

# Local Coverage Determination (LCD): Mechanical In-exsufflation Devices (L33795)

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">CGS Administrators, LLC</a>	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
<a href="#">CGS Administrators, LLC</a>	DME MAC	18003 -	DME MAC J-C	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	16013 -	DME MAC J-A	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	19003 -	DME MAC J-D	

## LCD Information

### Document Information

LCD ID L33795	Original Effective Date For services performed on or after 10/01/2015
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Original ICD-9 LCD ID <a href="#">L12872</a> <a href="#">L12930</a> <a href="#">L27043</a> <a href="#">L12744</a>	Revision Effective Date For services performed on or after 10/01/2017
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	Revision Ending Date N/A
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LCD Title Mechanical In-exsufflation Devices	Retirement Date N/A
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Proposed LCD in Comment Period N/A	Notice Period Start Date N/A
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Source Proposed LCD N/A	Notice Period End Date N/A
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## 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.

Mechanical in-exsufflation devices (E0482) are covered for beneficiaries who meet all of the following criteria;

1. They have a neuromuscular disease (refer to diagnosis code section below), and
2. This condition is causing a significant impairment of chest wall and/or diaphragmatic movement, such that it results in an inability to clear retained secretions.

If both of these criteria are not met, the claim 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

NA

## Analysis of Evidence (Rationale for Determination)

NA

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## 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

### **Group 1 Codes:**

A7020 INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY

E0482 COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE

### 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 "Coverage Indications, Limitations and/or Medical Necessity" for other coverage criteria and payment information.

For HCPCS Code E0482:

**Group 1 Codes:**

<b>ICD-10 Codes</b>	<b>Description</b>
B91	Sequelae of poliomyelitis
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
G71.11	Myotonic muscular dystrophy
G71.2	Congenital myopathies
G72.41	Inclusion body myositis [IBM]
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

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](#)

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## [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 physician'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 to justify 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

NA

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# **Revision History Information**

<b>Revision History Date</b>	<b>Revision History Number</b>	<b>Revision History Explanation</b>	<b>Reason(s) for Change</b>
10/01/2017	R4	<p><b>Revision Effective Date: 10/01/2017</b>            ICD-10 Codes that Support Medical Necessity:            Added: New ICD-10 codes            POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:            Clarified: Verbiage in Policy Specific Documentation Requirements            10/26/2017: 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.</p>	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>

Revision History Date	Revision History Number	Revision History Explanation	Reason(s) for Change
01/01/2017	R3	<p><b>Revision Effective Date: 01/01/2017</b>            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            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: Information under Miscellaneous and Appendices            RELATED LOCAL COVERAGE DOCUMENTS:            Added: LCD-related Standard Documentation Requirements article</p>	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>
07/01/2016	R2	<p>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.            Revision Effective Date: 10/01/2015            COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p>	<ul style="list-style-type: none"> <li>Change in Assigned States or Affiliated Contract Numbers</li> </ul>
10/01/2015	R1	<p>Revised: Standard Documentation Language to add covered prior to a beneficiary's Medicare eligibility            DOCUMENTATION REQUIREMENTS:            Revised: Standard Documentation Language to add who can enter date of delivery date on the POD            Added: Instructions for Equipment Retained from a Prior Payer            Added: Repair/Replacement section            Revised: Diagnosis code statement</p>	<ul style="list-style-type: none"> <li>Provider Education/Guidance</li> </ul>

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## Associated Documents

Attachments N/A

Related Local Coverage Documents Article(s) [A52510 - Mechanical In-exsufflation 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 10/19/2017 with effective dates 10/01/2017 - N/A [Updated on 04/21/2017 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: Mechanical In-exsufflation Devices - Policy Article (A52510)

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## Contractor Information

Contractor Name	Contract Type	Contract Number	Jurisdiction	State(s)
<a href="#">CGS Administrators, LLC</a>	DME MAC	17013 -	DME MAC J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi North Carolina New Mexico Oklahoma Puerto Rico South Carolina Tennessee Texas Virginia Virgin Islands West Virginia Connecticut District of Columbia Delaware Massachusetts Maryland Maine New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont Alaska American Samoa Arizona California - Entire State Guam Hawaii Iowa Idaho Kansas Missouri - Entire State Montana North Dakota Nebraska Nevada Oregon South Dakota
<a href="#">CGS Administrators, LLC</a>	DME MAC	18003 -	DME MAC J-C	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	16013 -	DME MAC J-A	
<a href="#">Noridian Healthcare Solutions, LLC</a>	DME MAC	19003 -	DME MAC J-D	

## Article Information

### General Information

**Article ID**

A52510

**Original Article Effective Date**

10/01/2015

Original ICD-9 Article ID

[A33767](#)[A33749](#)[A47096](#)[A33676](#)**Revision Effective Date**

01/01/2017

**Revision Ending Date**

N/A

**Article Title**

Mechanical In-exsufflation Devices - Policy Article

**Retirement Date**

N/A

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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").

Mechanical in-exsufflation equipment is 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 SPECIFIC DMEPOS ITEMS PERSUANT 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.

#### **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.

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

#### **CODING GUIDELINES**

Mechanical in-exsufflation devices are designed to slowly inflate the lungs with positive pressure during inspiration and simulate cough with rapidly applied negative pressure during expiration.

A7020 (INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY) is for replacement only. It must not be billed at the time of initial issue.

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

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## **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** N/A

**ICD-10 Codes that are Not Covered** N/A

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## Revision History Information

Revision History Date	Revision History Number	Revision History Explanation
01/01/2017	R4	<b>Revision Effective Date: 01/01/2017</b> NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES Added: 42 CFR 410.38(g) language, previously in Policy Specific Documentation Requirement section
01/01/2017	R3	<i>04/05/2018: 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</i> Revision Effective Date: 01/01/2017 POLICY SPECIFIC DOCUMENTATION REQUIREMENTS: Added: 42 CFR 410.38(g) requirements RELATED LOCAL COVERAGE DOCUMENTS: Added: LCD-related Standard Documentation Requirements Language Article 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	R2	Revision Effective Date: 10/01/2015 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
10/01/2015	R1	

[Back to Top](#) **Related Local Coverage Document(s)** Article(s) [A55426 - Standard Documentation Requirements for All Claims Submitted to DME MACs](#) LCD(s) [L33795 - Mechanical In-exsufflation 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

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## Keywords

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