Centers for Medicare & Medicaid Services (CMS)
Summary Report
HCPCS Public Meeting
Friday, May 5, 2006

Introduction and Overview

Louise Hsu, CMS Office of Operations Management, moderated the meeting. Approximately 70 people attended. The agenda included 29 items.

CMM staff Joel Kaiser presented an educational overview of the variety of methods used for setting the payment amount for items, and when the different methods are used. The overview was also provided as a written attachment to the agenda. For additional information, the DME payment rules are located at Section 1834 (a) of the Social Security Act. The Medicare fee schedule for DME, Prosthetics, Orthotics and Supplies, and background information, can be accessed and downloaded free of charge at: http://www.cms.hhs.gov/DMEPOSFeeSched/LSDMEPOSFEE/list.asp?filterType=none&filterByDID=0&sortByDID=3&sortOrder=descending.

Cindy Hake provided an overview of the HCPCS public meeting process and the overall HCPCS process.

Prior to Public Meetings, the CMS HCPCS workgroup meets to review the coding requests on the public meeting agenda, and to make a preliminary coding recommendations. CMS also makes preliminary recommendations regarding the applicable Medicare payment category and methodology that will be used to set a payment amount for the items on the agenda. The preliminary coding and payment recommendations are posted on the HCPCS world-wide web site at www.cms.hhs.gov/medhcpcsgeninfo, as part of the HCPCS public meeting agendas.

Following the public meeting, the CMS HCPCS workgroup will use the input provided at the Public Meeting to reconsider its preliminary coding recommendations, and CMS staff will reconsider its pricing recommendations. The CMS HCPCS workgroup is the entity that maintains the permanent HCPCS level II codes, and reserves final decision making authority concerning requests for permanent HCPCS codes. Final decisions regarding Medicare payment are made by CMS and must comply with the Statute and Regulations. Payment determinations for non-Medicare insurers, (e.g., state Medicaid Agencies or Private Insurers) are made by the individual state or insurer.

Public Meetings are not CMS HCPCS workgroup meetings. Final decisions are not made at the public meetings. All requestors will be notified in writing, in November, of the final decision regarding the HCPCS code request(s) they submitted.

The process for developing agendas and speaker lists for the public meetings, and Guidelines for Proceedings at CMS' Public Meetings are posted on the official HCPCS world wide web site at: http://cms.hhs.gov/medhcpcsgeninfo in a document entitled: "Alpha-Numeric HCPCS Coding Recommendation Format. The standard application

format for requesting a modification to the HCPCS Level II Coding System, along with instructions for completion and background information regarding the HCPCS Level II coding process is available on the same web site.

HCPCS Meeting Agenda Item #1
May 5, 2006
Request #06.02

Topic/Issue:
Request to establish a code for a self help transfer aid for patients with paraplegia, trade name: Para Ladder.

Background/Discussion:
According to the requester, the Para Ladder is a folding, light-weight, self-help transfer aid for patients with paraplegia. It is designed to allow a safe and unassisted transfer from the floor to a wheelchair. After a paraplegic experiences as fall, whether by accident or during a daily transfer, the Para Ladder is the only device that allows the client to return to their wheelchair unassisted. With the Para Ladder positioned behind the client, the client will be able to use his/her arms and hands to lift up three short steps (seat) and move safely into the wheelchair. Handles are positioned above each seat so that a person can place one's hands on the handles and lift oneself up seven and one half inches to the next higher seat. The client would then grasp the next higher handles and lift to the higher seat, where upon the person is then able to move smoothly and safely into the wheelchair seat.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify this item. It is not primarily medical in nature. For Medicare, there is no benefit category and code A9270 "NON-COVERED ITEM OR SERVICE", should be used. For guidance regarding appropriate coding for Private Sector health insurance systems, please contact the individual private insurance contractor. For Medicaid systems, please contact the Medicaid Agency in the state in which a claim would be filed. Use of miscellaneous codes is inappropriate.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
On behalf of We Care Designs, LLC, the primary speaker disagreed with two points stated in the preliminary decision regarding the Para Ladder.

- The preliminary decision stated that "no insurer identified a national program operating need to establish a code to identify this item". The speaker demonstrated the Para Ladder and discussed that demand for the product should translate to insurer need, and the lack of a code denies access to this device.
- The preliminary decision also stated that "For Medicare, there is no benefit category" and the speaker stated that lifts are coded in HCPCS and therefore this item should be considered a lift from the floor and coded as such.

The speaker suggested the use of **E0639 Patient lift moveable from room to room** for the Para Ladder.

HCPCS Meeting Agenda Item #2
May 5, 2006
Request #06.105

Topic/Issue:
Request to establish a new code for a transfer board, trade name: SafeSlideBoard™.

Background/Discussion:
According to the requester, this item is a replacement armrest for wheelchairs that can be lowered with one hand for use as a transfer board. It is needed by wheelchair users that cannot independently transfer to and from their wheelchairs. Unlike standard transfer boards which slide off the wheelchairs and cause falls, the SafeSlideBoard™ remains attached. Since it repositions as the armrest, it cannot be misplaced when needed. Code E0972 was used in the past for transfer boards, but was discontinued 12/31/05. No insurer has yet paid for this item.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify this item. The low volume of documented use does not warrant the administrative burden of creating a code. CMS will be happy to consider an application in a later coding cycle if sales volume increases substantially.

Primary Speaker:
On behalf of SafeSlideBoard, the primary speaker disagreed with the preliminary decision. The speaker stated that the SafeSlideBoard™ is different from regular slide boards because it is attached to the chair without having to use a separate device and shift weight in order to get onto the slide board. The speaker claimed that this device overcomes misplaced or slipped slide boards and that it may save on overall expenditures. The speaker doesn't anticipate increased sales because he feels he needs a code to sell. According to the speaker, the "SafeSlideBoard is something that could improve the lives of some wheelchair users and save Medicare and Medicaid money. The potential savings from prevention of fall related injuries and maintenance of independence of users more that makes up for the administrative costs of creating a new HCPCS code."

HCPCS Meeting Agenda Item #3
May 5, 2006
Request #06.112

Topic/Issue:
Request to establish a new code for a portable stair climber, trade name: Scalamobil. Requester suggested language**:** EXXXX "Manual wheelchair accessory, portable powered stair climber"

Background/Discussion:
According to the requester, the Scalamobil is a portable stair climber for wheelchair users. It attaches to most manual wheelchairs with a seat width of 11 inches or more. To climb the stairs, attach the scalamobil to the wheelchair bracket with the quick-release locks, remove the rear wheels, and go up the stairs. The Scalamobil has 4 different driving programs. It can be tailored to the individual requirements of the patient. The Scalamobil allows the user to access both levels of their home and complete their activities of daily living. There is no existing code to identify a portable stair climber for wheelchair users.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify a portable powered stair climber. This is a convenience item for use by a care provider. For Medicare, there is no benefit category, and code A9270 "NON-COVERED ITEM OR SERVICE" should be used, and use of miscellaneous codes is inappropriate. For coding guidance for other insurers, contact the entity in whose jurisdiction a claim would be filed. For Medicaid, contact the Medicaid agency in the state in which a claim would be filed. For private insurance, contact the individual private insurance contractor.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
There was no Primary Speaker for this item.

HCPCS Meeting Agenda Item #4
May 5, 2006
Request #06.144

Topic/Issue:
Request to establish an "L" code for a wedge that is attached to a shoe, trade name: Cluffy Wedge.

Background/Discussion:
According to the requester, the Cluffy Wedge is a wedge that is attached to a shoe underneath the hallux or large toe. The wedge functions by pretensioning the plantar fascia and overcoming limitation of motion at the first metatarsophalangeal joint. This limitation of motion is commonly referred to as functional hallux limitus and can result in a variety of gait changes resulting in various symptomatology in the individual affected with this condition. It is simply a wedge shaped pad that is placed underneath the large toe as an addition to a shoe. The patient population for whom the product is clinically indicated would be individuals that demonstrate mechanical changes in the foot structure with abnormal gait patterns. This can manifest clinically as plantar fasciitis, heel pain syndrome, metatarsalgia, pain in the ball of the foot, or pain in the large toe joint. Compensatory gait changes can also result in some supra-structural symptomatology.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify this item. It is not a prosthetic, therefore use of "L" codes is inappropriate. For Medicare, there is no benefit category, and code A9270 "NON-COVERED ITEM OR SERVICE" should be used, and use of miscellaneous codes is inappropriate. For coding guidance for other insurers, contact the insurer in whose jurisdiction a claim would be filed. For Medicaid, contact the Medicaid Agency in the state in which a claim would be filed. For private insurance, contact the individual private insurance contractor.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
There was no Primary Speaker for this item.

HCPCS Meeting Agenda Item #5
May 5, 2006
Request #06.48

Topic/Issue:
Request to establish a code for an upper extremity motion rehabilitation system, trade name: UE Ranger (Model 100-1).

Background/Discussion:
According to the requester, the UE Ranger is an upper extremity motion rehabilitation system that can be used as a prophylactic exercise device for the prevention of injuries in certain instances, and for certain patients. The use of existing code A9300 "Exercise Equipment" is causing health care reimbursement agencies and others to misinterpret or fail to recognize the more significant therapeutic functions as a neuro-motor and musculo-skeletal rehabilitation and therapeutic device. According to the requester, "the primary limitation of this coding is it fails to be recognized by insuring agencies as a device qualified to be adequately reimbursed".

The UE Ranger is designed to support the hand of the involved upper extremity so that gripping of this hand is not required. By avoiding the need for hand gripping, a patient is able to maintain a normal relaxed hand state of motor tone at the shoulder of the involved upper extremity. The activation of a gripping action, on the other hand, automatically causes the proximal shoulder muscles to amplify their resting tone. Maintaining a relaxed state at the shoulder enables the following to occur:

- Progressive neuro-motor re-education of previously dyskinetically involved movement patterns.
- Protection of injured tissues, for example at the site of a surgically repaired rotator cuff.
- Avoidance of the promotion of muscle guarding and resultant pathological bio-mechanics.
- Avoidance of the promotion of unnecessary pains.

To make the UE Ranger available to the largest number of people who can benefit from it, Rehab Innovations is suggesting that the UE Ranger be included in the DME section under a title of "upper extremity motion rehabilitation system".

CMS HCPCS Workgroup Preliminary Decision:
Existing code A9300 "EXERCISE EQUIPMENT" adequately identifies this item. No insurer identified a national program operating need to establish a code to distinguish this device from other devices coded at A9300. It is not primarily medical in nature.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
On behalf of Rehab Innovations Inc., the primary speaker disagreed with the preliminary decision regarding the request for a code for the UE Ranger. The speaker claimed that the UE Ranger is DME and is primarily used for medical rehabilitation. According to the speaker, the UE Ranger assists the patient through available range of motion (ROM) and safely supports earlier introduction of passive range of motion (PROM). The speaker asked that this device be coded as an "upper extremity ROM system" in the DME code section. The speaker also states that the likely reason that there have been no insurance requests for a distinguishing code is because they have not submitted claims after finding out that A9300 is not covered by Medicare.

HCPCS Meeting Agenda Item #6
May 5, 2006
Request #06.56

Topic/Issue:
Request to establish a code for a multifunction far infrared radiant heat physical therapy table, trade name: CERAGEM Thermal Massager. Requester suggested language**:** EXXXX "Multifunction Far Infrared Radiant Health Physical Therapy Table, includes spine traction and acupuncture capabilities, each"

Background/Discussion:
According to the requester, CERAGEM Thermal Massagers are therapy/rehab tables that are used in the home for the treatment of chronic/acute pain, muscle spasms, and the healing of tissue/muscle trauma utilizing Far Infrared Radiant heat. They can increase blood flow of the micro-circulatory systems of capillaries, reduce muscle spasms as muscle fibers are heated, reduce joint stiffness, assist in the reduction of swelling and inflammation by improving lymph flow, and reduce stress by loosening muscle fibers and relaxing the body. There are no existing codes to describe this type of product. There are CPT codes for the billing of physical therapy services; however this therapy can be used in the home, by the patient and/or caregiver.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify a therapy table. For Medicare, there is no benefit category and code A9270 "NON-COVERED ITEM OR SERVICE" should be used. For coding guidance for other insurers, contact the insurer in whose jurisdiction a claim would be filed. For private insurance, contact the individual private insurance contractor. For Medicaid, contact the Medicaid Agency in the state in which a claim would be filed.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
On behalf of CERAGEM International, Inc., the primary speaker disagreed with CMS' preliminary decision and reiterated the applicant's original request for a new code with language as proposed. The speaker stated that the Ceragem Thermal Massager aids in circulation, relieves arthritis joint pain and stiffness, and relaxes muscles. According to the speaker, rollers that travel up and down the spine provide traction and FAR penetrating radiant heat unblocks Chi energy. The speaker also stated that an unpublished study shows that it lowers blood pressure and cholesterol, and claims this item will save on overall expenditures to treat arthritis.

HCPCS Meeting Agenda Item #7
May 5, 2006
Request #06.91

Topic/Issue:
Request to establish a code for transdermal sustained oxygen therapy device (TSOT), trade name: EpiFLO^{SD} (previously known as Oxybox). Requester Suggested Language**:** AXXXX "Transdermal sustained oxygen therapy device and cannula system"

Background/Discussion:
According to the requester, the EpiFLO^{SD} provides transdermal sustained low dose oxygen therapy (TSOT) device for the treatment of chronic, difficult-to-heal wounds. The EpiFLO^{SD} consists of a disposable oxygen generator with a 43 in. long cannula connected to the side of the oxygen generator via a Luer Loc. It has no moving parts and weighs two-ounces. It delivers 3 mL/hour of 99.9% pure oxygen with ambient humidity directly into the wound bed providing treatment 24 hours per day, 7 days a week via the cannula. The patient can be fully ambulatory while the device is in use. EpiFLO^{SD} bathes the wound in pure oxygen and can stimulate epithelialization, granulation tissue, glycosaminoglycan production, and collagen synthesis. Indications for use include wounds due to diabetes, venous stasis, post surgical infections, gangrene; pressure ulcers; amputations/infected residual limbs; skin grafts; burns; frostbite. According to the requester, existing code A4575 "Topical Hyperbaric Oxygen Chamber, Disposable" is not appropriate because the EpiFLO^{SD} is neither a topical treatment nor a hyperbaric chamber.

CMS HCPCS Workgroup Preliminary Decision:
Clinical information provided by the applicant does not include human trials, and does not support a claim of improved patient outcome as a result of use of this product. For Medicare, code A9270 NON-COVERED ITEM OR SERVICE should be used. Use of A4575, E1399 or other miscellaneous codes is inappropriate. For coding guidance for other insurers, contact the entity in whose jurisdiction a claim would be filed. For Medicaid, contact the Medicaid Agency in the state in which a claim would be filed. For private insurance, contact the individual private insurance contractor.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
On behalf of Ogenix Corporation, the primary speaker disagreed with CMS' preliminary decision. According to the speaker, there are no HCPCS codes that describe this product, although it is the only TSOT device commercially available to treat chronic wounds. Ogenix is currently collecting evidence from two randomized clinical trials. They are also seeking appropriate coverage through evidence development.

HCPCS Meeting Agenda Item #8
May 5, 2006
Request #06.98

Topic/Issue:
Request to establish 8 HCPCS codes for various models of powered exercise devices, trade name: Flexiciser™. Requester suggested language**:**
1) EXXXX Multi-directional physical therapy device with range of motion adjustability and natural elongated stride, non weight-bearing on joints, simultaneously moving arms and legs and that has all three of passive, active, and resistive modes. 2) EXXXX w/ankle rotator model, 3) EXXXX w/chair attachment for individuals not wheelchair bound, 4) EXXXX fully adjustable adult model, 5) EXXXX fully adjustable child model, 6) EXXXX big and tall model, 7) EXXXX professional model, and 8) EXXXX with extended handlebars model. *(Note all machines perform the same as item #1 above but have some additional options).

Background/Discussion:
According to the requester, the Flexiciser is a multi-directional physical therapy device with range of motion adjustability and natural elongated stride, non-weight bearing on joints, simultaneously moving arms and legs and that has all three of passive, active, and resistive modes. It is used for physical therapy (medical) for improvement of range of motion and disability when associated with disease/disorders. The individual wheels up to the unit and foot straps are used to secure the feet to the foot pedals. They simply click on the on/off rocker switch. The control panel offers a 0-60 minute timer and a RPM setting dial at the patient's fingertips. It can be used passively or actively for up to 60 lbs of resistance on the arms for more strength development.

CMS HCPCS Workgroup Preliminary Decision:
Existing code A9300 "EXERCISE EQUIPMENT" adequately identifies this item. No insurer identified a national program operating need to establish a code to distinguish this device from other devices coded at A9300. It is not primarily medical in nature.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
On behalf of Flexiciser International, the primary speaker disagreed with CMS' preliminary decision, claiming that the Flexiciser is not exercise equipment, rather it is "movement therapy." It may be used for physical therapy for improvement of range of motion and disability when associated with diseases/disorders. It provides active, passive, and resistive therapy, and is the only product with all three modes. According to the applicant, the Flexiciser is durable medical equipment used in the home to serve a medical purpose and is not useful in the absence of illness or injury, and some insurers have reimbursed for it. Anecdotal comments were provided and the speaker claimed that the product has been use extensively in clinical trials.

HCPCS Meeting Agenda Item #9
May 5, 2006
Request #06.125

Topic/Issue:
Request to establish a new code for a breath-activated dose-counting companion to metered dose inhalers, trade name: MD Turbo™.

Background/Discussion:
According to the requester, the MD Turbo is a breath-activated dose-counting companion to metered dose inhalers. It is intended to assist with the delivery of aerosolized medications that are used in conjunction with commercialized, pressurized metered-dose inhalers (pMDI) as it is triggered to deliver the prescribed medication through breath or manual activation. It is also intended for use by patients to count the number of doses remaining in the pMDI. It must be used with compatible metered dose inhalers. It has an internal non-replaceable battery with one year life from the initial dose-counter activation.

CMS HCPCS Workgroup Preliminary Decision:
No insurer identified a national program operating need to establish a code to identify this device. It is a convenience item. For Medicare, there is no benefit category, and code A9270 "NON-COVERED ITEM OR SERVICE" should be used. For coding guidance for other insurers, contact the entity in whose jurisdiction a claim would be filed. For Medicaid, contact the Medicaid agency in the state in which a claim would be filed. For private insurance, contact the individual private insurance contractor.

Medicare Payment:
This item is not covered by Medicare.
Pricing = 00

Primary Speaker:
There was no Primary Speaker for this item.

PAYMENT FOR DMEPOS

DMEPOS

The term DMEPOS, which stands for durable medical equipment (DME), prosthetics, orthotics and supplies, is used in the Medicare program to describe a set of Medicare Part B device and supply benefits for which claims are processed by four DME Regional Carriers (DMERCs). The Part B device benefits covered by this term include:

- DME – equipment used in the home which can withstand repeated use, is primarily and customarily used to serve a medical purpose, and is generally not useful in the absence of an illness or injury;
- Prosthetic Devices – devices that replace all or part of an internal body organ, including ostomy, tracheostomy and urological supplies, parenteral and enteral nutrients, equipment and supplies (PEN), intraocular lenses (IOLs), and one pair of conventional eyeglasses or contact lenses after each cataract surgery;
- Prosthetics – artificial legs, arms, and eyes;
- Orthotics – rigid or semi-rigid leg, arm, back, and neck braces;
- Home Dialysis Supplies and Equipment
- Surgical Dressings
- Therapeutic Shoes and Inserts

Depending on the item or the setting in which the item is furnished, Medicare claims for some of these items may also be processed by local carriers and fiscal intermediaries (e.g., claims for DME implanted in an ambulatory surgical center are processed by local carriers). Claims for DME and ostomy, tracheostomy and urological supplies furnished by a home health agency are processed by Regional Home Health Intermediaries (RHHIs).

Fee Schedule Payments

Prior to January 1, 1989, payment for most DMEPOS items and services was made on the basis of the reasonable charge methodology. Reasonable charges are calculated using suppliers' charges and are limited by an inflation adjustment factor. Payment is still made on a reasonable charge basis for home dialysis supplies and equipment and for IOLs inserted in a physician's office. There is a monthly limit per beneficiary on payments for home dialysis supplies and equipment. Payment for most of the other DMEPOS items and services is based on the lower of the actual charge for the item or a fee schedule amount. The Part B deductible and 20 percent coinsurance both apply to the DMEPOS items and services described above.

The Social Security Act requires that the DMEPOS fee schedule amounts be established based on average reasonable charges made during a base period (e.g., July 1, 1986 thru June 30, 1987 for prosthetic devices, prosthetics and orthotics). The fee schedule amounts are increased by annual update factors. Because the reasonable charge data required by the law in establishing fee schedule amounts does not exist for new DMEPOS items, the fee schedule amounts for new DMEPOS items are "gap-filled" using fees for comparable items, supplier price lists, manufacturer suggested retail prices, or wholesale prices plus a markup. The gap-filling methodology is used to estimate the average reasonable charge for the item from the base period.

DMEPOS Payment Categories/HCPCS Pricing Indicators

The Social Security Act separates DMEPOS into different Medicare payment categories, each with its own unique payment rules. The pricing indicators in the HCPCS identify which major payment category a code falls under. The pricing indicators applicable to DMEPOS are as follows:

- **Pricing = 00 Service Not Separately Priced**
  Items or services described by the HCPCS codes that are either not covered under Medicare Part B or for which payment is bundled into the payment some other Medicare service or procedure.

- **Pricing = 31 Frequently Serviced Items**
  Payment is generally made on a monthly rental fee schedule basis for items such as ventilators that require frequent and substantial servicing in order to avoid risk to the patient's health.

- **Pricing = 32 Inexpensive and Other Routinely Purchased Items**
  Payment is made on a purchase or rental fee schedule basis. This category includes items that have a purchase price of $150 or less, are generally purchased 75 percent of the time or more, or which are accessories used in conjunction with a nebulizer, aspirator, continuous airway pressure device, or intermittent assist device with continuous airway pressure device. The beneficiary has the option to acquire the item on a purchase or monthly rental basis. Total payments for the item cannot exceed the purchase fee schedule amount for the item.

- **Pricing = 33 Oxygen and Oxygen Equipment**
  Monthly fee schedule payments are made for furnishing oxygen and oxygen equipment. An additional payment is made for those beneficiaries who require portable oxygen. The beneficiary takes over ownership of the equipment after the 36th monthly payment is made, after which payment for delivery of contents continues for patient owned gaseous or liquid systems.

- **Pricing = 34 Supplies Necessary for the Effective Use of DME**
  Payment is made on a purchase fee schedule basis for supplies necessary for the effective use of DME (e.g., lancets that draw blood for use in blood glucose monitor).

- **Pricing = 35 Surgical Dressings**
  Payment is made on a purchase fee schedule basis for surgical dressings.

- **Pricing = 36 Capped Rental Items**
  Payment is made on a monthly rental fee schedule basis. For items furnished on or after January 1, 2006, the beneficiary takes over ownership of the item after the 13th rental payment is made. The rental fee for capped rental items for each of the first 3 months of rental is equal to 10 percent of the purchase fee for the item. The rental fee for months 4 through 13 is equal to 7.5 percent of the purchase fee for the item. Power wheelchairs can be purchased in the first month.

- **Pricing = 37 Ostomy, Tracheostomy and Urological Supplies**
  Payment is made on a purchase fee schedule basis for ostomy, tracheostomy and urological supplies.

- **Pricing = 38 Orthotics, Prosthetics, Prosthetic Devices, and Vision Services (Prosthetic Lenses)**
  Payment is made on a purchase fee schedule basis for orthotics, prosthetics, and prosthetic devices & lenses.

- **Pricing = 39 Parenteral and Enteral Nutrition (PEN)**
  Payment is made on a purchase fee schedule basis for parenteral and enteral nutrients and supplies. Payment is made on a purchase or rental fee schedule basis for parenteral and enteral equipment. The beneficiary has the option to acquire the item on a purchase or monthly rental basis.

- **Pricing = 45 Customized DME**
  Payment is made for lump-sum purchase of DME that meets the Medicare regulatory definition of customized DME at 42 CFR 414.224. The payment amount is based on the carrier's individual consideration of the item.

- **Pricing = 46 Carrier Priced Item**
  For items falling under codes for miscellaneous or not otherwise classified items, the fee schedule or reasonable charge payment amount, whichever is applicable, is based on the carrier's individual consideration of the item.

- **Pricing = 52 Reasonable Charges**
  Payment continues to be made on a reasonable charge basis in accordance with Medicare regulations at 42 CFR 405.500 for splints, casts, and other devices used to reduce a fracture or dislocation, dialysis supplies and equipment, and intraocular lenses (IOLs) inserted in physician's offices.