Medicare A News

Jurisdiction E
July 2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

In this Issue

In this Issue

In this Issue

In this Issue

In this Issue

In this Issue

In this Issue

ACM Questions and Answers - March 20, 2024

Written Questions

Q1: Local Coverage Article (LCA) A52950 retired effective 11/01/23, does Noridian still have a system edit in place that will reject claims if providers do not enter the device manufacturer for C2616 (Brachytherapy)? Previously, when billing HCPC C2616, Noridian would reject claims if providers did not enter a remark/note with the device name of either TheraSphere, or Sir-Spheres. Now that the LCA has been retired, can providers begin billing without the device name without the claim rejecting or denying?
A1: The system edits related to Local Coverage Article (LCA) A52950 were turned off at the same time as the policy was retired. Therefore, Noridian is no longer editing for these claims. While the policy is retired, we do still give the following guidance to providers, which is indicated in the Revision History:

Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

Q2: We are seeing an uptick of line-item drug denials on our CAH claims that we believe are associated with them lacking the JW or JZ modifier, however they are N-status drugs, meaning packaged and typically wouldn't need the JW or JZ modifier because they are not separately payable. The two drugs we are seeing this on are J2795 and J9263. Noridian is not the only MAC we are seeing this on. We don't have our JW or JZ modifiers set to be billed on drugs that are not separately payable, but we don't see CMS guidance that indicates the rules around when to add these modifiers has changed. Thank you for any guidance you can provide!
A2: For the facilities paid under the Outpatient Prospective Payment System (OPPS), your statements would be correct. However, Critical Access Hospitals (CAHs) are not paid this way. CAHS are reimbursed separately based on reasonable cost for the services they provide, including these types of drugs. That means the Status Indicator of 'N' listed on the Addendum D1 will not apply for CAHs. So, in the end, these drugs are denying correctly for this CAH location for missing modifiers. Please see the current list of codes referenced below where the JW and JZ modifier policy applies, as well as Frequently Asked Question #6.

Discarded Drugs and Biologicals - JW Modifier and JZ Modifier Policy HCPCS Codes (cms.gov)

Medicare Program Discarded Drugs and Biologicals - JW Modifier and JZ Modifier Policy Frequently Asked Questions (cms.gov)

Q3: When a patient is an inpatient at IPF and pt's Medicare status in ancillary (12xTOB), who do outside providers bill on consults or treatments? Who is responsible for ancillary co-pay, the IPF or the outside facility?
A3: The IPF is responsible for all services provided at other facilities during the inpatient stay. Federal regulations state that Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR 412.50(b). This is detailed in CMS Medicare Learning Network (MLN) Matters Special Edition (SE)17033 - Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Stay at Other Facilities.

Acute-care hospitals, under arrangements with the LTCH, IRF, IPF, and/or CAH, should look to the LTCH, IRF, IPF, and/or CAH for payment for the outpatient services it provides to the beneficiary while an inpatient of that other facility. Additionally, acute care hospitals should not charge beneficiaries for outpatient deductibles and coinsurance payments due to such services.

Failure to submit a prior authorization request for a service on the prior authorization list will result in the denial of the service. These denials are considered initial determinations that are subject to appeal. In processing an appeal of a claim for which there was no submission of a prior authorization request, MACs will acknowledge the issues raised by a party in the redetermination notice. MACs will consider whether there was, in fact, a prior authorization request submitted for the OPD service as required in regulation. If no prior authorization request was submitted, payment shall not be made due to the failure to comply with a mandatory condition of payment, even if the item or service is otherwise covered.

Q4: If a patient were to fall in a hospital and the provider orders x-rays to check for fractures, I understand that CMS has a no-pay policy. Does that mean that I shouldn't bill the charge, or should I bill it and not expect to get paid?
A4: Any reimbursement for a billed service, including this example, could be reimbursed based on proper claim coding, documentation, and the medical necessity of the service provided. X-rays as a preventive service are not statutorily excluded from Medicare coverage. If your organization is billing for a service that is known to be statutorily excluded, or you know that it is not medically necessary, or you are billing to receive a Medicare denial, there may be specific coding requirements that will specifically assign the liability for the service either to the provider or the patient.

Q5: Can you please clarify what is the correct place of service (POS) for telehealth services performed when the provider is in a provider-based clinic, and the patient is in their home?
A5: Noridian has just updated its rolling slides for all presentations regarding this clarification. Starting January 1, 2024, use POS 02 for Telehealth to indicate you provided the billed service as a professional telehealth service, when the originating beneficiary site is other than the patient's home - no modifier required. Use POS 10 for Telehealth for services when the patient is in their home - no modifier required. Exceptions: For outpatient therapy telehealth services by a PT, OT, or SLP, continue to bill with their actual POS (e.g., office 11), as if the patient was seen at their site and append the modifier 95 rather than a telehealth POS code. For outpatient hospital clinicians using either POS 22 (on-campus) or 19 (off-campus) for services when the patient is in their home, append modifier 95.

Q6: As a federally qualified health center (FQHC), is there a maximum-allowed limit of diagnoses that can be reported on the electronic format of the UB-04?
A6: This answer can be found in the Claims Processing Manual, Chapter 23, Section 10.3 - Outpatient Claim Diagnosis Reporting. For outpatient claims, providers report the full diagnosis codes for up to 24 other diagnoses that coexisted in addition to the diagnosis reported as the principal diagnosis. So, 25 in total. Additional information and training are available on the CMS website: https://www.cms.gov/medicare/coding-billing/icd-10-codes

Q7: When a patient is an inpatient at IPF and the patient's Medicare status is ancillary (12x TOB), who do outside providers bill on consults or treatments? And who is responsible for ancillary co-pay, the IPF or the outside facility?
A7: The IPF is responsible for all services provided at other facilities during inpatient stay. Federal regulations state that Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR 412.50(b). Per MLN SE17033, acute-care hospitals, under arrangements with the LTCH, IRF, IPF, or CAH, should look to the LTCH, IRF, IPF, or CAH for payment for the outpatient services it provides to the beneficiary while an inpatient of that other facility. Additionally, acute care hospitals should not charge beneficiaries for outpatient deductibles and coinsurance payments because of such services.

Q8: When a patient is ex parte (committed involuntarily), the IPF is financially obligated for said charges. How about when patient goes from ex parte to voluntary commitment?
A8: This is answered in the Internet-Only Manual, Publication 100-02, Benefit Policy Manual, Chapter 16, Section 50.3.3 - Examples of Application of Government Entity Exclusion. In general, payment may be made under Medicare for covered services

furnished without charge by State or local psychiatric hospitals which serve the general community. (See §50.3.1.) However, payment may not be made for services furnished without charge to individuals who have been committed under a penal statute (e.g., defective delinquents, persons found not guilty by reason of insanity, and persons incompetent to stand trial). For Medicare purposes such individuals are "prisoners," as defined in subsection 3, and may have services paid by Medicare only under the exceptional circumstances described there. A psychiatric hospital to which patients convicted of crimes are committed is considered to be serving the general community if State law also provides for voluntary admissions to the institution.

Q9: Our facility is seeing total claim denials when G0260 is not billed with 77002 or 77012. CCI edit 3144 prevents us from adding the 59-modifier indicating that an add on code was reported without the appropriate base procedure. It does not seem correct to bill 77002 or 77012 in addition to G0260 when it goes against a CCI edit. Can we please have clarification on CMS guidance for the appropriate way to bill G0260?
A9: Per LCD - Sacroiliac Joint Injections and Procedures (L39462) (cms.gov) and Article - Billing and Coding: Sacroiliac Joint Injections and Procedures (A59244) (cms.gov):

ASC facilities and OPPS hospital outpatient departments should report HCPCS code G0260 for sacroiliac joint injections. The medical record must contain documentation that fluoroscopic guidance or CT guidance was used with HCPCS code G0260. Image guidance is packaged into G0260, and no separate payment is made to the ASC or OPPS hospital outpatient department for CPT codes 77002 and 77012.

Critical Access Hospitals (TOB 85X) should report sacroiliac joint injection with CPT 27096 and a sacral nerve block with CPT 64451. Bilateral injections should be reported using modifier 50. If a unilateral sacroiliac joint injection (CPT 27096) is performed and a unilateral sacral nerve block (CPT 64451) is performed on the contralateral side do not report modifier 50 with either code. Do not report a sacroiliac joint injection (CPT 27096) and a sacral nerve block (CPT 64451) for the same side, per the policy.

Q10: We are getting claims returned for Procedure to Device edits for Code C1761 - Catheter, transluminal intravascular lithotripsy, coronary when we bill 0715T - Percutaneous transluminal coronary lithotripsy (prior to 2024) and in 2024 code 92972 (same description as 0715T). HCPCS code C1761 became a transitional pass-through code in July 2021 (Transmittal 10825) with codes 92828 and C9600. In Transmittal 10997, code 92933, 92943, C9602 and C9607 were added to C9600 and 92928. Why do the claims not get paid with codes 0715T and 92972 when this coding guidance from the AMA? We have been told by the Provider Call Center that C1761 can only be paid with 92928 or C9600. Why does CMS not include 0715T and 92972 when that is the most appropriate procedure code? Can Noridian query CMS?
A10: According to CMS guidelines, the HCPCS code C1761, Coronary IVL device is used primary for endovascular procedures: C9600, 92928, 92943, or 92920. As described in the

2024 OPPS Final Rule, *"only a small share of the PCI procedures uses the Coronary IVL device. Less than 6 percent of the procedures billed with HCPCS code C9600, CPT code 92928, and CPT code 92943 use the device described by HCPCS code C1761. For CPT code 92920, the percentage of procedures using the Coronary IVL device is less than 0.5 percent. The low amount of utilization of the Coronary IVL device with these PCI procedures means that it would not be appropriate to assign these procedures to a higher-paying APC to account for the cost of the device. These code combinations would also not meet the criteria for a complexity adjustment, as discussed in section II.A.2.b of this final rule with comment period. Likewise, we do not see a justification for extending device pass-through status for HCPCS code C1761."*

Q11: Do you have examples of proper cardiac rehab documentation? We have received denials for no 'Outcome Assessment'. Our provider is providing goals/interventions and indicating if rehab should continue or be modified based on meeting or not meeting those goals but have been denied. Any guidance would be appreciated.
A11: Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

1. Evaluations, based on patient-centered outcomes, which must be measured by the physician or program staff at the beginning and end of the program. Evaluations measured by program staff must be considered by the physician in developing and/or reviewing individualized treatment plans.
2. Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

E.g., This refers to the need for the program to show the interventions or services did or did not result in some benefit to the patient. For example, if the goal was to lose one pound a week, there should be notation in the file of the beginning weight was 230 pounds and the weight after 4 weeks was 232 pounds, and the goal was not met. Or the goal was for the patient to be able to walk for 30 minutes on the treadmill at 2 miles per hour daily without chest pain or undue shortness of breath and the goal was met or not met. If the goal was not met, it is prudent to include what modifications were made to the care plan to address the failure. Like all such notes, it must be signed and dated by the person doing the assessment, with his or her credentials, on the day the assessment is done.

Q12: Can I get a breakdown of "spell of illness? If our IPF patient was discharged and readmitted, do I wait 60 days from admit and do the spell of illness all over again?
A12: "Spell of Illness," or benefit period, is a period of consecutive days during which medical benefits for covered services with certain maximum limitations, are available to beneficiary. The benefit period begins the day a beneficiary is admitted as an inpatient to a hospital or Skilled Nursing Facility (SNF) and ends when the beneficiary is not an

inpatient of a hospital or SNF for 60 consecutive days. If a beneficiary is admitted as an inpatient after 60 consecutive days, a new benefit period will begin.

In answer to your second question… No, it would be 60 days from discharge. Under Part A, 60 full days of hospitalization plus 30 coinsurance days represent the maximum benefit period. The benefit period is renewed when the beneficiary has not been an inpatient of a hospital or of a SNF for 60 consecutive days. Refer to IOM Publication 100-01, Medicare General Information, Eligibility, and Entitlement Manual, Chapter 3 for additional information on benefit periods.

Verbal Questions

Q13. We have a hospitalist no longer with our Critical Access Hospital facility. We have a couple of inpatient visits with missing progress notes for that provider. Can we bill out the whole visit minus that day with the missing progress note?
A13. Generally speaking, in a Medical Review situation, the medical records (progress notes) have to support the entire stay. However, it is an option for the facility to bill the 77 occurrence span code for a provider liable day.

Q14. We're in the process of redoing these claims that are going to be denied timely that involve spell of illness. Do I still need to add those in since the patient was inpatient? Are the spell of illness days included in the timely claims?
A14. The Inpatient claims that fail to be billed timely still do need to be submitted. The Medicare Claims Processing Manual, Chapter 1, Section 70 outlines how to bill when you are past timely filing. Untimely claims will also update spell of illness on the national file, yes.

Q15. We have confusion on our IPF ancillary billing. If our patient goes to an outside consult, does that consultant bill Medicare under the Part B benefit, or do they bill us?
A15. The physician will bill Medicare through the hospital on the 1500 form, yes. In the Medicare Claims Processing Manual, Chapter 3, Section 10.4, it states that all items in non-physician services provided by an outside entity that are provided during the inpatient stay will be billed through your facility under arrangements. If you do not have arrangements, then you will need to set these up with those providers.

Q16. We bill as a rehab agency on the UB04. With the billing manual, Chapter 3, Section 10.4, when it states we can bill hospitals for PT that's outpatient under arrangements. Is there a system we need to follow for those payment arrangements?
A16. Nowhere does CMS publish that you need to follow X, Y, or Z. The services need to be defined upfront. Both facilities should come to agreement on (a) the services that are going to be provided, and (b) the payment or reimbursement for those services. CMS has a best practices website that can be referenced for these situations - Best Practices Guidelines | CMS.

News

Ambulance Duplicate Denials - Appeals Newsletter Part 7

Are you getting duplicate denials for multiple trips for a single beneficiary the same day?

If all points of pickups are in the same zip code, they may be billed on the same claim.

If any of the points are in different zip codes:

- Submit a separate claim for each zip code.
- Item 19 (freeform text field) provide comments on multiple pickups
    - Example: 8:15 a.m. Transported to dialysis, 4:30 p.m. returned home from dialysis

If the second claim is denied as duplicate, submit a **Redetermination**. Only use GY modifier when the service is statutorily non-covered or is not a Medicare benefit.

Advanced Beneficiary Notice of Non-coverage cannot be presented in an emergency.

Resource:

- CMS Medicare Carriers Manual Part 3 08-95
- CMS Medicare Claims Processing Manual 30.2.4

Billing the Subsequent Inpatient Care 99232 Correctly - Appeals Newsletter Part 9

For the month of May there was a large number of appeals for CPT 99232.

CPT 99232 - Subsequent hospital inpatient or observation care, per day, for evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded. Below are some of the most common denial reasons from the appeals we received:

- Partially furnished by another provider
- Attachment or documentation required for adjudication was missing.
- Charge exceeds fee schedule or legislated fee amount - This is an information message telling you the amount you billed is more than the Medicare Physician Fee Schedule is allowed to pay by law.
    - There are usually no appeal rights attached with this message. The remainder is an amount you would write off, based on your agreement with Medicare to accept their payment as payment in full.
- Benefit for this service is included in the payment for another provider.

    - CMS does not reimburse a subsequent hospital visit in addition to hospital discharge day management service on the same day by the same physician.
- Payment adjusted because payer deems information submitted does not support this many, or frequency of services.

Resource

- CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 12 - Physician and Non-physician Practitioners
- Observation

Change Healthcare Security Incident - Resolved 04/24/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable.

Claim Coding Impact: Not applicable.

Description of Issue: Noridian is aware of the recent cyber security incident at Change Healthcare. Our priority is to ensure the security of our data. There is no indication of any impact on our data. In the meantime, we appreciate your patience and understanding.

Noridian Action Required: We are closely monitoring the situation and assessing any potential impact.

Provider/Supplier Action Required: If your Electronic Data Interchange (EDI) clearinghouse is impacted by the Change Healthcare cyber security incident, we recommend you check with them for further instructions.

Proposed Resolution/Solution:

Update 04/24/24: Optum, the parent company for Change Healthcare, has worked with Noridian to transition providers enrolled in Change Healthcare connections to the Optum iEDI Clearinghouse. The transition has been completed for claim submission as well as electronic remittance advices. Noridian will maintain dual enrollment for claim submission to ensure an easy transition as the Change Healthcare platforms come online. Partners and providers do not need to take any action. For additional information, visit: Optum Solution Status

Update 04/05/24: If providers are unable to submit medical records timely for requested Medical Review Additional Documentation Requests (ADRs) related to the recent Change Healthcare Security Incident, please reach out to the clinical reviewer contact

listed in your notification letter to discuss and possibly extend your documentation submission timeline. Please have a listing of the ordered ADRs identifier number ready. The Case Manager will require verbal or written attestation that your request is related to the Change Healthcare cyber security incident.

Update 03/29/24: Optum, the parent company for Change Healthcare, has worked with Noridian to transition providers enrolled in Change Healthcare connections to the Optum iEDI Clearinghouse. The transition at this time is for claim submission only, however work continues on determining a plan for electronic remittance advices. Noridian will maintain dual enrollment for claims to ensure an easy transition as the Change Healthcare platforms come online. Partners and providers do not need to take any action. This transition is ongoing and Optum will publish additional updates as they are available. For additional information, visit: Optum Solution Status

Update 03/15/24: Noridian offers four alternative options for submitting claims.

Option 1: Change to a new vendor

1. Provider will log into their EDISS Connect account at EDISS Connect
   Note: If it has been more than 90 days since your last login, select the 90 days since last login? option to regain access to your account.
2. Select Manage Transactions.
3. For the 837 transactions, select Add Vendor.
   Note: Only two submission methods can be listed in the EDISS Connect account. If you already have two listed, one will need to be removed to add the new vendor.
4. Search for the new Vendor by name or Trading Partner ID and Add the correct option once located.
5. Allow 2-4 business days for the transaction to be moved into production. For awareness, the typical processing timeframe is 7-10 business days.
   Note: You will not receive a notification when the new vendor has been moved to a production status. We encourage you to log into your account frequently to confirm the status of the transaction.

Option 2: Change to direct

1. Provider will log into their EDISS Connect account at EDISS Connect
   Note: If it has been more than 90 days since your last login, select the 90 days since last login? option to regain access to your account.
2. Select Manage Transactions.
3. For the 837 transactions, select the I will and/or check box.
   Note: Only two submission methods can be listed in the EDISS Connect account. If

you already have two listed, one will need to be removed to add the I will and/or check box.

4. Direct claim submission does require testing. To review the testing requirements, visit EDISS Registration
5. Once the test file is submitted, please allow 72 hours for review of the file.
6. If the test file is clean, the 837 I will and/or will be moved to a production status in your Connect account.
   Note: You will not receive a notification when the new vendor has been moved to a production status. We encourage you to log into your account frequently to confirm the status of the transaction.
7. Methods of submitting direct transactions:
   - Network Service Vendor (NSV)
   - Noridian Medicare Portal (NMP) Claim Submission

   Note: For those that are currently set up to receive their Electronic Remittance Advice (ERA) via Change Healthcare, you can either use NMP, if currently registered, to retrieve the ERA or you can update your 835 transactions in your EDISS Connect account to obtain future ERAs through the new retrieval option.

Option 3: Direct Data Entry (DDE)

This option is for Medicare Part A providers only. DDE is a real-time Fiscal Intermediary Shared System (FISS) application giving providers interactive access for inquiries, claims entry and correction purposes. For more information about this option, Jurisdiction E providers can visit JE Direct Data Entry (DDE) and Jurisdiction F providers can visit JF Direct Data Entry (DDE).

Option 4: Paper claim submission

Noridian is prepared to accept paper claims for the providers that have exhausted all options above. However, please be aware that paper claims take a minimum of 29 days for payment. Noridian recommends you review the other electronic alternatives available before submitting the request. If you do determine that there are no other options for you to submit claims, you may submit a waiver request on company letterhead that includes your billing PTAN and that you are requesting a waiver related to the Change Healthcare security incident. These requests can be faxed to 701-277-7850. Please allow 2 business days for the request to be processed before submitting claims. Once approved, please ensure that you are following the paper claim submission guidelines to avoid your claims from being rejected. Guidelines for completing a claim from can be found in the CMS Internet Only Manual (IOM) 100-04, Claims Processing Manual, Chapter 25.

Request for Change Healthcare/Optum Payment Disruption Accelerated and Advance Payment

Providers should use the request for Change Healthcare/Optum payment disruption (CHOPD) Accelerated Payment to Part A Providers and Advance Payments to part B Suppliers [DOCX] template to submit a request. The template must be initialed for all certification of facts and signed by the provider's authorized official that is legally able to make financial commitments and assume financial obligations on behalf of the provider/supplier.

Please submit the completed CHOPD Accelerated/Advance Payment request to: JE-reimb@noridian.com or Fax: 701-277-6572

For additional information such as eligibility requirements, required acknowledgement of terms, and payment amount, please refer to CMS Fact Sheet Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers [PDF]

Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated and Advance Payments for Part A Providers and Part B Suppliers Frequently Asked Questions

Date Reported: 02/28/24

Date Resolved: 04/24/24

Comprehensive Error Rate Testing: Reporting Year 2024 Progress Report Letters

The Noridian Comprehensive Error Rate Testing (CERT) team will not be issuing our annual Reporting Year (RY) 2024 Progress Report Letters. A Progress Report Letter is a summary of the claims selected by CERT for review, claims in error, and weighted error dollars, if any. We will resume sending Progress Report Letters for RY 2025. If you have any questions or concerns, please email CERTPartAQuestion@noridian.com.

Pass-Thru (PT) and Payment Confirmation Reports (PCR) Requests

The Reimbursement department has recently seen an increase in requests for additional copies of the Pass-Thru (PT) and Payment Confirmation Reports (PCRs). In almost all cases, these requests are coming from consulting firms or outside cost report preparers being utilized by the provider. If you are a provider who utilizes consulting firms or outside cost report preparers, please be aware that Noridian is unable to fulfill requests for these reports. These requests must come from the provider's System Tracking for Audit and Reimbursement (STAR) contact. Any requests coming into the

Reimbursement department or the Provider Contact Center (PCC) from an entity who is not the provider's STAR contact will not be approved, and the individual will be referred to reach out to the provider's STAR contact.

Preventive Services Codes on Eligibility Inquiry

Due to the recent CMS HIPAA Eligibility Transaction System (HETS) Quarter 1 release, Noridian implemented a section on the Eligibility inquiry screen that allows users to choose up to three Preventive Services HCPCS codes that can be checked to see when the patient is next eligible for that service. When this was implemented on the evening of April 5th, this section was required in order to perform an Eligibility inquiry, which was incorrect. The requirement of the HCPCS code selection was removed on the evening of April 8th, but the Preventive Services codes section is still available for users that wish to use this feature. Noridian will be looking into other user-friendly options to accommodate the use of the Preventive Services codes look up while still maintaining CMS regulations.

Noridian apologizes for any inconvenience and confusion this may have caused our users.

Prospective Payment System (PPS) Rate Request Changes

In the past, Noridian has sent copies of facility PPS rates when requested as a courtesy. This current practice will be discontinuing, and providers will be directed to use the self-service CMS Web Pricer to retrieve their rate information. The CMS Web Pricer enhances your Provider Audit and Reimbursement experience by allowing you the ability to get your rates in real time without waiting for an emailed response. We have added dedicated content to the Cost Report Rates page on our website where you can access instructions on how to use the pricer.

If you have any questions about the CMS Web Pricer, please call our Provider Contact Center (PCC).

Successful Claims and Appeals for Postoperative Pain Nerve Blocks - Appeals Newsletter Part 8

Make sure your staff know how to bill postoperative Nerve Blocks and the necessary documentation to get your claims or appeals right the first time. Review the following guidelines from the National Correct Coding Initiative (NCCI) Manual:

1. Postoperative pain management services are provided by the surgeon under a global payment policy for the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required of the anesthesiologist.

   The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner.
2. An epidural or peripheral nerve block injection administered preoperatively or intraoperatively **is not separately reportable** for postoperative pain management.
3. If an epidural or peripheral nerve block injection for postoperative pain management is reported separately on the same date of service as an anesthesia 0XXXX code, modifier 59 or XU may be appended to the epidural or peripheral nerve block injection code to indicate that it was administered for postoperative pain management.
4. An epidural or peripheral nerve block injection for postoperative pain management in patients receiving general anesthesia, spinal anesthesia, or postoperative pain management by epidural injection as described above may be administered preoperative or intraoperatively will be paid as part of the global surgery package, not separately.

Tip: To avoid denials, code to the highest level of specificity. Do not use an unlisted code unless there is no other more specific code to use. If using an unlisted code please be sure to submit documentation through the PWK segment to provide information regarding the procedure.

Resource:

- https://www.cms.gov/files/document/medicare-ncci-policy-manual-2024-chapter-2.pdf
- https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=35456

2024 CPT/HCPCS Local Coverage Article (LCA) Updates

Date Posted: June 27, 2024

These Local Coverage Articles (LCA) have been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: July 1, 2024

Summary of Changes: The following Billing and Coding Articles have been updated to include and/or remove CPT/HCPCS codes as well as update descriptions. For description changes, either the short and/or long code description was changed. Please Note: Depending on which descriptor was used, there may not be any changes to the code display in the article.

MCD Number	LCA Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A56119	Billing and Coding: Billing Limitations for Pharmacies	90637, 90638	N/A	N/A

Visit the Billing and Coding Articles webpage to view the Active LCA or access it via the CMS MCD.

Additional 2024 CPT/HCPCS Local Coverage Article (LCA) Updates

These Local Coverage Articles (LCA) have been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Date Posted: April 4, 2024

Effective Date: April 1, 2024

Summary of Changes: The following Billing and Coding Articles have been updated to include and/or remove CPT/HCPCS codes as well as update descriptions. For description changes, either the short and/or long code description was changed. Please Note: Depending on which descriptor was used, there may not be any changes to the code display in the article.

MCD Number	LCA Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A57185	Billing and Coding: Botulinum Toxin Types A and B Policy	J0589	N/A	N/A

Visit the Medicare Coverage Articles webpage to view the Active LCA or access it via the CMS MCD.

Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs) (A57161) - R3 - Effective October 1, 2019

Date Posted: April 25, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: October 1, 2019

Summary of Article Changes:

The following ICD-10 codes have been removed from the Group 2 ICD-10 codes and added to the Group 1 ICD-10 codes as they do not require a secondary diagnosis code to be billed:

D29.0, D29.4, and L72.3

This update is effective 10/01/2019.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Cryoneurolysis Instructions (A59752) - Effective January 1, 2024

Date Posted: April 25, 2024

This coverage article has been created and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2024

Medical Policies and Coverage

Summary of Article: View guidance in the billing of Cryoneurolysis, a medical treatment which has been proposed to be a mechanism for relieving pain by freezing the affected peripheral nerves.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Epidural Steroid Injections for Pain Management (A58993) - R3 - November 15, 2023

Date Posted: June 12, 2024

This Local Coverage Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: A58993

Effective Date: November 15, 2023

Summary of Changes: Updated statement #4 under Documentation Requirements to include, "Selective nerve root blocks (SNRBs) and TFESIs" and editorial changes under Coding Guidance and Utilization Parameters.

Visit the Active LCDs Noridian webpage to view the document or access it via the CMS MCD.

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R17 - Effective April 1, 2024

Date Posted: April 4, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2024

Summary of Article Changes:

Updated prices for Prialt (Ziconotide) and Ropivacaine per quarterly ASP Drug File update:

Effective 01/01/2024 - 03/31/2024

Prialt (Ziconotide) = $9.040

Ropivacaine = $0.077

Effective 04/01/2024 - 06/30/2024

Prialt (Ziconotide) = $9.041

Ropivacaine = $0.068

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Leadless Pacemakers (A59819) - Effective June 6, 2024

Date Posted: June 7, 2024

This coverage article has been created and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 6, 2024

Summary of Article: The CMS A/B Medicare Administrative Contractor's (MAC's) responsibility is to ensure compliance with Medicare National Coverage Determinations (NCDs) at the local jurisdictional level. Upon review of claim sampling, Noridian has observed errors in billing and coding for items/services discussed in NCD 20.8.4 Leadless Pacemakers, which became effective January 18, 2017. While most providers are following NCD coverage requirements, at the time of this instruction, Noridian has identified CPT/HCPCs codes that require updating as well as a few new CPT/HCPCs codes representing leadless pacemakers that would fall under the same NCD requirements. As a result, Noridian finds it important to provide additional billing and coding guidance to assist providers in meeting the requirements set forth by this NCD as well as to supplement information provided in the Medicare Claims Processing Manual (MCPM), Chapter 32, Section 380. While this guidance is considered effective, Noridian will continue to review claims by individual consideration for the immediate future to accommodate billing and coding adjustments by providers and/or billers and coders. However, as a reminder, this NCD has been effective since 2017 and is not considered a new coverage policy.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: 4q25-AF Risk Genotype (A55090) Retirement - Effective April 16, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 16, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: 9p21 Genotype Test (A55092) Retirement - Effective May 24, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 24, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: ApoE Genotype (A55094) - R4 - Effective April 3, 2024

Date Posted: April 11, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: August 31, 2023

Summary of Article Changes:

Updated Related Local Coverage Documents link.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: Aspartoacyclase 2 Deficiency (ASPA) Testing (A55088) Retirement - Effective May 14, 2024

Date Posted: May 23, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 14, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: ATP7B Gene Tests (A55097) Retirement - Effective April 23, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 23, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: BCKDHB Gene Test (A55099) Retirement - Effective May 8, 2024

Date Posted: May 16, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 8, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: BLM Gene Analysis (A55113) Retirement - Effective April 18, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 18, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: CDH1 Genetic Testing (A55970) Retirement - Effective May 30, 2024

Date Posted: June 6, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 30, 2024

Summary:

This article is being retired because the service is not relevant to the general Medicare population and it does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: CHD7 Gene Analysis (A55085) Retirement - Effective April 25, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 25, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: ENG and ACVRL1 Gene Tests (A55181) Retirement - Effective April 18, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 18, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: FANCC Genetic Testing (A55183) Retirement - Effective May 21, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 21, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: FDA-Approved EGFR Tests (A54422) - R6 - Effective May 30, 2024

Date Posted: May 30, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 30, 2024

Summary of Article Changes:

Under ***Article Text*** revised 2nd and 5th bullets to remove "DEX Z-Code™ " and replaced with "DEX Z-Code®". Under ***ICD-10 Codes that Support Medical Necessity Group 1: Codes*** added C34.00, C34.01, and C34.02. Formatting was corrected throughout the article.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: Fragile X (A55241) Retirement - Effective May 23, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 23, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: GBA Genetic Testing (A55243) Retirement - Effective April 19, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 19, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: HAX1 Gene Sequencing (A55249) Retirement - Effective May 14, 2024

Date Posted: May 23, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 14, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: HBB Gene Tests (A55253) Retirement - Effective April 17, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 17, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: HEXA Gene Analysis (A55255) Retirement - Effective May 8, 2024

Date Posted: May 16, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 8, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: IKBKAP Genetic Testing (A55612) Retirement - Effective May 7, 2024

Date Posted: May 16, 2024

Effective Date: May 7, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: KIF6 Genotype (A55272) Retirement - Effective April 26, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 26, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: Know Error® (A55274) Retirement - Effective April 24, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 24, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: L1CAM Gene Sequencing (A55277) Retirement - Effective May 24, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 24, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: LPA-Aspirin Genotype (A55279) Retirement - Effective April 16, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 16, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: LPA-Intron 25 Genotype (A55281) Retirement - Effective April 17, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 17, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: MCOLN1 Genetic Testing (A55283) Retirement - Effective May 23, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 23, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: MECP2 Genetic Testing (A55285) Retirement - Effective April 26, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 26, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: Mitochondrial Nuclear Gene Tests (A55290) Retirement - Effective May 29, 2024

Date Posted: June 6, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 29, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: MMACHC Test (A55288) Retirement - Effective May 30, 2024

Date Posted: June 6, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 30, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT) (A57526) - R18 - Effective April 01, 2024

Date Posted: April 04, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 01, 2024

Summary of Article Changes:

Under ***CPT/HCPCS Codes Group 1***: Codes deleted 0416U. Added 0439U, 0440U, 0444U, 0448U, and 0449U. This revision is due to the 2024 Q2 CPT/HCPCS Code Update and is effective 4/1/2024.

Under ***CPT/HCPCS Codes Group 1***: Codes added 0112U. This revision is effective 4/1/2024.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R17 - Effective February 29, 2024

Date Posted: April 11, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: February 29, 2024

Summary of Article Changes:

Under ***CPT/HCPCS Codes*** Group 9: Paragraph deleted "Arthropod" and replaced with "Zoonotic". Under ***ICD-10 Codes that Support Medical Necessity Group 9: Paragraph*** deleted "Arthropod" and replaced with "Zoonotic". This revision is effective 2/29/2024.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: myPap™ (A55292) Retirement - Effective April 19, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 19, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: NSD1 Gene Tests (A55609) Retirement - Effective April 30, 2024

Date Posted: May 9, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 30, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: PAX6 Gene Sequencing (A55625) Retirement - Effective May 29, 2024

Date Posted: June 6, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 29, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: Prometheus® IBD sgi Diagnostic® Policy (A57516) - R3 - Effective October 20, 2022

Date Posted: May 2, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: October 20, 2022

Summary of Article Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** deleted 82397, 83520, 86140. Formatting and punctuation were corrected throughout the article. This revision is effective on 10/20/2022.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: Proteomics Testing (A59641) - R3 - Effective April 1, 2024

Date Posted: April 11, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2024

Summary of Article Changes:

Under ***CPT/HCPCS Codes Group 1***: Codes added 0446U and 0447U. This revision is due to the 2024 Q2 CPT/HCPCS Code Update and is effective 4/1/2024.

Under ***CPT/HCPCS Codes Group 1***: Codes added 0412U. This revision is effective 1/31/2024.

Medical Policies and Coverage

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: Proteomics Testing (A59641) - R4 - Effective May 30, 2024

Date Posted: May 30, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 30, 2024

Summary of Article Changes:

Under ***Article Text*** 6th paragraph added sentence "MolDX is delaying enforcement for changes to reimbursement until 1/31/2025". This revision is in response to feedback received from clinical laboratories and is effective 5/30/2024.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: PTCH1 Gene Testing (A55608) Retirement - Effective April 25, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 25, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R11 - Effective April 1, 2024

Date Posted: April 11, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2024

Summary of Article Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** added 0439U, 0440U, and 0449U. This revision is due to the 2024 Q2 CPT/HCPCS Code Update and is effective 4/1/2024.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDx: ResponseDX Tissue of Origin® (A54494) Retirement - Effective May 30, 2024

Date Posted: June 6, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 30, 2024

Summary:

This article is being retired because the service(s) in scope are no longer in production and no claims based on these services are anticipated.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: RPS19 Gene Tests (A55610) Retirement - Effective April 30, 2024

Date Posted: May 9, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 30, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: Short Tandem Repeat (STR) Markers and Chimerism (CPT® codes 81265-81268) (A57842) - R3 - Effective April 4, 2024

Date Posted: April 4, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 4, 2024

Summary of Article Changes:

Under ***Article Title*** revised to read Billing and Coding: MolDX: Short Tandem Repeat (STR) Markers and Chimerism (CPT® codes 81265-81268). Under ***CMS National Coverage Policy*** revised 3rd section heading. Under Article Text revised 7th and 10th bullets to remove "DEX Z-Code™ " and replaced with "DEX Z-Code®". Added "**NOTE:** When entering the DEX Z-Code® on the SV101-7 documentation field for Part B claims please do not add additional characters and/or information on the line". Formatting was corrected throughout the article. This revision is effective 4/4/2024.

Under ***CPT/HCPCS Group 1: Codes*** added 81479. This is effective 3/5/2024.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: SMPD1 Genetic Testing (A55627) Retirement - Effective May 21, 2024

Date Posted: May 30, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 21, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: STAT3 Gene Testing (A55480) Retirement - Effective April 24, 2024

Date Posted: May 2, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 24, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: TERC Gene Tests (A55611) Retirement - Effective May 1, 2024

Date Posted: May 9, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 1, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: TP53 Gene Tests (A55484) Retirement - Effective May 1, 2024

Date Posted: May 9, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 1, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MolDX: VEGFR2 Tests (A55468) Retirement - Effective April 23, 2024

Date Posted: April 25, 2024

This coverage article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 23, 2024

Summary:

This article is being retired because it is not supported by a Local Coverage Determination (LCD) and does not comply with current 21st Century Cures requirements.

Visit the Noridian Medicare Coverage Articles webpage to access the Retired articles in the CMS MCD.

Billing and Coding: Percutaneous Vertebral Augmentation (PVA) for Osteoporotic Vertebral Compression Fracture (VCF) (A56572) - R6 - Effective January 10, 2021

Date Posted: June 13, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 10, 2021

Summary of Article Changes:

Revised the Group 2 asterisk explanation for more clarification, stating "Two diagnosis codes must be reported for Group 2. M84.58XA or M84.58XS must be reported in addition to one of the CXX.XX diagnosis codes listed."

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Peripheral Nerve Stimulation (A55530) - R7 - Effective March 1, 2024

Date Posted: April 25, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: March 1, 2024

Summary of Article Changes:

Added the diagnosis code M62.5A2 to Group 1 codes - Muscle wasting and atrophy, not elsewhere classified, back, lumbosacral.

Added language related to use of Restorative Neurostimulation Therapy and no requirement for a temporary trial or psychological evaluation.

Added language for use of Product Classification QLK with the ICD-10-CM code in the Additional ICD-10-CM section.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Sacroiliac Joint Injections and Procedures (A59244) - R5 - Effective June 1, 2024

Date Posted: June 12, 2024

This Local Coverage Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: A59244

Effective Date: June 1, 2024

Summary of Changes: Added statement under Coding Guidance, "For sacro-iliac joint injections performed without CT or fluoroscopic guidance in patients who are not pregnant and who do not have contrast allergies, do not bill CPT codes 27096, 20610, or 20611. Use CPT code 20552, one unit, for unilateral or bilateral sacroiliac joint injection(s)."

Visit the Active LCDs Noridian webpage to view the document or access it via the CMS MCD.

Billing and Coding: Serum Magnesium (A57189) - R8 - Effective (October 1, 2023)

Date Posted: April 18, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: October 1, 2023

Summary of Article Changes: Under **Group 1 ICD-10 Codes that Support Medical Necessity**, added D56.1, D57.1, D73.1, I45.81, I47.21 and R19.7.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Trigger Point Injections (A57701) - R5 - Effective April 1, 2024

Date Posted: April 25, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2024

Summary of Article Changes:

Added an asterisk (*) to ICD-10 Code M79.18 and statement indicating "ICD-10 code M79.18 may be used to code injection of sacroiliac joint without imaging or with ultrasound imaging in a patient who is not pregnant or who has no contrast allergies."

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: Wound and Ulcer Care (A58565) - R6 - Effective April 1, 2024

Date Posted: April 25, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 01, 2024

Summary of Article Changes: Updated hyperlink for MM10176 - Updated Editing of Always Therapy Services - MCS. This link can be found in the Other URL(s) field.

Visit the Noridian Active LCDs webpage to view the complete listing of LCDs and Billing and Coding Companion Articles.

Local Coverage Determinations (LCDs) Finalized - Effective July 7, 2024

Date Posted: May 23, 2024

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database Number	LCD Title
L39758	Cervical Fusion
L38801	Facet Joint Interventions for Pain Management

Medicare Coverage Database Number	Billing and Coding Article Title
A59624	Billing and Coding: Cervical Fusion
A58403	Billing and Coding: Facet Joint Interventions for Pain Management

Medicare Coverage Database Number	Response to Comments
A59796	Response to Comments: Cervical Fusion
A59793	Response to Comments: Facet Joint Interventions for Pain Management

Effective Date: July 7, 2024

View Active LCDs on our website or the Medicare Coverage Determination (MCD).

Local Coverage Determinations (LCDs) Finalized - Effective July 28, 2024

Date Posted: June 13, 2024

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database Number	LCD Title
L39682	MolDX: Molecular Testing for Risk Stratification of Thyroid Nodules

Medicare Coverage Database Number	Billing and Coding Article Title
A59509	Billing and Coding: MolDX: Molecular Testing for Risk Stratification of Thyroid Nodules

Medicare Coverage Database Number	Response to Comments
A59747	Response to Comments: MolDX: Molecular Testing for Risk Stratification of Thyroid Nodules

Effective Date: July 28, 2024

Medical Policies and Coverage

MolDX: Blood Product Molecular Antigen Typing (L38331) - R4 - Effective May 23, 2024

Date Posted: May 23, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 23, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** updated section heading for 2nd and 3rd regulation. Under ***Sources of Information changes*** were made to citations to reflect AMA citation guidelines. Under ***Bibliography*** changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. This revision is effective on 5/23/2024.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

MolDX: Clarification of Order Requirements for Laboratory and Molecular Diagnostic Services (A59743) - Effective May 2, 2024

Date Posted: May 2, 2024

This coverage article has been created and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 2, 2024

Summary of Article:

New Education Article - Clarification of Order Requirements for Laboratory and Molecular Diagnostic services.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

MolDX: Clarification of Order Requirements for Laboratory and Molecular Diagnostic services (A59743) - R1 - Effective May 23, 2024

Date Posted: May 23, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 23, 2024

Summary of Article Changes:

Under ***Article Text*** first sentence revised 2nd regulation. Revised 3rd bullet last sentence to read "signed order".

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer (L38972) - R1 - Effective April 18, 2024

Date Posted: April 18, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 18, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** updated section heading for 2nd regulation. Under ***Bibliography*** changes were made to citation to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

MolDX: Melanoma Risk Stratification Molecular Testing (L37750) - R6 - Effective June 20, 2024

Date Posted: June 20, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 20, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** updated section headings for 2nd and 3rd regulations. Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Medical Policies and Coverage

MolDX: Pigmented Lesion Assay (L38151) - R1 - Effective June 20, 2024

Date Posted: June 20, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 20, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** updated section headings for 2nd and 3rd regulations. Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

MolDX: Repeat Germline Testing (L38351) - R2 - Effective April 25, 2024

Date Posted: April 25, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 25, 2024

Summary of Changes:

Under ***CMS National Coverage*** Policy updated 3rd and 4th section headings. Under ***Bibliography*** changes were made to citations to reflect AMA citation guidelines.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Multi-Jurisdictional CAC Meeting Announcement - MolDX: Biomarker Risk Stratification Testing in DCIS - July 15, 2024, 2 p.m. to 4 p.m. ET

This article has been published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Palmetto GBA, CGS Administrators, Noridian Healthcare Solutions and WPS Government Health Administrators will host a Multi-Jurisdictional Contractor Advisory Committee (CAC) Meeting via Microsoft Teams Webinar on July 15, 2024, from 2 p.m. - 4 p.m. ET. Discussions will focus on MolDX: Biomarker Risk Stratification Testing in DCIS

The Centers for Medicare & Medicaid Services (CMS) assigned Medicare Administrative Contractors (MACs) the task of developing Local Coverage Determinations (LCDs). The purpose of the CAC meeting is to provide a formal mechanism for healthcare

professionals to be informed of the evidence used in developing an LCD and promote communications between the MACs and the healthcare community. The CAC panel will discuss the clinical literature related to MolDX: Biomarker Risk Stratification Testing in DCIS and rate their confidence in a series of Key Questions. Discussions will occur between CAC panelists and Contractor Medical Directors. The public may attend; however, questions from the public will not be entertained.

Interested stakeholders are invited to listen via Microsoft Teams Webinar; however, advance registration is required. Register here MolDX CAC Meeting You will receive your confirmation email once you complete registration.

Note: Registration deadline is July 14, 2024, 11:59 p.m. ET.

Lines will remain muted throughout the conference except for the invited CAC panelists and the MAC hosts.

View meeting details and register now from the CAC Meeting webpage.

Open Meeting Announcement Botulinum Toxin Injections, Micro Invasive Glaucoma Surgery (MIGS), Artificial Intelligence Enabled Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA) - June 27, 2024

Date Posted: May 30, 2024

This article has been published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Noridian Healthcare Solutions will be hosting an Open Public Meeting on Thursday June 27, 2024, from 2:00 pm CT - 4:00 pm CT.

Advance registration is required (link will be added when posted).

- Registration deadline to present comments on an LCD will close on June 20, 2024, at 11:59 pm CDT.
- General Registration deadline to participate by listen-only mode will close on June 26, 2024, at 11:59 pm CDT.

Proposed Local Coverage Determination (LCD) and Local Coverage Article (LCA):

- Botulinum Toxin Injections
- Micro Invasive Glaucoma Surgery (MIGS)
- Artificial Intelligence Enabled Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

View meeting details and register now from the Open Meeting webpage.

Medical Policies and Coverage

Open Meeting Announcement Skin Substitutes Grafts/Cellular Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers - May 16, 2024

Date Posted: April 25, 2024

This article has been published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Noridian Healthcare Solutions will be hosting an Open Public Meeting on May 16, 2024 from 2 p.m. to 4 p.m. CDT.

Advance registration is required.

- Registration deadline to present comments on an LCD will close on May 9, 2024, 11:59 p.m. CDT.
- General Registration deadline to participate by listen-only mode will close on May 15, 2024 at 11:59 p.m. CDT.

Proposed Local Coverage Determination (LCD) and Local Coverage Article (LCA):

- LCD Skin Substitutes Grafts/Cellular Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers, DL39760
- Billing and Coding: Skin Substitutes Grafts/Cellular Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers, DA59626

View meeting details and register now from the Open Meeting webpage.

Polysomnography and Other Sleep Studies (L36861) - R4 - Effective December 01, 2019

Date Posted: April 18, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: December 01, 2019

Summary of Changes: Under Coverage Indications, Limitations, and/or Medical Necessity, added the following information:

Beneficiaries who fail the initial 12-week trial are eligible to re-qualify for a PAP device but must have both:

1. In-person clinical re-evaluation by the treating practitioner to determine the etiology of the failure to respond to PAP therapy; and,

2. Repeat sleep test in a facility-based setting (Type 1 study). This may be a repeat diagnostic, titration or split night study.

These updates are effective December 01, 2019.

Visit the Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Self-Administered Drug Exclusion List (A53032) - R34 - Effective April 1, 2024

Date Posted: April 4, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2024

Summary of Changes:

Added a double asterisk for J0801 and J0802. Under Article Text section added the following:

Note: the drugs represented by HCPCS codes J0801 and J0802 (marked with a double asterisk**) are administered by IM or SQ, therefore they require the JB modifier to be reported for the SQ administration and they should not have any modifier reported for IM administration.

Visit the Self-Administered Drugs (SADs) webpage to view the Self-Administered Drug Exclusion List.

To view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.

Self-Administered Drug Exclusion List (A53032) - R35 - Effective June 23, 2024

Date Posted: May 9, 2024

This coverage article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 23, 2024

Summary of Changes:

The article has been updated to add brand names to the SAD list under their respective generic names for the following drugs:

Semaglutide: Ozempic, Wegovy

Tirzepatide: Mounjaro, Zepbound

The addition of the above mentioned brand names is effective 06/23/2024.

The article has also been updated to apply consistent formatting for drug names. The new format applied is "generic name (brand name)". This formatting update does not change any coverage or guidance.

Visit the Self-Administered Drugs (SADs) webpage to view the Self-Administered Drug Exclusion List.

To view the complete listing of coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.

Skin Substitutes Grafts/Cellular Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers - Published for Review and Comments

Date Posted: May 2, 2024

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: DL39760

LCD Title: Skin Substitutes Grafts/Cellular Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Comment period: April 25, 2024 - June 8, 2024

Visit the CMS MCD to access Proposed LCDs not released to final LCDs.

Providers may address details for comment submission. When sending comments, reference the specific policy to which they are related. See the Proposed LCDs webpage for email and mail specifics.

Trigger Point Injections (TPI) (L34211) - R9 and Billing and Coding: Trigger Point Injections (TPI) (A57701) - R4 - Effective April 1, 2024

Date Posted: April 11, 2024

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: L34211 and A57701

Effective Date: April 1, 2024

Summary of Changes: Removed broken link within Bibliography #40 in the LCD. Fixed broken link within the Article Text section of the Billing and Coding Article.

Visit the Noridian Active LCDs webpage or Noridian Medicare Coverage Articles webpages to view the document or access it via the CMS MCD.

MLN Connects

MLN Connects - April 4, 2024

MLN Connects Newsletter: Apr 4, 2024

Proposed Payment Rules

- FY 2025 Skilled Nursing Facility Prospective Payment System Proposed Rule
- FY 2025 Inpatient Psychiatric Facilities Prospective Payment System & Quality Reporting Updates Proposed Rule
- FY 2025 Hospice Payment Rate Update Proposed Rule

News

- ESRD Claims: Manual Update to Revise Section Title & Correct Condition Codes

Compliance

- Surgical Dressings: Prevent Claim Denials

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: April Update
- DMEPOS: Provider Level Adjustment Codes on Remittance Advice

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: April 2024 Update

From Our Federal Partners

- Providers Accepting CHAMPVA: Enroll in Direct Deposit Now
- Increase in Invasive Serogroup Y Meningococcal Disease in the U.S.
- Health Care Preparedness Resources

MLN Connects - April 11, 2024

MLN Connects Newsletter: Apr 11, 2024

Proposed Payment Rule

- CMS Proposes New Policies to Support Underserved Communities, Ease Drug Shortages, and Promote Patient Safety

MLN Connects

News

- CMS Roundup (Apr. 5, 2024)
- Medicare Shared Savings Program: Application Toolkit Materials
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Help Improve the Health of Minority Populations

Compliance

- Advance Care Planning: Bill Correctly for Services

Claims, Pricers, & Codes

- COVID-19 Monoclonal Antibody: New Codes for PEMGARDA
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - April 2024

Publications

- Medical Record Maintenance & Access Requirements - Revised

From Our Federal Partners

- Extended & Large-Scale Emergency Resources
- Highly Pathogenic Avian Influenza Virus: Identification of Human Infection and Recommendations for Investigations and Response

MLN Connects - April 18, 2024

MLN Connects Newsletter: Apr 18, 2024

News

- PrEP for HIV: Prepare for Potential Medicare Part B Coverage

Events

- Clinical Laboratory Fee Schedule Upcoming Meetings: Register to Present, Speak, or Attend in Person by June 1

MLN Connects

Publications

- Medicare Preventive Services - Revised
- Original Medicare vs. Medicare Advantage - Revised

MLN Connects - April 25, 2024

MLN Connects Newsletter: Apr 25, 2024

Editor's Note:

CMS updated a message because we delayed the effective date that physicians who certify hospice services must enroll in or opt-out of Medicare until June 3, 2024. You may have to refresh the webpage to see the updated content.

News

- Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule
- CMS Roundup (Apr 19, 2024)
- Hospice Requirement for Certifying Physicians to Enroll in or Opt-Out of Medicare: Delayed until June 3
- Comprehensive Error Rate Testing Program: Reduced Sample Size Starting with Reporting Year 2025
- Skilled Nursing Facility Value-Based Purchasing Program: FY 2026 Early Look Performance Score Report

Compliance

- Opioid Treatment Program: Bill Correctly for Opioid Use Disorder Treatment Services

Claims, Pricers, & Codes

- Hospital Outpatient Prospective Payment System: Correcting Errors to Codes 0621T, J7353, & C9167

MLN Matters® Articles

- Medicare Claims Processing Manual Update: Inpatient Rehabilitation Facility
- National Coverage Determination 20.7: Percutaneous Transluminal Angioplasty
- DMEPOS Fee Schedule: April 2024 Quarterly Update - Revised

MLN Connects

From Our Federal Partners

- Adverse Effects Linked to Counterfeit or Mishandled Botulinum Toxin Injections

MLN Connects - May 2, 2024

MLN Connects Newsletter: May 2, 2024

News

- CMS Statement on Proposed Local Coverage Determination for Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers
- Quality in Motion: Acting on the CMS National Quality Strategy
- ESRD: Oral-Only Renal Dialysis Service Drugs & Biological Products

Claims, Pricers, & Codes

- Clinical Laboratory Improvement Amendments: Adjusting Claims

Events

- CMS National Provider Enrollment Conference in San Diego - August 28 & 29

Publications

- Skilled Nursing Facility Place of Service Codes: Updated Resources

MLN Connects - May 9, 2024

MLN Connects Newsletter: May 9, 2024

News

- HHS Releases New Data Showing Over 10 million People with Medicare Received a Free Vaccine Because of the President's Inflation Reduction Act; Releases Draft Guidance for the Second Cycle of Medicare Drug Price Negotiation Program
- CMS Roundup (May 3, 2024)
- Medicare Shared Savings Program: Prepare to Apply & Register for June 5 Webinar
- Clinical Laboratory Fee Schedule Preliminary Gapfill Rates: Submit Comments by July 1

MLN Connects

- Home Health Quality Reporting Program: Draft OASIS-E1 Instruments & Manual
- Mental Health: It's Important at Every Stage of Life

Claims, Pricers, & Codes

- Skilled Nursing Facility Prospective Payment System: Patient Driven Payment Model FY 2024 ICD-10 Code Mappings

Events

- HCPCS Public Meeting - May 28-30

Publications

- Part B Drug Payment Limits Overview
- Resource of Health Equity-related Data Definitions, Standards, and Stratification Practices

From Our Federal Partners

- Providers Accepting CHAMPVA: Enroll in Direct Deposit Now

MLN Connects - May 16, 2024

MLN Connects Newsletter: May 16, 2024

News

- Administration Acts to Improve Access to Kidney Transplants
- DMEPOS: Updated List of Items Potentially Subject to Conditions of Payment
- Lymphedema Compression Treatment Items: New DMEPOS Benefit Category
- Hospice: New Requirement for Physicians Who Certify Patient Eligibility Effective June 3
- Medicare Physician Fee Schedule Database: July Update
- Women's Health: Talk with Your Patients About Prevention, Care, & Wellbeing

Compliance

- Diabetic Shoes: Prevent Claim Denials

Claims, Pricers, & Codes

- Home Health Claims: Additional Enforcement of Required County Codes

MLN Connects

Events

- Overcoming COVID-19 Vaccine Payment Challenges Webinar - May 30

MLN Matters® Articles

- Annual Wellness Visit: Social Determinants of Health Risk Assessment
- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update
- Diabetes Screening & Definitions Update: CY 2024 Physician Fee Schedule Final Rule
- ESRD Prospective Payment System: Quarterly Update
- Updates for Split or Shared Evaluation and Management Visits

Multimedia

- Skilled Nursing Facility Quality Reporting Program: Social Determinants of Health Video
- Skilled Nursing Facility Quality Reporting Program: Annual Payment Update Webinar Materials

Information for Patients

- Mental Health & Substance Use Disorders: Updated Medicare.gov Content

MLN Connects - May 23, 2024

MLN Connects Newsletter: May 23, 2024

News

- Medicare Shared Savings Program: Apply by June 17 for January 1 Start Date
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Institutional Providers: Medicare Enrollment & Certification Roadmap
- Improve Your Search Results for CMS Content

Compliance

- Medical Services Authorized by the Veterans Health Administration: Avoid Duplicate Payments

MLN Connects

Claims, Pricers, & Codes

- Pass-Through Device: Correct Returned Claims

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2024 Update
- National Coverage Determination 110.23: Allogeneic Hematopoietic Stem Cell Transplantation
- Hospice Claims Edits for Certifying Physicians - Revised

From Our Federal Partners

- Meningococcal Disease Cases Linked to Travel to the Kingdom of Saudi Arabia: Ensure Travelers are Current on Meningococcal Vaccination

MLN Connects - May 30, 2024

MLN Connects Newsletter: May 30, 2024

News

- Hospice Interdisciplinary Team: Addition of Marriage and Family Therapists & Mental Health Counselors
- Revised Part B Inflation Rebate Guidance: Using the 340B Modifier - Reminder

MLN Matters® Articles

- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: October 2024
- Medicare Claims Processing Manual Update: Gap-Filling DMEPOS Fees

Publications

- SBIRT Services – Revised

MLN Connects

MLN Connects - June 6, 2024

MLN Connects Newsletter: June 6, 2024

News

- CMS Roundup (May 31, 2024)
- Quality Payment Program: 2022 Performance Information on Medicare.gov Compare Tool
- Skilled Nursing Facility Value-Based Purchasing Program: June Confidential Feedback Reports
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Advancing Health Equity During Pride Month

Claims, Pricers, & Codes

- DMEPOS: Clarification of Claim Liability for Overlapping Inpatient Hospital Stays
- Integrated Outpatient Code Editor Version 25.2
- National Correct Coding Initiative: July Update

MLN Matters® Articles

- National Coverage Determination 200.3: Monoclonal Antibodies for the Treatment of Alzheimer's Disease

Publications

- Medicare Preventive Services - Revised

MLN Connects - June 13, 2024

MLN Connects Newsletter: June 13, 2024

News

- Medicare Shared Savings Program: Apply for January 1 Start Date by June 17
- Men's Health: Encourage Your Patients to Prioritize Their Health

Compliance

- Hospital Beds & Accessories: Prevent Claim Denials

MLN Connects

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2025

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting: Now Virtual-Only on June 25

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: July 2024 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: October 2024 Quarterly Update

Multimedia

- Medicare Ground Ambulance Data Collection System: Labor Costs Webinar Recording

Information for Patients

- Medicare Information in Other Languages

MLN Connects - June 20, 2024

MLN Connects Newsletter: June 20, 2024

News

- CMS Preparing to Close Program that Addressed Medicare Funding Issues Resulting from Change Healthcare Cyber-Attack
- Federal Study Examines Care Following Nonfatal Overdose Among Medicare Beneficiaries; Identifies Effective Interventions & Gaps in Care
- CMS Roundup (June 14, 2024)
- Medical Records Request Scam: Watch out for Phishing
- Provider & Supplier Enrollment Site Visits: CMS has Authority to Conduct
- Cognitive Health: Medicare Covers Services

Compliance

- Global Surgery: Bill Correctly

MLN Connects

Claims, Pricers, & Codes

- Outpatient Institutional Providers: Find Out When to Split Claims for Updated Rates

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting: Now Virtual-Only on June 25

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - July 2024
- Medicare Benefit Policy Manual Update: DMEPOS Benefit Category Determinations

From Our Federal Partners

- Disrupted Access to Prescription Stimulant Medications Could Increase Risk of Injury & Overdose
- Severe Illness Potentially Associated with Consuming Diamond Shruumz Brand Chocolate Bars, Cones, & Gummies
- CHAMPVA Claims: Enroll in Direct Deposit - Reminder

MLN Connects - June 27, 2024

MLN Connects Newsletter: June 27, 2024

News

- CY 2025 Home Health Prospective Payment System Proposed Rule
- PrEP Using Antiretroviral Therapy to Prevent HIV Infection: Technical FAQs for Pharmacies

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: July Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2024 Update

Events

- 2024 Virtual National Provider Compliance Conference - August 7 & 8

MLN Connects

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2024 Quarterly Update

Multimedia

- Medicare Ground Ambulance Data Collection System: Webinar Recordings

From Our Federal Partners

- Increased Risk of Dengue Virus Infections in the U.S.
- Health Care Preparedness Resources

MLN Matters

Annual Wellness Visit: SDOH Risk Assessment

Related CR Release Date: May 2, 2024

Effective Date: January 1, 2024

Implementation Date: October 7, 2024

MLN Matters Number: MM13486

Related Change Request (CR) Number: CR 13486

Related CR Transmittal Numbers: R12599BP & R12599CP

CR 13486 tells you about:

- A social determinants of health (SDOH) risk assessment is now an optional annual wellness visit (AWV) element
- The eligibility and billing requirements for doing the SDOH as part of the AWV

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13486.

April 2024 I/OCE Specifications Version 25.1

Related CR Release Date: March 21, 2024

Effective Date: April 1, 2024

Implementation Date: April 1, 2024

Related Change Request (CR) Number: CR 13567

Related CR Transmittal Number: R12551CP

CR 13567 provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a nonterminal illness. The attached recurring update notification applies to publication 100-04, chapter 4, section 40.1.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Change Request (CR)13567

MLN Matters

April 2024 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: December 21, 2023

Effective Date: April 1, 2024

Implementation Date: April 1, 2024

Related Change Request (CR) Number: CR 13492

Related CR Transmittal Number: R12422CP

CR 13492 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13492.

Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update

Related CR Release Date: May 2, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

MLN Matters Number: MM13613

Related Change Request (CR) Number: CR 13613

Related CR Transmittal Number: R12606CP

CR 13613 tells you about:

- Next private payor data reporting period of January 1, 2025 - March 31, 2025
- New and deleted HCPCS codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13613.

MLN Matters

DMEPOS Fee Schedule: April 2024 Quarterly Update - Revised

Related CR Release Date: April 15, 2024

Effective Date: January 1, 2024 or April 1, 2024, as noted in Article

Implementation Date: April 1, 2024

MLN Matters Number: MM13574 Revised

Related Change Request (CR) Number: CR 13574

Related CR Transmittal Number: R12584CP

Note: CMS revised the Article to show the addition of 4 HCPCS Level II codes to CWF category 58 (page 4). CMS also revised the effective date and the web address of CR 13574.

CR 13574 tells you about:

- Updates to CY 2024 fee schedule amounts for new and existing DMEPOS codes
- Changes in payment policy

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13574.

DMEPOS Fee Schedule: July 2024 Quarterly Update

Related CR Release Date: June 13, 2024

Effective Date: July 1, 2024 - except for fee schedules for HCPCS codes E2298 and K1007 effective April 1, 2024

Implementation Date: July 1, 2024

MLN Matters Number: MM13658

Related Change Request (CR) Number: CR 13658

Related CR Transmittal Number: R12685CP

Related CR Title: July Quarterly Update for 2024 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

CR 13658 tells you about:

- Updates to CY 2024 fee schedule amounts for certain DMEPOS codes
- Changes in payment policy
- New fee schedule information for HCPCS codes K1007 and E2298

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13658.

MLN Matters

ESRD Prospective Payment System: Quarterly Update

Related CR Release Date: May 9, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

MLN Matters Number: MM13608

Related Change Request (CR) Number: CR 13608

Related CR Transmittal Number: R12628CP

CR 13608 tells you about:

- Transitional Drug Add-On Payment Adjustment (TDAPA) for HCPCS code J0911
- Updated list of outlier services under the ESRD PPS

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13608.

HCPCS Codes Used for SNF CB Enforcement: October 2024 Quarterly Update

Related CR Release Date: June 6, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

MLN Matters Number: MM13661

Related Change Request (CR) Number: CR 13661

Related CR Transmittal Number: R12674CP

CR 13661 tells you about:

- Updates to the lists of HCPCS codes subject to the Consolidated Billing (CB) provision of the Skilled Nursing Facility (SNF) prospective payment system (PPS)
- Additions and deletions of chemotherapy, customized prosthetic devices, and blood clotting factors from the Medicare Part A and Part B SNF files

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13661.

MLN Matters

Hospital OPPS: July 2024 Update

Related CR Release Date: May 31, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

MLN Matters Number: MM13632

Related Change Request (CR) Number: CR 13632

Related CR Transmittal Number: R12665CP

CR 13632 tells you about:

- New CPT and HCPCS codes
- Covered devices for Outpatient Prospective Payment System (OPPS) pass-through payments
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes

Make sure your billing staffs know about these payment system updates for July.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13632.

Hospital Outpatient Prospective Payment System: April 2024 Update

Related CR Release Date: March 21, 2024

Effective Date: April 1, 2024

Implementation Date: April 1, 2024

MLN Matters Number: MM13568

Related Change Request (CR) Number: CR 13568

Related CR Transmittal Number: R12552CP

CR 13568 tells you about:

- New CPT & HCPCS codes
- Covered devices for OPPS pass-through payments
- Edit for Level 6 intraocular procedures ambulatory payment classification (APC)
- iDose TR (travoprost intracameral implant) for the treatment of glaucoma
- Clarification on the OPPS status indicator for the cardiovascular remote interrogation device evaluation

- Payment for intensive cardiac rehabilitation services (ICR) in an off-campus, nonexcepted provider-based department (PBD) of a hospital
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitutes

Make sure your billing staffs know about these payment system updates for April.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13568.

ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2024 Update

Related CR Release Date: May 9, 2024

Effective Date: October 1, 2024 or as noted in CR 13596

Implementation Date: October 1, 2024 or as noted in CR 13596

MLN Matters Number: MM13596

Related Change Request (CR) Number: CR 13596

Related CR Transmittal Number: R12626OTN

CR 13596 tells you about:

- New codes
- Recent coding changes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13596.

July 2024 I/OCE Specifications Version 25.2

Related CR Release Date: May 31, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

Related Change Request (CR) Number: CR 13626

Related CR Transmittal Number: R12666CP

CR 13626 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment

System or to a hospice patient for the treatment of a nonterminal illness. The attached recurring update notification applies to publication 100-04, chapter 4, section 40.1.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13626.

Medicare Benefit Policy Manual Update: DMEPOS BCD

Related CR Release Date: June 13, 2024

Effective Date: January 1, 2024 - for 3 orthotic brace determinations; April 1, 2024 - for all other items, equipment, and devices

Implementation Date: July 15, 2024

MLN Matters Number: MM13651

Related Change Request (CR) Number: CR 13651

Related CR Transmittal Number: R12684BP

CR 13651 tells you about:

- Updates to Section 110.8, Medicare Benefit Policy Manual, Chapter 15
- Added DMEPOS items and their national benefit category determinations (BCDs)

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13651.

Medicare Claims Processing Manual Update: IRF

Related CR Release Date: April 11, 2024

Effective Date: July 12, 2024

Implementation Date: July 12, 2024

MLN Matters Number: MM13587

Related Change Request (CR) Number: CR 13587

Related CR Transmittal Number: R12575CP

CR 13587 tells you about:

- Hospitals may open a new Inpatient Rehabilitation Facility (IRF) unit at any time during the cost reporting year
- Any IRF unit excluded during a cost reporting year will stay excluded for the rest of the cost reporting year

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13587.

National Coverage Determination 20.7: Percutaneous Transluminal Angioplasty

Related CR Release Date: April 11, 2024

Effective Date: October 11, 2023

Implementation Date: May 13, 2024

MLN Matters Number: MM13512

Related Change Request (CR) Number: CR 13512

Related CR Transmittal Numbers: R12571CP; R12571NCD

CR 13512 tells you about changes in coverage for PTA of the carotid artery concurrent with stenting effective October 11, 2023:

- Patients don't have to enroll in a clinical trial
- Facilities don't need CMS approval to perform this service
- You must engage in formal shared decision-making with the patient
- MACs can decide if this service is covered if it's not addressed in this NCD

Your MAC will adjust claims processed in error that you bring to their attention.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13512.

National Coverage Determination 110.23: Allogeneic HSCT

Related CR Release Date: May 9, 2024

Effective Date: March 6, 2024

Implementation Date: October 7, 2024

MLN Matters Number: MM13604

Related Change Request (CR) Number: CR 13604

Related CR Transmittal Numbers: R12627CP & R12627NCD

CR 13604 tells you about:

- Hematopoietic Stem Cell Transplantation (HSCT) using bone marrow, peripheral blood or umbilical cord blood stem cell products for Medicare patients

- All other indications for stem cell transplantation not otherwise specified

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13604.

National Coverage Determination 200.3: Monoclonal Antibodies for the Treatment of Alzheimer's Disease

Related CR Release Date: May 23, 2024

Effective Date: April 7, 2022

Implementation Date: June 24, 2024

MLN Matters Number: MM13598

Related Change Request (CR) Number: CR 13598

Related CR Transmittal Number: R12649CP

CR 13598 tells you about:

- FDA-approved monoclonal antibodies
- Criteria for coverage
- Coding information
- Claims processing instructions

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13598.

Outlier Reconciliation and CCR Updates for the IPPS and LTCH PPS - Rescinded

Related CR Release Date: April 26, 2024

Effective Date: October 1, 2024

Implementation Date: October 1, 2024

Related Change Request (CR) Number: CR 13566

Related CR Transmittal Number: R12594CP

Note: Transmittal 12558 issued March 28, 2024, is being rescinded and replaced by Transmittal 12594, dated April 26, 2024, to update example B in Publication 100-04, Chapter 3, Section 20.1.2.5 - Reconciliation.

CR 13566 adds new criteria for determining which hospitals shall have their outlier payments reconciled under the Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS. CMS is also cross walking the calculation of the IPPS operating and capital Cost-to-Charge Ratio (CCR) and the LTCH CCR from Form CMS-2552-1996 cost report to the Form 2552-2010 cost report.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13566.

Quarterly Update to the MPFS Database - July 2024 Update

Related CR Release Date: May 9, 2024

Effective Date: January 1, 2024

Implementation Date: July 1, 2024

Related Change Request (CR) Number: CR 13624

Related CR Transmittal Number: R12629CP

CR 13624 amends payment files that were issued to contractors based upon the 2024 Medicare Physician Fee Schedule (MPFS) Final Rule. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.1.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13624.

Updates for Split or Shared E/M Visits

Related CR Release Date: May 3, 2024

Effective Date: January 1, 2024

Implementation Date: August 1, 2024

MLN Matters Number: MM13592

Related Change Request (CR) Number: CR 13592

Related CR Transmittal Number: R12604CP

CR 13592 tells you about:

- The definition of split or shared visit and substantive portion
- How to bill appropriately for split or shared evaluation and management (E/M) visits

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13592.

Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Related CR Release Date: February 22, 2024

Effective Date: March 25,2024

Implementation Date: March 25,2024

Related Change Request (CR) Number: CR 13525

Related CR Transmittal Number: R12517CP

CR 13525 updates the title of chapter 8, section 50 and to update chapter 8, section 50.3 to insert existing condition codes related to home dialysis that were previously removed in error.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Change Request (CR)13525.

Update to Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 DMEPOS Benefit Category Determinations and Add Section 145 Lymphedema Compression Treatment Items

Related CR Release Date: March 7, 2024

Effective Date: October 1, 2023

Implementation Date: May 6, 2024

Related Change Request (CR) Number: CR 13526

Related CR Transmittal Number: R12532BP

CR 13526 updates Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Benefit Category Determinations and add Section 145 Lymphedema Compression Treatment Items.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13526.

Contacts, Resources, and Reminders

Noridian Part A Customer Service Contact

Provider Contact Center (PCC) - View hours of availability, call flow, authentication details and customer service areas of assistance.

Email Addresses - Providers may submit emails to Noridian for answers regarding basic Medicare regulations and coverage information. View this page for details and request form.

Fax Numbers - View fax numbers and submission guidelines.

Holiday Schedule - View holiday dates that Noridian operations, including PCC phone lines, will be unavailable for customer service.

Interactive Voice Response (IVR) - View conversion tool and information on how to use IVR and what information is available through system. General IVR inquiries available 24/7.

Mailing Addresses - View mail addresses for submitting written correspondence, such as claims, letters, questions, general inquiries, enrollment applications and changes, written redetermination requests and checks to Noridian.

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Sources for "Medicare A News" Articles

The purpose of "Medicare A News" is to educate the Noridian Medicare Part A provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it on the CMS

Manuals webpage. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters," which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Unsolicited or Voluntary Refunds Reminder

All Medicare providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified in no way affects or limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims.

Background

Medicare carriers and intermediaries and A/B MACs receive unsolicited or voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related Change Request (CR) 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

The official CMS CR3274 instruction may be viewed in the Medicare Learning Network (MLN) Matters article MM3274.

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

Sources: Transmittal 50, CR 3247 dated July 30, 2004; Internet Only Manual (IOM) Medicare Financial Management Manual, Publication 100-06, Chapter 5, Section 410

Contacts, Resources, and Reminders

Do Not Forward Initiative Reminder

The Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04 instructs Part A and Part B Medicare Administrative Contractors (A/B MACs) and carriers to use "return service requested" envelopes when mailing paper checks and remittance advices to providers.

When the post office returns a "return service requested" envelope, the A/B MAC/carrier applies a "do not forward" (DNF) flag to the provider's Medicare enrollment file. The A/B MAC/carrier will not generate any additional checks for that provider until the provider sends a properly completed change of address form back to the A/B MAC/carrier. We are not required to contact the provider to notify them that the flag has been added to their file.

Upon verifying the new address, the A/B MAC/carrier removes the DNF flag and can again generate payments for the provider. Electronic Funds Transfer (EFT) is required; therefore, when the address change update is completed, the provider will be set up to use EFT and will no longer receive paper checks.

Note: Because many providers get paid through EFT, there may be cases where a provider does not have a correct address on file, but the A/B MAC/carrier continues to pay the provider through EFT. It is still the provider's responsibility to submit and address change update so that remittance notices and special checks would be sent to the proper address.

Noridian encourages providers to enroll or make changes using Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for faster processing time. Applications and changes completed online currently have an average processing time of 10 days. All Medicare providers may use the new enrollment process on the CMS Medicare Enrollment website. To log into this internet-based PECOS, providers will use their NPI Userid and password.

Policy

Effective October 1, 2002, A/B MACs/carriers must use "return service requested" envelopes for hardcopy remittance advices and checks, with respect to providers that have elected to receive hardcopy remittance advices. (PM B-02-023, CR 2038 dated April 12, 2002; Transmittal 1794, CR 2684 dated May 2, 2003)

Implementation Process

1. "Return service requested" envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.

2. "Return service requested" envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
    - Flag the provider's file DNF.
    - A/B MAC/carrier staff will notify provider enrollment team.
    - A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.
4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
5. Previously, CMS only required corrections to the "pay to" address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider's location.

IRS-1099 Reporting

Provider or supplier checks returned and voided during the same year they were issued are not reported on the Internal Revenue Service (IRS) Form 1099 until the returned check is reissued (i.e., the DNF flag is removed and the A/B MAC/carrier reissues payment to the provider.) Checks returned and voided in the current year that were issued in prior years are not netted from the current year's IRS Form 1099.

Monies withheld because a DNF flag exists on a provider or supplier record are not reported on IRS-1099s until the calendar year in which payment is made (i.e., the point at which the A/B MAC/carrier pays the provider once the DNF flag is removed.) If DNF amounts are erroneously included on IRS-1099 forms, A/B MACs/carriers will issue corrected IRS Form 1099s to affected providers.

Source: IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 22, Section 50.1

Contacts, Resources, and Reminders

Jurisdiction E Part A Quarterly Ask the Contractor Meetings (ACM)

ACMs are designed to open communication between providers and Noridian, which allows for timely identification of problems, and sharing information in an informal and interactive question and answer (Q&A) format. No Personal Health Information (PHI) is allowed.

Noridian representatives from various Part A departments are available to address your Medicare questions and concerns. All questions are entertained and the Q&As are posted on our website for provider convenience.

ACM dates, times, toll-free number, and Q&As are available on the Jurisdiction E Part A Ask the Contractor Meetings (ACM) webpage.

Attendees must register through a free web-based training tool (GoToWebinar) which requires an Internet connection and a toll-free telephone number (provided in confirmation email). Allow email registrations@noridian.com. Unless otherwise specified, ACMs are general in nature. No CEUs are provided.

By completing and submitting the Noridian Part A ACM Question Submission Form, providers may ask question(s), up to five (5) days prior, to be answered during the next ACM. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. **Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center.**

We look forward to your participation in these important calls.

Medicare Part A ACMs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries.

If you are interested in attending a Part B or a DME ACM, select the appropriate link below for more information.

- Jurisdiction E Part B ACMs
- Jurisdiction D DME ACMs
- Jurisdiction A DME ACMs