catheter, with insertion supplies
A4354	Insertion tray with drainage bag but without catheter

A4355	Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter, each
A4356	External urethral clamp or compression device (not to be used for catheter clamp), each
A4357	Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each
A4358	Urinary leg bag; vinyl, with or without tube, each
A4359	Urinary suspensory without leg bag, each
A4365	Ostomy adhesive remover wipes, 50 per box
A4402	Lubricant, per ounce
A4455	Adhesive remover or solvent (for tape, cement or other adhesive), per ounce
A4554	Disposable underpads, all sizes (e.g., Chux)
A5102	Bedside drainage bottle with or without tubing, rigid or expandable, each
A5105	Urinary suspensory; with leg bag, with or without tube
A5112	Urinary leg bag; latex
A5113	Leg strap; latex, replacement only, per set
A5114	Leg strap; foam or fabric, replacement only, per set
A5131	Appliance cleaner, incontinence and ostomy appliances, per 16 oz.
A5149	Incontinence/ostomy supply; miscellaneous
A6265	Tape, all types, per 18 square inches
A9270	Non-covered item or service

K0280	Extension drainage tubing, any type, any length, with connector/adaptor; for use with urinary leg bag or urostomy pouch, each
K0281	Lubricant, individual sterile packet, for insertion of urinary catheter, each
K0407	Urinary catheter anchoring device, adhesive skin attachment
K0408	Urinary catheter anchoring device, leg strap
K0409	Sterile water irrigation solution, 1000 ml
K0410	Male external catheter, with adhesive coating, each
K0411	Male external catheter, with adhesive strip, each
ZZ002	Incontinence supply, component of another item

BENEFIT CATEGORY

Durable Medical Equipment

DEFINITIONS

1. A meatal cup female external urinary collection device (A4327) is a plastic cup which is held in place around the female urethra by suction or pressure and is connected to a urinary drainage container such as a bag or bottle.
2. A pouch type female external collection device (A4328) is a plastic pouch which is attached to the periurethral area with adhesive and which can be connected to a urinary drainage container such as a bag or bottle.
3. The general term “external urinary collection devices” used in this policy includes male external catheters and female pouches or meatal cups. This term does not include diapers or other types of absorptive pads.
4. Sterile catheterization technique involves the use of a new, sterile packaged catheter and sterile lubricant for each catheterization. It may also involve use of sterile gloves and drape and use of an antiseptic solution to cleanse the periurethral area. Clean, non-sterile intermittent catheterization technique involves the use of soap and water for cleansing of the periurethral area, a reusable catheter that is cleansed between episodes and non-sterile lubricant.

5. A urinary catheter anchoring device described by code K0407 has an adhesive surface that attaches to the patient's skin and a mechanism for releasing and re-anchoring the catheter multiple times without changing the device.
6. A urinary catheter anchoring device described by code K0408 is a strap that goes around a patient's leg and has a mechanism for releasing and re-anchoring the catheter multiple times without changing the device.
7. A urinary intermittent catheter with insertion supplies (A4353) is a kit that includes a catheter, lubricant, gloves, antiseptic solution, applicators, drape, and a tray or bag in a sterile package intended for single use.
8. Therapeutic agent for urinary irrigation (A4321) is defined as a solution containing agents in addition to saline or sterile water (for example acetic acid or hydrogen peroxide) that is used for the treatment or prevention of urinary catheter obstruction.

COVERAGE AND PAYMENT RULES

General:

1. Urinary catheters and external urinary collection devices are covered to drain or collect urine for a patient who has permanent urinary incontinence or permanent urinary retention. Permanent urinary retention is defined as retention that is not expected to be medically or surgically corrected in the patient within 3 months.
2. If the catheter or the external urinary collection device meets the coverage criteria then the related supplies that are necessary for their effective use are also covered. Urological supplies that are not used with, or for which use is not related to the covered use of catheters or external urinary collection devices (i.e., drainage and/or collection of urine from the bladder) will be denied as non-covered.
3. The patient must have a permanent impairment of urination. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgement of the attending physician, indicates the condition is of long and indefinite duration (ordinarily at least 3 months), the test of permanence is considered met. Catheters and related supplies will be denied as non-covered in situations in which it is expected that the condition will be temporary.
4. The use of a urological supply for the treatment of chronic urinary tract infection or other bladder condition in the absence of permanent urinary incontinence or retention is non-covered. Since the patient's urinary system is functioning, the criteria for coverage under the prosthetic benefit provision are not met.

5. The medical necessity for use of a greater quantity of supplies than the amounts specified in the policy must be well documented in the patient's medical record and provided to the Intermediary upon request.

Indwelling Catheters (A4311-A4316, A 4338-A4346)

1. No more than one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity, such as for the following indications:
    a. catheter is accidentally removed (e.g., pulled out by patient)
    b. malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter)
    c. catheter is obstructed by encrustation, mucous plug, or blood clot
    d. history of recurrent obstruction or urinary tract infection for which it has been established that an acute event is prevented by a scheduled change at intervals of less than once per month
2. When a specialty indwelling catheter (A4340) or an all silicone catheter (A4344, A4312 or A4315) is used, there must be documentation in the patient's medical record of the medical necessity for that catheter rather than a straight Foley type catheter with coating (such as recurrent encrustation, inability to pass a straight catheter, or sensitivity to latex). This documentation may be requested by the Intermediary. If documentation is requested and does not substantiate medical necessity, payment will be made based on the least costly medically appropriate alternative (A4338, A4311 or A4314, respectively).
3. A three-way indwelling catheter either alone (A4346) or with other components (A4313 or A4316) will be covered only if continuous catheter irrigation is medically necessary (refer to the section **Continuous Irrigation of Indwelling Catheter** for indications for continuous catheter irrigations). In other situations, payment will be based on the least costly medically appropriate alternative (A4338, A4311 or A4314 respectively).

Catheter Insertion Tray (A4310-A4316, A4353, A4354)

1. One insertion tray will be covered per episode of indwelling catheter insertion. More than one tray per episode will be denied as not medically necessary.
2. One intermittent catheter with insertion supplies (A4353) will be covered per episode of medically necessary ***sterile*** intermittent catheterization (see below). Catheter insertion trays will be denied as not medically necessary for clean, non-sterile intermittent catheterization.

3. Insertion trays that contain component parts of the urinary collection system (e.g., drainage bags and tubing) are inclusive sets and payment for additional component parts will be allowed only per the stated criteria in each section of the policy.

Urinary Drainage Collection System (A4314-A4316, A4354, A4357, A4358, A5102, A5112)

Payment will be made for routine changes of the urinary drainage collection system as noted below. Additional charges will be allowed for medically necessary non-routine changes when the documentation substantiates the medical necessity (e.g., obstruction, sludging, clotting of blood or chronic, recurrent urinary tract infection).

Usual Maximum Quantity of Supplies

Code	#/mo.	#/3 mo.
A4314	1	-
A4315	1	-
A4316	1	-
A4354	1	-
A4357	2	-
A4358	2	-
A5102	-	1
A5112	1	-

1. Leg bags are indicated for patients who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden patients would be denied as not medically necessary.
2. If there is a catheter change (A4314-A4315, A4354) and an additional drainage bag (A4357) change within a month, the combined utilization for A4314-A4316, A4354 and A4357 should be considered when determining if additional documentation should be submitted with the claim. For example, if 1 unit of A4314 and 1 unit of A4357 is provided, this should be considered as two drainage bags, which is the usual maximum quantity of drainage bags needed for routine changes.
3. Payment will be made for either a vinyl leg bag (A4358) or a latex leg bag (A5112). The use of both is not medically necessary.

4. The medical necessity for drainage bags containing gel matrix or other material which are intended to be disposed of on a daily basis has not been established. Payment for this type of bag will be based on the allowance and usual frequency of change for the least costly medically appropriate alternative, code A4357.

Intermittent Irrigation of Indwelling Catheter

1. Supplies for the intermittent irrigation of an indwelling catheter are covered when they are used on an as needed (non-routine) basis in the presence of acute obstruction of the catheter. Routine intermittent irrigations of a catheter will be denied as not medically necessary. Routine irrigations are defined as those performed at predetermined intervals. In individual cases, the Intermediary may request a copy of the order for irrigation and documentation in the patient's medical record of the presence of acute catheter obstruction when irrigation supplies are billed.
2. Covered supplies for medically necessary non-routine irrigation of a catheter include either an irrigation tray (A4320) or an irrigation syringe (A4322), and sterile saline (A4323) or sterile water (K0409). When syringes, trays, sterile saline or water are used for routine irrigation, they will be denied as not medically necessary. Irrigation solutions containing antibiotics and chemotherapeutic agents (9270) will be denied as non-covered. Irrigating solutions such as acetic acid or hydrogen peroxide that are used for the treatment or prevention or urinary obstruction (A4321) will be denied as not medically necessary.
3. Irrigation supplies that are used for care of the skin or perineum of incontinent patients are non-covered.

Continuous Irrigation of Indwelling Catheter

1. Supplies for continuous irrigation of a catheter are covered if there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes. Continuous irrigation as a primary preventive measure (i.e., no history of obstruction) will be denied as not medically necessary. Documentation must substantiate the medical necessity of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation. The records must also indicate the rate of solution administration and the duration of need. This documentation may be requested by the Intermediary.
2. Covered supplies for medically necessary continuous bladder irrigation include a 3-way Foley catheter (A4313, A4316, A4346), irrigation tubing set (A4355), and sterile saline (A4323) or sterile water (K0409). More than one irrigation tubing set per day for continuous catheter irrigation will be denied as not medically necessary.

3. Irrigation solutions containing antibiotics and chemotherapeutic agents (A9270) will be denied as non-covered. Payment for irrigating solutions such as acetic acid or hydrogen peroxide will be based on the allowance for sterile water (K0409) or sterile saline (A4323).

4. Continuous irrigation is a temporary measure. Continuous irrigation for more than 2 weeks is rarely medically necessary. The patient's medical records should indicate this medical necessity and these medical records made available to the Intermediary upon request.

Intermittent Catheterization

1. Intermittent catheterization is covered when basic coverage criteria are met and the patient or caregiver can perform the procedure. When clean, non-sterile catheterization technique is used, Medicare will cover replacement of intermittent catheters (A4351-A4352) on a weekly basis unless there is documentation of the medical necessity for more frequent replacement. Non-sterile lubricating gel (A4402) would be covered for use with ***clean*** non-sterile catheterization technique. Eight units of service (8 oz.) would be covered per month. An individual packet of lubricant (K0281) is not medically necessary for clean, non-sterile intermittent catheterization.

2. Intermittent catheterization using sterile technique is covered when:

    a. the patient resides in a nursing facility, ***or***

    b. the patient has had recurrent urinary tract infections with pyuria ***and*** fever and, in the judgement of the beneficiary's physician, sterile technique is indicated. Pyuria and/or bacteriuria by themselves are not diagnostic of a clinically significant urinary infection in a catheterized patient

3. For each episode of covered ***sterile*** catheterization, Medicare will cover:

    a. one catheter (A4351, A4352) and an individual packet of lubricant (K0281), ***or***

    b. an intermittent catheter kit (A4353). See ***DEFINITIONS*** for contents of the kit.

    The kit code should be used for billing even if the components are packaged separately rather than together as a kit. If sterile catheterization is not medically necessary, sterile supplies will be denied as not medically necessary.

4. When a Coude (curved) tip catheter (A4352) is used, there must be documentation in the patient's medical record of the medical necessity for that catheter rather than a straight tip catheter (A4351). An example would be the inability to catheterize with a straight tip catheter. This documentation may be requested by the Intermediary. If documentation is requested and does not substantiate medical necessity, payment will be based on the least costly medically appropriate alternative – A4351.

External Catheters/Urinary Collection Devices

1. Male external catheters (condom-type) or female external urinary collection devices are covered for patients who have permanent urinary incontinence when used as an alternative to an indwelling catheter.
2. The utilization of male external catheters (K0410) or K0411) generally should not exceed 35 per month. Greater utilization of these devices must be accompanied by documentation of medical necessity.
3. Adhesive strips or tape used with code K0411 (male external catheter, with adhesive strip, each) are included in the allowance for that code and are not separately payable by the Intermediary. If adhesive strips or tape are used with code K0410 (male external catheter, with adhesive coating, each), payment will be denied as not medically necessary.
4. Male external catheters (condom-type) or female external urinary collection devices will be denied as not medically necessary when ordered for patients who also use an indwelling catheter.
5. Specialty type male external catheters such as those that inflate or that include a faceplate (A4326) are covered only when documentation substantiates the medical necessity for such a catheter. Payment will be based on the least costly medically appropriate alternative if documentation does not substantiate medical necessity.
6. For female external urinary collection devices, more than one meatal cup (A4327) per week or more than one pouch (A4328) per day will be denied as not medically necessary.

Miscellaneous Supplies

1. Appliance cleaner (A5131) is covered when used to clean the inside of certain urinary collecting appliances (A5102, A5112). More than one unit of service (16 oz.) per month is rarely medically necessary.
2. One external urethral clamp or compression device (A4356) is covered every 3 months or sooner if the rubber/foam casing deteriorates.
3. Tape (A6265) that is used to secure an indwelling catheter to the patient’s body is covered. More than 10 units (1 unit = 18 sq. in.; 10 units = 180 sq. in. = 5 yds. of 1 inch tape) per month will be denied as not medically necessary unless the claim is accompanied by documentation justifying a larger quantity in the individual case.
4. Adhesive catheter anchoring devices (K0407) and catheter leg straps (K0408) are covered. More than 3 per week of K0407 or 1 per month of K0408 will be denied as not medically necessary unless the claim is accompanied by documentation justifying a larger quantity in the individual case.
5. Extension tubing (K0280) will be covered for use with a latex urinary leg bag (A5112). It is included in the allowance for codes A4314,

A4315, A4316, A4354, A4357, A4358 and A5105 and should not be separately billed with these codes.

6. Other supplies used in the management of incontinence, including but not limited to the following items, will be denied as non-covered because they are not prosthetic devices nor are they required for the effective use of a prosthetic device:
   a. creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250).
   b. Drainage bag or stand (A9270).
   c. Urinary suspensory without leg bag (A4359).
   d. Measuring container (A9270).
   e. Urinary drainage tray (A9270).
   f. Gauze pads (A6216-A6218) and other dressings (coverage remains under other benefits, e.g., surgical dressings).
   g. Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270).

CODING GUIDELINES

1. Procedure codes A4347 and K0132 are not valid for claims submitted to the Intermediary. When billing for male external catheters, use code K0410 or K0411 and one unit of service for each catheter supplied.
2. Irrigation solutions containing antibiotics and chemotherapeutic agents should be coded A9270.
3. Irrigating solutions such as acetic acid or hydrogen peroxide that are used for the treatment or prevention of urinary obstruction should be coded A4321.
4. Adhesive strips or tape used with code K0411 (male external catheter, with adhesive strip, each) should not be billed separately.
5. Adhesive strips and tape used in conjunction with code K0410 (male external catheter, with adhesive coating, each) should be billed with code A4335.
6. Procedure code A4329 is not valid for claim submission to the Intermediary. Components should be billed by individual codes.
7. Code A4454 (tape, all types, all sizes) is not valid for claim submission to the Intermediary. Code A6265 should be used instead.
8. Code A5149 is not valid for claims submitted to the Intermediary. Use code A4335 for miscellaneous incontinence supplies.
9. An external catheter that contains a barrier for attachment should be coded using A4335.

10. Codes A5113 and A5114 are for replacement leg straps used with a urinary leg bag (A4358, A5105 or A5112). These codes are not used for a leg strap for an indwelling catheter.

11. Codes for ostomy barriers (A5119, K0137-K0139) should not be used for skin care products used in the management of urinary incontinence.

12. In the following table, the Column I code includes the items identified by the codes in Column II. The Column I code must be used instead of multiple Column II codes when the items are provided at the same time.

COLUMN I	***COLUMN II***
A4310	K0281
A4311	A4310, A4338, K0281
A4312	A4310, A4344, K0281
A4313	A4310, A4344, K0281
A4314	A4310, A4311, A4338, A4354, A4357, K0280, K0281
A4315	A4310, A4312, A4344, A4354, A4357, K0280, K0281
A4316	A4310, A4313, A4346, A4354, A4357, K0280, K0281
A4353	A4310, A4351, A4352, K0281
A4354	A4310, A4357, K0280, K0281
A4357	K0280
A4358	A5113, A5114, K0280
A5112	A5113, A5114
A5105	A4358, A4359, A5112, A5113, A5114, K0280
K0411	A6265

13. If a code exists that includes multiple products, that code should be used in lieu of the individual codes.

DOCUMENTATION REQUIRED

1. An order for the supplies that has been signed and dated by the treating physician must be kept on file by the provider. The order must include the type of supplies ordered and the approximate quantity to be used per unit of time. On the order, there must be a statement indicating whether the patient has permanent or temporary urinary incontinence or retention or other indication for use of a catheter or urinary collection device.
2. If a provider is billing for items that are non-covered, this must be indicated on the claim. A letter of non-coverage (HINN) must be signed by the patient and kept in the patient's medical records. This information should be available to the Intermediary upon request.
3. When billing for quantities of supplies greater than those described in the policy as the usual replacement frequency (e.g., more than one indwelling catheter per month, more than two bedside drainage bags per month, more than 35 male external catheters per months, etc.), the patient's medical record must include documentation supporting medical necessity for the higher utilization, and the documentation provided to the Intermediary upon request.
4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Walkers

HCPCS CODES

A4636	Replacement, handgrip, cane, crutch, or walker, each
A4637	Replacement tip, cane, crutch, or walker, each
E0130	Walker, rigid (pickup), adjustable or fixed height
E0135	Walker, folding (pickup), adjustable or fixed height
E0141	Walker, wheeled, without seat
E0142	Rigid walker, wheeled, with seat
E0143	Folding walker, wheeled, without seat
E0145	Walker, wheeled, with seat and crutch attachments
E0146	Folding walker, wheeled, with seat
E0147	Heavy duty, multiple braking system, variable wheel resistance walker
E0154	Platform attachment, walker, each
E0155	Wheel attachment, rigid pickup walker
E0156	Seat attachment, walker
E0157	Crutch attachment, walker, each
E0158	Leg extension for a walker
E0159	Brake attachment for wheeled walker, replacement, each

K0458	Heavy duty walker, without wheels, each
K0459	Heavy duty wheeled walker, each

HCPCS MODIFIER

ZX	Specific requirements found in the ***DOCUMENTATION REQUIRED*** section of this policy have been met and evidence is available in the patient's medical record

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCES

HCFA Pub. 6, Coverage Issues Manual 60-9, 60-15

DEFINITIONS

1. A wheeled walker (E0141, E0143, K0459) is one with 2, 3 or 4 wheels. It may be fixed height or adjustable height. It may or may not include glide-type brakes (or equivalent). The wheels may be fixed or swivel.
2. A glide-type brake consists of a spring mechanism (or equivalent) that raises the leg post of the walker off the ground when the patient is not pushing down on the frame.
3. A heavy-duty walker (K0458, K0459) is one that is labeled as capable of supporting patients who weigh more than 300 pounds. It may be fixed height or adjustable height. It may be rigid or folding.
4. Code E0147 describes a 4-wheeled, adjustable height, folding walker that has all of the following characteristics:
    a. Capable of supporting patients who weigh greater than 350 pounds
    b. Hand operated brakes that cause the wheels to lock when the hand levers are released
    c. The hand brakes can be set so that either or both can lock both wheels
    d. The pressure required to operate each hand brake is individually adjustable
    e. There is an additional braking mechanism on the front crossbar

f. At least two wheels have brakes that can be independently set through tension adjustability to give varying resistance

5. An enhancement accessory is one that does not contribute significantly to the therapeutic function of the walker. It may include, but is not limited to style, color, hand operated brakes (other than those described in code E0147), or basket (or equivalent).

COVERAGE AND PAYMENT RULES

1. A walker is covered if both of the following criteria are met:

   a. when prescribed by a physician for a patient with a medical condition impairing ambulation and there is a potential for ambulation; and

   b. when there is a need for greater stability and security than provided by a cane or crutches

   2. A heavy-duty walker (K0458, K0459) is covered for patients who meet coverage criteria for a standard walker and who weigh more than 300 pounds. If a K0458 or K0459 walker is provided and the patient does not weigh more than 300 pounds (i.e., ZX modifier is absent – see ***DOCUMENTATION REQUIRED***) but does not meet coverage criteria for a standard walker, payment will be based on the allowance for the least costly medically appropriate alternative, E0135 or E0143 respectively.

   3. A heavy-duty, multiple braking system, variable wheel resistance walker (E0147) is covered for patients who meet coverage criteria for a standard walker ***and*** who are unable to use a standard walker due to a severe neurologic disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not a sufficient reason for an E0147 walker. If an E0147 walker is provided and the coverage criteria for a standard walker are met but the additional coverage criteria for an E0147 are not met, payment will be based on the allowance for the least costly medically appropriate alternative, E0143 or K0459 depending on the patient’s weight.

CODING GUIDELINES

1. The only walkers that may be coded and billed using code E0147 are those products for which a written coding determination letter dated on or after April 1, 1998 specifying the use of this code has been made by the Statistical Analysis Data Medical Equipment Regional Carrier (SADMERC).

2. Codes E0142, E0145 and E0146 are invalid for claim submission to the Intermediary. For walkers with a seat and/or crutch attachment, use codes for individual accessories (E0156, E0157) along with a base

walker code. For example, a folding wheeled walker ***with*** a seat is billed as E0143 plus E0156.

3. A4636 and E0159 are only used to bill for replacement items for covered, patient-owned walkers.
4. A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

Column I Codes	Column II Codes
E0130	A4636, A4637
E0135	A4636, A4637
E0141	A4636, A4637, E0130, E0155, E0159
E0142	A4636, A4637, E0155, E0156, E 159
E0143	A4636, A4637, E0159
E0146	A4636, A4637, E0143, E0156, E0159
E0147	A4636, E0155, E0159
K0458	A4636, A4637
K0459	A4636, A4637, E0155, E0159

DOCUMENTATION REQUIRED

1. If a heavy duty walker (K0458, K0459) is provided and if the provider has documentation in the medical record that the patient's weight (within one month of providing the walker) is greater than 300 pounds, the ZX modifier should be added to the code. The ZX modifier may only be used when these requirements are met.
2. If code E0147 is billed, the claim must be submitted hard copy and include the manufacturer's name, the model name/number, and a copy of a note or other documentation from the treating physician giving a detailed description of the functional limitations which preclude the patient using another type of wheeled walker and the diagnosis causing this limitation.
3. When code E1399 is billed for miscellaneous equipment or accessories, the claim must be accompanied by a clear description of the item including the manufacturer, the model/name/number if applicable and the medical necessity of the item for that patient.

4. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Manual Wheelchair Base

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

K0001	Standard wheelchair
K0002	Standard hemi(low seat) wheelchair
K0003	Lightweight wheelchair
K0004	High strength, lightweight wheelchair
K0005	Ultra-lightweight wheelchair
K0006	Heavy duty wheelchair
K0007	Extra heavy duty wheelchair
K0008	Custom manual wheelchair/base
K0009	Other manual wheelchair/base

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-6, 60-9

DEFINITIONS

1. A standard wheelchair (K0001) is characterized by:

Weight	> 36 lbs.
Seat width	16″ (narrow), 18″ (adult)
Seat depth	16″
Seat height	≥ 19″ and ≤ 21″

Back height	Nonadjustable 16″-17″
Arm style	Fixed or detachable
Footplate extension	16″-21″
footrests	Fixed or swingaway detachable

2. A standard hemi (low seat) wheelchair (K0002) is characterized by:

Weight	> 36 lbs.
Seat width	16″ (narrow), 18″ (adults)
Seat depth	16″
Seat height	17″-18″
Back height	Nonadjustable 16″-17″
Arm style	Fixed or detachable
Footplate extension	14″-17½ “
Footrests	Fixed or swingaway detachable

3. A lightweight wheelchair (K0003) is characterized by:

Weight	≤ 36 lbs.
Seat width	16″ or 18″
Seat depth	16″
Seat height	≥ 17″ and < 21″
Back height	Nonadjustable 16″-17″
Arm height	Fixed height, detachable
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable

4. A high strength, lightweight wheelchair (K0004) is characterized by:

Lifetime warranty	On side frames and crossbraces
Weight	< 34 lbs.
Seat height	≥ 17″ and < 21″
Back height	Sectional or adjustable 15″-19″
Arm style	Fixed or detachable
Seat width	14″, 16″ or 18″
Seat depth	14″ (child), 16″ (adult)
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable

5. An ultra-lightweight wheelchair (K0005) is characterized by:

Lifetime warranty	On side frames and crossbraces
Weight	< 30 lbs.
Adjustable rear axle position:	
Seat depth	14″ (child), 16″ (adult)
Seat width	14″, 16″ or 18″
Seat height	≥ 17″ and < 21″
Arm style	Fixed or detachable
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable

6. A heavy duty wheelchair (K0006) is characterized by:

Seat width	18″
Seat depth	16″ or 17″

Seat height	> 19″ and < 21″
Back height	Nonadjustable 16″-17″
Arm style	Fixed height, detachable
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable
Reinforced back and seat upholstery can support patient weighing	> 250 lbs.

7. An extra heavy duty wheelchair (K0007) is characterized by:

Seat width	18″
Seat depth	16″ or 17″
Seat height	> 19″ and < 21″
Back height	Nonadjustable 16″-17″
Arm style	Fixed height, detachable
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable
Reinforced back and seat upholstery can support patient weighing	> 300 lbs.

8. Wheelchair “poundage” (lbs.) represents the weight of the usual configuration of the wheelchair without front riggings.
9. A custom manual wheelchair base (K0008) is one which has been uniquely constructed or substantially modified for a specific beneficiary and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes.
10. The assembly of a wheelchair from modular components does not meet the requirements of a custom wheelchair base for payment purposes.

11. The use of customized options or accessories does not result in the wheelchair base being considered as custom.
12. There must be customization of the frame for the wheelchair base to be considered customized.

COVERAGE AND PAYMENT RULES

1. A wheelchair is covered if the patient's condition is such that without the use of a wheelchair, he would otherwise be bed or chair confined. An individual may qualify for a wheelchair and still be considered bed confined. This basic requirement must be met for coverage of any wheelchair.
2. An upgrade that is beneficial primarily in allowing the patient to perform leisure or recreational activities will be non-covered. Payment will be based on the allowance for the least costly medically acceptable alternative.
3. Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary. One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired.
4. Reimbursement for wheelchair codes includes all labor charges involved in the assembly of the wheelchair. Reimbursement also includes support services such as emergency services, delivery, set-up, education, and on-going assistance with use of the wheelchair.
5. A standard hemi-wheelchair (K0002) is covered when the patient requires a lower seat height (17″ to 18″) because of short stature or to enable the patient to place his/her feet on the ground for propulsion.
6. A lightweight wheelchair (K0003) is covered when a patient:
   a. cannot self-propel in a standard wheelchair using arms and/or legs, ***and***
   b. the patient can and does self-propel in a lightweight wheelchair.
7. A high strength lightweight wheelchair (K0004) is covered when a patient meets the following criteria (a ***and/or*** b):
   a. the patient self-propels the wheelchair while engaging in frequent activities that cannot be performed in a standard or lightweight wheelchair.
   b. the patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours per day in the wheelchair.
8. A high strength lightweight wheelchair is rarely medically necessary if the expected duration of need is less than three months (e.g., post-operative recovery).

9. Coverage of an ultra-lightweight wheelchair (K0005) is determined on an individual consideration basis.
10. If a K0005 wheelchair base is determined to be not medically necessary but criteria are met for a less costly wheelchair, payment will be based on the least costly alternative (K0001-K0004). However, since K0005 is in a different payment category it will be denied as not medically necessary if billed as a purchase.
11. A heavy-duty wheelchair (K0006) is covered if the patient weighs more than 250 pounds or the patient has severe spasticity.
12. An extra heavy-duty wheelchair (K0007) is covered if the patient weighs more than 300 pounds.
13. A custom wheelchair base (K0008) is covered only if the feature needed is not available as an option to an already manufactured base.
14. When the stated coverage criteria relating to medical necessity are not met, a claim will be considered for coverage if there is additional documentation which justifies the medical necessity for the item in the individual case. If the documentation does not support the medical necessity of the wheelchair that is billed, but does support the medical necessity of a lower level wheelchair, payment will be based on the allowance for the least costly medically acceptable alternative.

CODING GUIDELINES

1. Codes E1050-E1060, E1070-E1200, E1220-E1224, E1240-E1295 should only be used to bill for maintenance and service for an item for which the initial claim was paid by the Intermediary.
2. For wheelchair bases not on the list, providers should use their knowledge of the product and the information listed under ***DEFINITIONS*** to determine the correct code or call the Medicare Part A Service Center.
3. A product classification list for wheelchair bases is provided in the Wheelchair Options/Accessories Part A DME policy.

DOCUMENTATION REQUIRED

1. A certificate of medical necessity or an order that has been filled out, signed, and dated by the ordering physician, must be kept on file by the provider. The Certificate of Medical Necessity for manual wheelchairs is HCFA Form 844.
2. For claims with K0005 billed, the following must be documented in the patient’s medical record and made available to the Intermediary upon request:
    a. a description of the patient’s routine activities. This may include what types of activities the patient frequently

encounters, and whether the patient is fully independent in the use of the wheelchair.

b. List the manufacturer and model name of the wheelchair base.

c. Describe the features of the K0005 base which are needed compared to the K0004 base.

3. For claims with codes K0008 and K0009 billed, the following must be included in the patient's medical record and made available to the Intermediary upon request:

a. the brand name and model name/number of the base

b. a statement documenting the medical necessity of this base for the particular patient including why another base (K0001-K0007) was not acceptable

c. If it is a customized base (K0008), the statement must also clearly describe what was customized.

4. Documentation for individual consideration might include:

a. information on the patient's diagnosis

b. the patient's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence

d. frequency, and nature of the activities the patient performs, etc.)

e. the duration of the condition

f. the expected prognosis

g. past experience using similar equipment

5. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

Note: If there is a need for an extra wide wheelchair, but the patient does not meet the weight requirement for a heavy duty chair, code K0001 (standard wheelchair) or K0002 (standard Hemi wheelchair) should be used for the base and code K0108 should be used to bill the extra width option. The difference in the charge for a heavy-duty wheelchair and a standard wheelchair should be listed as the submitted charge for the K0108.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Motorized/Power Wheelchair Base

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

K0010	Standard-weight frame motorized/power wheelchair
K0011	Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking
K0012	Lightweight portable motorized/power wheelchair
K0013	Custom motorized/power wheelchair base
K0014	Other motorized/power wheelchair base

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-6, 60-9

DEFINITIONS

1. Motorized/power wheelchairs (K0010, K0011, K0012) are characterized by:

Seat width	14″-18″
Seat depth	16″
Seat height	≥ 19″ and ≤ 21″
Back height	Sectional 16″ or 18″

Arm style	Fixed height, detachable
Footplate extension	16″-21″
Footrests	Fixed or swingaway detachable

2. A lightweight power wheelchair (K0012) is characterized by:

Weight	< 80 lbs. without battery	Folding back or collapsible frame

3. Wheelchair "poundage" (lbs.) represents the weight of the usual configuration of the wheelchair without front riggings
4. A custom power wheelchair base (K0013) is one which has been uniquely constructed or substantially modified for a specific beneficiary and is so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes. The assembly of a wheelchair from modular components does not meet the requirement of a custom wheelchair base for payment purposes. The use of customized options or accessories does not result in the wheelchair base being considered as custom. There must be customization of the frame motorized/power wheelchair base for the wheelchair base to be considered customized.

COVERAGE AND PAYMENT RULES

1. A power wheelchair is covered when ***all*** of the following criteria are met:
   a. the patient's condition is such that without the use of a wheelchair the patient would otherwise be bed or chair confined.
   b. the patient's condition is such that a wheelchair is medically necessary and the patient is unable to operate a wheelchair manually.
   c. the patient is capable of safely operating the controls for the power wheelchair.
2. A patient who requires a power wheelchair usually is totally nonambulatory and has severe weakness of the upper extremities due to a neurologic or muscular disease/condition.
3. If the documentation does not support the medical necessity of a power wheelchair but does support the medical necessity of a manual wheelchair, payment is based on the allowance for the least costly medically appropriate alternative. However, if the power wheelchair has been purchased, and the manual wheelchair on which payment is based in the capped rental category, the power wheelchair will be denied as not medically necessary.

4. Options that are beneficial primarily in allowing the patient to perform leisure or recreational activities are non-covered.
5. A custom wheelchair base (K0014) is covered only if the feature needed is not available as an option in an already manufactured base.
6. A power wheelchair is covered if the patient's condition is such that the requirement for a power wheelchair is long term (at least six months).
7. Payment is made for only one wheelchair at a time. Backup chairs are denied as not medically necessary. One month's rental of a wheelchair is covered if a patient-owned wheelchair is being repaired.
8. Reimbursement for the wheelchair codes ***includes*** all labor charges involved in the assembly of the wheelchair and all covered additions or modifications. Reimbursement also ***includes*** support services, such as emergency services, delivery, set-up, education, and on-going assistance with use of the wheelchair.

CODING GUIDELINES

1. Codes K0010-K0014 are not used for manual wheelchairs with add-on power packs. Use the appropriate code for the manual wheelchair base provided (K0001-K0009) and code K0108 for the add-on power pack (see Wheelchair Options/Accessories Part A DME policy for additional information).
2. Codes E1210-E1220 should only be used to bill for maintenance and service for an item for which the initial claim was paid by the Intermediary.
3. For wheelchair bases not on the list, providers should use their knowledge of the product and the information in the ***DEFINITIONS*** section of this policy to determine the correct code.
4. A product classification list for wheelchair bases is provided in the Wheelchair Options/Accessories Part A DME policy.

DOCUMENTATION REQUIRED

1. A certificate of medical necessity or an order that has been filled out, signed and dated by the ordering physician, must be kept on file by the provider. The Certificate for Medical Necessity for wheelchairs is HCFA Form 843.
2. When billing K0013 or K0014, the claim must include documentation indicating the brand name and model name/number of the base, and a statement documenting the medical necessity of this base for the particular patient including why another base (K0010-K0012) was not acceptable. If it is a customized base (K0013), the statement must also clearly describe what was customized.
3. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy

PART A DURABLE MEDICAL EQUIPMENT POLICY
PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
Medicare Review Policy: Public Information

SUBJECT

Wheelchair Options/Accessories

HCPCS CODES

The appearance of a code in this section does not necessarily indicate coverage.

Arm of Chair

K0015	Detachable, non-adjustable height armrest, each
K0016	Detachable, adjustable height armrest, complete assembly each
K0017	Detachable, adjustable height armrest, base, each
K0018	Detachable, adjustable height armrest, upper portion, each
K0019	Arm pad, each
K0020	Fixed, adjustable height armrest, pair
L3964	Shoulder Elbow Orthosis, mobile arm support attached to wheelchair, balanced, adjustable
L3965	SEO, mobile arm support attached to wheelchair, balanced, adjustable Rancho type
L3966	SEO, mobile arm support attached to wheelchair, balanced, reclining
L3968	SEO, mobile arm support attached to wheelchair, balanced, friction arm support (friction dampening to proximal and distal joints)

L3969	SEO, mobile arm support, monosuspension arm and hand support, overhead elbow forearm hand sling support, yoke type arm suspension support
L3970	SEO, addition to mobile arm support, elevating proximal arm
L3972	SEO, addition to mobile arm support, offset or lateral rocker arm with elastic balance control
L3974	SEO, addition to mobile arm support, supinator

Back of Chair

K0021	Anti-tipping device, each
K0022	Reinforced back upholstery
K0023	Solid back insert, planar back, single density foam, attached with straps
K0024	Solid back insert, planar back, single density foam, with adjustable hook-on hardware
K0025	Hook-on headrest extension
K0026	Back upholstery for ultralightweight or high strength lightweight wheelchair
K0027	Back upholstery for wheelchair type other than ultralightweight or high strength lightweight wheelchair
K0028	Fully reclining back
K0114	Back support system for use with a wheelchair, with inner frame, prefabricated

K0115	Seating system, back module, posterior-lateral control, with or without lateral supports, custom fabricated for attachment to wheelchair base
K0116	Seating system, combined back and seat module, custom fabricated for attachment to wheelchair base

Seat

E0192	Low pressure and positioning equalization pad, for wheelchair
E0962	1″ cushion, for wheelchair
E0963	2″ cushion, for wheelchair
E0964	3″ cushion, for wheelchair
E0965	4″ cushion, for wheelchair
K0029	Reinforced seat upholstery
K0030	Solid seat insert, planar seat, single density foam
K0031	Safety belt/pelvic strap
K0032	Seat upholstery for ultralightweight or high strength lightweight wheelchair
K0033	Seat upholstery for wheelchair type other than ultralightweight or high strength lightweight wheelchair

Footrest/Leg rest

K0034	Heel loop, each
K0035	Heel loop with ankle strap, each
K0036	Toe loop, each
K0037	High mount flip-up footrest, each

K0038	Leg strap, each
K0039	Leg strap, H style, each
K0040	Adjustable angle footplate, each
K0041	Large size footplate, each
K0042	Standard size footplate, each
K0043	Footrest, lower extension tube, each
K0044	Footrest, upper hanger bracket, each
K0045	Footrest, complete assembly
K0046	Elevating leg rest, lower extension tube, each
K0047	Elevating leg rest, upper hangar bracket, each
K0048	Elevating leg rest, complete assembly
K0049	Calf pad, each
K0050	Ratchet assembly
K0051	Cam release assembly, footrest or leg rest, each
K0052	Swingaway, detachable footrests, each
K0053	Elevating footrests, articulating (telescoping), each
K0195	Elevating leg rests, pair (for use with capped rental wheelchair base)

Seat Width, Depth, Height

K0054	Seat width of 10″, 11″, 12″, 15″, 17″, or 20″ for a high strength, lightweight or ultralightweight wheelchair
K0055	Seat depth of 15″, 17″, or 18″ for a high strength, lightweight or ultralightweight wheelchair

K0056	Seat height < 17″ ***or*** ≥ 21″ for a high strength, lightweight or ultralightweight wheelchair
K0057	Seat width 19″ or 20″ for heavy duty or extra heavy duty chair
K0058	Seat depth 17″ or 18″ for motorized/power wheelchair

Handrims without Projections

K0059	Plastic coated handrim, each
K0060	Steel handrim, each
K0061	Aluminum handrim, each

Handrims with Projections

K0062	Handrim with 8-10 vertical or oblique projections, each
K0063	Handrim with 12-16 vertical or oblique projections, each

Rear Wheels, Manual Wheelchair

K0064	Zero pressure tube (flat free inserts), any size, each
K0065	Spoke protectors
K0066	Solid tire, any size, each
K0067	Pneumatic tire, any size, each
K0068	Pneumatic tire tube, each
K0069	Rear wheel assembly, complete, with solid tire, spokes or molded, each
K0070	Rear wheel assembly, complete, with pneumatic tire, spokes or molded, each

Front Casters

K0071	Front caster assembly, complete, with pneumatic tire, each
K0072	Front caster assembly, complete, with semi-pneumatic tire, each
K0073	Caster pin lock, each
K0074	Pneumatic caster tire, any size, each
K0075	Semi-pneumatic caster tire, any size, each
K0076	Solid caster tire, any size, each
K0077	Front caster assembly, complete, with solid tire, each
K0078	Pneumatic caster tire tube, each

Wheel Lock

K0079	Wheel lock extension, pair
K0080	Anti-rollback device, pair
K0081	Wheel lock assembly, complete, each

Batteries/Chargers for Motorized/Power Wheelchairs

K0082	22 NF deep cycle lead acid battery, each
K0083	22 NF gel cell battery, each
K0084	Group 24 deep cycle lead acid battery, each
K0085	Group 24 get cell battery, each
K0086	U-1 lead acid battery, each
K0087	U-1 gel cell battery, each
K0088	Battery charger, lead acid or gel cell

K0089	Battery charger, dual mode

Motorized/Power Wheelchair Parts

K0090	Rear wheel tire for power wheelchair, any size, each
K0091	Rear wheel tire tube other than zero pressure for power wheelchair, any size, each
K0092	Rear wheel assembly for power wheelchair, complete, each
K0093	Rear wheel zero pressure tire tube (flat free insert) for power wheelchair, any size, each
K0094	Wheel tire for power base, any size, each
K0095	Wheel tire tube other than zero pressure for each base, any size, each
K0096	Wheel assembly for power base, complete, each
K0097	Wheel zero pressure tire tube (flat free insert) for power base, any size, each
K0098	Drive belt for power wheelchair
K0099	Front caster for power wheelchair

Miscellaneous Accessories

K0100	Amputee adapter, pair
K0101	One-arm drive attachment
K0102	Crutch and cane holder
K0103	Transfer board, < 25”
K0104	Cylinder tank carrier
K0105	IV hanger
K0106	Arm trough, each

K0107	Wheelchair tray
K0108	Other accessories
K0452	Wheelchair bearings, any type

BENEFIT CATEGORY

Durable Medical Equipment

REFERENCE

HCFA Pub. 6, Coverage Issues Manual 60-6, 60-9

DEFINITIONS

Code K0114 describes a device with the following characteristics:

1. Plastic frame which is padded and covered with cloth, or other material.
2. Designed to be attached to a wheelchair base; doesn't completely replace the wheelchair back.
3. Limited degree of custom fitting/molding possible.

Codes K0115 and K0116 describe custom fabricated seating components that are incorporated into a wheelchair base. Custom fabricated means the item is individually made for a patient using:

   a. a plaster model of the patient
   b. a computer generated model of the patient (CAD-CAM technology), ***or***
   c. detailed measurements of the patient used to create a carved foam custom fabricated component

4. These codes are ***not*** used for seating components that are ready made but subsequently modified to fit an individual patient. In addition, code K0116 describes a ***one-piece*** system including both the back and seat components.

COVERAGE AND PAYMENT RULES

1. Options and accessories for wheelchairs are covered if ***all*** of the following criteria are met:
   a. the patient has a wheelchair that meets Medicare coverage criteria, ***and***
   b. the patient's condition is such that without the use of a wheelchair, he would otherwise be bed or chair confined (an

individual may qualify for a wheelchair and still be considered bed confined, ***and***

c. the options/accessories are necessary for the patient to perform ***one or more*** of the following activities:

- function in the home
- perform instrumental activities of daily living

2. An option/accessory that is beneficial primarily in allowing the patient to perform leisure or recreational activities is non-covered.
3. Adjustable arm height option (K0016-K0018, K0020) is covered if the patient requires an arm height that is different than that available using nonadjustable arms ***and*** the patient spends at least two hours per day in the wheelchair.
4. Reinforced back upholstery (K0022) or reinforced seat upholstery (K0029) is covered if used with a power wheelchair base (K0010-K0012) ***and*** the patient weighs more than 200 pounds. When used in conjunction with heavy-duty (K0006) or extra heavy-duty (K0007) wheelchair bases, the allowance for reinforced upholstery is included in the allowance for the wheelchair base.
5. Reinforced back and seat upholstery are not medically necessary if used in conjunction with other manual wheelchair bases (K0001-K0005).
6. Hook-on headrest extension (K0025) is covered if the patient:
   a. has weak neck muscles and needs a headrest for support, ***or***
   b. meets the criteria for and has a reclining back on the wheelchair
7. A fully reclining back option (K0028) is covered if the patient spends at least two hours per day in the wheelchair and has one or more of the following conditions/needs:
   a. Quadriplegia
   b. fixed hip angle
   c. trunk or lower extremity casts/braces that require the reclining back feature for positioning
   d. excess extensor tone of the trunk muscles
   e. the need to rest in a recumbent position two or more times during the day and transfer between wheelchair and bed is very difficult
8. A solid seat insert (K0030) is covered when the patient spends at least two hours per day in the wheelchair.

9. A safety belt/pelvic strap (K0031) is covered if the patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of this item for proper positioning.
10. Elevating leg rests (K0046-K0048, K0053, K0195) are covered if:
    a. the patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90° flexion at the knee; ***or***
    b. the patient has significant edema of the lower extremities that requires an elevating leg rest; ***or***
    c. the patient meets the criteria for and has a reclining back on the wheelchair
11. Swingaway, detachable footrests (K0052) are included in the allowance for the wheelchair base. They should be billed separately only when they are replacements.
12. A non-standard seat width, depth, or height (K0054-K0058) is covered only if:
    a. the ordered item is at least two inches greater than or less than a standard option, ***and***
    b. the patient's dimensions justify the need
13. Anti-rollback device (K0080) is covered if the patient self-propels the wheelchair and needs the device because of ramps.
14. Either a U-1 or 22 NF deep-cycle lead acid battery (K0082, K0086) provides adequate power for a power wheelchair. Up to two batteries at one time are allowed if required for the power wheelchair. A battery is separately payable form the wheelchair base. Group 24 or gel cell batteries (K0083-K0085, K0087) are usually not medically necessary. Unless there is individual documentation of medical necessity, payment is based on the allowance for the least costly medically appropriate alternative.
15. A battery charger (K0088, K0089) is included in the allowance for a power wheelchair base (K0010-K0014). A battery charger should be billed separately only when it is a replacement. A dual mode charger (K0089) is not medically necessary; when it is provided as a replacement, payment is based on the allowance for the least costly medically appropriate alternative, K0088.
16. A one-arm drive attachment (K0101) is covered if the patient self-propels the chair with only one hand and the need is expected to last at least six months.
17. A crutch and can holder (K0102) is not medically necessary.
18. An arm trough (K0106) is covered if the patient has quadriplegia, hemiplegia, or uncontrolled arm movements.

19. Back support systems described by code K0114 are not generally accepted as being reasonable and necessary to provide trunk support to patients in wheelchairs. An adequate seating system would allow the patient to function appropriately in the wheelchair. Code K0114 will be denied as not medically necessary.

20. A custom fabricated back module for seating (K0115, K0116) is covered when:

    a. the patient has a significant spinal deformity and/or severe weakness of the trunk muscles, ***and***

    b. the patient's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a prefabricated seating system, ***and***

    c. the patient is expected to be in the wheelchair at least two hours per day

21. The medical necessity for all options and accessories must be documented in the patient's medical record and be available to the Intermediary on request.

CODING GUIDELINES

1. Codes A4631, E0950-E0954, E0959, E0961, E0966, E0967, E0969-E1001, E1065-E1069, E1226, E1227, E1296-E1298 are not valid for claims submitted to the Intermediary. Codes E0958, E0968, E1225 and E1228 should only be used to bill for maintenance and service for an item for which the initial claim was paid by the Intermediary.

2. Attachment #1 is a table that defines the bundling guidelines for wheelchair bases and options/accessories. ***Codes listed in Column II are not separately payable from the wheelchair base and must not be billed separately at the time of initial purchase or rental of the wheelchair.***

3. It should be documented in the patient's medical record when options or accessories are billed as a replacement of a previously used part for the same type that has been worn or damaged, add modifier RP to the code for the part.

4. The right (RT) and left (LT) modifiers must be used when appropriate.

5. Code K0028 is for a fully reclining back which is manually operated. A power reclining back is coded using the miscellaneous accessory code K0108.

6. A prefabricated back seating module which is incorporated into a wheelchair base is coded using the wheelchair back accessory codes (K0023, K0024 or K0108).

7. Elevating leg rests that are used with a wheelchair that is purchased or owned by the patient are coded K0048. This code is per leg rest.

Elevating leg rests that are used with a capped rental wheelchair base should be coded K0195. This code is per pair of leg rests.

8. When a wheelchair is provided with seat dimensions that are different than those included in the wheelchair base code, use the code for the appropriate wheelchair base ***plus*** a code or codes for the nonstandard seat dimensions (K0054-K0058). Other combinations, which are listed in the manufacturer's order form or price list, should be coded K0108. The submitted charge for code K0108 should represent the incremental additional charge for the nonstandard dimensions not included in other submitted codes. If the seat dimensions needed for the patient are not listed on the manufacturer's order form or price list and require unique fabrication, than custom wheelchair base code (K0008 or K0013) may be used.
9. Miscellaneous options, accessories, or replacement parts for wheelchairs that do not have a specific HCPCS code should be coded K0108. If multiple miscellaneous accessories are provided, each should be billed on a separate claim line using code K0108. The patient's medical record should have documented the medical necessity for each item billed.
10. Seating systems in which distinct back and seat cushion components are connected do not meet the definition of code K0116. If a ***custom-fabricated*** two-piece seating system is provided, the back component is coded K0115. The seat component is coded K0108.

DOCUMENTATION REQUIRED

1. Wheelchair options/accessories that require a CMN or a physician's order are: K0016-K0018, K0020, K0028, K0046-K0048, K0053 and K0195. For these items, a Certificate of Medical Necessity (CMN) and/or a physician's order that have been filled out, signed and dated by the ordering physician must be kept on file by the provider. Depending on the type of wheelchair, the CMN for these options/accessories is either HCFA Form 843 (power wheelchairs) or HCFA Form 844 (manual wheelchairs). For items not requiring a CMN, an order for the item which has been signed and dated by the ordering physician must be kept on file by the provider and made available to the Intermediary upon request.
2. Accessories to the wheelchair base should be billed on the same claim as the wheelchair base itself.
3. When billing option/accessory codes as a replacement (modifier RR), ***all*** of following should be clearly documented in the patient's medical record and made available to the Intermediary upon request.
    a. documentation of the medical necessity for the item
    b. make and model name of the wheelchair base it is being added to

c. date of purchase of the wheelchair should be documented in the patient's medical record

4. Claims for codes K0115 and K0116 ***must*** include the following documentation:
   a. the patient's diagnosis and description of the spinal problem including a detailed evaluation of the patient
   b. a description of the features of the device and medical necessity of each
   c. an explanation of why a prefabricated seating system is not adequate for the patient
   d. a statement of the number of hours per day that the patient is expected to be in the wheelchair
   e. the manufacture's name and model name/number, if applicable; otherwise, a photograph of the device, a brief description of materials used, ***and*** an estimate of the fitting/fabrication time
5. A claim for code K0108 must include a narrative description of the item, the brand name and model name/number of the item and a statement defining the medical necessity of this item for the particular patient.

6. If it is a customized option/accessory, the statement must clearly describe what was customized. If a formal wheelchair evaluation has been done, it would be appropriate to include this information as documentation.
7. Documentation for individual consideration might include information on the patient's diagnosis, the patient's abilities and limitations as they relate to the equipment (e.g., degree of independence/dependence, frequency and nature of the activities the patient performs, etc.), the duration of the condition, the expected prognosis, and past experience using similar equipment.
8. Documentation requirements must be kept on file in the patient's medical record and be available to the Intermediary upon request.

Attachment #1

Wheelchair Options/Accessories Correct Coding Guidelines

A Column II code is included in the allowance for the corresponding Column I code when provided at the same time.

COLUMN I	**COLUMN II**
Manual Wheelchair Base:	
K0001, K0002, K0003, K0004, K0005, K0006, K0007, K0008, K0009	K0015, K0017, K0018, K0019, K0022, K0026, K0027, K0029, K0032, K0033, K0042, K0043, K0044, K0045, K0046, K0047, K0049, K0050, K0051, K0052, K0060, K0061, K0066, K0070, K0071, K0072, K0076, K0077, K0081, K0452
Power Wheelchair Base:	
K0010, K0011, K0012, K0013, K0014	K0015, K0017, K0018, K0019, K0029, K0042, K0043, K0044, K0045, K0046, 50047, K0049, K0050, K0051, K0052, K0088, K0089, K0090, K0092, K0094, K0096, K0098, K0099, K0452
K0016	K0017, K0018, K0019
K0035	K0034
K0039	K0038
K0045	K0043, K0044
K0046	K0043
K0047	K0044
K0048	K0043, K0044, K0045, K0046, K0047, K0049
K0053	K0048
K0069	K0066
K0070	K0067, K0068
K0071	K0074, K0078

K0072	K0075
K0077	K0076
K0090	K0091
K0092	K0090, K0091
K0096	K0094, K0095
K0195	K0043, K0044, K0045, K0046, K0047

WHEELCHAIR BASES PRODUCT CLASSIFICATION

1. The Intermediary medical policies for Manual Wheelchair Bases and Motorized/Power Wheelchair Bases define characteristics of the wheelchairs included in each code, K0001-K0014. In an effort to standardize the interpretation of these codes, Region C Durable Medical Equipment Regional Carrier has determined the appropriate code for many of the most commonly billed wheelchairs. The following product classification list identifies the correct HCPCS code to be used for specific wheelchair bases. The code designations on this list ***must*** be used for all purchased wheelchairs and for rental wheelchairs in which the claim for the first month's rental is received on or after 9//1/95.
2. This list is not all-inclusive. For wheelchairs not on the list, providers should use their knowledge of the wheelchair and the information in the medical policies to determine the correct code.
3. The appearance of a product on this list, particularly those with codes K0009 or K0014, does not guarantee coverage.
4. When submitting claims for wheelchair bases using codes K0005, K0008, K0009, K0013 or K0014, the provider must list the manufacturer and model name in the medical records.
5. Some wheelchair base models can be coded using different wheelchair base codes depending on their seat dimensions. Attachment #2 is footnotes. The footnotes (A) - (H) define which codes should be used. Footnotes (I) and (J) give other coding guidelines for specific wheelchair bases.
6. The table on the following pages addresses adult wheelchair models. When pediatric wheelchair bases are provided, the miscellaneous wheelchair base codes should be used – K0009 for manual and K0014 for power.

Footnotes:

***** E&J Traveler and Universal were consolidated to create the New Traveler.

Attachment #1

WHEELCHAIR PRODUCT CLASSIFICATION

Manufacturer/ Brand Name	Model Name/Number		
Dalton	Jaquar SeaHawk Convertible 790	SeaHawk Super Hemi 799 (Q) SeaHawk Super Hemi 799C	K0004
Damaco	Electro Lite (N)		K0004
Electric Mobility	Rascal 250 (M) Rascal 255 (M)	Rascal 270 (M) Rascal 275 (M)	K0010
Etac	Swede Basic	Swede F3	K0004
	Swede ACT Swede Cross	Swede Elite	K0005
Everest & Jennings	New Traveler (I)* Premier Classic (D)** Traveler (A)*	Traveler L Universal (A)* Vista	K0001
	New Traveler Hemi Traveler (B)	Universal (B)	K0002
	EZ Lite**	Lightning	K0003
	Lightning LX P2 Plus SPF II	Vision Millenium Metro	K0004

Everest & Jennings (cont.)	Metro Lx Vision Barracuda Vision Epic Vision FX**	Vision Nitro Vision Reactor Vision Record	K0005
	New Traveler (K) (L)	Universal (C)	K0006
	Premier Classic (F)**		K0007
	Magnum MX Navigator	Sabre Sprint Vortex	K0011
	Metro Power Tempest	Quest	K0012
	Lancer	Xcaliber	K0014
Gendron	5810LFW 5812 5814 (D) 5825 (D) 5830 (D)	7108 7810 (D) 8555 Acti-Lite Recliner 2000 (I)	K0001
	5811 (G)		K0002

Gendron (cont.)	2058 2811 (D)	5810 Medi-Lite DX 2158	K0003
	4000 Acti-Lite Adult 1000	Acti-Lite Wide 1000 (N) (O)	K0004
	2811 (F) 5811 (F) 5830 (F) 6500	7810 (F) 5814 (F) 5825 (F)	K0007
	Acti-Lite Youth 3000		K0009
Guardian	GS-2000 (A) H-1000	H-2000 (A)	K0001
	GL-2000 (B) GS-2000 (B)	H-2000 (B)	K0002
	GL-2000 (H)		K0003
Gunnell	MAC Complete MAC Mobility Base	TNT Adult TNT Lite	K0009
Hoveround	LTV MPV	Teknique HVR 200	K0011

Invacare	9000 Recliner (I) Rolls 900 (D) Rolls 4000 (D)	Tracer Tracer LX-SA (A) Tracer Plus	K0001
	Tracer LX-Hemi (B)		K0002
	Rolls 2000	Tracer LT	K0003
	9000 SL Series 9000 Tall 9000 XT Series Action Patriot	Ride Lite 2000 Ride Lite 9000 Tracer Titan	K0004
	Action Allegro Action Xtra Action MVP Action Style	Action Pro-T Super Action Pro-T Action Pro	K0005
	Rolls 900 (E)		K0006
	9000 SDT Rolls 4000 (F)	Tracer IV	K0007
	Youthmobile 3000 Series		K0009
	Ranger II Ranger X	Storm Ranger X Storm Torque	K0011

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Invacare (cont.)	Action P7E	Power 9000	K0012
	Arrow Storm Arrow	XT	K0014
Kareco	Impact Recliner (I)	Rough Rider	K0001
	Impact-Hemo		K0002
Kareco (cont.)	Impact-Lite Hemi Klassic Lite	Klassic-Plus	K0003
	Impact-Lite Wide (K)		K0006
	Impact Wide (K)		K0007
	Cabbie Companion		K0009
Kuschall	Champion 1000		K0004
	Champion 3000 Competitor	Rebel	K0005
Labac	MRC (I)		K0001
	MTC BTC	MTRC	K0009
Love Lift	Love Lift System 2214P		K0014

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Lumex	1000 Series 5000 Series Transport 4000 Series	Trekker Trekker Heavy Duty Wide (L) Trekker X (Deluxe) (L)	K0001
	5000 Series Hemi Trekker Full Recliner (I)	Trekker Hemi	K0002
Otto Bock Group	Z-700B Z-700C	Z-700L	K0005
Permobil	Chairman (J) Hexior (J)	Max 90 (J)	K0014
Pride	Jazzy 1100		K0011
Quickie	Recliner (I) Breezy Breezy 2	EX RX LX	K0004

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Quickie (cont.)	LXI Carbon GP GPS GPS Swing-away GPS Ti GPV	Quickie 2 Quickie 2HP Revolution Shadow Ti Triumph	K0005
	TS		K0009
	P190 P-200	P-210 (J)	K0011
	P-100	P-110	K0012
	P-300	P320	K0014
Redman	Geronimo RC Geronimo PR (J)	Power Road Warrior Road Savage	K0011
	Chief RU	Chief SR	K0014
The Standing Co.	Lifestand		K0009

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Tuffcare	Eagle	Reliance	K0001
	Hemi Deluxe-Adult		K0002
	Hawk Convertible 795 Hawk Super Hemi	Falcon Falcon Hemi/Adult	K0003
	Super Eagle		K0006
	Newport Extra Wide (L)	Super Extra Wide	K0007
	Newport Recliner/Adult Newport Recliner/ Pediatric Falcon Pediatric Falcon Pediatric Recliner Transporter	Ultra Lightweight Transporter Falcon Hemi/Pediatric Hemi Deluxe/Pediatric	K0009
	Challenger 2000	Challenger Recliner 2040	K0011
	Challenger Pediatric 1000		K0014
Wheelchairs of Kansas	WIZZ-ard		K0006
	BCW 600	BCW Recliner	K0007
	BCW Power		K0014
Wheelcare USA	Powerchair		K0014

XL Manufacturing	Pacer		K0003
	Comp		K0004
	Challenger		K0009

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Attachment #2

Footnotes:

1. Use K0001 if seat height is ≥ 19 inches and seat width is <22 inches.
2. Use K0002 if seat height is <19 inches and seat width is <22 inches.
3. Use K0006 if seat width is ≥22 inches.
4. Use K0001 if seat width is <20 inches.
5. Use K0006 if seat width is ≥20 inches.
6. Use K0007 if seat width is ≥20 inches.
7. Use K0002 if seat width is <20 inches.
8. Use K0003 if seat height is <19 inches.
9. Code the reclining back separately using K0028.
10. Code the power recline/tilt separately using K0108.
11. Code seat width of 19 or 20 inches separately using K0057.
12. Code seat width >18 inches separately using K0108.Use code K0010 only if these models come with joystick control. Use E1230 if they come with side-mounted tiller control.
13. Code the power module separately using K0108.

SOURCE OF INFORMATION

Adapted from existing Durable Medical Equipment Regional Carrier policy.