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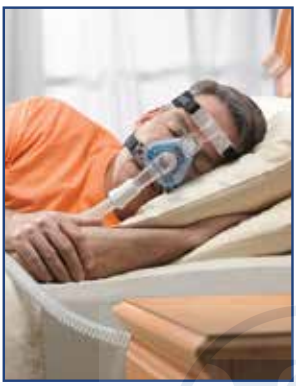


Medicare Quick Reference Guide

Reimbursement guidelines for our referral sources

317.872.9702 Main Office
317.228.2340 Retail Showroom
800.848.4670 Toll Free
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MEDICARE-FACE-TO-FACE RULES

The items covered in this guide are part of the face-to-face rule that was implemented July 1, 2013, under the Affordable Care Act 6407. These items require that the DME supplier obtain the detailed written order and the medical record prior to delivery of the item. The face-to-face evaluation must have occurred within six months of the order date on the detailed written order. The face-to-face evaluation may be performed by a Nurse Practitioner (NP), Physician Assistant (PA), or Clinical Nurse Specialist (CNS). If the NP, PA, or CNS performs the face-to-face evaluation, the physician must sign off on the medical record prior to delivery of the item.

For any item to be considered for coverage by Medicare, the patient must meet the guidelines as outlined in the medical policies and associated articles as described on the Medicare websites, and the clinical records must prove the medical necessity.

The information in this guide was compiled by U.S. Rehab, a division of VGM Group, Inc., a Member Service Organization of which we are a proud Member.

U.S. REHAB®

Bedside Commodes

- Bedside commodes are only covered if the patient is room-confined or unable to get to toilet facilities. Commodes are not covered if they are placed over the toilet in the bathroom. Medical need must be documented in patient's medical record.
- Heavy duty commodes: Width equal to or greater than 23 inches and a weight capacity 300 pounds or more.
- Detachable arms are covered when used to facilitate transfers or if the patient has a body configuration that requires extra width. This applies to any commode.
- Supplier must have documentation on file detailing why patient is room-confined or unable to access toilet facilities.

Patient Lifts

- Patient lifts (Hoyer or other types) are covered if transfer between bed and a chair, a wheelchair or commode requires the assistance of more than one person and, without the use of a lift, the patient would be bed confined.

Lift Chairs

All of the following criteria must be met in order to consider coverage:

- Patient must be able to ambulate once standing (cannot be used in conjunction with a wheelchair or POV).
- Has severe arthritis of hip or knee or severe neuromuscular disease. Diagnosis required.
- Must be a part of the physician's course of treatment and be prescribed to effect improvement, or arrest or retard deterioration of the patient's condition.
- 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.
- Once standing, the patient must have the ability to ambulate.

Support Surfaces

Group 1 (overlays)
Group 2 (pressure reducing)
Group 3 (air-fluidized bed)

GROUP 1 (mostly overlays) Patient must meet criteria 1, 2 or 3.

1. Completely immobile – Patient cannot make changes in body position without assistance, **OR**
2. Limited mobility – Patient cannot independently make changes in body position significant enough to alleviate pressure **OR**
3. Any stage pressure ulcer on the trunk or pelvis.

If the patient meets criteria 2 or 3 above he/she must also have at least one of the following conditions:

A. Impaired nutritional status
B. Fecal or urinary incontinence
C. Altered sensory perception
D. Compromised circulatory status

GROUP 2 (powered pressure-reducing mattresses)
Patient must meet criteria 1 **AND** 2 **OR** criterion 3 **OR** criterion 4 below.

1. Multiple stage II pressure ulcers located on trunk or pelvis that have failed to improve over the last month **AND**
2. 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; regular assessment; appropriate turning, positioning and wound care; moisture and incontinence management; and nutritional assessment and intervention.
3. Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis **OR**
4. Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and patient has been on a Group 2 or 3 support surface immediately prior to discharge from the hospital or nursing facility (discharge within the past 30 days).

GROUP 3 (air-fluidized bed) Patient must meet ALL of the following.

1. Stage III (full-thickness tissue loss) or stage IV (deep tissue destruction) pressure sore.
2. Bedridden or chair bound as a result of severely limited mobility.
3. In 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. Conservative treatment should generally include: frequent repositioning; use of Group 2; wound management; nutritional optimization; education of patient and caregiver on the prevention and/or management of pressure ulcers and; assessment by physician, nurse or other licensed health care practitioner at least weekly.

Beds

Coverage is considered for a fixed-height hospital bed when at least one of the following are met:

- Has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
- Patient requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain.
- Requires the head of the bed to be elevated more than 30 degrees most of the time because of CHF, COPD or problems with aspiration.
- Requires traction equipment that can only be attached to a hospital bed.

If a heavy duty-type bed is medically necessary, the weight must be at least 350 pounds and must be documented. Medicare does not cover full electric beds.

- **Semi-electric beds are considered for coverage if one of the above criteria is met AND**
- **If the patient requires frequent changes in body position such as to alleviate pain, prevent aspiration or a respiratory issue.**

Detailed Written Order requirements:

- Beneficiary's name
- Date of order, and start date if different
- Detailed description of the item being ordered (be specific to the type of bed, for example: fixed height, semi-electric, high/low semi-electric bed, etc)
- Any other items being billed
- Length of need
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and signature date

Mobility Equipment

What are the rules? Remember you must rule out each lower level item. Medicare pays for the least costly alternative.

ITEM REQUIRED

1. **Cane** – Written order and there is a mobility impairment but potential for ambulation.
2. **Walker** – Written order and there is mobility impairment that cannot be corrected with a cane but potential for ambulation. Heavy duty would need weight greater than 300 pounds.
3. **Specialty walker** (HD – multiple braking system, variable wheel resistance walker) – patient meets criteria for a walker but cannot use standard due to severe neurologic disorder or other condition causing restricted use of one hand (obesity alone is not sufficient reason).
4. **Manual wheelchairs** – Must rule out use of cane/walker
   a. Standard – Rule out cane and walker; does not have to be able to self-propel, but needs manual wheelchair for use within the home.
   b. Hemi-height – Needs manual wheelchair; needs lower seat to floor height for transfers and/or to assist with self-propelling with feet.
   c. Lightweight – Rule out cane/walker and standard weight manual wheelchair. MUST be independent in self-propelling with the lightweight wheelchair (cannot be needed solely for caregiver convenience).
   d. High strength lightweight – Rule out standard, hemi-height and lightweight. Needs a seat width/seat depth/seat-to-floor height not available in ANY lower level base and/or patient is up in chair greater than two hours per day and highly active. Does not have to be self-propeller. Needs could relate to activity level or size of patient (i.e., extremely tall or very short and requires ultra-hemi seat height).
   e. Ultra lightweight – As of March 1, 2013, requires ATP and PT/OT evaluation as well as face-to-face exam by physician and must have past history of use of same type base and activity both inside and outside the home. Patient must be a full-time independent manual wheelchair user and must require individualized fitting and adjustments such as, but not limited to, axle configuration, wheel chamber or seat and back angles that are not available on a lower-level wheelchair. Need to be very specific as to what is needed on this base that is NOT available on a high-strength lightweight base (K0004).
   f. Heavy-duty base is covered if patient needs a manual wheelchair and weight is greater than 250 pounds.
   g. Extra heavy duty is covered if patient needs a manual wheelchair and weight is greater than 300 pounds.
   h. A transport chair (E1037, E1038 or E1039) is covered in lieu of a standard manual wheelchair for use within the home.

With all manual wheelchairs, the first rule to remember is that the need is for IN THE HOME and must rule out each lower-level item before a higher level is covered.

Mobility Equipment, continued

Detailed Written Order requirements:

- Beneficiary's name
- Height and weight
- Date of order, and start date if different
- Detailed description of the item being ordered (be specific to the type of mobility equipment, for example: walker with wheels, lightweight manual wheelchair, hemi-height manual wheelchair, heavy duty manual wheelchair, etc.)
- Any other items being billed
- Length of need
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and signature date

Non-invasive Ventilators

Non-invasive ventilator treatment is generally covered if treatment is needed for:

- Neuromuscular disorder
- Thoracic disorder diseases
- Chronic respiratory failure associated with a respiratory illness such as chronic obstructive pulmonary disease (COPD)

If patient has had repeated hospital admissions due to respiratory failure, make sure that this information is documented because it will help meet coverage. If a ventilator is used, make sure follow-up visits are documented in the medical record by treating practitioner to show there was a decrease in admissions. ***Remember Medicare pays for least costly alternative, which means a BiPAP or BiPAP S/T needs to be considered, or tried and ruled out. Clinical documentation must be specific to the individual patient's needs.***

Make sure the documentation is very clear and thorough as to why the patient needs a ventilator versus a respiratory assist device such as a BiPAP or BiPAP S/T.

Justifications might include the fact that the only other alternative would be a tracheostomy which would increase chances of infections and adds increased trauma to an already stressed patient and his/her family.

Monthly rental payments include the payment for supplies and accessories.

Detailed Written Order requirements:

- Beneficiary's name
- Date of order, and start date if different from date of order
- Detailed description of the item being ordered and any other items being billed
- Ventilator settings
- Frequency of use
- Length of need
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and signature date

Oxygen and Oxygen Equipment

The key is to make sure there is documentation in the medical record indicating need for home oxygen therapy.

GROUP I

1. Patient has a severe lung disease or hypoxia-related symptom that might improve with therapy.
   Examples:
   - COPD, diffuse interstitial lung disease, bronchiectasis, cystic fibrosis.
   - Hypoxia-related symptoms such as pulmonary hypertension, recurring CHF due to chronic cor pulmonale, erythrocytosis, impairment of cognitive process, nocturnal restlessness and morning headache.
   - Hypoxemia alone will not be covered. There needs to be an underlying condition causing the hypoxemia.
   - Non-covered conditions: angina pectoris in absence of hypoxemia, breathlessness without cor pulmonale or hypoxemia, severe peripheral vascular disease, terminal illnesses that do not affect lungs, pneumonia.

2. Blood gas study meets criteria indicated below:
   - Method 1: On room air at rest while awake, oxygen saturation equal to or less than 88 percent or ABG equal to or less than 55 mm Hg
   - Method 2: If during exercise must have the following three tests documented:
     1. Oxygen saturation on room air at rest – (should be above 88 percent)
     2. Oxygen saturation on room air with exercise – needs to be equal to or less than 88 percent
     3. Oxygen saturation on oxygen with exercise – shows improvement with oxygen

     NOTE: If patient qualifies with method 2, then WHOMEVER does the testing **must document and provide** all three test results described above; otherwise the oxygen will not be covered.
   - Method 3: During sleep on room air oxygen saturation equal to or less than 88 percent for at least 5 minutes and does not have to be continuous.

3. Alternative treatment measures, such as inhalers or nebulizer treatments, have been tried or considered, and ruled out or clinically ineffective.

For Group I, all three items listed above need to be met.

GROUP 2

1. Dependent edema suggesting CHF, **OR**
2. Pulmonary HTN or cor pulmonale, determined by measurement of pulmonary artery pressure, echocardiogram, or "P" pulmonale on EKG, **OR**
3. Erythrocythemia with hematocrit greater than 56 percent, **OR**
4. ABG with PO2 of 56-59 mm Hg or oxygen saturation of 89 percent at rest, while awake, during sleep for five minutes or during exercise as described under Group I.

For Group I and Group 2, there must be evidence of an in-person visit with the treating practitioner performed within 30 days before the initial set-up.

Blood gas study:

1. Performed by a physician, qualified provider, or laboratory service that can bill Medicare such as an IDTF, and
2. Study must have been performed within 30 days of initial certification while patient is in a chronic stable state, or
3. During an inpatient hospital stay and done within two days prior to discharge date.
4. If the testing was performed in an emergency room, then it's considered an acute situation and would not be considered as acceptable for coverage.

Helpful notes:

- If portable oxygen is being ordered, there needs to be documentation in the medical records indicating the patient is mobile within the home.
- Portable oxygen is considered when the blood gas study is performed while patient is awake or with exercise. At-night use only does not qualify for a portable unit.
- A frequency of use must be indicated, i.e. 2 lpm continuous or 3 lpm at night. PRN, or as needed basis, is not covered by Medicare.
- DMEPOS suppliers are not considered as qualified to perform blood gas studies.
- If patient is under a Part A covered stay payment such as hospital, nursing facility, home health or hospice meets the qualified provider standard. Need to be sure that patient is under a Part A covered payment; if not, then the requirements are not met and qualification would be invalid.

Detailed Written Order (DWO) must contain the following:

1. Beneficiary's name
2. Date of order and start date, if different from date of order
3. Detailed description of the item being ordered
4. Route of administration
5. Frequency of use
6. Length of need
7. Treating practitioner's printed name and NPI
8. Treating practitioner's signature and date

- The CMN can be the DWO but must contain all the information listed above.

Obstructive sleep apnea with use of home oxygen therapy:
For patients requiring the use of home oxygen with PAP device, both the PAP and oxygen policies must be met. The qualifying blood gas study must be performed during a titration study at a sleep lab facility making sure the pressure is at an optimal setting. The oximetry study performed during this titration shows oxygen saturation of 88 percent or less for five total minutes (does not have to be continuous). There has to be a reduction in AHI/RDI reduced to less than or equal to an average of 10 events/hours or if the initial AHI/RDI was less than an average of 10 events per hour, then the titration demonstrates further reduction in AHI/RDI.

Recertification:
The following to be obtained with the recert CMN for either Group 1 or Group 2:

1. Re-evaluation by treating physician documenting patient is benefiting from the oxygen therapy and has shown improvement.
2. Copy of most recent blood gas study (can be from the initial test, if that is the most recent) BUT should not be the normal practice.

GROUP 1 = Required after 12 months of initial certification, which means the re-evaluation **must occur within 90 days prior to the date of recertification.**
GROUP 2 = Required after 3 months of initial certification, which means the re-evaluation **must occur between the 61st-90th day following the initial date.**

Respiratory Assist Devices (RAD)

There are four different clinical groups characterized as:
GROUP I: Restrictive Thoracic Disorders
GROUP II: Severe Chronic Obstructive Pulmonary Disease (COPD)
GROUP III: Central Sleep Apnea (CSA) or Complex Sleep Apnea (Comp SA)
GROUP IV: Hypoventilation Syndrome

FOR INITIAL COVERAGE:

GROUP I: Restrictive Thoracic Disorders

1. Neuromuscular disease or severe thoracic cage abnormality **AND**
2. One of the following
   a. Arterial blood gas $PaCO_2$, while awake and breathing patient's prescribed FIO2 is greater than 45 mm Hg, **OR**
   b. Sleep oximetry demonstrates oxygen saturation less than 88 percent for more than 5 minutes nocturnal, while breathing prescribed FiO_2, **OR**
   c. For neuromuscular disease (only)
      i. Maximal inspiratory pressure less than 60 cm H_2O **OR**
      ii. Forced vital capacity less than 50 percent predicted
3. COPD does not contribute significantly to patient's pulmonary function.

GROUP II: Severe COPD

Standard BiPAP without backup (E0470):

1. ABG $PaCO_2$, while awake and breathing patient's prescribed FiO_2 greater than 52 mm Hg; **AND**
2. Sleep oximetry demonstrates oxygen saturation of less than or equal to 88 percent for at least 5 minutes nocturnal, done while breathing at 2 lpm or the patient's prescribed FiO_2 (whichever is higher); **AND**
3. Prior to initiating therapy, sleep apnea and treatment with a continuous positive airway pressure device (CPAP) has been considered and ruled out. (Note: Formal sleep testing is not required if there is sufficient information in the medical record to demonstrate that the beneficiary does not suffer from some form of sleep apnea (Obstructive Sleep Apnea (OSA), CSA and/or Comp SA) as the predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation).

BiPAP with backup (E0471):
Covered for COPD in following two situations:

Situation 1 – BiPAP with backup started any time after a period of initial use of BiPAP without backup if both A and B are met:

A. ABG $PaCO_2$, while awake and breathing beneficiary's prescribed FiO_2, shows that the beneficiary's $PaCO_2$ worsens greater than or equal to 7 mm Hg compared to original result from #1 above.
B. Facility-based PSG demonstrates oxygen saturation less than or equal to 88 percent for at least five minutes nocturnal (minimum recording 2 hours) while using BiPAP without backup that is not caused by obstructive upper airway event.

Situation 2 – BiPAP with backup no sooner than 61 days after initial issue of BiPAP without backup if both A and B are met:

A. ABG $PaCO_2$ done while awake and breathing beneficiary's prescribed FiO_2, still remains greater than or equal to 52 mm Hg **AND**
B. Sleep oximetry, while breathing with BiPAP without backup, demonstrates oxygen saturation less than or equal to 88 percent for at least five minutes nocturnal, (minimum recording time of two hours) while breathing oxygen at 2 lpm or prescribed FiO_2, whichever is higher.

GROUP III: Central Sleep Apnea or Complex Sleep Apnea

Prior to initiating therapy, a complete, facility-based, attended polysomnogram must be performed documenting both A and B

A. Diagnosis of central sleep apnea (CSA) or complex sleep apnea (CompSA), **AND**
B. Significant improvement of the sleep-associated hypoventilation with the BiPAP with or without backup while breathing prescribed FIO2

Central sleep apnea (CSA) is defined as:

1. An apnea-hypopnea index (AHI) greater than or equal to five, **AND**
2. The sum total of central apneas plus central hypopneas is greater than 50% of the total apneas an hypopneas, AND
3. A central apnea-central hypopnea index (CAHI) is greater than or equal to 5 per hour, AND
4. Presence of at least one of the following:
   - Sleepiness
   - Difficulty initiating or maintaining sleep, frequent awakenings, or nonrestorative sleep,
   - Awakening short of breath
   - Snoring
   - Witnessed apneas
5. There is no evidence of daytime or nocturnal hypoventilation

Complex sleep apnea (CompSA) is a form of central apnea specifically identified by all of the following:

1. With use of a positive airway pressure device without a backup rate (E0601 or E0470), the polysomnogram (PSG) shows a pattern of apneas and hypopneas that demonstrates the persistence or emergence of central apneas or central hypopneas upon exposure to CPAP (E0601) or a bi-level device without backup rate (E0470) device when titrated to the point where obstructive events have been effectively treated (obstructive AHI less than 5 per hour).
2. After resolution of the obstructive events, the sum total of central apneas plus central hypopneas is greater than 50% of the total apneas and hypopneas; and
3. After resolution of the obstructive events, a central apnea-central hypopnea index (CAHI) greater than or equal to 5 per hour.

- For diagnosis of CSA, the central apnea-central hypopnea index (CAHI) is defined as the average number of episodes of central apnea and central hypopnea per hour of sleep without the use of a positive airway pressure device. For CompSA, the CAHI is determined during the use of a positive airway pressure device after obstructive events have disappeared.
- If the AHI or CAHI is calculated based on less than 2 hours of continuous recorded sleep, the total number of recorded events used to calculate the AHI or CAHI must be at least the number of events that would have been required in a 2-hour period (i.e., greater than or equal to 10 events).

GROUP IV: Hypoventilation Syndrome

BiPAP without backup covered if 1, 2, and either 3 or 4 are met:

1. ABG $PaCO_2$, done while awake breathing prescribed FiO_2 is greater than or equal to 45 mm Hg.
2. Spirometry shows FEV1/FVC greater than or equal to 70 percent.
3. ABG $PaCO_2$, done during sleep or immediately upon awaking breathing prescribed FiO_2 shows the beneficiary's $PaCO_2$ worsened greater than or equal to 7mm Hg compared to result in criterion 1 above.
4. PSG demonstrates oxygen saturation less than or equal to 88 percent for at least 5 minutes nocturnal (minimum recording time of two hours) not caused by obstructive upper airway events.

RADs continued

BiPAP with backup covered if 1, 2, and either 3 or 4 are met:

1. BiPAP without backup is being used.
2. Spirometry shows FEV1/FVC greater than or equal to 70 percent.
3. ABG $PaCO_2$ done while awake breathing prescribed FiO_2 shows the beneficiary's $PaCO_2$ worsens greater than or equal to 7 mm Hg compared to ABG performed to qualify for BiPAP without backup.
4. PSG demonstrates oxygen saturation less than or equal to 88 percent for at least 5 minutes nocturnal (minimum recording time of 2 hours) that is not caused by obstructive upper airway events.

Detailed Written Order requirements:

- Beneficiary's name
- Date of order, and start date if different
- Detailed description of item(s) being ordered such as device, humidity, type of mask, headgear, filters or tubing, or brand name/model number
- Pressure settings
- Frequency of use or duration
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and date

Continued coverage beyond the first three months:
Must be re-evaluated by treating practitioner no sooner than 61st day after initial therapy.

- Documenting that patient is compliant with the device. Compliance is using the machine for at least four hours per a 24-hour period.
- Documentation that patient is benefiting from use of the therapy.
- Make sure it's signed and dated by treating practitioner.

Positive Airway Pressure Devices (PAP)

For Positive Airway Pressure or BiPAP **without** backup—the only diagnosis that is covered is obstructive sleep apnea (OSA), 327.23.

For initial coverage, all three of the following have been met:

1. Evidence of a face-to-face evaluation by the treating practitioner prior to the sleep test to assess the patient for OSA.
2. Sleep test that meets the following:
   a. The AHI or RDI is greater than or equal to 15 events per hour with minimum of 30 events, **OR**
   b. The AHI or RDI is greater than or equal to 5 and less than 14 events per hour with a minimum of 10 events and documentation of:
      i. Excessive daytime sleepiness, impaired cognition, mood disorders, insomnia **OR**
      ii. Hypertension, ischemic heart disease or history of stroke
3. The patient and/or caregiver has received instruction from the supplier on the proper use and care of the equipment.

Detailed Written Order requirements:

- Beneficiary's name
- Date of order and start date, if different
- Detailed description of item(s) being ordered such as device, humidity, type of mask, headgear, filters or tubing, or brand name/model number
- Pressure settings
- Frequency of use or duration
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and date

Continued coverage beyond the first three months:
Between 31 and 91 days of therapy, the following must occur:

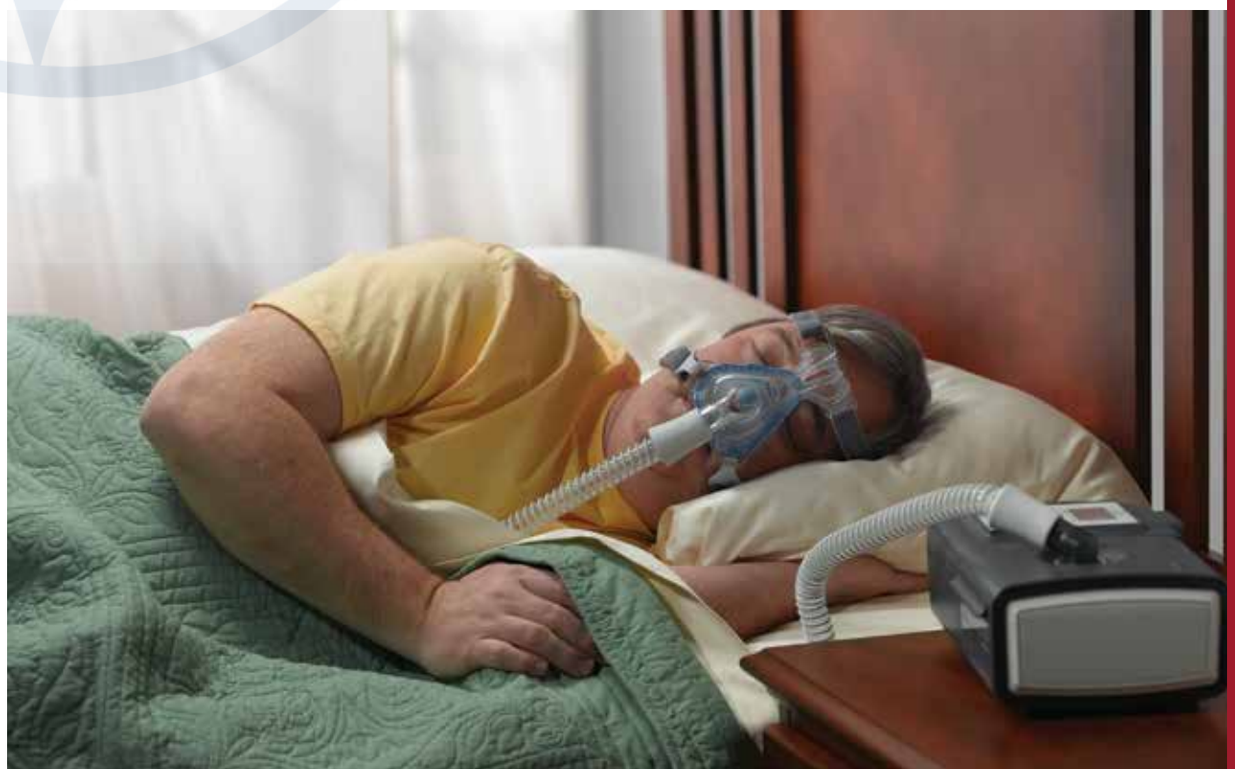
1. Face-to-face clinical re-evaluation with treating practitioner documenting that symptoms of OSA are improved and the patient is benefiting from therapy.
2. Objective evidence of adherence to therapy, reviewed by the treating practitioner. Adherence to therapy is using the PAP at a minimum of 4 hours per night on 70 percent of nights during a consecutive 30-day period anytime during the trial period.

If patient fails the initial three-month trial period, then they need to re-qualify for a PAP device and then follow the initial coverage criteria.

If PAP device is tried and found ineffective, whether it's during the facility testing or in the home, substitution of a BiPAP without backup may occur according to the following:

- If more than 30 days remaining in trial period, the length of the trial period does not change.
- If less than 30 days remaining in trial period, the length of the trial the clinical re-evaluation and adherence to therapy must occur before the 120th day.
- If PAP device was used more than 3 months, then switched, the clinical re-evaluation must occur between the 31st-91st day following the initiation of the BiPAP without backup.

Concurrent use of oxygen with PAP therapy
If a patient requires simultaneous use of home oxygen therapy and a PAP device, documentation by the treating practitioner in the medical record must clearly demonstrate that the requirements for coverage outlined in both the PAP and Oxygen policy have been met. Refer to the oxygen section for coverage criteria of home oxygen therapy.



Small Volume Nebulizer Machines

Nebulizers are covered only in the following situations indicated below by the charts. The medical record needs documentation to support the medical necessity to administer one of the following inhalation drugs for one of the listed conditions:

Drug	HCPCS Code	Covered Condition	ICD-9 Codes
Albuterol Arformoterol Budesonide Cromolyn Formoterol Ipratropium Levalbuterol Metaproterenol	J7611, J7613 J7605 J7626 J7631 J7606 J7644 J7612, J7614 J7669	Obstructive pulmonary disease	491.0–508.9
Dornase alpha	J7639	Cystic fibrosis	277.02
Tobramycin	J7682	 Cystic fibrosis Bronchiectasis	277.02 011.50–011.56 494.0, 494.1 748.61
Pentamidine	J2545	HIV Pneumocystosis Complications of organ transplant	042 136.3 996.80–996.89
Acetylcysteine	J7608	Persistent thick or tenacious pulmonary secretions	480.0–508.9, 786.4

Other Types of Nebulizers:

Equipment	Covered Condition and ICD-9 Codes
Large Volume Nebulizer = A7007, A7017 Related Compressor = E0565, E0572 Water or Saline = A4217, A7018	Cystic Fibrosis = 277.02 Bronchiectasis = 011.50-011.56, 494.0, 494.1, 748.61 Tracheostomy = V44.0, V55.0 Tracheobronchial stent = 519.19
Filtered Nebulizer = A7006 Compressor = E0565, E0572	HIV = 042 Pneumocystosis = 136.3 Complications of organ transplant = 996.80-996.89

Ultrasonic Nebulizer (E0574) with Treprostinil (J7686) or Controlled Dose Inhalation Drug Delivery System (K0730) and Iloprost (Q4074), the following criteria needs to be met:

1. Patient has diagnosis of pulmonary artery hypertension (416.0 or 416.8), **AND**
2. Pulmonary hypertension is not secondary to pulmonary venous hypertension or disorders of the respiratory system, **AND**
3. Patient has primary pulmonary hypertension or pulmonary hypertension which is secondary to one of the following conditions:
   - Connective tissue disease, **OR**
   - Thromboembolic disease of the pulmonary arteries, **OR**
   - HIV infection, **OR**
   - Cirrhosis, **OR**
   - Anorexigens (diet drugs), **OR**
   - Congenital left to right shunts, etc, **AND**

   a) If one of the above conditions is present, the following criteria must also be met:
      i. Pulmonary hypertension has progressed despite maximal medical and/or surgical treatment of the identified condition, **AND**
      ii. Mean pulmonary artery pressure is greater than 25 mm Hg at rest or greater than 30 mm Hg with exertion, **AND**
      iii. Patient has significant symptoms from the pulmonary hypertension (such as severe dyspnea on exertion, fatigue, angina, syncope) **AND**
      iv. Treatment with oral calcium channel blocking agents has been tried and failed, or has been considered and ruled out

If none of the drugs used with a nebulizer are covered, the compressor, the nebulizer, and other related accessories/supplies will be denied as not reasonable and necessary.

Detailed Written Order requirements:

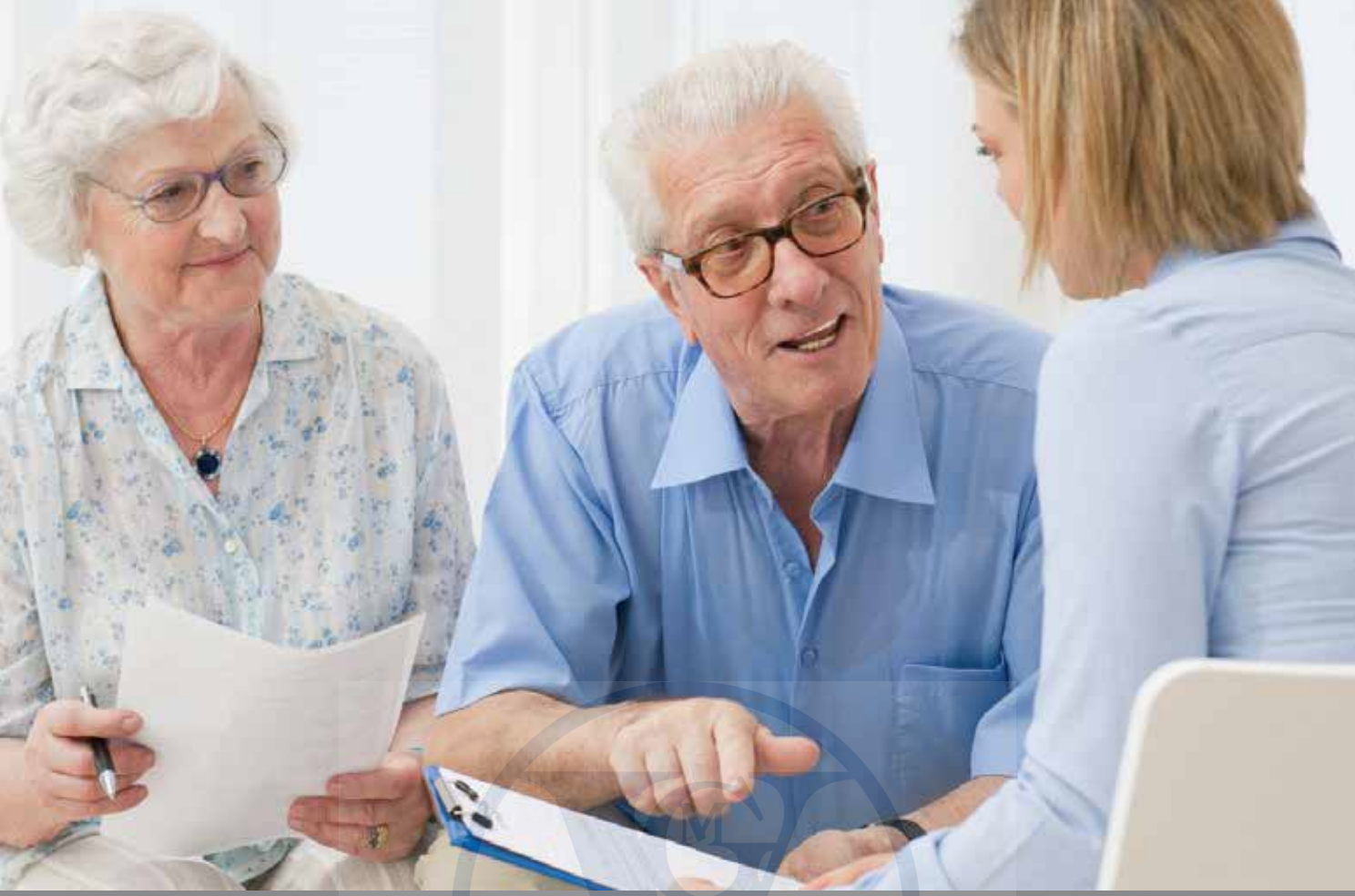
- Beneficiary's name
- Date of order, and start date if different
- Detailed description of the DME item being ordered or brand name/model number
- Name, dosage, and concentration of drug(s) being dispensed
- Specific frequency and duration of administration
- Quantity to be dispensed
- Number of refills
- Treating practitioner's printed name and NPI
- Treating practitioner's signature and date

INHALATION DRUGS AND SOLUTIONS	MAXIMUM MILLIGRAMS/MONTH
Acetylcysteine	74 grams/month
Albuterol	465 mg/month (See below for exception)
Albuterol/Ipratropium combination	186 units/month
Arformoterol	930 micrograms per month – 62 units per month
Budesonide	62 units per month
Cromolyn sodium	2480 mg/month – 248 units/month
Dornase alpha	78 mg/month
Formoterol	1240 micrograms per month – 62 units per month
Ipratropium bromide	93 mg/month
Levalbuterol	232.5 mg/month – 465 units/month (See below for exception)
Metaproterenol	2800 mg/month – 280 units per month (See below for exception)
Pentamidine	300 mg/month
Treprostinil	31 units/month
Sterile saline or water, 10ml/unit (A4216, A4218)	56 units/month
Distilled water, sterile water, or sterile saline in large volume nebulizer	18

When albuterol, levalbuterol, or metaproterenol are prescribed as rescue/supplemental medication for beneficiaries who are taking formoterol or arformoterol, the maximum milligrams/month that are reasonably billed are:

DRUG	MAXIMUM MILLIGRAMS/MONTH
Albuterol	78 mg/month
Albuterol/Ipratroprium combination	31 units/month
Levalbuterol	39 mg/month – 78 units/month
Metaproterenol	470 mg/month – 47 units/month

Claims for more than these amounts of drugs will be denied as not reasonable and necessary.



We are happy to provide the equipment needed by your Medicare patients and, for your convenience, we've provided this quick reference guide, which contains reimbursement guidelines. Together we can continue to ensure that patients get the highest quality care and the equipment they need in the most timely manner possible.

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