Disclaimer: Draft articles are works in progress and not necessarily a reflection of the current billing and coding practices. The draft article information contained in this document does not represent nor does it include all information found in an active LCD-related Policy Article. For example, abridged ICD-10-CM code information relevant to the proposed LCD may be included; unchanged ICD-10-CM code information may not be included. Please refer to the active LCD-related Policy Article in effect on the Medicare Coverage Database, if applicable, for current billing and coding information.

Contractor Information:

Contractor Name	Contract Type	Contract Number	Jurisdiction
CGS Administrators, LLC	DME MAC	17013 - DME MAC	Jurisdiction B
CGS Administrators, LLC	DME MAC	18003 - DME MAC	Jurisdiction C
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	Jurisdiction A
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	Jurisdiction D

DRAFT

Nebulizers – Policy Article

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").

Nebulizers are covered under the Durable Medical Equipment (DME) benefit (Social Security Act §1861(s)(6)). In order for a beneficiary's equipment 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.

A large volume pneumatic nebulizer (E0580) and water or saline (A4217 or A7018) are not separately payable and should not be separately billed when used for beneficiaries with rented home oxygen equipment.

If a large volume nebulizer, related compressor/generator, and water or saline are used predominantly to provide room humidification it will be denied as noncovered.

A prefilled disposable large volume nebulizer (A7008) is noncovered under the DME benefit because it is a convenience item. An unfilled nebulizer (A7007, A7017, or E0585) filled with water or saline (A4217 or A7018) by the beneficiary/caregiver is an acceptable alternative.

Kits and concentrates for use in cleaning respiratory equipment will be denied as noncovered.

Aztreonam lysine is an inhalation solution that is indicated for beneficiaries with cystic fibrosis with chronic Pseudomonas aeruginosa infection. Because it has been determined that the nebulizer that is FDA-approved for administration of aztreonam lysine is not sufficiently durable to meet the DME statutory requirements for coverage, claims for that nebulizer, aztreonam lysine inhalation solution and related accessories will be denied as noncovered under the Medicare Part B DME benefit. (The aztreonam lysine inhalation solution and related accessories may be eligible for coverage under a different Medicare benefit (e.g., Medicare Part D)).

Amikacin liposome is an inhalation solution that is used to treat adults with refractory Mycobacterium avium complex (MAC) lung disease. Because it has been determined that the nebulizer that is FDA-approved for administration of amikacin liposome is not sufficiently durable to meet the DME statutory requirements for coverage, claims for that nebulizer, amikacin liposome inhalation solution and related accessories will be denied as noncovered under the Medicare Part B DME benefit. (The amikacin liposome inhalation solution and related accessories may be eligible for coverage under a different Medicare benefit (e.g., Medicare Part D)).

Drugs that are not administered through DME (e.g. Foradil Aerolizer and metered-dose inhalers (MDI's)) are not billed to the DME MAC but may be covered under other Medicare benefits (i.e., Medicare Part D). If the supplier chooses to submit a claim for drugs not administered through DME, the drug must be billed using code J3535 (DRUG ADMINISTERED THROUGH A METERED DOSE INHALER) and is non-covered by the DME MACs.

Disposable equipment or equipment in which a major component required for their function is disposable do not meet the definition of durable medical equipment and must be billed using code A9270 (noncovered item or service).

DISPENSING FEE:

An initial dispensing fee (G0333) is payable to a pharmacy for the initial 30-day supply of covered inhalation drug(s) regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time. This initial 30-day dispensing fee is a once in a lifetime fee and only applies to beneficiaries who are using inhalation drugs for the first time as a Medicare beneficiary on or after 01/01/2006. If code G0333 is billed for a 30-day supply of covered inhalation drugs and it is not the initial 30-day supply (i.e., G0333 has already been billed to Medicare for that beneficiary), the claim will be denied as incorrect coding. When code G0333 has been billed once in a beneficiary's lifetime, subsequent claims for a 30-day dispensing fee must be billed using code Q0513.

Medicare will only pay for one of the following for covered inhalation drugs regardless of the number of drugs dispensed, the number of shipments, or the number of pharmacies used by the beneficiary during that time period - an initial dispensing fee (G0333), a 30-day dispensing fee (Q0513), or a 90-day dispensing fee (Q0514).

For a refill prescription, payment of a dispensing fee will be allowed no sooner than 10 days before the end of usage for the current 30-day or 90-day period for which a dispensing fee was previously paid. Medicare will not pay for more than 12 months of dispensing fees per beneficiary per 12-month period.

If the dispensing fee is billed sooner than the interval specified above, it will be denied as not separately payable. For example, if a 90-day fee (Q0514) is billed on 1/30/06 and is covered and there is a subsequent claim for a 30-day fee (Q0513) on 4/10/06, the dispensing fee on 4/10/06 will be denied as not separately payable.

Both a Q0513 and a Q0514 dispensing fee are not covered on the same date of service. If a supplier dispenses a 90-day supply of one drug and a 30-day supply of another drug on the same day, code Q0514 (90-day fee) must be billed.

The dispensing fee must be billed on the same claim as the inhalation drug(s). If it is not, it will be denied as incorrect billing.

A dispensing fee is not separately billable or payable for saline, whether used as a diluent or for humidification therapy. This does not apply to hypertonic saline J7131, which is administered as an inhalation drug and not a diluent.

Medicare will not pay for a separate fee for the compounding of inhalation drug(s).

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 provide a list of the specified codes, which is periodically updated. The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.

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.

For coverage of ensifentrine, the medical records must document that the beneficiary continues to experience COPD exacerbations or persistent dyspnea while on a dual long-acting beta-agonist (LABA) and long-acting muscarinic-agonist (LAMA) maintenance regimen or a triple therapy maintenance regimen with LABA+LAMA and inhaled corticosteroid (ICS). For continued exacerbations, at least one of the following must be documented:

a. One or more COPD-related hospitalizations within a 12-month period; or
b. Two or more COPD exacerbations leading to emergency room visits within a 12-month period; or
c. Two or more COPD exacerbations leading to new prescriptions for oral steroids or antibiotics within a 12-month period; or

d. A combination of one COPD-related emergency room visit and one new COPD-related prescription for oral steroids or antibiotics within a 12-month period that are unrelated to the same exacerbation; or
e. Chart notes by the treating practitioner documenting a history of exacerbations (a, b, c, or d above).

MISCELLANEOUS

A diagnosis code describing the condition which necessitates nebulizer therapy must be included on each claim for equipment, accessories, and/or drugs.

MODIFIERS

JW AND JZ MODIFIERS:

Effective for claims with dates of service on or after January 1, 2017, the JW modifier is required when billing for unused and discarded amounts of drugs and biologicals from single-dose containers that are administered by the supplier.

Effective for claims with dates of service on or after July 1, 2023, the JZ modifier is required when billing for drugs and biologicals from single-dose containers that are administered by the supplier but have no unused and discarded amounts. Effective for claims with dates of service on or after January 1, 2024, the JZ modifier is also required when billing for drugs and biologicals from single-dose containers that are dispensed by the supplier but have no unused and discarded amounts that are self-administered by the beneficiary or the beneficiary's caregiver.

Effective for claims with dates of service on or after January 1, 2025, the JW modifier is also required if a billing supplier is not administering a drug or biological, but there are unused and discarded amounts during the preparation process before supplying the drug or biological to the patient as described in scenario 3 below. The JZ modifier is required for drugs and biologicals that are dispensed by the supplier but have no unused and discarded amounts during the preparation process and are self-administered by the beneficiary or the beneficiary's caregiver in the beneficiary's home.

Multi-use vials are not subject to payment for discarded amounts of drugs or biologicals.

The DME MACs expect rare use of the JW modifier on claims due to HCPCS code descriptors and their associated Units of Service (UOS) for DMEPOS in addition to the limited instructions for use.

Below are three (3) scenarios in regard to the JW and JZ modifiers.

Scenario 1
When the HCPCS code UOS is less than the drug quantity contained in the single-use vial or single-dose package, the following applies:

- The quantity administered is billed on one claim line without the JW modifier; and,
- The quantity discarded is billed on a separate claim line with the JW modifier.

In this scenario, the JW modifier must be billed on a separate claim line to provide payment for the amount of discarded drug or biological. For example:

- A single-use vial is labeled to contain 100 mg of a drug.
- The drug's HCPCS code UOS is 1 UOS = 1 mg.
- 95 mg of the 100 mg in the vial are administered to the beneficiary by the supplier.
- 5 mg remaining in the vial are discarded.
- The 95 mg dose is billed on one claim line as 95 UOS.
- The discarded 5 mg is billed as 5 UOS on a separate claim line with the JW modifier.
- Both claim line items would be processed for payment.

Scenario 2
When the HCPCS code UOS is equal to or greater than the total of the actual dose and the amount discarded, use of the JW modifier is not permitted. As of July 1, 2023, the JZ modifier is required in this situation. If the quantity of drug administered is less than a full UOS, the billed UOS is rounded to the appropriate UOS. For example:

- A single-use vial is labeled to contain 100 mg of a drug.
- The drug's HCPCS code UOS is 1 UOS = 100 mg.
- 70 mg of the 100 mg in the vial are administered to the beneficiary by the supplier.
- 30 mg remaining in the vial are discarded.
- The 70 mg dose is billed correctly by rounding up to one UOS (representing the entire 100 mg vial) on a single claim line item with the JZ modifier.
- The single claim line item of 1 UOS would be processed for payment of the combined total 100 mg of administered and discarded drug.

- The discarded 30 mg must not be billed as another 1 UOS on a separate claim line item with the JW modifier. Billing an additional 1 UOS for the discarded drug with the JW modifier is incorrect billing and will result in an overpayment.

Scenario 3
There are cases such as in a pharmacy where the billing supplier does not administer a drug but prepares it prior to supplying the drug to the beneficiary. Beginning January 1, 2025, the JW modifier is required if a billing supplier is not administering a drug, but there are amounts discarded during the preparation process before supplying the drug to the patient. Such a supplier would report the JZ modifier if no amounts were discarded during the preparation process before supplying the drug to the patient. For example:

- A single-use vial is labeled to contain 50 mg of a drug.
- The drug's HCPCS code UOS is 1 UOS = 1 mg.
- A supplier prepares the prescribed dose of 45 mg to supply to the beneficiary.
- The 45 mg dose is billed on one claim line as 45 UOS.
- The discarded 5 mg is billed as 5 UOS on a separate claim line with the JW modifier.
- Both claim lines would be processed for payment.

KX, GA, AND GZ MODIFIERS:

Suppliers must add a KX modifier to claim lines billed for the nebulizer, drugs and supplies only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the related LCD have been met. Evidence supporting the use of the KX modifier must be retained in the supplier's files and available to the DME MAC upon request.

If all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section have not been met, the GA or GZ modifier must be added to the code. When there is an expectation of a medical necessity denial, suppliers must enter GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or GZ modifier if they have not obtained a valid ABN.

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

CODING GUIDELINES

EQUIPMENT:

In this policy, nebulization of inhalation solutions is accomplished by two types of devices. Pneumatic compressor nebulizers achieve nebulization of liquid by means of air flow. Ultrasonic or electronic nebulizers produce nebulization of liquid by means of a vibrating mechanism.

HCPCS code E0565 describes an aerosol compressor, which can be set for pressures above 30 psi at a flow of 6-8 L/m and is capable of continuous operation.

A nebulizer with compressor (E0570) is an aerosol compressor, which delivers a fixed, low pressure and is used with a small volume nebulizer. It may be AC-powered, DC-powered or both.

A light duty adjustable pressure compressor (E0572) 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.

HCPCS code E0574 describes an ultrasonic/electronic generator used with a small volume chamber for medication delivery. Aerosolization of the inhalation solution occurs in a nebulization chamber by means of a vibrating mechanism such as (not all inclusive) a vibrating disk, pizo-electric device or vibrating mesh.

Accessories used in conjunction with ultrasonic nebulizers coded E0574 should be billed on separate claim lines. The dome and mouthpiece should be billed with code A7016. Other accessories should be billed with code A9999. When code A9999 is used, the claim must clearly describe the type and quantity of accessories provided.

For dates of service on or after April 1, 2011, products coded E0574 must have received coding verification review (CVR) from the Pricing, Data Analysis and Coding (PDAC) contractor. The only products that may be billed using code E0574 are those that are specified in the Product Classification List (PCL) on the PDAC contractor web site.

If a product is billed to Medicare using a HCPCS code that requires written CVR, but the product is not on the PCL for that particular HCPCS code, then the claim line will be denied as incorrect coding.

HCPCS code E0575 describes a large volume ultrasonic nebulizer system which is used for medication and humidification delivery, and which is capable of continuous operation.

HCPCS code K0730 describes a controlled dose inhalation drug delivery system. Aerosol is delivered in pulses during the inspiration. The duration of each pulse is adapted according to the breathing pattern.

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

ACCESSORIES:

HCPCS codes A7003, A7005, and A7006 include the lid, jar, baffles, tubing, T-piece and mouthpiece. In addition, code A7006 includes a filter.

HCPCS code A7004 includes only the lid, jar and baffles.

HCPCS code A7012 describes a device to collect water condensation, which is placed in line with the corrugated tubing, used with a large volume nebulizer.

HCPCS code A7016 describes the dome and mouthpiece containing the aerosolization mechanism for an ultrasonic/electronic nebulizer system.

HCPCS code E0585 is used when a heavy-duty aerosol compressor (E0565), durable bottle type large volume nebulizer (A7017), and immersion heater (E1372) are provided at the same time. If all three items are not provided initially, the separate codes for the components would be used for billing. Code A7007 or A7017 is billed when an unfilled large volume nebulizer is used with an E0572 compressor or a separately billed E0565 compressor. Code A7007 or A7017 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 A7017, but should only be billed when this type of nebulizer is used with a beneficiary-owned oxygen system.

INHALATION DRUGS:

The following instructions apply to claims billed using J codes. When claims are billed in NCPDP format using NDC numbers, different instructions may apply. Refer to the NCPDP Companion Document available through the CMS website.

A compounded inhalation solution is one in which the product that is delivered to the beneficiary is not an FDA-approved preparation. It is produced by a pharmacy that is not an FDA-approved manufacturer and involves the mixing, combining, or altering of ingredients for an individual beneficiary. Even if one the ingredients is an FDA-approved product (e.g., an injectable form of the drug), if that is mixed by the pharmacy with other ingredients, the solution that is dispensed to the beneficiary is considered to be a compounded product.

There are distinct codes for FDA-approved final products and for compounded final products. The appropriate code must be used when a claim is submitted. Code J7999 (COMPOUNDED DRUG, NOT OTHERWISE CLASSIFIED) does not apply to compounded nebulizer drugs and must not be used. Claims for compounded nebulizer drugs using J7999 will be denied as incorrect coding.

HCPCS codes J2545 (pentamidine), J7608 (acetylcysteine), J7631 (cromolyn), J7639 (dornase alfa) and Q4074 (iloprost) may only be used for inhalation solutions which are FDA-approved. If compounded versions of these drugs are provided, they must be billed using code J7699.

There are no FDA-approved final products that are described by the following codes: J7633 (budesonide, concentrate), J7648 (isoetharine, concentrate), J7649 (isoetharine, unit dose), J7658 (isoproterenol, concentrate), J7659 (isoproterenol, unit dose), and J7668 (metaproterenol, concentrate). These codes are invalid for claim submission.

HCPCS codes J7602 (Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, concentrated form, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)) and J7603 (Albuterol, all formulations including separated isomers, inhalation solution, FDA-approved final product, non-compounded, administered through DME, unit dose, per 1 mg (albuterol) or per 0.5 mg (levalbuterol)) were effective for claims with dates of service from 1/1/2008 – 3/31/2008. They are invalid for claim submission for dates of service on or after 4/1/2008.

Unit dose form of an inhalation drug or a combination of drugs is one in which the medication is dispensed to a beneficiary (1) in a bottle/vial/ampule which contains the dose usually used for a single inhalation treatment, and (2) in a concentration which is dilute enough that it may be administered to a beneficiary without adding any separate diluent.

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

The coding of a unit dose form or a concentrated form of an inhalation drug is determined by the formulation of the drug as it is dispensed to the beneficiary. For example, 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 beneficiary in a single-dose bottles/vials/ampules, the inhalation solution is billed as the compounded unit dose form, not the concentrated form.

When there is a single drug in a unit dose container, the KO modifier is added to the unit dose form code. (Exception: The KO modifier is not used with code J2545 or Q4074.)

Except for code J7620, when two or more drugs are combined and dispensed to the beneficiary in the same unit dose container, each of the drugs is billed using its unit dose form code. 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).

Whenever a unit dose form code is billed, it must have a KO, KP or KQ modifier. (Exception: The KO, KP and KQ modifiers should not be used with code J7620.) 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.

The only FDA-approved unit dose preparation containing more than one drug is J7620, the combination of albuterol and ipratropium. Therefore, if the following FDA-approved unit dose codes are billed with a KP or KQ modifier, they will be rejected as invalid for claim submission: J7605, J7606, J2545, J7601, J7608, J7613, J7614, J7626, J7631, J7639, J7644, J7669, J7682, J7686, and Q4074.

The billing unit of service for inhalation drug codes varies. Suppliers must be sure that they use the correct billing unit or the code when calculating the number of units of service to enter on the claim. The following is guidance on a few codes where errors are commonly seen:

- HCPCS code J7620 is used for an FDA-approved combination of albuterol and ipratropium which contains 3.0 mg of albuterol sulfate (which is 2.5 mg of albuterol base) and 0.5 mg of ipratropium bromide in each unit dose vial. For these products, 1 unit of service of J7620 equals 1 unit dose vial.

- For HCPCS codes J7626 and J7627 (budesonide, unit dose), bill one unit of service for each vial dispensed, regardless of whether a 0.25 mg vial or a 0.5 mg vial is dispensed.

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 2.5mg of albuterol (3 X 0.83 equals 2.5). If a pharmacist provides 120 ampules of an FDA-approved inhalation solution of 0.083% albuterol solution each containing 3 ml, the billed units of service would be 300 (2.5 X 120) units of code J7613 (for albuterol, 1 mg equals 1 unit).

When a compounded unit dose preparation is billed, the diluent must not be billed separately.

The nebulizer used to administer aztreonam lysine must be coded and billed using HCPCS code A9270, noncovered item or service.

The nebulizer used to administer amikacin liposome must be coded and billed using HCPCS code A9270, noncovered item or service.

HCPCS code A4218 is used for metered dose sterile saline products that are used to dilute the concentrated form of inhalation drugs.

When a drug is provided in a concentration which is dilute enough that it may be administered to the beneficiary without adding any separate diluent and is dispensed in a multidose container, use J7699.

Claims for revefenacin for dates of service on or after November 9, 2018, through June 30, 2019, must be submitted using the HCPCS code J7699 (NOC DRUGS, INHALATION SOLUTION ADMINISTERED THROUGH DME).

Claims for revefenacin for dates of service on or after July 1, 2019, must be submitted using HCPCS code J7677 (REVEFENACIN INHALATION SOLUTION, FDA-APPROVED FINAL PRODUCT, NON-COMPOUNDED, ADMINISTERED THROUGH DME, 1 MICROGRAM).

HCPCS code J7699 is also used for an inhalation drug which does not have a valid specific code. Claims for drugs that are incorrectly coded J7699 instead of the appropriate code will be denied for invalid coding.

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

Coding Information

ICD-10-CM Codes that Support Medical Necessity

[addition] **Group 15 Paragraph**
For HCPCS Codes J7131:

Group 15 Codes
[addition] E84.0 Cystic fibrosis with pulmonary manifestation
[addition] J47.0 Bronchiectasis with acute lower respiratory infection
[addition] J47.1 Bronchiectasis with (acute) exacerbation
[addition] J47.9 Bronchiectasis, uncomplicated
[addition] Q33.4 Congenital bronchiectasis
[addition] Q89.3 Primary ciliary dyskinesia

[addition] **Group 16 Paragraph**
For HCPCS codes J7601:

Group 16 Codes

[addition] J41.0 Simple chronic bronchitis
[addition] J41.1 Mucopurulent chronic bronchitis
[addition] J41.8 Mixed simple and mucopurulent chronic bronchitis
[addition] J42 Unspecified chronic bronchitis
[addition] J43.0 Unilateral pulmonary emphysema [MacLeod's syndrome]
[addition] J43.1 Panlobular emphysema
[addition] J43.2 Centrilobular emphysema
[addition] J43.8 Other emphysema
[addition] J43.9 Emphysema, unspecified
[addition] J44.0 Chronic obstructive pulmonary disease with (acute) lower respiratory infection
[addition] J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
[addition] J44.89 Other specified chronic obstructive pulmonary disease
[addition] J44.9 Chronic obstructive pulmonary disease, unspecified

ICD-10-CM Codes that DO NOT Support Medical Necessity

[no change]

Associated Documents:

This draft document is an attachment to the proposed Nebulizers LCD (DL33370) that has a Proposed LCD Posting Date of 08/28/2025.