Via Electronic Mail

September 2, 2014

The Honorable Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services (CMS)
United States Department of Health and Human Services
Attention: CMS-1614-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Medicare Program; End-Stage Renal Disease Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics and Supplies[1]

Dear Administrator Tavenner:

The American Association for Homecare (AAHomecare) submits these comments in response to the above captioned proposed rule. The Centers for Medicare and Medicaid's (CMS') is seeking comments on several issues pertaining to the competitive bidding program for durable medical equipment (DME) orthotics, prosthetics and supplies (collectively, DMEPOS). AAHomecare represents over 600 providers and manufacturers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

CMS intends to use the single payment amounts (SPAs) from the DMEPOS competitive bidding program to adjust Medicare payment rates in areas outside the competitive bidding areas (CBAs). AAHomecare commented on this issue in response to CMS' advanced notice of proposed rulemaking (ANPRM) which the Agency published last spring. As we stated in those comments, SPAs are the product of a profoundly flawed competitive bidding program and do not reflect the true cost of doing business in a CBA or group of CBAs. They should not be used to establish Medicare payment rates in areas outside CBAs.

We are disappointed that CMS has not done more to understand the demographic and economic conditions that distinguish areas outside CBAs from CBAs and each other. CMS acknowledges in the preamble that §1834a of the Social Security Act (Act) requires the Agency to consider the "costs of items and services" in areas in which the SPAs will be applied,[2] but the Agency has ignored that mandate, asserting without any substantive discussion that there is no conclusive evidence to support the differences. To make this point, CMS relies on a 1996 Agency study that concludes that:

[1] 79 Fed. Reg. 40208 (July 11, 2014).
[2] 42 USC § 1395m (a) (1) (F).

> [T]here is no conclusive evidence that urban and rural costs differed significantly or that the cost of furnishing DME items and services were higher in urban versus rural areas or vice versa.[3]

CMS' reliance on an 18 year old study was surprising inasmuch as we stated in our comments on the ANPRM that suppliers have closed facilities in hard-to-service areas because they can no longer offset the cost of running these locations with revenue from other branches. This is a tangible threat to access for beneficiaries outside CBAs and a direct result of the austere payment rates under the bidding program. We know that CMS recognizes geographic cost differences under payment systems that include "add-on" payments to reconcile those differences. We believe that CMS has access to data that would support add-on payments for DMEPOS suppliers in rural and "frontier" areas. We recommend that CMS incorporate supplemental payments in the form of add-ons to the basic reimbursement rate in areas outside CBAs.

Further, although §1847 requires the Agency to use "information" from the bidding programs to adjust Medicare pricing in areas outside CBAs, the statute does not require CMS to use SPA data only.[4] AAHomecare recommends that CMS use the clearance price for products in a product category in a CBA or groups of CBAs instead of the SPAs. The clearance price, or pivotal bid, is where pricing and expected demand for an item in a CBA intersect. The clearance price is not subject to the distortions inherent under the design of the current bidding program which identifies the SPA as the median of all the bids up to the pivotal bid. The current program systematically skews pricing downward which would place beneficiaries in rural and other hard to serve areas at risk. Payment amounts derived from the pivotal bid should also be subject to add-on payments as we described above.

CMS also proposes to amend the competitive bidding regulations to permit the Agency to conduct auctions using bundles of equipment, services and supplies for enteral products and DME. As we understand the proposed rule, CMS will establish one bundled monthly payment for all the DME or enteral products and related supplies a beneficiary would need during a period of medical necessity. The bundled monthly payment would replace the current rental and routinely purchased payment categories established by Congress. This hybrid payment methodology, combining bundling and competitive bidding, is a radical departure from the current fee schedule methodology. CMS lacks the authority to replace the payment categories under the fee schedules with a new bundled payment for DME and enteral products. Competitive bidding may be used to determine new payment amounts for items and services, but Congress intended for the payments to be made according to rules the established under § 1834a.

We are worried and alarmed because CMS has not thought through the possible ramifications of this type of program and plans to move forward despite the lack of information. As far as we know, CMS has not determined how to align the needs of beneficiaries with chronic, progressive conditions with different bundles of equipment, supplies and services. Unlike the home health or the skilled nursing facility (SNF) prospective payment systems (PPS), this proposal lacks any mechanism to tie the medical needs of the patient to the payment for the items and services he or she needs. On the contrary, the

[3] 79 Fed. Reg. at 40279.
[4] 42 USC §1395w-3

sole purpose of the proposed changes is drive the price for DME and enteral products as far down as possible

In this context, bundling would create the wrong incentives for suppliers and would prove especially bad for beneficiaries. Bundling will force suppliers to establish formularies which, in turn, diminish access for beneficiaries with specific individual needs. Bidding will be based on generic bundles that would be different from one supplier to the next; and because there is no consensus for what is in a baseline bundle, CMS would have no basis for evaluating bids. The lack of transparency that results from using generic bundles would also eliminate CMS' ability to identify and track changes in utilization that place beneficiaries at risk. CMS' proposal would be particularly harsh for beneficiaries with long term or lifelong equipment needs who would be forced to bear the costs of beneficiaries with shorter term acute care needs whose need for equipment ends once they recuperate. Chronically ill beneficiaries who typically have a lifetime need for equipment will face a lifetime of co-pays instead of the 13 months they do today.

AAHomecare is also troubled by the cursory Regulatory Flexibility Act (RFA) and economic impact analyses CMS published in the proposed rule. The Agency has limited itself to making broad statements about the impact of the two new programs on a substantial number of small suppliers without any substantiation of the claims. We believe that the lack of quantifiable data and analyses are signs that the proposed rule is not well thought-out. Moving forward with two such ambitious programs without first marshalling the data to guide their implementation is rash and places suppliers and beneficiaries at risk.

Each one of these proposals would be a complex undertaking on its own, and we urge caution in attempting to launch the programs in concert. We recommend that CMS withdraw the proposed rule until it has unbiased bidding data to implement payment adjustment in areas outside the CBAs. CMS lacks the authority to engage in a bundling bidding program and must withdraw this portion of the proposed rule. We discuss our concerns in more detail below.

I. COMPETITIVE BIDDING PROPOSALS

A. PAYMENT ADJUSTMENTS FOR AREAS OUTSIDE CBAS

1. Calculation Of Adjusted Payment Amount For Noncompetitive Bid Areas

a. Calculating Payment Amounts

CMS proposes to create a fee schedule using the average regional SPA (RSPA) amount for an item subject to national payment ceilings and floors. The fee schedule jurisdictions would be determined using boundaries identified by the Bureau of Economic Analysis (BEA). As we noted above, CMS is not required to use SPA data to adjust payment amounts in areas outside CBAs. We believe that the appropriate data point is the clearance price for an item in a product category in a CBA or group of CBAs. The clearance price, or pivotal bid, represents the point where capacity meets demand and serves as the cut-off for determining the winning bids. The pivotal bid more accurately reflects bidders' cost of doing business in a CBA than the SPAs which are set at the median of all winning bids. Under this formula, half of all winning bidders in a CBA are paid below the costs they assumed in their bids. This is an artificially low amount and a product of the other distortions inherent under CMS' bidding design. Given the

characteristics of hard to service areas outside CBAs, SPA data should not be applied to adjust payment amounts there.

Further, whether CMS uses SPA data or pivotal bids, we believe CMS should use regional data specific to each state. The designations used by the BEA allow for broad groupings of states with very different economic environments that could create unfair disparities in the payment rates. Disparity among the states is already reflected in the SPAs and using the BEA data to determine regional payment amounts will result in unreliable and inaccurate payment amounts.

In addition, to ensure that the regional payment data are actually aligned with the cost of doing business in a state, CMS must[5] first remove bids from unlicensed bidders from the bid pool. This is important because licensing captures the threshold regulatory requirements for doing business in a state and can be a useful proxy for the cost of doing business there. For example, a majority of states require that respiratory therapists perform CPAP set-ups and a smaller number of states also require therapists for oxygen set-ups. Suppliers in states where professional staff must perform these services have a higher cost of doing business compared to suppliers in states that do not. Unlicensed bidders who were awarded contracts did not invest the time and resources necessary to satisfy even the minimum state requirements. Reasonably, these bidders are more likely to submit low bids that skew the pivotal bid downward because they do not understand the cost of doing business in the CBA.[6] So, whether CMS uses pivotal bids or SPAs to adjust payment amounts outside CBAs, it must first purge the data to exclude bids from unlicensed bidders from the bid pool.

We recommend that CMS purge bids in a CBA by removing bids from unlicensed suppliers, recalculate the pivotal bids, and determine regional pricing by using the revised pivotal bids from CBAs in a state.

b. Add-on Payments

Regardless of whether CMS adjusts Medicare payment rates for DMEPOS using regional SPAs or pivotal bids, CMS must provide add-on payments to the base rates in areas outside CBAs. Without the addition of supplemental payments, these difficult to serve areas could very quickly yield to a reduction in access for beneficiaries who need DMEPOS. Suppliers who service these areas are either independent local suppliers who do not have economies of scale or larger suppliers with local branches in the rural area. Larger suppliers have at least been able to cross subsidize these locations with Medicare revenue from branches in other areas, but they cannot afford to do this in the current reimbursement environment.

We know that Medicare recognizes cost differentials between rural and other areas through add-on payments to the basic reimbursement rates of providers or suppliers. The payment system for ambulance services includes add-on payments as high as 50% of the base fee schedule amount for the first 17 miles of travel if the transport originates in a rural area. The ambulance services payment system also includes three additional temporary add-on payments depending on whether a transport begins in

[5] We continue to believe that SPA data from the Medicare competitive bidding program are not accurate measure of suppliers' costs to do business in a CBA and should not be applied in areas outside CBAs, but make these recommendations in response to the question raised by CMS under the proposed rule.

[6] Attestation of Peter Cramton, Professor of Economics, University of Maryland, filed in American Association for Homecare, et. al. v. Kathleen Sebelius, Civil Action No. 13-00922-BAH.

a rural, urban, or super rural area.[7] CMS' distinction between rural and "frontier" areas under the proposed rule suggests the Agency is aware of the impact low density populations have on the cost of furnishing DMEPOS in an area. Like suppliers of ambulance services, a large portion of DME suppliers' costs are allocated to transportation costs which are directly related to servicing areas with low population densities. We see no valid rationale for affording ambulance suppliers add-on payment for servicing rural and other areas, but withholding them from DMEPOS suppliers. AAHomecare recommends that CMS adopt an add-on payment for DME suppliers in areas outside CBAs.

2. Items With Limited History In Competitive Bidding

CMS plans to pay for items with limited or no SPA history *at 110% of the average of the SPAs for the areas where CBPs were implemented*. We believe that CMS' assumptions for this proposal are incorrect and, as such, the proposed methodology should not be implemented. Utilizing data collected from nine CBAs certainly does not produce a representative sample of the United States. Further, most, if not all, of the items this proposal refers to are accessories and related products used in conjunction with a wheelchair. For such items, CMS' data is even more limited because it only contains the SPAs for such items when included in CB product categories for standard power wheelchairs. It is completely unreasonable to assume that this data reflects:

- The costs associated with providing such products in other geographic areas. For example, the data CMS has does not reflect the largest metropolitan areas (New York, Los Angeles or Chicago), or rural areas.
- The provider's margin needs when such items are associated with other types of wheelchairs (complex rehab and manual) which may require more labor and other costs and / or produce lower margins than a standard power wheelchair.
- The provider's costs when such items are provided at a separate moment in time from a wheelchair. While these products may be used by wheelchair users it is not reasonable to assume that they will meet the medical necessity criteria for the item at the same moment as the wheelchair. For example, the medical necessity for some wheelchair cushions requires that the individual have a pressure ulcer. If the item is provided to the beneficiary at a separate moment in time from the wheelchair the provider will be required to duplicate costs associated with delivery, set-up and billing.

We would argue that these items were not rebid because it was concluded that these HCPCS codes, in their current format, are not suitable for competitive bidding. Attached in the Appendix is a chart displaying the 110 HCPCS codes removed from subsequent rounds of bidding. The disparity in the SPAs among these codes is apparent when contrasted with the HCPCS codes that were included in several rounds of bidding.

Many of these HCPCS codes are under-defined and do not represent homogenous groups of products. The continued bidding of under-defined items would most certainly reduce the quality of goods provided and restrict beneficiary access to the specific products that they truly needed. Given the limited competitive bidding data for these items, the SPAs for these items should not be the basis of a nationally rolled out fee schedule.

[7] MEDPAC, Ambulance Services Payment Systems, (October 2013), available at: http://www.medpac.gov/payment_basics.cfm

3. Accessory Codes That Apply To More Than One Product Category Under A Bidding Program

CMS plans to calculate the SPA in each CBA by weighting SPAs in each product category for that CBA by national allowed services to create a single SPA. It is not appropriate to assume that the amount bid for an accessory, when included in a broader bidding product category that includes high value base equipment (e.g. standard power wheelchairs), has any real basis in the bidders' actual cost or margin calculation. Furthermore, it is not reasonable to assume that a supplier can afford to provide an accessory for the same price:

- in a non-bid area,
- with another type of base equipment, or
- when provided at an entirely separate time from any base product

as they can in the situation that has occurred within specific bid product categories in specific competitive bid areas.

In considering the pricing for accessories on a broader basis, it appears evident that CMS recognized that the price for accessories would vary depending upon the base equipment it was associated with and that CMS incorporated this logic into the competitive bidding program:

- It was CMS that created the bidding categories, which resulted in accessories being included in multiple bidding product categories with varying winning bid rates.
- It was CMS that excluded accessories, when used in conjunction with base equipment that was not bid, from the single payment amounts established from a bid product category. As such, it is CMS itself that created the multiple payment rates that exist today for accessories.

All of these factors certainly served as part of the basis for Congress' action when they enacted the Medicare Improvements for Patients and Providers Act (MIPPA). In MIPPA Congress clearly recognized the variety of scenarios that existed and saw fit to address them:

> *(i) in the case of items and services furnished in any geographic area, if such items or services were selected for competitive acquisition in any area under the competitive acquisition program under section 1847(a)(1)(B)(i)(I) before July 1, 2008, including related accessories but only if furnished with such items and services selected for such competition and diabetic supplies but only if furnished through mail order, - 9.5 percent; …"*

Congress clearly recognized the high level of skill and service required to address the needs of complex rehab patients and, therefore, excluded complex rehab wheelchairs and related accessories from competitive bidding. Similarly, Congress recognized that the bid rates for accessories included in large, competitively bid product categories were not necessarily representative of the cost that a supplier would need to charge in the litany of other scenarios that existed.

4. Applying Spas In The Northern Mariana Islands

If CMS intends to adjust payment rates for a national mail order programs in the Northern Mariana Islands CMS must include add-on payments for the reasons we discussed above.

5. Adjustments To Spas That Result From Unbalanced Bidding

According to the preamble, "unbalanced bidding" occurs when the bid for an item without additional features is higher than the bid for the item with additional features. When this happens, CMS proposes to adjust the SPAs for bids with items without the features so that they are not higher than the items that have the additional features. This phenomenon is the direct result of the Agency's flawed bidding process and should not be "fixed" by further manipulating suppliers' bids.

Unbalanced bidding happens because CMS uses composite bids to create the SPAs. This means that individual bids for items in a product category are weighed according to the item's utilization. The use of composite bids tends to skew bids downward because bidders can bid low on high demand items and high on low demand items. The result is that bids do not reflect the supplier's costs.[8] SPAs derived from composite bids are inherently unreliable and cannot serve as proxies for the cost of doing business in a CBA. CMS is implicitly acknowledging this point by its proposal to "fix" unbalanced bidding.[9]

The flaws in the DMEPOS competitive bidding program have been widely acknowledged by experts outside and go well beyond the use of composite bids as part of the design. Among the experts who have analyzed the program two hundred forty-four independent economists who are experts in the design of complex auctions were so troubled by the program's shortcomings that they felt compelled to bring them to President Obama's attention.[10] These economists analyzed the bid submission and selection components of the program, concluding that these key design features systematically skew bid pricing downward. The result is that the SPAs are inaccurate and unreliable. Aside from the distortions that result from the use of composite bids, the economists who examined the program found:

- Bidders are not bound by their bids which allows bidders to submit lowball bids with impunity. In true auctions bidders must be prepared to do business at the price they bid. Under the Medicare program, however, a low ball bidder that is awarded a contract does not have to accept it if the price is too low. Because bidders are not compelled to accept a contract award, there is no penalty for submitting irrational bids that result in unsustainable pricing.[11] Low ball bidders are free to reject a contract offer, but their low bids are used to calculate SPAs.

- The SPAs are determined using a mechanism deliberately designed to skew pricing down. SPAs are set at the median of the initial contract offers, meaning half of the "winners" are offered a contract below their bids. This too encourages lowball bidding because a very low bid guarantees winning, but lowball bidders can be reasonably sure they will be paid at a higher rate.[12] Finally, the lack of transparency in awarding contracts undermines the credibility of the process. Suppliers do not know how CMS applies the quality and financial standards to individual suppliers.[13]

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[8] *Ibid*.

[9] In fact as we stated above, CMS should use pivotal bid data, not Spas, for making payment adjustments in areas outside CBAs.

[10] Letter from 244 concerned auction experts, 2011, available at: http://www.cramton.umd.edu/papers2010-2014/further-comments-of-concerned-auction-experts-on-medicare-bidding.pdf

[11] *Ibid*.

[12] *Ibid.*

[13] *Ibid*.

CMS' proposal to alter the outcomes of unbalanced bidding only manipulates the bidding process, moving the program further away from a commercially reasonable bidding process. The solution to unbalanced bidding is for CMS to correct the design flaws in the program. CMS has the authority to modify the program by eliminating the use of composite bids and using the median of the pivotal bids to set the SPAs. AAHomecare would like to assist CMS in designing a commercially reasonable bid process.

We also would like to point out that what CMS is articulating regarding unbalanced bidding, and the rationale CMS is applying to it, is also resulting in unintended, unbalanced delivery of products within a code. Many HCPCS codes are under-defined and include products with numerous and substantial differences in features and benefits. However, because of the apparent resistance to expand the HCPCS code list to truly reflect homogenous groups of products, and the existing competitive bidding structure, which rewards solely on the median of the pivotal bids, all of the following are occurring:

- The quality of products being provided to beneficiaries from these under-defined codes is declining.
- Clinical influence over product selection has diminished.
- Providers have a financial incentive to select the products that cost them the least, regardless of quality or clinical benefits.
- CMS' safeguards to protect beneficiaries, and curtail all of this from occurring, are totally inadequate.

B. CMS MUST WITHDRAW THE PROPOSAL TO INCLUDE BUNDLING UNDER A COMPETITIVE BIDDING PROGRAM (VI)

1. CMS does not have the authority to substitute a bundled payment for DME or enteral products in place of the payment rules that Congress established under the Social Security Act.

a. CMS cannot substitute a bundled continuous rental payment for the payment rules under the fee schedules.

CMS's authority under §1847[14] of the Act is limited to establishing payment amounts for DME or enteral products using competitive bidding. Congress never intended for CMS to use the authority under § 1847 to replace the payment rules it created under the fee schedules.[15]

Congress did specify under § 1834(a) that CMS must use the payment amounts derived under competitive bidding as the payment basis for DME furnished under the statute. However, CMS' authority is limited to using the SPA as the payment basis for DME. Congress refrained from extending CMS' authority to making changes to the payment rules specified under § 1834 (a) (2)-(7). Those sections establish six carefully thought out classes of DME and specify the payment rules applicable to each class, including equipment in the routinely purchased and "capped" rental payment categories.

Section 1834(a) was added to the Act by § 4062 of the Omnibus Budget Resolution Act of 1987 (OBRA)[16] and established a "six point plan" for Medicare payment of DME. Given the diversity of DME and the

[14] 42 U.S.C. §1395w-3.
[15] 42 U.S.C. §1395m

purposes for which it is used, Congress tied reimbursement for the equipment to the type of equipment, the likely duration of a beneficiary's medical need and the cost to Medicare of paying for it. Section 1834 (a) created six classes of DME: inexpensive or routinely purchased, frequently serviced, oxygen and oxygen equipment, customized items, and other DME.[17] The payment basis and the rules that control how frequently the payment is made are tied to the type of equipment.[18] In contrast, §1847 authorizes CMS to determine single payment amounts for DME based on suppliers' bids for items and services, but generally does not address the rules for making such payments.[19]

Under § 1834 (a) the "payment basis" for DME is either 80% of the supplier's actual charge for an item or the fee schedule amount for each class of equipment calculated using the formula specified under the statute for each type of equipment.[20] There is only one exception to this rule. Section 1834(a) (1) (F) (i), requires that the Secretary use the SPA derived through competitive bidding in a CBA as the "payment basis" under § 1834 (a) for an item or service furnished in the CBA.[21] However, the structure of the payment provisions for each category of equipment shows that Congress did not intend to cede to the Secretary its control over the payment rules for DME on account of competitive bidding. For each class of equipment, § 1834 (a) specifies both the *frequency* of payment and the payment *amount* for the equipment. To avoid ambiguity, § 1834 (a) (1) (A) distinguishes between the rules that determine the frequency of payment and how the payment basis is determined. Section 1834 (a) (1) (A), states, in part:

> (a) Payment for durable medical equipment
>
> (1) General rule for payment
>
> (A) In General
>
> With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, *payment shall be made in the **frequency** specified in paragraphs (2) through (7) and **in an amount** equal to 80 percent of the payment basis* described in subparagraph (B).

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[16] PL 100-203 (1987)

[17] 42 U.S.C. § 1395m (a) (2)-(7)

[18] 42 U.S.C. § 1395m (a) (1) (A) & (B)

[19] 42 U.S.C. §1395w-3 (b) (5).

[20] 42 U.S.C § 1395m (1) (B), states, in part:

> Subject to subparagraph (F)(i), the payment basis described in this subparagraph is the lesser of—
>
> (i) the actual charge for the item, or
>
> (ii) the payment recognized under paragraphs (2) through (7) of this subsection for the item [.]

[21] § 1395m (a) (1) (F), states, in part:

> (F) Application of competitive acquisition; limitation of inherent reasonableness authority
>
> In the case of covered items furnished on or after January 1, 2011, subject to subparagraphs (G) and (H), that are included in a competitive acquisition program in a competitive acquisition area under section 1395w-3(a) of this title--
>
> **(i)** the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program;

Under the statute, the frequency of the payment for equipment is tied to its payment category. Both the payment frequency and the payment amount for a type of equipment are defined for each payment category. Section 1834 (a) (2) (A) for example, establishes that the *frequency* of the payment for inexpensive or routinely purchased equipment can be either a rental payment or a one- time lump sum purchase of the equipment. Whereas, the *amount* of the payment is computed based on state-by-state data from suppliers' reasonable charges subject to a national ceiling on the payment.[22]

Similarly for equipment that beneficiaries "rent-to-own," the statute establishes that Medicare pays for the equipment as a rental during a period of medical necessity not to exceed 13 months. The statute also specifies the payment amount for each rental month and instructs the Secretary on how to determine applicable fee schedule amounts.[23]

With respect to rental equipment, Congress explicitly requires the Secretary to apply the payment rules under § 1834 (a) in the CBA's. Section 1847 requires the Secretary to ensure that it pays for oxygen and rental DME according to the rules under § 1834 (a). Further, as CMS points out in the preamble, the statute explicitly *excludes* respiratory equipment such as CPAP and RAD devices from the frequent and substantial servicing payment category under §1834a and explicitly *includes* accessories used with those devices in the routinely purchased payment category. Thus, while CMS must determine payment amounts for DME and enteral products using competitive bidding, the Agency must reimburse suppliers in using the payment frequencies established under § 1834a.

Importantly, as CMS shows in its very thorough legislative history of the fee schedules established under § 1834a, the adoption of the DMEPOS fee schedules was very carefully thought out by Congress over a period of many years. As the legislative history in the preamble shows, Congress had ample opportunity to adopt a different system, and in fact tested a number of payment systems, including continuous rentals, before it created the current fee schedules. The fee schedules under § 1834(a) were adopted in response to a long series of reports by the General Accountability Office (GAO) finding that continuous rental payments for medical equipment was expensive for the Medicare program because of the long term medical needs of the beneficiaries who use medical equipment.

Even as it proposes to disregard Congress' mandate under the fee schedules, CMS acknowledges that the Agency does not know really know whether it is more expensive to transfer ownership of equipment to beneficiaries and pay for repairs and accessories separately than it is to pay for continuous rentals thus, calling into question the Agency's motives for the changes it proposes. CMS lacks the authority to create bundled payments for DME under competitive bidding. The controlling statutes give CMS authority to use the SPA as the payment basis for DME, but CMS is not authorized to change the payment rules for equipment.

b. CMS has not demonstrated that a competitive bidding program that includes bundling meets the criteria for a demonstration under the Center for Medicare and Medicaid Innovation (CMMI)

CMS has requested comments on whether it should proceed with a demonstration of competitive bidding for bundled DME and enteral products under the Agency's CMMI authority. Congress gave CMS

[22] § 1395m (a) (2) (A) & (B)
[23] §1395m (2) (7).

broad authority to test innovative payment systems that reduce Medicare or Medicaid expenditures while improving quality and access to care. Based on the information CMS published in the proposed rule, the Agency has not met the threshold requirements for a CCMI demonstration. Specifically, CMS has not shown how requiring suppliers to bid on bundles of equipment supplies and accessories would benefit Medicare beneficiaries. On the contrary, a competitive bidding program that uses bundling would create the wrong incentives for suppliers and is especially bad for beneficiaries. Bundling will force suppliers to establish formularies which, in turn, diminish access for beneficiaries with specific individual needs. Bidding will be based on generic bundles that would be different from one supplier to the next; and CMS would have no basis for evaluating bids because of the lack of transparency for what is in a bundle.

Generic bundles would also eliminate CMS' ability to identify and track changes in utilization that put beneficiaries at risk. CMS' proposal would be particularly harsh for beneficiaries with long term or lifelong equipment needs who would be forced to bear the costs of beneficiaries with short term, acute needs whose medical necessity for equipment ends when they recover from the acute episode. Chronically ill beneficiaries who typically have a lifetime need for equipment will face a lifetime of co-pays instead of 13 months as they do today.

The preamble cites only one possible benefit that would accrue to beneficiaries from bundling. CMS believes that bundling will permit beneficiaries to change suppliers and facilitate the repair of equipment they own. According to the Agency, beneficiaries could change suppliers without restriction because suppliers would continue to get paid for furnishing the equipment regardless of how long the beneficiary has been renting it. Similarly, because equipment repairs are include in the monthly rental, suppliers would be responsible for the equipment on an ongoing basis.

CMS is misguided in relying on these rationales to show the benefit of bundling for beneficiaries. Today, beneficiaries own their equipment after 13 rental months. They are not responsible for copays once they own their equipment. However, under the proposed rule, beneficiaries would face a lifetime of co-pays. Importantly, CMS recently amended the Program Integrity Manual (PIM) to relieve the medical necessity documentation burden on suppliers for equipment repairs.[24] The new contractor instruction, removes from consideration what had been the largest impediment to repairs for beneficiary owned equipment. This seems to have been CMS' primary justification for bundling, having resolved that issue in favor of beneficiaries, we see no rational to support bundling.

CMS' other rationale—that beneficiaries would find it easier to change suppliers – is also misguided. CMS' reliance on this as a justification for bundling shows that the Agency incorrectly assumes that Medicare reimbursement is what drives beneficiaries' ability to change suppliers. While we do not disagree that reimbursement is a factor, it is not the only factor, or even the most important one. CMS' overly prescriptive medical necessity requirements are the primary reason beneficiaries have trouble changing suppliers. A bundling program will not change that.

Medical necessity documentation and payment methodologies are unrelated requirements. Payment for an item may be adequate but because documentation criteria are excessive, beneficiaries may not have access to the item. CMS' CMMI authority applies only to payment programs. CMS has no authority

to address documentation under that authority. Regardless of the bundling program, beneficiaries will still need to re-establish medical necessity for base equipment and any necessary supplies when they change suppliers. This means that beneficiaries must be able to demonstrate to the new supplier that they have met and documented every element of a local coverage policy, including and applicable diagnostic tests or trial periods. These requirements will remain in place, notwithstanding a bundling methodology.

Stripped of these rationales, the proposed rule can be seen for what it is – simply a new mechanism for driving DMEPOS prices down. Because CMS cannot make the case that a bundling competitive bidding program can save money without harming beneficiaries' access to quality DMEPOS care, it is not suitable for a demonstration program under CMS' CMMI authority.

2. CMS cannot proceed with bundling without first establishing criteria for determining the "bundle" of equipment and services.

We are alarmed by the proposal to move forward with competitive bidding for bundles of DME, services and supplies. CMS lacks any data that can be used to align an individual's medical necessity for equipment and service to the Medicare payment for those items and services. This type of bundling would be so complex that it is unrealistic for CMS to expect it can implement this new methodology in the near future without placing the welfare of beneficiaries at risk.

There is no data to establish what bundles may be appropriate for specific patients and no coverage criteria to determine when a beneficiary qualifies for a bundle of equipment, services and supplies. Second, without assessment criteria like the ones used for PPS, suppliers have to guess at the type of equipment and the frequency of the services different patients may need. Because there is no baseline for what constitutes a bundle in a product category, suppliers will not know what to bid. Without an assessment tool and a baseline bundle, CMS also has no way of comparing bids because there is no consensus on what is in the bundle or the intensity of the services patients who receive the bundle need.

Presumably, suppliers will bid on one code that represents an entire bundle, not on individual HCPCS codes for specific items in a product category as they currently do. The lack of transparency as to what a bundle contains will make it very difficult for CMS to be able to verify whether a bid is *"bona fide."* More importantly, bundling will of necessity drive the use of formularies and as a result will limit beneficiary choice.

If CMS plans to use a single HCPCS code to represent a bundle, CMS will not be able to track utilization for specific items of DME or identify patterns of utilization that could be harmful to beneficiaries. Generic bundles must also be reconciled with the applicable coverage and documentation rules. For example a bundle that includes all respiratory equipment would be impossible to administer because the coverage policies for items within a bundle vary among different modalities of respiratory equipment. Wheelchair accessories often have medical necessity and documentation criteria that are different from that of the base equipment so a wheelchair bundle that includes all accessories would be difficult to administer.

3. Transition Rules

a. Bundling would not eliminate the need for patients to requalify for equipment when they change suppliers.

CMS seems to suggest that bundling will make it easier for beneficiaries to change suppliers. However, beneficiaries will still need to re-establish medical necessity for base equipment and any necessary supplies when they change suppliers. In addition, under the face-to-face rule, suppliers must obtain a written order for the item and documentation that an appropriate face-to-face encounter between the beneficiary and a physician or qualified practitioner occurred before delivering the item to the beneficiary. CMS has interpreted this requirement to apply every time a beneficiary changes suppliers. This means that beneficiaries who change suppliers as a result of competitive bidding – or for any reason – must have a face-to-face encounter with a physician (or other practitioner recognized under the regulations) in order to receive equipment from a new supplier. The supplier must, in turn, have documentation that the face-to-face encounter occurred and a written order for the item before delivering the item to the beneficiary. Beneficiaries cannot change suppliers unless: 1) they are prepared to visit their doctor for a determination that the medical equipment they use continues to be necessary 2) medical necessity for the item is fully documented. This latter point means that if an LCD or NCD requires a specific test, the beneficiary must be able to show documentation of a current valid test or be prepared to be retested and in some cases to pay for the test or their medical supplies out of pocket.

b. Equipment Repairs

CMS proposes to eliminate the current competitive bidding transition rules. A noncontract supplier could decide to grandfather, but would have to accept the bundled rate. CMS will not pay for repairs of beneficiary owned equipment. These beneficiaries would be required to get new equipment from a contract supplier. This punishes beneficiaries who own their equipment because they will forced to resume paying for copays and deductibles. Beneficiaries would be better served by paying a copay for an occasional equipment repair than paying copays for renting equipment for the rest of their lives. CMS regulations also adequately protect beneficiaries from receiving shoddy equipment when the supplier transfers title to the beneficiary. Medicare billing rules require suppliers to replace beneficiary owned equipment without charge to Medicare or the beneficiary when the aggregate cost of repairing the equipment is 60% or more of the cost to replace it.

From the beneficiaries' perspective, the recently expanded access to equipment repairs and the beneficiary protection rules under Medicare regulations weigh in favor of their owning the equipment when compared to the prospect of having to pay copays for the rest of their lives.

4. Selection Of CBAs For Bundling And Phase-In

Although CMS does not have the authority to use bundled payments under competitive bidding and has not met the burden for establishing a demonstration under CMMI, CMS intends to conduct a bidding program using bundling in 12 CBAs. However, CMS will roll out the new bidding rules as if it were performing a demonstration. We preface our comments below by reiterating that CMS does not have the authority to pursue either one of these two paths.

In order to assess the effect of bundling in those CBAs, the Agency will roll out another 12 bidding programs in "comparator" CBAs. CMS has not provided information on how it will select the bundling and the comparator CBAs. At a minimum, comparator CBAs must have the same demographics as the CBAs selected for the bundling demonstration. This means that the beneficiary population in the test

and control CBAs must have the same utilization history for the items that are part of the demonstration. The beneficiary population must have similar acuity for the specific items and must be similar in other demographics including financial and social resources.

Finally, our understanding is that CMS plans to add 24 new competitive bidding sites in addition to existing or new CBAs. If this is the case, how much lead time will the MACs have to develop protocols for claims processing and to ensure that that their "systems" are ready to timely process and pay for bundled claims. AAHomecare members report that MACs continue to have problems processing claims for certain PMD accessories that are used on both competitively bid and non-competitively bid items.

5. Establishing Specific Equipment Bundles

CMS has not provided any information on how it intends to create different equipment bundles. Our understanding is that CMS plans to consolidate HCPCS codes for base equipment, supplies and accessories under one bundle with one HCPCS code. However CMS has not articulated the criteria it will use to select what models in a product category will go into a bundle. This is not as straightforward as it may seem.

For example, CMS cannot consolidate CPAP and RAD under one HCPCS code. These devices are very different and are used on patients with very different clinical profiles. This is also true for specialty enteral formulas. Many beneficiaries who receive enteral therapies do not actually require equipment. In addition, the specialty formulas are designed for specific conditions and are not interchangeable. Beneficiaries may switch formulas over the course of treatment depending on how their condition changes. The beneficiary's condition cannot be divorced from the type of formula or equipment that a beneficiary needs. One HCPCS code and one medical policy cannot account for all of these variables.

As we explain below, we believe bundling without significantly more data and details on developing the bundling parameters, as well as comprehensive changes to coverage and documentation policies places beneficiaries at risk. However, if CMS insists on moving forward with the proposed demonstration, AAHomecare has attached an Appendix with recommendations for specific product bundles.

a. Wheelchair bundles

AAHomecare is opposed to the Medicare bundling proposal for power wheelchairs. We are opposed to bundling both by product category that would result in one code and also by base power wheelchair HCPCS code. Plain and simple, we are opposed to bundling. As we discussed above, bundling will drive the use of equipment formularies which diminish beneficiary choice. There is no consensus on what a "wheelchair bundle" must contain and this lack of transparency almost certainly will result in lower quality care for beneficiaries.

However, if Medicare intends to move forward with a bundling program notwithstanding the concerns we have raised, a very limited, properly authorized pilot program then it must be structured like NY Medicaid's bundle:

- By Standard Power wheelchair by base codes only;
- Not include items with a separate medical policy; and
- Provide opportunity for separate billing for repairs after 13 months (from date of initial issue)

The recommendation is that the AAHomecare power wheelchair bundle include:

- All items in the current Medicare BEP
- Heel loops
- Batteries
- General use cushion and backs (since the only requirement to qualify is a wheelchair)

Further, knowing that Medicare's goal is to bundle everything in with the base and provide continuous rental payments, we also came up with a recommendation on how to calculate the repair amount to be added to the equipment bundle. We recommend that Medicare utilize its 60% rule for calculating the repair costs that would be a part of the bundle. Taking the base bundle amount and adding an additional 60% to that amount is a clean, transparent and predictable way to calculate the estimated repair costs.

Finally, CMS must release utilization and payment data to determine what the repair amounts would be over the term on the rental.

b. Infusion Drugs

CMS does not have the authority to change payment amounts for infusion drugs. Congress determined that infusion drugs should be paid under the statutory AWP methodology. CMS cannot change payment for infusion drugs using competitive bidding.

6. Impact Of Bundling On Beneficiaries

Establishing a bundled payment for DME and enteral products would not work in the beneficiary's favor. Beneficiaries would derive mostly administrative advantages if Medicare adopts bundled payments for these items and services. For example, beneficiaries might see simpler EOBs and experience more streamlined interactions with their suppliers because one supplier would furnish an entire bundle. In exchange for these modest administrative advantages, beneficiaries would encounter serious disadvantages including the loss of access to high end or specialized equipment, higher copays and difficulty in changing suppliers.

A bundled payment would also adversely affect beneficiaries financially. The cost burden would shift to beneficiaries with long term rentals who would subsidize the care of those with short term, service intensive acute conditions. One way to offset the impact of this cost shift for beneficiaries is to ensure that payments are front loaded so that suppliers are fully compensated for servicing short term patients.

Under a bundled payment, beneficiaries who are more costly to treat may find it more difficult to access care. For example, suppliers may find that beneficiaries who need long-term rentals with low service and utilization needs are easier to treat because their conditions are stable or they have caregivers that allow them to function with less expensive equipment or services. In contrast, beneficiaries who have short term acute conditions that require more intensive services will be more difficult to treat and could have a harder time accessing care. This occurred when CMS transitioned to the SNF PPS. Patients with high service needs such as wound care patients had a more difficult time finding a SNF that would accept them than did patients with more routine care needs.

7. Bidding Rules

a. Bid Limits

CMS has provided virtually no information about how the Agency will administer a bundled bid program. Given that CMS is proposing a radical new reimbursement methodology, the lack of information violates the Administrative Procedure Act (APA) which requires Agencies to give public notice and solicit comments on proposed rules. In this case, the notice of proposed rulemaking (NPRM) gives only a general outline describing the bundling program. CMS has not explained how it will determine what makes up a bundle; how it evaluate bids or select the pivotal bid to establish payment amounts. Given the lack of information on how the program will work, CMS must publish a new NPRM soliciting comments on the elements of the bidding program CMS proposes to adopt.

What we do know is that CMS proposes to cap bids at the total Medicare payments for the items in a bundle in the bid area prior to the start of bidding. However, for CPAP, CMS proposes to use the 1993 bundled DME fee schedule as the cap. CMS does not give any rationale for this proposal. The only reason to propose different caps for CPAPS, accessories and supplies than other DME is to arbitrarily manipulate the bids downward. Clearly this is unacceptable and places access to these products at risk. Further, the gap-filled 1993 pricing would not reflect the diversity and the sophistication of the technology in these devices available today. Suppliers will bid on devices on the market in 2014, not outdated technology from almost 20 years ago.

b. Bid Specifications

To facilitate accurate bidding, CMS must also give suppliers per patient expenditures and utilization by HCPCS code. Importantly, claims payment data is not indicative of utilization. Paid claims data are distorted as a result of CMS' aggressive audit programs because a disproportionate number of claims do not get paid until they have been through the appeals system. AAHomecare recommends that CMS give suppliers submitted claims data on which to base their bids. Submitted claims more closely reflect the units that are furnished to beneficiaries.

In addition, if CMS were to proceed with a bundling bid program, CMS must grandfather beneficiaries who already own their equipment. Requiring these beneficiaries to follow the transition rules in a CBA would be patently unfair because it would force them to resume their liability for co-pays and deductible amounts on new equipment for as long as they use the equipment.

Finally, bid limits must take into account all repairs, accessories, and rental payments divided by the number of patients to create a monthly per patient allowable. In order to have an accurate measure, CMS must include only patients with active rental periods. Otherwise, the data will skew downward. We request that CMS identify the data parameters from which it will take the data.

8. Change In Transfer Of Ownership Provision

AAHomecare would support this proposal if the bidding design is changed to require binding bids. AAHomecare believes that the current change of ownership process is unworkable, but we are concerned that without binding bids the proposal to allow the sale of a contract would strongly encourage low ball bidding.

II. ORTHOTIC DEVICES THAT REQUIRE MINIMAL SELF ADJUSTMENT

AAHomecare is also concerned about the proposed new definition of "minimal self-adjustment" for off-the-shelf (OTS) orthotics. We have serious concerns about the proposed definition and concerns about CMS's apparent adoption of the definition under new DMEPOS quality standards that the Agency published without notice and comment.

The proposed definition is contrary to the language established by Congress under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Clearly, if an orthoses requires fitting by a supplier, it cannot meet the definition for a "self-adjusted" orthotic device. Congress chose to protect beneficiaries under competitive bidding by limiting orthoses subject to bidding to those that required minimal self-adjustment by the patient. Congress understood that competitively bid items would likely be drop shipped or provided to beneficiaries without the proper adjustments or instructions. Thus, we question the wisdom of expanding the definition to include devices that require adjustment by the supplier. Notwithstanding explicit direction from Congress, CMS is "boot strapping" the regulatory definition by relying on DMEPOS quality standards that were announced summarily, without notice or request for public comments. The standards contradict both the statutory language and FDA labeling for these products. CMS should withdraw the proposal to revise the definition of OTS and rescind the supplier quality standards.

III. REGULATORY FLEXIBILITY ACT ANALYSIS

CMS does not have the authority to use bundled payments under competitive bidding and has not met the burden for establishing a demonstration under CMMI, CMS intends to conduct a bidding program using bundling in 12 CBAs. However, CMS will roll out the new bidding rules as if it were performing a demonstration. We preface are comments below by reiterating that CMS does not have the authority to pursue either one of these two paths.

The CMS has not adequately considered and addressed the impact of the proposed rule in the Agency's economic and Regulatory Flexibility Act (RFA) analyses under the proposed rule. CMS' analyses focuses primarily on the savings the new programs would generate for Medicare while glossing over important issues of beneficiary access, continuity of care, financial impact on suppliers, and the administrative burden of documenting medical necessity in the context of competitive bidding.

CMS should withdraw the proposed rule until the Agency performs meaningful RFA and economic impact analyses of the new programs. The current analysis is so sparse, that it is impossible for the public to submit meaningful comments. We summarize our concerns below.

A. Methodology For Adjusting Medicare Payment Amounts Using Information From DMEPOS Competitive Bidding Programs

The proposed rule states that the Agency's proposal to use competitive bidding payment amounts in in areas outside CBAs would save the Medicare program $7 billion over FY 2016 -2020.[25] These savings would result from payment reductions for DMEPOS items in non CBA areas. However, CMS provides no analysis to support its projections except to say that "approximately half" of all DMEPOS items paid by Medicare are furnished to beneficiaries that are not in CBAs. Other than a barebones chart projecting savings to Medicare and beneficiaries over the period in question, CMS does not articulate the assumptions on which the projections are based and provides no financial analysis to support its

[25] *Id*. At 40307.

projections. Importantly, the Agency does not evaluate the impact the proposed payment reductions will have on access to DMEPOS in rural and other areas outside CBAs, stating only that the Agency lacks the data on which to base the analysis.

The RFA requires CMS to provide an estimate of the number of small entities that will be affected by the proposed rule and to consider alternative approaches that would accomplish the same objectives. CMS' RFA analysis falls short of these requirements. Although, the Agency acknowledges that the payment reductions will have a significant impact on a substantial number of small suppliers, CMS makes no effort to quantify how many suppliers will be affected or how the payment reductions would affect them. The analysis also appears to suggest that the payment reductions will not impact beneficiaries in affected areas because suppliers would not be precluded from furnishing items to beneficiaries as is the case under a "conventional" competitive bidding program. Again, however, CMS does not substantiate these conclusions.

Neither the proposed rule nor the RFA examines the demographic and economic variables that distinguish areas outside CBAs from CBAs or from each other. Consequently, CMS summarily concludes that competitive bidding payment amounts are accurate proxies for the cost of doing business in a CBA and will result in adequate reimbursement in areas outside CBAs. The proposed rule does not consider whether demographic and economic factors would justify other approaches like including "add-ons" to payment amounts such like the rural add-on CMS includes under other fee schedules or PPS methodologies.

CMS' failure to account for these variables in the proposed rule or the RFA analysis is a serious deficiency in the approach it is undertaking. By way of background, the program's design flaws have been documented by 244 auction experts, including three Nobel Laureate economists, who were sufficiently concerned to bring these issues to the attention of President Obama.[26] The economists analyzed the bid submission and selection components of the program, concluding that these key design features systematically skew bid pricing downward. The result is that the competitive bidding payment amounts, or single payment amounts (SPAs) are inaccurate. The economists who examined the program found the problems below.

First, bidders are not bound by their bids. In true auctions bidders must be prepared to do business at the price they bid. Under the Medicare program, however, a low ball bidder that is awarded a contract does not have to accept it if the price is too low. Because bidders are not compelled to accept a contract award, there is no penalty for submitting irrational bids that result in unsustainable pricing.[27] Low ball bidders are free to reject a contract offer, but their low bids are used to calculate SPAs.

Next, the SPAs are based on a flawed pricing mechanism. SPAs are set at the median of the initial contract offers, meaning half of the "winners" are offered a contract below their bids. This too encourages low ball bidding because a very low bid guarantees winning, but low ball bidders can be reasonably sure they will be paid at a higher rate.[28]

[26] Letter from 244 concerned auction experts, 2011, available at: http://www.cramton.umd.edu/papers2010-2014/further-comments-of-concerned-auction-experts-on-medicare-bidding.pdf
[27] *Ibid*.
[28] *Ibid.*

Third, the use of composite bids tends to skew bids downward because bidders can bid low on high demand items and high on low demand items. The result is that bids do not reflect the supplier's costs.[29] Finally, the lack of transparency in awarding contracts undermines the credibility of the process. Suppliers do not know how CMS applies the quality and financial standards to individual suppliers.[30]

Importantly, as far as we know, CMS has not published any data measuring the program's financial impact on suppliers or beneficiaries' access to care. For example, AAHomecare is aware that, since the program's inception, many suppliers have closed their businesses. However, CMS has made no attempt to quantify these impacts in its RFA and economic impact analyses. Clearly CMS has data on how many suppliers in CBAs have been sold or are no longer in business since the program was implemented. Likewise CMS has not quantified how many beneficiaries have been affected by these changes because it is difficult for them to transfer their care to another supplier.

Finally CMS has made no effort to quantify the impact of CMS' aggressive audit practices on suppliers and beneficiaries in CBAs. The Agency's audit strategies have caused suppliers to reallocate and increase their staff and financial resources in order to respond to audits. When these new costs are considered in light of the low payment amounts resulting from competitive bidding, suppliers are facing a grave challenge to their ability to remain operational.

CMS should withdraw the proposed rule until it can perform and publish meaningful RFA and economic analyses of the rule's impact on suppliers and beneficiaries in areas outside CBAs.

B. Special Payment Rules for Enteral Products and DME

CMS also proposes to combine competitive bidding with a new bundling payment methodology. The Agency's RFA and economic impact analyses of this new program are also deficient. In this case, the Agency's analyses are inadequate for the same reasons we described above. CMS has not articulated the objectives it intends to accomplish by adopting bundling; the projected impact the new approach would have on small suppliers and beneficiaries, or whether the objectives of the program would justify any negative impact from bundling.

CMS dismisses its requirement to perform an RFA analysis, concluding that the proposed rule would not have an impact on small suppliers and beneficiaries. However, the Agency does not provide the facts and assumptions that form the basis of this conclusion. It is alarming that CMS is proposing a radically different payment methodology for enteral products and DME without having first marshalled the data to support the change.

The RFA requires that agencies perform at least a threshold analysis to determine whether a proposed rule will have a significant impact on a substantial number of small business entities. It is only after performing this review that an agency head can certify that the rule is exempt from the requirements of the RFA.[31] However, this conclusion does not mean that the agency can skip the RFA analysis altogether.

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[29] *Ibid*.
[30] *Ibid*.
[31] THE RFA IN A NUTSHELL: A CONDENSED GUIDE TO THE REGULATORY FLEXIBILITY Act, available at: http://www.sba.gov/sites/default/files/advocacy/RFA_in_a_Nutshell2010.pdf

The Agency's certification must include the reasons for concluding that the proposed rule will not have a significant impact on a substantial number of small business entities.

At a minimum, CMS must describe the economic data the Agency used to perform the analysis and an analysis of the likely impact the proposed rule will have on small suppliers. CMS has not addressed these variables under the RFA analysis or otherwise in the proposed rule, either because the Agency has not thought them through or because the Agency lacks the data it needs to give an informed analysis.

We are concerned that CMS' inability to perform an adequate RFA analysis is an indication of CMS' overall lack of data to guide the implementation of the new program. CMS should not be allowed to proceed with an experiment of bundling payments for DME or enteral products without regard to the payment categories for equipment that Congressed established in the Social Security Act until it performs and publishes an RFA analysis that addresses all of the elements required under the law. This is crucial to insure that CMS has carefully studied all of the factors that must go into establishing a bundled payment for these items.

First, as far as we know, CMS does not have any data that can be used to align an individual's medical necessity for equipment and service to the Medicare payment for those items and services. This type of bundling is so complex that it is unrealistic to expect that this methodology can be implemented without a comprehensive analysis of the costs to furnish equipment to a chronically ill patient with a progressive medical condition.

Second, we are unaware of any data to establish what bundles may be appropriate for specific patients and no coverage criteria to determine when a beneficiary qualifies for higher level equipment in a bundle. Without assessment criteria like the ones used for the various PPS methodologies, suppliers have to guess at the type of equipment and the frequency of the services different patients may need. Without such an assessment tool, CMS has no way of comparing bids for a bundle because there is no consensus on what it takes to service patients who receive the bundle. More importantly, even assuming that that these issues could be addressed in the near term, we simply have no confidence that payment amounts for the bundled items and services resulting from the current flawed competitive bidding program will be sufficient to allow suppliers to remain operational.

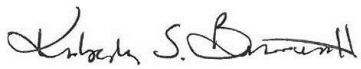
Finally, the preamble to the proposed rule suggests CMS believes that adding bundling to competitive bidding will address beneficiaries' inability to transition to new suppliers when their current supplier goes out of business or loses a contract in the CBA. This is an incorrect assumption. Medicare's rules for documenting medical necessity are separate from payment rules for equipment. Beneficiaries' must prove their medical need for an item every time they change suppliers. If the new supplier cannot access this information, the beneficiary does not qualify for Medicare payment of the item and suppliers will not admit him or her to its service. Consequently, the hurdles to access that beneficiaries face are the result of excessive documentation rules and not solely the result of low reimbursement – although suppliers do close their business because the SPAs are so low they cannot remain operational.

IV. CONCLUSION

Based on our comments above, we recommend that CMS withdraw the proposal to implement bidding programs using bundling. We request that CMS adopt our recommendations on the other issues raised on our comments. We sincerely appreciate the opportunity to submit these comments.

Please feel free to contact me if you have any questions or if I can be of assistance in any way.

Sincerely,



Kimberley S. Brummett, MBA
Vice President for Regulatory Affairs

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

LEGEND: **RED = LOWEST SPA**
Unusual difference between lov **BLUE= HIGHEST SPA**

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
A4221	Supplies For Maintenance Of Drug Infusion Catheter, Per Week (List Drug Separately)	$18.97	$16.50	$19.33	$18.24	$16.96	$16.77	$16.54	$19.46	$15.96	$17.64
A4222	Infusion Supplies For External Drug Infusion Pump, Per Cassette Or Bag (List Drugs Separately)	$38.78	$31.88	$32.39	$31.38	$31.62	$32.79	$32.58	$38.00	$31.62	$33.45
A4557	Lead Wires, (E.G., Apnea Monitor), Per Pair	$14.37	$13.97	$15.64	$13.97	$15.00	$14.39	$15.49	$14.22	$12.50	$14.39
A4595	Electrical Stimulator Supplies, 2 Lead, Per Month, (E.G. TENS, NMES)	$15.12	$15.48	$15.48	$12.36	$16.50	$17.02	$18.50	$15.50	$10.84	$15.20
A4619	Face tent	$1.77	$1.79	$1.75	$1.74	$1.76	$1.50	$1.69	$1.80	$1.89	$1.74
A4640	Replacement Pad For Use With Medically Necessary Alternating Pressure Pad Owned By Patient	$42.42	$48.13	$48.13	$45.01	$47.30	$38.44	$41.24	$42.44	$45.49	$44.29
A4640-RR	Replacement Pad For Use With Medically Necessary Alternating Pressure Pad Owned By Patient	$4.24	$4.81	$4.81	$4.50	$4.73	$3.84	$4.12	$4.24	$4.55	$4.43
A4640-UE	Replacement Pad For Use With Medically Necessary Alternating Pressure Pad Owned By Patient	$31.82	$36.10	$36.10	$33.76	$35.48	$28.83	$30.93	$31.83	$34.12	$33.22
A7003	Administration set, with small volume nonfiltered pneumatic nebulizer, disposable.	$1.94	$1.63	$1.46	$2.01	$1.72	$1.96	$1.96	$1.70	$1.74	$1.79
A7004	Small volume nonfiltered pneumatic nebulizer, disposable	$1.34	$1.35	$1.13	$1.32	$1.32	$1.16	$1.25	$1.13	$1.27	$1.25

AMERICAN ASSOCIATION FOR HOMECARE
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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
A7005	Administration set, with small volume nonfiltered pneumatic nebulizer, non-disposable	$19.22	$23.18	$18.22	$19.99	$19.99	$19.71	$19.71	$17.31	$19.00	$19.59
A7006	Administration set, with small volume filtered pneumatic nebulizer	$9.75	$9.22	$10.00	$8.42	$8.25	$8.15	$8.50	$8.00	$9.12	$8.82
A7007	Large volume nebulizer, disposable, unfilled, used with aerosol compressor	$4.50	$4.00	$3.95	$3.97	$4.20	$3.36	$3.80	$3.90	$4.46	$4.02
A7010	Corrugated tubing, disposable, used with large volume nebulizer, 100 feet	$19.70	$20.00	$17.55	$17.92	$19.12	$16.06	$18.00	$17.74	$19.49	$18.40
A7012	Water collection device, used with large volume nebulizer.	$3.98	$2.89	$2.90	$3.26	$3.62	$2.92	$3.25	$2.90	$3.81	$3.28
A7013	Filter, disposable, used with aerosol compressor or ultrasonic generator	$0.72	$0.69	$0.62	$0.60	$0.74	$0.54	$0.59	$0.60	$0.76	$0.65
A7014	Filter, nondisposable, used with aerosol compressor or ultrasonic generator	$4.40	$3.95	$3.60	$3.96	$3.97	$3.50	$3.96	$3.45	$3.97	$3.86
A7015	Aerosol mask, used with DME nebulizer	$1.74	$1.50	$1.50	$1.61	$1.68	$1.41	$1.72	$1.36	$1.78	$1.59
A7017	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	$142.53	$140.00	$140.00	$127.28	$134.30	$116.26	$124.00	$134.72	$138.60	$133.08
A7017-RR	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	$14.25	$14.00	$14.00	$12.73	$13.43	$11.63	$12.40	$13.47	$13.86	$13.31
A7017-UE	Nebulizer, durable, glass or autoclavable plastic, bottle type, not used with oxygen	$106.90	$105.00	$105.00	$95.46	$100.73	$87.20	$93.00	$101.04	$103.95	$99.81
A7018	Water, distilled, used with large volume nebulizer, 1000 ml	$0.34	$0.35	$0.35	$0.30	$0.35	$0.30	$0.30	$0.33	$0.36	$0.33

AMERICAN ASSOCIATION FOR HOMECARE
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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0160-NU	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode	$25.00	$24.95	$28.38	$25.00	$26.63	$20.22	$24.57	$25.00	$28.00	$25.31
E0160-RR	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode	$2.50	$2.50	$2.84	$2.50	$2.66	$2.02	$2.46	$2.50	$2.80	$2.53
E0160-UE	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode	$18.75	$18.71	$21.29	$18.75	$19.97	$15.17	$18.43	$18.75	$21.00	$18.98
E0161-NU	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode, With Faucet Attachment/S	$23.50	$24.95	$28.00	$21.00	$24.00	$19.72	$22.27	$23.48	$22.00	$23.21
E0161-RR	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode, With Faucet Attachment/S	$2.35	$2.50	$2.80	$2.10	$2.40	$1.97	$2.23	$2.35	$2.20	$2.32
E0161-UE	Sitz Type Bath Or Equipment, Portable, Used With Or Without Commode, With Faucet Attachment/S	$17.63	$18.71	$21.00	$15.75	$18.00	$14.79	$16.70	$17.61	$16.50	$17.41
E0163	Commode Chair, Mobile Or Stationary, With Fixed Arms	$58.88	$65.00	$69.79	$65.15	$67.00	$68.43	$69.10	$54.64	$56.64	$63.85
E0163	Commode Chair, Mobile Or Stationary, With Fixed Arms	$5.89	$6.50	$6.98	$6.52	$6.70	$6.84	$6.91	$5.46	$5.66	$6.38
E0163	Commode Chair, Mobile Or Stationary, With Fixed Arms	$44.16	$48.75	$52.34	$48.86	$50.25	$51.32	$51.83	$40.98	$42.48	$47.89
E0165	Commode Chair, Mobile Or Stationary, With Detachable Arms	$11.88	$12.00	$12.73	$12.00	$13.97	$12.50	$13.97	$11.67	$13.11	$12.65
E0167	Pail Or Pan For Use With Commode Chair, Replacement Only	$9.04	$10.97	$11.00	$10.00	$10.00	$7.70	$9.25	$9.43	$10.50	$9.77
E0167-RR	Pail Or Pan For Use With Commode Chair, Replacement Only	$0.90	$1.10	$1.10	$1.00	$1.00	$0.77	$0.93	$0.94	$1.05	$0.98

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0167-UE	Pail Or Pan For Use With Commode Chair, Replacement Only	$6.78	$8.23	$8.25	$7.50	$7.50	$5.78	$6.94	$7.07	$7.88	$7.33
E0168	Commode Chair, Extra Wide And/Or Heavy Duty, Stationary Or Mobile, With Or Without Arms, Any Type, Each	$130.00	$147.14	$148.00	$114.50	$113.47	$108.00	$117.53	$128.84	$115.56	$124.78
E0168-RR	Commode Chair, Extra Wide And/Or Heavy Duty, Stationary Or Mobile, With Or Without Arms, Any Type, Each	$13.00	$14.71	$14.80	$11.45	$11.35	$10.80	$11.75	$12.88	$11.56	$12.48
E0168-UE	Commode Chair, Extra Wide And/Or Heavy Duty, Stationary Or Mobile, With Or Without Arms, Any Type, Each	$97.50	$110.36	$111.00	$85.88	$85.10	$81.00	$88.15	$96.63	$86.67	$93.59
E0170	Commode Chair With Integrated Seat Lift Mechanism, Electric, Any Type	$167.09	$170.00	$170.00	$159.50	$140.00	$120.85	$146.30	$148.99	$167.09	$154.42
E0171	Commode Chair With Integrated Seat Lift Mechanism, Non-Electric, Any Type	$30.22	$27.50	$30.50	$26.50	$27.50	$21.75	$26.39	$27.81	$29.95	$27.57
E0181	Powered Pressure Reducing Mattress Overlay/Pad, Alternating, With Pump, Includes Heavy Duty	$18.70	$19.80	$19.50	$16.23	$19.31	$17.63	$18.35	$18.62	$16.75	$18.32
E0182	Pump For Alternating Pressure Pad, For Replacement Only	$17.91	$18.50	$18.66	$16.62	$18.80	$15.54	$16.73	$18.96	$18.91	$17.85
E0184	Dry Pressure Mattress	$162.08	$149.00	$165.00	$156.44	$167.31	$142.22	$156.42	$165.00	$157.93	$157.93
E0184-RR	Dry Pressure Mattress	$16.21	$14.90	$16.50	$15.64	$16.73	$14.22	$15.64	$16.50	$15.79	$15.79
E0184-UE	Dry Pressure Mattress	$121.56	$111.75	$123.75	$117.33	$125.48	$106.67	$117.32	$123.75	$118.45	$118.45

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0185	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length And Width	$194.74	$175.99	$192.00	$192.00	$206.14	$191.63	$203.31	$175.52	$173.46	$189.42
E0185-RR	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length And Width	$19.47	$17.60	$19.20	$19.20	$20.61	$19.16	$20.33	$17.55	$17.35	$18.94
E0185-UE	Gel Or Gel-Like Pressure Pad For Mattress, Standard Mattress Length And Width	$146.06	$131.99	$144.00	$144.00	$154.61	$143.72	$152.48	$131.64	$130.10	$142.07
E0186	Air Pressure Mattress	$16.40	$18.54	$19.43	$17.50	$16.50	$15.27	$17.22	$17.00	$19.22	$17.45
E0187	Water Pressure Mattress	$16.70	$19.20	$22.19	$21.00	$17.45	$15.27	$17.50	$18.20	$21.15	$18.74
E0188	Synthetic Sheepskin Pad	$22.00	$26.87	$27.00	$21.23	$22.71	$16.89	$19.75	$22.44	$23.50	$22.49
E0188-RR	Synthetic Sheepskin Pad	$2.20	$2.69	$2.70	$2.12	$2.27	$1.69	$1.98	$2.24	$2.35	$2.25
E0188-UE	Synthetic Sheepskin Pad	$16.50	$20.15	$20.25	$15.92	$17.03	$12.67	$14.81	$16.83	$17.63	$16.87
E0189	Lambswool Sheepskin Pad, Any Size	$47.94	$43.99	$46.00	$46.10	$41.87	$39.07	$46.22	$42.70	$47.00	$44.54
E0189-RR	Lambswool Sheepskin Pad, Any Size	$4.79	$4.40	$4.60	$4.61	$4.19	$3.91	$4.62	$4.27	$4.70	$4.45
E0189-UE	Lambswool Sheepskin Pad, Any Size	$35.96	$32.99	$34.50	$34.58	$31.40	$29.30	$34.67	$32.03	$35.25	$33.41
E0196	Gel Pressure Mattress	$30.09	$29.90	$34.00	$28.04	$26.18	$23.00	$26.34	$25.30	$30.00	$28.09
E0197	Air Pressure Pad For Mattress, Standard Mattress Length And Width	$143.36	$172.00	$188.69	$161.33	$178.50	$131.70	$141.62	$165.41	$175.00	$161.96
E0197-RR	Air Pressure Pad For Mattress, Standard Mattress Length And Width	$14.34	$17.20	$18.87	$16.13	$17.85	$13.17	$14.16	$16.54	$17.50	$16.20
E0197-UE	Air Pressure Pad For Mattress, Standard Mattress Length And Width	$107.52	$129.00	$141.52	$121.00	$133.88	$98.78	$106.22	$124.06	$131.25	$121.47
E0199	Dry Pressure Pad For Mattress, Standard Mattress Length And Width	$26.99	$28.08	$27.80	$27.05	$25.00	$23.14	$25.72	$25.00	$29.50	$26.48

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0199-RR	Dry Pressure Pad For Mattress, Standard Mattress Length And Width	$2.70	$2.81	$2.78	$2.71	$2.50	$2.31	$2.57	$2.50	$2.95	$2.65
E0199-UE	Dry Pressure Pad For Mattress, Standard Mattress Length And Width	$20.24	$21.06	$20.85	$20.29	$18.75	$17.36	$19.29	$18.75	$22.13	$19.86
E0275	Bed Pan, Standard, Metal Or Plastic	$14.20	$15.72	$15.46	$13.00	$12.00	$9.79	$12.00	$13.00	$14.50	$13.30
E0275-RR	Bed Pan, Standard, Metal Or Plastic	$1.42	$1.57	$1.55	$1.30	$1.20	$0.98	$1.20	$1.30	$1.45	$1.33
E0275-UE	Bed Pan, Standard, Metal Or Plastic	$10.65	$11.79	$11.60	$9.75	$9.00	$7.34	$9.00	$9.75	$10.88	$9.97
E0276	Bed Pan, Fracture, Metal Or Plastic	$11.96	$12.00	$11.99	$12.00	$10.34	$8.90	$10.58	$11.46	$12.08	$11.26
E0276-RR	Bed Pan, Fracture, Metal Or Plastic	$1.20	$1.20	$1.20	$1.20	$1.03	$0.89	$1.06	$1.15	$1.21	$1.13
E0276-UE	Bed Pan, Fracture, Metal Or Plastic	$8.97	$9.00	$8.99	$9.00	$7.76	$6.68	$7.94	$8.60	$9.06	$8.44
E0325	Urinal; Male, Jug-Type, Any Material	$8.52	$8.85	$8.75	$8.69	$9.05	$6.42	$8.00	$8.88	$8.62	$8.42
E0325-RR	Urinal; Male, Jug-Type, Any Material	$0.85	$0.89	$0.88	$0.87	$0.91	$0.64	$0.80	$0.89	$0.86	$0.84
E0325-UE	Urinal; Male, Jug-Type, Any Material	$6.39	$6.64	$6.56	$6.52	$6.79	$4.82	$6.00	$6.66	$6.47	$6.32
E0326	Urinal; Female, Jug-Type, Any Material	$9.20	$9.59	$10.00	$9.50	$8.50	$7.59	$8.73	$8.76	$9.79	$9.07
E0326-RR	Urinal; Female, Jug-Type, Any Material	$0.92	$0.96	$1.00	$0.95	$0.85	$0.76	$0.87	$0.88	$0.98	$0.91
E0326-UE	Urinal; Female, Jug-Type, Any Material	$6.90	$7.19	$7.50	$7.13	$6.38	$5.69	$6.55	$6.57	$7.34	$6.81
E0565	Compressor, air power source for equipment which is not self-contained or cylinder driven	$55.58	$42.50	$45.00	$52.22	$49.55	$40.67	$45.00	$44.57	$51.83	$47.44
E0570	**Nebulizer, with compressor**	$9.75	$10.29	$9.00	$10.84	$11.07	$11.60	$10.48	$10.00	$8.43	$10.16

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0572	Aerosol compressor, adjustable pressure, light duty for intermittent use	$40.50	$37.38	$37.50	$36.61	$37.68	$29.18	$32.01	$37.50	$37.83	$36.24
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	$122.86	$111.69	$117.90	$111.59	$117.12	$98.56	$105.49	$115.25	$120.00	$113.38
E0580-RR	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	$12.29	$11.17	$11.79	$11.16	$11.71	$9.86	$10.55	$11.53	$12.00	$11.34
E0580-UE	Nebulizer, durable, glass or autoclavable plastic, bottle type, for use with regulator or flowmeter	$92.15	$83.77	$88.43	$83.69	$87.84	$73.92	$79.12	$86.44	$90.00	$85.04
E0585	**Nebulizer, with compressor and heater**	$31.69	$35.00	$35.00	$32.03	$31.25	$29.00	$32.05	$32.05	$35.39	$32.61
E0621	Sling Or Seat, Patient Lift, Canvas Or Nylon	$76.92	$83.30	$88.57	$78.91	$72.50	$60.13	$67.17	$75.19	$74.00	$75.19
E0621-RR	Sling Or Seat, Patient Lift, Canvas Or Nylon	$7.69	$8.33	$8.86	$7.89	$7.25	$6.01	$6.72	$7.52	$7.40	$7.52
E0621-UE	Sling Or Seat, Patient Lift, Canvas Or Nylon	$57.69	$62.48	$66.43	$59.18	$54.38	$45.10	$50.38	$56.39	$55.50	$56.39
E0627	Seat Lift Mechanism Incorporated Into A Combination Lift-Chair Mechanism	$248.19	$299.00	$284.17	$248.50	$250.00	$239.86	$250.00	$249.25	$248.25	$257.47
E0627-RR	Seat Lift Mechanism Incorporated Into A Combination Lift-Chair Mechanism	$24.82	$29.90	$28.42	$24.85	$25.00	$23.99	$25.00	$24.93	$24.83	$25.75
E0627-UE	Seat Lift Mechanism Incorporated Into A Combination Lift-Chair Mechanism	$186.14	$224.25	$213.13	$186.38	$187.50	$179.90	$187.50	$186.94	$186.19	$193.10

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0628	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Electric	$310.18	$287.02	$290.00	$250.00	$271.75	$250.00	$256.82	$284.09	$292.90	$276.97
E0628-RR	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Electric	$31.02	$28.70	$29.00	$25.00	$27.18	$25.00	$25.68	$28.41	$29.29	$27.70
E0628-UE	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Electric	$232.64	$215.27	$217.50	$187.50	$203.81	$187.50	$192.62	$213.07	$219.68	$207.73
E0629	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Non-Electric	$253.21	$287.02	$295.00	$250.00	$266.42	$240.00	$249.33	$271.21	$278.21	$265.60
E0629-RR	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Non-Electric	$25.32	$28.70	$29.50	$25.00	$26.64	$24.00	$24.93	$27.12	$27.82	$26.56
E0629-UE	Separate Seat Lift Mechanism For Use With Patient Owned Furniture-Non-Electric	$189.91	$215.27	$221.25	$187.50	$199.82	$180.00	$187.00	$203.41	$208.66	$199.20
E0630	Patient Lift, Hydraulic Or Mechanical, Includes Any Seat, Sling, Strap(S) Or Pad(S)	$63.34	$58.50	$71.00	$69.00	$67.96	$59.50	$60.23	$61.64	$58.44	$63.29
E0635	Patient Lift, Electric With Seat Or Sling	$111.64	$111.60	$111.02	$105.00	$105.00	$89.00	$100.27	$105.57	$107.50	$105.18
E0636	Multipositional Patient Support System, With Integrated Lift, Patient Accessible Controls	$954.73	$1,080.00	$1,050.00	$1,055.00	$900.00	$804.22	$906.18	$914.46	$915.55	$953.35
E0705	Transfer Device, Any Type, Each	$49.50	$40.26	$41.90	$40.13	$45.25	$41.22	$45.00	$41.85	$40.00	$42.79

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0705-RR	Transfer Device, Any Type, Each	$4.95	$4.03	$4.19	$4.01	$4.53	$4.12	$4.50	$4.19	$4.00	$4.28
E0705-UE	Transfer Device, Any Type, Each	$37.13	$30.20	$31.43	$30.10	$33.94	$30.92	$33.75	$31.39	$30.00	$32.10
E0720	Transcutaneous Electrical Nerve Stimulation (TENS) Device, Two Lead, Localized Stimulation	$234.22	$210.00	$197.41	$175.00	$219.00	$197.41	$245.97	$218.38	$148.40	$205.09
E0730	Transcutaneous Electrical Nerve Stimulation (TENS) Device, Four Or More Leads, For Multiple Nerve Stimulation	$186.85	$128.49	$175.00	$125.32	$199.25	$199.02	$202.60	$168.95	$109.66	$166.13
E0731	Form Fitting Conductive Garment For Delivery Of TENS Or NMES (With Conductive Fibers Separated From The Patient's Skin By Layers Of Fabric)	$227.28	$195.39	$275.00	$185.00	$202.23	$229.88	$252.02	$219.89	$198.48	$220.57
E0779	Ambulatory Infusion Pump, 8 Hours or Greater	$17.45	$16.80	$16.10	$17.50	$16.80	$14.24	$15.56	$15.56	$16.23	$16.25
E0780	Ambulatory Infusion Pump, Less Than 8 Hours	$10.92	$9.18	$10.00	$11.13	$9.46	$10.00	$11.00	$11.00	$10.29	$10.33
E0781	Ambulatory Infusion Pump, Single Or Multiple Channels, Electric Or Battery Operated, With Administrative Equipment, Worn By Patient	$229.57	$192.01	$226.18	$227.60	$206.26	$173.94	$218.68	$220.00	$203.56	$210.87
E0784	External Ambulatory Infusion Pump, Insulin	$385.00	$346.41	$385.00	$401.00	$393.00	$357.16	$385.00	$358.82	$410.50	$380.21
E0791	Parenteral Infusion Pump, Stationary, Single Or Multi-Channel	$288.69	$235.19	$250.00	$250.00	$247.50	$235.51	$230.95	$245.00	$271.71	$250.51

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0958	Manual Wheelchair Accessory, One-Arm Drive Attachment, Each	$41.59	$38.90	$38.90	$35.00	$40.42	$30.57	$35.35	$38.45	$35.00	$37.13
E0959	Manual Wheelchair Accessory, Adapter For Amputee, Each	$41.34	$40.00	$39.15	$39.48	$39.97	$32.14	$34.31	$39.60	$38.10	$38.23
E0959-RR	Manual Wheelchair Accessory, Adapter For Amputee, Each	$4.13	$4.00	$3.92	$3.95	$4.00	$3.21	$3.43	$3.96	$3.81	$3.82
E0959-UE	Manual Wheelchair Accessory, Adapter For Amputee, Each	$31.01	$30.00	$29.36	$29.61	$29.98	$24.11	$25.73	$29.70	$28.58	$28.68
E0966	Manual Wheelchair Accessory, Headrest Extension, Each	$64.42	$61.28	$61.44	$61.34	$61.34	$57.00	$59.72	$61.17	$57.50	$60.58
E0966-RR	Manual Wheelchair Accessory, Headrest Extension, Each	$6.44	$6.13	$6.14	$6.13	$6.13	$5.70	$5.97	$6.12	$5.75	$6.06
E0966-UE	Manual Wheelchair Accessory, Headrest Extension, Each	$48.32	$45.96	$46.08	$46.01	$46.01	$42.75	$44.79	$45.88	$43.13	$45.44
E0967	Manual Wheelchair Accessory, Hand Rim With Projections, Any Type, Each	$59.97	$64.74	$61.74	$57.71	$59.25	$56.00	$59.50	$59.47	$55.56	$59.33
E0967-RR	Manual Wheelchair Accessory, Hand Rim With Projections, Any Type, Each	$6.00	$6.47	$6.17	$5.77	$5.93	$5.60	$5.95	$5.95	$5.56	$5.93
E0967-UE	Manual Wheelchair Accessory, Hand Rim With Projections, Any Type, Each	$44.98	$48.56	$46.31	$43.28	$44.44	$42.00	$44.63	$44.60	$41.67	$44.50
E0974	Manual Wheelchair Accessory, Anti-Rollback Device, Each	$64.36	$67.38	$67.38	$67.38	$67.38	$56.32	$57.27	$67.38	$63.00	$64.21
E0974-RR	Manual Wheelchair Accessory, Anti-Rollback Device, Each	$6.44	$6.74	$6.74	$6.74	$6.74	$5.63	$5.73	$6.74	$6.30	$6.42

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E0974-UE	Manual Wheelchair Accessory, Anti-Rollback Device, Each	$48.27	$50.54	$50.54	$50.54	$50.54	$42.24	$42.95	$50.54	$47.25	$48.16
E0985	Wheelchair Accessory, Seat Lift Mechanism	$190.66	$192.02	$196.10	$184.85	$191.80	$164.20	$175.00	$192.02	$179.50	$185.13
E0985-RR	Wheelchair Accessory, Seat Lift Mechanism	$19.07	$19.20	$19.61	$18.49	$19.18	$16.42	$17.50	$19.20	$17.95	$18.51
E0985-UE	Wheelchair Accessory, Seat Lift Mechanism	$143.00	$144.02	$147.08	$138.64	$143.85	$123.15	$131.25	$144.02	$134.63	$138.85
E1015	Shock Absorber For Manual Wheelchair, Each	$110.89	$118.24	$107.24	$100.36	$112.50	$95.00	$99.00	$114.74	$92.50	$105.61
E1015-RR	Shock Absorber For Manual Wheelchair, Each	$11.09	$11.82	$10.72	$10.04	$11.25	$9.50	$9.90	$11.47	$9.25	$10.56
E1015-UE	Shock Absorber For Manual Wheelchair, Each	$83.17	$88.68	$80.43	$75.27	$84.38	$71.25	$74.25	$86.06	$69.38	$79.21
E1035	Multi-Positional Patient Transfer System, With Integrated Seat, Operated By Care Giver, Patient Weight Capacity Up To And Including 300 Lbs	$611.08	$590.00	$586.21	$559.86	$558.66	$461.06	$549.75	$592.79	$558.31	$563.08
E1036	Multi-Positional Patient Transfer System, Extra-Wide, With Integrated Seat, Operated By Caregiver, Patient Weight Capacity Greater Than 300 Lbs	$825.52	$890.00	$890.00	$800.00	$820.00	$646.36	$770.00	$825.52	$840.00	$811.93
E1037	Transport Chair, Pediatric Size	$96.06	$93.22	$93.22	$93.22	$88.43	$86.11	$85.69	$93.22	$84.05	$90.36
E1039	Transport Chair, Adult Size, Heavy Duty, Patient Weight Capacity Greater Than 300 Pounds	$32.48	$29.38	$30.64	$29.38	$30.64	$26.98	$27.90	$30.30	$26.00	$29.30
E1372	Immersion external heater for nebulizer	$154.09	$133.95	$140.00	$147.50	$146.84	$120.00	$126.51	$140.00	$143.70	$139.18

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E1372-RR	Immersion external heater for nebulizer	$15.41	$13.40	$14.00	$14.75	$14.68	$12.00	$12.65	$14.00	$14.37	$13.92
E1372-UE	Immersion external heater for nebulizer	$115.57	$100.46	$105.00	$110.63	$110.13	$90.00	$94.88	$105.00	$107.78	$104.38
E2205	Manual Wheelchair Accessory, Handrim Without Projections (Includes Ergonomic Or Contoured), Any Type, Replacement Only, Each	$29.92	$29.66	$30.62	$29.00	$29.25	$27.68	$29.83	$29.42	$28.61	$29.33
E2205-RR	Manual Wheelchair Accessory, Handrim Without Projections (Includes Ergonomic Or Contoured), Any Type, Replacement Only, Each	$2.99	$2.97	$3.06	$2.90	$2.93	$2.77	$2.98	$2.94	$2.86	$2.93
E2205-UE	Manual Wheelchair Accessory, Handrim Without Projections (Includes Ergonomic Or Contoured), Any Type, Replacement Only, Each	$22.44	$22.25	$22.97	$21.75	$21.94	$20.76	$22.37	$22.07	$21.46	$22.00
E2207	Wheelchair Accessory, Crutch And Cane Holder, Each	$40.74	$40.12	$42.50	$37.95	$36.94	$34.56	$39.58	$42.50	$38.93	$39.31
E2207-RR	Wheelchair Accessory, Crutch And Cane Holder, Each	$4.07	$4.01	$4.25	$3.80	$3.69	$3.46	$3.96	$4.25	$3.89	$3.93
E2207-UE	Wheelchair Accessory, Crutch And Cane Holder, Each	$30.56	$30.09	$31.88	$28.46	$27.71	$25.92	$29.69	$31.88	$29.20	$29.49
E2212	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	$5.68	$5.85	$5.85	$5.06	$5.98	$5.02	$5.36	$5.56	$5.45	$5.53

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2212-RR	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	$0.57	$0.59	$0.59	$0.51	$0.60	$0.50	$0.54	$0.56	$0.55	$0.56
E2212-UE	Manual Wheelchair Accessory, Tube For Pneumatic Propulsion Tire, Any Size, Each	$4.26	$4.39	$4.39	$3.80	$4.49	$3.77	$4.02	$4.17	$4.09	$4.15
E2214	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	$29.30	$27.15	$29.12	$27.00	$31.72	$25.50	$26.30	$29.26	$30.00	$28.37
E2214-RR	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	$2.93	$2.72	$2.91	$2.70	$3.17	$2.55	$2.63	$2.93	$3.00	$2.84
E2214-UE	Manual Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Each	$21.98	$20.36	$21.84	$20.25	$23.79	$19.13	$19.73	$21.95	$22.50	$21.28
E2215	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	$9.14	$8.92	$9.34	$8.57	$9.50	$8.25	$8.76	$8.88	$8.67	$8.89
E2215-RR	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	$0.91	$0.89	$0.93	$0.86	$0.95	$0.83	$0.88	$0.89	$0.87	$0.89
E2215-UE	Manual Wheelchair Accessory, Tube For Pneumatic Caster Tire, Any Size, Each	$6.86	$6.69	$7.01	$6.43	$7.13	$6.19	$6.57	$6.66	$6.50	$6.67
E2219	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	$39.75	$38.18	$35.48	$32.00	$38.60	$30.10	$30.57	$36.66	$36.00	$35.26
E2219-RR	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	$3.98	$3.82	$3.55	$3.20	$3.86	$3.01	$3.06	$3.67	$3.60	$3.53

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2219-UE	Manual Wheelchair Accessory, Foam Caster Tire, Any Size, Each	$29.81	$28.64	$26.61	$24.00	$28.95	$22.58	$22.93	$27.50	$27.00	$26.45
E2220	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Each	$26.81	$25.50	$24.76	$22.13	$26.39	$25.00	$26.04	$24.76	$26.10	$25.28
E2220-RR	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Each	$2.68	$2.55	$2.48	$2.21	$2.64	$2.50	$2.60	$2.48	$2.61	$2.53
E2220-UE	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Propulsion Tire, Any Size, Each	$20.11	$19.13	$18.57	$16.60	$19.79	$18.75	$19.53	$18.57	$19.58	$18.96
E2221	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	$24.00	$23.66	$22.82	$22.48	$23.70	$21.95	$23.32	$22.82	$22.90	$23.07
E2221-RR	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	$2.40	$2.37	$2.28	$2.25	$2.37	$2.20	$2.33	$2.28	$2.29	$2.31
E2221-UE	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Each	$18.00	$17.75	$17.12	$16.86	$17.78	$16.46	$17.49	$17.12	$17.18	$17.31
E2222	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	$19.75	$19.36	$19.12	$18.50	$19.25	$18.55	$19.23	$18.86	$19.35	$19.11

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2222-RR	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	$1.98	$1.94	$1.91	$1.85	$1.93	$1.86	$1.92	$1.89	$1.94	$1.91
E2222-UE	Manual Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Each	$14.81	$14.52	$14.34	$13.88	$14.44	$13.91	$14.42	$14.15	$14.51	$14.33
E2224	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	$91.20	$75.92	$75.56	$77.02	$87.26	$83.08	$88.00	$71.62	$76.10	$80.64
E2224-RR	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	$9.12	$7.59	$7.56	$7.70	$8.73	$8.31	$8.80	$7.16	$7.61	$8.06
E2224-UE	Manual Wheelchair Accessory, Propulsion Wheel Excludes Tire, Any Size, Each	$68.40	$56.94	$56.67	$57.77	$65.45	$62.31	$66.00	$53.72	$57.08	$60.48
E2225	Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	$16.36	$17.75	$17.50	$14.98	$16.50	$14.95	$15.00	$16.69	$15.82	$16.17
E2225-RR	Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	$1.64	$1.78	$1.75	$1.50	$1.65	$1.50	$1.50	$1.67	$1.58	$1.62
E2225-UE	Manual Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each	$12.27	$13.31	$13.13	$11.24	$12.38	$11.21	$11.25	$12.52	$11.87	$12.13

AMERICAN ASSOCIATION FOR HOMECARE
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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2226	Manual Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each	$35.84	$34.57	$34.57	$32.61	$32.61	$30.68	$34.65	$33.55	$34.68	$33.75
E2226-RR	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	$3.58	$3.46	$3.46	$3.26	$3.26	$3.07	$3.47	$3.36	$3.47	$3.38
E2226-UE	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	$26.88	$25.93	$25.93	$24.46	$24.46	$23.01	$25.99	$25.16	$26.01	$25.31
E2228	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	$905.09	$900.00	$875.00	$854.78	$902.54	$807.26	$825.85	$877.40	$850.00	$866.44
E2228-RR	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	$90.51	$90.00	$87.50	$85.48	$90.25	$80.73	$82.59	$87.74	$85.00	$86.64
E2228-UE	Manual Wheelchair Accessory, Wheel Braking System And Lock, Complete, Each	$678.82	$675.00	$656.25	$641.09	$676.91	$605.45	$619.39	$658.05	$637.50	$649.83
E2375	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	$634.40	$634.40	$634.40	$594.75	$634.40	$565.35	$600.00	$654.22	$599.00	$616.77
E2375-RR	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	$63.44	$63.44	$63.44	$59.48	$63.44	$56.54	$60.00	$65.42	$59.90	$61.68

AMERICAN ASSOCIATION FOR HOMECARE
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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2375-UE	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only	$475.80	$475.80	$475.80	$446.06	$475.80	$424.01	$450.00	$490.67	$449.25	$462.58
E2397	Power Wheelchair Accessory, Lithium-Based Battery, Each	$389.06	$410.68	$410.68	$397.85	$405.00	$355.00	$355.87	$410.68	$378.10	$390.32
E2397-RR	Power Wheelchair Accessory, Lithium-Based Battery, Each	$38.91	$41.07	$41.07	$39.79	$40.50	$35.50	$35.59	$41.07	$37.81	$39.03
E2397-UE	Power Wheelchair Accessory, Lithium-Based Battery, Each	$291.80	$308.01	$308.01	$298.39	$303.75	$266.25	$266.90	$308.01	$283.58	$292.74
E2626	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable	$558.54	$583.56	$571.06	$504.00	$578.44	$533.66	$567.09	$579.60	$567.00	$560.33
E2626-RR	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable	$55.85	$58.36	$57.11	$50.40	$57.84	$53.37	$56.71	$57.96	$56.70	$56.03
E2626-UE	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable	$418.91	$437.67	$428.30	$378.00	$433.83	$400.25	$425.32	$434.70	$425.25	$420.25
E2627	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type	$907.44	$881.00	$851.33	$900.44	$875.44	$851.66	$875.00	$901.55	$910.00	$883.76

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2627-RR	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type	$90.74	$88.10	$85.13	$90.04	$87.54	$85.17	$87.50	$90.16	$91.00	$88.38
E2627-UE	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Adjustable Rancho Type	$680.58	$660.75	$638.50	$675.33	$656.58	$638.75	$656.25	$676.16	$682.50	$662.82
E2628	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining	$699.00	$620.12	$645.80	$612.96	$645.80	$643.30	$681.69	$680.10	$701.00	$658.86
E2628-RR	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining	$69.90	$62.01	$64.58	$61.30	$64.58	$64.33	$68.17	$68.01	$70.10	$65.89
E2628-UE	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Reclining	$524.25	$465.09	$484.35	$459.72	$484.35	$482.48	$511.27	$510.08	$525.75	$494.15
E2629	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	$880.84	$940.00	$906.20	$805.06	$837.50	$811.92	$850.00	$906.20	$899.00	$870.75

AMERICAN ASSOCIATION FOR HOMECARE
ANALYSIS OF <10 CBA SPAS

HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2629-RR	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	$88.08	$94.00	$90.62	$80.51	$83.75	$81.19	$85.00	$90.62	$89.90	$87.07
E2629-UE	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support Attached To Wheelchair, Balanced, Friction Arm Support (Friction Dampening To Proximal And Distal Joints)	$660.63	$705.00	$679.65	$603.80	$628.13	$608.94	$637.50	$679.65	$674.25	$653.06
E2630	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension Support	$558.89	$587.00	$567.39	$585.13	$571.36	$567.78	$603.26	$578.98	$600.00	$579.98
E2630-RR	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension Support	$55.89	$58.70	$56.74	$58.51	$57.14	$56.78	$60.33	$57.90	$60.00	$58.00
E2630-UE	Wheelchair Accessory, Shoulder Elbow, Mobile Arm Support, Monosuspension Arm And Hand Support, Overhead Elbow Forearm Hand Sling Support, Yoke Type Suspension Support	$419.17	$440.25	$425.54	$438.85	$428.52	$425.84	$452.45	$434.24	$450.00	$434.98

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
E2631	Wheelchair Accessory, Addition To Mobile Arm Support, Elevating Proximal Arm	$248.42	$231.00	$226.56	$238.45	$226.06	$225.00	$225.00	$240.66	$227.00	$232.02
E2631-RR	Wheelchair Accessory, Addition To Mobile Arm Support, Elevating Proximal Arm	$24.84	$23.10	$22.66	$23.85	$22.61	$22.50	$22.50	$24.07	$22.70	$23.20
E2631-UE	Wheelchair Accessory, Addition To Mobile Arm Support, Elevating Proximal Arm	$186.32	$173.25	$169.92	$178.84	$169.55	$168.75	$168.75	$180.50	$170.25	$174.01
E2632	Wheelchair Accessory, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	$154.53	$145.00	$147.37	$151.00	$147.50	$144.00	$150.00	$153.22	$144.00	$148.51
E2632-RR	Wheelchair Accessory, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	$15.45	$14.50	$14.74	$15.10	$14.75	$14.40	$15.00	$15.32	$14.40	$14.85
E2632-UE	Wheelchair Accessory, Addition To Mobile Arm Support, Offset Or Lateral Rocker Arm With Elastic Balance Control	$115.90	$108.75	$110.53	$113.25	$110.63	$108.00	$112.50	$114.92	$108.00	$111.39
E2633	Wheelchair Accessory, Addition To Mobile Arm Support, Supinator	$121.16	$121.12	$122.00	$129.92	$121.12	$121.12	$125.00	$126.25	$122.00	$123.30
E2633-RR	Wheelchair Accessory, Addition To Mobile Arm Support, Supinator	$12.12	$12.11	$12.20	$12.99	$12.11	$12.11	$12.50	$12.63	$12.20	$12.33
E2633-UE	Wheelchair Accessory, Addition To Mobile Arm Support, Supinator	$90.87	$90.84	$91.50	$97.44	$90.84	$90.84	$93.75	$94.69	$91.50	$92.47

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
K0065	Spoke Protectors, Each	$40.04	$39.38	$39.38	$39.38	$39.38	$38.20	$39.50	$39.12	$39.00	$39.26
K0065-RR	Spoke Protectors, Each	$4.00	$3.94	$3.94	$3.94	$3.94	$3.82	$3.95	$3.91	$3.90	$3.93
K0065-UE	Spoke Protectors, Each	$30.03	$29.54	$29.54	$29.54	$29.54	$28.65	$29.63	$29.34	$29.25	$29.45
K0071	Front Caster Assembly, Complete, With Pneumatic Tire, Each	$99.38	$94.44	$93.09	$93.88	$99.22	$84.98	$93.88	$96.44	$93.50	$94.31
K0071	Front Caster Assembly, Complete, With Pneumatic Tire, Each	$9.94	$9.44	$9.31	$9.39	$9.92	$8.50	$9.39	$9.64	$9.35	$9.43
K0071	Front Caster Assembly, Complete, With Pneumatic Tire, Each	$74.54	$70.83	$69.82	$70.41	$74.42	$63.74	$70.41	$72.33	$70.13	$70.74
K0072	Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Each	$61.81	$56.51	$56.04	$59.46	$59.58	$55.00	$55.00	$60.00	$59.23	$58.07
K0072	Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Each	$6.18	$5.65	$5.60	$5.95	$5.96	$5.50	$5.50	$6.00	$5.92	$5.81
K0072	Front Caster Assembly, Complete, With Semi-Pneumatic Tire, Each	$46.36	$42.38	$42.03	$44.60	$44.69	$41.25	$41.25	$45.00	$44.42	$43.55
K0073	Caster Pin Lock, Each	$33.16	$34.20	$31.78	$29.35	$32.22	$28.69	$30.00	$33.20	$29.99	$31.40
K0073	Caster Pin Lock, Each	$3.32	$3.42	$3.18	$2.94	$3.22	$2.87	$3.00	$3.32	$3.00	$3.14
K0073	Caster Pin Lock, Each	$24.87	$25.65	$23.84	$22.01	$24.17	$21.52	$22.50	$24.90	$22.49	$23.55
K0098	Drive Belt For Power Wheelchair	$22.36	$22.22	$22.00	$20.11	$22.14	$19.12	$20.00	$22.22	$19.64	$21.09
K0098	Drive Belt For Power Wheelchair	$2.24	$2.22	$2.20	$2.01	$2.21	$1.91	$2.00	$2.22	$1.96	$2.11
K0098	Drive Belt For Power Wheelchair	$16.77	$16.67	$16.50	$15.08	$16.61	$14.34	$15.00	$16.67	$14.73	$15.82
K0105	IV Hanger, Each	$22.36	$22.22	$22.00	$20.11	$22.14	$19.12	$20.00	$22.22	$19.64	$21.09
K0105	IV Hanger, Each	$2.24	$2.22	$2.20	$2.01	$2.21	$1.91	$2.00	$2.22	$1.96	$2.11
K0105	IV Hanger, Each	$16.77	$16.67	$16.50	$15.08	$16.61	$14.34	$15.00	$16.67	$14.73	$15.82

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HCPCS	DESCRIPTION	Charlotte	Cinn	Clev	Dallas	KC	Miami	Orlando	Pitt	Riverside	AVG
K0552	Supplies For External Drug Infusion Pump, Syringe Type Cartridge, Sterile, Each	$2.61	$2.10	$2.20	$2.66	$2.46	$1.98	$2.37	$2.25	$2.66	$2.37
K0601	Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 1.5 Volt, Each	$1.15	$1.02	$1.05	$1.13	$1.02	$1.10	$1.13	$1.05	$1.00	$1.07
K0602	Replacement Battery For External Infusion Pump Owned By Patient, Silver Oxide, 3 Volt, Each	$6.50	$5.92	$6.04	$6.04	$5.92	$5.92	$6.04	$5.81	$6.26	$6.05
K0603	Replacement Battery For External Infusion Pump Owned By Patient, Alkaline, 1.5 Volt, Each	$0.59	$0.50	$0.52	$0.58	$0.52	$0.55	$0.55	$0.52	$0.56	$0.54
K0604	Replacement Battery For External Infusion Pump Owned By Patient, Lithium, 3.6 Volt, Each	$6.40	$5.40	$5.55	$6.00	$5.40	$5.72	$6.48	$5.55	$6.00	$5.83
K0605	Replacement Battery For External Infusion Pump Owned By Patient, Lithium, 4.5 Volt, Each	$15.37	$12.63	$13.33	$15.00	$12.94	$12.94	$15.00	$13.33	$14.94	$13.94
K0733	Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each	$24.98	$24.46	$25.17	$22.94	$22.83	$23.20	$23.49	$23.88	$22.50	$23.72
K0733	Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each	$2.50	$2.45	$2.52	$2.29	$2.28	$2.32	$2.35	$2.39	$2.25	$2.37
K0733	Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each	$18.74	$18.35	$18.88	$17.21	$17.12	$17.40	$17.62	$17.91	$16.88	$17.79

AMERICAN ASSOCIATION FOR HOMECARE
BED BUNDLES RECOMMENDATION

Bed Bundle Profile		
Key Items:		
E0250, E0255, E0260, E0303, E0304, E0328, E0329		
	Hospital beds with side rails and mattress	
Plus any one of the following two HCPCS Codes:		
E0271	Mattress, Innerspring	
E0272	Mattress, Foam Rubber	
Plus any one of the following two HCPCS Codes:		
E0305	Bed Side Rails, Half Length	
E0310	Bed Side Rails, Full Length	
Key Items:		
E0290, E0292, E0294		
	Hospital beds without side rails, with mattress	
Plus any one of the following two HCPCS Codes:		
E0271	Mattress, Innerspring	
E0272	Mattress, Foam Rubber	
Key Items:		
E0251, E0256, E0261, E0301, E0302		
	Hospital beds with rails, without mattress	
Key Items:		
E0291, E0293, E0295		
	Hospital beds without side rails, without mattress	

AMERICAN ASSOCIATION FOR HOMECARE
RECOMMENDED CPAP/RAD BUNDLES

CPAP Bundle Profile		
E0601 as the Key Item:		
E0601	Continuous Airway Pressure (Cpap) Device	
Plus any one of the following two HCPCS Codes:		
E0561	Humidifier, Non-Heated, Used With Positive Airway Pressure Device	
E0562	Humidifier, Heated, Used With Positive Airway Pressure Device	
Plus ANY of the following HCPCS Codes:		**Maximum Allowed:**
A4604	Tubing With Integrated Heating Element For Use With Positive Airway Pressure Device	1 per 3 months
A7027	Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each	1 per 3 months
A7028	Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each	2 per 1 month
A7029	Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair	2 per 1 month
A7030	Full Face Mask Used With Positive Airway Pressure Device, Each	1 per 3 months
A7031	Exhalation Port With Or Without Swivel Used With Accessories For Positive Airway Devices, Replacement Only	1 per 1 month
A7032	Cushion For Use On Nasal Mask Interface, Replacement Only, Each	2 per 1 month
A7033	Pillow For Use On Nasal Cannula Type Interface, Replacement Only, Pair	2 per 1 month
A7034	Nasal Interface (Mask Or Cannula Type) Used With Positive Airway Pressure Device, With Or Without Head Strap	1 per 3 months
A7035	Headgear Used With Positive Airway Pressure Device	1 per 6 months
A7036	Chinstrap Used With Positive Airway Pressure Device	1 per 6 months
A7037	Tubing Used With Positive Airway Pressure Device	1 per 3 months
A7038	Filter, Disposable, Used With Positive Airway Pressure Device	2 per 1 month
A7039	Filter, Non Disposable, Used With Positive Airway Pressure Device	1 per 6 months
A7045	Exhalation Port With Or Without Swivel Used With Accessories For Positive Airway Devices, Replacement Only	1 per 6 months
A7046	Water Chamber For Humidifier, Used With Positive Airway Pressure Device, Replacement, Each	1 per 6 months

AMERICAN ASSOCIATION FOR HOMECARE
RECOMMENDED CPAP/RAD BUNDLES

RAD Bundle Profile		
ANY ONE of the following three HCPCS codes as the Key item:		
E0470	Respiratory Assist Device, Bi-Level Pressure Capability, Without Backup Rate Feature, Used With Noninvasive Interface, E. G. , Nasal Or Facial Mask (Intermittent Assist Device With Continuous Positive Airway Pressure Device)	
E0471	Respiratory Assist Device, Bi-Level Pressure Capability, With Back-Up Rate Feature, Used With Noninvasive Interface, E. G. , Nasal Or Facial Mask (Intermittent Assist Device With Continuous Positive Airway Pressure Device)	
E0472	Respiratory Assist Device, Bi-Level Pressure Capability, With Backup Rate Feature, Used With Invasive Interface, E. G. , Tracheostomy Tube (Intermittent Assist Device With Continuous Positive Airway Pressure Device)	
Plus any one of the following two HCPCS Codes:		
E0561	Humidifier, Non-Heated, Used With Positive Airway Pressure Device	
E0562	Humidifier, Heated, Used With Positive Airway Pressure Device	
Plus ANY of the following HCPCS Codes:		**Maximum Allowed:**
A4604	Tubing With Integrated Heating Element For Use With Positive Airway Pressure Device	1 per 3 months
A7027	Combination Oral/Nasal Mask, Used With Continuous Positive Airway Pressure Device, Each	1 per 3 months
A7028	Oral Cushion For Combination Oral/Nasal Mask, Replacement Only, Each	2 per 1 month
A7029	Nasal Pillows For Combination Oral/Nasal Mask, Replacement Only, Pair	2 per 1 month
A7030	Full Face Mask Used With Positive Airway Pressure Device, Each	1 per 3 months
A7031	Face Mask Interface, Replacement For Full Face Mask, Each	1 per 1 month
A7032	Cushion For Use On Nasal Mask Interface, Replacement Only, Each	2 per 1 month
A7033	Pillow For Use On Nasal Cannula Type Interface, Replacement Only, Pair	2 per 1 month
A7034	Nasal Interface (Mask Or Cannula Type) Used With Positive Airway Pressure Device, With Or Without Head Strap	1 per 3 months
A7035	Headgear Used With Positive Airway Pressure Device	1 per 6 months
A7036	Chinstrap Used With Positive Airway Pressure Device	1 per 6 months
A7037	Tubing Used With Positive Airway Pressure Device	1 per 3 months
A7038	Filter, Disposable, Used With Positive Airway Pressure Device	2 per 1 month
A7039	Filter, Non Disposable, Used With Positive Airway Pressure Device	1 per 6 months
A7045	Exhalation Port With Or Without Swivel Used With Accessories For Positive Airway Devices, Replacement Only	1 per 6 months
A7046	Water Chamber For Humidifier, Used With Positive Airway Pressure Device, Replacement, Each	1 per 6 months

AMERICAN ASSOCIATION FOR HOME CARE
ENTERAL BUNDLES RECOMMENDATION

Enteral Syringe Bundle Profile		
B4034	Enteral feeding supply kit: syringe fed, per month, includes but not limited to feeding/flushing syringes, administration set, tubing, dressings, tape.	**Change description by adding modifier**
Plus ANY of the following HCPCS Codes:		**Maximum Allowed:**
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment	1 per 3 months
B4081	Nasogastric tubing with stylet	3 per 3 months
B4082	Nasogastric tubing without stylet	3 per 3 months
B4083	Stomach tube - levine type	3 per 3 months
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type, each	1 per 3 months
B4088	Gastrostomy/Jejunostomy tube, low profile, any material, any type, each	1 per 3 months
Plus ANY of the following HCPCS Codes Monthly Allowable:		**Change description by adding modifier**
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4152	Enteral formula, nutritionally complete calorically dense (equal to or greater than 1.5 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4155	Enteral formula, nutritionally incomplete/module nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination administered through an enteral feeding tube - monthly allowable.	NA
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA

B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
Enteral Pump Bundle Profile		
B4035	Enteral feeding supply kit: pump fed, per month, includes but not limited to feeding/flushing syringes, administration set, tubing, dressings, tape, IV pole, pump with or without alarm.	**Change description by adding modifier**
Plus the following HCPCS Code:		
E0776	IV Pole	
Plus any one of the following two HCPCS Codes:		
B9000	Enteral nutrition infusion pump - without alarm	
B9002	Enteral nutrition infusion pump - with alarm	
Plus ANY of the following HCPCS Codes:		**Maximum Allowed:**
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment	1 per 3 months
B4081	Nasogastric tubing with stylet	3 per 3 months
B4082	Nasogastric tubing without stylet	3 per 3 months
B4083	Stomach tube - levine type	3 per 3 months
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type, each	1 per 3 months
B4088	Gastrostomy/Jejunostomy tube, low profile, any material, any type, each	1 per 3 months
Plus ANY of the following HCPCS Codes Monthly Allowable:		**Change description by adding modifier**
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4152	Enteral formula, nutritionally complete calorically dense (equal to or greater than 1.5 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4155	Enteral formula, nutritionally incomplete/module nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination administered through an enteral feeding tube - monthly allowable.	NA

B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
Enteral Gravity Bundle Profile		
B4036	Enteral feeding supply kit: gravity, per month, includes but not limited to feeding/flushing syringes, administration set, tubing, dressings, tape, IV pole	**Change description by adding modifier**
Plus the following HCPCS Code:		
E0776	IV Pole	
Plus ANY of the following HCPCS Codes:		**Maximum Allowed:**
A5200	Percutaneous catheter/tube anchoring device, adhesive skin attachment	1 per 3 months
B4081	Nasogastric tubing with stylet	3 per 3 months
B4082	Nasogastric tubing without stylet	3 per 3 months
B4083	Stomach tube - levine type	3 per 3 months
B4087	Gastrostomy/Jejunostomy tube, standard, any material, any type, each	1 per 3 months
B4088	Gastrostomy/Jejunostomy tube, low profile, any material, any type, each	1 per 3 months
Plus ANY of the following HCPCS Codes Monthly Allowable:		**Change description by adding modifier**
B4149	Enteral formula, manufactured blenderized natural foods with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4150	Enteral formula, nutritionally complete with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4152	Enteral formula, nutritionally complete calorically dense (equal to or greater than 1.5 Kcal/ml) with intact nutrients, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4153	Enteral formula, nutritionally complete, hydrolyzed proteins (amino acids and peptide chain), includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA

B4154	Enteral formula, nutritionally complete, for special metabolic needs, excludes inherited disease of metabolism, includes altered composition of proteins, fats, carbohydrates, vitamins and/or minerals, may include fiber, administered through an enteral feeding tube - monthly allowable	NA
B4155	Enteral formula, nutritionally incomplete/module nutrients, includes specific nutrients, carbohydrates (e.g. glucose polymers), proteins/amino acids (e.g. glutamine, arginine), fat (e.g. medium chain triglycerides) or combination administered through an enteral feeding tube - monthly allowable.	NA
B4157	Enteral formula, nutritionally complete, for special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
B4161	Enteral formula, for pediatrics, hydrolyzed/amino acids and peptide chain proteins, includes fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA
B4162	Enteral formula, for pediatrics, special metabolic needs for inherited disease of metabolism, includes proteins, fats, carbohydrates, vitamins and minerals, may include fiber, administered through an enteral feeding tube - monthly allowable.	NA

AMERICAN ASSOCIATION FOR HOME CARE
OXYGEN BUNDLES RECOMMENDATION

Oxygen Bundle Profile		
E1390 as the Key Item:		
E1390	OXYGEN CONCENTRATOR, SINGLE DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE	na
Plus either of the following two HCPCS Codes:		
E0431	PORTABLE GAS OXYGEN SYSTEM, RENTAL	na
K0738	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	na
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	na
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL: INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING	na
Plus this code:		
A4616	Tubing, oxygen, per foot	na
Plus one of these three HCPCs:		
A4615	CANNULA, NASAL	na
A4620	VARIABLE CONCENTRATION MASK	na
A7525	TRACH MASK	na
You may choose any one of these three HCPCs:		
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E0580	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E1352	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
You may choose any or all of these three HCPC Codes:		
E1353	REGULATOR	na
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	na
E1355	STAND/RACK	na
	NO FILLS REQUIRED	

E1391 as the Key Item:		
E1391	OXYGEN CONCENTRATOR, DUAL DELIVERY PORT, CAPABLE OF DELIVERING 85 PERCENT OR GREATER OXYGEN CONCENTRATION AT THE PRESCRIBED FLOW RATE, EACH	
Plus the following two HCPCS Code:		
E0431	PORTABLE GAS OXYGEN SYSTEM, RENTAL	na
K0738	PORTABLE GASEOUS OXYGEN SYSTEM, RENTAL; HOME COMPRESSOR USED TO FILL PORTABLE OXYGEN CYLINDERS; INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK, AND TUBING	na
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	na
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL: INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING	na
Plus this code:		
A4616	Tubing, oxygen, per foot	
Plus one of these three HCPCs:		
A4615	CANNULA, NASAL	
A4620	VARIABLE CONCENTRATION MASK	
You may choose any one of these three HCPCs:		
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	
E0580	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	
E1352	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	
You may choose any or all of these HCPC Codes:		
E1353	REGULATOR	na
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	na
E1355	STAND/RACK	na
	PLUS E0443 PORTABLE CONTENTS, GAS, ONE MONTH	

AMERICAN ASSOCIATION FOR HOME CARE
OXYGEN BUNDLES RECOMMENDATION

E0424 as the Key Item:		
E0424	STATIONARY COMPRESSED GASEOUS OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, AND TUBING	
Plus the following HCPCS Code:		
E0431	PORTABLE GAS OXYGEN SYSTEM, RENTAL	na
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	na
Plus this code:		
A4616	Tubing, oxygen, per foot	na
Plus one of these three HCPCs:		
A7525	TRACH MASK	na
A4615	CANNULA, NASAL	na
A4620	VARIABLE CONCENTRATION MASK	na
You may choose any one of these three HCPCs:		
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E0580	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E1352	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
You may choose any or all of these HCPC Codes:		
E1353	REGULATOR	na
E1354	OXYGEN ACCESSORY, WHEELED CART FOR PORTABLE CYLINDER OR PORTABLE CONCENTRATOR, ANY TYPE, REPLACEMENT ONLY, EACH	na
E1355	STAND/RACK	na
	PLUS E0441 STATIONARY CONTENTS, GAS, ONE MONTH	
	PLUS E0443 PORTABLE CONTENTS, GAS, ONE MONTH	

E0439 as the Key Item:		
E0439	STATIONARY LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES CONTAINER, CONTENTS, REGULATOR, FLOWMETER, HUMIDIFIER, NEBULIZER, CANNULA OR MASK, & TUBING	
Plus either of the following two HCPCS Codes:		
E0433	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; HOME LIQUEFIER USED TO FILL PORTABLE LIQUID OXYGEN CONTAINERS, INCLUDES PORTABLE CONTAINERS, REGULATOR, FLOWMETER, HUMIDIFIER, CANNULA OR MASK AND TUBING, WITH OR WITHOUT SUPPLY RESERVOIR AND CONTENTS GAUGE	na
E0434	PORTABLE LIQUID OXYGEN SYSTEM, RENTAL; INCLUDES PORTABLE CONTAINER, SUPPLY RESERVOIR, HUMIDIFIER, FLOWMETER, REFILL ADAPTOR, CONTENTS GAUGE, CANNULA OR MASK, AND TUBING	na
E1392	PORTABLE OXYGEN CONCENTRATOR, RENTAL	na
Plus this code:		
A4616	Tubing, oxygen, per foot	na
Plus one of these three HCPCs:		
A7525	TRACH MASK	na
A4615	CANNULA, NASAL	na
A4620	VARIABLE CONCENTRATION MASK	na
You may choose any one of these three HCPCs:		
E0555	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E0580	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
E1352	HUMIDIFIER, DURABLE, GLASS OR AUTOCLAVABLE PLASTIC BOTTLE TYPE, FOR USE WITH REGUATOR OR FLOWMETER	na
	PLUS E0442 STATIONARY CONTENTS, LIQUID, ONE MONTH	
	PLUS E0444 PORTABLE CONTENTS, LIQUID, ONE MONTH	

CARVED OUT SUPPLIES THAT MAY BE SEPERATLY PRESCRIBED AND REIMBURSED		**Maximum Allowed:**
A4575	TOPICAL HYPERBARIC OXYGEN CHAMBER, DISPOSABLE	na
A4606	OXYGEN PROBE FOR USE WITH OXIMETER DEVICE, REPLACEMENT	na
A4608	TRANSTRACHEAL OXYGEN CATHETER, EACH	na
A4617	MOUTH PIECE	na
A4619	FACE TENT	na
A7525	TRACHEOSTOMY MASK, EA	na
E0455	OXYGEN TENT	na

AMERICAN ASSOCIATION FOR HOME CARE
MANUAL WHEELCHAIR BUNDLES RECOMMENDATION

Manual Wheelchair Bundle Profile		
K0001 as the Key Item:		
K0001	**Standard wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0978	Seat belt	na
E2213	Flat free tires	na
K0002 as the Key Item:		
K0002	**Standard hemi (low wheel) wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0978	Seat belt	na
E2213	Flat free tires	na
K0003 as the Key Item:		
K0003	**Lightweight wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0978	Seat belt	na
E2213	Flat free tires	na
K0004 as the Key Item:		
K0004	**High strength lightweight wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0978	Seat belt	na
E2213	Flat free tires	na

AMERICAN ASSOCIATION FOR HOME CARE
MANUAL WHEELCHAIR BUNDLES RECOMMENDATION

K0006 as the Key Item:		
K0006	**Heavy duty wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0978	Seat belt	na
E2213	Flat free tires	na
K0007 as the Key Item:		
K0007	**Extra heavy duty wheelchair**	na
Plus any of the following six HCPCS Codes:		
E0951	Heel loops	na
E0961	Wheel lock extensions	na
E0971	Anti tippers	na
E0973 or K0020	Adjustable height arms OR fixed adjustable ht arms	na
E0978	Seat belt	na
E2213	Flat free tires	na

AMERICAN ASSOCIATION FOR HOMECARE
POWER WHEELCHAIR BUNDLES RECOMMENDATION

Key Items:	K0815	K0816	K0820	K0821	K0822	K0823	K0824	K0825	K0826	K0827	K0828	K0829	Code Description
Plus any of the following HCPCS Codes:													
	E0951	E0951	E0951	E0951	E0951	E0951	E0951	E0951	E0951	E0951	E0951	E0951	Heel Loop/Holder, Any Type, With Or Without Ankle Strap, Each
	E0978	E0978	E0978	E0978	E0978	E0978	E0978	E0978	E0978	E0978	E0978	E0978	Wheelchair Accessory, Positioning Belt/Safety Belt/Pelvic Strap, Each
	E2210	E2210	E2210	E2210	E2210	E2210	E2210	E2210	E2210	E2210	E2210	E2210	Wheelchair Accessory, Bearings, Any Type, Replacement Only, Each
	E2361	E2361	E2361	E2361	E2361	E2361	E2361	E2361	E2361	E2361	E2361	E2361	Power Wheelchair Accessory, 22nf Sealed Lead Acid Battery, Each, (E. G. Gel Cell, Absorbed Glassmat)
	E2363	E2363	E2363	E2363	E2363	E2363	E2363	E2363	E2363	E2363	E2363	E2363	Power Wheelchair Accessory, Group 24 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)
	E2365	E2365	E2365	E2365	E2365	E2365	E2365	E2365	E2365	E2365	E2365	E2365	Power Wheelchair Accessory, U-1 Sealed Lead Acid Battery, Each (E. G. Gel Cell, Absorbed Glassmat)
	E2366	E2366	E2366	E2366	E2366	E2366	E2366	E2366	E2366	E2366	E2366	E2366	Power Wheelchair Accessory, Battery Charger, Single Mode, For Use With Only One Battery Type, Sealed Or Non-Sealed, Each
	E2368	E2368	E2368	E2368	E2368	E2368	E2368	E2368	E2368	E2368	E2368	E2368	Power Wheelchair Component, Drive Wheel Motor, Replacement Only
	E2369	E2369	E2369	E2369	E2369	E2369	E2369	E2369	E2369	E2369	E2369	E2369	Power Wheelchair Component, Drive Wheel Gear Box, Replacement Only
	E2370	E2370	E2370	E2370	E2370	E2370	E2370	E2370	E2370	E2370	E2370	E2370	Power Wheelchair Component, Integrated Drive Wheel Motor And Gear Box Combination, Replacement Only
	E2375	E2375	E2375	E2375	E2375	E2375	E2375	E2375	E2375	E2375	E2375	E2375	Power Wheelchair Accessory, Non-Expandable Controller, Including All Related Electronics And Mounting Hardware, Replacement Only
	E2378	E2378	E2378	E2378	E2378	E2378	E2378	E2378	E2378	E2378	E2378	E2378	Power Wheelchair Component, Actuator, Replacement Only
	E2381	E2381	E2381	E2381	E2381	E2381	E2381	E2381	E2381	E2381	E2381	E2381	Power Wheelchair Accessory, Pneumatic Drive Wheel Tire, Any Size, Replacement Only, Each
	E2383	E2383	E2383	E2383	E2383	E2383	E2383	E2383	E2383	E2383	E2383	E2383	Power Wheelchair Accessory, Insert For Pneumatic Drive Wheel Tire (Removable), Any Type, Any Size, Replacement Only, Each
	E2384	E2384	E2384	E2384	E2384	E2384	E2384	E2384	E2384	E2384	E2384	E2384	Power Wheelchair Accessory, Pneumatic Caster Tire, Any Size, Replacement Only, Each
	E2386	E2386	E2386	E2386	E2386	E2386	E2386	E2386	E2386	E2386	E2386	E2386	Power Wheelchair Accessory, Foam Filled Drive Wheel Tire, Any Size, Replacement Only, Each
	E2387	E2387	E2387	E2387	E2387	E2387	E2387	E2387	E2387	E2387	E2387	E2387	Power Wheelchair Accessory, Foam Filled Caster Tire, Any Size, Replacement Only, Each
	E2391	E2391	E2391	E2391	E2391	E2391	E2391	E2391	E2391	E2391	E2391	E2391	Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire (Removable), Any Size, Replacement Only, Each
	E2392	E2392	E2392	E2392	E2392	E2392	E2392	E2392	E2392	E2392	E2392	E2392	Power Wheelchair Accessory, Solid (Rubber/Plastic) Caster Tire With Integrated Wheel, Any Size, Replacement Only, Each
	E2394	E2394	E2394	E2394	E2394	E2394	E2394	E2394	E2394	E2394	E2394	E2394	Power Wheelchair Accessory, Drive Wheel Excludes Tire, Any Size, Replacement Only, Each
	E2395	E2395	E2395	E2395	E2395	E2395	E2395	E2395	E2395	E2395	E2395	E2395	Power Wheelchair Accessory, Caster Wheel Excludes Tire, Any Size, Replacement Only, Each
	E2396	E2396	E2396	E2396	E2396	E2396	E2396	E2396	E2396	E2396	E2396	E2396	Power Wheelchair Accessory, Caster Fork, Any Size, Replacement Only, Each
	K0015	K0015	K0015	K0015	K0015	K0015	K0015	K0015	K0015	K0015	K0015	K0015	Detachable, Non-Adjustable Height Armrest, Each
	K0019	K0019	K0019	K0019	K0019	K0019	K0019	K0019	K0019	K0019	K0019	K0019	Arm Pad, Each
	K0040	K0040	K0040	K0040	K0040	K0040	K0040	K0040	K0040	K0040	K0040	K0040	Adjustable Angle Footplate, Each
	K0052	K0052	K0052	K0052	K0052	K0052	K0052	K0052	K0052	K0052	K0052	K0052	Swingaway, Detachable Footrests, Each
	K0098	K0098	K0098	K0098	K0098	K0098	K0098	K0098	K0098	K0098	K0098	K0098	Drive Belt For Power Wheelchair
	K0733	K0733	K0733	K0733	K0733	K0733	K0733	K0733	K0733	K0733	K0733	K0733	Power Wheelchair Accessory, 12 To 24 Amp Hour Sealed Lead Acid Battery, Each (E. G. , Gel Cell, Absorbed Glassmat)
	E2601		E2601		E2601		E2601		E2601		E2601		General Use Wheelchair Seat Cushion, Width Less Than 22 Inches, Any Depth
	E2602		E2602		E2602		E2602		E2602		E2602		General Use Wheelchair Seat Cushion, Width 22 Inches Or Greater, Any Depth
	E2611		E2611		E2611		E2611		E2611		E2611		General Use Wheelchair Back Cushion, Width Less Than 22 Inches, Any Height, Including Any Type Mounting Hardware
	E2612		E2612		E2612		E2612		E2612		E2612		General Use Wheelchair Back Cushion, Width 22 Inches Or Greater, Any Height, Including Any Type Mounting Hardware