Medicare B News

Jurisdiction E
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Healthcare Solutions
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

2023 Medicare Parts A & B Premiums and Deductibles

On September 27, CMS released the 2023 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs and the 2023 Medicare Part D income-related monthly adjustment amounts.

Each year the Medicare Part B premium, deductible, and coinsurance rates are determined according to the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be $164.90 for 2023, a decrease of $5.20 from $170.10 in 2022. The annual deductible for all Medicare Part B beneficiaries is $226 in 2023, a decrease of $7 from the annual deductible of $233 in 2022.

The Medicare Part A inpatient hospital deductible that beneficiaries pay if admitted to the hospital will be $1,600 in 2023, an increase of $44 from $1,556 in 2022. The Part A inpatient hospital deductible covers beneficiaries' share of costs for the first 60 days of Medicare-covered inpatient hospital care in a benefit period. In 2023, beneficiaries must pay a coinsurance amount of $400 per day for the 61st through 90th day of a hospitalization ($389 in 2022) in a benefit period and $800 per day for lifetime reserve days ($778 in 2022). For beneficiaries in skilled nursing facilities, the daily coinsurance for days 21 through 100 of extended care services in a benefit period will be $200.00 in 2023 ($194.50 in 2022).

Sources:

- CMS MLN Connects dated September 29, 2022
- CMS Fact Sheet 2023 Medicare Parts A & B Premiums and Deductibles 2023 Medicare Part D Income-Related Monthly Adjustment Amounts

2023 Medicare Physician Fee Schedule Available Soon

The 2023 Medicare Physician Fee Schedule will be available on Noridian's website after the calendar year (CY) 2023 physician fee schedule Final Rule is put on display. Stay tuned for further updates: Noridian Medicare JE Part B Fee Schedules.

CMS Change Request (CR) 12912 - Calendar Year (CY) 2023 Participation Enrollment and Medicare Participating Physicians and Suppliers Directory (MEDPARD) Procedures provides additional information.

The CY 2023 fee schedule takes effect January 1, 2023. Noridian will publish an article when the fee schedule becomes available.

2023 Medicare Physician Fee Schedule Now Available

The 2023 Medicare Physician Fee Schedule (MPFS) has been published and posted in Microsoft Excel formats. Go to the MPFS webpage under the Fees and News tab on the Noridian website for further information.

ACT B Questions and Answers - October 19, 2022

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

Updates and Reminders:

- Public Health Emergency (PHE) signed again October 13, 2022 for additional 90 days (now January 13, 2022)
    - CMS pledged to notify 60 days prior to expiration
- Check the 2023 "CMS Final Rule" and stay tuned for Noridian implementation from CMS directives
- Provider Customer Service (PCC) reminds providers of busy call times from 11am - 2pm Central
- Don't share Noridian's PCC number with patients as they must call 1-800-Medicare
- If patient has managed care, instead of traditional fee-for-service Medicare, do not bill Noridian
- Seek external sources for coding advice

PRE-QUESTIONS:

Q1. The American Society of Echocardiography (ASE) requests an editorial correction to add on CPTs 93325 (doppler echocardiography) and 93319 (3-D echocardiography) because the National Correct Coding Initiative (NCCI) does not allow those billed together. Will Noridian allow this current billing?
A1. No. Those claims, with 93319 and 93325 billed together, will continue to deny as Noridian Medicare must follow all NCCI editing. If this bundling changes in 2023, providers will be notified.

Q2. Can you differentiate Critical Care time reported by multiple providers in the same specialty and group practice?
A2. Yes. When the visit is split or shared between a physician and a non-physician practitioner (NPP), the practitioner who provides the substantive portion of accumulated time (greater than 50% of the time) would bill the critical care service with modifier FS, per CMS IOM Publication 100-04, Chapter 12, Sections 30.6.12.5 and 30.6.18.

CMS allows critical care to be performed on a single date of service by one physician or practitioner, or by a **combination** of providers in a group; including both physicians and nonphysician practitioners (NPPs). The total time spent providing critical care services by a single or multiple practitioners determines the billing for those services. This means that the full

timeframe for each code must be met to add it to the claim. In critical care for 99291, 74 minutes must be spent. To report additional time, another full 30 minutes of time spent is required for 99292, totaling 104 minutes to bill for the two codes. Each 30-minute segment beyond that time, supports an additional unit of CPT 99292.

Q3. Is there guidance for second interpretation when a Radiologist requests a second reading of an image, other than CMS Internet Only Manual (IOM) Publication 100-04, Chapter 13, Section 100.1, when the initial reading was from an outside image center?
A3. Yes. Medicare pays for only one read unless it's medically necessary to have an additional read. Medical necessity must be documented when a second reading of the image is to be considered for reimbursement. The second report must clearly state the purpose of the interpretation, with the name of the ordering provider requesting the new and second interpretation. Modifier 77 (repeat procedure by another physician) could be appended to the second radiologic interpretation code. See CMS IOM Publication 100-04, Chapter 16, Section 100.5.

Q4. When an interventionalist performs an add-on CPT 93571 (flow wire-FFR) or 92978 (endolumnil ivus) to the cardiologist's performing a diagnostic catheter (both part of the same group), during the same session in the catheter lab; how can we bill and be reimbursed appropriately?
A4. If cardiac procedures are billed by two different providers, the second provider should not bill for the add on CPTs (+92978 or +93571), as there must be a primary or parent CPT (e.g., 93454-93461) to bill add on codes on the same claim. Occasionally, billing an undifferentiated (unlisted) code and indicating exactly what is being performed may help. If this meets the co-surgeon requirement, both providers must append modifier 62 to their claims. Please check with your respective societies to resolve nationally.

Q5. What guidelines are there regarding pre-charting of progress notes, date of entry limitations, content, and new templates? Are scribes, non-physician practitioners, and medical assistants allowed to provide note pre-preparation?
A5. Yes. Any staff can provide documentation in the medical record when effectively **authenticated** by the billing provider's signature, with date and time. CMS does not require the scribe to sign or date the documentation. Documentation needs to support the service(s) submitted to Medicare. All services provided are expected to be documented at the time they are rendered. More information can be found in the CMS Complying with Medicare Signature Requirements Fact Sheet.

Q6. Can clinical staff provide Advance Care Planning (CPT code 99497) under the order and medical management of the billing provider?
A6. Yes. Clinical staff can perform Advance Care Planning, using a team-based approach, under the order and medical management of the billing provider. The 2016 Federal Register 2016 Final Rule provides the answer. CMS published the Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services and the CMS MLN Advance Care Planning Fact Sheet, referencing the 2016 Final Rule.

Q7. Is it fraudulent billing if the lab claim first denies with diagnosis (Z00.00-encounter for general exam without complaint, suspected or reported diagnosis) for CPT 80061 (lipid panel) and then, since the lab order included E78.2 (mixed hyperlipidemia), the lab rebilled with just that diagnosis and not the noncovered ICD-10 Z00.00?
A7. No. If the ICD-10 E78.2 was erroneously omitted, and clearly documented beforehand, including why the test is performed, the claim could be reopened or appealed to add the additional diagnosis. If a provider is sending the lab an order with a diagnosis of Z00.00, it's beneficial for the lab to contact the provider, before billing, to ensure the correct order was sent. Do not omit the Z00.00; just do not point it as primary diagnosis in billing. The patient may be examined for hyperlipidemia and viewed for hypertension if the physician is monitoring patient with known condition. In this claim example, link CPT 80061 to the diagnosis E78.2 to resolve the issue.

Q8. Some Local Coverage Articles (LCAs) do not have an associated Local Coverage Determination (LCD). Can we have the Noridian Medicare Portal (NMP) link to LCAs like the NMP offers for LCD policies?
A8. Thank you for your suggestion and our Medical Policy and NMP teams will address adding those links. As a reminder, not all LCDs have LCAs and vice-versa.

Q9. Where can I locate medical necessity documentation for a particular CPT and when billed in conjunction with the same or opposite breast sites (i.e., CPTs 15877, 19316, 19318, 19342, 19370)?
A9. Under Noridian's home page, Browse by Topic, there's great JEB Documentation Requirements information. Check if a CPT or HCPCS has a National or Local Coverage Determination policy (NCD or LCD) with matching Billing and Coding articles. Researching your specialty and medical associations for guidance is also helpful. The CMS National Correct Coding Initiative (NCCI) edit webpage provides rational as to which codes are mutually exclusive, bundled and why. Always check each code combination.

Q10. How is the payment calculated with multiple procedure payment reduction (MPPR) for outpatient therapies speech language treatment (CPT 92507) and 30 minutes of therapeutic exercises with a physical therapist (CPT 97110, each 15 minutes)?
A10. These are therapy services with a multiple pricing indicator of 5. This means when multiple therapy services are billed on the same date of service, the first unit of service with the greatest allowance will allow at 100% of the fee schedule amount. There is a 50% reduction for the next procedure's **practice expense only** provided to the same patient on the same day. Do not append modifier 51 as the processing system auto-calculates.

This reduction is applied when more than one unit or therapy procedure is provided to the same patient on the same day. This applies to all therapy disciplines, not just one. It applies to the HCPCS codes contained on the list of "always therapy" services that are paid under physician fee schedule. More specific information is available within the CMS Change Request (CR) 8206 and Noridian's JEB Fees and News/Fee Schedules/Multiple Procedure Payment Reduction (MPPR) for Selected Therapy Services webpage.

Q11. We have orders, procedures, and other supplemental information (scanned paper documentation with the providers signature, date, and time), indicating it was the same patient encounter as the typed note and is clearly in the Electronic Medical Record (EMR). Can it be used to support reporting a service with claim submission, even if the provider did not mention in their note?
A11. Yes. For providers billing Medicare, the documentation must be present in the patient records. These records must be legible, and the provider signs each entry, with clear and concise information that reflects the patient's condition and provides sufficient detail to support necessity for diagnostic test. This should be created at the same original time.

Q12. Can the drug name and dosage be used in the E-order to supplement the clinical note for Evaluation and Management (E/M) moderate risk level determination?
A12. Yes. The drug and dosage can supplement the clinical note in an E-order. The clinical note needs to reflect the drug management and moderate risk of morbidity.

Q13. Is tissue removal the only deciding factor for biopsy and would billing involve CPT 11300 rather than CPT 11102?
A13. No. The term biopsy would not be the only decision factor. Physicians clearly need to indicate the purpose of the procedure. 11102 is a biopsy where a sample of tissue is taken for diagnostic pathology examination. The 11300 is a therapeutic, complex removal of symptomatic epidermal or dermal lesion of 0.5 cm diameter or less (also known as an epidermal lesion shaving).

Q14. When performing a bronchoscopy, via endotracheal tube, would you append a modifier 52 for reduced services?
A14. It would depend on the documentation and reason for reducing the procedure. In determining whether to append modifier 52, review the Noridian JEB, Browse by Topic, Modifiers page, as it explains correct uses, incorrect uses, examples, and resources.

Q15. Can fully licensed advanced practice providers (NPs and PAs) document supervision of students by attesting to the students' notes (as opposed to re-documenting the encounter) using a phrase like: "*I was present with the student during the entire history taking and exam of the patient. I discussed the history, physical, pertinent studies, and medical management with the student. I have reviewed the student's note for accuracy and agree with the findings and plan as documented in the students note.*" and still bill for their services?
A15. Yes. As long as the student is eligible (not a college undergraduate), then CMS Change Request (CR) 11862 allows all physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse Midwives (CNMs) and Certified Registered Nurse Anesthetists (CRNAs), recognized as Advanced Practice Registered Nurses (APRNs), to review and verify (sign and date) documentation in medical records without having to re-document notes already included in the medical record. However, mid-level providers (NPs and PAs) cannot supervise residents.

Q16. When a controlled substance is administered during an emergency room visit, would the medication always be considered high risk under the management options?
A16. The answer depends on the situation. There isn't an "always" answer when determining the risk management of a patient. The documentation would determine the work involved by the billing provider in managing the patient's risk, the involvement of the controlled substance, and the intensive drug monitoring for toxicity. When providing an injection for pain, is it intra-muscular (IM) or subcutaneous (sub-Q)? What other conditions or comorbidities does the patient have, and age may have a factor when managing for toxicity.

Q17. If a patient has Diabetic Sensory Neuropathy with Loss of Protective Sensation (LOPS), do we also need to include one of the Class A, B, or C modifiers Q7, Q8 or Q9? NCD 70.2.1 shows this diagnosis with an asterisk.
A17. Yes. When the patient's condition is one of those designated by an asterisk (*), routine procedures are covered only if the patient is under the active care of a Doctor of Medicine or Osteopathy, who documents the condition. Modifier Q7, Q8, or Q9 are required to indicate the documentation supports a necessary and integral part of foot care that meets the exceptions of routine foot care. NCD 290.2 supersedes the LCD and/or LCA and the provider must document sufficiently to demonstrate medical necessity which includes the Class findings.

The provider must also clearly indicate why the callous(es) required debridement, including the Class A, B and/or C that the provider has noted the presence of such findings, how these findings integrate into the foot care of the beneficiary, and documented within the medical record. The paring of a callus is not reasonable; however, the presence of a callous must indicate repetitive trauma to the area with a systemic condition diagnosis. Noridian expects the record to reflect what measures are taken to prevent recurrence; in particular, how the footwear is or was being modified. Review the CMS IOM Publication 100-02, Chapter 15, Section 290 - Foot Care.

Q18. When do providers refer to the Local Coverage Article (LCA), Billing and Coding to indicate treatment of painful calluses?
A18. Refer to your jurisdiction LCA for Routine Foot Care that provides billing and coding guidance, when paring or cutting of benign hyperkeratotic lesion(s); e.g., corn or callus.

Q19. Do we know when the COVID-19 Public Health Emergency (PHE) waivers will end?
A19. No. The Department of Health and Human Services (HHS) has stated they will provide 60-day notice prior to the PHE termination. More information can be found at the HHS.gov under Administration for Strategic Preparedness and Response (ASPR) website.

VERBAL Q/A DURING ACT:

Q20. Are the Wound Care LCDs and LCAs still active?
A20. Yes. There is Wound Care and Debridement - Provided by a Therapist, Physician, NPP, or as Incident-to Services, Wound and Ulcer Care, and Routine Foot Care articles. Some LCDs have more than one LCA. There are a small number of CPTs that can be used for different conditions (wound care vs. debridement), which may be found in the LCDs and LCAs.

Q21. Is ICD-10 diagnosis D48.5 (Neoplasm of uncertain behavior of skin) used when pathology cannot determine if the lesion is malignant or benign? If the provider is unsure of whether the skin lesion is benign or malignant and submits to pathology, should we bill ICD-10 D49.2 (Neoplasm of unspecified behavior of bone, soft tissue, and skin), because this code includes Neoplasm, not otherwise specified (NOS)?
A21. Yes. If the provider is unsure of whether the skin lesion is benign or malignant and submits to pathology, the provider should use diagnosis D49.2.

Q22. In terms of benign lesion destruction codes, can providers not submit a claim to Medicare? Is there any regulation stating a healthcare facility cannot offer a discount or reduced rate for a non-medically necessary procedure?
A22. Review the coverage conditions and make sure the service has never been covered by Medicare. Please speak with a healthcare attorney and make sure it doesn't fall within anti-kickback or similar laws. You could send a request to the Health and Human Services (HHS)-Office of Inspector General (OIG) for an opinion on your unique circumstances. Be careful as the procedure cannot be an inducement for other disallowed behavior. If the beneficiary requests to have Medicare billed, even for statutorily excluded services, providers must bill on their behalf.

Q23. Under Routine Foot Care article, it looks as though CPT 11720 and 11721 have been modified for what is medically necessary based on billing denials. When looking at the material, I'm not seeing requirements for the pain code section (pain of foot, pain of toes), and appears it needs to be included on the claim. Primary and secondary diagnosis requirements had been billed. Was there an article change recently? Please confirm about the use of the Q modifier not included on Group 1 or 2 pairing?
A23. Providers must have two diagnoses (appropriate primary and secondary) from the article. The updated article only had changes to the phrasing and layout and the tables were clarified for easier reading. These services can be billed with a primary from group 1, and then a diagnosis from group 2 or 4. If billed with a Q modifier, they must have a primary diagnosis from group 1 and secondary diagnosis from group 3 only.

CPTs 11720 and 11721 have additional, unique diagnosis criteria and can be billed in three approaches with the third option including a primary diagnosis in group 5 with a secondary diagnosis from group 6. Again, this was not a change in policy as the grouping had differed and broken down for easier reading. The primary and secondary need to be from the appropriate groups. Q modifier is specifically for secondary diagnosis code from group 3. Do not bill a Q modifier if diagnoses are from Group 1 and 2 together or from Group 1 and 4 together. Review the Billing and Coding: Routine Foot Care - Local Coverage Article (LCA) A57954.

Q24. For teaching students and supervision, does this include residents or teacher students? We have students in family medical offices acquiring residency. Can we have our NP and PA sign off for them?
A24. No. Physician Assistants (PAs) and Nurse Practitioners (NPs) training does not contain the same elements as that of a physician, and neither does the scope of practice, which for both includes supervision or delegation by a physician. If you are speaking of medical

students, the answer is still no, as their supervision is by the Medical School physician staff. It is possible that a NPP could observe while a medical student performs some part, but there would still need to be a qualified Physician teaching the event for those medical students. Residents are licensed or eligible, so their scope of practice supersedes that of NPPs.

Noridian would ask if the resident's criteria was satisfied and what type of student they are supervising. Review the CMS Medicare Learning Network (MLN) Teaching Physicians, Interns, & Residents Guidelines Fact Sheet, pages 4, 5, and 6. These requirements must be met:

- The services are identifiable physician services, the nature of which require performance by a physician in person and contribute to the diagnosis or treatment of the patient's condition and
- The intern or resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State where the services are performed

Students Providing Evaluation & Management Documentation

- Students taking part in and contributing to a billable service must perform in the physician's or resident's physical presence, and meet teaching physician billing conditions. E/M services include separately billable services, except systems review and/or past family and social history.
- Students may document services in the patient medical records. Teaching physicians must verify all student medical record documentation or findings, including history, physical exam, and medical decision-making.
- Teaching physicians must personally perform (or re-do) all billed physical exam and medical E/M decision-making services. They can verify any student documentation in the medical record rather than re-documenting.
- CMS Teaching Physicians, Interns and Residents Guidelines Booklet - May2022

Q25. When billing for an Evaluation and Management (E/M), do multiple (two or more) acute, uncomplicated illnesses or injuries make a moderate Number and Complexity of Problems Addressed?

A25. The answer depends on the situation. When you look in the AMA CPT book, it indicates under Table 2: Levels of Medical Decision-Making (MDM); based on 2 out of 3 elements. Moderate complexity of problems during the encounter include:

- One or more chronic illnesses with exacerbation, progression, or side effects of treatment OR
- Two or more stable, chronic illnesses OR
- One undiagnosed new problem with uncertain prognosis OR
- One acute, complicated injury

The CPT book also shows Amount and/or Complexity of Data to be Reviewed and Analyzed for moderate level of medical decision-making (MDM).

Q26. Can you clarify pathology billing of 76098 (radiological exam, surgical specimen) and is it appropriate for a pathologist to bill a second film for the purpose of pathology evaluation separate from the intraoperative session?
A26. No. Medicare does not generally allow two physicians to read and interpret a film or specimen, so you may not receive payment if the radiologist has previously submitted a claim for the same service. Since the pathologist is not the radiologist performing the exam and is evaluating the report, modifier 26 should be appended to 76098. If the claim denies, because the CPT was "paid to another provider," you could appeal with modifier 77 (repeat by another physician). Noridian recommends checking with your national association "American Society for Clinical Pathology (ASCP)" for additional guidance.

Q27. When performing two diagnostic procedures (i.e., colonoscopy and Esophagogastroduodenoscopy-EGD) with modifier 51), should moderate sedation be billed for both procedures? Should we bill G0500 for the first 15 minutes on the same claim, as long as the diagnosis pointers are correct? Should the units for sedation be added together as 2 units? Would the same answers be true for a diagnostic and screening colonoscopy procedure on the same day? How should we bill for a single procedure that takes longer than 15 minutes?
A27. Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure, except when the anesthesia service is bundled into the procedure (e.g., radiation treatment management). For example, CPT **45378** (Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression [separate procedure]) and CPT **43235** (EGD) billed with the HCPCS **G0500** ((moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; patient aged 5 years or older; first 15 mins.) can be billed. CPT **99153** (moderate sedation; ***each additional 15 minutes*** of intra-service time) may be reported for additional time as appropriate.

For the endoscopy or GI CPT codes, HCPCS **G0500** would need to be appropriate for the situation and providers involved. These are no longer bundled and place of service (POS) 22 is also allowed if the physician directly supervises the RN. G0500 can be used with several endoscopy codes (43xxx, 453xx series, G0105, and G0121).

A physician must continuously be present to monitor and personally provide care to patients. The presence of an underlying condition alone, as reported by an ICD-10-CM code, may not be sufficient evidence that Moderate Sedation is necessary. The medical condition must be significant enough to impact the need to provide Moderate Sedation. The presence of a stable, treated condition of itself is not necessarily sufficient. Change Request (CR) 10075 discusses the CMS Payment for Moderate Sedation Services Furnished with Colorectal Cancer Screening Tests and states Medicare shall not apply deductible and coinsurance to claim lines with HCPCS codes G0500 or 99153 when submitted with the **PT** modifier.

Note: MPPR rules do apply allowing at 50% of practice expense. In the case of multiple unrelated endoscopies (e.g., 45xxx series), watch the allowance reduced based on the "family base procedure code". More information is available in the CMS IOM Publication 100-04, Chapter 12, 100.1.2.5.

Additional Documentation Requests (ADR) and Appeals - Appeals Newsletter Part 2

When submitting an appeal as a result of an Additional Documentation Request (ADR):

- All fields must be completed on the Appeal form.
- If submitting ADR letter, please make it clear what it is you are appealing, and what you would like us to do.

How can the provider resolve this error?

- Complete all sections on the Appeal form
- If sending an appeal from your ADR, please include a letter telling us what you would like us to do and why
    - It is always better to submit a completed appeal form

Resource

Redetermination

Annual Participation Program

CMS Manual 100-04 Chapter 1 Section 30.3.12 outlines an annual open enrollment process, to provide eligible practitioners and suppliers with the opportunity to enroll in or terminate enrollment in the participation program.

For providers (including physicians and suppliers) who have enrolled in Medicare, to sign participation agreement (Form CMS-460) is to agree to accept assignment for all covered services that are provided to Medicare patients. The benefits of signing a participation agreement include:

- No 5 percent reduction in the Medicare approved amount.
- Beneficiaries with Medigap coverage (private supplemental insurance) may assign the payment on the supplemental claim to the provider or supplier. Under the current mandatory Medigap (claim-based) crossover process, beneficiaries must assign payment on their claims to a participating provider or supplier as a condition for their claims to be forwarded to their Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer, in turn, must pay the participating provider or supplier directly, thereby relieving the need of having to

file a second claim. (Refer to the Medicare Claims Processing Manual, Chapter 28, Section 70.6, for more information regarding the eligibility-file based crossover process.)

- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the MAC Web site.
- Participants receive direct and timely reimbursement from Medicare.

Eligibility

All practitioners and suppliers eligible to receive payments under Part B of Medicare may choose to enter into a participation agreement. This includes practitioners whose services are subject to mandatory assignment. The reason why it could still be appropriate for such practitioners to enter into a participation agreement is because the mandatory assignment provisions apply only to the particular practitioner service benefit (e.g., nurse practitioner services). Thus, for example, if a nurse practitioner is eligible to bill for, and is indeed billing under, Part B for something other than a nurse practitioner service (e.g., an EKG tracing), the mandatory assignment provision of the law does not apply to that other service. However, if the nurse practitioner has entered into a participation agreement, that agreement requires that the nurse practitioner accept assignment for any service for which he or she submits a Medicare Part B claim.

Hold billing until notified of status change. Noridian is unable to submit claims revisions on your behalf for this reason. This open enrollment cycle runs from November 15, 2022 through December 31, 2022.

We encourage you to visit the 2023 Open Enrollment webpage for more information.

Bill Correctly: Power Mobility Device Repairs

An Office of Inspector General report stated that Medicare improperly paid claims for power mobility device (PMD) repairs when suppliers didn't provide sufficient documentation to support billing charges. The Power Mobility Devices booklet explains how to properly document and bill for PMD repairs.

Follow these steps to bill for repair charges:

- Check the Standard Written Order (SWO)
- Make a prior authorization request
- Complete a home assessment
- Keep the following documents: SWO; face-to-face visit supporting documents; written home assessment report; proof of delivery; records describing repairs, including a detailed explanation that justifies components or parts replaced and labor time to fix the item
- Review all information to avoid improper payments

More Information:

- 42 CFR 414.210
- Section 110.2 Medicare Benefit Policy Manual, Chapter 15
- Section 510.1 Medicare Program Integrity Manual, Chapter 5

Source: CMS MLN Connects dated December 8, 2022

Colorectal Cancer Screening Test: Reduced Coinsurance for Related Procedures Begins January 1

Currently, planned colorectal cancer screening tests are free. However, if you add a procedure in the same clinical encounter as a result of the colorectal cancer screening, the patient pays a coinsurance. Beginning January 1, 2023, CMS will gradually reduce coinsurance for procedures performed in connection with a colorectal cancer screening test, as a result of a screening test, or in the same clinical encounter as the screening test. The reduced coinsurance applies regardless of the code you bill.

Effective January 1, 2022, when a screening colorectal cancer procedure, G0104, G0105, or G0121 has **the PT modifier submitted on the claim line item** with HCPCS codes 10000 - 69999, G0500, 00811, or CPT code 99153 for diagnostic colonoscopy, or diagnostic flexible sigmoidoscopy, or other procedure to indicate that a screening colorectal cancer procedure, HCPCS G0104, G0105, or G0121, has become a diagnostic or therapeutic service, coinsurance is reduced or waived for claims for dates of service in Calendar Years (CYs) as follows:

- 2023-2026, coinsurance is 15%
- 2027-2029, coinsurance is 10%
- Beginning 2030, no coinsurance

Learn more about phasing out coinsurance in CMS MLN Matters (MM) 12656, Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests.

Source: CMS *MLN Connects* dated November 23, 2022

Diabetes: Recommend Preventive Services

In 2019, 27.5% of Medicare Fee-for-Service patients had a diagnosis of diabetes (see data snapshot (PDF)). National Diabetes Month is the perfect time to talk with your patients about their risk factors, and recommend preventive services to detect, prevent, and treat diabetes.

Medicare covers:

- Diabetes screening
- Diabetes self-management training

- Medicare Diabetes Prevention Program
- Medical nutrition therapy

Find out when your patient is eligible (PDF) for diabetes screenings and the Medicare Diabetes Prevention Program. If you need help, contact your eligibility service provider.

More Information:

- Medicare Diabetes Self-Management Training (PDF) fact sheet
- Medicare Diabetes Prevention Program Expanded Model (PDF) booklet
- Diabetes screenings, diabetes self-management training, Medicare Diabetes Prevention Program, and nutrition therapy services: Get information for your patients

Source

- CMS MLN Connects dated November 3, 2022

DMEPOS Fee Schedules and Labor Payment - 3rd quarter 2022 update

Updates to the DMEPOS Jurisdiction listing for 3rd quarter 2022 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

Help Your Patients Make Informed Health Care Decisions

Health literacy can reduce adverse events for your patients, like missed screenings, inappropriate care transitions, and diagnostic errors (see CMS Framework for Health Equity (PDF)). During Health Literacy Month, get in the habit of promoting health literacy and language access resources so your patients can find, understand, and use information for health-related decisions.

More Information:

- CMS Office of Minority Health: Health Observances webpage
- Introduction to Language Access Plans web-based training
- Coverage to Care webpage

Source: CMS *MLN Connects* dated October 20, 2022

How to Submit Successful Appeals, or Reopenings - Appeals Newsletter Part 1

Reopening Process - Simple Clerical Error Corrections

Do not submit a new claim to fix the error.

Utilize the Noridian Medicare Portal (NMP) when a reopening is appropriate for faster results. A correction can be done instantly, whereas a paper appeal can take 60 days.

- Routine Denials - Do you need to change your diagnosis, or point to the correct diagnosis?
- Bundling Denials - Do you need to add a modifier?

Redetermination Process

Determine if you need to appeal to get paid.

- Is it paid correctly? Review your remittance advice before appealing
  - CMS Internet Only Manual (IOM) Pub 100-04 Chapter 12 Medicare Claims Processing Manual
  - CMS Internet Only Manual Pub 100-04 Chap 5 page 34 - 2022 Multiple Procedure Payment Reduction for Selected Therapy Services
  - CMS Therapy Services
  - Noridian Medicare JE Part B Multiple Procedure Payment Reduction on Certain Diagnostic Imaging Procedures
- Are there any MSP issues involved? Utilize the MSP website to send to the correct team
- Are you replying to an Additional Documentation Request (ADR)
  - Where does the letter state to send documentation?

Submit a valid and complete appeal

- Make sure you use the **Redetermination** form, not the **Reopening** form
- Complete the “Action Request and Comments (paper), or Details and Explanation” on the portal form, with what, or why you are appealing
- Clear reason for the appeal not provided
  - Documentation to support your appeal
- Wrong form being submitted
- Does primary diagnosis follow the NCD/LCD for medical necessity
  - Verify your diagnosis pointer in Box 24E, or the electronic equivalent, refers to the correct primary diagnosis code in Box 21

How can the provider help?

- Make sure you are aware of what, and how many, your billing service is appealing
    - Excess appeals mean excess costs to you
- Check to see if your issue is something that can be done through reopenings
- Make sure you are not submitting appeals for multiple procedure reductions or reductions for mid-level providers (Nurse Practitioner or Physician Assistant).
- Understand reductions for non-participating versus participating Medicare providers
- Confirm your place of service on the claim is correct
- Verify your diagnosis pointer in Box 24E, or the electronic equivalent, refers to the correct primary diagnosis code in Box 21
    - Review NCD/LCD for medically necessary diagnosis codes

Noridian Medicare Redetermination/Reopening Form

CMS MCD Search

42 CFR 410.75 Chapter-IV Subchapter-B Part-424 Subpart-D Ssection-424.55

Indirect Independent Diagnostic Testing Facility Updates

Due to healthcare having more technical resources at it's disposal, the CMS has updated some indirect IDTF rules.

As a reminder, an IDTF is independent of **BOTH** an attending or consulting physician's office AND a hospital.

Updated in CY 2022 in the Medicare Program Integrity Manual, Chapter 10 are the changes for an indirect IDTF.

- Diagnostic services via offsite computer modeling and analytics, or
- Other forms of testing that do not involve direct patient contact

Facilities that qualify are exempt from the following requirements:

- Comprehensive liability insurance
- Posting the standards outlined in 42 CFR 410.33(g)(9) for review publicly by patients
- Documentation of beneficiary's complaint

To find out more read the Independent Diagnostic Testing Facility (IDTF) MLN Booklet

News

Manipulated, Reconstituted and/or Injectable Amniotic and Placental Derived Products - Resolved 10/03/22

Provider/Supplier Type(s) Impacted: All Providers

Reason Codes: Not Applicable

Claim Coding Impact: All Q codes related to amniotic and/or placental derived membrane and liquid Q codes.

Description of Issue: An educational article has been published to address Manipulated, Reconstituted and/or Injectable Amniotic and Placental Derived Products for previously processed claims. Please refer to this article for further guidance on this matter.

Noridian Action Required: N/A

Provider/Supplier Action Required: Informational only

Proposed Resolution/Solution: Please refer to the notice mentioned under Description of Issue.

Date Reported: 05/20/22

Date Resolved: 10/03/22

Medically Unlikely Edit for J1559

CMS plans to increase the current Medically Unlikely Edit (MUE) units allowed per day for HCPCS code J1559 (Injection, immune globulin (Hizentra), 100 mg), currently set at 1600 to 2400. This update is scheduled with the implementation of the January 2023 quarterly MUE file and will be retroactive to July 1, 2022.

Until the change is implemented, Medicare contractors will hold claims submitted with J1559 with units of service >300 and ≤2400 for dates of service on or after July 1, 2022, through October 1, 2022, and hold claims submitted with units of service >1600 and ≤2400 for dates of service on or after October 1, 2022 through December 31, 2022.

Noridian will be adjusting claims that have already processed during this time that were denied. Adjustments will be processed within 60 business days following the MUE update in January 2023.

Prior to the implementation of the MUE quarterly update file for January 1, 2023, providers may choose to delay submission of claims until after the January 1, 2023 implementation of the July 1, 2022 retroactive date.

Note: Appeals will not be necessary for denials as the claims will be adjusted as listed above.

News

Medicare Ground Ambulance Data Collection System: Information to Help You Report

Get the latest information on the Medicare Ground Ambulance Data Collection System (GADCS). Starting January 1, selected ground ambulance organizations in Year 1 and Year 2 may report data through the GADCS portal. Other highlights include:

- New GADCS User Guide (PDF) that walks you through the portal.
- Lists of Year 3 (ZIP) and Year 4 (ZIP) ground ambulance organizations required to collect data starting in 2023 and report data starting in 2024. Medicare Administrative Contractors will email and send a letter to these organizations starting in December 2022.
- Revised Medicare Ground Ambulance Data Collection Instrument (PDF), including changes finalized in the CY 2023 Physician Fee Schedule final rule.
- Facilities (ZIP) and Vehicles (ZIP) templates revised after the August 4, 2022, webinar.
- Copy of Hardship Exemption Request (PDF) form you submit through the portal.
- Revised FAQs (PDF).
- Ground Ambulance Industry Trends, 2017-2020 Report: Analysis of Medicare Fee-for-Service Claims (PDF).
- Bookmark the CMS Ambulance Events webpage for upcoming events planned in December 2022.

Source: CMS *MLN Connects* dated November 23, 2022

Medicare Part B Immunosuppressant Drug (PBID) New Benefit

Effective January 1, 2023, a new benefit is available for certain individuals with Medicare coverage for End-Stage Renal Disease (ESRD) coverage only. Individuals that have received a kidney transplant may need an extension of Medicare coverage for immunosuppressant drugs once they have exhausted their 36 months of coverage.

Consolidated Appropriations Act (CAA) of 2020 allows individuals whose Medicare entitlement based on ESRD ends 36 months after the month in which they received a successful kidney transplant to continue enrollment under Medicare Part B only for the coverage of immunosuppressive drugs described in section 1861(s)(2)(J) of the Act without a time limit.

Individuals entitled to PBID, would not receive Medicare coverage for any other items or services, and would only be eligible for the immunosuppressive drug coverage if they are not enrolled in certain other types of coverage (e.g., group health plan, TRICARE, or a Medicaid state plan that covers immunosuppressive drugs). Coverage for premiums and cost sharing may be available for some individuals.

Claims for the immunosuppressive drug would be submitted through the Durable Medical Equipment contractor.

- Resource: CMS New Medicare Part B Immunosuppressant Drug Benefit MLN Matters Number: MM12804 Revised

Medicare Preventive Services

Educational tool updated September 2022 to help properly provide and bill Medicare preventive services. Service information including National Coverage Determination (NCD) services web page (if NCD applies), HCPCS and CPT codes, prolonged preventive services information, ICD-10 diagnosis codes, telehealth, coverage requirements, frequency requirements and patient liability.

Source: CMS | MLN006559 dated September 2022

Medicare Preventive Services - Revised

Learn about updates to preventive services, including pneumococcal shot resources and new ICD-10 codes effective October 1, 2022:

- 13 bone mass measurement codes
- 3 hepatitis B screening codes

Source

- CMS *MLN Connects* dated October 13, 2022

New Codes Published for Telehealth

On November 2, CMS published Transmittal 11502 on its website, as well as the corresponding MLN Matters (MM) 12805, which details new codes G0320, G0321, and G0322 to report Home Health (HH) services furnished by telehealth. Reporting of the new G-codes beginning with HH periods of care that start on or after January 1, 2023 is voluntary; mandatory reporting of the codes will begin with HH periods of care that start on or after July 1, 2023.

This article is informational for providers. Noridian does not process Home Health claims, which should be submitted to the provider's Home Health contractor.

View CMS Medicare Learning Network (MLN) Matters (MM) 12805

News

New Total Invoice Price/Rebates Page

Do you have a rebate/discount/refund or other adjustment for a code that is priced per invoice? If so, please review the new Total Invoice Price/Rebates page. It provides all the necessary steps to submit an overpayment.

Provider Responsibilities When Using Third Parties

Noridian has received an increase of inquiries from third party billers and outsourced companies representing providers. Many of these companies call throughout the day, asking questions required to be answered via self-service tools, or are available through your practice's remittance advice or office staff. Examples of the frequently asked questions include, Provider's mailing address, electronic submitter id, claim number, Medicare timely filing, to name a few. Often, the individuals call multiple times a day asking the same questions through each interaction.

The Centers for Medicare and Medicaid Services (CMS) requires providers utilize self-service tools in the CMS Internet Only Manual (IOM), Publication 100-09, Medicare Administrative Contractor (MAC) Beneficiary and Provider Communications Manual, Chapter 6, Section 50.1. These self-service tools include the Noridian Medicare Portal (NMP), Interactive Voice Response (IVR) system, provider remittance advice, and Medicare public websites.

To best protect both Medicare and provider's interests, Noridian has comprised the following suggestions for providers who utilize third-party companies.

- Carefully review all contracts signed with any billing agency and clearing house.
- Ensure these agencies are not further contracting their work to additional companies without your full approval.
- Strictly monitor which individuals have access to your patient's Protected Health Information (PHI) and Personal Identifiable Information (PII).
- Ensure all employees working with Medicare information are trained how to use NMP, IVR, remits, and Noridian's public website.

To assist our providers with common questions they may have, Noridian has comprised a list of helpful Tools we hope will benefit your offices.

Screening Colonoscopies versus Diagnostic Colonoscopies

Medicare covers screening colonoscopies once every 24 months for high-risk patients and for patients not at high risk, once every ten years (120 months), or four years (48 months) after a previous flexible sigmoidoscopy.

Screening colonoscopy indicated for patients:

- Aged 50-85 years

- Asymptomatic
- Average colorectal cancer risk

When a screening colonoscopy transitions to a diagnostic colonoscopy, medical records must indicate:

- Medical reasonableness, necessity, and frequency of each diagnostic service supplied
- Colonoscopy report must describe maximum depth of penetration, description of abnormal findings and any procedures performed from the findings (e.g., biopsy).
- Append -PT modifier to CPT indicating screening colonoscopy switched to diagnostic colonoscopy.

Diagnostic colonoscopy indicated for patients:

- Abnormality determined by radiology exam consistent with colonic lesion
- Abnormal oncology colorectal screening or stool-based DNA test
- Unexplained gastrointestinal bleeding:
    - Hematochezia not from rectum or perianal source
    - Melena of unknown origin
    - Presence of fecal occult blood
    - Unexplained iron deficiency anemia
- Clinically significant diarrhea of unexplained origin
- Needs evaluation of acute colonic ischemia or ischemic bowel disease
- Needs evaluation due to streptococcus bovis endocarditis when source determined to be colonic origin
- Clinical suspicion of inflammatory bowel disease
- Known chronic inflammatory bowel disease of the colon when a more precise extent of disease determination will influence treatment
- Surveillance of Crohn's colitis or chronic ulcerative colitis to rule out colorectal cancer
- Surveillance of colonic neoplasia

Sources:

- Local Coverage Determination (LCD) - Diagnostic and Therapeutic Colonoscopy, L34213
- Local Coverage Determination (LCD) - Billing and Coding: Diagnostic and Therapeutic Colonoscopy, A57342
- CMS, Publication 100-03, Screening for Colorectal Cancer, CR12280

News

Security Acknowledgement on NMP

Effective October 1, 2022, the Noridian Medicare Portal (NMP) will have an additional Security Acknowledgment that all users will need to accept in order to continue when logging in. This additional security acknowledgment is required by CMS for all MACs to maintain standards and minimize potential security risks.

The additional acknowledgment will be presented after the Multi-Factor Authentication (MFA) code is entered. This security acknowledgment will only be presented to users once every two weeks. If a user declines the acknowledgment, they will be logged out of the Portal and will have the opportunity to log back in.

Self Service Reopenings Denied in Error - Resolved 12/20/22

Provider/Supplier Type(s) Impacted: Providers who submit reopenings though the Noridian Portal

Reason Codes: CO 16

Claim Coding Impact: Not applicable.

Description of Issue: Noridian identified an issue that denied all Self Service Reopenings submitted through the Noridian Portal. This impacted reopenings submitted on 11/16/22 through 11/28/22.

Noridian Action Required: Noridian corrected the issue on 11/28/22.

Provider/Supplier Action Required: No provider action is required at this time.

Proposed Resolution/Solution: Noridian will mass adjust the impacted reopenings. The process will begin after 12/12/22 to allow the system to finish processing the adjustments, so claims may be re-adjusted.

12/20/22 - Noridian has initiated the mass adjustments.

Date Reported: 12/02/22

Date Resolved: 12/20/22

Utilizing Noridian Custom Edits (NCE) Edits to Improve Your Claims Processing

Noridian has customized edits that help reduce provider burden. These edits, since they are front-end edits, don’t go through the processing system, and you get notified sooner of the errors. Since these are front-end edits, they will not be seen in the Portal under the Claim Status function. Instead, they will appear on your claim rejection report, and you will need to contact EDI if you have any questions.

If you are seeking a denial, remittance advice, or do not wish to make any corrections, simply resubmit the claim at least 10 - 24 hours after the original submission.

NCE will populate in the STC elements of the 277CA with distinct code sets that can be cross referenced to the NCE Spreadsheet. To assist submitters' NCE review, Noridian will establish an edit spreadsheet at EDISS Part B NCE Edits.

Benefits of NCE:

- Alert providers about issues around medical necessity, non-covered services, missing modifiers, and other clinical editing
- Save administrative time for claim resubmissions
- Provide information or reminders on claim submissions

Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period

On September 28, 2022, the United States District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs in the Calendar Year 2022 Outpatient Prospective Payment System (OPPS) final rule with respect to their prospective application. The Court ruled:

- CMS can't apply the average sales price (ASP) minus 22.5% drug payment rate for these drugs for the rest of the year
- As a result, CMS will revert to paying the default rate (generally ASP plus 6%) under Medicare statute for 340B-acquired drugs

CMS is uploading revised OPPS drug files that will apply the default rate (generally ASP plus 6%) to 340B-acquired drugs for the rest of the year. CMS also will reprocess claims our contractors paid on or after September 28, 2022, using the default rate (generally ASP plus 6%).

Source: CMS *MLN Connects* dated October 13, 2022

Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period - Resolved 10/26/22

Provider/Supplier Type(s) Impacted: Outpatient

Reason Codes: Not Applicable

Claim Coding Impact: Not Applicable

Description of Issue: CMS recently provided an update in 2022-10-13-MLNC regarding the 340B-Acquired Drugs. All Medicare Administrative Contractors (MACs) were instructed to

automatically adjust claims from September 28, 2022, forward. Additional guidance is provided below under Provider/Supplier action required

Noridian Action Required: Will adjust claims from September 28, 2022 forward.

Provider/Supplier Action Required: Although MACs shall not reprocess 2022 date of service claims paid prior to 09/28/22 as contractor-initiated adjustments, MACs shall process provider-submitted adjustments to 2022 date of service claims that were paid prior to September 28, 2022. The adjustments can be submitted using type of bill (TOB) XX7 with condition code D9 and remarks indicating “340B Adjustment”.

Proposed Resolution/Solution: MACs will update the production alert when they have completed the adjustments from September 28, 2022 forward.

10/26/22 - Mass adjustments have been completed.

Date Reported: 10/20/22

Date Resolved: 10/26/22

Webinar on Demand Recordings Library is Growing and Event Availability is Extended

Recordings of Noridian’s live webinars are available in our Education and Outreach / Webinar on Demand Recordings webpage. Based on feedback received in our satisfaction surveys, we have extended the availability from two months to six months.

We hope you find that our webinar library, with its newly extended event access, supports your knowledge and refresher training. Please continue to complete the satisfaction survey for educational webinars, tutorials, and webinar recordings so we may best meet your needs.

Medical Policies and Coverage

Billing and Coding: Billing Medicare for the SphenoCath® and Other Similar Devices (A55584) - R5 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: Per 2023 CPT/HCPCS updates, either the long or short description of CPT code 64999 has been updated.

- 64999 - Unlisted procedure, nervous system

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: Botulinum Toxin Types A and B Policy (A57185) - R3 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: Per 2023 CPT/HCPCS updates, either the long or short descriptions of CPT codes 43499 and 64999 have been updated.

- 43499 - Unlisted procedure, esophagus
- 64999 - Unlisted procedure, nervous system

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) - R11 - Effective January 01, 2023

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, 2023

Summary of Article Changes: Per 2023 CPT/HCPCS updates, either the long or short description of CPT code 96379 has been updated.

Medical Policies and Coverage

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

Billing and Coding: Immune Globulin Intravenous (IVIg) (A57187) - R5 - October 01, 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: A57187

Effective Date: October 01, 2022

Summary of Changes: Added ICD-10 D81.82 to Group 1, ICD-10-CM Codes that Support Medical Necessity.

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

Billing and Coding: Implantable Automatic Defibrillators - (A56340) - R5 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: HCPCS codes C7537, C7538, C7539 and C7540 will be added 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.

Billing and Coding: Implantable Continuous Glucose Monitors (I-CGM) - (A58133) - R2 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: HCPCS codes G0308 and G0309 will be removed from Group 1. Verbiage changes were made throughout the article.

Medical Policies and Coverage

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

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R10 - 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: Updated prices for Prialt (Ziconotide) and Ropivacaine per quarterly ASP Drug File.

Effective 10/01/2022 - 12/31/2022

Prialt (Ziconotide) = $9.065

Ropivacaine = $0.092

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) - R11 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: Updated prices for Prialt (Ziconotide) and Ropivacaine per quarterly ASP Drug File.

Effective 01/01/2023 - 03/31/2023

Prialt (Ziconotide) = $9.105

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.

Medical Policies and Coverage

Billing and Coding: Lab: Controlled Substance Monitoring and Drugs of Abuse Testing (A55001) - R15 - 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 Group 1: ICD-10 Codes That Support Medical Necessity, added F11.21, F12.20, F15.20, F19.10, F19.14 effective 01/01/2022.

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: Lab: Controlled Substance Monitoring and Drugs of Abuse Testing (A55001) - R15 - 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: Under Group 1: ICD-10 Codes That Support Medical Necessity, added Z91.198 and Z91.199 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: Lab: Flow Cytometry (A57689) - R6 - 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: Added CPT codes 86053 and 86363 to the Group 1 Paragraph for ICD-10 codes.

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

Medical Policies and Coverage

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R6 - 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 Article Text revised the thirteenth bullet first sentence to add “for the same (or highly similar) intended use”. Under ***CPT/HCPCS Codes Group 5: Codes*** added 87999. This revision is retroactive effective for dates of service on or after 4/17/2022.

Under CPT/HCPCS Codes Group 5: Codes added 0352U and 0353U. Under ***CPT/HCPCS Codes Group 8: Codes*** added 87593. This revision is due to the Q4 CPT/HCPCS Code Update and is effective for dates of service on or after 10/1/2022.

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

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

Billing and Coding: MolDX: Next-Generation Sequencing for Solid Tumors (A57901) - R2 - Effective October 1, 2022, and 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: October 1, 2022, and July 1, 2022

Summary of Article Changes:
Under ***CPT/HCPCS Codes Group 1***: Codes added 0329U. This revision is due to the Q3 2022 CPT/HCPCS Code Update and is effective for dates of service on or after 7/1/2022.

Under ***CPT/HCPCS Codes Group 1***: Codes added 0334U. This revision is due to the Q4 2022 CPT/HCPCS Code Update and is effective for dates of service on or after 10/1/2022

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.

Billing and Coding: MolDX: Pharmacogenomics Testing (A57384) - R6 - 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:
Under ***CPT/HCPCS Codes Group 1: Codes*** added 0345U. Typographical errors were corrected throughout the article. This revision is due to Q4 CPT®/HCPCS Code Update and is effective for dates of service on or after 10/1/2022.

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.

Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors (A58973) Final Billing and Coding Article - Effective December 26, 2022

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

Medicare Coverage Database (MCD) Number/Contractor Determination Number: A58973

Billing and Coding Article Title: Billing and Coding MolDX: Plasma-Based Genomic Profiling in Solid Tumors

Effective Date: December 26, 2022

Summary of LCA: The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Plasma-Based Genomic Profiling in Solid Tumors L39230.

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

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R4 - 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:
Under ***CPT/HCPCS Codes Group 1***: Codes added 81307 and 81309. This revision is effective for dates of service on or after 10/1/2022.

Under ***CPT/HCPCS Codes Group 1***: Codes Deleted 0012U. Added 0345U, 0347U, 0348U, 0349U, and 0350U. This revision is due to the Q4 CPT/HCPCS Code Update and is effective for dates of service on or after 10/1/2022.

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.

Billing and Coding: MolDX: ThermoFisher Oncomine Dx Target Test for Non-Small Cell Lung Cancer (A55881) Retirement - Effective October 27, 2022.

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

Effective Date: October 27, 2022

Summary: This article is being retired as it is no longer applicable as the test is covered under NCD 90.2.

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

Billing and Coding: Peripheral Nerve Stimulation (A55530) - R3 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: Per 2023 CPT/HCPCS updates, either the long or short description of CPT code 64999 has been updated.

- 64999 - Unlisted procedure, nervous system

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

Medical Policies and Coverage

Billing and Coding: Plastic Surgery (A57221) - 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: Updated Group 4: Medical Necessity ICD-10-CM Codes Asterisk Explanation to say: When billing for surgery on the unaffected breast to restore symmetry following breast cancer surgery on the contralateral breast, N65.1 must be used as the primary diagnosis with one of the C50.XXX ICD-10 codes as a secondary diagnosis.

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: Tomosynthesis-Guided Breast Biopsy (A57848) - R1 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: HCPCS codes C7501 and C7502 were added 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.

Billing and Coding: Topical HBO and Physician Related Services Billing and Coding Guidelines (A56025) - R2 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: Per 2023 CPT/HCPCS updates, either the long or short description of CPT code 99199 has been updated.

- 99199 - Unlisted special service, procedure or report

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

Medical Policies and Coverage

Billing and Coding: Treatment of Varicose Veins of the Lower Extremities (A57706) - R1 - Effective January 1, 2023

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 1, 2023

Summary of Article Changes: CPT codes 36299 and 37799 have had either the long or short description changed.

- 36299 - Unlisted procedure, vascular injection
- 37799 - Unlisted procedure, vascular procedure

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

MolDX: Molecular Biomarker Testing to Guide Targeted Therapy Selection in Rheumatoid Arthritis - 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: DL39467

LCD Title: MolDX: Molecular Biomarker Testing to Guide Targeted Therapy Selection in Rheumatoid Arthritis

Comment period: October 06, 2022

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

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

MolDX: Plasma-Based Genomic Profiling in Solid Tumors L39230 Final LCD - Effective December 26, 2022

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

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L39230

LCD Title: MolDX: Plasma-Based Genomic Profiling in Solid Tumors

Medical Policies and Coverage

Effective Date: December 26, 2022

Summary of LCD: This is a limited coverage policy for next-generation sequencing (NGS) assays performed on solid tumor cell-free deoxyribonucleic acid (DNA) in plasma, from here on called “liquid biopsies.”

Visit the Proposed LCDs webpage to access this LCD.

MolDX Providers Liability Change Notification

This article serves as a notice that effective January 16, 2023, Noridian will be assigning liability to the provider for molecular diagnostic tests that fail to meet the requirements of the foundational policy of the MolDX program, when services are provided and billed without a valid advance beneficiary notice of non-coverage (ABN). As these services do not meet the clinical validity and utility of Medicare’s reasonable and necessary requirement, they fall within the language of the CMS Internet Only Manual, Medicare Program Integrity Manual 100-8, Chapter 3, Section 3.3.3 which indicates in the absence of a policy, MACs shall determine if the service is covered based on the conditions in CMS Internet Only Manual, Medicare Program Integrity Manual 100-8, Chapter 3,Section 3.6.2.1.

Claims Processing:

- Claims deny Provider liable if submitted without GA modifier
- Claims deny Beneficiary liable when submitted with GA modifier

Remittance Advices will reflect liability by displaying the following messages:

- CARC Code C0-50 Provider liable or PR-50 for Beneficiary liable
- RARC Code N372 - These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Resources:

- Remittance Advice (RA)
- Advance Beneficiary Notice of Noncoverage (ABN)

Polysomnography Medical Reviews

On November 2, 2022, the American Academy of Sleep Medicine (AASM) released an article on their website discussing an increase in claim denials related to follow-up diagnostic sleep studies. Noridian has contacted the AASM to request clarification to the published article regarding the Targeted Probe and Educate (TPE) sleep study claim reviews.

Noridian has verified that there were no identified claims denied during a TPE review due to an LCD misinterpretation; therefore, there will not be any re-review of previously denied claims. If you have additional documentation for claims in an open TPE file, you may work with your

Noridian nurse clinician using the medical review reopening request process. If you have additional documentation or disagree with Noridian's determination for a closed file, your facility should follow the redetermination process.

Additionally, monitoring will remain in place and any new TPE reviews or other actions may be initiated as appropriate through the improper payment reduction strategy efforts.

Self-Administered Drug Exclusion List (A53032) - R28 - Effective November 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: November 11, 2022

Summary of Changes: Under Excluded CPT/HCPCS Codes added: Mounjaro™ (Tirzepatide) - C9399, J3490, J3590 effective 11/19/2022.

Under Excluded CPT/HCPCS Codes updated: Descriptor Brand Names for insulin products, the verbiage has been revised to read "All insulin products" for HCPCS codes C9399, J1815, J1817, J3490 and J3590.

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.

MLN Connects - October 6, 2022

MLN Connects Newsletter: Oct 6, 2022

News

- Resources & Flexibilities to Assist with Public Health Emergency in South Carolina
- Implementation of Inflation Reduction Act Provision Addressing Medicare Payments for Biosimilars
- CMS Asks for Public Input on Establishing First, National Directory of Health Care Providers and Services
- Inflation Reduction Act Lowers Health Care Costs for Millions of Americans
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4
- Inpatient Rehabilitation Facilities: IRF-PAI & September Care Compare Release
- Long-Term Care Hospitals: September Care Compare Release
- Help Detect Breast Cancer Early

Claims, Pricers, & Codes

- October 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.3

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: October 2022 Update
- DMEPOS Fee Schedule: October 2022 Quarterly Update
- Inpatient Prospective Payment System Hospitals in the 9th Circuit: Updated Fiscal Years 2019 and 2020 Supplemental Security Income Medicare Beneficiary Data

Information for Patients

- 2023 Medicare & You Handbook

MLN Connects

MLN Connects - October 13, 2022

MLN Connects Newsletter: Oct 13, 2022

News

- Protect Your Patients in October: Give Them a Flu Shot & COVID-19 Vaccine
- Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period
- Clinical Laboratory Fee Schedule: Final Gapfill Recommendations

Claims, Pricers, & Codes

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update Fiscal Year (FY) 2023

MLN Matters® Articles

- Home Health Claims: New Grouper Edits
- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI

Publications

- Medicare Preventive Services - Revised
- National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model - Revised

From Our Federal Partners

- Outbreak of Ebola Virus Disease in Central Uganda

MLN Connects - October 20, 2022

MLN Connects Newsletter: Oct 20, 2022

News

- Skilled Nursing Facility Provider Preview Reports: Review by November 14
- Help Your Patients Make Informed Health Care Decisions
- Ambulance Fee Schedule: CY 2023 Ambulance Inflation Factor & Productivity Adjustment

Compliance

- Implanted Spinal Neurostimulators: Document Medical Records

MLN Connects

Claims, Pricers, & Codes

- DMEPOS: Corrected 2022 E2102 Fee Schedule Amounts

MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2023 Update

Information for Patients

- Medicare Open Enrollment: October 15 - December 7

MLN Connects - October 27, 2022

MLN Connects Newsletter: Oct 27, 2022

News

- COVID-19 Updated Booster Vaccines Covered Without Cost-Sharing for Eligible Children Ages 5-11
- Oversight of Nation's Poorest-Performing Nursing Homes
- Initial Nursing Facility Evaluation & Management Visits: Comparative Billing Report in October
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4

MLN Matters® Articles

- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program
- Patient Driven Payment Model: Claim Edit Enhancements

MLN Connects - October 31, 2022

MLN Connects Newsletter: Final Rules

Final Rules

- CY 2023 Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Requirements
- Calendar Year 2023 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)
- Finalized Policies to Simplify Enrollment and Expand Access to Coverage

MLN Connects

MLN Connects - November 1, 2022

MLN Connects Newsletter: OPPS/ASC & PFS Final Payment Rules

Final Rules

- HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule
- HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care

MLN Connects - November 3, 2022

MLN Connects Newsletter: Nov 3, 2022

News

- COVID-19 Vaccine: Novavax Booster Authorized
- Medicare Part B Immunosuppressive Drug: Get Information on New Benefit
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Skilled Nursing Facilities: October Care Compare Release
- Clinical Diagnostic Laboratories: Report Private Payor Rate Data Beginning January 1
- Diabetes: Recommend Preventive Services

Claims, Pricers, & Codes

- Home Health Consolidated Billing Enforcement: CY 2023 HCPCS Codes

Publications

- Medicare Provider Compliance Tips - Revised

Multimedia

- Hospice Quality Reporting Program: September Forum Materials

MLN Connects

MLN Connects - November 10, 2022

MLN Connects Newsletter: Nov 10, 2022

News

- Teaching Hospitals: Phase 2 Section 131 Reviews - Submission Deadline November 18
- Medicare Participation for CY 2023
- CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care
- DMEPOS: Appeals & Rebuttals Contractor Clarification
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- HCPCS Application Summary for Continuous Glucose Monitoring: Updated

MLN Matters® Articles

- Telehealth Home Health Services: New G-Codes

From Our Federal Partners

- Increased Respiratory Virus Activity, Especially Among Children
- Ebola Virus Disease Outbreak in Central Uganda: Update

MLN Connects - November 17, 2022

MLN Connects Newsletter: Nov 17, 2022

News

- Hospital Price Transparency: Download Machine-Readable File Sample Formats & Data Dictionaries
- Medical Review After the COVID-19 Public Health Emergency: New FAQ
- Flu Shots & COVID-19 Vaccines: Each Visit is an Opportunity

MLN Connects

Claims, Pricers, & Codes

- DMEPOS: Corrected 2022 Fee Schedule Amounts
- Hospital Part B Inpatient Services Billing
- Outpatient Prospective Payment System Payment Rate for HCPCS Code Q5124

Events

- HCPCS Public Meeting: November 29 - December 1

MLN Matters® Articles

- Provider Enrollment Instructions: Seventh General Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations (NCDs): April 2023 Update

Publications

- Home Health & Hospice: Medicare Provider Resources
- Independent Diagnostic Testing Facility (IDTF) - Revised

Multimedia

- Quality in Focus Videos to Increase Quality of Care

MLN Connects - November 23, 2022

MLN Connects Newsletter: Nov 23, 2022

News

- Colorectal Cancer Screening Test: Reduced Coinsurance for Related Procedures Begins January 1
- Ambulance Fee Schedule: CY 2023 Inflation Factor & Productivity Adjustment
- Medicare Ground Ambulance Data Collection System: Information to Help You Report
- Health Professional Shortage Area: CY 2023 Bonus Payments
- Rural Health: Help Address Disparities

MLN Matters® Articles

- ESRD & Acute Kidney Injury Dialysis: CY 2023 Updates
- Home Health Prospective Payment System: CY 2023 Update
- Medicare Physician Fee Schedule Final Rule Summary: CY 2023

MLN Connects

Publications

- Federally Qualified Health Center - Revised

From Our Federal Partners

- Managing Monkeypox in Patients Receiving Therapeutics: CDC Update

MLN Connects - December 1, 2022

MLN Connects Newsletter: Dec 1, 2022

News

- CMS Urges Timely Patient Access to COVID-19 Vaccines, Therapeutics
- Quality Payment Program: Preview Your Performance Information by December 20
- Clinical Laboratory Fee Schedule: CY 2023 Final Payment Determinations
- HIV: Screening is Knowledge

Compliance

- LAAC & ICD National Coverage Determinations: Submit Proper Documentation

MLN Matters® Articles

- National Fee Schedule for Medicare Part B Vaccine Administration
- New Waived Tests
- New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE - Revised
- Home Health Claims: New Grouper Edits - Revised

Publications

- Checking Medicare Eligibility - Revised

From Our Federal Partners

- Biosimilars: Are They the Same Quality?

Information for Patients

- Options When ESRD Coverage with Medicare Ends

MLN Connects

MLN Connects - December 8, 2022

MLN Connects Newsletter: Dec 8, 2022

News

- CMS Proposes Rule to Expand Access to Health Information and Improve the Prior Authorization Process
- Rural Emergency Hospitals: New Institutional Provider Type Starting January 1
- Certificates of Medical Necessity & DME Information Forms Discontinued January 1
- Drugs & Biologics: Reporting Average Sales Price Data
- Provider Enrollment Application Fee: CY 2023
- Skilled Nursing Facility Value-Based Purchasing Program: December Feedback Report
- Bronchodilator Nebulizer Medications: Comparative Billing Report in December
- Short-term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Flu Shots: Help Address Disparities

Compliance

- Bill Correctly: Power Mobility Device Repairs

Claims, Pricers, & Codes

- Medicare National Correct Coding Initiative: Annual Policy Manual Update
- National Correct Coding Initiative: January Update

Events

- FY 2024 New Technology Town Hall Meeting - December 14
- Medicare Ground Ambulance Data Collection System Webinar: Data Certifier Role - December 15

MLN Matters® Articles

- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2023 Changes
- National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy
- Rural Health Clinic All-Inclusive Rate: CY 2023 Update

From Our Federal Partners

- Biosimilars & Interchangeable Products: Free Continuing Education Courses from FDA

MLN Connects

MLN Connects - December 15, 2022

MLN Connects Newsletter: Dec 15, 2022

News

- Opioid Treatment Programs: New Information for 2023
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Home Health Quality Reporting Program: Get Final OASIS-E Instrument

Compliance

- Bill Correctly: Power Mobility Devices

Claims, Pricers, & Codes

- Intravenous Immune Globulin Treatment in the Home: ICD-10 Code Update

MLN Matters® Articles

- DMEPOS Fee Schedule: CY 2023 Update
- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2023
- Home or Residence Services: Billing Instructions
- National Coverage Determination 200.3: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Publications

- Post-Acute Care Quality Reporting Program: Patient Health Questionnaire Cue Card

MLN Connects - December 22, 2022

MLN Connects Newsletter: Dec 22, 2022

Editor's Note:

Happy holidays from the MLN Connects team. We'll release the next regular edition on Thursday, January 5, 2023.

News

- HHS Proposes to Standardize Electronic Health Care Attachments Transactions and Electronic Signature Processes to Improve the Care Experience for Patients and Providers
- Long-Term Care Hospital Provider Preview Reports: Review by January 17

- Inpatient Rehabilitation Facility Provider Preview Reports: Review by January 17
- Hospital Ownership Data Release
- Clotting Factor: CY 2023 Furnishing Fee
- Medicare Diabetes Prevention Program: CY 2023 Payment Rates
- CMS Burden Reduction News & Insights

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: January Update
- Integrated Outpatient Code Editor: Version 24.0
- DMEPOS: Revised 2023 Fee Schedule Public Use File
- National Correct Coding Initiative: Annual Policy Manual Update & Information on Other Payers

MLN Matters® Articles

- Clinical Laboratory Fee Schedule: CY 2023 Annual Update
- Hospital Outpatient Prospective Payment System: January 2023 Update
- Laboratory Edit Software Changes: April 2023
- New Medicare Part B Immunosuppressant Drug Benefit
- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program - Revised

Publications

- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier
- Rural Emergency Hospitals
- Intravenous Immune Globulin Demonstration - Revised
- Medicare Preventive Services - Revised

From Our Federal Partners

- CDC Interim Guidance: Antiviral Treatment of Influenza
- Important Updates from the CDC on COVID-19 Therapeutics for Treatment & Prevention

MLN Matters

2023 Annual Update for the HPSA Bonus Payments

Related CR Release Date: August 18, 2022

Related CR Transmittal Number: 12806

Related Change Request (CR) Number: R11565CP

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12806 provides files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2023, through December 31, 2023. This recurring update notification applies to Chapter 4, Section 250.2 and Chapter 12, Section 90.4.2.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12806.

AIF for Calendar Year (CY) 2023 and Productivity Adjustment

Related CR Release Date: October 13, 2022

Related CR Transmittal Number: R11642CP

Related Change Request (CR) Number: 12948

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12948 tells you to manualize the Ambulance Inflation Factor (AIF) so that Medicare contractors can accurately determine payment amounts for ambulance services. This recurring update notification applies to publication 100-04, Medicare Claims Processing Manual, chapter 15, section 20.4.

View the complete CMS Change Request (CR)12948.

MLN Matters

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

Related CR Release Date: September 15, 2022

Related CR Transmittal Number: R11601CP

Related Change Request (CR) Number: 12911

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12911 provides the January 2023 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. The attached recurring update notification applies to chapter 10, section 20.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12911.

ASC Payment System: October 2022 Update - Revised

MLN Matters Number: MM12915

Related CR Release Date: October 25, 2022

Related CR Transmittal Number: R11661CP

Related Change Request (CR) Number: 12915

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

Note: CMS revised this article due to a revised CR 12915. The revision added HCPCS J1952 to Table 2 in the CR and changed the number of new drug and biological HCPCS codes to 11. CMS changed the number of new drug and biological HCPCS codes to 11 on page 2 in dark red font in this Article. CMS also changed the CR release date, transmittal number and CR web address. All other information is unchanged.

CR 12915 tells you about:

- Updates to the Ambulatory Surgical Center (ASC) payment system in October
- New Outpatient Prospective Payment System (OPPS) device pass-through code
- Newly established HCPCS codes for drugs and biologicals
- New skin substitute products low-cost group or high-cost group assignment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12915.

MLN Matters

CLFS: CY 2023 Annual Update

MLN Matters Number: MM13023
Related CR Release Date: December 9, 2022
Related CR Transmittal Number: R11733CP
Related Change Request (CR) Number: 13023
Effective Date: January 1, 2023
Implementation Date: January 3, 2023

CR 13023 tells you about:

- Instructions for the CY 2023 Clinical Laboratory Fee Schedule (CLFS)
- Mapping for new codes for clinical laboratory tests
- Updates for laboratory costs subject to the reasonable charge payment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13023.

DMEPOS Fee Schedule: CY 2023 Update

MLN Matters Number: MM13006
Related CR Release Date: December 2, 2022
Related CR Transmittal Number: R11722CP
Related Change Request (CR) Number: 13006
Effective Date: January 1, 2023
Implementation Date: January 3, 2023

CR 13006 tells you about:

- Fee schedule amounts for new and existing codes
- Payment policy changes

Make sure your billing staff knows about this annual update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13006.

MLN Matters

DMEPOS Fee Schedule: October 2022 Quarterly Update

MLN Matters Number: MM12918

Related CR Release Date: September 29, 2022

Related CR Transmittal Number: R11619CP

Related Change Request (CR) Number: 12918

Effective Date: October 1, 2022

Implementation Date: October 3, 2022

CR 12918 tells you about:

- The October 2022 quarterly update for the DMEPOS fee schedule
- Fee schedule amounts for new and existing codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12918.

HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2023

MLN Matters Number: MM13024

Related CR Release Date: December 8, 2022

Related CR Transmittal Number: R11735CP

Related Change Request (CR) Number: 13024

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

CR 13024 tells you about:

- New HCPCS codes
- Discontinued HCPCS codes
- Required CLIA certificates

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13024.

MLN Matters

Home or Residence Services: Billing Instructions

MLN Matters Number: MM13004

Related CR Release Date: December 8, 2022

Related CR Transmittal Number: R11732CP

Related Change Request (CR) Number: 13004

Effective Date: January 1, 2022

Implementation Date: January 3, 2023

CR 13004 tells you about:

- Codes
- Care settings

Make sure your billing staff knows about billing for the new E/M visit family.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13004.

ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2023 Update

MLN Matters Number: MM12960

Related CR Release Date: November 4, 2022

Related CR Transmittal Number: R11676OTN

Related Change Request (CR) Number: 12960

Effective Date: April 1, 2023 - or as noted in this Article

Implementation Date: April 3, 2023

CR 12960 tells you about:

- Newly available codes
- Separate NCD coding revisions
- Coding feedback

Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12960.

CMS isn't including any policy changes in this ICD-10 quarterly update. CMS covers NCD policy

changes using the current, longstanding NCD process.

Make sure your staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12960.

International Classification of Disease (ICD-10) Code Update for Coverage of IVIG Treatment of Primary Immune Deficiency Diseases in the Home

Related CR Release Date: November 9, 2022

Related CR Transmittal Number: R11693BP

Related Change Request (CR) Number: 12973

Effective Date: October 1, 2022

Implementation Date: December 12, 2022

CR 12973 implements a maintenance coding update of Chapter 15, Section 50.6 of the Medicare Benefit Policy Manual (BPM), Publication (Pub) 100-02, Coverage of Intravenous Immune Globulin (IVIG) for Treatment of Primary Immune Deficiency Diseases in the Home.

View the complete CMS Change Request (CR)12973.

January 2023 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: September 23, 2022

Related CR Transmittal Number: September 23, 2022

Related Change Request (CR) Number: 12925

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12925 supplies the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The Average Sales Price (ASP) payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

View the complete CMS Change Request (CR)12925.

MLN Matters

Laboratory Edit Software Changes: April 2023

MLN Matters Number: MM13026

Related CR Release Date: December 8, 2022

Related CR Transmittal Number: R11734CP

Related Change Request (CR) Number: 13026

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

CR 23026 tells you about changes to the laboratory NCD edit module for April 2023.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13026.

Medicare Deductible, Coinsurance & Premium Rates: Calendar Year 2023 Update

MLN Matters Number: MM12903

Related CR Release Date: October 13, 2022

Related CR Transmittal Number: R11641GI

Related Change Request (CR) Number: 12903

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12948 tells you about:

- Medicare Part A and Medicare Part B deductible and coinsurance rates
- Part A and Part B premium amounts

Make sure your billing staff knows about these Calendar Year (CY) 2023 rate changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12903.

MLN Matters

Medicare Physician Fee Schedule Final Rule Summary: CY 2023

MLN Matters Number: MM12982

Related CR Release Date: November 17, 2022

Related CR Transmittal Number: R11708CP

Related Change Request (CR) Number: 12982

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12892 tells you about:

- Telehealth originating site facility fee payment amount
- Expansion of coverage for colorectal cancer screening
- Coverage of Audiology services
- Other covered services

Make sure your billing staff knows about the following CY 2023 MPFS updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12982.

National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy

MLN Matters Number: MM12928

Related CR Release Date: November 28, 2022

Related CR Transmittal Number: R11721CP

Related Change Request (CR) Number: 12928

Effective Date: January 1, 2022

Implementation Date: January 3, 2023

CR 12928 tells you about:

- Include additional place of service (POS) codes for office and independent clinics
- Bill in 0.1-unit fractions
- Use 3 modifiers, including new modifier -LU

Make sure your billing staff knows about these changes for CAR T-cell Therapy (CAR-T) changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12928.

MLN Matters

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

MLN Matters Number: MM12950

Related CR Release Date: November 9, 2022

Related CR Transmittal Number: R11692

Related Request (CR) Number: 12950

Effective Date: April 7, 2022

NCD Implementation Date: December 12, 2022

CR 12950 tells you about:

- FDA-approved monoclonal antibodies
- CMS-approved studies

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12950.

National Fee Schedule for Medicare Part B Vaccine Administration

MLN Matters Number: MM12943

Related CR Release Date: November 17, 2022

Related CR Transmittal Number: R11710OTN

Related Change Request (CR) Number: 12943

Effective Date: January 1, 2023

Implementation Date: April 3, 2023

CR 12943 tells you about:

- Updated payment amount for preventive vaccine administration
- HCPCS codes to which these adjustments apply
- COVID-19 vaccine administration codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12943.

MLN Matters

New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE - Revised

MLN Matters Number: SE20016 Revised

Article Release Date: November 22, 2022

Note: CMS revised this article to add the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red (pages 2, 3, 5, and 6). All other information is the same.

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE. We'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the COVID-19 FAQs on Medicare Fee-for-Service (FFS) Billing.

View the complete CMS Medicare Learning Network (MLN) Special Edition (SE)20016.

New Waived Tests

MLN Matters Number: MM12996

Related Change Request (CR) Number: 12996

Related CR Release Date: November 23, 2022

Effective Date: April 1, 2023

Related CR Transmittal Number: R11717CP

Implementation Date: April 3, 2023

CR 12996 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)12996.

MLN Matters

Provider Enrollment Instructions: Seventh General Update

MLN Matters Number: MM12880

Related CR Release Date: November 4, 2022

Related CR Transmittal Number: R11682PI

Related Change Request (CR) Number: 12880

Effective Date: December 5, 2022

Implementation Date: December 5, 2022

CR 12880 tells you about:

- Ownership disclosures
- Electronic funds transfers (EFTs)
- Special payment addresses

Make sure your billing staff knows about the updated provider enrollment instructions.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12880.

Quarterly Update to the NCCI PTP Edits, Version 29.0, Effective January 1, 2023

Related Request (CR) Number: 12908

Related CR Release Date: September 15, 2022

Related CR Transmittal Number: R11599CP

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12908 updates the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12908.

Updating CY 2023 MDPP Payment Rates

Related CR Release Date: December 15, 2022

Related CR Transmittal Number: R11751OTN

Related Change Request (CR) Number: 12987

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12987 contains instructions to A/B MACs (Part B) and the Railroad Specialty MAC to update the Medicare Diabetes Prevention Program (MDPP) Expanded Model payment rates for Calendar Year (CY) 2023. CMS has calculated the MDPP payment rates for CY 2023 and included them in an attachment to this CR.

View the complete CMS Change Request (CR)12987.

Contacts, Resources, and Reminders

Noridian Part B Customer Service Contact

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

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

Fax Numbers - View fax numbers and submission guidelines.

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for “Medicare 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 Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it on the CMS Manuals webpage. CMS Change Requests and the date issued will be referenced within the “Source” portion of applicable articles.

Contacts, Resources, and Reminders

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

Unsolicited or Voluntary Refunds Reminder

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

Background

Medicare carriers and intermediaries and 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 MM3274.

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

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

Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

1. “Return service requested” envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
2. “Return service requested” envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
    - Flag the provider’s file DNF.
    - A/B MAC/carrier staff will notify provider enrollment team.

- A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.

4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
5. Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider's location.

IRS-1099 Reporting

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

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

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

Jurisdiction E Part B Quarterly Ask-the-Contractor Teleconferences

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.

ACT dates, times, toll-free number, and Q&As are available on the Jurisdiction E Part B Ask-the-Contractor Teleconferences webpage.

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

Contacts, Resources, and Reminders

By completing and submitting the Noridian Part B ACT 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.**

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.

- Jurisdiction E Part A ACTs
- Jurisdiction D DME ACTs
- Jurisdiction A DME ACTs