

Medicare B News

Jurisdiction E

October 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>

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select “Subscribe” on the bottom right-hand corner of any page.



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

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Healthcare Solutions



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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>. 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>

A2002-A2010 - Priced per invoice

The below list of codes are 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.

A2002, **Mirrugen advanced wound matrix, per square centimeter**

A2003, **Bio-connekt wound matrix, per square centimeter**

A2004, **Xcellistem, per square centimeter**

A2005, **Microlyte matrix, per square centimeter**

A2006, **Novosorb synpath dermal matrix, per square centimeter**

A2007, **Restrata, per square centimeter**

A2008, **Theragenesis, per square centimeter**

A2009, **Symphony, per square centimeter**

A2010, **Apis, per square centimeter**

ADR Development Errors - Resolved 09/28/22

Provider/Supplier Type(s) Impacted: Providers who received Additional Documentation Request (ADR) letter(s) dated August 17 through August 26 may be impacted.

Reason Codes: Variable

Claim Coding Impact: N/A

Description of Issue: Additional, unintended, ADRs may have been requested in error and sent to Providers. Noridian does not have a way to identify which ADRs were sent incorrectly at this time.

Noridian Action Required: Noridian is attempting to identify ADRs sent in error and remove the ADR to allow the claim(s) to process without the need for the documentation.

Provider/Supplier Action Required: Providers should review any ADRs dated August 17 through August 26. If the ADR refers to one of the five below scenarios, follow the instructions in the ADR. If the ADR does not meet the scenarios below, providers should monitor this production alert for updates. If a paid remittance advice for the claim is received, the ADR is no longer needed and can be disregarded.

Continue to address ADRs if:

1. Providers otherwise notified of being part of a review;
2. Providers receiving documentation requests for Q#### CPT codes related to Amniotic services;
3. Providers receiving documentation request for codes billed with a PA, PB, or PC modifier;
4. Providers receiving documentation request for code 0295U; or
5. Providers receiving documentation request for G0460, G0465, K1004, Q4213, 93595-93598, 97151, 97156, or codes ending in "T" (####T).

Proposed Resolution/Solution: Noridian is working on a solution. Another update will be provided the week of September 16.

09/19/22 - Noridian has identified the claims which had ADRs issued in error. The claims are being released to continue processing as normal. Affected providers, who do not need to submit documentation, will begin receiving remittance advice(s) by the end of the week.

09/28/22 - Noridian released the claims not requiring ADR.

Date Reported: 09/06/22

Date Resolved: 09/28/22

Appeals and Timely Filing

Make sure your staff is aware of the time frames, and which appeal should be submitted:

Timely Filing calculator - See first link below

Submitting a Reopening, instead of a Redetermination, could cause you to miss timely filing

NOT AN APPEAL

- Reopening - 365 days from initial determination date

APPEAL LEVELS

- Redetermination - 120 days from initial determination
- Reconsideration - 180 days from Redetermination date
- Administrative Law Judge - 60 days from Reconsideration receipt date
- Medicare Appeals Council Review - 60 days from ALJ hearing decision receipt
- Federal Court Review - 60 days from receipt of Medicare Appeals Council Review

EXAMPLE:

- You send a Reconsideration 130 days after your remit date on a group of 20 claims for \$10,000 each.
- A list is generated monthly and sent to Noridian for providers that send Reconsideration, instead of Redetermination.
- Then we send out education to everyone on the list (potentially 160 days past remit date now).
- On Day 170 you try to submit a Redetermination, but you are past timely filing.
- Your appeal is denied. There is NO late forgiveness for appeals.
- You have now lost \$200,000.00

Submitting a reopening leaves your level of appeals open but always keep track of your timely filing dates

Appeals have shorter times allowed than Reopening

*Initial Determination Date - The date your claim processed the first time

- [Noridian Medicare JE Part B Timeliness Calculators](#)
- [CMS Internet Only Manual \(IOM\) Publication 100-04 Chapter 29 Appeals of Claim Decisions](#)
- [CMS Internet Only Manual \(IOM\) Publication 100-04 Chapter 34 Reopening and Revision of Claim Determinations and Decisions](#)

Appropriate Use of Fax Numbers

Noridian would like to remind providers to utilize the appropriate fax numbers to ensure inquiries are processed in a timely manner. To view departmental fax numbers, please visit our [fax numbers webpage](#).

CERT Documentation Deadline August 22, 2022

The end to the Comprehensive Error Rate Testing (CERT) Review Year (RY) 2022 is quickly coming to an end. In order to give sufficient time for the CERT Review Contractor (RC) to complete the review of your claims, all documentation and additional documentation must be received by **August 22, 2022** to be considered for review. A favorable CERT decision restores recouped money and lowers the provider or supplier error rate. Any questions can be sent to the Noridian CERT team at the following email addresses.

- Part A JE and JF: CERTPartAQuestion@noridian.com
- Part B JE and JF: CERTQuestion@noridian.com
- DME JA: JADMECERT@noridian.com
- DME JD: JDDMECERT@noridian.com

CERT Redetermination Deadline September 13, 2022

The end to the Comprehensive Error Rate Testing (CERT) Review Year (RY) 2022 is quickly coming to an end. The deadline for redetermination submission is September 13, 2022 to be considered for the CERT RY. Noridian requests redeterminations be submitted by **September 6, 2022** to allow time for processing. A favorable redetermination decision restores recouped money and lowers the provider or supplier error rate. Any questions can be sent to the Noridian CERT team the following email addresses.

- Part A JE and JF: CERTPartAQuestion@noridian.com
- Part B JE and JF: CERTQuestion@noridian.com
- DME JA: JADMECERT@noridian.com
- DME JD: JDDMECERT@noridian.com

CMS-855O Application - Enrollment for Eligible Ordering/Certifying Physicians and Other Eligible Professionals

Do You Only Order or Certify Services? Use Revised Enrollment Form CMS-855O by January 1

The revised Enrollment for Eligible Ordering/Certifying Physicians and Other Eligible Professionals (Form CMS-855O) is required beginning January 1, 2023. We'll post it on the CMS Forms List (<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List>) by early fall.

Medicare Administrative Contractors will accept the current and revised versions of Form CMS- 855O through December 31, 2022. Visit the Medicare Provider Enrollment and Certification webpage (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification>) for more information.

Changes to the form include:

- New title
- Uniform language across all CMS 855 applications
- Revised reporting requirements and formatting in Section 3: Final Adverse Legal Actions
- 8 new specialties, including Adult Congenital Heart Disease
- Corrections in response to public comments

Coding Resources to Answer Your Questions

Providers have asked Noridian for help on procedural and diagnostic coding for their claims. Noridian understands the importance of using the appropriate codes. Providers are encouraged to reach out to their specialty associations, the [American Medical Association \(AMA\)](#) or the [American Hospital Association \(AHA\) Coding Clinic Advisor](#) to assist with coding questions. The HCPCS Quarterly Updates is also a great searchable resource provided by CMS.

Noridian call centers and education representatives are not permitted to provide coding advice. The [CMS IOM Publication 100-09, Chapter 6, Section 30.3.1](#) indicates providers are responsible for determining the correct diagnostic and procedural coding for services they furnish to the beneficiary.

Correct Medicare Contact Information for Beneficiaries

Noridian has received an increase of inquiries from beneficiaries. As a Medicare Administrative Contract (MAC), Noridian is unable to speak directly with beneficiaries about their claims, eligibility, or other questions. Providers may refer beneficiaries to the following phone numbers if they need assistance:

- For updates to their demographic information (e.g., name, date of birth, Medicare effective date), beneficiaries may refer to social security at 1-800-772-1213.
- For updates to their Medicare Secondary Payer (MSP) information beneficiaries may refer to the Benefits Coordination and Recovery Contract (BCRC) at 1-855-798-2627.
- For all other questions, beneficiaries can refer to the Medicare Beneficiary Call Center at 1-800-633-4227.

RESOURCES

- [CMS Internet Only Manual \(IOM\) Publication 100-09, Provider Communications Manual, Chapter 2, Section 20.2](#)

COVID-19 Monoclonal Antibody Therapy Q0222 Injection, Bebtelovimab, 175 mg Payment Allowance Update

On August 15, drug manufacturer, Eli Lilly, will start commercial distribution of their COVID-19 monoclonal antibody therapy, [bebtelovimab, 175 mg](#). CMS will pay 95% average wholesale price (AWP) or \$2394.00 for this product.

You might have both United States Government (USG)-purchased and commercial product in your inventory. For dates of service on or after August 15, only bill Medicare if you use commercially purchased products; don't bill for USG-purchased products. Continue to bill for administering either type of product.

Check the Batch # on the vial. If the Batch # is D534422, the product was commercially purchased. Watch for Eli Lilly to release more information about future batch numbers.

Continue to use the HCPCS codes from the [CMS COVID-19 Vaccines and Monoclonal Antibodies](#) webpage:

- Q0222: Injection, 175 mg for the product
- M0222: Intravenous injection, includes injection and post administration monitoring
- M0223: Intravenous injection, includes injection and post administration monitoring in the home or residence; this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency

There's no cost sharing (no copayment/coinsurance or deductible) through the calendar year that the COVID-19 public health emergency ends for monoclonal antibody therapies to treat COVID-19 for people with Medicare.

More Information:

- [COVID-19 Monoclonal Antibodies](#) webpage
- [COVID-19 Vaccine and Monoclonal Antibodies](#) ASP webpage

Source: CMS [MLN Connects](#) dated August 11, 2022

COVID-19 Novavax Vaccine, Adjuvanted New Codes

The FDA authorized emergency use of the [Novavax COVID-19 vaccine, Adjuvanted](#) for the prevention of COVID-19 disease in patients 18 years and older. CMS issued three new CPT codes for the vaccine product (91304) and the administration (0041A, 0042A) effective July 13, 2022.

Beneficiary cost sharing shall not be applied to the new vaccine product code or the new administration codes.

Code 91304 for vaccine product:

- Long descriptor: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage, for intramuscular use
- Short descriptor: SARSCOV2 VAC 5MCG/0.5ML IM

Code 0041A for vaccine administration, first dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; first dose
- Short descriptor: ADM SARSCOV2 5MCG/0.5ML 1ST

Code 0042A for vaccine administration, second dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; second dose
- Short descriptor: ADM SARSCOV2 5MCG/0.5ML 2ND

Visit the [COVID-19 Vaccine Provider Toolkit](#) for more information, and get the COVID-19 Vaccines and Monoclonal Antibodies [most current list of billing codes, payment allowances, and effective dates](#). Note: You may need to refresh your browser if you recently visited this webpage.

Source: CMS [MLN Connects](#) dated July 21, 2022

DME Certificates of Medical Necessity (CMN) Discontinued by CMS for Dates of Service Starting January 2023

As part of its ongoing efforts to increase access to care and to reduce unnecessary administrative burden for stakeholders, CMS will be discontinuing the use of certificates of medical necessity (CMNs) and durable medical equipment (DME) information forms (DIFs) for claims with dates of service on or after January 1, 2023. CMS suppliers must continue to submit CMN and DIF information for claims with dates of service before January 1, 2023, if it's required.

This change in process aligns with the Biden-Harris Administration's priority of improving access to quality, affordable care, and coverage by enabling quicker access to needed medical supplies for people with Medicare. It also enables frontline clinicians to focus on providing direct care and streamlines the coverage process for suppliers.

Originally, CMS required the CMNs and DIFs to help document medical necessity and other coverage criteria for selected DME. Through stakeholder outreach, CMS received feedback that CMNs and DIFs are burdensome and duplicative of information already available on the claim or in the medical record. Additionally, CMS heard that submission of these forms is often particularly difficult for small or rural providers without administrative staff and technical support. In response to this feedback, CMS evaluated options for easing this process and determined it could end the use of these forms.

For more information, see [MLN Matters Article SE22002 \(PDF\)](#).

Source: CMS [MLN Connects](#) dated August 18, 2022

Facet Joint Interventions for Pain Management Questions and Answers

Following Noridian's July 2022, webinar, the below questions and answers have been compiled with the Noridian Education and Medical Review team members to offer clarity.

Q1: Is a patient allowed four diagnostic and four therapeutic injections in a rolling 12 months?

A1: Correct. Four diagnostic and four therapeutic injections are allowed in a rolling 12-month period for CPT 64490, 64491, 64493, 64494. CPT 64633-64636 only allow two sessions in 12 months, 64492 and 64495 are only allowed on appeals basis.

Q2: Can we have clarification of pain scales?

A2: Pain assessment must be performed and documented at baseline and after each diagnostic procedure using the same pain scale for each assessment. The scales used for measurement of pain and/or disability must be documented in the medical record. Acceptable scales include but are not limited to: verbal rating scales, Numerical Rating Scale (NRS), Visual Analog Scale (VAS) for pain assessment, Pain Disability Assessment Scale (PDAS), Oswestry Disability Index (ODI), Oswestry Low Back Pain Disability Questionnaire (OSW), Quebec Back Pain Disability Scale (QUE), Roland Morris Pain Scale, Back Pain Functional Scale (BPFS), and the Patient-Reported Outcomes Measurement Information System (PROMIS) profile domains to assess function.

[LCD - Facet Joint Interventions for Pain Management \(L38801\)](#)

Q3: Do you have references to support the KX modifier for pain injections for all three levels?

A3: The KX modifier should be appended to the line for all diagnostic injections. In most cases, the KX modifier will only be used for the two initial diagnostic injections. If the initial diagnostic injections do not produce a positive response as defined by the policy and are not indicative of identification of the pain generator, it is necessary to perform additional diagnostic injections at different levels and append the KX modifier to the line. Aberrant use of the KX modifier may trigger focused medical review. The KX modifier demonstrates medical necessity. The need for a three or four-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal. A session is a time period, which includes all procedures (i.e., medial branch block (MBB), intraarticular injections (IA), facet cyst ruptures, and radiofrequency ablation (RFA) that are performed during the same day. Also, remember that the diagnostic blocks and all requirements must be met for each level injected.

Q4: Is the diagnostic procedure required before the therapeutic procedure?

A4: Yes. Two diagnostic procedures, two weeks apart, with the defined criteria in the policy are required before any additional procedure. For the beneficiary to receive any therapeutic intraarticular injections, there must be documentation of why the beneficiary is not able to go on to the definitive treatment of radiofrequency ablation (RFA).

Q5: With respect to therapeutic intraarticular (IA) injections, Noridian requires providers to state why Radiofrequency ablation (RFA) is unable to be performed. If the patient refuses or has failed an (RFA), is this sufficient?

A5: If a patient refuses an RFA or has failed RFA at the same site as the current pain generator, then those are acceptable to perform a therapeutic injection, meeting the same criteria of response to diagnostic injections, etc. is required by the LCD. However, if a large percentage of patients in a practice all refuse or fail RFA routinely, it could trigger a review.

Q6: Can conscious sedation be used for an RFA? Is monitored anesthesia care (MAC) for RFAs allowable?

A6: General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor (MAC) is routinely necessary for intraarticular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be provided on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.

Q7: If the patient has symptoms at two separate regions (T12-L1 and L1-L2). Do they have to have procedures on separate days?

A7: Correct. One region per session is allowed. Reminder that Lumbar (L1-L5) and Thoracic (T1-T12) are different regions.

Q8: If a provider performs 2 medial branch blocks (MBBs), then are we required to do a Radiofrequency ablation (RFA)?

A8: Diagnostic procedures should be performed with the intent that if successful, radiofrequency ablation (RFA) procedure would be considered the primary treatment goal at the diagnosed level(s).

Q9: If the diagnosis supports medical necessity, and the claim is denied for medical necessity, does that typically mean the denial was based on frequency?

A9: Yes, a medical necessity denial may be based on inappropriate frequency, documentation not supporting the diagnosis reported, failure to document pre and post procedure pain levels, number of levels or regions addressed or any other documented failure to adhere to the provisions of the LCD, some of which may be determined on review or appeal.

Q10: We have patients who have greatly benefited from three level facet injections previously and are wanting to continue, even if they must pay for it. The physician would not do a third level if he did not feel it was necessary. Why are providers supposed to perform the procedure, then hope to get paid on appeal? Providers should be allowed to obtain an Advance Beneficiary Notice (ABN) from the patient and have them pay for it if they are requesting it, if Medicare does not feel it meets their criteria. Otherwise, we will be providing them for free.

A10: Yes, providers would be correct in obtaining an ABN from the patient in this circumstance and append the GA modifier

on the claim. If the third level procedure were appealed, and found to be reasonable and necessary on appeal, the beneficiary would be reimbursed.

Q11: What would be considered medically necessity for an additional third or more level at the first level of appeal?

A11: Establishing medically reasonable and necessary criteria for a third or more levels would start with responses to the two required diagnostic blocks. Frequency limitations per session are one to two levels, either unilateral or bilateral, per spinal region. This means the maximum levels identified in any diagnostic work up would be two levels identified with the two sessions. For each covered spinal region, four diagnostic joint sessions will be reimbursed per rolling 12 months. Should the provider and beneficiary still believe that additional facet joints could be contributing to pain outside of the area where the diagnostic facet injections have been completed, supporting documentation would be required to allow the provider to perform the additional two diagnostic blocks in the same spinal region, with the same criteria of 80 percent pain reduction after each.

Q12: Can transforaminal epidural injection (TFESI) and facet injections to one area of the spine be performed at the same time?

A12: It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as facet joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection (at the same or a different level[s]) must be clearly documented in the medical record. For example, the performance of both paravertebral facet joint procedures(s) and a TFESI at the same or close spinal level at the same encounter would not be expected unless a synovial cyst is compressing the nerve root. In this situation, TFESI may provide relief for the radicular pain, while the facet cyst rupture allows nerve root decompression. Frequent reporting of multiple blocks on the same day may trigger a focused medical review.

Q13: If a patient cannot have the RFA due to a spinal cord stimulator, for example, and injections are performed for pain as therapeutic, is the third level appealable because its therapeutic?

A13: Yes, however, the documentation must support why an RFA is unable to be performed. Independent consideration may be considered with sufficient documentation on appeal.

Q14: How can we bill T12-L1 and L1-L2?

A14: Only one region is allowed per session per day as lumbar and thoracic are different regions. The limitations section of the LCD states, "It is not expected that patients will routinely present with pain in both cervical/thoracic and lumbar spinal regions. Therefore, facet joint interventions (both diagnostic and therapeutic) are limited to one spinal region per session. Since T12/L1 is coded using CPT 64490 and L1/L2 is coded using CPT 64493 and these are different spinal regions, these two levels would not be appropriate to perform in the same session."

Q15: If an RFA was performed six years ago and patient reports the same symptoms, do we go right to repeat RFA?

A15: Yes, if the symptoms are the same and there is no question the same level is the source of pain.

Q16: Can practitioners perform four injections on the same side in one session?

A16: No, the policy allows a maximum of two unilateral or two bilateral per session (one spinal region allowed per session with one-two levels unilateral or bilateral per session).

Q17: Are there any extenuating circumstances (i.e., patients taking anticoagulants, etc.) that would allow a second diagnostic test sooner than two weeks?

A17: Yes, if documentation supports it, it will be considered for payment upon review.

Q18: Can a person who has an anterior lumbar interbody fusion have an RFA above or below the anterior lumbar interbody fusion site?

A18: Yes, an RFA can be performed above or below the fusion site.

Flu Shot: Encourage Preferred Vaccines for Patients 65+

It's time to talk with your patients about flu shots. The CDC recommends annual flu shots for everyone 6 months and older by the end of October or as soon as possible each flu season. You can give flu and COVID-19 vaccines at the same visit.

New for this flu season: [Patients 65 and older](#) should get a preferred vaccine if available. Preferred vaccines are potentially more effective than standard dose flu vaccines. There are 3 recommended vaccines:

1. [Fluzone High-Dose Quadrivalent vaccine](#)
2. [Flublok Quadrivalent recombinant flu vaccine](#)
3. [Fluad Quadrivalent adjuvanted flu vaccine](#)

If one of these recommended vaccines isn't available, give your patients a standard-dose flu vaccine instead.

Medicare Part B covers the seasonal flu shot and additional flu shots if medically necessary. Your patients pay nothing if you accept assignment.

You can now check [eligibility \(PDF\)](#) for the flu shot. If you need help, contact your eligibility service provider. CMS gives information from claims billed in the last 18 months:

- CPT or HCPCS codes
- Dates of service
- NPIs who administered the shots

More Information:

- [CMS Flu Shot](#) webpage
- [CDC Influenza \(Flu\)](#) webpage
- [Vaccines.gov](#)
- [Medicare Part D Vaccines \(PDF\)](#) fact sheet
- [Flu shots](#): Get information for your Medicare patients

Source

- CMS [MLN Connects](#) dated September 22, 2022

Healthy Aging: Recommend Services for Your Patients

Medicare covers many services. During Healthy Aging® Month, encourage your patients to adopt a healthy lifestyle. Recommend appropriate services, including:

- [Preventive services](#)
- [Cognitive assessment & care plan services](#)
- [Chronic care management \(CCM\) services \(PDF\)](#) booklet & CCM Health Care Professional Resources webpage
- [Behavioral health integration services \(PDF\)](#)

More Information for Your Patients:

- [Preventive & screening services](#)
- [Cognitive assessment & care plan services](#)
- [Chronic care management services](#)
- [Behavioral health integration services](#)

Source: CMS [MLN Connects](#) dated September 1, 2022

Immunization: Protect Your Patients

Adult vaccination rates remain low, especially among racial and ethnic minority populations who are less likely to be vaccinated. During National Immunization Awareness Month (NIAM), encourage your patients to get back on track with routine vaccines:

- Help protect your patients against serious diseases. Talk to them about vaccines they may have missed.
- Help high-risk patients learn about the benefits of vaccines.
- Use your recommendation to make a difference. You're a valued and trusted source of health information.
- Refer patients to other vaccine providers and follow up even if your practice doesn't administer or stock certain vaccines.

Medicare covers the following vaccines:

- [COVID-19](#)
- [Flu](#)
- [Hepatitis B](#)
- [Pneumococcal](#)

Your patients pay nothing if you accept assignment. Use the [CMS Checking Medicare Eligibility MLN Fact Sheet](#) to check eligibility for CPT or HCPCS codes, date of service, and NPI that billed for flu shots in the last 18 months. If you need help, contact your eligibility service provider.

More Information:

- [Medicare Preventive Services](#) educational tool
- [CDC NIAM](#) and [Adult Vaccination Resources](#) webpages
- Office of Minority Health: [Health Observances](#) and [Immunization and Vaccine Resources](#) webpages
- [Vaccines.gov](#) website
- [Medicare Part D Vaccines \(PDF\)](#) fact sheet
- [COVID-19 vaccine](#), [flu shots](#), [pneumococcal shots](#), and [Hepatitis B shots](#): Get information for your patients

Source:

CMS [MLN Connects](#) dated August 4, 2022

Implanted Spinal Neurostimulators: Document Medical Records

In a recent [report](#), the Office of Inspector General found that Medicare improperly paid claims for implanted spinal neurostimulators when providers didn't provide sufficient documentation supporting medical necessity. For dates of service on or after July 1, 2021, you must ask your Medicare Administrative Contractor to authorize these services before performing the procedure in the hospital outpatient department.

Learn what you need to include in patient medical records:

- [Prior Authorization and Pre-Claim Review Initiatives](#) webpage
- Section XVII [Calendar Year 2021 Hospital Outpatient Prospective Payment System](#) final rule
- Section 6.3.2.2 [Prior Authorization Program for Certain Hospital Outpatient Department Services \(PDF\)](#) operational guide
- [2021 Final List of Outpatient Department Services That Require Prior Authorization \(PDF\)](#)

Source: CMS [MLN Connects](#) dated July 21, 2022

Modifier Education On-Demand Tutorials Available

Noridian offers 10 self-paced training tutorials to assist providers and facilities in better understanding the modifiers. You may access these tutorials through our [Education On-Demand Tutorials](#) webpage.

1. Ambulance Modifiers - 4 minutes
2. Anatomical Modifiers - 3 minutes
3. Clinical Trial and Drug Modifiers - 5 minutes
4. Critical Access Hospital (CAH) Modifiers - 11 minutes
5. End Stage Renal Disease (ESRD) Modifiers - 6 minutes
6. Laboratory Modifiers - 4 minutes
7. Modifier Basics and Miscellaneous Modifiers - 7 minutes
8. Outpatient Rehabilitation Modifiers - 5 minutes
9. Surgery Modifiers 54, 55, 58, 59 - 8 minutes
10. Surgery and Co-Surgery Modifiers 62, 66, 78, 79, 80, 81, 82, AS - 9 minutes

Providers and facilities are encouraged to view our [Modifiers webpage](#), 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 to produce more tutorials and conduct education on modifiers.

Monkeypox Lab Code

Effective July 26, 2022, the Centers for Medicare and Medicaid Services (CMS) has adopted the American Medical Association (AMA) CPT code 87593 for Monkeypox laboratory diagnostic testing.

Noridian's reimbursement for Monkeypox lab test is \$35.09.

- 87593: LD: Infectious agent detection by nucleic acid (DNA or RNA); orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each MD: IADNA ORTHOPOXVIRUS AMPLIFIED PROBE TECHNIQUE EA SD: ORTHOPOXVIRUS AMP PRB EACH

Monkeypox and Smallpox Vaccine Codes 90611 and 90622

Through the World Health Organization public health emergency, the federal government will distribute Monkeypox vaccines to providers. Two new vaccine codes were developed.

- 90611 - Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use
- 90622 - Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use

When the government provides vaccines at no cost, only bill for the vaccine administration:

- Submit vaccine codes with a penny charge with the administration code(s) 90471 if just one vaccine is administered or 90471 and 90472 if additional vaccines are administered to the same beneficiary.
 - Do not charge the beneficiary when vaccines are free
- Patient cost sharing applies for the administration code

Source: CMS [MLN Connects, August 11, 2022](#), Vaccine information

CORRECTION: Monkeypox & Smallpox vaccines: Include Product Code on Claims

CMS's August 11 edition told providers to only bill for vaccine administration when they got the vaccine at no cost from the government. The correct instructions are to include these three elements on claims, even if providers receive the vaccine from the government free:

1. Product code (90611 pr 90622)
2. Applicable ICD-10 diagnosis code
3. Administration code

CMS will address the no cost government vaccine product payment adjustments during claims processing. Providers will see it on the remittance advice.

Code 90611 for smallpox and monkeypox vaccine product:

- Long descriptor: Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5mL dosage, suspension, for subcutaneous use
- Short descriptor: SMALLPOX & MONKEYPOX VAC 0.5ML

Code 90622 for vaccinia (smallpox) virus vaccine product:

- Long descriptor: Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use
- Short descriptor: Vaccinia VRS VAC 0.3ML PERQ

Patient cost sharing applies. Your Medicare Administrative Contractor will give you more information soon about coverage and billing.

Source: CMS [MLN Connects](#) dated September 1, 2022

Multi-Factor Authentication (MFA) Passcode Valid for 8 Hours

Noridian has enhanced the Multi-Factor Authentication (MFA) passcode on the Noridian Medicare Portal (NMP) to be valid for an 8-hour time period. Users will continue to request the passcode at each log in but will be able to just enter in the same passcode for 8 hours instead of receiving a new passcode at each log in. A text message or email will still be received at each log in with the same passcode.

Note: If a different MFA method is selected during the 8-hour time period, a new passcode will be provided.

Noridian recognizes that users have been asking for this enhancement and we strive to provide the best user experience possible. Thank you for your continued support of the Noridian Medicare Portal.

Opioid Treatment Programs: Comment by September 6, 2022

CMS issued the [Calendar Year \(CY\) 2023 Physician Fee Schedule \(PFS\)](#) proposed rule that includes proposals to strengthen Opioid Treatment Program (OTP) policies. See a [summary of key provisions](#).

Proposals include:

- Revising pricing methodology for drug component of methadone weekly bundle and add-on code for take-home methadone supplies
- Modifying payment rate for individual therapy in non-drug component of the bundled payments for episodes of care
- Allowing OTP intake add-on code to initiate treatment with buprenorphine provided via 2-way audio-video communications technology or audio-only technology when audio-video technology isn't available and all requirements are met
- Clarifying OTPs can bill for medically reasonable and necessary services provided via mobile units

CMS encourage you to review the rule and submit formal comments by September 6, 2022.

Source: CMS [MLN Connects](#) dated July 21, 2022

Physicians Are You Ordering Glucose Monitors and Supplies for Your Patients?

The Comprehensive Error Rate Testing (CERT) program has noted a high error rate for glucose monitor claims. The following information is provided to assist you in reducing these types of errors.

Medicare will consider coverage of a glucose monitor and related supplies when your patient's medical record shows they have diabetes and you have determined that your patient or a caregiver is sufficiently trained to use the prescribed device appropriately. (Reference: [CMS publication 100-3](#).)

ORDER REQUIREMENTS

The Standard Written Order (SWO) for the glucose monitor and supplies must include the following:

- Patient name or Medicare Beneficiary Identifier (MBI)
- Order date
- General description of the item (may be a narrative description, a HCPCS code, HCPCS code narrative, or brand name/model number)
- For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (list each separately)
- For supplies - In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (list each separately)
- Quantity to be dispensed, if applicable
- Treating practitioner's name or NPI
- Treating practitioner's signature

TESTING REQUIREMENTS

Medicare will provide coverage for the diabetic testing regimen as outlined in the [Glucose Monitors Local Coverage Determination \(LCD\) \(L33822\)](#):

Treatment Regimen	Basic Coverage for Test Strips and Lancets	Prescribed Testing Frequency
Insulin treated	Up to 300 per 3 months	Up to 3 times a day
Non-insulin treated	Up to 100 per 3 months	Once a day

For your patients who require additional testing per day, or the quantities of supplies ordered exceeds Medicare's standard utilization parameters, there are some additional documentation requirements that must be met. These are outlined in the Glucose Monitors LCD (L33822):

- Basic requirements outlined above have been met; and,
- Within the six (6) months prior to ordering quantities of strips and lancets that exceed the utilization guidelines, you have had an in-person visit* with your patient to evaluate their diabetes control and their need for the specific quantity of supplies that exceeds the usual utilization amounts described above; and,
- Every six (6) months, for continued dispensing of quantities of testing supplies that exceed the usual utilization amounts, you must verify adherence to the high utilization testing regimen. The medical record should contain clinical rationale for excess testing as well as any changes to the diabetic treatment plan.

CONTINUOUS GLUCOSE MONITORS (CGMS)

A therapeutic or non-adjunctive CGM can be used to make treatment decisions without the need for a stand-alone blood glucose monitor (BGM) to confirm testing results. A non-therapeutic or adjunctive CGM requires the user verify their glucose levels or trends displayed on a CGM with a BGM prior to making treatment decisions. On February 28, 2022, CMS determined that both therapeutic/non-adjunctive and non-therapeutic/adjunctive CGMs may be classified as DME.

CGMs and related supplies are covered by Medicare when all of the following coverage criteria (1-5) are met**:

1. Your patient has diabetes mellitus; and
2. Your patient is insulin-treated with multiple (three or more) daily administrations of insulin or a Medicare-covered continuous subcutaneous insulin infusion (CSII) pump; [For coverage and limitations relevant to insulin treatment via a continuous subcutaneous insulin infusion pump, review the [External Infusion Pumps LCD \(L33794\)](#) and LCD-related [Policy Article \(A52507\)](#)]; and,
3. Your patient's insulin treatment regimen requires frequent adjustment by the patient or caregiver on the basis of BGM or CGM testing results; and,
4. Within six (6) months prior to ordering the CGM, you have an in-person visit* with your patient to evaluate their diabetes control and determined that criteria (1-3) above are met; and,
5. Every six (6) months following the initial prescription of the CGM, you have an in-person visit* with your patient to assess adherence to their CGM regimen and diabetes treatment plan.

For coverage and limitations of these supplies review the [Glucose Monitors LCD \(L33822\)](#) and LCD-related [Policy Articles A52464](#) and [A55426](#)

*Note that during the Public Health Emergency, CMS has waived the in-person visit requirement. This may be accomplished by Medicare-approved methods of telehealth.

**Note that during the Public Health Emergency, CMS has instructed the A/B/DME MACs to not enforce the clinical indications of coverage for CGMs. Additional details at [CMS Issues Interim Final Rules with Comment \(CMS-1744-IFC & CMS-5531-IFC\) - COVID-19 Public Health Emergency - Revised](#)

PUBLICATION HISTORY

Date of Change	Description
July 18, 2022	Added references to Glucose Monitors LCD (L33822), External Infusion Pumps LCD (L33794), and LCD-related Policy Article (A52507); revised the diabetic testing regimen language; added information in regard to treatment with a therapeutic/non-adjunctive CGM and non-therapeutic/adjunctive CGM; changed insulin injections to insulin administrations; removed the four or more times a day testing requirement; added information in regard to non-enforcement directives and waivers associated with the COVID-19 PHE
July 2020	Revised
November 9, 2018	Originally Published

Prior Authorization Request Submission and Status Now Available in the Noridian Medicare Portal for Part B Users

The Noridian Medicare Portal (NMP) now allows Part B users to submit Prior Authorization Requests (PAR) and view the decision letter following review. At this time, PAR submissions are only required for Ambulance HCPCS codes A0426 and A0428.

Part B users who don't currently have access to Prior Authorizations will need to request access to the Prior Authorization function in NMP by going to Manage Account and then the Provider/Supplier Combinations tab.

To begin submitting PARs, view the [Prior Authorizations \(Part B\)](#) section of the NMP Inquiry Guide.

Prostate Cancer: Talk to Your Patients about Screening

Medicare covers [prostate cancer screenings](#), but in 2019, only 17% of male Fee-for-Service patients took advantage of this benefit. During Prostate Cancer Awareness Month, talk to your patients about their risk, and help them make an informed decision about screening.

Check for [eligibility \(PDF\)](#). If you need help, contact your eligibility service provider.

More Information:

- [CDC Prostate Cancer](#) webpage
- [National Cancer Institute Prostate Cancer](#) webpage
- [Prostate Cancer \(PDF\)](#) data snapshot
- [Prostate cancer screenings](#): Get information for your patients

Source: [CMS MLN Connects dated September 8, 2022](#)

Provide Ostomy Supplies Promptly - Provider Completion of Standard Written Orders

CMS heard from Medicare patients living with an ostomy that they've run out of supplies. Incomplete standard written orders (SWOs) or delayed physician signatures can cause late shipments. Providers can prevent this issue by returning the signed, dated, and completed SWO promptly to the supplier.

If the supplier bills for an item without first getting a completed SWO, we'll deny the claim as not reasonable and necessary. Valid prescriptions must have all the same elements as the SWO. There isn't an annual requirement for a new SWO (or prescription).

A complete SWO must have all the following elements:

- Beneficiary's name or MBI
- Order date
- Description of the item: general description (for example, wheelchair or hospital bed), brand name and model number, HCPCS code, or HCPCS code narrative
- For supplies, you may order all supplies at the same time, even if you bill separately (Note: If you don't order these items at the same time, you must include an order for payment purposes)
- Quantity to be dispensed (if applicable)
- Treating provider's name or NPI
- Treating provider's signature

More Information:

- [Medicare Provider Compliance Tips for Ostomy Supplies](#) educational tool
- [Standard Documentation Requirements for All Claims Submitted to Durable Medical Equipment Medicare Administrative Contractors](#) local coverage article
- [Ostomy Supplies](#) local coverage article
- [Ostomy Supplies](#) local coverage determination

Source:

- CMS [MLN Connects](#) dated June 30, 2022

Suicide Crisis Hotline Reminder

Share the resources provided below with all providers and staff to be aware of the Nationwide Suicide and Crisis Hotline - 988. In July, they updated it to a shorter 3 digit number to make it easier to remember. The Lifeline Network provides patients with more than 200 crisis centers to provide support for a suicidal mental health and/or substance use crisis.

The last link below provides access to promotional material that you can order or download to print for your office to highlight this important change.

Does not have to be Medicare beneficiary to call

The number, 988, can be accessed by talk, or text.

Suicide is the 12th leading cause of death in the US

In 2020 - 45,979 Americans committed suicide

In 2020 - There were 1.20 million suicide attempts

- [988 Lifeline Suicide Hotline Lifeline](#)
- [SAMHSA 988 Partner Toolkit](#)
- [988 America's Suicide Prevention and Mental Health Crisis Lifeline](#)
- [SAMHSA 988 Partner Toolkit](#)

Source: [CMS 2022-07-21-MLNC](#)

Viral Hepatitis: Talk to Your Patients about Screening

Viral hepatitis affects millions of people worldwide, causing acute and chronic liver disease. Most people don't know they're infected. On [World Hepatitis Day](#), encourage your patients to get a screening. Medicare covers viral hepatitis screening and immunization services, including:

- [Hepatitis B screening](#)
- [Hepatitis B shot & administration](#)
- [Hepatitis C screening](#)
- [Sexually transmitted infection \(STI\) screening & high-intensity behavioral counseling to prevent STIs](#)

Your patients pay nothing if you accept assignment. Review the [CMS Checking Medicare Eligibility MLN Fact Sheet](#) [PDF] 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
- [CDC Viral Hepatitis](#) webpage
- [Hepatitis Disparities](#) [PDF] data snapshot
- [Hepatitis B virus infection screenings](#), [hepatitis B shots](#), [hepatitis C screening tests](#), and [STI screenings & counseling](#): Get information for your patients
- [Noridian Medicare Portal \(NMP\) Inquiry Guide, Eligibility Benefits](#)
- [NMP Eligibility Education-on-Demand Tutorial on YouTube](#)

Source: CMS [MLN Connects](#) dated July 28, 2022

Was Your Claim Underpaid? Check Before Appealing

Noridian's appeal team has been receiving hundreds of appeals requesting additional

reimbursement amounts. The Medicare fee schedule amounts do not reflect all appropriate reductions that apply in a variety of situations.

Nurse Practitioners (NP), Physicians Assistants (PA), Licensed Clinical Social Workers (LCSW), and other non-physician type providers are reimbursed less than physicians when billed under their own Provider Transaction Access Number (PTAN). [MLN Information-for-APRNs-AAs-PAs](#)

Another reduction is providers who select to be Medicare Non-Participating (Non-PAR) vs Medicare Participating (PAR). Non-PAR Providers receive a 5 percent reduction.

Participation means you agree to accept claims assignment for all Medicare-covered services to your patients. Par providers agree to accept Medicare allowed amounts as payment in full along with any deductible and coinsurance amounts. Non-PAR providers agree to not charge the patient more than the limiting charge which represents 115 percent of the Medicare Physician Fee Schedule amount. You must not "exceed the limiting charge" or appeal amounts.

Incorrect place of service (POS) can also affect the payment amounts you receive. Facility POS such as outpatient hospital (22), or inpatient hospital (21) are paid at a lower rate than an office (11). Make sure you are using the correct POS for the service location you are billing for. The payment amounts for a facility on the fee schedule is identified with a # in the column (note) next to the CPT Code.

Reviewing your remittance advice, fee schedules and the payment methods for the provider type your billing for is the best way to determine if there is a valid reason for an appeal.

RESOURCES:

- [CMS Medicare Claims Processing Manual, 100-4, Chapter 12](#)
- [CMS Medicare Benefit Policy Manual, Chapter 15](#)
- [42 CFR 410.75](#)

Webinar-on-Demand Event Recordings Available

The satisfaction survey responses indicate providers want access to webinar recordings. We listened to your requests. Noridian offers [Webinar-on-Demand Recordings](#) within the Education and Outreach section of our website.

Additional information regarding the recordings is provided.

- The MP4 webinar recordings are published one-to-two weeks following the live event and remain available for approximately two months after the recording is published.
- After watching the webinar, we provide a survey link to receive comments and suggestions from your observations.
- While it is our goal to publish all our webinar recordings; there may be unforeseen challenges that prevent a webinar recording from being published.
- Continuing Education Units (CEUs) are not offered for the Webinars-on-Demand recordings. We hope you find the information is still valuable.
- Once published, all providers who registered to attend the webinar will be emailed notification of the availability of the recording. This proactive communication approach began in May 2022.

Noridian appreciates the recommendations you provide during our webinars and the subsequent surveys. We will continue to review every survey received to best meet your needs.

MEDICAL POLICIES AND COVERAGE

2022 ICD-10 Local Coverage Determination (LCD) and Local Coverage Article (LCA) Updates

The following LCA's have been revised under contractor numbers: 0112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Effective: October 1, 2022

Summary of Changes: The following LCAs have been updated to add, change description and/or remove ICD-10 codes.

LCD Title	LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: Pulmonary Function Testing	A57216	J95.87	N/A	N/A
Billing and Coding: Routine Foot Care	A57954	D68.01, D68.020, D68.021, D68.022, D68.023, D68.029, D68.03, D68.04, D68.09, D81.82	D68.0	N/A
Billing and Coding: Lab: Controlled Substance Monitoring and Drugs of Abuse Testing	A55001	E87.21, E87.22, E87.29, I47.20, I47.21, I47.29, T43.651A, T43.651D, T43.652S, T43.652A, T43.652D, T43.652S, T43.653A, T43.653D, T43.653S, T43.654A, T43.654D, T43.654S, T43.655A, T43.655D, T43.655S, T43.656A, T43.656D, T43.656S, Z91.190	E87.2, I47.2, Z91.19	N/A
Billing and Coding: MoIDX: Minimal Residual Disease Testing for Hematologic Cancers	A58996	N/A	N/A	C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C94.6
Billing and Coding: MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer	A58679	Q85.81, Q85.82, and Q85.83	N/A	N/A
Billing and Coding: MoIDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease	A57421	N/A	N/A	C94.6

LCD Title	LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: MoIDX: Next-Generation Sequencing Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies	A57891	N/A	N/A	C94.6
Billing and Coding: MDS FISH	A57661	N/A	N/A	C94.6
Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices	A52966	I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762, I25.792	I34.81, I34.89, I47.21, I47.29, Q21.11, Q21.12, Q21.13, Q21.14, Q21.15, Q21.16, Q21.19, Q21.21, Q21.22 & Q21.23	N/A
Billing and Coding: Diagnostic and Therapeutic Colonoscopy	A57342	Q85.81, Q85.82, Q85.83, Q85.89	Q85.8	N/A
Billing and Coding: Electrocardiograms	A57326	E87.20, E87.21, E87.21. E87.22. E87.29, G93.31, G93.32, G93.39, I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762, I25.792, I31.31, I31.39, I34.81, I34.89, I47.20, I47.21, I47.29, I71.010, I71.011, I71.012, I71.019, I71.10, I71.11, I71.12, I71.13, I71.20, I71.21, I71.22, I71.23, I71.30, I71.31, I71.32, I71.33, I71.40, I71.41, I71.42, I71.43, I71.50, I71.51, I71.52, I71.60, I71.61, I71.62, I77.82, J95.87, Q21.10, Q21.11, Q21.12, Q21.13, Q21.14, Q21.15, Q21.16, Q21.19, Q21.20, Q21.21, Q21.22, Q21.23, T43.651A, T43.651D, T43.651S, T43.652A, T43.652D, T43.652S, T43.653A, T43.653D, T43.653S, T43.654A, T43.654D, T43.654S, T43.655A, T43.655D, T43.655	E87.2, G93.3, I31.3, I34.8, I47.2, I71.01, I71.1, I71.2, I71.3, I71.4, I71.5, I71.6, Q21.1, Q21.2.	N/A
Billing and Coding: Lab: Flow Cytometry	A57689	D75.822, D75.828, D75.829, D75.84, D81.82	N/A	C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C94.6

LCD Title	LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: MRI and CT Scans of the Head and Neck	A57204	E34.30 E34.31 E34.321 E34.322 E34.328 E34329 E34.39 F01.511 F01.518 F01.52 F01.53 F01.54 F02.811, F02.818, F02.82, F02.83, F02.84, F03.911, F03.918, F03.92, F03.93, F03.94, F01.511, F01.518, F01.52, F01.53, F01.54, F01.A11, F01.A18, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B4, F01.C0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, I77.82, S06.0XAA, S06.0XAD, S06.0XAS, S06.1XAA, S06.1XAD, S06.1XAS, S06.2XAA, S06.2XAD, S06.2XAS, S06.30AA, S06.30AD, S06.30AS, S06.31AA, S06.31AD, S06.31AS, S06.32AA, S06.32AD, S06.32AS, S06.33AA, S06.33AD, S06.33AS, S06.34AA, S06.34AD, S06.34AS, S06.35AA, S06.35AD, S06.35AS, S06.36AA, S06.36AD, S06.36AS, S06.37AA, S06.37AD, S06.37AS, S06.38AA, S06.38AD, S06.38AS, S06.4XAA, S06.4XAD, S06.4XAS, S06.5XAA, S06.5XAD, S06.5XAS, S06.6XAA, S06.6XAD, S06.6XAS, S06.81AA, S06.81AD, S06.81AS, S06.82AA, S06.82AD, S06.82AS, S06.89AA, S06.89AD, S06.89AS, S06.8A0A, S06.8A0D, S06.8A0S, S06.8A1A, S06.8A1D, S06.8A1S, S06.8A2A, S06.8A2D, S06.8A2S, S06.8A3A, S06.8A3D, S06.8A3S, S06.8A4A, S06.8A4D, S06.8A4S, S06.8A5A, S06.8A5D, S06.8A5S, S06.8A6A, S06.8A6D, S06.8A6S, S06.8A7A, S06.8A8A, S06.8A9A, S06.8A9D, S06.8A9S, S06.8AAA, S06.8AAD, S06.8AAS, S06.9XAA, S06.9XAD, S06.9XAS, Z87.731	E34.3, F01.51, F02.81 & F03.91	C84.41 C84.48, F01.50, F02.80, F0390, G31.09, G31.83
B-Type Natriuretic Peptide (BNP) Testing	A57083	I20.2, I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762, I25.792	N/A	N/A
Frequency of Hemodialysis	A55675	E87.20, E87.21, E87.22, E87.29	E87.2	N/A
Vitamin D Assay Testing	A57718	Z79.85, Z79.60, Z79.61, Z79.620, Z79.621, Z79.622, Z79.623, Z79.624, Z79.630, Z79.631, Z79.632, Z79.633, Z79.634, Z79.64, Z79.69	N/A	N/A

LCD Title	LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography	A57183	I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762, I25.792, I34.81, I34.89, I47.21, I47.29, I71.010, I71.011, I71.012, I71.019, I71.10, I71.11, I71.12, I71.13, I71.21, I71.22, I71.23, I71.30, I71.31, I71.32, I71.33, I71.40, I71.41, I71.42, I71.43, I71.50, I71.51, I71.52, I71.60, I71.61, I71.62, Q21.10, Q21.11, Q21.12, Q21.13, Q21.14, Q21.15, Q21.16, Q21.19, Q21.20, Q21.21, Q21.22, Q21.23, Z79.85	I34.8, I47.2, I71.01, I71.1, I71.2, I71.3, I71.4, I71.5, I71.6, Q21.1, Q21.2	N/A
Billing and Coding: Serum Magnesium	A57189	T43.651A, T43.651D, T43.651S, T43.652A, T43.652D, T43.652S, T43.653A, T43.653D, T43.653S, T43.654A, T43.654D, T43.654S, T43.655A, T43.655D, T43.655S	E87.2, G93.3, I47.2, N14.1	N/A

Visit the [Noridian](#) website to view all LCDs and LCAs or access them via the CMS [MCD](#).

2022 ICD-10 Local Coverage Determination (LCD) and Local Coverage Article (LCA) Updates

The following LCA's have been revised under contractor numbers: 0112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Effective: October 1, 2022

Summary of Changes: The following LCAs have been updated to add, change description and/or remove ICD-10 codes.

LCD Title	LCD/LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: Allergy Testing	A57181	T43.655A, T43.655D, T43.655S		
Billing and Coding: Lumbar MRI	A57206	M51.A1, M51.A2, M51.A3, M51.A4, M51.A5, M62.5A2, Z79.61, Z79.620		

Visit the [Noridian](#) website to view all LCDs and LCAs or access them via the CMS [MCD](#).

Additional 2022 ICD-10 Local Coverage Determination (LCD) and Local Coverage Article (LCA) Updates

The following LCA's have been revised under contractor numbers: 0112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), 01312 (NV).

Effective: October 1, 2022

Summary of Changes: The following LCAs have been updated to add, change description and/or remove ICD-10 codes.

LCD Title	LCD/LCA Number	ICD-10 Added	ICD-10 Deleted	ICD-10 Description Change
Billing and Coding: Respiratory Care (Respiratory Therapy)	A57224	D81.82, E87.20, E87.21, E87.22, E87.29, J95.87, K76.82	E87.2	N/A
Billing and Coding: Nerve Conduction Studies and Electromyography	A54969	G93.31, G93.32, G93.39, G71.031, G71.032, G71.033, G71.0341, G71.0342, G71.0349, G71.035, G71.038, M62.5A0, M62.5A1, and M62.5A2	G93.3	N/A
Billing and Coding: Outpatient Cardiac Rehabilitation	A54068	I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762 & I25.792	N/A	N/A
Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)	A58236	N/A	N/A	C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49
Zika Virus Testing by PCR and ELISA	A55326	O35.00X1, O35.00X2, O35.00X3, O35.00X4, O35.00X5, O35.00X9, O35.07X1, O35.07X2, O35.07X3, O35.07X4, O35.07X5, O35.07X9, O35.09X1, O35.09X2, O35.09X3, O35.09X4, O35.09X5, O35.09X9	O35.0XX0, O35.0XX1, O35.0XX2, O35.0XX3, O35.0XX4, O35.0XX5, O35.0XX9	N/A
Billing and Coding: Positron Emission Tomography Scans Coverage	A54666	Group 1: I47.20, I47.21, I47.29, I25.112, I25.702, I25.712, I25.722, I25.732, I25.752, I25.762, I25.792 Group 4: F01.511, 01.518, F01.52, F01.53, F01.54, F01.A0, F01.A11, F01.A18, F01.A2, F01.A3, F01.A4, F01.B0, F01.B11, F01.B18, F01.B2, F01.B3, F01.B4, F01.C0, F01.C11, F01.C18, F01.C2, F01.C3, F01.C4, F02.811, F02.818, F02.82, F02.83, F02.84, F02.A0, F02.A11, F02.A18, F02.A2, F02.A3, F02.A4, F02.B0, F02.B11, F02.B18, F02.B2, F02.B3, F02.B4, F02.C0, F02.C11, F02.C18, F02.C2, F02.C3, F02.C4, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A0, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4	Group 1: I47.2 Group 4: F01.51, F02.81, F03.91	Group 2: F03.90 Group 4: F01.50, F03.90, G31.09, G31.84. Group 5: C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49

Visit the [Noridian](#) website to view all LCDs and LCAs or access them via the CMS [MCD](#).

Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices (A52966) - R13 - Effective October 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: October 1, 2022

Summary of Article Changes: Asterisked ICD-10 codes I50.21, I50.23, I50.31, I50.33, I50.41, I50.43, added the asterisked codes I50.1, I50.20, I50.22, I50.30, I50.32, I50.40, I50.42, I50.84, I50.9, I51.4, and I51.9 in **Group 1** and added the statement "All the asterisked diagnosis codes listed in Group 1 will only be payable when billed with ICD-10-PCS Code **02WA4QZ** - Revision of Implantable Heart Assist System in Heart, Percutaneous Endoscopic Approach in the hospital setting effective DOS 04/01/2022" to the **Group1 Medical Necessity ICD-10-CM Codes Asterisk Explanation** section.

Deleted ICD-10 codes I50.811 and I50.813 because Noridian does not cover ventricular assist devices for right heart failure at this time.

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: Cataract Surgery in Adults (A57195) - R4 - Effective January 01, 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: January 01, 2022

Summary of Article Changes: Under Article Text, corrected the typographical error to indicate "For Complex Cataract Surgery (CPT code 66982)" as it incorrectly listed CPT code 66892.

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: Complex Drug Administration Coding (A58532) - R9 - Effective July 21, 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: July 21, 2022

Summary of Article Changes: Effective 07/21/2022, patisiran (Onpattro™) (J0222) has been removed from the Infusions Non-Chemotherapy table and the CPT/HCPCS Codes Group 2. Effective for dates of service on or after 09/04/2022, ezeplumab-ekko (Tezspire™) (J2356) has been added to the Subcutaneous and Intramuscular Injection Non-Chemotherapy table and the CPT/HCPCS Codes Group 1.

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: Hydration Services (A54635) - R4 - Effective May 07, 2020

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 07, 2020

Summary of Article Changes: The effective date of this article is being changed for Revision Number 2 and 3. The effective date should have been 05/07/2020 instead of 01/20/2017.

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: Hydration Services (A54635) - R5 - Effective May 07, 2020

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 07, 2020

Summary of Article Changes: In the Article Text, provided clarification under the **Documentation would include but is not limited to:** "B. These codes are not intended to be reported/billed by the physician or other qualified healthcare professional in the facility setting, as these codes most likely represent facility charges with applicable reimbursement through the respective fee schedule. However, in the physician office setting (example, Place of Service 11), the physician may report these codes when the physician's clinical staff or the physician administers the fluids."

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: Implantable Infusion Pumps for Chronic Pain (A55239) - R9 - Effective July 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: July 1, 2022

Summary of Article Changes:

Updated prices for Prialt (Ziconotide) per quarterly ASP Drug File Update:

Effective: 07/01/2022 - 09/30/2022

Prialt (Ziconotide) = \$9.078

Ropivacaine = \$0.071

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: JW Modifier Billing Guidelines (A53024) - R4 - September 29, 2022

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

Effective Date: September 29, 2022

Summary of Article Changes:

Updated Article Text: Typographical error corrected. SE1316 was removed under resources due to no longer being published.

The article was replaced with JW Modifier: Drug/Biological Amount Discarded/Not Administered To Any Patient Frequently Asked Questions.

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: Micro-Invasive Glaucoma Surgery (MIGS) - R5 - Effective October 3, 2022

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

Effective Date: October 3, 2022

Summary of Article Changes: Under article text, *Specific Coding Guideline*: Added verbiage regarding the billing and reporting of Goniopuncture.

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: MoIDX: APC and MUTYH Gene Testing (A57352) Retirement - Effective August 20, 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 20, 2022

Summary: The information in this article has been incorporated within the Billing and Coding: MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the Noridian [Medicare Coverage Articles](#) webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MoIDX: BRCA1 and BRCA2 Genetic Testing (A57354) Retirement - Effective August 20, 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 20, 2022

Summary: The information in this article has been incorporated within the Billing and Coding: MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the Noridian [Medicare Coverage Articles](#) webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MoIDX: Genetic Testing for Lynch Syndrome (A54995) Retirement - Effective August 20, 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 20, 2022

Summary: The information in this article has been incorporated within the Billing and Coding: MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer A58679. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the Noridian [Medicare Coverage Articles](#) webpage to access the Retired articles in the CMS MCD.

Billing and Coding: MoIDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer (A58679) - R1 - Effective August 08, 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: August 08, 2022

Summary of Article Changes: **Under CPT/HCPCS Codes Group 1: Codes** deleted 81321. Added 81322, 81403, 81404, 81405, and 81406. **Under CPT/HCPCS Codes Group 2: Paragraph** added verbiage "These code(s) are non-covered". **Under CPT/HCPCS Codes Group 2: Codes** added 81162, 81163, 81164, 81165, 81166, 81167, 81201, 81203, 81212, 81216, 81292, 81294, 81295, 81297, 81298, 81300, 81307, 81317, 81319, 81321, 81323, and 81351.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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: MoIDX: Molecular Diagnostic Tests (MDT) (A57526) - R8 - Effective July 1, 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: July 1, 2022

Summary of Article Changes:

Under CPT/HCPCS Codes Group 1: Codes the description was revised for 0016M, 0229U, and 0306U.

Under CPT/HCPCS Codes Group 1: Codes added 0323U, 0326U, 0329U, 0330U, 0331U.

This revision is due to the Q3 2022 CPT/HCPCS Code Update and is effective on July 1, 2022

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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: MoIDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R4 - Effective October 1, 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: October 1, 2022

Summary of Article Changes:

Under **ICD-10 Codes that Support Medical Necessity Group 6**: Paragraph revised second sentence to add “POS 19, 21, 22 or 23”. Under ICD-10 Codes that Support Medical Necessity Group 7: Paragraph revised second sentence to add “POS 19, 21, 22 or 23”. This revision is retroactive effective for dates of service on or after 5/17/2022.

Under ICD-10 Codes that Support Medical Necessity Group 5: Paragraph added “NOTE: Claims with diagnosis code Z11.3 would be expected to also include a high-risk diagnosis code”. **Under ICD-10 Codes that Support Medical Necessity Group 5**: Codes added Z11.3, Z33.1, Z33.3, Z72.51, Z72.52, Z72.53, Z72.89. This revision is retroactive effective for dates of service on or after 9/6/2022.

Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added D59.30 and D59.31. Under ICD-10 Codes that Support Medical Necessity Group 4: Codes added D59.30 and D59.31. **Under ICD-10 Codes that Support Medical Necessity Group 5**: Codes deleted B37.3. Added B37.31, B37.32, and N76.82. Under ICD-10 Codes that Support Medical Necessity Group 6: Codes added D81.82. **Under ICD-10 Codes that Support Medical Necessity Group 7**: Codes added D59.30, D59.31, and D81.82. This revision is due to the Annual ICD-10-CM Update and will become effective on 10/1/2022.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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: MoIDX: Molecular Testing for Solid Organ Allograft Rejection (A58168) - R3 - 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: July 14, 2022

Summary of Article Changes:

Under **CMS National Coverage Policy** updated section heading. Under **Article Text** revised the methodology for the third test on the table. Formatting, punctuation, and typographical errors were corrected throughout the article.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the locally hosted MoIDX 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: MoIDX: Molecular Testing for Solid Organ Allograft Rejection (A58168) - R3 - Effective July 14, 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 14, 2022

Summary of Article Changes:

Under **CMS National Coverage Policy** updated section heading. Under **Article Text** revised the methodology for the third test on the table. Formatting, punctuation, and typographical errors were corrected throughout the article.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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: MoIDX: Myriad’s BRACAnalysis CDx (A55294) - R9 - Effective July 28, 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 28, 2022

Summary of Article Changes:

Under **Article Title** revised to Germline testing for use of PARP inhibitors.

Under **Article Text** deleted second paragraph and revised the verbiage in the third paragraph. Added new verbiage following the third paragraph. Deleted Table 1, fourth, fifth, and sixth paragraphs. Revised seventh paragraph first sentence to read, “To report service, please submit the following claim information”. Revised the seventh paragraph first bullet to read, “Select appropriate CPT® code”. Deleted the eighth and ninth paragraphs.

Under **CPT/HCPCS Codes Group 1**: Codes added 81479.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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: MoIDX: Phenotypic Biomarker Detection from Circulating Tumor Cells (A58183) - 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 **ICD-10 Codes that Support Medical Necessity Group 1** typographical error regarding removal of C50.819 retroactive for dates of service on or after 07/25/2021.

Visit the [Molecular Diagnostic Services \(MoIDX\)](#) webpage to access the MoIDX 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 MRI and CT Scans of the Head and Neck (A57204) - R5 - Effective October 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: October 1, 2022

Summary of Article Changes: ICD-10 code E34.30 - Shore stature due to endocrine disorder, unspecified was not added to the original ICD-10 update.

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: Positron Emission Tomography Scans Coverage - R35 - Effective July 1, 2022

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: See below.

Summary of Article Changes:

- Group 19 effective 7/1/2022: added A9596- Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie
- Group 14 effective 1/1/2021: added, "NOTE: The PI modifier must be billed with C79.81 along with one of the C50.XXX diagnosis codes listed below AND the KX modifier to attest the initial anti-tumor treatment strategy is for male and female breast cancer only when used in staging distant metastasis per NCD 220.6.17.2.B1a effective 1/1/2021."
- Groups 14, 16, 17, 19 effective 5/10/22: added, "PSMA-PET/CT or PSMA-PET/MRI with Gallium 68-ga Gozetotide/PSMA-11 may be used to screen patients for Pluvicto™ eligibility per NCCN Guidelines and SNMMI AUC."

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 Thromboembolism (A59048) Retirement - Effective July 9, 2022

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

Effective Date: July 9, 2022

Summary: This coverage article has been retired due to further review of coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

Visit the Noridian [Medicare Coverage Articles](#) webpage to access the Retired articles in the CMS MCD.

Billing and Coding: Routine Foot Care (A57954) - R12 - Effective October 01, 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: October 01, 2022

Summary of Article Changes: Updated the Group 1 Asterisk Section in the ICD-10 Codes That Support Medical Necessity to read:

- Effective 06/19/2022, L60.8 is to be billed with 11719 - trimming of non-dystrophic nails - only if one of the systemic conditions from Group 2, 3 or 4 below is present AND the patient does NOT have dystrophic nails. G0127 is the appropriate code for the trimming of dystrophic nails.
- Effective 06/19/2022, G0127 is to be billed for dystrophic nails only. It is inappropriate to bill L60.8, L84 and L98.7 with G0127.

In Group 4 ICD-10 Codes That Support Medical Necessity, added an asterisk (*) to the following codes: D68.01, D68.020, D68.021, D68.022, D68.023, D68.029, D68.03, D68.04, D68.09 effective 10/01/2022.

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

Billing and Coding: Wound and Ulcer Care - R2 - Effective February 3, 2022

This coverage article has been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

Effective Date: February 3, 2022

Summary of Article Changes: Replaced information pertaining to National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services Chapter 4, Section G to current language found in the manual effective 1/1/2022.

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

Cataract Surgery in Adults (L34203) - R3 - Effective October 01, 2019

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: L34203

Effective Date: October 01, 2019

Summary of Changes: Updated #1 under Sources of Information to remove broken link.

Visit the [Active LCDs](#) webpage to view the Active LCD or access it via the CMS MCD.

Coverage Article - Revised Article Notification - Computed Tomography Cerebral Perfusion Analysis (CTP) (A58223) - R1 - Effective June 3, 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 3, 2022

Summary of Article Changes: Added ICD-10-CM codes H53.131, H53.132, H53.133, R47.89 to Group 1.

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.

Coverage Article - Revised Article Notification - Intensity Modulated Radiation Therapy (IMRT) (A58236) - R3 - Effective December 23, 2021

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: See below.

Summary of Article Changes: Effective 10/15/2021 - added ICD-10-CM codes C7B.01, C7B.02, C7B.03, C7B.04, C7B.1, D42.0 to Group 1.

Effective 12/23/2021 - added D11.0 to Group 1.

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.

Final LCD Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease and Associated Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease - Effective September 18, 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).

Medicare Coverage Database Number	LCD Title
L38613	Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease

Medicare Coverage Database Number	Billing and Coding Article Title
A58095	Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Ischemic Heart Disease

Effective Date: September 18, 2022

Summary: LCD describes the coverage indications, limitations, and/or medical necessity for FDA-approved FFRct technology and the Billing and Coding Article provides billing and coding guidance for the LCD.

Visit the [CMS Medicare Coverage Database \(MCD\)](#) webpage to access this LCD.

Final Nerve Blockade for Treatment of Chronic Pain and Neuropathy LCD and Associated Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy - Effective September 4, 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
L35456	Nerve Blockade for Treatment of Chronic Pain and Neuropathy

Medicare Coverage Database Number	LCA Title
A56034	Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy

Effective Date: September 4, 2022

Summary: LCD describes the Coverage and Provider Qualifications that support the medical necessity of a nerve block for treating chronic pain and peripheral neuropathy and the Billing and Coding Article provides billing and coding guidance and documentation requirements for the LCD.

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

Lumbar MRI (L34220) - R9 - Effective August 18, 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: L34220

Effective Date: August 18, 2022

Summary of Changes: In the Bibliography removed the link in #4 due to a broken link.

Visit the [Active LCDs](#) webpage to view the Active LCD or access it via the CMS MCD.

MoldX: APC and MUTYH Gene Testing L36882 Retirement - Effective August 20, 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 20, 2022

Rationale: This policy has been incorporated within the MoldX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the [Retired LCDs](#) webpage to access the retired LCDs.

MolDX: BRCA1 and BRCA2 Genetic Testing L36161 Retirement - Effective August 20, 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 20, 2022

Rationale: This policy has been incorporated within the MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the [Retired LCDs](#) webpage to access the retired LCDs.

MolDX: Genetic Testing for Lynch Syndrome L36370 Retirement - Effective August 20, 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 20, 2022

Rationale: This policy has been incorporated within the MolDX: Lab-Developed Tests for Inherited Cancer Syndromes in Patients with Cancer L38972 LCD. The previous retirement date of August 08, 2022 has been rescinded and replaced with August 20, 2022.

Visit the [Retired LCDs](#) webpage to access the retired LCDs.

MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (DL38647) - 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: DL38647

LCD Title: MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer

Comment period: July 14, 2022 - August 27, 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.

Molecular Assays for the Diagnosis of Cutaneous Melanoma (DL39373) - 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: DL39373

LCD Title: Molecular Assays for the Diagnosis of Cutaneous Melanoma

Comment period: July 07, 2022 - August 20, 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.

Repetitive Transcranial Magnetic Stimulation (rTMS) in Adults with Treatment Resistant Major Depressive Disorder (L37086) - R3 - Effective December 01, 2019

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: L37086

Effective Date: December 01, 2019

Summary of Changes: Removed and replaced the broken link in Source Number 13 of the Bibliography.

Visit the [Active LCDs](#) webpage to view the Active LCD or access it via the CMS MCD.

Self-Administered Drug Exclusion List (A53032) - R26 - Effective August 11, 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: August 11, 2022

Summary of Changes:

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

*Note: J2356 assigned to Tezspire™ (tezepelumab-ekko) was also not added due to the removal.

The article is updated to add an asterisk to Skyrizi™ - C9399, J3490, J3590 as this drug has multiple routes of administration and must be billed with the appropriate modifier. - Effective 06/17/2022.

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

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

Self-Administered Drug Exclusion List (A53032) - R27 - Effective November 01, 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: November 01, 2022

Summary of Changes: The article is updated to add: Adbry™ (tralokinumab-ldrm) - C9399, J3490, J3590 effective 11/01/2022.

The most current version of the [Self-Administered Drug Exclusion List](#) is available on the Medicare Coverage Database (MCD).

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

Self-Administered Drug Exclusion List - Effective June 30, 2022

Effective Date: June 30, 2022

Summary of Changes:

Noridian's Self-Administered Drugs (SADs) webpage was redesigned to deliver a direct hyperlink to the most current version of the article. Instead of hosting the full version on our website, providers will now have a direct hyperlink to access the information from the CMS Medicare Coverage Database (MCD).

Should you need assistance accessing or navigating our website or the MCD to find the policy, please reach out to our provider contact center and our customer service representative would be happy to assist.

To view a complete listing of Noridian articles please visit the [CMS MCD](#).

MLN CONNECTS

MLN Connects - July 7, 2022

Expanding Access to Emergency Care Services in Rural Communities

[MLN Connects newsletter for Thursday, July 7, 2022](#)

NEWS

- Taking Action to Expand Access to Emergency Care Services in Rural Communities
- People with Disabilities: Help Address Disparities

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- Long COVID: Use ICD-10 Code U09.9

MLN MATTERS® ARTICLES

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

PUBLICATIONS

- Teaching Physicians, Interns, & Residents Guidelines - Revised

MLN Connects Special Edition - July 7, 2022 - CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

On July 7, CMS issued the Calendar Year 2023 Physician Fee Schedule (PFS) proposed rule, which would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care - particularly in rural and underserved areas. These proposed changes play a key role in the Biden-Harris Administration's Unity Agenda - especially its priorities to tackle our nation's mental health crisis, beat the overdose and opioid epidemic, and end cancer as we know it through the Cancer Moonshot - and ensure CMS continues to deliver on its goals of advancing health equity, driving high-quality, whole-person care, and ensuring the sustainability of the Medicare program for future generations.

"At CMS, we are constantly striving to expand access to high quality, comprehensive health care for people served by the Medicare program," said CMS Administrator Chiquita Brooks-LaSure. "Today's proposals expand access to vital medical services like behavioral health care, dental care, and cancer treatment options, all while promoting access, innovation, and cost savings in the Medicare program."

"Integrated coordinated, whole-person care - which addresses physical health, behavioral health, and social determinants of health - is crucial for people with Medicare, especially those with complex needs," said Dr. Meena Seshamani, CMS Deputy Administrator and Director of the Center for Medicare. "If finalized, the proposals in this rule will advance equity, lead to better care, support healthier populations, and drive smarter spending of the Medicare dollar."

The proposed CY 2023 PFS conversion factor is \$33.08, a decrease of \$1.53 to the CY 2022 PFS conversion factor of \$34.61. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units.

Modernizing Coverage for Behavioral Health Services

In the [2022 CMS Behavioral Health Strategy](#), CMS set goals to remove barriers to care and improve access to, and the quality of, mental health and substance use care. To help address the acute shortage of behavioral health practitioners, the agency is proposing to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. Additionally, CMS is

proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team.

CMS is also proposing to bundle certain chronic pain management and treatment services into new monthly payments, improving patient access to team-based comprehensive chronic pain treatment. Lastly, CMS is proposing to cover opioid treatment and recovery services from mobile units, such as vans, to increase access for people who are homeless or live in rural areas.

Expanding Access to Accountable Care Organizations

ACOs are groups of health care providers who come together to give coordinated, high-quality care to their Medicare patients. The Medicare Shared Savings Program covers more than 11 million people with Medicare and includes more than 500,000 providers.

CMS is proposing changes to the Medicare Shared Savings Program that, if finalized, represent some of the most significant reforms since the final rule that established the program was finalized in November 2011 and ACOs began participating in 2012. Building on the CMS Innovation Center's successful ACO Investment Model, CMS is proposing to incorporate advance shared savings payments to certain new Medicare Shared Savings Program ACOs that could be used to address Medicare beneficiaries' social needs. This is one of the first times Traditional Medicare payments would be permitted for such uses and is expected to be an opportunity for providers in rural and other underserved areas to make the investments needed to become an ACO and succeed in the program. CMS is also proposing that smaller ACOs have more time to transition to downside risk, further helping to grow participation in rural and underserved communities. CMS is also proposing a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations. Finally, CMS is proposing benchmark adjustments to encourage more ACOs to participate and succeed, which would help achieve the goal of having all people with Traditional Medicare in an accountable care relationship with a healthcare provider by 2030.

Improving Access to Colon Cancer Screening

Colon and rectal cancer were the second-leading cause of cancer deaths in the United States in 2020, with higher colorectal cancer death rates for Black Americans, American Indians, and Alaska Natives. To reduce barriers to getting a colonoscopy, CMS is proposing that a follow-up colonoscopy to an at-home test be considered a preventive service, which means that cost sharing would be waived for people with Medicare. Additionally, Medicare is proposing to cover the service for individuals 45 years of age and above, in line with the newly lowered age recommendation (down from 50) from the United States Preventive Services Task Force.

Proposing Payment for Dental Services that are Integral to Covered Medical Services

Medicare Part B currently pays for dental services when that service is integral to medically necessary services required to treat a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following accidental injury or tooth extractions done in preparation for radiation treatment for jaw cancer. CMS is proposing to pay for dental services, such as dental examination and treatment preceding an organ transplant. In addition, CMS is seeking comment on other medical conditions where Medicare should pay for dental services, such as for cancer treatment or joint replacement surgeries, as well as on a process to get public input when additional dental services may be integral to the clinical success of other medical services.

More Information:

- [PFS](#) fact sheet
- [Quality Payment Program](#) fact sheet
- [Medicare Shared Savings Program Proposals](#) fact sheet
- [Blog](#)
- [Proposed rule](#)

MLN Connects - July 14, 2022

COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits

[MLN Connects newsletter for Thursday, July 14, 2022](#)

NEWS

- COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits
- COVID-19: Moderna Vaccines for Children as Young as 6 Months - New Codes
- Establishing the Framework for Health Equity at CMS
- Post-Acute Care Report to Congress: Prototype Unified Payment for Medicare
- Long Term Care Facilities: Nursing Home Five Star Rating Changes
- Program for Evaluating Payment Patterns Electronic Reports for Home Health Agencies & Partial Hospitalization Programs
- Home Health Quality Reporting Program: Final OASIS Data Specifications

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

CLAIMS, PRICERS, & CODES

- Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- New Edit for Prospective Payment System (PPS) Outpatient and Inpatient Bill Types Receiving an Outlier Payment When a Device Credit is Reported

EVENTS

- Medicare Ground Ambulance Data Collection System Webinar: Allocating Expenses & Revenue - July 21

INFORMATION FOR PATIENTS

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

MLN Connects Special Edition - July 15, 2022 - CMS Proposes Rule to Advance Health Equity, Improve Access to Care, & Promote Competition and Transparency

CMS is proposing actions to advance health equity and improve access to care in rural communities by establishing policies for Rural Emergency Hospitals (REH) and providing for payment for certain behavioral health services furnished via communications technology. Additionally, in line with President Biden's Executive Order on Promoting Competition in the American Economy, the calendar year 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System proposed rule includes proposed enhanced payments under the OPPS and the Inpatient Prospective Payment System for the additional costs of purchasing domestically made NIOSH-approved surgical N95 respirators and a comment solicitation on competition and transparency in our nation's health care system.

More Information:

- [Press release](#)
- [Proposed rule](#) fact sheet
- [REH fact sheet](#)
- [Proposed rule](#)

MLN Connects - July 21, 2022

988 Suicide & Crisis Lifeline Available Nationwide

[MLN Connects newsletter for Thursday, July 21, 2022](#)

NEWS

- 988 Suicide & Crisis Lifeline Available Nationwide
- COVID-19: Novavax Vaccine, Adjuvanted - New Codes
- Allergy & Immunology: Comparative Billing Report in July
- Inpatient Rehabilitation Facilities: Care Compare July Refresh
- Long-Term Care Hospitals: Care Compare July Refresh
- Hospices & Home Health Agencies: Submit Technical Expert Panel Nominations by August 12
- Skilled Nursing Facility Provider Preview Reports: Review by August 15
- Opioid Treatment Programs: Comment by September 6

COMPLIANCE

- Implanted Spinal Neurostimulators: Document Medical Records

INFORMATION FOR PATIENTS

- Medicare Savings Programs Help Pay Premiums

MLN Connects Special Edition - July 27, 2022 - 3 Final FY 2023 Payment Rules: Hospices, Inpatient Psychiatric Facilities, & Inpatient Rehabilitation Facilities

HOSPICES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued a [Fiscal Year \(FY\) 2023 Hospice Payment Rate Update](#) final rule to update Medicare hospice payments, wage index, quality reporting programs, and policies. See a [summary of key provisions](#) effective October 1, 2022:

- Routine annual rate setting changes resulting in a 3.8% increase in payments for FY 2023
- Permanent 5% cap on negative wage index changes
- Hospice Quality Reporting Program (HQRP) updates, including the new Hospice Outcomes and Patient Evaluation Tool, the Consumer Assessment of Healthcare Providers and Systems hospice survey, quality measures for FY 2023, and a summary of public comments from the request for information to inform future efforts related to HQRP health equity

INPATIENT PSYCHIATRIC FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the [Fiscal Year 2023 Inpatient Psychiatric Facilities \(IPF\) Prospective Payment System](#) final rule to update IPF payments, wage index, and policies. See a [summary of key provisions](#) effective October 1, 2022:

- Updated payment rates by 3.8% with estimated payments to increase by 2.5% after productivity adjustment
- Applied a permanent 5% cap on wage index decreases

INPATIENT REHABILITATION FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the [Fiscal Year 2023 Inpatient Rehabilitation Facility \(IRF\) Prospective Payment System \(PPS\)](#) final rule to update Medicare payment policies and rates. See a [summary of key provisions](#) effective October 1, 2022:

- Updated IRF PPS payment rates by 3.9% with estimated overall payments to increase by 3.2% after productivity and outlier adjustments
- Applied a permanent 5% cap on annual wage index decreases
- Expanded quality data reporting on all IRF patients, regardless of payer

MLN Connects - July 28, 2022

Enhanced Nursing Home Rating System

[MLN Connects newsletter for Thursday, July 28, 2022](#)

NEWS

- CMS Enhances Nursing Home Rating System with Staffing & Turnover Data
- Clinical Laboratory Improvement Amendments Proposed Rule: Submit Comments by August 25
- Hospices: Submit Technical Expert Panel Nominations by August 12
- Viral Hepatitis: Talk to Your Patients about Screening

CLAIMS, PRICERS, & CODES

- Integrated Outpatient Code Editor: Java Beta File Release

EVENTS

- Medicare Ground Ambulance Data Collection System Webinar: Using Facilities & Vehicles Templates - August 4

MLN Connects Special Edition - July 29, 2022 - Skilled Nursing Facilities: Final FY 2023 Payment Rule

SKILLED NURSING FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the [Fiscal Year \(FY\) 2023 Skilled Nursing Facility \(SNF\) Prospective Payment System](#) final rule to update payment policies and rates. See a [summary of key provisions](#) effective October 1, 2022:

- 2.7% net payment rate increase for skilled nursing facilities
- Patient Driven Payment Model parity adjustment recalibration (use the FY 2023 proposed rule [calculator](#) to learn more) and changes in ICD-10 code mappings
- Permanent 5% cap on annual wage index decreases
- SNF Quality Reporting Program: compliance date revisions for certain requirements, new influenza vaccination coverage for health care personnel measure, and regulation text revisions
- SNF Value Based Purchasing: not apply the SNF 30-Day All Cause Readmission Measure for the FY 2023 program year and add 3 new measures for FY 2026 & 2027 program expansion years

CMS SEEKS PUBLIC FEEDBACK TO IMPROVE MEDICARE ADVANTAGE

The Centers for Medicare & Medicaid Services (CMS) released a Request for Information seeking public comment on the Medicare Advantage program. CMS is asking for input on ways to achieve the agency's vision so that all parts of Medicare are working towards a future where people with Medicare receive more equitable, high quality, and person-centered care that is affordable and sustainable.

CMS encourages the public to submit comments to the Request for Information. Feedback from plans, providers, beneficiary advocates, states, employers and unions, and other partners to this Request for Information will help inform the Medicare Advantage policy development and implementation process.

More Information:

- [Press release](#)
- [Request for Information](#)

MLN Connects Special Edition - August 1, 2022 - New CMS Rule Increases Payments for Acute Care Hospitals & Advances Health Equity, Maternal Health

On August 1, CMS issued a final rule for inpatient and long-term care hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. As required by statute, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule updates Medicare payments and policies for hospitals, drives high-quality, person-centered care, and promotes fiscal stewardship of the Medicare program. In addition, the rule finalizes new measures to encourage hospitals to build health equity into their core functions. These actions will improve care for people and communities who are disadvantaged or underserved by the health care system.

The rule includes three health equity-focused measures in hospital quality programs and establishes a "Birthing-Friendly" hospital designation. CMS will award this new designation to hospitals that participate in a statewide or national perinatal quality improvement collaborative program and have implemented the recommended quality interventions.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record users, the final rule will result in an increase in operating payment rates of 4.3%. This reflects a FY 2023 projected hospital market basket update of 4.1%, reduced by a statutorily required productivity adjustment of a 0.3 percentage point and plus a 0.5 percentage point adjustment required by statute. This is the highest market basket update in the last 25 years and is primarily due to higher expected growth in compensation prices for hospital workers. Under the LTCH PPS, CMS expects payments in FY 2023 to increase by approximately 2.4% or \$71 million.

"CMS is taking action to support hospitals, including updating payments to hospitals by a significantly higher rate than in the proposed IPPS rule. This final rule aligns hospital payments with [CMS' vision](#) of ensuring access to health care for all people with Medicare and maintaining incentives for our hospital partners to operate efficiently," said CMS Administrator Chiquita Brooks-LaSure. "It also takes important steps to advance health equity by encouraging hospitals to implement practices that reduce maternal morbidity and mortality."

Advancing Health Equity:

Consistent with the agency's [definition of health equity](#), CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

To address health care disparities in hospital inpatient care and beyond, CMS is adopting three health equity-focused measures in the IQR Program. The first measure assesses a hospital's commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement. The second and third measures capture screening and identification of patient-level, health-related social needs - such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

In the near future, CMS is also interested in using measures focused on connecting patients with identified social needs to community resources or services. CMS sought comment on the proposed rule. In the final rule, CMS acknowledges the robust comments received on key considerations that inform our approach to improving data collection, to better measure and analyze disparities across programs and policies, and approaches for updating the Hospital Readmissions Reduction Program (HRRP) that encourage providers to improve performance for socially at-risk populations.

CMS is also discontinuing the use of proxy data for uncompensated care costs in determining uncompensated care payments for Indian Health Service and Tribal hospitals, and hospitals in Puerto Rico, and we are establishing a new supplemental payment to prevent undue long-term financial disruption for these hospitals and to promote long-term payment stability. CMS is also finalizing new flexibilities for graduate medical education for rural hospitals participating in rural track programs, which will help promote workforce development in rural areas.

Improving Maternal Health Outcomes:

CMS is creating a new hospital designation to identify "Birthing-Friendly" hospitals and additional quality measure reporting to drive improvements in maternal health outcomes. CMS is finalizing this designation following the release of the comprehensive [CMS Maternity Care Action Plan](#).

The Biden-Harris Administration has championed policies to improve maternal health and equity since taking office. Earlier this year, Vice President Harris convened a first-ever White House meeting with Cabinet Secretaries and agency leaders, including Secretary Becerra and CMS Administrator Chiquita Brooks-LaSure, to discuss the Administration's whole-of-government approach to reducing maternal mortality and morbidity. In December 2021, Vice President Harris announced a historic call to action to improve health outcomes for parents and their young children in the United States. Implementing this new hospital designation is part of the Biden-Harris Administration's continued response to that call to action, as noted in the CMS Maternity Care Action Plan.

The "Birthing-Friendly" hospital designation will provide important information to consumers about hospitals with a demonstrated commitment to reducing maternal morbidity and mortality by implementing best practices that advance health care quality and safety for pregnant and postpartum patients.

Conditions of Participation Pandemic Reporting for Hospital and Critical Access Hospitals (CAH):

CMS proposed to continue the current COVID-19 reporting requirements for hospitals and CAHs as well as establish new reporting requirements for future public health emergencies (PHE). Based on public feedback, CMS is finalizing the proposed requirements for continued COVID-19-related reporting for hospitals and CAHs with a reduced number of data categories as an off ramp to the current PHE. CMS is not finalizing the proposed reporting requirements for future PHEs.

Continued Public Reporting of Patient Safety Metrics:

CMS uses quality measures to ensure safety and quality within the health care system and to pay providers through value-based programs. For the FY 2023 Hospital-Acquired Condition (HAC) Reduction Program, CMS proposed to pause - meaning not calculate and subsequently not publicly report - the data for the PSI-90 measure, which is a composite measure that covers multiple patient safety indicators, such as pressure sores, falls, and sepsis. CMS' proposal reflected concerns about the impact COVID-19 would have on the ability to interpret data and was also sensitive to the risks of financially penalizing hospitals for factors potentially out of their control. CMS recognizes the importance of this measure for patients and providers and is finalizing the calculation and public reporting of the CMS PSI-90 measure results. CMS will include the measure in Star Ratings in alignment with the feedback we received. Although this measure will be publicly reported, it will not be used in payment calculations in the HAC to avoid unintentional penalties related to the uneven impacts of COVID-19 across the country.

More Information:

- [Final Rule](#) fact sheet
- [Maternal Health](#) fact sheet
- [Final Rule](#)

MLN Connects - August 4, 2022

ICD-10-CM Code Files: Fiscal Year 2023

[MLN Connects newsletter for Thursday, August 4, 2022](#)

NEWS

- Hospices: Volunteer to Test Hospice Outcomes & Patient Evaluation Instrument
- Immunization: Protect Your Patients

CLAIMS, PRICERS, & CODES

- ICD-10-CM Code Files: Fiscal Year 2023
- ICD-10 Medicare Severity Diagnosis-Related Group Version 40

EVENTS

- ICD-10 Coordination & Maintenance Committee Meeting - September 13-14

PUBLICATIONS

- Items & Services Not Covered Under Medicare - Revised

MLN Connects - August 11, 2022**Monkeypox & Smallpox Vaccines: New Product Codes**

[MLN Connects newsletter for Thursday, August 11, 2022](#)

NEWS

- Monkeypox & Smallpox Vaccines: New Product Codes
- Payment Allowance Update for COVID-19 Monoclonal Antibody Therapy Q0222 Injection, Bebtelovimab, 175 mg
- CMS Announces Resources & Flexibilities to Assist Kentucky Due to Recent Storms
- Hospice Quality Reporting Program: Measure Change

COMPLIANCE

- What's the Comprehensive Error Rate Testing Program?

CLAIMS, PRICERS, & CODES

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2022
- Integrated Outpatient Code Editor: Java Beta File Release

MLN MATTERS® ARTICLES

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2023
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2023
- New Waived Tests
- Implementation of the Capital Related Assets (CRA) Adjustment for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End-Stage Renal Disease Prospective Payment System (ESRD PPS) - Revised

PUBLICATIONS

- Skilled Nursing Facility Billing Reference - Revised

MULTIMEDIA

- Hospice Quality Reporting Program Videos

MLN Connects - August 18, 2022**Discontinuing Use of Certificates of Medical Necessity & Durable Medical Equipment Information Forms**

[MLN Connects newsletter for Thursday, August 18, 2022](#)

NEWS

- CMS Discontinuing the Use of Certificates of Medical Necessity and Durable Medical Equipment Information Forms to Increase Efficiency and Reduce Burden for Clinicians, DME Suppliers, and Beneficiaries
- Quality Payment Program: Comment on Proposed Changes by September 6
- Skilled Nursing Facilities: Participate in Interoperability Survey
- Home Health: Revised Guide to Help Desks

CLAIMS, PRICERS, & CODES

- Claim Status Category and Claim Status Codes Update

EVENTS

- Home Health OASIS-E Virtual Workshops - September 13 & 14

MLN MATTERS® ARTICLES

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - January 2023 Update
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - January 2023 Update - 2 of 2
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2023
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update - Revised

MLN Connects Special Edition - August 18, 2022 - Creating a Roadmap for the End of the COVID-19 Public Health Emergency

NEWS

- [Creating a Roadmap for the End of the COVID-19 Public Health Emergency](#)
- [Health Care System Resiliency](#)

Preparing the Health Care System for Operation After the Public Health Emergency: Secretary of Health and Human Services (HHS) Xavier Becerra extended the existing COVID-19 public health emergency (PHE) through October 15, 2022 - and has committed to providing states, health care providers, and other stakeholders a 60-day notice before ending the PHE.

MLN Connects - August 25, 2022

Medicare Secondary Payer: Manual Updates

[MLN Connects newsletter for Thursday, August 25, 2022](#)

NEWS

- Interns and Residents Information System XML Format: Updated Vendor List

CLAIMS, PRICERS, & CODES

- Integrated Outpatient Code Editor: Java Beta File Release

MLN MATTERS® ARTICLES

- Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5

INFORMATION FOR PATIENTS

- Coverage to Care: Updated Resources

MLN Connects - September 1, 2022

Payment Allowances for Influenza Vaccine

[MLN Connects newsletter for Thursday, September 1, 2022](#)

NEWS

- CORRECTION: Monkeypox & Smallpox Vaccines: Include Product Code on Claims
- COVID-19: Novavax Vaccine Authorized for Patients 12-17 Years Old
- Medicare Shared Savings Program Saves Medicare More Than \$1.6 Billion in 2021 & Continues to Deliver High-quality Care
- Increased Use of Telehealth for Opioid Use Disorder Services During COVID-19 Pandemic Associated with Reduced Risk of Overdose
- Sickle Cell Disease: What You Need to Know Video
- Healthy Aging: Recommend Services for Your Patients

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- Influenza Vaccine Payment Allowances - Annual Update for 2022-2023 Season
- Quarterly Update to Home Health (HH) Grouper

MULTIMEDIA

- Introduction to Language Access Plans Web-Based Training
- Combating Medicare Parts C and D Fraud, Waste, & Abuse Web-Based Training - Revised

INFORMATION FOR PATIENTS

- How to Report a Medicare Complaint

MLN Connects - September 8, 2022

Prostate Cancer: Talk to Your Patients about Screening

[MLN Connects newsletter for Thursday, September 8, 2022](#)

NEWS

- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Prostate Cancer: Talk to Your Patients about Screening

MLN MATTERS® ARTICLES

- Exceptions to Average Sales Price (ASP) Payment Methodology - Claims Processing Manual Changes

MLN Connects - September 12, 2022 - Updated COVID-19 Vaccines Providing Protection Against Omicron Variant Available at No Cost

The Department of Health & Human Services (HHS), through CMS announced that people with Medicare, Medicaid, Children's Health Insurance Program coverage, private insurance coverage, or no health coverage can get COVID-19 vaccines, including the updated Moderna and Pfizer-BioNTech COVID-19 vaccines, at no cost, for as long as the federal government continues purchasing and distributing these COVID-19 vaccines.

The FDA has authorized the Moderna and Pfizer-BioNTech updated vaccines that target the original COVID-19 viral strain and two Omicron variants (BA.4/BA.5) that are currently the most prevalent in the U.S. Individuals are eligible for their updated

vaccine shot at least two months after completing at least their primary vaccination series (two doses of Pfizer-BioNTech, Moderna, or Novavax, or one dose of Johnson & Johnson)-regardless of how many monovalent COVID-19 boosters they have received to date.

CMS issued 4 new CPT codes effective August 31, 2022:

Code 91312 for Pfizer-BioNTech COVID-19 Vaccine, Bivalent Product:

- Long descriptor: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- Short descriptor: SARSCOV2 VAC BVL 30MCG/0.3ML

Code 91313 for Moderna COVID-19 Vaccine, Bivalent Product:

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

Code 0124A for Pfizer-BioNTech COVID-19 Vaccine, Bivalent - Administration - Booster Dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, booster dose
- Short descriptor: ADM SARSCV2 BVL 30MCG/.3ML B

Code 0134A for Moderna COVID-19 Vaccine, Bivalent - Administration - Booster Dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, booster dose
- Short descriptor: ADM SARSCV2 BVL 50MCG/.5ML B

Visit the [COVID-19 Vaccine Provider Toolkit](#) for more information, 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 this webpage.

See the [full news alert](#).

MLN Connects - September 15, 2022

Make Your Voice Heard

[MLN Connects newsletter for Thursday, September 15, 2022](#)

NEWS

- Make Your Voice Heard Request for Information Seeks Public Comment to Promote Efficiency, Reduce Burden, & Advance Equity within CMS Programs
- Enhancing Oncology Model to Improve Cancer Care: Apply by September 30
- Revision to National Coverage Determination (NCD) 240.2 (Home Use of Oxygen) to Align to 1834(a)(5)(E) of the Social Security Act

CLAIMS, PRICERS, & CODES

- Billing for Hospital Part B Inpatient Services
- National Correct Coding Initiative: October Quarterly Update

MLN MATTERS® ARTICLES

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment - Revised

MLN Connects - September 22, 2022

Encourage Preferred Flu Vaccines for Patients 65+

[MLN Connects newsletter for Thursday, September 22, 2022](#)

NEWS

- Flu Shot: Encourage Preferred Vaccines for Patients 65+
- Cataract Surgery: Comparative Billing Report
- Do You Only Order or Certify Services? Use Revised Enrollment Form CMS-855O by January 1
- Cardiovascular Disease: Talk with Your Patients about Screening

CLAIMS, PRICERS, & CODES

- October 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN MATTERS® ARTICLES

- October 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

PUBLICATIONS

- Hospice Quality Reporting Program: New Resources

MLN Connects - September 29, 2022

[MLN Connects Newsletter: Sept 29, 2022](#)

NEWS

- Resources & Flexibilities to Assist with Public Health Emergency in Puerto Rico
- Resources & Flexibilities to Assist with Public Health Emergency in Florida
- 2023 Medicare Parts A & B Premiums and Deductibles
- Clinical Laboratory Fee Schedule Payment Determinations & Voting Results: Submit Comments by October 24
- DMEPOS: Change to Enrollment Contractor After November 6
- Hispanic or Latino Patients: Help Address Disparities

CLAIMS, PRICERS, & CODES

- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines
- HCPCS Application Summary for Non-Drug & Non-Biological Items and Services

MLN MATTERS

Changes to the Laboratory NCD Edit Software for January 2023

MLN Matters Number: MM12888

Related CR Release Date: September 1, 2022

Related CR Transmittal Number: R11583CP

Related Change Request (CR) Number: 12888

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12888 tells you about:

- Changes to the Laboratory National Coverage Determination (NCD) Edit Module for January 2023
- 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 \(MM\)12888](#).

Claim Status Category and Claim Status Codes Update

Related CR Release Date: August 10, 2022

Related CR Transmittal Number: R11552CP

Related Change Request (CR) Number: 12778

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12778 updates, 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. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete [CMS Change Request \(CR\)12778](#).

Exceptions to ASP Payment Methodology - Claims Processing Manual Changes

MLN Matters Number: MM12854

Related CR Release Date: August 25, 2022

Related CR Transmittal Number: R11572CP

Related Change Request (CR) Number: 12854

Effective Date: October 26, 2022

Implementation Date: October 26, 2022

CR 12854 tells you about:

- Updates to [Chapter 17](#) of the Medicare Claims Processing Manual
- Exceptions to Average Sales Price (ASP) payment methods

Make sure your billing staff knows about these changes.

View the complete [CMS Medicare Learning Network \(MLN\) Matters \(MM\)12854](#).

ICD-10 and Other Coding Revisions to NCDs - January 2023 Update - 1 of 2

MLN Matters Number: MM12822

Related CR Release Date: August 5, 2022

Related CR Transmittal Number: R11545OTN

Related Change Request (CR) Number: 12822

Effective Date: as shown in CR 12822

Implementation Date: January 3, 2023

CR 12822 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 12822.

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 \(MM\)12822](#).

ICD-10 and Other Coding Revisions to NCDs - January 2023 Update - 2 of 2

MLN Matters Number: MM12842

Related CR Release Date: August 4, 2022

Related CR Transmittal Number: R11546OTN

Related Change Request (CR) Number: 12842

Effective Date: January 1, 2023, unless otherwise specified in CR 12842

Implementation Date: January 3, 2023

CR 12842 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 12842.

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 \(MM\)12842](#).

Influenza Vaccine Payment Allowances - Annual Update for 2022-2023 Season

Related CR Release Date: August 18, 2022

Related CR Transmittal Number: R11564CP

Related Change Request (CR) Number: 12856

Effective Date: August 1, 2022

Implementation Date: No later than September 30, 2022; November 1, 2022

CR 12856 provides the availability of payment allowances for the seasonal influenza virus vaccines as updated on an annual basis, effective August 1 of each year. The attached recurring update applies to publication 100-04, chapter 17, section 20.5.9.

Make sure your billing staff knows about these changes.

View the complete [CMS Change Request \(CR\)12856](#).

New Waived Tests

MLN Matters Number: MM12841

Related CR Release Date: August 4, 2022

Related CR Transmittal Number: R11547CP

Related Change Request (CR) Number: 12841

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12841 tells you about:

- CLIA requirements
- New CLIA waived tests approved by the FDA
- Use of modifier QW for CLIA-waived tests

Make sure your billing staff knows about these changes.

View the complete [CMS Medicare Learning Network \(MLN\) Matters \(MM\)12841](#).

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

Related CR Release Date: July 14, 2022

Related CR Transmittal Number: July 14, 2022

Related Change Request (CR) Number: 12788

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12788 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete [CMS Change Request \(CR\)12788](#).

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

MLN Matters Number: MM12870 Revised

Related CR Release Date: September 8, 2022

Related CR Transmittal Number: R11595CP

Related Change Request (CR) Number: 12870

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

Note: CMS revised this Article due to a revised CR 12870. The CR revision added a note about code 0340U. CMS added that note in dark red font on page 3. CMS also changed the CR release date, the transmittal number, and the web address of the CR. All other information is the same.

CR 12870 tells you about:

- Updates to Advanced Diagnostic Laboratory Tests (ADLTs)
- Next Clinical Laboratory Fee Schedule (CLFS) data reporting period
- New codes added to the National HCPCS file

Make sure your billing staff knows about these changes.

View the complete [CMS Medicare Learning Network \(MLN\) Matters \(MM\)12870](#).

Quarterly Update to the MPFSDB - October 2022 Update

Related CR Release Date: August 4, 2022

Related CR Transmittal Number: R11544CP

Related Change Request (CR) Number: 12869

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12869 tells you that payment files were issued to contractors based upon the 2022 Medicare Physician Fee Schedule (MPFS) Final Rule. The purpose of this Change Request (CR) is to amend those payment files. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.1.

Make sure your billing staff knows about these changes.

View the complete [CMS Change Request \(CR\)12869](#).

Quarterly Update to the NCCI PTP Edits, Version 28.3, Effective October 1, 2022

Related CR Release Date: June 23, 2022

Related CR Transmittal Number: R11471CP

Related Change Request (CR) Number: 12795

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12795 tells you that the latest package of National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits, Version 28.3 effective October 1, 2022, will be available via the CMS Virtual Data Center (VDC). A test file will be available on or about August 2, 2022, and a final file will be available on or about August 17, 2022.

Make sure your billing staff knows about these changes.

View the complete [CMS Change Request \(CR\)12795](#).

RARC, CARC, MREP and PC Print Update - Revised

MLN Matters Number: MM12774 Revised

Related CR Release Date: August 10, 2022

Related CR Transmittal Number: R11549CP

Related Change Request (CR) Number: 12774

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

Note: CMS revised this Article due to a revised CR 12774. CMS changed a date in the Background section from July 1 to August 1. CMS shows this in dark red font on page 2. CMS also changed the CR release date, transmittal number and the CR web address. All other information is the same.

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

Make sure your billing staff knows about these changes.

View the complete [CMS Medicare Learning Network \(MLN\) Matters \(MM\)12774](#).

Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 MSP Manual, Chapter 5

MLN Matters Number: MM12765

Related CR Release Date: August 12, 2022

Related CR Transmittal Number: R11550MSP

Related Change Request (CR) Number: 12765

Effective Date: October 13, 2022

Implementation Date: October 13, 2022

CR 12765 tells you about:

- Updates to Chapter 5 of the [Medicare Secondary Payer \(MSP\) Manual](#)
- Sending claims to primary payers before billing Medicare

Make sure your billing staff knows about these changes.

View the complete [CMS Medicare Learning Network \(MLN\) Matters \(MM\)12765](#).