

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

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

## LCD Information

### Document Information

**LCD ID**

L33795

**Original Effective Date**

For services performed on or after 10/01/2015

**LCD Title**

Mechanical In-exsufflation Devices

**Revision Effective Date**

For services performed on or after 01/01/2020

**Proposed LCD in Comment Period**

N/A

**Revision Ending Date**

N/A

**Source Proposed LCD**

N/A

**Retirement Date**

N/A

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**Notice Period Start Date**

N/A

**Notice Period End Date**

N/A

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## **CMS National Coverage Policy**

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.

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

1. They have a neuromuscular disease (refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses), 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 Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. If the supplier bills for an item addressed in this policy without first receiving a completed SWO, 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 have received a signed SWO before the DMEPOS item is delivered to a beneficiary. If a supplier delivers a DMEPOS item without first receiving a WOPD, the claim shall be denied as not reasonable and necessary. Refer to the LCD-related Policy Article, located at the bottom of this policy under the Related Local Coverage Documents section.

For DMEPOS base items that require a WOPD, and also require separately billed associated options, accessories, and/or supplies, the supplier must have received a WOPD which lists the base item and which may list all the associated options, accessories, and/or supplies that are separately billed prior to the delivery of the items. In this scenario, if the supplier separately bills for associated options, accessories, and/or supplies without first receiving a completed and signed WOPD of the base item prior to delivery, the claim(s) shall be denied as not reasonable and necessary.

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

**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:**

CODE	DESCRIPTION
A7020	INTERFACE FOR COUGH STIMULATING DEVICE, INCLUDES ALL COMPONENTS, REPLACEMENT ONLY
E0482	COUGH STIMULATING DEVICE, ALTERNATING POSITIVE AND NEGATIVE AIRWAY PRESSURE

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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 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:

- SWO
- 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**

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
01/01/2020	R8	<p><b>Revision Effective Date: 01/01/2020</b></p> <p>CODING INFORMATION:  Removed: Field titled "Bill Type"  Removed: Field titled "Revenue Codes"  Removed: Field titled "ICD-10 Codes that Support Medical Necessity"  Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"  Removed: Field titled "Additional ICD-10 Information"</p> <p><i>As required by CR 10901, the ICD-10 information has been moved to all Policy Articles. There is no change in coverage.</i></p>	<ul style="list-style-type: none"> <li>• Other</li> </ul>
01/01/2020	R7	<p><b>Revision Effective Date: 01/01/2020</b></p> <p>COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:  Removed: Statement to refer to ICD-10 Codes that are Covered section in the LCD-related PA  Added: Statement to refer to ICD-10 code list in the LCD-related Policy Article</p> <p>GENERAL:  Revised: Order information as a result of Final Rule 1713</p> <p>DOCUMENTATION REQUIREMENTS:  Revised: "physician's" to "treating practitioner's"</p> <p>GENERAL DOCUMENTATION REQUIREMENTS:  Revised: "Prescriptions (orders)" to "SWO"</p> <p><i>02/06/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates reflective of CMS FR-1713.</i></p>	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> </ul>
01/01/2019	R6	<p><b>Revision Effective Date: 01/01/2019</b></p> <p>COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:  Removed: Statement to refer to diagnosis code section below  Added: Refer to Covered ICD-10 Codes in the LCD-related Policy Article</p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:  Moved: All diagnosis codes to the LCD-related Policy Article diagnosis code section per CMS instruction</p>	<ul style="list-style-type: none"> <li>• Other (ICD-10 code relocation per CMS instruction)</li> </ul>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:            Moved: Statement about noncovered diagnosis code moved to LCD-related Policy Article noncovered diagnosis section per CMS instruction</p>	
10/01/2018	R5	<p><b>Revision Effective Date: 10/01/2018</b>            ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:            Removed: ICD-10 Code G71.0 due to annual ICD-10 Code updates            Added: New expanded ICD-10 codes for those removed.</p> <p><i>09/27/2018: 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.</i></p>	<ul style="list-style-type: none"> <li>• Revisions Due To ICD-10-CM Code Changes</li> </ul>
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>
01/01/2017	R3	<p><b>Revision Effective Date: 01/01/2017</b>            COVERAGE INDICATIONS, INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:</p>	<ul style="list-style-type: none"> <li>• Provider Education/Guidance</li> </ul>



REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		<p>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>	
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.</p>	<ul style="list-style-type: none"> <li>• Change in Assigned States or Affiliated Contract Numbers</li> </ul>
10/01/2015	R1	<p>Revision Effective Date: 10/01/2015  COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:  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>

## 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 02/13/2020 with effective dates 01/01/2020 - N/A

Updated on 01/30/2020 with effective dates 01/01/2020 - N/A

Updated on 02/15/2019 with effective dates 01/01/2019 - 12/31/2019

Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

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## **Keywords**

N/A

**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)
CGS Administrators, LLC	DME MAC	17013 - DME MAC	J-B	Illinois Indiana Kentucky Michigan Minnesota Ohio Wisconsin
CGS Administrators, LLC	DME MAC	18003 - DME MAC	J-C	Alabama Arkansas Colorado Florida Georgia Louisiana Mississippi New Mexico North Carolina Oklahoma Puerto Rico South Carolina Tennessee Texas Virgin Islands Virginia West Virginia
Noridian Healthcare Solutions, LLC	DME MAC	16013 - DME MAC	J-A	Connecticut Delaware District of Columbia Maine Maryland Massachusetts New Hampshire New Jersey New York - Entire State Pennsylvania Rhode Island Vermont

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	DME MAC	19003 - DME MAC	J-D	Alaska American Samoa Arizona California - Entire State Guam Hawaii Idaho Iowa Kansas Missouri - Entire State Montana Nebraska Nevada North Dakota Northern Mariana Islands Oregon South Dakota Utah Washington Wyoming

## Article Information

### General Information

**Article ID**

A52510

**Original Effective Date**

10/01/2015

**Original ICD-9 Article ID**

[A33767](#)

[A33749](#)

[A47096](#)

[A33676](#)

**Revision Effective Date**

10/01/2020

**Revision Ending Date**

N/A

**Article Title**

Mechanical In-exsufflation Devices - Policy Article

**Retirement Date**

N/A

**Article Type**

Article

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## **Article Guidance**

### **Article Text:**

### **NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES**

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. Information provided in this policy article relates to determinations other than those based on Social Security Act §1862(a)(1)(A) provisions (i.e. "reasonable and necessary").

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 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 link will be located here once it is available.

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

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

Code E0467 (HOME VENTILATOR, MULTI-FUNCTION RESPIRATORY DEVICE, ALSO PERFORMS ANY OR ALL OF THE ADDITIONAL FUNCTIONS OF OXYGEN CONCENTRATION, DRUG NEBULIZATION, ASPIRATION, AND COUGH STIMULATION, INCLUDES ALL ACCESSORIES, COMPONENTS AND SUPPLIES FOR ALL FUNCTIONS) describes a ventilator that integrates the function of multiple types of equipment into a single device. Code E0467 combines the function of a ventilator with those of any combination or all of the following:

- Oxygen equipment
- Nebulizer and compressor
- Aspirator (suction device)
- Cough stimulator (multiple products)

- Positive airway pressure devices (PAP and RAD)
- Custom fabricated oral appliances

The following mechanical in-exsufflation HCPCS codes for individual items are included in the functionality of code E0467:

- HCPCS codes E0482 and A7020

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

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

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

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

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

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

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

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

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

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## Coding Information

### CPT/HCPCS Codes

N/A

### ICD-10 Codes that Support Medical Necessity

#### Group 1 Paragraph:



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

For HCPCS Code E0482:

**Group 1 Codes:**

ICD-10 CODE	DESCRIPTION
B91	Sequelae of poliomyelitis
E74.02	Pompe disease
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
G70.01	Myasthenia gravis with (acute) exacerbation
G71.00	Muscular dystrophy, unspecified
G71.01	Duchenne or Becker muscular dystrophy
G71.02	Facioscapulohumeral muscular dystrophy
G71.09	Other specified muscular dystrophies
G71.11	Myotonic muscular dystrophy
G71.20	Congenital myopathy, unspecified
G71.21	Nemaline myopathy
G71.220	X-linked myotubular myopathy
G71.228	Other centronuclear myopathy
G71.29	Other congenital myopathy
G72.41	Inclusion body myositis [IBM]

ICD-10 CODE	DESCRIPTION
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

### Additional ICD-10 Information

N/A

#### Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the 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

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## Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
10/01/2020	R9	<p><b>Revision Effective Date: 10/01/2020</b></p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:  Removed: ICD-10 code G71.2 from Group 1, due to annual ICD-10 Code updates</p> <p>Added: ICD-10 codes G71.20, G71.21, G71.220, G71.228, G71.29 to Group 1 codes, due to annual ICD-10 Code updates</p> <p><i>09/24/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
04/03/2020	R8	<p><b>Revision Effective Date: 04/03/2020</b></p> <p>CODING GUIDELINES:  Revised: Guidance for billing HCPCS code E0467 based on DOS</p> <p><i>07/16/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2020	R7	<p><b>Revision Effective Date: 01/01/2020</b></p> <p>REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO 42 CFR 410.38(g):  Removed: Due to Final Rule 1713</p> <p>REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):  Added: Section information based on Final Rule 1713</p> <p>ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:  Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"</p> <p>ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:  Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"</p> <p><i>02/06/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2019	R6	<p><b>Revision Effective Date: 01/01/2019</b></p> <p>CODING GUIDELINES:  Revised: E0467 Coding Guidelines to include custom fabricated oral appliances</p> <p><i>04/04/2019: At this time 21st Century Cures Act applies to new and revised</i></p>

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
		<i>LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i>
01/01/2019	R5	<p><b>Revision Effective Date: 01/01/2019</b></p> <p>CODING GUIDELINES:  Added: E0467 Coding Guidelines</p> <p>ICD-10 CODES THAT ARE COVERED:  Added: All diagnosis codes formerly listed in the LCD  Added: ICD-10 codes E74.02 and G70.01</p> <p>ICD-10 CODES THAT ARE NOT COVERED:  Added: Notation excluding all unlisted diagnosis codes from coverage</p> <p><i>02/21/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.</i></p>
01/01/2017	R4	<p><b>Revision Effective Date: 01/01/2017</b></p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES  Added: 42 CFR 410.38(g) language, previously in Policy Specific Documentation Requirement section</p> <p><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></p>
01/01/2017	R3	<p>Revision Effective Date: 01/01/2017</p> <p>POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:  Added: 42 CFR 410.38(g) requirements</p> <p>RELATED LOCAL COVERAGE DOCUMENTS:  Added: LCD-related Standard Documentation Requirements Language Article</p>
07/01/2016	R2	<p>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.</p>
10/01/2015	R1	<p>Revision Effective Date: 10/01/2015</p> <p>NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:  Removed: "When required by state law" from ACA new prescription requirements</p> <p>Revised: Face-to-Face Requirements for treating practitioner</p>

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## Associated Documents

**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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