Local Coverage Determination (LCD):
High Frequency Chest Wall Oscillation Devices (L33785)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

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 North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC J-A		Connecticut District of Columbia Delaware Massachusetts Maryland Maine 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 Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Utah Washington Wyoming Northern Mariana Islands

Back to Top

LCD Information

Document Information

LCD ID
L33785

Original ICD-9 LCD ID
L27042
L12934
L12870
L12739

LCD Title
High Frequency Chest Wall Oscillation Devices

Proposed LCD in Comment Period
N/A

Source Proposed LCD
N/A

CMS National Coverage Policy N/A

Original Effective Date
For services performed on or after 10/01/2015

Revision Effective Date
For services performed on or after 10/01/2017

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
N/A

Notice Period End Date
N/A

Coverage Guidance
Coverage Indications, Limitations, and/or Medical Necessity

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.

The purpose of a Local Coverage Determination (LCD) is to provide information regarding "reasonable and necessary" criteria based on Social Security Act § 1862(a)(1)(A) provisions.

In addition to the "reasonable and necessary" criteria contained in this LCD there are other payment rules, which are discussed in the following documents, that must also be met prior to Medicare reimbursement:

- The LCD-related Standard Documentation Requirements Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- The LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.
- Refer to the Supplier Manual for additional information on documentation requirements.
- Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

For the items addressed in this LCD, the "reasonable and necessary" criteria, based on Social Security Act § 1862(a)(1)(A) provisions, are defined by the following coverage indications, limitations and/or medical necessity.

High frequency chest wall oscillation devices (HFCWO) (E0483) are covered for beneficiaries who meet:

A. Criterion 1, 2, or 3, and
B. Criterion 4
    1. There is a diagnosis of cystic fibrosis (see diagnosis codes that support medical necessity section below).
    2. There is a diagnosis of bronchiectasis (see diagnosis codes that support medical necessity section below) which has been confirmed by a high resolution, spiral, or standard CT scan and which is characterized by:
        a. Daily productive cough for at least 6 continuous months; or
        b. Frequent (i.e., more than 2/year) exacerbations requiring antibiotic therapy.

       Chronic bronchitis and chronic obstructive pulmonary disease (COPD) in the absence of a confirmed diagnosis of bronchiectasis do not meet this criterion.
    3. The beneficiary has one of the following neuromuscular disease diagnoses (see diagnosis codes that support medical necessity section below):
       Post-polio
       Acid maltase deficiency
       Anterior horn cell diseases
       Multiple sclerosis
       Quadriplegia
       Hereditary muscular dystrophy
       Myotonic disorders
       Other myopathies
       Paralysis of the diaphragm
    4. There must be well-documented failure of standard treatments to adequately mobilize retained secretions.

If all of the criteria are not met, the claim will be denied as not reasonable and necessary.

It is not reasonable and necessary for a beneficiary to use both a HFCWO device and a mechanical in-exsufflation device (E0482).

Replacement supplies, A7025 and A7026, used with beneficiary owned equipment, are covered if the beneficiary meets the criteria listed above for the base device, E0483. If these criteria are not met claims will be denied as not reasonable and necessary.

GENERAL

A Detailed Written Order (DWO) (if applicable) must be received by the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) base items that require a Written Order Prior to Delivery (WOPD), the supplier must also obtain a DWO before submitting a claim for any associated options, accessories, and/or supplies that are separately billed. In this scenario, if the supplier bills for associated options, accessories, and/or supplies without first receiving a completed DWO, the claim shall be denied as not reasonable and necessary.

A WOPD (if applicable) must be received by the supplier before a DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a completed WOPD, the claim shall be statutorily denied. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

An item/service is correctly coded when it meets all the coding guidelines listed in CMS HCPCS guidelines, LCDs, LCD-related Policy Articles, or DME MAC articles. Claims that do not meet coding guidelines shall be denied as not reasonable and necessary/incorrectly coded.

Proof of delivery (POD) is a Supplier Standard and DMEPOS suppliers are required to maintain POD documentation in their files. Proof of delivery documentation must be made available to the Medicare contractor upon request. All services that do not have appropriate proof of delivery from the supplier shall be denied as not reasonable and necessary.

Summary of Evidence

N/A

Analysis of Evidence
(Rationale for Determination)

N/A

Back to Top

Coding Information

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy 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 policy, 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 policy should be assumed to apply equally to all Revenue Codes.

N/A
CPT/HCPCS Codes
Group 1 Paragraph:

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

HCPCS MODIFIERS:

EY - No physician or other licensed health care provider order for this item or service

GA - Waiver of liability statement issued as required by payer policy, individual case

GZ - Item or service expected to be denied as not reasonable and necessary

KX – Requirements specified in the medical policy have been met

HCPCS CODES:

Group 1 Codes:

A7025	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH
A7026	HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH
E0483	HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES HOSES AND VEST), EACH

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 section on "Indications and Limitations of Coverage and/or Medical Necessity" for other coverage criteria and payment information.

Group 1 Codes:

ICD-10 Codes	Description
A15.0	Tuberculosis of lung
B91	Sequelae of poliomyelitis
D81.810	Biotinidase deficiency
D84.1	Defects in the complement system
E84.0	Cystic fibrosis with pulmonary manifestations
E84.9	Cystic fibrosis, unspecified
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.20	Motor neuron disease, unspecified
G12.21	Amyotrophic lateral sclerosis
G12.22	Progressive bulbar palsy
G12.23	Primary lateral sclerosis
G12.24	Familial motor neuron disease
G12.25	Progressive spinal muscle atrophy
G12.29	Other motor neuron disease
G12.8	Other spinal muscular atrophies and related syndromes
G12.9	Spinal muscular atrophy, unspecified
G14	Postpolio syndrome
G35	Multiple sclerosis
G71.0	Muscular dystrophy

ICD-10 Codes	Description
G71.11	Myotonic muscular dystrophy
G71.12	Myotonia congenita
G71.13	Myotonic chondrodystrophy
G71.14	Drug induced myotonia
G71.19	Other specified myotonic disorders
G71.2	Congenital myopathies
G71.3	Mitochondrial myopathy, not elsewhere classified
G71.8	Other primary disorders of muscles
G72.0	Drug-induced myopathy
G72.1	Alcoholic myopathy
G72.2	Myopathy due to other toxic agents
G72.89	Other specified myopathies
G73.7	Myopathy in diseases classified elsewhere
G82.50	Quadriplegia, unspecified
G82.51	Quadriplegia, C1-C4 complete
G82.52	Quadriplegia, C1-C4 incomplete
G82.53	Quadriplegia, C5-C7 complete
G82.54	Quadriplegia, C5-C7 incomplete
J47.0	Bronchiectasis with acute lower respiratory infection
J47.1	Bronchiectasis with (acute) exacerbation
J47.9	Bronchiectasis, uncomplicated
J98.6	Disorders of diaphragm
M33.02	Juvenile dermatomyositis with myopathy
M33.12	Other dermatomyositis with myopathy
M33.22	Polymyositis with myopathy
M33.92	Dermatopolymyositis, unspecified with myopathy
M34.82	Systemic sclerosis with myopathy
M35.03	Sicca syndrome with myopathy
Q33.4	Congenital bronchiectasis

ICD-10 Codes that DO NOT Support Medical Necessity
Group 1 Paragraph: All ICD-10 codes that are not specified in the previous section

Group 1 Codes: N/A

ICD-10 Additional Information Back to Top

General Information

Associated Information
DOCUMENTATION REQUIREMENTS

Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider." It is expected that the beneficiary's medical records will reflect the need for the care provided. The beneficiary's medical records include the treating practitioner's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request.

GENERAL DOCUMENTATION REQUIREMENTS

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Prescription (orders)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

Refer to the LCD-related Standard Documentation Requirements article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information regarding these requirements.

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

Refer to the DME MAC web sites for additional bulletin articles and other publications related to this LCD.

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS

Items covered in this LCD have additional policy-specific requirements that must be met prior to Medicare reimbursement.

Refer to the LCD-related Policy article, located at the bottom of this policy under the Related Local Coverage Documents section for additional information.

Miscellaneous

Appendices

Utilization Guidelines

Refer to Coverage Indications, Limitations and/or Medical Necessity.

Sources of Information
N/A
Bibliography

N/A

Back to Top

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
10/01/2017	R5	Revision Effective Date: 10/01/2017 ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY: Added: New ICD-10 codes Revised: ICD-10 code descriptions *11/30/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.*	• Revisions Due To ICD-10-CM Code Changes
01/01/2017	R4	Revision Effective Date: 01/01/2017 COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Removed: Standard Documentation Language Added: New reference language and directions to Standard Documentation Requirements Added: General Requirements DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: General Documentation Requirements	• Provider Education/Guidance

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
		Added: New reference language and directions to Standard Documentation Requirements POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Removed: Standard Documentation Language Added: Direction to Standard Documentation Requirements Removed: Supplier Manual reference under Miscellaneous Removed: PIM reference under Appendices RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements article	
07/01/2016	R3	**Revision Effective Date 07/01/2016** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation language - ACA order requirements – Effective 04/28/16 DOCUMENTATION REQUIREMENTS: Revised: Standard documentation language for orders, ACA order requirements, added New order requirements, and Correct coding instructions; revised Proof of delivery instructions – Effective 04/28/16	• Provider Education/Guidance
07/01/2016	R2	Effective July 1, 2016 oversight for DME MAC LCDs 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 LCDs.	• Change in Assigned States or Affiliated Contract Numbers
10/01/2015	R1	**Revision Effective Date: 10/31/2014** COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY: Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility Removed: Refill Requirements DOCUMENTATION REQUIREMENTS: Revised: Standard Documentation Language to add who can enter date of delivery date on the POD Removed: Request for refill documentation requirements Added: Instructions for Equipment Retained from a Prior Payer Added: Instruction for Repair Replacement	• Provider Education/Guidance

Back to Top

Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) A52494 - High Frequency Chest Wall Oscillation Devices - Policy Article A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs

Related National Coverage Documents N/A

Public Version(s) Updated on 11/21/2017 with effective dates 10/01/2017 - N/A Updated on 03/24/2017 with effective dates 01/01/2017 - 09/30/2017 Some older versions have been archived. Please visit the MCD Archive Site to retrieve them. Back to Top

Keywords

N/A Read the **LCD Disclaimer** Back to Top

END OF LOCAL COVERAGE DETERMINATION

Per the Code of Federal Regulations, 42 C.F.R § 426. 325, only those portions of the currently effective Local Coverage Determination (LCD) that are based on section 1862(a)(1)(A) of the Social Security Act, may be challenged through an acceptable complaint as described in 42 C.F.R § 426.400. Also, per 42 C.F.R § 426.325 items that are not reviewable, and therefore cannot be challenged, include the Policy Article. Please note the distinction of the documents when reviewing the materials.

Local Coverage Article:
High Frequency Chest Wall Oscillation Devices - Policy Article (A52494)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

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 North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC J-A		Connecticut District of Columbia Delaware Massachusetts Maryland Maine 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 Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
				Oregon South Dakota Utah Washington Wyoming Northern Mariana Islands

Back to Top

Article Information

General Information

Article ID
A52494

Original ICD-9 Article ID
A47080
A25519
A25231
A25365

Article Title
High Frequency Chest Wall Oscillation Devices - Policy Article

Original Article Effective Date
10/01/2015

Revision Effective Date
01/01/2018

Revision Ending Date
N/A

Retirement Date
N/A

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").

High frequency chest wall oscillation devices are covered under the Durable Medical Equipment 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.

Requirements for specified DMEPOS items pursuant to 42 CFR 410.38(g)

42 CFR 410.38(g) requires a face-to-face evaluation and a specific written order prior to delivery for specified HCPCS codes. CMS provides a list of the specified codes, which is periodically updated, located here.

Claims for the specified items subject to 42 CFR 410.38(g) that do not meet the requirements specified in the LCD-related Standard Documentation Requirements Article will be denied as statutorily noncovered – failed to meet statutory requirements.

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

The diagnosis code that justifies the need for these items must be included on the claim.

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.

MODIFIERS

KX, GA, AND GZ MODIFIERS:

Suppliers must add a KX modifier to codes for an HFCWO device and accessories only if all of the criteria in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD have been met.

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

There must be information in the beneficiary's medical record that describes in detail the underlying medical condition(s) that cause the accumulation of pulmonary secretions, the treatment interventions (for example, chest physiotherapy, postural drainage, medications used, mechanical modalities such as in-exsufflation devices, etc. (not all-inclusive)) and the effectiveness of the treatment. This information must be available upon request.

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

CODING GUIDELINES

HCPCS Code E0483 (HIGH FREQUENCY CHEST WALL OSCILLATION AIR-PULSE GENERATOR SYSTEM, (INCLUDES

HOSES AND VEST), EACH) devices (HFCWO) use positive and negative pressure changes to augment peripheral and tracheal mucus movement towards the airway opening. This function is performed by extra-thoracic oscillations generated by forces external to the respiratory system. External chest wall oscillations are applied using a vest worn around the torso, which vibrates at variable frequencies and intensities, as set by the operator. E0483 devices may use differing technologies, e.g. air-pulse generators and an inflatable vest, an array of mechanical oscillators in a vest providing synchronized oscillation, etc. E0483 is all-inclusive regardless of the technique used to produce HFCWO.

HCPCS Code A7025 (HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM VEST, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH) describes a complete replacement vest. This includes all components such as mechanical oscillators, electrical componentry, inflatable air sacs, connectors, etc. Separate billing of vest components when an entire vest is replaced is incorrect coding – unbundling.

HCPCS Code A7026 (HIGH FREQUENCY CHEST WALL OSCILLATION SYSTEM HOSE, REPLACEMENT FOR USE WITH PATIENT OWNED EQUIPMENT, EACH) describes the tubing used with an air pulse generator type of HFCWO device.

HCPCS Code E0483 describes a complete system. Separate billing of A7025 and/or A7026 in combination with E0483 is incorrect coding – unbundling.

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

Back to Top

Coding Information

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

CPT/HCPCS Codes N/A

ICD-10 Codes that are Covered

Group 1 Paragraph:

Group 1 Codes: N/A

ICD-10 Codes that are covered Information Table

Code Description

ICD-10 Codes that are Not Covered N/A

Back to Top

Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
		Revision Effective Date: 01/01/2018 CODING GUIDELINES: Added: Coding guidelines for HCPCS codes E0483, A7025, A7026
01/01/2018	R6	
		04/05/18: 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:
01/01/2017	R5	Added: REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PERSUANT TO 42 CFR 410.38(g), previously in the Policy Specific Documentation Requirements section
		11/23/17: 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:
01/01/2017	R4	Added: 42 CFR 410.38(g) and Modifier instructions RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article
07/01/2016	R3	**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	R2	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.
10/01/2015	R1	**Revision Effective Date: 10/31/2014** NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Removed: "When required by state law" from ACA new prescription requirements Revised: Face-to-Face Requirements for treating practitioner

Back to Top **Related Local Coverage Document(s)** Article(s) A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs LCD(s) L33785 - High Frequency Chest Wall Oscillation Devices

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

Public Version(s) Updated on 03/28/2018 with effective dates 01/01/2018 - N/A Updated on 11/21/2017 with effective dates 01/01/2017 - N/A Updated on 03/24/2017 with effective dates 01/01/2017 - N/A Some older versions have been archived. Please visit MCD Archive Site to retrieve them. Back to Top

Keywords

N/A Read the **Article Disclaimer** Back to Top