

Local Coverage Article:

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article (A52467)

Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland

				Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

Article Information

General Information

General Article Information Table

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N/A

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Article Title

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea - Policy Article

Article Type

Article

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Article Guidance

Article Text:

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES

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. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. “reasonable and necessary”).

Positive airway pressure devices are covered under the Durable Medical Equipment benefit [Social Security Act §1861(s)(6)]. In order for a beneficiary’s DME to be eligible for reimbursement, the reasonable and necessary (R&N) requirements set out in the related Local Coverage Determination must be met. In addition, there are specific statutory payment policy requirements, discussed below, that also must be met.

Accessories are separately reimbursable at the time of initial issue and when replaced.

No aspect of a home sleep test, including but not limited to delivery and/or pickup of the device, may be performed by a DME supplier. This prohibition does not extend to the results of studies conducted by hospitals certified to do such tests or to tests conducted in facility-based sleep laboratories.

A liner used in conjunction with a PAP mask is considered comfort/convenience item. There is no additional payment for liners used with a PAP mask. These products should be coded A9270 (Noncovered item or service) in accordance with the Medicare Benefit Policy Manual (CMS Pub. 100-02) Chapter 15, Section 110.1.

Claims for A9279 (MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED) are denied as statutorily non-covered (No Medicare benefit).

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217)

Final Rule 1713 (84 Fed. Reg Vol 217) requires a face-to-face encounter and a Written Order Prior to Delivery (WOPD) for specified HCPCS codes. CMS and the DME MACs provides a list of the specified codes, which is periodically updated. The link will be located here once it is available.

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

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

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

In addition to policy specific documentation requirements, there are general documentation requirements that are applicable to all DMEPOS policies. These general requirements are located in the DOCUMENTATION REQUIREMENTS section of the LCD.

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this Policy Article under the Related Local Coverage Documents section for additional information regarding GENERAL DOCUMENTATION REQUIREMENTS and the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS discussed below.

INITIAL EVALUATION

For the initial in-person evaluation, the report would commonly document pertinent information about the following elements, but may include other details. Each element would not have to be addressed in every evaluation.

History

- Signs and symptoms of sleep disordered breathing including snoring, daytime sleepiness, observed apneas, choking or gasping during sleep, morning headaches;
- Duration of symptoms
- Validated sleep hygiene inventory such as the Epworth Sleepiness Scale (see Appendices of related LCD)

Physical Exam

- Focused cardiopulmonary and upper airway system evaluation
- Neck circumference
- Body mass index (BMI)

Suppliers are reminded that all Medicare coverage and documentation requirements for DMEPOS also apply. There must be sufficient information included in the medical record to demonstrate that all of the applicable coverage criteria are met. This information must be available upon request.

For beneficiaries changing from an E0601 to E0470 due to ineffective therapy while on E0601 (either during a facility-based titration or in the home setting), the treating practitioner must document that both of the following issues were addressed prior to changing to an E0470 device:

- A. Interface fit and comfort. An appropriate interface has been properly fit and the beneficiary is using it without difficulty. This properly fit interface will be used with the E0470 device; and,
- B. E0601 pressure settings. The current pressure setting of the E0601 prevents the beneficiary from tolerating the therapy and lower pressure settings of the E0601 were tried but failed to:
 1. Adequately control the symptoms of OSA; or,
 2. Improve sleep quality; or,
 3. Reduce the AHI/RDI to acceptable levels.

The re-evaluation must take place within the first 3 months of treatment; however, formal assessment of improvement cannot be documented before the 31st day. The re-evaluation must document both improvement in subjective symptoms of OSA and objective data related to adherence to PAP therapy.

Documentation of adherence to PAP therapy shall be accomplished through direct download or visual inspection of usage data with documentation provided in a written report format to be reviewed by the treating practitioner and included in the beneficiary's medical record. This information does not have to be submitted with the claim but must be available upon request.

Many suppliers have created forms which have not been approved by CMS which they send to practitioners and ask them to complete. Even if the practitioner completes this type of form and puts it in his/her chart, this supplier-generated form is not a substitute for the comprehensive medical record as noted above. Suppliers are encouraged to help educate practitioners on the type of information that is needed to document a beneficiary's need for PAP therapy.

Proper use of modifiers is discussed below. Specific modifiers must be used and differ depending on whether or not the requirements outlined in the documentation section have been met.

INITIAL COVERAGE (FIRST THREE MONTHS):

On claims for the first through third months, suppliers must add a KX modifier to codes for PAP equipment (E0470 or E0601) and accessories only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the related LCD ("Initial Coverage") have been met.

CONTINUED COVERAGE BEYOND THE FIRST THREE MONTHS OF THERAPY:

On the fourth month's claim (and any month thereafter), the supplier must add a KX modifier to codes for PAP equipment (E0470 or E0601) and accessories only if both the "Initial Coverage" criteria and the "Continued Coverage" criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the related LCD have been met.

If the supplier does not obtain information from the treating practitioner that the beneficiary has demonstrated improvement in their OSA symptoms and is adhering to PAP therapy in time for submission of the fourth or succeeding months' claims, the supplier may still submit the claims, but a KX modifier must not be added.

If the supplier chooses to hold claims for the fourth and succeeding months pending receipt of information from the treating practitioner that the beneficiary received a clinical re-evaluation between the 31st and 91st day, had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier.

If the supplier chooses to hold claims for the fourth and succeeding month pending receipt of information from the treating practitioner but learns that the beneficiary did not receive a clinical re-evaluation between the 31st and 91st day but rather was re-evaluated at a later date and had documented improvement in OSA symptoms and is adhering to PAP therapy, those claims may then be submitted with the KX modifier but only for dates of service following the date of the clinical re-evaluation.

For a PAP device dispensed prior to November 1, 2008, if the initial coverage criteria in effect at the time were met and the criteria for coverage after the first 3 months that were in effect at the time were met, the KX modifier may be added to claim with dates of service on or after November 1, 2008 as long as the beneficiary continues to use the device.

REPLACEMENT OF ACCESSORIES FOR MEDICARE-PAID, BENEFICIARY-OWNED EQUIPMENT:

For claims for replacement accessories (e.g., interfaces, tubing, filters, humidifier chambers), if Medicare paid for the base PAP device initially (i.e., for 13 months of continuous use), the medical necessity for the beneficiary-owned base PAP device is assumed to have been established. Therefore, to make a payment determination, there must only be documentation that the base DME item continues to meet medical need; and (2) The replacement of specific accessories or furnishing of new accessories remain medically necessary and are essential for the effective use of the base DME.

Documentation of continued medical need for the base item must come from the treating practitioner's records. The supplier's documentation records must support the need to replace the accessory to maintain the equipment's functionality and meet the beneficiary's medical need.

This guidance does not apply to PAP devices when Medicare did not originally provide payment for the base item. In cases where Medicare did not originally pay for the DME item, all coverage, coding and documentation requirements in effect for the date of service (DOS) on the claim under review must be met (see below for beneficiary-owned devices entering Medicare).

BENEFICIARIES ENTERING MEDICARE:

For beneficiaries who received a PAP device prior to enrollment in fee for service (FFS) Medicare and are seeking Medicare coverage of either rental of the device, a replacement device or accessories, the supplier may add the KX modifier only if both of the criteria listed in the Coverage Indications, Limitations and/or Medical Necessity for Beneficiaries Entering Medicare section of the related LCD have been met.

The supplier may hold claims, pending confirmation that the above requirements are met, and then submit claims with the KX modifier beginning with the date of FFS Medicare enrollment.

CONCURRENT USE OF OXYGEN WITH PAP THERAPY

In the rare instance where beneficiaries require the simultaneous use of home oxygen therapy and a PAP device, documentation by the treating practitioner in the beneficiary's medical record must clearly demonstrate that the requirements for coverage outlined in the PAP LCD Coverage Indications, Limitations and/or Medical Necessity have been met. In addition, the beneficiary's medical record must also clearly demonstrate that the requirements for coverage outlined in the Oxygen and Oxygen Equipment LCD Coverage Indications, Limitations and/or Medical Necessity have been met. This information does not have to be submitted with the claim but must be available upon request.

Suppliers should refer to the Oxygen and Oxygen Equipment LCD and related Policy Article for additional coverage, coding and documentation requirements.

MODIFIERS

GA, GZ, and KX MODIFIERS:

In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the PAP equipment and accessories. When there is an expectation of a reasonable and necessary denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a GA, GZ or KX modifier will be rejected as missing information.

MISCELLANEOUS

Items billed before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code.

The order must include the type(s) of supplies ordered and the approximate quantity to be used per unit of time. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used.

The supplier must enter the diagnosis code for the PAP device on each claim submitted for PAP supplies.

Refer to the Supplier Manual for additional information on documentation requirements.

CODING GUIDELINES

A respiratory cycle is defined as an inspiration, followed by an expiration.

A single-level continuous positive airway pressure (CPAP) device (E0601) delivers a constant level of positive air pressure (within a single respiratory cycle) by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

For auto-titrating single-level CPAP devices use HCPCS code E0601.

A bi-level respiratory assist device without backup rate (E0470) allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure within a single respiratory cycle by way of tubing and a noninvasive interface (such as a nasal, oral, or facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs.

A bi-level respiratory assist device with backup rate (E0471) allows independent setting of inspiratory and expiratory pressures to deliver positive airway pressure within a single respiratory cycle by way of tubing and a noninvasive interface (such as a nasal or oral facial mask) to assist spontaneous respiratory efforts and supplement the volume of inspired air into the lungs. In addition, E0471 devices have a timed backup feature to deliver this air pressure whenever sufficient spontaneous inspiratory efforts fail to occur.

Code A4604 describes tubing used with a heated humidifier and has a heated wire running the length of the tubing. It is designed for use with a positive airway pressure device and a non-invasive interface – i.e., nasal or face mask, nasal cannula, or oral interface.

Code A7032 is used for a replacement nasal mask interface that goes around the nose, but not into the nostrils. The unit of service for this code is “each”.

Code A7033 is used for a replacement nasal cannula-type interface. This interface extends a short distance into the nostrils. The unit of service for this code is “pair”. For some products, there are two physically separate cushions or “pillows” – one for each nostril. Two cushions/pillows equals one unit of service of A7033. For other products, the interface is a single piece with two protrusions that extend into the nostrils. One of these interfaces equals one unit of service of A7033.

Code A7027 (Combination oral/nasal mask, used with continuous positive airway pressure device, each) is a two piece system with separate elements for oral and nasal use. One unit of service for A7027 includes both the oral and the nasal components.

A liner is soft, flexible material which is placed between the patient’s skin and the PAP mask interface. Liners used with a PAP mask are made of cloth, silicone or other materials.

Liners are not interfaces for use with a PAP mask. Consequently, liners should not be billed as replacement features of a PAP mask such as A7031 (Face mask interface, replacement for full face mask, each) or A7032 (Cushion for use on nasal mask interface, replacement only, each).

Monitoring devices (integrated or modular) are capable of tracking data generated by a RAD or PAP device, which can be subsequently downloaded for further analysis by a healthcare provider, DME supplier, or beneficiary. Such technologies include, but are not limited to:

- Smart cards and readers
- USB/Thumb drive accessories
- Wired telephonic transmission modules
- Wireless modems

Code A9279 (MONITORING FEATURE/DEVICE, STAND-ALONE OR INTEGRATED, ANY TYPE, INCLUDES ALL ACCESSORIES, COMPONENTS AND ELECTRONICS, NOT OTHERWISE CLASSIFIED) describes any type of monitoring technology. Code A9279 is all-inclusive, and is to be used whether the monitoring technology is incorporated as part of a base item, supplied as an add-on module or is a stand-alone item.

Use of multiple instances of A9279 to bill separately for individual monitoring features is incorrect coding.

There is no Medicare benefit or payment to DMEPOS suppliers for remote monitoring services. Suppliers must not bill A9279 for remote monitoring services.

Claims billed for monitoring technologies using other NOC codes such as E1399 [DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS] will be denied as incorrect coding.

Code E0467 (HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN CONCENTRATION, DRUG NEBULIZATION, ASPIRATION,

AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS) describes a ventilator that integrates the function of multiple types of equipment into a single device. Code E0467 combines the function of a ventilator with those of any combination of or all of the following:

- Oxygen equipment
- Nebulizer and compressor
- Aspirator (suction device)
- Cough stimulator (multiple products)
- Positive airway pressure devices (PAP and RAD)
- Custom fabricated oral appliances

The following positive airway pressure devices HCPCS codes for individual items are included in the functionality of code E0467:

- HCPCS codes E0470, E0471, E0472, E0601, A4604, A7027, A7028, A7029, A7030, A7031, A7032, A7033, A7034, A7035, A7036, A7037, A7038, A7039, A7044, A7045, A7046, E0561, E0562

For E0467 claims with dates of service before April 3, 2020:

Claims for any of the HCPCS codes listed above that are submitted on the same claim or that overlap any date(s) of service for E0467 is considered to be unbundling.

In addition, any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by HCPCS codes listed above is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service for any of the following scenarios are considered as a claim for same or similar equipment when the beneficiary:

- Is currently in a rental month for any of the items listed above
- Owns any of the equipment listed above that has not reached the end of its reasonable useful lifetime

For E0467 claims with dates of service on or after April 3, 2020:

Any claim for repair (HCPCS code K0739 for labor and any HCPCS code for replacement items) of beneficiary-owned equipment identified by HCPCS codes listed above is considered as unbundling if the date(s) of service for the repair overlaps any date(s) of service for code E0467.

Claims for code E0467 with a date(s) of service that overlaps date(s) of service in a rental month for any of the items listed above are considered as a claim for same or similar equipment.

Suppliers should contact the Pricing, Data Analysis and Coding (PDAC) contractor for guidance on the correct coding of these items.

Coding Information

CPT/HCPCS Codes

N/A

ICD-10 Codes that Support Medical Necessity

Group 1 Paragraph:

The presence of an ICD-10 code listed in this section is not sufficient by itself to assure coverage. Refer to the LCD section on **“Coverage Indications, Limitations, and/or Medical Necessity”** for other coverage criteria and payment information.

Group 1 Codes:

ICD-10 CodeDescription

G47.33 Obstructive sleep apnea (adult) (pediatric)

ICD-10 Codes that DO NOT Support Medical Necessity

Group 1 Paragraph:

All ICD-10 codes that are not specified in the preceding section.

Group 1 Codes: N/A

Additional ICD-10 Information

N/A

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the article does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the article should be assumed to apply equally to all claims.

N/A

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the article, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the article should be assumed to apply equally to all Revenue Codes.

N/A

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
Xx/xx/xxxx	R12	Revision Effective Date: xx/xx/xxxx NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Revised: Medicare Benefit Policy Manual reference CODING GUIDELINES: Revised: Language related to the incorrect use of NOC codes for monitoring technologies <i>Xx/xx/xxxx: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination</i>
04/03/2020	R11	Revision Effective Date: 04/03/2020 CODING GUIDELINES: Revised: Guidance for billing HCPCS code E0467 based on DOS <i>07/16/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i>
01/01/2020	R10	Revision Effective Date: 01/01/2020 NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES: Removed: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g) section REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217): Added: Section and related information based on Final Rule 1713 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: "in-person" to initial evaluation Revised: "practitioner" to "treating practitioner"

Removed: Dispensing order and WOPD related information

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:

Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:

Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

03/05/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Revision Effective Date: 01/01/2019

CODING GUIDELINES:

Revised: E0467 Coding Guidelines to include custom fabricated oral appliances

01/01/2019 R9

04/04/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Revision Effective Date: 01/01/2019

CODING GUIDELINES:

Added: E0467 Coding Guidelines

ICD-10 CODES THAT ARE COVERED:

Added: Diagnosis code formerly listed in the LCD

01/01/2019 R8

ICD-10 CODES THAT ARE NOT COVERED:

Added: Notation excluding all unlisted diagnosis codes from coverage

02/28/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Revision Effective Date: 08/01/2018

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Claims for A9279 are denied as statutorily non-covered.

CODING GUIDELINES:

08/01/2018 R7

Revised: Coding guidance for A9279 and other NOC codes

07/19/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.

Revision Effective Date: 01/01/2017
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
ADDED: Direction for REPLACEMENT OF ACCESSORIES FOR MEDICARE-PAID,
BENEFICIARY-OWNED EQUIPMENT

01/01/2017 R6

06/14/2018: At this time 21st Century Cures Act applies to new and revised LCDs that restrict coverage, which require comment and notice. This revision is to an article that is not a local coverage determination.

Revision Effective Date: 01/01/2017
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: 42 CFR 410.38(g)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Policy specific coverage criteria and Miscellaneous instructions (previously in the related LCD), and Modifier instructions
RELATED LOCAL COVERAGE DOCUMENTS:
Added: LCD-related Standard Documentation Requirements Language Article

01/01/2017 R5

Revision Effective Date: 07/01/2016
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised Standard Language to add Statutory prescription (order) requirements, revised Face to Face and ACA requirements (Effective 04/28/2016)

07/01/2016 R4

Effective July 1, 2016 oversight for DME MAC Articles is the responsibility of CGS Administrators, LLC 18003 and 17013 and Noridian Healthcare Solutions, LLC 19003 and 16013. No other changes have been made to the Articles.

07/01/2016 R3

Revision Effective Date: 10/01/2015
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Standard language reference to benefit category citation in Social Security Act.
Added: Statutory denial for liners
Revised: Face-to-Face Standard Language
CODING GUIDELINES:
Added: Correct coding of liners
Added: Correct coding of monitoring technology

10/01/2015 R2

Revision Effective Date: 10/01/2014
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

10/01/2015 R1

Added: Added: HCPCS codes E0470 and E0471 to the ACA 6407 requirement table (effective 07/01/13)

Associated Documents

Related Local Coverage Document(s)

Article(s)

A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

LCD(s)

Related National Coverage Document(s)

N/A

Statutory Requirements URL(s)

N/A

Rules and Regulations URL(s)

N/A

CMS Manual Explanations URL(s)

N/A

Other URL(s)

N/A