Medicare B News

Jurisdiction E

July 2022

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This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://med.noridianmedicare.com

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https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

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NEWS

Noridian Part B Customer Service Contact

General IVR Inquiries Available 24/7

Phone Number	Inquiry	Hours (PT)
855-609-9960	Claim Specific	Monday - Friday 6 a.m. - 5 p.m.

- Interactive Voice Response (IVR)
- Provider Contact Center (PCC)
- Provider Enrollment
- EDISS
- User Security (including NMP)

Text Teletype Calls (TTY) - 855-549-9874

Monday - Friday 8a.m. - 5 p.m. PT

MLN Matters Disclaimer Statement

Below is the 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 B News" Articles

The purpose of "Medicare B News" is to educate the Noridian Medicare Part B provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever we publish 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 at the CMS website https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index. The CMS Change Request (CR) and the date issued will be referenced within the "Source" portion of applicable articles.

CMS publishes a series of educational articles within their Medicare Learning Network (MLN), titled "MLN Matters." These "MLN Matters" articles are also included 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 AB 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 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/mm3274.pdf.

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

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 website https://pecos.cms.hhs.gov. 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

2022 JE Part B Quarterly Ask-the-Contractor Teleconferences

Below is the listing of the 2022 Part B Quarterly Ask-the-Contractor Teleconferences (ACTs).

- October 19, 2022 - General

ACTs 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 B 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.

To view ACT dates, times, toll-free number, and Q&As, go to https://med.noridianmedicare.com/web/jeb/education/act.

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, ACTs are general in nature. No CEUs are provided.

By completing and submitting the Noridian "Ask the Contractor Teleconference Question Submission Form," providers may ask question(s), up to five (5) days prior, to be answered during the next ACT. 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**. Providers will need to have Version 7 or higher of Adobe Reader to use this form.

We look forward to your participation in these important calls.

Medicare Part B ACTs do not address Medicare Part A or Durable Medical Equipment (DME) inquiries. If you are interested in attending a Part A or a DME ACT, select the appropriate link below for more information.

- **JE Part A** - https://med.noridianmedicare.com/web/jea/education/act
- **JD DME** - https://med.noridianmedicare.com/web/jddme/education/act
- **JA DME** - https://med.noridianmedicare.com/web/jadme/education/act

A2001 - Priced Per Invoice

A2001, *Innovamatrix ac, per square centimeter*, is priced per invoice. This update is effective for dates of service January 1, 2022 and after. More information on how to submit an invoice can be found on our Avoiding Denials on Priced per Invoice Claims page.

ACT Questions and Answers - January 25, 2022

ACT PRIOR AUTHORIZATION OF REPETITIVE, SCHEDULED NON-EMERGENT AMBULANCE TRANSPORTS (RSNAT) - JANUARY 25, 2022

The following questions and answers (Q&As) are cumulative from the RSNAT Part B Ask the Contractor Teleconference (ACT). Some questions have been edited for clarity and answers may have been expanded to provide further details. Similar questions were combined to eliminate redundancies. If a question was specific just for that office, Noridian addressed this directly with the provider. This session included educational material, pre-submitted questions, and verbal questions posed during the event.

RSNAT EDUCATIONAL MATERIAL

RSNAT Defined

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished in three or more round trips during a ten-day period; or at least one round trip per week for at least three weeks. Medicare may cover repetitive, scheduled non-emergent transportation by ambulance if:

- The medical necessity requirements described are met, and
- The ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met.

Ambulance HCPCS Subject to Prior Authorization

- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport

For prior authorization the mileage code, A0425, is treated as an associated procedure and not needed for prior authorization request. Ambulance suppliers are required to bill the mileage code on the same claim as the transport code.

Authorization Decisions and Affirmations

The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips (which equates to 80 one-way trips) per prior authorization request in a 60-day period.

- Provisional Affirmation
    - Provisional affirmative prior authorization decision may affirm less than 40 round trips or affirm a request that seeks to provide a specified number of transports (40 round trips or less) in less than a 60-day period. A provisional affirmative decision can be for all or part of the requested number of trips.
    - Transports exceeding 40 round trips (or 80 one-way trips) in a 60-day period require an additional prior authorization request.
- Affirmations
    - Provisional affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service likely meets Medicare's coverage, coding, and payment requirements.
    - After the review, Noridian will send the decision letter with the provisional affirmative unique tracking number to the submitter via fax, mail, or the provider portal (when available) postmarked within 10 business days. Decision letters sent via esMD are not available at this time. Noridian will also mail a copy of the decision letter to the beneficiary.
    - A provisional affirmative prior authorization decision does not follow the beneficiary. Only one ambulance supplier is allowed to request prior authorization per beneficiary per time period.
    - If the initial supplier cannot complete the total number of prior authorized transports, the initial supplier should contact their MAC to cancel their prior authorization. A subsequent ambulance supplier may submit a

prior authorization request to provide transport for the same beneficiary and must include the required documentation in the submission.

- Non-Affirmative Decision
    - A non-affirmative decision is a preliminary finding that a future claim submitted to Medicare for the service does not meet Medicare's coverage, coding, and payment requirements.

RSNAT Prior Authorization Submission and Resubmission

Submitters are encouraged to use the form specifically designed for prior authorization requests and submit through postal, fax, portal or ESMD.

- Jurisdiction E Part B (JEB) Submitting a Prior Authorization Request
- Prior Authorization Request for Repetitive, Scheduled Non-Emergent Ambulance Transports Medicare Part B Fax/Mail Coversheet

Resubmissions are permitted. A resubmission is any subsequent submissions to correct an error or omission identified after the initial prior authorization request decision was non-affirmed and prior to claim submission. When a prior authorization request is non-affirmed, the submitter should review the detailed decision letter. The submitter may then resubmit the request with additional documentation showing that Medicare requirements have been met using the same submission procedures. Resubmissions are unlimited during the prior authorization process.

Pre-Submitted Question

Q1. If a transport is not approved in the prior authorization process, can transports that occur later be submitted with a modifier GY?
A1. Yes. Ambulance suppliers may submit the claim without a prior authorization decision if the claim is non-covered using the GY modifier. Claim submitted with a non-affirmative prior authorization decision will deny. The beneficiary and the supplier have appeal rights.

Question Posed During Event

Q1. Have you heard of the community programs, CEMS? I work for St. Luke's in ID. They have a community outreach to see several patients during the day who have chronic issues or trans care type patients.

A1. (CEM) or Community Emergency Medical are services coordinated with primary providers that may be provided as a paramedic or EMT service to see the patient in their home. There are some communities (i.e., in AZ) that do offer this. While yes, we have heard of this, the prior authorization program is specific to patient transports.

Resources

Webinars are available and can be found on our Schedule of Events. A Webinar-on-Demand recording is available, and inquiries on the program can be submitted through our Provider Contact Center or through email, PartBpriorauth@noridian.com.

ACT B Questions and Answers - April 20, 2022

The following questions and answers (Q&As) are cumulative from the general Part B Ask the Contractor Teleconference (ACT). Some questions have been edited for clarity and answers may have been expanded to provide further details. Related questions were combined to eliminate redundancies. If a question was specific just for that office, Noridian addressed this directly with the provider. This session included pre-submitted questions and verbal questions posed during the event.

PRE-QUESTIONS:

Q1. Can Noridian provide instructions on the COVID-19 administration HCPCS 0011A that had a mass adjustment, and we still do not have resolution for approximately 30 claims?
A1. Yes, there was a mass adjustment in May of 2021 and if the provider has any more claims with this HCPCS 0011A administration issue, cancel the adjustment and submit a new claim. On the line 19 narrative field, reflect "timely filing waived per Medicare fee issue".

Q2. Regarding bilateral Radiofrequency Ablation (RFA) LCD L38801 policy; if a patient has not had an RFA for two years or more, do the diagnostic procedures need to be repeated?
A2. Depends. If the provider is sure the pain is from the same level previously blocked, then s/he does not need to repeat the diagnostic blocks. The LCD, Facet Joint Interventions for Pain Management, addresses the frequency and number of services, as well as when repeat services are appropriate.

If the dual Medial Branch Blocks (MBBs) provided >80% pain relief and the initial RFA received at least 50% improvement in pain for at least six months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs, a repeat RFA can be performed. These would be at least six months from one another and in addition, each encounter date that a facet procedure is performed is one session.

Q3. What level of detail must be documented to support billing with modifier -AS (non-physician practitioner (NPP) assistant at surgery)?
A3. If the code is eligible, the provider must provide a documentation level to clearly reflect the role of the assistant, during the procedure, with the medical reason the patient required an NPP assistant at surgery. Make sure that the CPT allows assistant surgeons found under Noridian's Fee Schedule "Indicators and Descriptions."

An operative report may be requested. Noridian does have documentation guidelines on our website under Medical Review's tab.

Q4. With Acupuncture for Chronic Low Back Pain, can the physician supervise auxiliary personnel, under incident to rules of direct or general supervision, if all applicable state requirements met?
A4. Yes. The authorized Medicare billing provider must directly supervise all auxiliary personnel. The National Coverage Determination (NCD) policy allows acupuncture to be performed by auxiliary personnel, but s/he must be under the direct supervision. As required by Medicare's Code of Federal (CFR) regulations (42 CFR §§ 410.26 and 410.27), the supervising physician must be able to oversee the treatments in the office and be actively involved with that patient's care.

Q5. What does Noridian expect to see documented in order to support independent interpretation? How does Noridian interpret the "surgery" guidelines around tests and treatments considered, but not selected?"
A5. Documentation for independent interpretation should indicate a review of the results in the provider's own words. There should be additional work shown to support a separate interpretation other than the one received. Tests or treatments considered, but not selected, would need to be documented in the medical record. In determining surgery levels with the E/M services, the professional interpretation of those tests and studies are reported separately by the physician or other qualified health care professional.

Tests that do not require separate interpretation (e.g., test results only) are analyzed as part of Medical Decision-Making (MDM) and do not count as an independent interpretation; however, may be counted as ordered or reviewed for selecting an MDM level.

Q6. If the beneficiary is considered Homebound and receiving Home Health and is referred to an Outpatient pain rehab program, can the patient receive telehealth psychology services without jeopardizing his or her homebound status? Do we bill Medicare or Home Health?
A6. The psychologist telehealth visits would be billed to Part B and should not jeopardize their Homebound status. Since Noridian only adjudicates Part A, B, and Durable Medical Equipment (DME) claims, if Home Health does not employ the provider, append modifiers -GV (attending physician not employed or paid by patient's hospice provider) or -GW (service not related to hospice terminal condition).

Providers should refer to Home Health Consolidated Billing (CB) Master List found on CMS' Home Health page Coding and Billing Information. This ensures their specific procedure code does not fall under home health CB.

Q7. Do Opioid Treatment Program (OTP) providers bill only with the group NPI # in Box 33 and no individual NPI # in Box 24J?
A7. Yes. Check with your electronic data interchange (EDI) partner to confirm the correct billing for OTP on the CMS-1500. Box 24J, the individual NPI#, is NOT needed as OTP is not considered physician services. Item 24J - Do not bill individual provider NPI and leave blank or bill OTP group NPI from Item 33. More information under Noridian Browse by Topics, under Drugs and Bios, OTP section.

Q8. When these two services, CPTs 93458 (coronary angiography) and 92978 (intravascular ultrasound (IVU) are performed by two different providers who bill separately; how should the +92978 add on code be billed by the provider who did not perform the left heart catheter? S/he only billed the IVU and there was no intervention based on coronary images.
A8. Again, if cardiac procedures are billed by two different providers, the second provider would not bill able to bill for the add on CPT +92978, as there must be a primary CPT (e.g., 93458) to bill add on codes. Occasionally, billing an undifferentiated code and indicating exactly what is being performed may help. Co-surgeon only works if both are from the same practice. Please check with your respective societies to resolve nationally.

Q9. Can physicians bill CPT 93355, who are not performing the structural heart procedure, and only the TEE interpretation?
A9. Looking at the Noridian Medicare Physician Fee Schedule (MPFS), you will see that CPT 93355 is a global code that cannot be split into technical and professional interpretation. As only one payment allows, if there is a separate physician reading the transesophageal echocardiogram (TEE), it will be up to the entity how to pay that other professional "reading" portion of the code.

Q10. Can a beneficiary have pulmonary rehab (PR) if COVID is the ONLY diagnosis and the beneficiary experiences persistent symptoms that include respiratory dysfunction for at least four weeks?
A10. Yes. They can participate in PR if they have COPD confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks. They would NOT need to have the COPD diagnosis, if the COVID-related issues are the problem.

Beneficiaries who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks and complete PR, may participate in PR again if they have moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease.

Q11. Will there be any future reform or changes to the required amount of intra-service time for billing Moderate Sedation services (CPT 99151-99157) with Elective Cardioversion (CPT 92960)?
A11. Any future reform or changes would be published from CMS. Watch proposed and final rules that publish through the Federal Register and CMS websites. Specialty societies are a resource to suggest changes as well.

Q12. What are acceptable examples of medically necessary E/M services in the context of prolonged services with direct patient contact?
A12. The medical necessity would be determined based on the patient's condition(s) and the status of the patient. A condition that has exacerbated and requires additional time to treat or counsel the patient, should include documentation of the status for the condition, along with the time spent.

Q13. Is there a department to obtain a specific account remit list that are offset?
A13. Offsets can be viewed in the Noridian Medicare Portal (NMP). Search under specific claim remittance, type in the provider information and the Internal Claim Number (ICN) claim number. The ICN is the financial control number (FCN) of the offset, minus the first two digits.

To look up what beneficiary a withholding (PLB reason code=WO), the NMP provides information under "Claim Specific Remittance Advice Inquiry". Type the provider information and ICN claim number in the details. Under "Financials", enter provider information and the letter number or ICN. This also provides the debt balance as well.

Q14. For COVID-19 mass vaccination sites, do we need to complete a Medicare Secondary Payer Questionnaire (MSPQ)?
A14. CMS determined in 2021 that the MSPQ would not be mandated for COVID vaccine administrations.

Q15. When a Skilled Nursing Facility (SNF) or Hospice patient is seen by another Part B provider for an outpatient, unrelated service, can we bill Medicare Part B?
A15. When a patient is in a SNF stay, a physician's professional service could be billed. Refer to the Consolidated Billing at CMS Skilled Nursing Facility (SNF) Consolidated Billing. For Hospice patients, if the patient is seen for a condition unrelated to their Hospice stay, providers may append modifier -GV (attending physician not employed or paid by patient's hospice provider) or -GW (service not related to hospice terminal condition).

Q16. Will HCPCS C1734 (orthopedic implantable device) be reimbursed with the J7 pass-through status code that is "Contractor Priced"? Are there pricing limitations and is there a policy?
A16. C1734 always requires an invoice, and this information can be found on Noridian's Claims page, Claim Submission Billing, Errors, and Solutions, "Avoiding Denials on Priced Per Invoice Claims". It can be billed with CPTs 27870, 28715, and 28725.

Currently, there is no Local Coverage Determination (LCD) or National Coverage Determination (NCD) policy attached to this code. A web page update on pass-through devices has been added.

Q17. How should we list CPTs when notes and medical necessity support units over the allowed MUE? Ex: if supported to bill 36 units of 11045, do you want 36 units on one line, or split by MUE (12) on three lines with or without modifiers -59 or -76? Since we appeal, does it matter?
A17. Yes, it does matter. If your practice is billing OVER the approved MUEs; none of them may be paid. This allows you to appeal with supporting documentation for all the "units." Billing on one line with all the units is preferred. See additional information on our Noridian claims MUE webpage under

- JE Claims Submission-Medically Unlikely Edits
- JF Claims Submission-Medically Unlikely Edits

Q18 Please clarify the use of modifier "CS" for COVID-19 and respiratory testing (CPTs 87631-87633)?
A18. Modifier -CS (cost-sharing) waiver is not an appropriate modifier for those tests. During the COVID-19 PHE, modifier -CS for COVID-19 testing-related services, is only allowed on evaluative services outlined in the Medicare Learning Network (MLN) Article, Special Edition (SE) 20011. Clinical lab tests on the Clinical Laboratory Fee Schedule (CLFS) already pay at 100 percent of the fee schedule allowed amount.

Q19. Our lab is seeing National Correct Coding Initiative (NCCI) edit denials and need compliant information on a) ordering provider chart notes needed? b) Must a lab bill for every target that it tests? c) Must the lab bill Medicare for all the services it provided?
A19. All lab services must contain one of the following:

- Signed order or requisition listing specific test
- Unsigned order or requisition, with authenticated medical record listing specific test(s) and authenticated medical record with physician's intent to order tests (e.g., "order labs", "check blood", "repeat urine")

Further documentation requirements for labs can be located in CMS' Medicare Learning Network (MLN) booklet at Complying with Laboratory Services Documentation Requirements.

All separately reportable services must be billed to Medicare in accordance with Section 1848(g)(4) of the Social Security Act. In accordance with the Internet Only Manual (IOM) Publication 100-04, Claims Processing, Chapter 12, Section 30(A); if a provider knows a service is bundled into another procedure, then they should not be separately reporting on a claim as they would already be receiving payment for the "comprehensive code." It would be the provider's responsibility to obtain an Advance Beneficiary Notice (ABN) or accept the denial.

Q20. Where can I find information on reconstructive eye surgery, including reporting grafts and flaps?
A20. Refer to the Local Coverage Determination (LCD) policy and its Billing and Coding Companion-Local Coverage Article (LCA) on Blepharoplasty, Eyelid Surgery and Brow Lift found on the Noridian Websites under Policies.

- Noridian JE Active LCDs
- Noridian JF Active LCDs

Q21. How can our appeals be allowed for HCPCS J1040, when we send in medical records for Medically Unlikely Edits (MUEs) over the approved amount?
A21. If your office is experiencing a large volume of MUE denials related to J codes, it is encouraged that verification of the correct units are being billed and appropriate dosing is administered by the provider. It is recommended that documentation submitted supports the medical reasonableness of the service(s) performed. Since MUEs associated with drugs (J codes) are typically set by the NCCI, based on the manufacturer's prescribing recommendations or CMS-approved drug compendia.

Q22. Where would Eyeglass prescription fall under Risk of Complications and/or Morbidity or Mortality of Patient Management? Can we count this as Prescription Drug Management or Low risk of morbidity?
A22. Eye exams for prescribing, fitting, or changing eyeglasses are considered a noncovered charge per the CMS' MLN booklet, Items & Services Not Covered Under Medicare. Eyeglass prescriptions would not meet drug management or count toward Medical Decision-Making (MDM) of a covered E/M. See the Risk definition included in the CPT 2022 book and on Noridian's website under the Browse by Specialty, E/M section.

Q23. For an urgent care E/M visit, would a referral to a specialist count as Low or Moderate risk?
A23. A notation in the medical record indicating another practitioner is treating, without additional assessment or care coordination, does not qualify for medical decision-making (MDM). Referral without evaluation (by history, exam, or diagnostic study{ies}) or consideration of treatment, also does not qualify for MDM as nothing is being addressed or managed. To assign your category of MDM, address the problem, utilize the problem level, amount, data complexity, and risk to the patient referred.

Q24. What are Noridian's billing guidelines when the amount of a medication (HCPCS J3111-Evenity, 210 mg) is split into two injections at 105 mg each), instead of administered as one injection on the same day? Would the CPT 96372 administration be billed on one line or two lines with the second line reflecting 96372-59?
A24. Bill 96372 on one line without modifier -59. Since the kit contains one dose of two injections, for a total of 210 mg, the administration covers both injections.

Q25. In Podiatry, if the patient has evidence of neuropathy; however, no vascular impairment, are class finding modifiers required? If one of these diagnoses is billed, is it payable with or without a class-finding Q modifier on the claim?
A25. The Local Coverage Article (LCA) from the NCD below shows Group diagnoses codes for neuropathy do NOT require a Q modifier to be paid. The Group 3 paragraph indicated the diagnosis below do require the Q modifier.

Providers must include a systemic condition diagnosis listed from the Internet Only Manual (IOM) 100-02, Chapter 15, Section 290. All claims for routine foot care, based on the presence of a systemic condition, must have a billing modifier of Q7, Q8 or Q9 to be considered for payment.

Read more at "Services Provided for the Diagnosis and Treatment of Diabetic Sensory Neuropathy with Loss of Protective Sensation (aka Diabetic Peripheral Neuropathy)" under National Coverage Determination (NCD) 290.2.

Q26. CPT 93319 (new 2022) is receiving an CCI edit when trying to bill CPT add on code +93325 (doppler echocardiography) and 93319 (3D echocardiographic imaging, etc.). We requested to have 93325 removed from the "do not report" parenthetical. However, this change may not take place until 2023. Will Noridian accept our current billing of 93325 and 93319?
A26. No. CMS requires Medicare Administrative Contractors (MACs) to follow the National Correct Coding Initiative (NCCI) edits. There is a current edit in place to deny CPT 93319 when billed with 93325.

If this edit is updated with the information you have indicated, Noridian will be able to allow 93319 when billed with 93325. If you have not already submitted a request to change this edit, follow the guidance provided on this website: National Correct Coding Initiative Edits.

Q27. Can we get clarification that Osteopathic Manipulation Treatment (OMT) procedures do or do not include initial evaluation and management (E/M) and appropriate billing when performed on the same date of service?
A27. CMS requires MACs to follow the National Correct Coding Initiative (NCCI) edits. There is a current edit in place to deny Evaluation and Management (E/M) codes when billed with Osteopathic Manipulative Treatment (OMT) codes 98925-98929. This edit is indicated as following CPT manual. You may refer to guidance provided in the 2022 CPT book and when modifier -25 may be appropriate to append to the E/M code.

Q28. Another physician who is caring for the patient requests that the outside image be re-read by one of our radiologists. The Medicare Claims Processing Manual, Chapter 13, Section 100.1 states that "Generally A/B MACs (B) must pay for only one interpretation of an EKG or X-ray procedure furnished to an emergency room patient. They pay for a second interpretation (identified through modifier "77"), only under unusual circumstances (for which documentation is provided); such as a questionable finding for which the physician performing the initial interpretation believes another physician's expertise is needed or a changed diagnoses resulting from a second interpretation of the results of the procedure". Does this same guidance regarding unusual circumstances, application of modifier -77 and additional documentation requirements apply outside of the emergency room (ER)?
A28. Medicare pays for only one read, even in the ER, unless it is medically necessary to have an additional read.

Q29. Does critical care state that the entire 30 minutes (over 74 minutes) must be spent to bill CPT 99292 by a single practitioner? What about in the same specialty, subsequent providers? When documentation shows 80 minutes of critical care, can the additional critical care (CPT 99292) be added to CPT 99291? Is it after 75 minutes spanning to 104 minutes?
A29. Yes. CMS allows providers, in the same specialty, to report concurrent follow-up care for subsequent critical care time intervals. IOM 100-04, Chapter 12, Section 30.6.12.4 follows the table on our website. "Once the cumulative required critical

care service time is met to report CPT code 99291, CPT code 99292 can **only** be reported, by a practitioner in the same specialty and group, when an **additional 30 minutes** of critical care services have been furnished to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes)."

To reiterate, first, there must be at least 30 minutes documented to be able to bill add-on code 99292. If we add 30 minutes to 74 minutes, 99292 can be reported at 104 minutes (not at 75 minutes). The follow up care that does not meet the critical care criteria does **not** get added.

For example, subsequent care Internist A = initial critical care, 70 min 99291 x 1. CPT 99291 would still be reported by one provider in **same specialty**, per DOS. Internist B = subsequent critical care later in the day, 90 minutes 99292 x 3.

Q30. Does a single practitioner have to provide 104 minutes of critical care, BEFORE they can bill 99291 and one unit of 99292?
A30. No. See Q/A #29 above. At least 74 minutes + 30 minutes = 104 total minutes, as the duration is between 75-104 minutes. Billing would read 99291 x 1 and 99292 x 1. The CMS Internet Only Manual (IOM) 100-04, Chapter 12, Sections 30.6.12.2 and 30.6.12.4, states 99292 for additional 30-minute time increments provided to the same patient.

For example, if Pulmonologist A = 20 mins. of critical care (unbillable as did not reach minimum time). Pulmonologist B = 30 mins. of critical care now qualifies with 50 total minutes, so one claim is billed with aggregated time for 99291. There is **no 99292 added** in this scenario.

VERBAL Q/A DURING ACT:

Q31. How do we get reimbursed when place of service (POS) 65 is denied for billing Transitional Care Management (TCM) CPT 99496 in the dialysis unit for End-Stage Renal Disease (ESRD) and Cardiokymography (CKG)?
A31. Place of service 65 is allowed for TCM when billed with 90960-90962 or 90970 on the same claim. The example provided appears to have denied because add on CPT 99496 was billed on its own in POS 65. It cannot be billed on its own if rendered in POS 65. The additional 909xx code would provide the information that your facility is treating this patient for the month. When the patient is part of the Kidney Innovation Model, the claim will process correctly with zero payment.

Q32. Claims are denied for the Home Sleep Study (HST) HCPCS G codes, with POS 11 and allowing POS 12. The home sleep study is done in the office setting up the patient, onsite visit in the office. Our doctor instructs the patient at the office how to use, then the patient takes the equipment home and returns the next day.
A32. POS 12 is correct when billing the HST with G0398 - G0400. This includes set up, take down, interpretation and report.

Q33. J7170 is one of the only medications covered by Medicare Part B and not DME. Patients would self-administer in the home just like hemophilia clotting factor. Does J7170 (Hemlibra-emicizumab-kxwh) fall under the home administration benefit and could a pharmacy bill?
A33. Noridian does have a Billing and Coding article entitled "Billing Limitations for Pharmacies" (A56124-Jurisdiction F). At this time, in the article it does allow Medicare Part B payment for J7170 when billed with Pharmacy (specialty A5). Please see the article for exact verbiage and guidance. Noridian had a glitch in the system that was preventing this from happening and is now rectified.

Q34. We have patients that have more than twelve diagnoses and our electronic medical records (EMR) only sends twelve at a time. We are part of a demonstration project for advanced illness process. Can you use this to send the additional diagnosis for a second claim unspecified E/M (CPT 99499) just to report the additional diagnosis?
A34. No. An additional code should not be billed just to report additional diagnosis. Only reflect the significant twelve "acting" codes. Medicare understands that patients may have several chronic conditions. The claim and paperwork for a demonstration may differ for that purpose.

Q35. We often treat patients with acute injuries or illnesses with ibuprofen 800 mg, etc. For the E/M MDM, does over the counter (OTC) at prescription drug strength qualifies for the risk?
A35. We do know high doses are provided and have impacts (i.e., kidney). The level of risk depends on the polypharmacy. There can be, depending on the situation, risk from OTC medications and can be included as one of the many factors involved in decision making.

Q36. Is CPT 99406 covered with diagnosis Z7891? Are you really counseling them to quit smoking?
A36. Please see Noridian's website under Preventive Services, Counseling to Prevent Tobacco Use for a list of diagnoses. Z87.891 (personal history of nicotine dependence), not Z7891 is listed. 99406 and 99407 replaced HCPCS G0436 and G0437

for symptomatic individuals. Patients must be using tobacco, competent and alert at time of counseling and furnished by qualified physician or another Medicare-recognized practitioner. See also the National Coverage Determination (NCD) at CMS NCD 210.4.1 Counseling to Prevent Tobacco Use.

Q37. Can the Medical Decision-Making (MDM) for prescription drug management in the electronic medical record (EMR) to show the success or change in strength and dosage?
A37. Place in the EMR where it cannot be misunderstood to prevent duplication. The more places you can list for safety of the patient, the better. It's a matter of quality of assurance for as many people taking responsibility for the patient have access to this information. The record needs to evidence what service was performed.

Q38. When billing an unlisted procedure, because there is no allowed CPT, how does Noridian make the decision if the service will be covered?
A38. Medicare would normally ask for additional records to support the service. Providers can fax, mail, or utilize the electronic additional documentation Paperwork (PWK). Read more at

- JE B Noridian Browse by Topic, Claim Submission, PWK
- JF B Noridian Browse by Topic, Claim Submission, PWK

Q39. When determining shared visits (new or established) and documenting time, is the mid-level advanced practice provider (APP) and MD required to document their total time or can the MD reflect they performed substantive time without documenting minutes? Since split and shared services are inpatient, how will Noridian look at this if their specific time in minutes is not documented. If they are billing based on time, and the MD said "performed substantive portion of time" but didn't have minutes spent, would Noridian accept this?
A39. Since critical care is a time-based code, the physician's progress note must contain documentation of the total time involved providing critical care service. Critical Care is based on time. You can bill based on 50 percent or more time, counseling of care or the history and physical (H&P) exam which doesn't require time. If time is not listed, we'd have to default to the other elements. Time would have to be documented by the MD and APP with total time by each provider in the record to bill time-based code. Also, the basis for critical care documented. Do not reflect "not reported".

Q40. We have several denials for 0296T, 93242 or 93246 depending on length of the recording. Physicians bill 93000 (EKG) and then determining if the patient needs the placement. Medicare is not allowing per the NCCI edits.
A40. CPT 93000 bundles with 9324X codes. Modifier -59 can be added to unbundle IF they do not relate and are independent services. Also, check to see if the EKG should have only been billed as technical (93005) or professional (93010). See also Q/A #41 below.

Q41. Can Noridian provide guidance on billing 93242 (cardiovascular ECG monitoring-more than 48 hours-up to 7 days) or 93246 (cardiovascular ECG monitoring-more than 7 days-up to 15 days) with 93000 (Electrocardiogram, routine ECG with at least 12 leads; with interpre¬tation and report)? Since moving from temporary 0296T status, our office is having a difficult time getting the ZIO XT heart monitor placement with a separate EKG, paid on the same DOS.
A41. See also Q/A #40 above. You may want to look at CPT 93241 instead. Per NCCI, 93242 and 93246 can never be billed together, because of a "zero" indicator. However, 93000 can be unbundled with modifier -59, when billed with either 93242 or 93246. Also, take a look at the National Coverage Determination: NCD 20.15 Electrocardiographic Services and under Billing and Coding: Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring.

Q42. We have issues with unlisted codes rejecting through our clearinghouse. How do we get unlisted code claims through for (e.g., 77399) with a modifier -26?
A42. Do not append modifiers to unlisted codes. That is the reason it is rejecting. Explain in the narrative field (Item 19) that this is for the professional only (-26) and in the documentation.

Q43. For Medicare acupuncture supervision of the chronic low back pain, does the physician need to be in the same building, as opposed to somewhere on the campus with more than one building? What is required for supervision vs. remote supervision (with real time audio-video) allowed for a short term due to public health emergency (PHE)? There could be other physicians who are not supervising in the same building.
A43. Direct supervision means the supervising physician must be in the same building; in fact, usually on the same floor, to be "immediately available to assist". Be careful of "appropriate level of supervision". Here's the link at NCD 30.3 Acupuncture. All indications for acupuncture outside of NCD section 30.3.3 remain non-covered. Medicare patients must receive acupuncture from a doctor, or by another health care provider (like a nurse practitioner or physician assistant) who has both of these:

- Masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation

Commission on Acupuncture and Oriental Medicine

- Current, full, active, and unrestricted license to practice acupuncture in state where providing care

Q44. Physicians will perform deep sedation (especially with pediatric patients), instead of moderate sedation. CCI edits bundle when the same physician is performing medical treatment and sedation (e.g., fracture reduction or shoulder dislocation-CPT 23655) and cannot bill moderate. Medicare does not allow separate payment for anesthesia except with limited exceptions. The doctor is performing a riskier sedation at a reduced reimbursement. How can we receive additional reimbursement?
A44. This should not be performed by the physician and would be denied in appeal. It would not be expected that a physician reducing the shoulder would be conducting the deep or general anesthesia. Depending on the patient status, the provider may have to prove that situation through an appeal. These types are set up as general anesthesia which is considered deep sedation.

Advance Beneficiary Notice of Noncoverage On-Demand Tutorials Available

Noridian offers self-paced training tutorials to assist providers and facilities in better understanding the Advance Beneficiary Notice of Noncoverage (ABN). View ABN-related tutorials on our Education-on-Demand Tutorials webpage.

- ABN Common Questions - October 2021, 7 minutes
- ABN Form Completion - August 2020, 10 minutes
- ABN Modifiers and Tips - July 2020, 5 minutes
- ABN Overview - August 2020, 8 minutes

Providers and facilities are encouraged to attend our webinars and view tutorials to assist with proper billing and team member education. Noridian appreciates the provider feedback received through our satisfaction surveys, including the request for outreach on ABNs and the production of more tutorials.

Ambulance Prior Authorization Model Expands August 1

On August 1, 2022, the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model will expand.

- Alaska, Arizona, Idaho, Kentucky, Montana, North Dakota, Ohio, Oregon, South Dakota, Utah, Washington, and Wyoming
- Nationwide for Railroad Retirement Board patients

Visit the CMS Prior Authorization and Pre-Claim Review Initiatives webpage for the timeline, updates, and other information.

Noridian Resources

- Education-on-Demand Tutorial, Prior Authorization of Repetitive, Scheduled Non-emergent Ambulance Transport (RSNAT)
- Webinar-on-Demand Recording, Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance (RSNAT)

Source:

- CMS MLN Connects dated June 23, 2022

Anesthesia CPT 00537 for 2022 Services Underpaid - Resolved 04/06/22

Provider/Supplier Type(s) Impacted: All providers billing CPT 00537

Reason Codes: n/a

Claim Coding Impact: 00537

Description of Issue: The 2022 Anesthesia Base Unit (ABU) for 00537, which is provided by CMS, was not updated for dates of service starting 01/01/22. This has resulted in claims being underpaid.

Noridian Action Required: The ABU will be updated and affected claims reprocessed.

Provider/Supplier Action Required: There is no provider action.

Proposed Resolution/Solution: The 2022 ABU for CPT 00537 was updated on 03/14/22. Noridian will identify the underpaid claims and reprocess them.

04/06/22 - Noridian initiated the mass adjustments on 03/31/22.

Date Reported: 03/17/22

Date Resolved: 04/06/22

Biosimilars: Safe, Effective, & May Reduce Patient Costs

Biosimilars are safe and effective for treating many illnesses, including chronic skin diseases, inflammatory bowel diseases, arthritis, kidney conditions, diabetes, and cancer. Get an FDA Overview of Biosimilar Products. Bookmark FDA's Biosimilars webpage and materials for health care providers and patients.

Additional FDA resources you may find helpful:

- Interchangeable Biological Products
- Biosimilar Regulatory Review and Approval (PDF)

Source: CMS MLN Connects, dated May 19, 2022

C1833 - Priced per invoice

C1833, *Monitor, cardiac, including intracardiac lead and all system components (implantable)*, is priced per invoice. This update is effective for dates of service January 1, 2022 and after. More information on how to submit an invoice can be found on our Avoiding Denials on Priced per Invoice Claims page.

Chronic Care Management Services - Revised

Learn about billing and coding changes in the CMS Chronic Care Management Services MLN Booklet.

- In 2021, CMS added 5 codes to report principal care management services provided by staff under physician supervision
- Starting in 2022, Rural Health Clinics and Federally Qualified Health Centers can bill chronic care management and transitional care management services for the same patient during the same time
- Starting in 2022, 99439 replaced G2058

This booklet includes information on the topics of supervision, patient eligibility, initiating visits, patient consent, comprehensive care plan, concurrent billing, and many other resources.

Source: CMS MLN Connects, dated May 19, 2022

CMS MLN Outpatient Rehabilitation Therapy Fact Sheet

The Complying with Outpatient Rehabilitation Therapy Documentation Requirements fact sheet has been updated to include modifiers CO and CQ. This resource can be accessed on the CMS CERT A/B MAC Outreach & Education Task Force webpage.as well as on the MLN website.

Cognitive Assessment: What's in the Written Care Plan?

Do you have a patient with a cognitive impairment? Medicare covers a separate visit for a cognitive assessment so you can more thoroughly evaluate cognitive function and help with care planning. Any clinician eligible to report evaluation and management services can offer this service, including: physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants.

The Cognitive Assessment & Care Plan Services (CPT code 99483) typically start with a 50-minute face-to-face visit that includes a detailed history and patient exam. Use information you gather from the exam to create a written care plan.

The resulting written care plan includes initial plans to address:

- Neuropsychiatric symptoms
- Neurocognitive symptoms
- Functional limitations
- Patient or caregiver referrals to community resources, as needed, with initial education and support

Effective January 1, 2022, Medicare pays approximately $283 (may be geographically adjusted) for these services when provided in an office setting.

Get details on Medicare coverage requirements and proper billing on the CMS Cognitive Assessment & Care Plan Services website.

Source: CMS MLN Connects dated June 23, 2022

Cognitive Impairment: Medicare Provides Opportunities to Detect and Diagnose

Do you have a patient with a cognitive impairment? Medicare covers a separate visit for a cognitive assessment, so you can more thoroughly evaluate cognitive function and help with care planning. Three things you need to know:

1. If your patient shows signs of cognitive impairment at an Annual Wellness Visit or other routine visit, you may perform a more detailed cognitive assessment and develop a care plan
2. Cognitive Assessment & Care Plan Services (CPT code 99483) typically start with a 50-minute face-to-face visit that includes a detailed history and patient exam, resulting in a written care plan
3. Any clinician eligible to report evaluation and management services can offer this service, including: physicians (MD and DO), nurse practitioners, clinical nurse specialists, and physician assistants

Effective January 1, 2022, Medicare pays approximately $283 (may be geographically adjusted) for these services when provided in an office setting.

Get details on Medicare coverage requirements and proper billing at cms.gov/cognitive.

Source: CMS MLN Connects dated March 31, 2022

Collaborative Patient Care is a Provider Partnership

As a physician, supplier, or other health care provider, you may need to collaborate with other providers when providing care to your Medicare patients. For example, you may write orders, make referrals, and request health care services or items for your patients. It's important to understand Medicare coverage criteria and documentation requirements that apply for those services or items to help ensure quality care for your patient and accurate and timely processing and payment. Learn about coverage criteria and documentation when you partner with others to care for your patient.

- If you don't provide enough information to support medical necessity when you refer or write orders, the other provider or supplier may not get paid, which can cause delays or no treatment for your patient.
- You must provide documentation and information to other health care providers to support their claims for services or items.

- You can give protected health information, without patient authorization, to other health care providers covered under the privacy rule to carry out treatment, payment, or health care operations.

Resource: CMS MLN Fact Sheet Learn Collaborative Patient Care is a Provider Partnership

Source: CMS MLN Connects dated April 14, 2022

COVID-19: New Administration Code 0074A for Pfizer Pediatric Vaccine Booster Dose

On May 17, 2022, the FDA amended the Pfizer-BioNTech COVID-19 vaccine emergency use authorization (PDF) to authorize the use of a single booster pediatric dose (orange cap) for all patients 5-11 years old. CMS issued a new code, effective May 17, 2022, for the vaccine administration:

Code: 0074A

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation
- Short descriptor: ADM SARSCV2 10MCG TRS-SUCR B

For more information, visit the COVID-19 Provider Toolkit, and get the most current list of billing codes, payment allowances, and effective dates. (Note: you may need to refresh your browser if you recently visited these webpages).

Source: CMS MLN Connects dated May 26, 2022

COVID-19: New Codes for Moderna Vaccine Booster Doses

On March 29, 2022, the FDA amended the Moderna COVID-19 vaccine emergency use authorization (PDF), including new packaging for vaccine boosters (blue cap). CMS issued new codes, effective March 29, 2022, for the vaccine booster (91309) and administration (0094a).

Code: 91309

- Long descriptor: Severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use
- Short descriptor: SARSCOV2 VAC 50MCG/0.5ML IM

Code: 0094A

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose
- Short descriptor: ADM SARSCOV2 50 MCG/.5 MLBST

For more information, visit the CMS COVID-19 Provider Toolkit, and get the most current list of billing codes, payment allowances, and effective dates. (Note: you may need to refresh your browser if you recently visited these webpages).

Source: CMS MLN Connects dated April 14, 2022

DMEPOS Items: Medical Record Documentation

For Medicare to cover any Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) item, the patient's medical record must include enough documentation to justify the need for the a) type and quantity of items ordered and b) frequency of use (or replacement if applicable). The medical record should include the patient's diagnosis and:

- Condition duration
- Clinical course (worsening or improving)

- Prognosis
- Nature and extent of functional limits
- Other therapeutic interventions and results
- Experience with related items

The medical record may include records from hospitals, nursing facilities, home health agencies, and other health care professionals.

See Section 5.9 of the Medicare Program Integrity Manual, Chapter 5 (PDF) for more information.

Source: CMS MLN Connects dated April 21, 2022

Improper Use of Modifier GY and Bundled Services

Noridian has seen a large volume of status (B) bundled CPT codes billed with the addition of modifier GY. The modifier is being incorrectly used to circumvent the financial liability of the provider to the beneficiary.

You can find the status indicator of most CPT codes on the Medicare Physician Fee Schedule (MPFS) provided in the resources at the bottom of this page.

Example of bundle (B) code listing on fee schedule:

Code	Mod	S	GLB	Pre-OP Percent	Intra-OP Percent	Post-OP Percent	P/T	M	B	A	C	T	ICI	PSDP	ENDO Base
99072	blank	B	XXX	000000	000000	000000	9	9	9	9	9	9	9	09	blank

- CPT 99072 - Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency as defined by law, due to respiratory-transmitted infectious disease.

CMS Status "B" or bundled service means:

- Payment for these services always bundle into payment for other services
- There are no RVUs, or payment amounts for these codes and no separate payment is allowed
- Providers may not bill the beneficiary for this service
- Issuing an **Advanced Beneficiary Notice related to this service is not an option**
- Usage of the GY is for statutorily excluded services and not appropriate for bundled services

For Medicare purposes the codes with a status indicator of (B) should never be unbundled using any sort of modifier and the liability is the providers as the items and services are already part of the payment to other service(s) performed on that day and are not separately payable.

RESOURCES:

- 2022 MPFS Indicator List and Descriptors JE Part B
- Modifier GY
- IOM 100-04, Chapter 30, Section 50.9 ABN

Kidney Health: Help Address Disparities

About 15% of adults have chronic kidney disease. It's most common in Medicare patients and disproportionately affects Black, American Indian/Alaskan Native, and Hispanic patients. During National Kidney Month, learn about preventive services, and find out how to advance health equity.

Medicare covers preventive services for the 2 most common causes of chronic kidney disease: diabetes and high blood pressure. Your patients pay nothing if you accept assignment.

More Information:

- Medicare Preventive Services educational tool
- CMS Office of Minority Health, Health Observances webpage
- Preventive & Screening Services webpage: Get information for your patients

Source

- CMS MLN Connects dated March 17, 2022

Laboratory Claims Submitting with a CLIA Number

Starting June 24, 2022, claims submitted with more than one CLIA number will be denied as unprocessable.

More information can be found within the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 16, Section 70.10.

May is Mental Health Month

There are many issues that impact continuity of care when you have a patient with Mental Health issues impacting their medical and social life and this can be greatly increased when there are chronic pain issues. CMS has created a visual to help you meet the beneficiary where they are in their journey.

Sources: CMS MLN Connects dated May 12, 2022

- CMS Chronic Pain Experience Visual
- CMS Addressing & Improving Behavioral Health
- CMS CCI Fact Sheet Behavioral Health

Medicare Cards Without Full Names

Due to a character limit, some Medicare cards don't display patients' full names. According to section 10.2 of the Medicare Claims Processing Manual, Chapter 26, you should, "Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card."

Your claims will still process using the name displayed on the patient's Medicare card, even if it isn't their full name.

Source: CMS MLN Connects dated May 12, 2022

Medicare Coverage for Monoclonal Antibodies for Alzheimer's Disease

The Centers for Medicare and Medicaid Services (CMS) published a National Coverage Analysis (NCA) decision memo on April 7, 2022. The NCA only allows Medicare coverage for monoclonal antibodies for treatment of Alzheimer's disease, to beneficiaries that are participating in a CMS approved clinical trial. Aduhelm was recently approved by the Food and Drug Administration (FDA) and would need to follow the coverage criteria included in the NCA. Claims for these drugs with dates of service on or after April 7, 2022 will be denied for payment unless the beneficiary is actively enrolled in and receiving the treatment from a bona fide clinical trial with evidence development as required in the NCA.

NCA - Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (CAG-00460N) - Decision Memo (cms.gov)

Men's Health: Talk to Your Patients About Preventive Services

During Men's Health Week, encourage your male patients to make their health a priority. Medicare covers preventive services, including:

- Alcohol misuse screening & counseling
- Cancer screening: colorectal and prostate
- Cardiovascular disease: screening tests and intensive behavioral therapy (IBT)
- Counseling to prevent tobacco use
- IBT for obesity

Your patients pay nothing if you accept assignment. Review the CMS Checking Medicare Eligibility MLN Fact Sheet to learn how to check eligibility for preventive services. If you need help, contact your eligibility service provider.

More Information

- Medicare Preventive Services educational tool
- Coverage to Care Prevention Resources: See flyer for men in eight languages
- Preventive & Screening Services webpage: Get information for your patients
- Noridian Medicare Portal (NMP) User Guide - Eligibility Benefits
- NMP Eligibility Education-on-Demand Tutorial

Source

- CMS MLN Connects dated June 16, 2022

Mental Health Help: Address Disparities

Depression affects about 16 million American adults every year. Frequency varies by age, sex, race, ethnicity, and geographic area. During Mental Health Month, learn about preventive services, including depression screening and alcohol misuse screening & counseling, and find out how to advance health equity.

Medicare covers preventive services, and your patients pay nothing if you accept assignment. Learn how to check eligibility (PDF) for preventive services. If you need help, contact your eligibility service provider.

More Information:

- Medicare Mental Health booklet
- Achieving Health Equity web-based training
- Roadmap to Behavioral Health (PDF)
- CMS Behavioral Health Strategy webpage
- Preventive & Screening Services webpage: Get information for your patients
- Noridian Medicare Portal (NMP) User Manual Eligibility Inquiries
- NMP Eligibility Tutorial (on YouTube; some advertisements may appear)

Source: CMS MLN Connects, dated May 19, 2022

Modifier Basics and Miscellaneous Modifiers - On-Demand Tutorials Available

Noridian is offering a self-paced training tutorial to assist providers and facilities in better understanding appropriate usage of modifiers. This tutorial will walk you through how to use modifiers correctly when having more than four modifiers, disasters, Health Professional Shortage Areas (HPSA), substitute and teaching hospitals, and claim form placement.

Education on Demand Tutorials

- Modifier Basics and Miscellaneous Modifiers

Providers and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education. Noridian appreciates the provider feedback received through our satisfaction surveys, including the request for outreach on modifiers and the production of more tutorials.

Ordered, Referred, and Prescribed Services - On-Demand Tutorial Available

Noridian offers a self-paced training tutorial to assist providers and facilities in better understanding ordered, referred, and prescribed services. This Noridian Medicare presentation covers claim form and enrollment requirements, services which mandated a referral or order, eligible and ineligible professionals to order services, limitations on referrals from select professionals, opting out of Medicare. It addresses acceptable orders, intent, medical documentation, common errors, coverage policies and resources.

Education on Demand Tutorials

- Ordered, Referred, and Prescribed Services

Providers and facilities are encouraged to attend our webinars and view other tutorials available to assist with proper billing and team member education. Noridian appreciates the provider feedback received through our satisfaction surveys, including the request for production of more tutorials.

Repetitive, Scheduled Non-Emergent Ambulance Transports (RSNAT) Delays - Resolved 04/22/22

Provider/Supplier Type(s) Impacted: Ambulance suppliers

Reason Codes: N/A

Claim Coding Impact: A0426, A0428

Description of Issue: Noridian is aware of issues involved with the implementation of the RSNAT program. Noridian is actively processing a higher volume of pending RSNAT workloads to reduce delays ambulance suppliers may be experiencing with claims processing.

Noridian Action Required: Noridian is processing the higher volume of workloads and plans to have the backlog finalized by April 15.

Provider/Supplier Action Required: Ambulance suppliers should monitor their remittance advices and any other communications received regarding the RSNAT program to determine if any actions should be taken.

Proposed Resolution/Solution: The backlog of workloads will be finalized by April 15.

Date Reported: 04/11/22

Date Resolved: 04/22/22

Surgical Dressings: Medicare Requirements

Medicare covers primary or secondary surgical dressings when used to protect or treat a wound and if needed after you debride a wound.

You must:

- Include clinical information in patients' medical records that demonstrates a reasonable and necessary need for the type and quantity of surgical dressings
- Evaluate the wound monthly and update the record, unless you document why you cannot do a monthly evaluation and how you are monitoring the patient's ongoing use of dressings

For more information, see the Surgical Dressings - Policy Article.

Source: CMS MLN Connects dated May 26, 2022

Telehealth Place of Service Code

Effective for date of service on or after January 1, 2022, the Center for Medicare and Medicaid Services (CMS) allowed the new telehealth place of service (POS) code 10 - telehealth provided in patient's home. The telehealth POS change was implemented on April 4, 2022.

CMS has implemented this change to meet the needs of the Healthcare Industry and adopted the ASC X12N 837 professional standards required for electronic claim transactions. CMS will continue to accept POS 02 for all telehealth services. However, if a claim is received with POS 10 indicating the telehealth service was performed in the patient's home, the service will process appropriately.

- POS 02: Telehealth Provided Other than in Patient's Home
  Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. The patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS 10: Telehealth Provided in Patient's Home
  Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology

CR 12427 states, Medicare hasn't identified a need for new POS code 10. MACs will instruct providers to continue to use the Medicare billing instructions for Telehealth claims in the Internet Only Manual, 100-04, Chapter 12, Section 190.

CR 12427

CR 12549

Website Feedback and Cookies

Does it seem like you are being asked to provide feedback every day? The Noridian Website Experience survey is designed to be presented every 30 days once a survey has been completed, and every 15 days if the survey invitation is declined. These surveys use "cookies" on your internet browser to determine when the survey will be presented. A cookie is a piece of information that is sent to your browser when you access a website. Your facility's network or browser may delete these cookies daily. If this is the case, the survey cookie is no longer on your computer which causes the survey to be presented more than designed. Check with your facility's IT professionals for your company's cookie standards.

To learn more about cookies view the "Cookies" section of the Noridian Privacy Policy.

Women's Health: Talk to Your Patients About Preventive Services

During National Women's Health Week and National Osteoporosis Month, encourage your female patients to make their health a priority. Medicare covers preventive services to address women's unique health concerns, including:

- Bone mass measurements
- Cervical cancer screening
- Mammography screening
- Pap test screening
- Sexually transmitted infection screening & counseling
- Screening pelvic exams

Your patients pay nothing if you accept assignment. Learn how to check eligibility for preventive services. If you need help, contact your eligibility service provider.

More Information:

- Medicare Preventive Services educational tool
- CDC Women's Health webpage
- Coverage to Care Prevention Resources: See flyer for women in 8 languages
- Preventive & Screening Services webpage: Get information for your patients

Source:

- CMS MLN Connects, dated May 12, 2022

MEDICAL POLICIES AND COVERAGE.....

BDX-XL2 (L37054) - R3 - Effective April 28, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L37054
LCD Title: BDX-XL2
Effective Date: April 28, 2022
Summary of Changes:
Under LCD Title revised to BDX-XL2. Under Coverage Indications, Limitations and/or Medical Necessity removed the verbiage "Boulder, CO". Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD.

Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests and §80.1.1 Certification Changes.

Under Bibliography changes were made to citations to reflect AMA citation guidelines. Registered marks were added throughout the LCD where applicable. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were defined and inserted where appropriate throughout the LCD.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the "Active LCD" Webpage.

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

Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices - R9 - Effective April 1, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: 04/01/2022
Summary of Article: The following update was made to this coverage article. Added 02WA4QZ to the Group 1 ICD-10-PCS codes effective 04/01/2022 per CR 12480.

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

Billing and Coding: BDX-XL2 (A57356) - R2 - Effective April 28, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: April 28, 2022
Summary of Article Changes:
Under Article Title revised to BDX-XL2. Under Article Text revised title to BDX-XL2. Formatting, punctuation, and typographical errors were corrected throughout the article.

Noridian has modified certain language in this article to mirror the language used presently by the MolDX team at Palmetto GBA as part of an annual review. Revision history dates and language may not exactly match the MolDX PGBA revision history but is updated with the revisions made in an accurate timeline. However, these revisions do not change coverage or guidance.

10.22.2020: Under CMS National Coverage Policy §60.1.2 and §60.2 were added to CMS Internet-Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 16 and added regulation CMS Internet-Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.0, §80.1.1, and §80.1.2. Formatting, punctuation, and typographical errors were corrected throughout the article.

10.17.2019: This article is being revised in order to adhere to CMS requirements per chapter 13, section 13.5.1 of the Program Integrity Manual, to remove all coding from LCDs and incorporate into related Billing and Coding Articles. Regulations regarding billing and coding were removed from the CMS National Coverage Policy section of the related MolDX: BDX-XL2 L37031 LCD and placed in this article. Under Article Text removed ICD-10 code R91.1 from the last bullet. Under CPT/HCPCS Modifiers added Group 1: Paragraph and KX under Group 2: Codes. Under ICD-10 Codes that Support Medical Necessity added Group 2: Paragraph and ICD-10 code R91.8 under Group 2: Codes

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: Complex Drug Administration Coding (A58532) - R8 - Effective June 11, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: June 11, 2022
Summary of Article Changes: J0491 anifrolumab-fnia was added under Infusions Non-Chemotherapy Generic/Trade Names table and to CPT/HCPCS Codes Group 2 Codes. J0248 was also added to the CPT/HCPCS Codes Group 2 Codes.

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

Billing and Coding: Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification (NAATs) (A56706) Retirement - Effective June 1, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 1, 2022
Summary: This article is being retired because the information in this article has been incorporated within the Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing A58720 article.

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

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R8 - Effective April 1, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: April 1, 2022
Summary of Article Changes: Updated price for Prialt (Ziconotide) per quarterly ASP Drug File. Effective 04/01/2022 - 06/30/2022, Prialt (Ziconotide) will be $8.998. Ropivacaine ASP is unchanged from January quarter.

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

Billing and Coding: MolDX: APC and MUTYH Gene Testing (A57352) Retirement - Effective August 08, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: August 08, 2022
Summary: The information in this article has been incorporated within the Billing and Coding: MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679.

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

Billing and Coding: MolDX: BRCA1 and BRCA2 Genetic Testing (A57354) Retirement - Effective August 08, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: August 08, 2022
Summary: The information in this article has been incorporated within the Billing and Coding: MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679.

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

Billing and Coding: MolDX: ConfirmMDx Epigenetic Molecular Assay (A57605) Retirement - Effective August 08, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: August 08, 2022
Summary: The information in this article has been incorporated within the Billing and Coding: MolDX Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer A58718.

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

Billing and Coding: MolDX: Cystatin C Measurement (A57643) - R3 - Effective June 09, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 09, 2022
Summary of Article Changes:
Under Article Title revised the title to read Billing and Coding: Lab: Cystatin C Measurement. Under Article Text revised title to Lab: Cystatin C Measurement. Formatting and punctuation were corrected throughout the article.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.

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.

Billing and Coding: MolDX: DecisionDx-UM (Uveal Melanoma) (A57621) - R3 - Effective June 30, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: June 30, 2022
Summary of Article Changes: Formatting, punctuation, and typographical errors were 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.

Billing and Coding: MolDX: Genetic Testing for Lynch Syndrome (A54995) Retirement - Effective August 08, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: August 08, 2022
Summary: The information in this article has been incorporated within the Billing and Coding: MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679.

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

Billing and Coding: MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer (A58679) Final Billing and Coding Article - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: A58679
Billing and Coding Article Title: Billing and Coding MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer
Effective Date: August 08, 2022
Summary of LCA: The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972

Visit the Proposed LCDs webpage to access this Billing and Coding Article.

Billing and Coding: MolDX: Melanoma Risk Stratification Molecular Testing (A57268) Final Billing and Coding Article - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: A57268
Billing and Coding Article Title: Billing and Coding MolDX: Melanoma Risk Stratification Molecular Testing
Effective Date: August 08, 2022
Summary of LCA: The information in this article contains billing, coding, or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Melanoma Risk Stratification Molecular Testing L37750.

Visit the Proposed LCDs webpage to access this Billing and Coding Article.

Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58718) Final Billing and Coding Article - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number/Contractor Determination Number: A58718
Billing and Coding Article Title: Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer
Effective Date: August 08, 2022
Summary of LCA: The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer L39005

Visit the Proposed LCDs webpage to access this Billing and Coding Article.

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT) (A57526) - R6 - Effective April 17, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: April 17, 2022
Summary of Article Changes:
Under CPT/HCPCS Codes Group1: Codes deleted 81599.

Under CPT/HCPCS Codes Group 2: Paragraph added the verbiage, “The following CPT codes require a Z-code if the testing is molecular (DNA/RNA) based.”

Under CPT/HCPCS Codes Group 2: added codes 81599 AND 87999.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R3 - Effective June 02, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 02, 2022
Summary of Article Changes:
Under CPT/HCPCS Codes Group 6: Codes deleted 0151U. **Under CPT/HCPCS Codes Group 7**: Codes deleted 0097U. This revision is due to the Q2 CPT/HCPCS Code Update and is effective for dates of service on or after 4/1/2022.

Under **Article Text** revised first and second bullet verbiage to add "or PLA" and deleted third and fourth bullet verbiage. Revised fifth bullet verbiage to add, "and a TA." Deleted the sixth and seventh bullet verbiage. Added two new bullet verbiages, "Tests that are FDA-approved/cleared and performed in ways consistent with their intended-use labeling directions do not require a Z-code when billed with an appropriate accompanying ICD-10 code. However, the performance of multiple (>1) FDA-approved/cleared molecular Infectious Disease pathogen identification tests on the same date of service (DOS) for the same intended use on the same patient sample is considered as one distinct service. As such, it would require the use of CPT® code 87999. Tests using CPT® code 87999 will require a Z-code and a TA." And "Add modifier 59 for different species or strains reported by the same code, as allowed by the policy." Revised Additional Information nineth bullet verbiage to "Places of service (POS) 19, 21, 22, 23 OR" and "(for healthcare POS other than the POS listed in 1 (a)." **Under CPT/HCPCS Group 1: Paragraph** deleted second sentence. **Under CPT/HCPCS Codes Group 1**: Codes added 87801. **Under CPT/HCPCS Group 2: Paragraph** deleted second sentence. **Under CPT/HCPCS Group 3**: Paragraph deleted second sentence. Under CPT/HCPCS Group 4: Paragraph deleted second sentence. **Under CPT/HCPCS Group 5**: Paragraph deleted second sentence. **Under CPT/HCPCS Group 5**: Codes deleted 87623, 87624, and 87625. **Under CPT/HCPCS Group 6**: Paragraph deleted third sentence. Revised fourth sentence to add "POS 19, 21, 22, 23" and "(for healthcare POS other than those listed in (a)." **Under CPT/HCPCS Group 6**: Codes added 87801. **Under CPT/HCPCS Group 7**: Paragraph deleted third sentence. Revised fourth sentence to add "POS 19, 21, 22, 23" and "(for healthcare POS other than those listed in (a)." **Under CPT/HCPCS Group 8**: Paragraph added verbiage, "Conditionally Non-covered CPT codes: The following CPT codes are NOT covered for a given beneficiary on the same DOS when >1 is billed in combination with another CPT or PLA code from Groups 1-7 for the same intended use. Additionally, the following CPT codes are NOT covered for a given beneficiary on the same DOS when >2 are billed for the same intended use." **Under CPT/HCPCS Group 8**: Codes added U0001, U0002, U0003, U0004, U0005, 87471, 87472, 87475, 87476, 87480, 87481, 87482, 87485, 87486, 87487, 87490, 87491, 87492, 87493, 87495, 87496, 87497, 87498, 87501, 87502, 87503, 87510, 87511, 87512, 87516, 87517, 87520, 87521, 87522, 87525, 87526, 87527, 87528, 87529, 87530, 87531, 87532, 87533, 87534, 87535, 87536, 87537, 87538, 87539, 87540, 87541, 87542, 87550, 87551, 87552, 87555, 87556, 87557, 87560, 87561, 87562, 87563, 87580, 87581, 87582, 87590, 87591, 87592, 87623, 87624, 87625, 87634, 87635, 87640, 87641, 87650, 87651, 87652, 87653, 87660, 87661, 87662, 87797, 87798, and 87799. **Under CPT/HCPCS Modifiers Group 8**: Codes added 59. **Under ICD-10 Codes that Support Medical Necessity Group 3**: Codes added B60.2. **Under ICD-10 Codes that Support Medical Necessity Group 5**: Codes added N76.89, N77.1, and N89.8. This revision is effective 06/02/2022.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: MolDX: Molecular Testing for Solid Organ Allograft Rejection (A58168) - R2 - Effective March 24, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: March 24, 2022
Summary of Article Changes:

Under Article Text revised the table to add the last row for QSant™ (NephroSant). This revision is retroactive effective for dates of service on or after 7/4/2021.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (A57338) Retirement - Effective June 1, 2022

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 1, 2022
Summary: This article is being retired because the information in this article has been incorporated within the Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing A58720 article.

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

Billing and Coding: MolDX: Next-Generation Sequencing Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies (A57891) - R3 - Effective February 24, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: February 24, 2022
Summary of Article Changes: Under ICD-10 codes that support medical necessity Group I: Codes added C92.90, C92.91, C92.92, C93.90, C93.92, D46.4, D46.9, D61.9, D64.9, and D69.6. The deletion of these codes in Revision 1 was done in error and is retroactive effective for dates of service on or after 7/8/2021.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: MolDX: Pharmacogenomics Testing (A57384) - R4 - Effective April 28, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: April 28, 2022
Summary of Article Changes:
Under **Article Text**, revised Table 2 to add the verbiage, "or Neuropsychiatric."

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: MolDX: Phenotypic Biomarker Detection from Circulating Tumor Cells (A58183) - R2 - Effective June 02, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 02, 2022
Summary of Article Changes:
Under *CMS National Coverage Policy* added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts with Independent Clinical Laboratories.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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.

Billing and Coding: MolDX: Progensa® PCA3 Assay (A54489) Retirement - Effective August 08, 2022.

This coverage article has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: August 08, 2022
Summary: The information in this article has been incorporated within the Billing and Coding: MolDX Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer A58718.

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

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R3 - Effective May 12, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: May 12, 2022
Summary of Article Changes:
Under CPT/HCPCS Codes Group 1: Codes added 0318U. This revision is due to the Q2 CPT/HCPCS Code Update and is effective for dates of service on or after 4/1/2022.

Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, §60.1.2 Independent Laboratory Specimen Drawing, §60.2 Travel Allowance. Under CPT/HCPCS Codes Group 1: Codes deleted 81340, 81341, and 81342. Added 81220, 81221, 81222, 81223, 81224, 81419, 81493, 81554, 0001U, 0004M, 0012U, 0029U, 0030U, 0031U, 0032U, 0033U, 0034U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0078U, 0079U, 0084U, 0094U, 0101U, 0102U, 0103U, 0129U, 0130U, 0131U, 0132U, 0133U, 0134U, 0135U, 0136U, 0137U, 0138U, 0156U, 0157U, 0158U, 0159U, 0160U, 0161U, 0162U, 0169U, 0170U, 0173U, 0175U, 0180U, 0181U, 0182U, 0183U, 0184U, 0185U, 0186U, 0187U, 0188U, 0189U, 0190U, 0191U, 0192U, 0193U, 0194U, 0195U, 0196U, 0197U, 0198U, 0199U, 0200U, 0201U, 0203U, 0205U, 0209U, 0212U, 0213U, 0214U, 0215U, 0216U, 0217U, 0218U, 0221U, 0222U, 0230U, 0231U, 0232U, 0233U, 0234U, 0235U, 0236U, 0237U, 0238U, 0246U, 0258U, 0260U, 0264U, 0265U, 0266U, 0267U, 0268U, 0269U, 0270U, 0271U, 0272U, 0273U, 0274U, 0276U, 0277U, 0278U, 0282U, 0286U, 0289U, 0290U , 0291U, 0292U, 0293U, and 0294U. This revision is effective 5/12/2022.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: MolDX: ThermoFisher Oncomine Dx Target Test for Non-Small Cell Lung Cancer (A55881) - R3 - Effective May 12, 2022

This Billing and Coding Article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: May 12, 2022
Summary of Article Changes:
Under CPT/HCPCS Codes Group1: Codes the description was revised for 0022U. This revision is due to the Q2 CPT/HCPCS Code Update and is effective for dates of service on or after 4/1/2022.

Under CMS National Coverage Policy added regulation Title XVIII of the Social Security Act (SSA) §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the "Covered Tests" or the "Excluded Tests" webpage.

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

Billing and Coding: Outpatient Cardiac Rehabilitation - R9 - Effective January 1, 2022

The following Noridian coverage requirements for the Billing and Coding Outpatient Cardiac Rehabilitation National Coverage Determination (NCD) have been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

NCD: Outpatient Cardiac Rehabilitation 20.10.1
Effective Date: January 1, 2022
Summary of Changes: In the **Article Text** under **Sources** corrected the links to Transmittal 11175, CR 12549 dated January 14, 2022, and Transmittal 11272, CR 12613 dated February 14, 2022.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

To access a complete list of CMS NCDs, visit the National Coverage Determinations (NCDs) Alphabetical Index.

Billing and Coding: Positron Emission Tomography Scans Coverage - R33 - Article effective February 18, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: February 18, 2022
Summary of Article Changes: In the **Article Text** deleted the statement "The section below is quoted from the IOM Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Chapter 1, Part 4, Section 220.6" per CR 12613 and changed formatting throughout the article text.

Under **Indications and Limitations of Coverage** in the **Article Text**, added the specific NCD numbers addressed in this article, added language indicating any uses of PET scans that are not specifically listed in the NCDs listed may be covered per local MAC discretion and removed NaF for PET imaging for oncologic conditions using the PI or PS modifier since this tracer is non-covered per NCD 220.6.19.

In the **Group 6-10 Paragraphs** under **ICD-10-CM Codes that Support Medical Necessity**, added A9552 as the tracer to use and clarified PS modifier is used for subsequent strategy.

In **Group 10 Paragraph** added Gallium 68- ga Gozetotide/PSMA-11 (Illuccix®), effective 12/17/2021 as a newly local contractor approved tracer.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

Billing and Coding: Positron Emission Tomography Scans Coverage - R34 - Article effective February 18, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

NCD: 220.6.17 - Positron Emission Tomography (FDG PET) for Oncologic Conditions
Effective Date: February 18, 2022
Summary of Article Changes: In the **Article Text** corrected the link to CR12613 and the effective date to 5-20-2022 under Sources

In the **Group 14 Paragraph** under **ICD-10-CM Codes that Support Medical Necessity**, indicated Z85.3 MUST be billed with either any of the C50.XXX or C79.81 and added the breast cancer diagnosis codes: C50.011-C50.012, C50.021-C50.022, C50111-C50.112, C50.121-C50.122, C50.211-C50.212, C50.221-C50.222, C50.311-50.312, C50.321-C50.322, C50.411-C50.412, C50.421-C50.422, C50.511-C50.512, C50.521-C50.522, C50.611-C50.612, C50.621-C50.6.22, C50.811-C50.812 and C50.821-C50.822 to the **Group 14** Codes section.

Removed the following statements in the **Groups 11 and 13 Paragraphs** respectively, "Effective 09/10/2021, the NCCN Guidelines have been updated to allow PET/CT or PET/MRI with Fluciclovine F18 to be considered for equivocal results on initial bone imaging with the '**PI**' modifier" and "Effective 09/10/2021, the NCCN Guidelines have been updated to allow PET/CT or PET/MRI with Fluciclovine F18 to be considered for equivocal results on initial bone imaging with the use of the '**PI**' modifier" as the use of the '**PI**' continues to be nationally non-cover per NCD 220.6.17 C.1a.

In the **Group 1, 17 and 19 Paragraphs** added the statement "Providers must amend the KX modifier on the claim to attest that the use of the PI modifier is per NCCN Guidelines" and the approved FDA label indications for each tracer.

In the **Group 20 Paragraph** added A9597 for LOCAMETZ® (kit for the preparation of gallium Ga 68 gozetotide injection) as payable with 78811-78816 and the 'PI' or 'PS' modifier, the approved FDA label indications for the tracer and added the statement "Providers must amend the KX modifier on the claim to attest that the use of the PI modifier is per NCCN Guidelines." Also added the diagnosis codes listed below to the **Group 20 Codes** section.

- C61 - Malignant neoplasm of prostate
- R97.21 - Rising PSA following treatment for malignant neoplasm of prostate
- Z85.46 - Personal history of malignant neoplasm of prostate

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

To access a complete list of CMS NCDs, visit the National Coverage Determinations (NCDs) Alphabetical Index.

Billing and Coding: Pulmonary Rehabilitation Services - R4 - Effective May 19, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: May 19, 2022
Summary of Article Changes: In the **Article Text** under **Sources**, corrected the hyperlink to Transmittal 11426CP, CR 12613

dated May 20, 2022, and clarified the appropriate use of the KX modifier when billing for services related to 94625 and 94626 for both COPD and COVID-19.

In the **HCPCS/CPT Codes Group1 Paragraph**, clarified HCPCS codes G0237-G0239 are for outpatient respiratory services.

In the **Group 1 Paragraph** in the **ICD-10-CM Codes That Support Medical Necessity** added the statement "The diagnosis codes below are applicable only when performing pulmonary rehabilitation services billed with CPT® codes 94625 and 94626."

In the **Group 1 Asterisk Explanation** portion in **the ICD -10-CM Codes That Support Medical Necessity** section added the statement "For diagnosis code U09.9 assign a code(s) for the specific symptom(s) or condition(s) related to the previous COVID-19 infection, if known."

Added the following DX codes to the **Group1 ICD-10-CM Codes That Support Medical Necessity**:

- J41.1 Mucopurulent chronic bronchitis
- J41.8 Mixed simple and mucopurulent chronic bronchitis

Noted in the Revision History the diagnosis codes J40.0, J40.1 & J40.9 in Revision History #2 should be J44.0, J44.1 & J44.9.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of coverage articles and access the **Future** articles available in the CMS MCD.

Billing and Coding: Pulmonary Thromboembolectomy (A59048) - Effective July 9, 2022

This coverage article has been created and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: July 9, 2022
Summary of Article: Noridian is providing coding clarification and advice for reporting percutaneous mechanical removal of a venous thrombus embolized to the central cardiopulmonary circulation, including the right heart and central pulmonary vessels.

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: Routine Foot Care (A57954) - R9 - Effective June 19, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: June 19, 2022
Summary of Article Changes: Deleted the unspecified diagnosis codes L90.9, L91.9 & Q81.9 because there are more specific diagnosis codes to bill listed. Asterisked L84 and L98. And added the statement "*L84, L98.7 and L60.8 are non-covered diagnosis codes and will be denied when billed with G0127" under **the Group 1: medical Necessity ICD-10-CM Codes Asterisk Explanation**. Added D60.0, D68.1, D68.2, D68.311, D68.312, D68.318, D68.32, D68.4, D70.1 and D70.2 in **Group 4** of the **ICD-10 Codes that Support Medical Necessity**.

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

Billing and Coding: Routine Foot Care (A57954) - R10 - Effective June 19, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (HI and Territories), and 01312 (NV).

Effective Date: June 19, 2022
Summary of Article Changes: Typographical error in Revision 9 Explanation corrected: D68.0 was added in Group 4 of the ICD-10 Codes that Support Medical Necessity, not D60.0.

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: Short Tandem Repeat (STR) Markers and Chimerism (CPT® codes 81265-81268) (A57842) - R1 - Effective March 17, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: March 17, 2022
Summary of Article Changes: Under CMS National Coverage Policy added regulations Title XVIII of the Social Security Act, §1833(e) Prohibits Medicare payment for any claim which lacks the necessary information to process the claim, CMS Internet-Only Manuals, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts With Independent Clinical Laboratories, and CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, §60.1.2 Independent Laboratory Specimen Drawing, §60.2. Travel Allowance. Under Article Text deleted the verbiage, “Laboratories are encouraged to register tests based on the use of the test” and “Through the MolDX identification process”. Revised third sentence to read, “Tests indicated for recipient/donor testing will be considered for payment and tests for twin zygosity will be denied as a statutorily excluded service.” and added verbiage regarding instructions on how to submit claims information. Formatting, punctuation, and typographical errors were corrected throughout the article

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.

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

Botulinum Toxin Types A and B Policy (L35170) - R14 - Effective October 01, 2019, and Associated Billing and Coding: Botulinum Toxin Types A and B Policy (A57185) - R2 - Effective October 01, 2020

This Local Coverage Determination (LCD) and Billing and Coding Local Coverage Article (LCA) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L35170 and A57185
Effective Date: LCD Botulinum Toxin Types A and B Policy (L35170) - October 01, 2019; Billing and Coding: Botulinum Toxin Types A and B Policy (A57185) - October 01, 2020
Summary of Changes: LCD - Under Coverage Indications, Limitations and/or Medical Necessity removed 17, "Due to the short life of Botulinum toxin, Medicare will reimburse the unused portion of these drugs only when vials are not split between patients. Use modifier JW to code for drug wastage on a separate line of the claim form. The documentation must show in the patient's medical record the exact dosage of the drug given, exact amount and reason for unavoidable wastage, and the exact amount of the discarded portion of the drug" and 18, "Scheduling of more than one patient is encouraged to prevent wastage of Botulinum toxins. If a vial is split between two patients, the billing in these instances must be for the exact amount of Botulinum toxin used on each individual patient. Medicare would not expect to see billing for the full fee amount for

Botulinum toxin on each beneficiary when the vial is split between two or more patients." Also corrected grammatical and typographical errors.

Billing and Coding - Under Article Text added 'anatomic' to bullet, "A complete anatomic description of the site(s) injected." Added language to provide guidance on the unused portion of these drugs.

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

Final Epidural Steroid Injections for Pain Management LCD and Associated Billing and Coding: Epidural Steroid Injections for Pain Management - Effective June 19, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting comment period and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV). Responses to comments received may be found as a link at the bottom of the final LCD.

Medicare Coverage Database Number	LCD Title
L39240	Epidural Steroid Injections for Pain Management

Medicare Coverage Database Number	LCA Title
A58993	Billing and Coding: Epidural Steroid Injections for Pain Management

Effective Date: June 19, 2022
Summary: LCD describes the Coverage Limitations, Medical Necessity, Provider Qualifications and Definitions of terms used in epidural steroid injections and the Billing and Coding Article provides billing and coding guidance for the LCD.

Visit the CMS Medicare Coverage Database (MCD) to access this LCD.

Lab: Cystatin C Measurement (L37616) - R4 - Effective June 09, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L37616
LCD Title: Lab: Cystatin C Measurement
Effective Date: June 09, 2022
Summary of Changes:
Under LCD Title revised the title to read Lab: Cystatin C Measurement. Under Bibliography changes were made to citations to reflect AMA citation guidelines.

Formatting and punctuation were corrected throughout the LCD.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

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

Lumbar Epidural Injections Local Coverage Determination, Associated Billing and Coding Article and Response to Comments Retirement- June 20, 2022

The following Local Coverage Determination (LCD), associated Billing and Coding Articles (LCA) and Response to Comments have been retired under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database Number	LCD Title and Revision Number
L34982	Lumbar Epidural Injections

Medicare Coverage Database Number	Billing and Coding Article Title and Revision Number
A57202	Billing and Coding: Lumbar Epidural Injections
A59165	Response to Comments: Lumbar Epidural Injections

Effective Date: June 20, 2022
Summary: The Lumbar Epidural Injections LCD, associated Billing and Coding Article and Response to Comments Article are being retired and replaced with the Epidural Steroid Injections for Pain Management LCD, associated Billing and Coding Article and Response to Comments Article, which covers epidural injections for all spinal levels.

Visit the Noridian Medicare Coverage Articles webpage or access the Retired LCDs and articles in the CMS MCD.

Lumbar Epidural Injections - Retirement

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: DL34982/DA57202
LCD Title: Lumbar Epidural Injections
LCA Title: Billing and Coding: Lumbar Epidural Injections
Comment period: April 28, 2022 - June 11, 2022

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

Providers may address details for comment submission for the retirement of this policy due to the finalization of the Epidural Steroid Injections for Pain Management/ Billing and Coding: Epidural Steroid Injections for Pain Management LCD/LCA effective June 19, 2022. When sending comments, reference the specific policy to which they are related. See the Proposed LCDs webpage for email and mail specifics.

Manipulated, Reconstituted And/or Injectable Amniotic and Placental Derived Products

PREVIOUSLY PROCESSED CLAIMS

At this time, Noridian will be re-evaluating claims previously denied regarding manipulated, reconstituted and/or injectable amniotic and placental derived products. **Any claim already undergoing the appeals (redetermination) process will continue as such and NOT be-revisited.**

What to Expect:

- Noridian will issue an Additional Documentation Request (ADR) letter for any denied claim that has not been appealed. Letters are expected to be sent in May and/or early June.
- Noridian will conduct a post-payment review on claims for those providers whose Part A or B claims are affected.
- The ADR letter will be requesting documentation that supports the medical necessity in the form of medical records, as well as any publicly available evidence-based peer-reviewed literature demonstrating the safety and efficacy in the

Medicare population regarding the use of the product for the condition(s) being treated.

- If the individual claim in question is not part of the post-payment review, then you may exercise your appeal rights should you choose to do so.

CURRENT OR FUTURE CLAIMS

For current and future claims in which manipulated, reconstituted and/or injectable amniotic and placental derived products are billed, additional medical review may be performed. Providers will be notified via an ADR letter that will request similar supportive documentation as noted above.

- **Please note: Do not resubmit the same claim, as it may delay all claim reviews for that specific date of service.**

WHAT DOES THIS MEAN FOR YOU?

What if I have already appealed my claim?
If your claim is already undergoing the appeals process, please continue in that process and disregard the post-payment review letter should you receive one. Noridian encourages providers exercising their appeal rights to include medical records, as well as any evidence-based peer-reviewed literature including results from clinical trials, demonstrating the safety and efficacy in the Medicare population for the use of the product in the condition(s) being treated.

I have already appealed my claim and got a determination. What happens next?
If you are not in agreement with the first level of appeals determination, you may then exercise your rights to appeal at the next level (reconsideration).

How will I know if my previously denied claim is affected?
If your previously denied claim has been identified for individual review, Noridian will issue an ADR that will outline the time-frame to respond. If you are still uncertain whether your claim is affected, please access the Noridian Medicare Portal prior to contacting the PCC to confirm if your particular claim in question is affected; or you may choose to exercise your appeal rights.

Should I resubmit instead?
No. If you have already sent in a claim for that item/service and it is currently undergoing review, or you have exercised your appeal rights and it is currently undergoing the appeals process, do NOT resubmit as this will further delay any processing of the claim.

Should I proactively send my supportive documentation in?
Providers are encouraged to respond with documentation only after they receive the ADR letter within the timeframes outlined to avoid non-response denials.

What documentation should I provide?
Examples (not an all-inclusive list): Medical records (i.e., History and physical, documentation of trial and failure of conservative therapies, results of diagnostic testing, procedure note(s), plan of care), invoices, as well as any evidence-based peer-reviewed literature, including results from clinical trials that demonstrate the safety and efficacy in use of the product for the condition(s) being treated.

How long will it take to review my claim? And will this affect my appeals timeframe?
Timeframes for rendering a decision are outlined on the Internet Only Manual (IOM) 100-08 Chapter 3. When the documentation is received, the contractor has 30 calendar days to make a determination on a prepayment claim. For post-payment review, up to 60 days is allowed. Appeals timeframes per the Medicare Claims Processing Manual (MCPM), Chapter 29, Section 310.4 state, For *appeals of a specific line item or service, the date of the first Medicare Summary Notice (MSN) or Remittance Advice (RA) that states the coverage and payment decision is the date of the initial determination. Adjustments to the initial claim or claim resubmissions for the same item/service on the same date of service that are included on subsequent MSNs or RAs, but do not revise the initial determination, do not extend/change the appeal rights on the initial determination.*

Can I have a list of affected products?
Unfortunately, Noridian is not at liberty to provide a listing of amniotic and/or placental derived product Q codes. In addition, there are products still utilized that do not have a specific Q code assigned. Providers may refer to their product label to determine if their product is manipulated, reconstituted and/or injectable.

Will this affect current and future claims?
Yes, claims billed will be prioritized for review. If your claim is affected, you will receive or have received a letter requesting additional documentation that contains instructions on how to submit the information requested.

What if I have further general questions?
Noridian requests that providers and other external stakeholders check the Noridian Medicare website or Listserv for updates. General correspondences related to these issues may be emailed to **amnion_placentalconcern@noridian.com**. Please do not include any PHI or other confidential information. For a specific individual claim, you can check the Noridian Medicare Portal to see if a Request for Documentation letter has been sent.

What if I have an individual claim question?
If you are still uncertain whether your claim is affected, please access the Noridian Medicare Portal prior to contacting the PCC to confirm if your particular claim in question is affected. You may call the PCC if you need a response to a question and/or collaborate with other stakeholders to secure the information needed.

MDS FISH LCD (L37620) - R5- Effective June 30, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L37620
Effective Date: June 30, 2022
Summary of Changes:
Under CMS National Coverage Policy updated regulation description. Under *Bibliography* revised Source #2 to remove the broken hyperlink and changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD.

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

MolDX: 4Kscore® Assay - Retirement

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: DL37120/DA57336
LCD Title: MolDX: 4Kscore® Assay
LCA Title: Billing and Coding: 4Kscore® Assay
Comment period: April 21, 2022 - June 4, 2022

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

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

MolDX: APC and MUTYH Gene Testing L36882 Retirement - Effective August 08, 2022

This Local Coverage Determination (LCD) has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L36882
Effective Date: August 08, 2022
Rationale: This policy has been incorporated within the MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Blood Product Molecular Antigen Typing (L38331) - R3 - Effective May 26, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L38331

LCD Title: MolDX: Blood Product Molecular Antigen Typing

Effective Date: May 26, 2022

Summary of Changes:

Under Sources of Information changes were made to citations to reflect AMA citation guidelines.

Under Bibliography revised the broken hyperlink for the first reference and changes were made to citations to reflect AMA citation guidelines. Formatting and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the "Active LCD" Webpage.

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

MolDX: BRCA1 and BRCA2 Genetic Testing L36161 Retirement - Effective August 08, 2022

This Local Coverage Determination (LCD) has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L36161
Effective Date: August 08, 2022
Rationale: This policy has been incorporated within the MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: ConfirmMDx Epigenetic Molecular Assay L36327 Retirement - Effective August 08, 2022

This Local Coverage Determination (LCD) has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L36327
Effective Date: August 08, 2022
Rationale: This policy has been incorporated within the MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer L39005 LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: DecisionDx-UM (Uveal Melanoma) LCD (L37070) - R6 - Effective June 30, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L37070
Effective Date: June 30, 2022
Summary of Changes:
Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD.

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

MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease LCD Title (L36180) - R11 - Effective June 30, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L36180
Effective Date: June 30, 2022
Summary of Changes:
Under **Coverage Indications, Limitations and/or Medical Necessity** revised the first sentence to read, "This policy provides coverage for multi-gene non-next generation sequencing (NGS) panel testing and NGS testing for the diagnostic workup for myeloproliferative disease (MPD), also known as myeloproliferative neoplasms (MPNs), and limited coverage for single-gene testing of patients with BCR-ABL negative MPD. BCR-ABL negative MPD includes polycythemia vera (PV), essential thrombocythemia (ET), and primary myelofibrosis (PMF)."

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

MolDX: Genetic Testing for Lynch Syndrome L36370 Retirement - Effective August 08, 2022

This Local Coverage Determination (LCD) has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L36370
Effective Date: August 08, 2022
Rationale: This policy has been incorporated within the MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer (L38972) Final LCD - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV). Responses to comments received may be found as a link at the bottom of the final LCD.

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L38972
LCD Title: MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer
Effective Date: August 08, 2022
Summary of LCD: This policy describes and clarifies coverage for Lab-Developed Tests (LDTs), Federal Drug Administration (FDA)-cleared, and FDA-approved clinical laboratory tests in hereditary cancer tests including Next Generation Sequencing (NGS) tests as allowable under the National Coverage Determination (NCD) 90.2, under section D describing Medicare Administrative Contractor (MAC) discretion for coverage.

This policy's scope is specific for hereditary germline testing, and is exclusive of polygenic risk scores, solid tumor, hematologic malignancies, circulating tumor deoxyribonucleic acid (DNA) testing (ctDNA), and other acquired cancer-related tests

Visit the Proposed LCDs webpage to access this LCD.

MolDX: Melanoma Risk Stratification Molecular Testing (L37750) Final LCD - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV). Responses to comments received may be found as a link at the bottom of the final LCD.

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L37750
LCD Title: MolDX: Melanoma Risk Stratification Molecular Testing
Effective Date: August 08, 2022
Summary of LCD: This policy describes and clarifies coverage for molecular diagnostic tests used to assist in risk stratification of melanoma patients.

Visit the Proposed LCDs webpage to access this LCD.

MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (L39005) Final LCD - Effective August 08, 2022

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV). Responses to comments received may be found as a link at the bottom of the final LCD.

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L39005
LCD Title: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer
Effective Date: August 08, 2022
Summary of LCD: This policy describes and clarifies limited coverage for molecular Deoxyribonucleic acid/ribonucleic acid (DNA/RNA) biomarker tests for the diagnosis of prostate cancer that help differentiate men who may or may not benefit from a prostate biopsy.

Visit the Proposed LCDs webpage to access this LCD.

MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (L39001) and Associated Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - Effective June 02, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L39001 and A58720
Effective Date: June 02, 2022
Summary of Changes: The notice period for LCD L39001 MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing is being changed to 03/03/2022 - 06/01/2022.The original notice period for this was 03/03/2022 - 04/16/2022 before the extension. Noridian is removing the effective date of 07/16/2022 for this policy and changing to 06/02/2022.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the "Active LCD" Webpage.

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

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

MolDX: Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia - Published for Review and Comments

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: DL39262
LCD Title: MolDX: Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia
Comment period: April 28, 2022 - June 11, 2022

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.

MolDX: Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia - Published for Review and Comments

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: DL396262/DA59032
LCD Title: MolDX: Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia
LCA Title: Billing and Coding: MolDX: Molecular Testing for Detection of Upper Gastrointestinal Metaplasia, Dysplasia, and Neoplasia
Comment period: April 28, 2022 - June 11, 2022

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

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

MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (L37301) Retirement - Effective June 01, 2022

This Local Coverage Determination (LCD) has been retired under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L37301
Effective Date: June 01, 2022
Rationale: This LCD is being retired because the information in this policy has been incorporated within the MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing L39001 LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Phenotypic Biomarker Detection from Circulating Tumor Cells (L38643) - R2 - Effective June 02, 2022

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: L38643
LCD Title: MolDX: Blood Product Molecular Antigen Typing
Effective Date: June 02, 2022
Summary of Changes:
Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts with Independent Clinical Laboratories.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the MolDX Medicare Local Coverage Determination from the "Active LCD" Webpage.

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

Nerve Blockade for Treatment of Chronic Pain and Neuropathy - Published for Review and Comments

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database (MCD) Number: DL35456/DA56034
LCD Title: Nerve Blockade for Treatment of Chronic Pain and Neuropathy
LCA Title: Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy
Comment period: April 28, 2022 - June 11, 2022

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

Providers may address details for comment submission for the removal of the coverage of cervical and thoracic epidurals **only** due to the finalization of the Epidural Steroid Injections for Pain Management/ Billing and Coding: Epidural Steroid Injections for Pain Management LCD/LCA effective June 19, 2022, for this policy. When sending comments, reference the specific policy to which they are related. See the Proposed LCDs webpage for email and mail specifics.

Policy Revision for Nerve Conduction Studies and Electromyography Local Coverage Determination and Associated Billing and Coding Nerve Conduction Studies and Electromyography Local Coverage Article - R7 - Effective December 1, 2019

The following Local Coverage Determinations (LCD) and associated Billing and Coding Article (LCA) have been revised under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database Number	LCD Title and Revision Number
L36524	Nerve Conduction Studies and Electromyography

Medicare Coverage Database Number	Billing and Coding Article Title and Revision Number
A54969	Billing and Coding: Nerve Conduction Studies and Electromyography

Effective Date: December 1, 2019
Summary of Changes: Corrected a typographical in the statement "Nerve conduction studies performed independent of needle electromyography (EMG) may only provide a portion of the information needed to diagnose muscle, nerve root, and most nerve disorders. When the nerve conduction study (NCS) is used on its own without integrating needle EMG findings or when an individual relies solely on a review of NCS data, the results can be misleading, and important diagnoses may be missed" in the LCD. No updates to the LCA were made.

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

Self-Administered Drug Exclusion List - R25 - Effective July 17, 2022

This coverage article has been revised and published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Effective Date: July 17, 2022
Summary of Changes:
The article is updated to add: Kesimpta® (ofatumumab) subcutaneous use* - C9399, J3490, J3590 effective 07/17/2022.

The article is updated to add: Tezspire™ (tezepelumab-ekko) - C9399, J3490, J3590 effective 07/17/2022.

Note: Effective July 1, 2022 - J2356 will be established and added to this article for Tezspire™ (tezepelumab-ekko) and should be used in place of the 3 miscellaneous codes in this revision.

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.

MLN CONNECTS .....

MLN Connects Special Edition - April 4, 2022 - Biden-Harris Administration Announces a New Way for Medicare Beneficiaries to Get Free Over-the-Counter COVID-19 Tests

On April 4, The Biden-Harris Administration announced that more than 59 million Americans with Medicare Part B, including those enrolled in a Medicare Advantage plan, now have access to FDA approved, authorized, or cleared over-the-counter COVID-19 tests at no cost. People with Medicare can get up to 8 tests per calendar month from participating pharmacies and health care providers for the duration of the COVID-19 public health emergency.

"With today's announcement, we are expanding access to free over-the-counter COVID-19 testing for people with Medicare Part B, including those enrolled in a Medicare Advantage plan. People with Medicare Part B will now have access to up to 8 FDA-approved, authorized or cleared over-the-counter COVID-19 tests per month at no cost. This is all part of our overall strategy to ramp -up access to easy-to-use, at-home tests free of charge," said HHS Secretary Xavier Becerra. "Since we took office, we have more than tripled the number of sites where people can get COVID-19 tests for free, and we're also delivering close to 250 million at-home, rapid tests to send for free to Americans who need them. Under the Biden-Harris Administration's leadership, we required state Medicaid programs, insurers and group health plans to make tests free for millions of Americans. With today's step, we are further expanding health insurance coverage of free over-the-counter tests to Medicare beneficiaries, including our nation's elderly and people with disabilities."

This is the first time that Medicare has covered an over-the-counter self-administered test at no cost to beneficiaries. This new initiative enables payment from Medicare directly to participating eligible pharmacies and other health care providers to allow Medicare beneficiaries to receive tests at no cost, in addition to the 2 sets of 4 free at-home COVID-19 tests Americans can continue to order from covidtests.gov. National pharmacy chains are participating in this initiative, including: Albertsons Companies, Inc., Costco Pharmacy, CVS, Food Lion, Giant Food, The Giant Company, Hannaford Pharmacies, H-E-B Pharmacy, Hy-Vee Pharmacy, Kroger Family of Pharmacies, Rite Aid Corp., Shop & Stop, Walgreens, and Walmart.

"Testing remains a critical tool in mitigating the spread of COVID-19, and we are committed to making sure people with Medicare have the tools they need to stay safe and healthy," said CMS Administrator Chiquita Brooks-LaSure. "By launching this initiative, the Biden-Harris Administration continues to demonstrate that we are doing everything possible to make over-the-counter COVID-19 testing free and accessible for millions more Americans."

Providers and suppliers eligible to participate include certain types of pharmacies and other health care providers who are enrolled in Medicare and able to furnish ambulatory health care services such as preventive vaccines, COVID-19 testing, and regular medical visits. To ensure that people with Medicare have access to these tests, Medicare is not requiring participating eligible pharmacies and health care providers go through any new Medicare enrollment processes. If a health care provider currently provides ambulatory health care services such as vaccines, lab tests, or other clinic type visits to people with Medicare, then they are eligible to participate in this initiative.

"For the first time in its history, Medicare is paying for an over-the-counter test," said Deputy Administrator Dr. Meena Seshamani, Director of the Center for Medicare at CMS. "This is because COVID-19 testing is a critical part of our pandemic response. Combined with the free over-the-counter tests available through covidtests.gov, this initiative will significantly increase testing access for Americans most vulnerable to COVID-19 and will provide valuable information for future payment policy supporting accessible, comprehensive, person-centered health care."

A list of eligible pharmacies and other health care providers that have committed publicly to participate in this initiative can be found here. Because additional eligible pharmacies and health care providers may also participate, people with Medicare should check with their pharmacy or health care provider to find out whether they are participating.

This initiative adds to existing options for people with Medicare to access COVID-19 testing, including:

- Requesting free over-the-counter tests for home delivery at covidtests.gov. Every home in the U.S. is eligible to order 2 sets of 4 at-home COVID-19 tests.
- Access to no-cost COVID-19 tests through health care providers at over 20,000 testing sites nationwide. A list of

community-based testing sites can be found here.

- Access to lab-based PCR tests and antigen tests performed by a laboratory when the test is ordered by a physician, non-physician practitioner, pharmacist, or other authorized health care professional at no cost through Medicare.
- In addition to accessing a COVID-19 laboratory test ordered by a health care professional, people with Medicare can also access one lab-performed test without an order and cost-sharing during the public health emergency.

People with Medicare can get additional information by contacting 1-800-MEDICARE and going to: https://www.medicare.gov/medicare-coronavirus. Medicare also maintains several resources to help ensure beneficiaries receive the correct benefits while also avoiding the potential for fraud or scams. More details—particularly on identifying scams due to COVID-19—can be found at https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse.

Pharmacies and other health care providers interested in participating in this initiative can get more information here: https://www.cms.gov/COVIDOTCtestsProvider.

More Information:

- Fact Sheet
- COVID-19 Over-the-Counter Tests webpage

MLN Connects Special Edition - April 6, 2022 - Eligible Individuals Can Receive Second COVID-19 Booster Shot at No Cost

On April 6, CMS announced it will pay for a second COVID-19 booster shot of either the Pfizer-BioNTech or Moderna COVID-19 vaccines without cost sharing, as it continues to provide coverage for this critical protection from the virus. People with Medicare pay nothing to receive a COVID-19 vaccine, and there is no applicable copayment, coinsurance, or deductible. People with Medicaid coverage can also get COVID-19 vaccines, including boosters, at no cost.

The CDC recently updated its recommendations regarding COVID-19 vaccinations. Certain immunocompromised individuals and people ages 50 years and older who received an initial booster dose at least 4 months ago are eligible for another booster to increase their protection against severe disease from COVID-19. Additionally, the CDC recommends that adults who received a primary vaccine and booster dose of Johnson & Johnson's Janssen COVID-19 vaccine at least 4 months ago can receive a second booster dose of a Pfizer-BioNTech or Moderna COVID-19 vaccine.

The COVID-19 vaccine, including the booster doses, is the best defense against severe illness, hospitalization, and death from the virus. CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.

People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

MLN Connects - April 7, 2022

Improve the Health of Minority Populations with Covered Preventive Services

MLN Connects newsletter for Thursday, April, 7, 2022

NEWS

- Fiscal Year 2021 Program for Evaluating Payment Patterns Electronic Reports
- Preventive Services & Health Equity: Improve the Health of Minority Populations

COMPLIANCE

- What's the Comprehensive Error Rate Testing Program?

CLAIMS, PRICERS, & CODES

- April 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.1

- Claim Status Category and Claim Status Codes Update

MLN MATTERS® ARTICLES

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02)
- April 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 - Revised

PUBLICATIONS

- Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants - Revised

MLN Connects Special Edition - April 7, 2022 - Returning to Certain Pre-COVID-19 Policies & Coverage of Monoclonal Antibodies for Alzheimer's Disease Stakeholder Call

Returning to Certain Pre-COVID-19 Policies & Coverage of Monoclonal Antibodies for Alzheimer's Disease Stakeholder Call

CMS RETURNING TO CERTAIN PRE-COVID-19 POLICIES IN LONG-TERM CARE AND OTHER FACILITIES

CMS is taking steps to continue to protect nursing home residents' health and safety by announcing guidance that restores certain minimum standards for compliance with CMS requirements. Restoring these standards will be accomplished by phasing out some temporary emergency declaration waivers that have been in effect throughout the COVID-19 public health emergency (PHE). These temporary emergency waivers were designed to provide facilities with the flexibilities needed to respond to the COVID-19 pandemic.

During the PHE, CMS used a combination of emergency waivers, regulations, and sub-regulatory guidance to offer health care providers the flexibility needed to respond to the pandemic. In certain cases, these flexibilities suspended requirements in order to address acute and extraordinary circumstances. CMS has consistently monitored data within nursing homes and has used these data to inform decision making.

With steadily increasing vaccination rates for nursing home residents and staff, and with overall improvements seen in nursing homes' abilities to respond to COVID-19 outbreaks, CMS is taking steps to phase out certain flexibilities that are generally no longer needed to re-establish certain minimum standards while continuing to protect the health and safety of those residing in skilled nursing facilities/nursing facilities. Similarly, some of the same waivers are also being terminated for inpatient hospices, intermediate care facilities for individuals with intellectual disabilities, and ESRD facilities.

More Information:

- Full press release
- Quality, Safety, and Oversight memo

JOIN CMS FOR A STAKEHOLDER CALL ON THE MEDICARE COVERAGE POLICY FOR MONOCLONAL ANTIBODIES DIRECTED AGAINST AMYLOID FOR THE TREATMENT OF ALZHEIMER'S DISEASE

Today, the Centers for Medicare & Medicaid Services (CMS) released a national policy for coverage of aducanumab (brand name Aduhelm™) and any future monoclonal antibodies directed against amyloid approved by the FDA with an indication for use in treating Alzheimer's disease. From the onset, CMS ran a transparent, evidence-based process that incorporated more than 10,000 stakeholder comments and more than 250 peer-reviewed documents into the determination.

As finalized in this two-part National Coverage Determination (NCD), Medicare will cover monoclonal antibodies that target amyloid (or plaque) for the treatment of Alzheimer's disease that receive traditional approval from the Food and Drug Administration (FDA) under coverage with evidence development (CED). CMS, as a part of this decision, will provide enhanced access and coverage for people with Medicare participating in CMS-approved studies, such as a data collection through

routine clinical practice or registries. Registry data may be used to assess whether outcomes seen in carefully controlled clinical trials (e.g., FDA trials) are reproduced in the real-world and in a broader range of patients. Any new drugs in this class that receive FDA traditional approval may be available in additional care settings that people with Medicare can use, such as an outpatient department or an infusion center. Secondly, for drugs that FDA has not determined to have shown a clinical benefit (or that receive an accelerated FDA approval), Medicare will cover in the case of FDA or National Institutes of Health (NIH) approved trials. Under this NCD, CMS will support the FDA by covering the drug and any related services (including, in some cases, PET scans if required by trial protocol) for people with Medicare who are participating in these trials.

More Information:

- Complete press release
- Fact sheet on Medicare coverage policy for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease
- Final NCD CED decision memorandum

STAKEHOLDER CALL

What: CMS invites you to join a stakeholder call on the Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Decision Follows Robust Stakeholder Input and Creates Pathway for Enhanced Access and Coverage of Drugs that Receive Traditional FDA Approval

When: April 11, 2022 at 11:00 AM ET

How to register.

MLN Connects Special Edition - April 11, 2022 - HHS Takes Actions to Promote Safety & Quality in Nursing Homes

HHS Takes Actions to Promote Safety & Quality in Nursing Homes

On April 11, CMS issued its fiscal year (FY) 2023 Skilled Nursing Facilities Prospective Payment System (SNF PPS) proposed rule, which includes asking for public feedback on how staffing in nursing homes and health equity improvements could lead to better health outcomes.

The proposed rule builds upon the Biden-Harris Administration's commitment to advance health equity, drive high-quality person-centered care, and promote sustainability of its programs. The rule is an important step in fulfilling its goal to protect Medicare skilled nursing facility (SNF) residents and staff by improving the safety and quality of care of the nation's SNFs (commonly referred to as nursing homes). The SNF PPS provides Medicare payments to over 15,000 nursing homes, serving more than 1.5 million people. Medicare spending to nursing homes is projected to be approximately $35 billion in FY 2022. Through the SNF PPS proposed rule, CMS is continuing its work to transform the SNF payment system to a more patient-centered model by making payments based on the needs of the whole patient, rather than focusing on the volume of certain services the patient receives.

"Everyone deserves to receive safe, dignified, and high-quality care, no matter where they live," said HHS Secretary Xavier Becerra. "Today we are starting the necessary work to ensure our loved ones living in nursing homes receive the best care at the staffing levels they need. We are working hard to deliver on President Biden's commitment to protecting seniors and improving the quality of our nation's nursing homes."

The SNF PPS proposed rule aims to realize the President's vision for the nation's nursing homes as outlined in his State of the Union Address, with a focus on providing safe, dignified, and appropriate care for residents. As part of this vision, the Biden-Harris Administration recently set a goal to improve the quality of nursing homes so that seniors, people with disabilities, and others living in nursing homes get the reliable, high-quality care they deserve. A key part of reaching this goal is addressing staffing levels in nursing homes, which have a substantial impact on the quality of care and outcomes residents experience.

"The COVID-19 pandemic has highlighted serious problems at some of the nation's nursing homes that have persisted for too long. And we have seen the tragic impact that inadequate staff resources can have on residents and staff," said CMS

Administrator Chiquita Brooks-LaSure. "The Biden-Harris Administration has promised that we will work with all stakeholders to do better for nursing home residents, and today's proposed rule includes important steps toward our goal to promote safety and quality of care for all residents and staff."

In the SNF PPS proposed rule, CMS is soliciting input to help the agency establish minimum staffing requirements that nursing homes will need to meet to ensure all residents are provided safe, high-quality care, and nursing home workers have the support they need. This input will be used in conjunction with a new research study being conducted by CMS to determine the optimal level and type of nursing home staffing needs. The agency intends to issue proposed rules on a minimum staffing level requirement for nursing homes within one year.

CMS is also requesting stakeholder input on a measure that would examine staff turnover levels in nursing homes for possible inclusion in CMS' SNF Value-Based Purchasing (VBP) Program, which rewards facilities with incentive payments based on the quality of care they provide to people with Medicare. Looking at the relationship between staff turnover and quality of care, preliminary analysis by CMS has shown that as the average staff turnover decreases, a facility's overall rating on CMS' Nursing Home Five Star Quality Rating System increases, which suggests that lower turnover is associated with higher overall quality. CMS will use the stakeholder feedback to inform a proposal of this measure to include in the SNF VBP Program in the future.

In January, CMS began posting nursing home staff turnover rates (as well as weekend staff levels) on the Medicare.gov Care Compare website, and CMS will be including this information in the star rating system starting in July 2022. This information helps consumers better understand each nursing home facility's staffing environment and also helps providers to improve the quality of care and services they deliver to residents.

The proposed rule also proposes the adoption of 3 new measures into the SNF VBP Program:

- The Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) is an outcome measure that assesses SNF performance on infection prevention and management.
- The Total Nursing Hours per Resident Day is a structural measure that uses auditable electronic data to calculate total nursing hours per resident each day.
- The Adoption of the Discharge to Community - Post Acute Care Measure for SNFs (DTC) is an outcome measure that assesses the rate of successful discharges to community from a SNF setting.

To advance health equity and address the health disparities that underlie the U.S. health care system, CMS is requesting stakeholder feedback on the role health equity plays in improving health outcomes and the quality of care in nursing homes. Specifically, CMS is seeking comment on how to arrange or classify measures in nursing home quality reporting programs by indicators of social risk to better identify and reduce disparities.

CMS is proposing a 3.9%, or $1.4 billion, update to the payment rates for nursing homes, which is based on a 2.8% SNF market basket update plus a 1.5 percentage point market basket forecast error adjustment and less a 0.4 percentage point productivity adjustment. The proposed rule also contains a proposed adjustment to payment rates as the result of the transition to the SNF payment case-mix classification model - the Patient Driven Payment Model (PDPM) that went into effect on October 1, 2019. When finalizing the PDPM, CMS also stated that the transition to PDPM would not result in an increase or decrease in aggregate SNF spending. Since PDPM implementation, CMS' data analysis has shown an unintended increase in payments. Therefore, CMS is proposing to adjust SNF payment rates downward by 4.6%, or $1.7 billion, in FY 2023 to achieve budget neutrality with the previous payment system. As a result, the estimated aggregate impact of the payment policies in this proposed rule would be a decrease of approximately $320 million in Medicare Part A payments to SNFs in FY 2023 compared to FY 2022.

More Information:

- Proposed rule
- Fact sheet: President Biden's remarks during the State of the Union Address on improving nursing home safety and quality
- Fact sheet: FY 2023 SNF PPS proposed rule

MLN Connects - April 14, 2022

COVID-19: New Codes for Moderna Vaccine Booster Doses

MLN Connects newsletter for Thursday, April 14, 2022

NEWS

- Launch of the Cross-Cutting Initiatives
- Value-Based Insurance Design Model: Medicare Advantage Organizations Pay for Hospice Care

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

CLAIMS, PRICERS, & CODES

- COVID-19: New Codes for Moderna Vaccine Booster Doses

EVENTS

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar - April 26

MLN Connects Special Edition - April 18, 2022 - CMS Proposes Policies to Advance Health Equity & Maternal Health, Support Hospitals

On April 18, CMS issued a proposed rule for inpatient and long-term hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. In addition to annual policies that promote Medicare payment accuracy and hospital stability, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule includes measures that will encourage hospitals to build health equity into their core functions, thereby improving care for people and communities who are disadvantaged and/or underserved by the health care system. The rule includes 3 health equity-focused measures in hospital quality programs, seeks stakeholder input related to documenting social determinants of health in inpatient claims data, and proposes a "Birthing-Friendly" hospital designation.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users, the proposed increase in operating payment rates is projected to be 3.2%. This reflects a FY 2023 projected hospital market basket update of 3.1% reduced by a projected 0.4 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by statute. Under the LTCH PPS, CMS expects payments to increase by approximately 0.8% or $25 million.

Additional items in the proposed rule related to payment stability for hospitals include a policy that smooths out significant year-to-year changes in hospitals' wage indexes and a solicitation for comments on payment adjustments for purchasing domestically made surgical N95 respirators. Specifically, CMS is proposing to apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior FY; and is considering the appropriateness of payment adjustments accounting for additional costs of purchasing surgical N95 respirators made in the U.S.

More Information:

- Complete press release
- Proposed payment rule fact sheet
- Maternal health & health equity measures fact sheet
- White House statement on Reducing Maternal Mortality and Morbidity
- Proposed rule: Comment by June 17

MLN Connects - April 21, 2022

Medicare Provider Compliance News

MLN Connects newsletter for Thursday, April 21, 2022

NEWS

- Hospice Quality Reporting Program: Key Dates & Measure Change
- Ambulance Ground Transport: Comparative Billing Report in April
- Hospices: Aggregate & Inpatient Caps under the Value-Based Insurance Design Model

COMPLIANCE

- Medicare Provider Compliance Newsletter
- DMEPOS Items: Medical Record Documentation

EVENTS

- CMS Health Equity Symposium - April 28

MLN MATTERS® ARTICLES

- Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

PUBLICATIONS

- Medicare Modernization of Payment Software - Revised

MLN Connects - April 28, 2022

Get Patient Eligibility Information for Additional Services

MLN Connects newsletter for Thursday, April 28, 2022

NEWS

- Patient Eligibility Information for Additional Services - Now Available
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Are You on the Missing Digital Contact Information Report?

CLAIMS, PRICERS, & CODES

- HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals
- Corrections to Home Health Billing for Denial Notices and Calculation of 60-Day Gaps in Services
- Updates for Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy Fiscal Years (FYs) 2021-2022
- Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

EVENTS

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program - June 15-16

MLN Connects - May 5, 2022

COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers

MLN Connects newsletter for Thursday, May 5, 2022

NEWS

- COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers
- Immunosuppressive Drug Coverage for Kidney Transplant Patients: Proposed Rule
- Diabetic Testing Supplies Ordering Guide
- Inpatient Rehabilitation Facilities: Care Compare March Preview Reports Reissued & April Refresh
- Long-Term Care Hospitals: Care Compare March Preview Reports Reissued & April Refresh
- Skilled Nursing Facilities: Care Compare April Preview Reports & Refresh
- May is National Asian American, Native Hawaiian, & Pacific Islander Heritage Month

CLAIMS, PRICERS, & CODES

- Outpatient Claims with Reason Code W7120 Returned in Error
- Eliminating Certificates of Medical Necessity & Durable Medical Equipment Information Forms - January 1, 2023

EVENTS

- CMS National Provider Enrollment Conference in Boston - August 16 & 17

MLN MATTERS® ARTICLES

- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance
- Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022
- Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs)
- New Waived Tests - Revised
- Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02) - Revised

PUBLICATIONS

- Medical Record Maintenance & Access Requirements - Revised
- Medicare Mental Health - Revised

MLN Connects - May 12, 2022

Biosimilars Curriculum: Resources for Teaching Your Students

MLN Connects newsletter for Thursday, May 12, 2022

NEWS

- Comprehensive Error Rate Testing Documentation Center Moved on April 13
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Ambulance Prior Authorization Model Expands June 1
- Clinical Laboratory Fee Schedule 2023 Preliminary Gapfill Rates: Submit Comments by July 11
- Medicare Cards Without Full Names
- CMS Releases Chronic Pain Experience Journey Map
- Biosimilars Curriculum: Resources for Teaching Your Students
- Women's Health: Talk to Your Patients About Preventive Services

COMPLIANCE

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

EVENTS

- HCPCS Public Meeting - June 7-10

MLN MATTERS® ARTICLES

- Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model - Implementation
- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests
- National Coverage Determination (NCD) 210.14 Reconsideration - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

INFORMATION FOR MEDICARE PATIENTS

- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

MLN Connects - May 19, 2022

Biosimilars: Safe, Effective, & May Reduce Patient Costs

MLN Connects newsletter for Thursday, May 19, 2022

NEWS

- Biosimilars: Safe, Effective, & May Reduce Patient Costs
- PECOS Scroll Functionality
- Clinical Laboratory Improvement Amendments: Unpaid Certificate Fees
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB)
- Mental Health: Help Address Disparities

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

MLN MATTERS® ARTICLES

- Elimination of Certificates of Medical Necessity & Durable Medical Equipment Information Forms
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)-October 2022 Update
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2

PUBLICATIONS

- Chronic Care Management Services - Revised
- Home Health Quality Reporting Program: Draft OASIS-E Guidance Manual

MLN Connects - May 26, 2022

Biosimilars: Interchangeable Products May Increase Patient Access

MLN Connects newsletter for Thursday, May 26, 2022

NEWS

- COVID-19: New Administration Code for Pfizer Pediatric Vaccine Booster Dose
- Biosimilars: Interchangeable Products May Increase Patient Access
- Critical Care Evaluation & Management Services: Comparative Billing Report in May

COMPLIANCE

- Surgical Dressings: Medicare Requirements

PUBLICATIONS

- Screening Pap Tests & Pelvic Exams - Revised

MLN Connects - June 2, 2022

ICD-10-PCS Procedure Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 2, 2022

NEWS

- Medicare Shared Savings Program: Application Deadlines for January 1 Start Date

CLAIMS, PRICERS, & CODES

- ICD-10-PCS Procedure Codes: Fiscal Year 2023
- July 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.2

MULTIMEDIA

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program - Part 1

MLN Connects - June 9, 2022

Learn about the CMS National Quality Strategy

MLN Connects newsletter for Thursday, June 9, 2022

NEWS

- CMS National Quality Strategy: A Person-Centered Approach to Improving Quality
- Strategy to Strengthen Behavioral Health Care
- Program for Evaluating Payment Patterns Electronic Reports for Short-Term Acute Care Hospitals
- Interns and Residents Information System (IRIS) XML Format
- LGBTQ+ Community: Help Address Disparities

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

MLN MATTERS® ARTICLES

- Update to 'J' Drug Code List for Billing Home Infusion Therapy (HIT) Services
- July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

PUBLICATIONS

- Medicare Preventive Services - Revised

MLN Connects - June 16, 2022

ICD-10-CM Diagnosis Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 16, 2022

NEWS

- Comprehensive Error Rate Testing Program Report: Sample Reduced for Reporting Year 2023
- Men's Health: Talk to Your Patients About Preventive Services

COMPLIANCE

- Implanted Spinal Neurostimulators: Document Medical Records

CLAIMS, PRICERS, & CODES

- ICD-10-CM Diagnosis Codes: Fiscal Year 2023
- July 2022 Quarterly Average Sales Price [ASP] Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN MATTERS® ARTICLES

- July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

MLN Connects Special Edition - June 21, 2022 - Home Health and ESRD Proposed CY 2023 Payment Rules

Home Health & ESRD Proposed CY 2023 Payment Rules

HOME HEALTH AGENCIES: CALENDAR YEAR 2023 PROPOSED RULE - SUBMIT COMMENTS BY AUGUST 16

CMS issued a Calendar Year (CY) 2023 Home Health Prospective Payment System (HH PPS) Rate Update proposed rule to update Medicare payment policies and rates for home health agencies. See a summary of key provisions. Proposals include:

- Routine updates to the Medicare HH PPS and home infusion therapy services payment rates for CY 2023
- Permanent prospective payment adjustment to the home health 30-day period payment rate
- Requests for input on how best to implement a temporary payment adjustment for CYs 2020 and 2021, and collecting telehealth data on home health claims

We encourage you to review the rule, and submit formal comments by August 16, 2022.

ESRD FACILITIES: CALENDAR YEAR 2023 PROPOSED RULE-SUBMIT COMMENTS BY AUGUST 22

CMS issued a Calendar Year 2023 ESRD Prospective Payment System (PPS) proposed rule to update Medicare payment policies and rates for renal dialysis services. See a summary of key provisions. Proposals include:

- Rebase and revise ESRD Bundled market basket to a 2020 base year and update the labor-related share
- Change ESRD PPS methodology for calculating the outlier threshold for adult patients
- Apply a permanent 5% cap on decreases in the ESRD PPS wage index and increase the wage index floor
- Change definition of "oral-only drug" beginning January 1, 2025, and clarify ESRD PPS functional category definitions
- Request comments on whether 3 products meet eligibility criteria for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Request input on a potential add-on payment adjustment for new renal dialysis drugs and biological products and health equity issues under the ESRD PPS, with a focus on pediatric dialysis payment
- Update requirements and input requests for the ESRD Quality Incentive Program

We encourage you to review the rule, and submit formal comments by August 22, 2022.

MLN Connects - June 23, 2022

Medical Records Correspondence Address

MLN Connects newsletter for Thursday, June 23, 2022

NEWS

- Ambulance Prior Authorization Model Expands August 1
- Orthoses Referring Providers: Comparative Billing Report in June
- Medical Records Correspondence Address
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by July 15
- Long-Term Care Hospital Provider Preview Report: Review by July 15
- Cognitive Assessment: What's in the Written Care Plan?

CLAIMS, PRICERS, & CODES

- Quarterly Update to the National Correct Coding Initiative [NCCI] Procedure-to-Procedure [PTP] Edits, Version 28.2, Effective July 1, 2022

MLN MATTERS® ARTICLES

- July Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

PUBLICATIONS

- Medicare Diabetes Self-Management Training - Revised

MLN Connects - June 30, 2022

No Surprises Act: Fact Sheets for Your Patients

MLN Connects newsletter for Thursday, June 30, 2022

NEWS

- CMS Issues Significant Updates to Improve the Safety and Quality Care for Long-Term Care Residents & Calls for Reducing Room Crowding
- COVID-19: Pfizer-BioNTech Vaccines for Children as Young as 6 Months - New Codes
- New Model to Improve Cancer Care for Medicare Patients: Apply by September 30
- Internet-Only Manual Update to Publication 100-04, Chapter 16, Sections 70.5, 70.8, and 70.9 to Remove References to the Clinical Laboratory Improvement Amendments (CLIA) Files
- Provide Ostomy Supplies Promptly

EVENTS

Cancelled - CMS National Provider Enrollment Conference in Boston

MLN MATTERS® ARTICLES

- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2022
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2 - Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - July 2021 – Revised

PUBLICATIONS

- Hospital Price Transparency - Updated Resources
- Medicare Provider Enrollment - Revised

INFORMATION FOR MEDICARE PATIENTS

- No Surprises Act: Fact Sheets for Your Patients

MLN MATTERS .....

Calendar Year 2023 Modifications/Improvements to VBID Model - Implementation

MLN Matters Number: MM12688
Related CR Release Date: April 29, 2022
Related CR Transmittal Number: R11383DEMO
Related Change Request (CR) Number: 12688
Effective Date: January 1, 2023
Implementation Date: January 3, 2023

CR 12688 tells you about:

- Modifications in the Value-Based Insurance Design (VBID) Model's Hospice Benefit Component for Calendar Year (CY) 2023; and
- The applicable requirements in CR 11754 and CR 12349 that still apply.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12688.

Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests

MLN Matters Number: MM12656
Related CR Release Date: April 29, 2022
Related CR Transmittal Number: R11374OTN
Related Change Request (CR) Number: 12656
Effective Date: January 1, 2022
Implementation Date: January 1, 2023

CR 12656 tells you about:

- Reduced coinsurance for certain screening flexible sigmoidoscopies and screening Colonoscopies

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12656.

Changes to the Laboratory NCD Edit Software for October 2022

MLN Matters Number: MM12803
Related CR Release Date: June 23, 2022
Related CR Transmittal Number: R11465CP
Related Change Request (CR) Number: 12803
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12803 tells you about:

- Changes to the Laboratory National Coverage Determination (NCD) Edit Module for October 2022
- How to access the NCD spreadsheet that lists relevant changes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12803.

Claim Status Category and Claim Status Codes Update

Related CR Release Date: February 4, 2022
Related CR Transmittal Number: R11251CP
Related Change Request (CR) Number: 12505
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12505 is to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12505.

Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759

Related CR Release Date: April 22, 2022
Related CR Transmittal Number: R11362CP
Related Change Request (CR) Number: 12686
Effective Date: January 11, 2022
Implementation Date: July 5, 2022

CR 12686 provides instructions to update the Common Working File (CWF) and the Fiscal Intermediary Shared System (FISS) to include the new. Hepatitis B vaccine code. This update will include new Hepatitis B vaccine code 90759 for claims with dates of service on or after January 11, 2022.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12686.

Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 - Revised

MLN Matters Number: MM12439 Revised
Related CR Release Date: March 29, 2022
Related CR Transmittal Number: R11329CP
Related Change Request (CR) Number: 12439
Effective Date: July 1, 2021, for 90677, July 16, 2021, for 90671
Implementation Date: April 4, 2022

Note: CMS revised this Article due to a revised CR 12439. The revised CR shows the MACs will adjust certain previously processed and rejected claims with HCPCS code 90671 after April 4, 2022. CMS made the same change in the Article in dark red font on page 2. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 12439 tells you about:

- A new code for a pneumococcal vaccine
- Where to find pricing for the code
- The basis for Medicare's payment to institutional providers for this code

Make sure your billing staff knows about new vaccine code:

- 90677, which is effective for Dates of Service (DOS) on or after July 1, 2021
- 90671, which is effective for DOS on or after July 16, 2021

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12439.

ICD-10 and Other Coding Revisions to NCDs - July 2021 - Revised

MLN Matters Number: MM12124 Revised
Related CR Release Date: June 10, 2022
Related CR Transmittal Number: R11453OTN
Related Change Request (CR) Number: 12124
Effective Date: July 1, 2021
Implementation Date: July 6, 2021

Note: CMS revised this article due to a revised CR 12124. The CR revision changed business requirements for NCD 90.2, Next Generation Sequencing. This results in a new spreadsheet for that NCD by retaining all ICD-10 Not Otherwise Classified (NOC) diagnosis codes proposed for deletion effective July 1, 2022. See important note in dark red font on page 2. Also, CMS changed the CR release date, transmittal number, and the CR web address. All other information is the same.

CR 12124 tells you about updates of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These changes result from:

- Newly available code
- Coding revisions to NCDs released separately
- Coding feedback received

CMS continues to implement any policy-related changes to NCDs via the current, longstanding NCD process. There are no policy-related changes with these updates. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12124.

ICD-10 and Other Coding Revisions to NCDs--October 2022

MLN Matters Number: MM12705
Related CR Release Date: May 4, 2022
Related CR Transmittal Number: R11400OTN
Related Change Request (CR) Number: 12705
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12705 tells you about:

- Newly available codes
- Separate National Coverage Determination (NCD) coding revisions
- Coding feedback

Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12705.

CMS isn't including any policy changes in this International Classification of Diseases, 10th Revision (ICD-10) quarterly update. CMS covers NCD policy changes using the current, longstanding NCD process.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12705.

Internet Only Manual Update to Publication 100-04, Chapter 16, Sections 70.5, 70.8, and 70.9 to Remove References to the CLIA Files

Related CR Release Date: June 23, 2022
Related CR Transmittal Number: R11463CP
Related Change Request (CR) Number: 12766
Effective Date: July 25, 2022
Implementation Date: July 25, 2022

CR 12766 revises the claims processing manual, publication 100-04, chapter 16, sections 70.5, 70.8, and 70.9. These changes are being made to remove the references to the Clinical Laboratory Improvement Amendments (CLIA) files.

These files are mentioned in the following chapter 16 sections:

- 70.5 - CLIA Categories and Subcategories
- 70.8 - Certificate of Waiver
- 70.9 - Healthcare Common Procedure Coding System Subject To and Excluded From CLIA Edits

Information regarding CLIA test complexity categorization can be found by searching the U.S. Food and Drug Administration website (http://www.fda.gov/).

View the complete CMS Change Request (CR)12766.

July 2022 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: March 29, 2022
Related CR Transmittal Number: R11318CP
Related Change Request (CR) Number: 12685
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12685 tell you that the Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in chapter 4, section 50 of the Internet Only Manual.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12685.

July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised

MLN Matters Number: MM12773 Revised
Related CR Release Date: June 23, 2022
Related CR Transmittal Number: R11472CP
Related Change Request (CR) Number: 12773
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

Note: CMS revised this Article due to a revised CR 12773. The CR revision removed HCPCS codes A9601 and J0739 from Table 3 of the CR and reduced the number of new codes from 16 to 14 in Section 3a, as shown in dark red font on page 2. CMS also revised the CR release date, transmittal number, and the CR web address. All other information is the same.

CR 12773 tells you about:

- A new CPT Category III Code effective July 1, 2022
- Newly established HCPCS codes for drugs, biologicals, and radiopharmaceuticals effective July 1, 2022
- New skin substitute products and low-cost/high-cost group assignment effective July 1, 2022

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12773.

July Quarterly Update for 2022 DMEPOS Fee Schedule

MLN Matters Number: MM12772
Related CR Release Date: June 9, 2022
Related CR Transmittal Number: R11451CP
Related Change Request (CR) Number: 12772
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12772 tells you about:

- The July 2022 quarterly update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule
- Fee schedule amounts for new and existing codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12772.

Mental Health Visits via Telecommunications for RHCs & FQHCs

MLN Matters Number: SE22001 Revised
Article Release Date: June 6, 2022

SE22001 tells you about:

- Regulatory changes for mental health visits in Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)
- Billing information for mental health visits done via telecommunications

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)22001.

NCD 210.14 Reconsideration - Screening for Lung Cancer with LDCT

MLN Matters Number: MM12691
Related CR Release Date: April 29, 2022
Related CR Transmittal Number: R11388CP, R11388NCD
Related Change Request (CR) Number: 12691
Effective date: February 10, 2022
Implementation Date: October 3, 2022

CR 12691 tells you about National Coverage Determination (NCD) 210.14:

- CMS expanded patient eligibility for screening for lung cancer with low dose computed tomography (LDCT), including lowering the minimum age for screening
- CMS removed the restriction that a physician or non-physician practitioner must provide the counseling and shared decision-making (SDM)
- CMS removed the requirement that facilities participate in a registry

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12691.

New Waived Tests - Revised

MLN Matters Number: MM12581 Revised
Related CR Release Date: April 26, 2022
Related CR Transmittal Number: R11363CP
Related Change Request (CR) Number: 12581
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

Note: CMS revised this Article due to a revised CR 12581. The CR revision changed the HCPCS code for the test with an effective date of November 10, 2021. CMS made the same change to the Article. You'll find substantive content updates in dark red font on page 2. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

CR 12581 tells you about:

- The latest tests approved by the FDA as waived tests under CLIA
- Laboratory claim edits
- Facility certification requirements

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12581.

Quarterly Update for CLFS and Laboratory Services Subject to Reasonable Charge Payment

MLN Matters Number: MM12737
Related CR Release Date: May 4, 2022
Related CR Transmittal Number: R11398CP
Related Change Request (CR) Number: 12737
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12737 tells you about:

- Where to find updates pertaining to Advanced Diagnostic Laboratory Tests (ADLTs)
- Delays in the next Clinical Laboratory Fee Schedule (CLFS) data reporting period for clinical diagnostic laboratory tests
- New codes, effective July 1, 2022

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12737.

Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Related CR Release Date: March 25, 2022
Related CR Transmittal Number: R11299CP
Related Change Request (CR) Number: 12668
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12668 provides the July 2022 quarterly update to the list of HCPCS codes used by Medicare systems to enforce consolidated billing of home health services. The attached recurring update notification applies to chapter 10, section 20.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12668.

Quarterly Update to the MPFSDB - July 2022 Update

Article Release Date: May 12, 2022
Related CR Transmittal Number: R11408CP
Related Change Request (CR) Number: 12747
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12747 amends the payment files, which were issued to contractors based upon the 2022 Medicare Physician Fee Schedule Database (MPFSDB) Final Rule. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12747.

Quarterly Update to the NCCI PTP Edits, Version 28.2, Effective July 1, 2022

Related CR Release Date: March 25, 2022
Related CR Transmittal Number: R11309CP
Related Change Request (CR) Number: 12680
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12680 is the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12680.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM12676
Related CR Release Date: March 25, 2022
Related CR Transmittal Number: R11301CP
Related Change Request (CR) Number: 12676
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12676 tells you about:

- The latest update of the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) code sets
- What you must do if you use Medicare Remit Easy Print (MREP) or PC Print
- Where to find the official code lists

If you use MREP or PC Print, be sure to get the latest version when available.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12676.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM12774
Related CR Release Date: June 23, 2022
Related CR Transmittal Number: R11466CP
Related Change Request (CR) Number: 12774
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12774 tells you about:

- The latest update of the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) code sets
- What you must do if you use Medicare Remit Easy Print (MREP) or PC Print
- Where to find the official code lists

If you use MREP or PC Print, be sure to get the latest version when available.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12774.

Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2 - Revised

MLN Matters Number: MM12723 Revised
Related CR Release Date: June 6, 2022
Related CR Transmittal Number: R11448BP
Related Change Request (CR) Number: 12723
Effective Date: July 1, 2021
Implementation Date: June 6, 2022

Note: CMS revised this Article due to a revised CR 12723. The revised CR added language that was inadvertently left out of the CR. CMS added that language in dark red font on page 2. CMS also revised the CR release date, transmittal number, and the CR web address. All other information is the same.

CR 12723 tells you about:

- CMS updated the Medicare coverage for pneumococcal vaccinations to align with the Advisory Committee on Immunization Practices (ACIP) recommendations
- The ACIP recommendations vary based on patient age and risk factors

Make sure your billing staff knows about these changes to the Benefit Policy Manual.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12723.

Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance

MLN Matters Number: MM12707
Related CR Release Date: April 28, 2022
Related CR Transmittal Number: R11365CP
Related Change Request (CR) Number: 12707
Effective Date: May 31, 2022
Implementation Date: May 31, 2022

CR 12707 tells you about:

- Billing when the patient dies before the ambulance arrives
- Billing when the patient dies after being loaded on the ambulance

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12707.

Update to 'J' Drug Code List for Billing Home Infusion Therapy (HIT) Services

MLN Matters Number: MM12667
Related CR Release Date: May 24, 2022
Related CR Transmittal Number: R11430OTN
Related Change Request (CR) Number: 12667
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12667 tells you about:

- Updates due to Section 5012(d) of the 21st Century Cures Act detailing necessary changes to those systems and processes to include a newly assigned HCPCS drug code for payment beginning July 1, 2022.
- Updates the list of home infusion drugs to add J1551 to payment category 2. The corresponding G-codes for category 2 drugs are G0069 or G0089.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12667.

Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding COVID-19 and its Administration to Current Claims Processing Requirements and Other General Updates

MLN Matters Number: MM12634
Related CR Release Date: April 14, 2022
Related CR Transmittal Number: R11355BP and R11355CP
Related Change Request (CR) Number: 12634
Effective Date: May 16, 2022
Implementation Date: May 16, 2022

CR 12634 tells you about:

- Add information for Novel Coronavirus (COVID-19) claims processing
- Revise the centralized billing enrollment process to streamline provider enrollment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12634.