Medicare B News

Jurisdiction E
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACM (previously ACT) B Questions and Answers - April 19, 2023

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:

- Ask the Contractor Meeting (ACM) acronym has replaced Teleconference (ACT)
- If patient has managed care or railroad Medicare, instead of traditional fee-for-service Medicare, do not bill Noridian
- Seek external sources for coding advice

PRE-QUESTIONS:

Q1. Can CPT 64719 unbundle from CPT 64721, if the OP report shows both the release of the carpal ligament and the Guyon's Canal was decompressed?
A1. Yes. Always check National Correct Coding Initiative (NCCI) edit combinations first, as the 64719 (ulnar nerve release) does bundle into 64721 (medial nerve release) with a "1" indicator. If the separate requirement for surgery, site, or injury is documented, this may allow modifier 59 to be appended on either code. Be sure your notes describe the extra work for performing the ulnar nerve release. Read more at https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-procedure-procedure-ptp-edits.

Q2. Can physicians performing interdisciplinary rounds include "discussion of management with external physician" as a data component to determine level for evaluation and management (E/M) service?
A2. Yes. CPT guidelines definition for an external physician or other qualified health care professional is not in the same group practice or is of a different specialty.

Q3. Can we bill an office visit for a patient seen in our office when they are listed as inpatient at a skilled nursing facility (SNF) or rehab hospital?
A3. Yes. Providers can bill Part B for a separate "office" visit, as the SNF Consolidated Billing does not bundle office visits into the Part A stay. When the service is rendered to a patient, registered as an inpatient in a rehab hospital or SNF, regardless of where the face-to-face encounter occurred, place of service (POS) 21 or 31 is billed, instead of POS 11 (office). Read more at https://www.cms.gov/medicare/snf-consolidated-billing/2023-part-b-mac-update. The Internet Only Manual (IOM) excerpt explains https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c26pdf.pdf.

'When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter. In other words, reporting the inpatient hospital POS code 21 is a minimum requirement for purposes of triggering the facility payment under the PFS when services are provided to a registered inpatient. If the physician/practitioner is aware of the exact setting the beneficiary is a registered inpatient, the appropriate inpatient POS code may be reported consistent with the code list annotated in this section (instead of POS 21). For example, a physician/practitioner may use POS 31, for a patient in a SNF receiving inpatient skilled nursing care, POS 51, for a patient registered in a Psychiatric Inpatient Facility, and POS 61 for patients registered in a Comprehensive Inpatient Rehabilitation Facility.'

Q4. When performing a Neurogram, do we bill individual MRI CPTs or an unlisted code?
A4. The MRI Neurogram scan would involve CPT 76498 (Unlisted magnetic resonance procedure, when specified as magnetic resonance neurography). More information under the National Coverage Determination (NCD) 220.2 titled Magnetic Resonance Imaging (MRI).

Q5. When billing unlisted CPT codes what type of documentation should be submitted to support medical necessity and reimbursement?
A5. Under Noridian's Browse by Topics, Documentation Requirements, there are specific requirements for specialties and topics. These include checklists to assist and no need to send documentation, unless asked. Enter a well-defined description of the procedure and how it differs from available codes in Item 19, or the electronic equivalent. Medicare may ask for additional records to support the service. Providers can fax, mail, or utilize the electronic additional documentation Paperwork (PWK). Read more under Browse by Topic, Claims, General, PWK at Jurisdiction E (JE) B https://med.noridianmedicare.com/web/jeb/topics/claim-submission/pwk or JFB https://med.noridianmedicare.com/web/jfb/topics/claim-submission/pwk.

Q6. How many days count time towards an E/M visit for office or outpatient services?
A6. Time is limited to the date of the patient's visit. CMS includes time required to bill the office or outpatient code. Internet Only Manual (IOM) Publication 100-04, Chapter 12, Section 30.6.15.1.F at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. Updates for 2023 found in change request (CR) 13064 at this link: https://www.cms.gov/files/document/r11842cp.pdf.

Q7. Does Medicare have a "Patient Order's" template or guidelines for ordering Radiation Therapy from a free-standing radiation clinic?
A7. No. The use of order forms can vary for each clinic and Medicare does not have guidelines for template use. It is important that the medical record reflects the need for care and services provided. The provider's signature supports evidence that the order is correct. Please refer to the Radiation Therapy Documentation Requirements page on our website under Browse by Topic, Documentation Requirements, at Radiation Therapy.

Q8. Do two separate offices within the same building qualify as the same "office suite"?
A8. This depends. We consider "office suite" as limited to the dedicated area, or suite, designated by records of ownership, rent or other agreement with the owner, in which the supervising physician or practitioner maintains his or her practice or provides his or her services as part of a multi-specialty clinic.

If the diagnostic imaging center is separate from the supervising provider's dedicated office area, then the physician would need to be in attendance in the imaging center to qualify as "direct supervision". For direct supervision, the physician does not need to be in the same room during the procedure.

Q9. Does a patient with dementia or medically decompensated need to be present to bill an office visit, when the caregiver, family, or durable power of attorney (DPOA) are present to discuss patient issues?
A9. Yes. The patient would need to be present for a majority of the visit to bill for the service. The caregiver or power of attorney may present with the patient. Per CMS IOM Publication, 100-02, Chapter 15, Section 30. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf

Q10. Which E/M code category should be used by the other physician (not the primary treating physician) evaluating the patient in observation status?
A10. Other practitioners providing evaluation services to a patient in observation would submit the appropriate outpatient E/M service codes with the correct place of service. Per CR 13064 and under Section 30.6.8.B at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Q11. Are Transitional Care Management (TCM) CPTs (99495 and 99496) medical decision-making (MDM) determined by 2023 audit tool for office visits or '95 guidelines for office visits?
A11. MDM for TCM CPTs 99495 and 99496 determine moderate or high-level MDM for the current medical and psychosocial needs. Follow the current guidelines, providers need to consider the following factors:

- Number of diagnoses and management options;
- Amount and complexity of records, tests, reviewed and analyzed; and
- Risks and possible management options.

For additional information, read page 11 of the August 2022 CMS TCM Medicare Learning Network (MLN) Booklet at https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/transitional-care-management-services-fact-sheet-icn908628.pdf

Q12. If a Botulinum toxin vial is split between two patients, how will providers incorporate JZ modifier when required on July 1, 2023? For example; if a provider treats with 250 units of the toxin, uses a 200-unit vial in its entirety and 50 units from a 100-unit vial?
A12. Per Noridian Local Coverage Article (LCA), providers will complete this information on one line, as compared to two lines for modifier JW that indicates wastage. Use the applicable HCPCS code, append the JZ modifier to indicate there was no wastage, and the number of units provided to the patient.

Lastly, calculate the submitted price for the amount given. CMS also has published a great FAQ regarding the JW and JZ modifier at this link: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf.

Q13. Does the patient need to be present for Psychiatric Diagnostic Assessments (CPT codes 90791 and 90792)?
A13. Yes. Due to Medicare changing the focus to the patient, the beneficiary must be present for "most" of the session for all mental health codes.

Q14. Are both a pain assessment and disability scale required for the Facet Joint Interventions for Pain Management Local Coverage Determination (LCD) policy?
A14. Yes. The pain scale would be used for diagnostic injections. For therapeutic injections, one can use pain OR disability scales. If planning to assess disability going forward with therapeutic injections, then at the very beginning, when performing diagnostic injections, use both pain AND disability scales. This allows a baseline for disability to be used following each therapeutic injection if that is the treatment plan to follow. If providers only using the pain scale, then you don't need the disability. The problem may start with one and then use the other interchangeably, and there is no baseline for comparison.

Q15. Our Ambulance provided emergency transport to a Part A resident of a Skilled Nursing Facility (SNF). Can you explain why only Ambulance mileage was paid and not the base rate?
A15. Inpatient and consolidated billing denials are managed by the Common Working File (CWF). We are unable to review the processing of a claim on this call. Please work with the contact center if you have not already. In accordance with IOM 100-04, Chapter 6, Section 20.3.1, an ambulance transport to Critical Access Hospital (CAH) and back to a SNF is only payable when the patient is receiving emergency or other excluded services outlined in section 20.1.2 of this manual.

Q16. If the provider, not the independent trained observer, performs CPT 99152 for moderate sedation, can we use the RN's documentation not signed by the MD to code? Often, the MD will document time, drugs administered, but not name and credentials of the observer.
A16. Moderate sedation documentation must have the independent trained observer; Nurse Practitioner (NP), Physician Assistant (PA), or Registered Nurse (RN), whose sole duty is to monitor beneficiary's level of consciousness, physiological status and must be present throughout entire diagnostic or therapeutic service. Their name and credentials must be identified in the notes.

Q17. What are the administration CPTs for magnesium sulfate for infusions, hydrations or pushes and is the drug billable? Are there specific diagnoses needed?
A17. Read Noridian's Local Coverage Article (LCA) JE A54635-https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=54635) or JF A52732-https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=52732) titled Billing and Coding: **Hydration Services** that show CPTs 96360 (Intravenous Infusion, hydration; initial, 31 minutes to 1 hour) and on CPT +96361 (Intravenous Infusion, hydration; each additional hour) may be billed. Documentation of the assessment should describe symptoms warranting hydration, such as those associated with dehydration, the inability to ingest fluids or clear clinical contraindication to oral intake, abnormal fluid

losses, abnormal vital signs, and/or abnormal laboratory studies, such as an elevated BUN, creatinine, glucose, or lactic acid.

Q18. Can an attending or supervising physician receive credit in data for an independent review of an image noted by the resident without actual independent review by the attending?
A18. No. CMS will allow an interpretation of diagnostic radiology or other diagnostic tests under the Medicare Physician Fee Schedule (MPFS), when performed by a physician other than a resident. When a resident is interpreting diagnostic radiology or other tests in a residency training site outside the Metropolitan Statistical Area (MSA), the teaching physician must be present through audio or video real-time technology. The medical records must show the physician took part in interpreting diagnostic radiology tests. If the attending physician did not provide the interpretation, they would not receive credit. May 2022 resource https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/teaching-physicians-fact-sheet-icn006437.pdf.

Q19. If an Ophthalmologist notes a problem in the history and examines the patient, is that enough to consider it a problem addressed? What should be documented to support?
A19. To bill an E/M 992xx series, there must also be either time reflected or medical decision-making (MDM). Documentation needs to follow the 2021 guidelines. Guidelines include preparing for the visit (such as reviewing tests); reviewing history that was separately obtained; performing the exam; counseling and providing education to the patient, family, or caregiver; ordering medicines, tests, or procedures; communicating with other healthcare professionals; documenting information in the medical record; interpreting results and sharing that information with the patient, family, or caregiver; and care coordination. Total time does not include time for clinical staff activities they normally perform.

Q20. Medical Nutritional Therapy (MNT) CPTs 97802 and 97803 (*assessment or re-assessment*) show billing for each 15 minutes. Can we use the time-based guideline for the 8-minute rule thresholds?
A20. Yes. With the time-based rule, one unit = 8-22 minutes and is attained when the midpoint is passed. For 97802 and 97803, at least eight minutes would need to be spent in order to bill.

Q21. Can you clarify the documentation requirements for both the physician and NP or PA for shared visits when using time as the substantive?
A21. Medical record documentation will be used to objectively determine the medical necessity of the visit and accuracy of documented time spent. Time can be documented with either start and stop time or total time. CMS has not indicated if stating "more than 50% of time spent" would be supporting the time requirement. Under the split or shared visit in a facility, if the non-physician practitioner spent less time than the physician, it would be correct to bill under the physician's name. Documentation would need to support the time indicated for each provider, either by start and stop time or total time. The substantive portion may also be determined by three key components of the E/M visit: history, exam, or medical decision-making.

Q22. Can HCPCS G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact) be reported for time spent on the same day or even time on a different day?

A22. HCPCS G2212 includes time spent only on the date of the encounter. It's only added to an E/M CPT 99205 or 99215 for clinician time only. The full 15-minutes or maximum time must be met to bill G2212. Medicare Administrative Contractors (MACs) will process claims per the IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.15.

Q23. Does Medicare reimburse for HCPCS G0323 if billed by a Licensed Clinical Social Worker (LCSW)? Can the same 20 minutes of care management time spent for G0323 count toward the required time for CPT 99493, Coordination of Care Model (CoCM), 60 minutes) billed under the primary care physician?

A23. Per CMS' recent January 2023 MLN 909432 article: Behavioral Health Integration (BHI) Services, https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf, included now are a clinical psychologist (CP) or licensed clinical social worker (LCSW) that can perform to account for monthly care integration. They can also serve as the focal point of care integration that furnishes the mental health services. Therefore, at least 20 minutes of CP or LCSW time (per calendar month) would only be able to be billed for Behavior Health Integration (BHI), and not shared with other care management types. They can both enroll and bill directly as long as they are part of the primary team and follow all of the required elements.

Q24. If the Resident admits a patient late night and the Nephrologist sees next day as a split/shared visit with the Advance Practice Provider (APP) that includes NP, PA, certified nurse midwife (CNM), advanced practice registered nurse (APRN), and certified registered nurse anesthetist (CRNA). Does the Nephrologist bill initial and include the resident's notes for additional documentation? Is modifier FS approved or are both modifiers FS and GC on same line?

A24. For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician or practitioner, who performs the substantive portion that bills for the visit. The physician or practitioner providing the substantive portion would bill for the visit, sign, and date the medical record.

If billing based on time, documentation needs to support time for both providers involved. Documentation in the medical record must identify the physician and NPP who performed the visit. Modifier FS is appropriate if related to the E/M split and shared services. Modifier GC (for resident E/M codes under direction of teaching physician in approved teaching program), would not be appended on the split and share visit, since the resident was not part of the second day visit. GC is all about teaching physicians.

Read more at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf under CMS IOM Publication 100-04, Chapter 12, Section 30.6.18 that explains split and share services with the new January 2023 E/M guidelines. It includes an example with the Non-Physician Practitioner (NPP) or APP.

Q25. Can status indicator "M" be billed to Part B on a CMS-1500, as it's defined as not paid through the Outpatient Prospective Payment System (OPPS) or not billable to Part A or Durable Medical Equipment (DME)?
A25. Depending on the drug, it may be covered under Part B or even Part D. Check the Part B Fee Schedule, under Indicator List and Descriptors to research. We will have a MPFS webinar next Friday. On the CMS webpage, Part B covered drugs are located at https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/2023-asp-drug-pricing-files.

Q26. Which payment methodology is used with new drug code pricing for not otherwise classified (NOC) J codes (J3490, J3590, J9999, C9399)?
A26. Unlisted J-codes are paid based on Wholesale Acquisition Cost (WAC) plus 3 percent.

Q27. How should services be billed with higher units than allowed by the Medically Unlikely Edit (MUE)?
A27. MUE billing is either a) line item edit with MUE Adjudication Indicator (MAI) of 1 or b) per day edit of MAI-1 or MAI-3. If it's a line edit and providers bill over the allowed number of units, the whole line will deny. You could appeal if it's an allowed amount. Providers can bill two lines with modifier 76 appended on the second line. Either way, you can't charge the patient for the overage. If per day edit, bill one line, services will deny and providers may appeal. Make sure that documentation supports. Read more at https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare/medicare-ncci-faq-library#mue.

Q28. Which E/M codes should modifier AI (Principal Physician of Record) be appended?
A28. Modifier AI would be appended to the initial visits only (hospital, skilled nursing facility or nursing facility). By appending AI, the principal physician of record will be identified as the admitting physician. Modifier AI should never be appended to subsequent visits.

Q29. With the new 2023 E/M coding guidelines for inpatient and observation visits, do we use the initial hospital inpatient codes (99221-99223) for an initial inpatient consultation? Can only the admitting physician bill observation codes, while consultants bill outpatient or office visit codes?
A29. Medicare doesn't cover consultation codes. Physicians from a different group or specialty, providing an E/M service to the patient, which has been admitted by another physician, submit an initial hospital or observation E/M code when seeing the patient for the first time during the hospital encounter. If seeing the patient for subsequent visits, use the appropriate subsequent codes. The treating practitioner bills observation care codes. All other practitioners seeing the patient during observation would bill the appropriate outpatient service codes. See CR 13064 and CMS IOM 100-04, Chapter 12, Section 30.6.8.B.

Q30. With the COVID-19 emergency ending, do patients need an in-person visit with providers, prior to a sleep study, or will telehealth be acceptable as part of 2023 Consolidated Appropriations Act (CAA) that goes to the end of 2024?
A30. While Sleep studies are not addressed specifically in the Telehealth waiver, in the CY 2023 Final Rule, CMS finalized alignment of availability of services on the telehealth list with the extension

timeframe enacted by the 2022 CAA. The 2023 CAA further extended those flexibilities through CY 2024. Here's the updated CMS Public Health Emergency (PHE) flexibilities FAQ updated May 5, 2023:

- https://www.cms.gov/files/document/what-do-i-need-know-cms-waivers-flexibilities-and-transition-forward-covid-19-public-health.pdf
- CMS updated and simplified the Medicare Telehealth Services List to clarify that these services will be available through the end of CY 2023. They anticipate addressing updates to the Medicare Telehealth Services List for CY 2024 and beyond through established processes as part of the CY 2024 Physician Fee Schedule proposed and final rules.

VERBAL Q/A:

Q31. How do providers use JW modifier with an unlisted code and document what was wasted?
A31. Make sure all your narrative and documents supports modifier JW and it's applicable to single-dose drug. Follow the unlisted code with Box 19 requirements.

Q32. Where can I find a list of all drugs with status N1 indicator with the JZ modifier?
A32. The indicator is on the Outpatient Prospective Payment System (OPPS) site. Only single dose vials may include wastage with JZ modifier appended. There is not a specific list of injections that require the modifier.

Q33. What kind of medical necessity is required to report CPT 93281 (*programming device evaluation in-person; with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional multiple lead pacemaker system*) with modifier 90 (*sent to reference lab*) for reprogramming vs. what seems like a routine interrogation code situation? Reprogramming is a higher level code that requires medical necessity. What is the difference between interrogation and reprogramming?
A33. The difference between the two is that interrogation involves evaluation up to 90 days and re-programming requires an indication. As you know, these codes are reported for patients with pacemakers, implantable defibrillators, implantable loop records (ILRs), or subcutaneous implantable defibrillators for in-person programming device evaluation. Reprogramming requires an indication. Interrogation is part of routine E/M, but a separate procedure.

This CPT does not qualify for modifier 90 per Anti-Markup rules that do not apply. Principles of the CPT coding book that AMA publishes. CPTs 93270-93285 are used to report customized program evaluations. These codes are reported when all device functions, including the battery, programmable settings, and leads(s), when present, are evaluated. The final program parameters may or may not be changed as a result of the evaluation.

Q34. Would Modifier 25 be appropriate in a care center to evaluate a laceration repair (minor procedure)?
A34. In new patient visits, it doesn't automatically mean providers have a separate E/M with the procedure, as the documentation would need to support. E/M visits bundle into laceration repairs (CPT 12001-12007); however, modifier 25 is appropriate per the NCCI edits of indicator 1. Place of service is not a deciding factor when appending modifier 25.

Q35. Since the PHE is ending, will we stop using the CS modifier as of May 11, 2023?
A35. Yes. The CS modifier is applicable to any emergency (designated emergency - waiver applied), it will no longer be allowed after the COVID PHE ends on May 11, 2023.

Advance Beneficiary Notice of Noncoverage (ABN): Form Renewal

The Office of Management and Budget approved the Advance Beneficiary Notice of Noncoverage (Form CMS-R-131) for renewal. This renewed form expires January 31, 2026.

In addition to the expiration date, CMS also updated the non-discrimination notice on the form. These changes are cosmetic only and do not impact how providers and suppliers fill out the form.

You may use the renewed form now, but you must use it beginning June 30, 2023, when the previous version expires.

Resources:

- CMS Advance Beneficiary Notice (ABN) - Renewed
- ABN Form Instructions (PDF)
- ABN Forms English and Spanish (Incl Large Print) (ZIP)
- MLN Connects April 6, 2023

Audiology Furnishing Certain Diagnostic Tests Without Physician Order

Starting January 1, 2023, audiologists can furnish certain diagnostic audiology tests without a physician or non-physician practitioner (NPP) order using the AB modifier:

- Covered once per patient per 12-month period
- Limited to non-acute hearing conditions
- Excludes services related to:
- Disequilibrium
- Hearing aids
- Exams for prescribing, fitting, or changing hearing aids

Tips when you bill with the AB modifier:

- Document good faith efforts were made to provide services for non-acute hearing conditions without the order of a treating physician or NPP so that the claim won't deny if you unexpectedly discover an acute condition
- You can leave box 17 A & B (name and NPI of the referring provider) blank or incomplete

More Information:

- Audiology Services webpage
- CY 2023 Physician Fee Schedule final rule

Resource: MLN Connects March 16, 2023

Behavioral Health Integration (BHI) Services Revised

New HCPCS Code Added for Behavioral Health Integration

- G0323 - Care Management Services for Behavioral Health Conditions
    - Describes general BHI that a clinical psychologist (CP) or clinical social worker (CSW) performs to account for monthly care integration.
    - A CP or CSW, serving as the focal point of care integration, furnishes the mental health services.
    - At least 20 minutes of CP or CSW time per calendar month.
    - Initial assessment or follow-up monitoring, including using applicable validated rating scales; behavioral health care planning about behavioral or psychiatric health problems, including revision for patients who aren't progressing or whose status changes.
    - Facilitating and coordinating treatment such as psychotherapy, coordination with and referral to physicians and practitioners who Medicare authorizes to prescribe medications and furnish E/M services, counseling or psychiatric consultation and continuity of care with an appointed member of the care team.

Resource: CMS MLN 909432 Behavioral Health Integration Services

Clinicians: Ordering Oxygen for Your Patient

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when a beneficiary meets all of the requirements set out in the CMS Internet Only Manual (IOM), Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 240.2 and the corresponding DME MAC Oxygen and Oxygen equipment Local Coverage Determination (LCD). When ordering home oxygen therapy for a patient with Medicare, a blood gas study must be ordered and

evaluated at the time of need. Time of need is defined as during the patient's illness when it is presumed that oxygen therapy will improve the patient's condition in the home setting. If the oxygen is initially prescribed at the time of hospital discharge, qualification testing must be performed within the 2 days prior to discharge home. Note that this 2-day prior to discharge rule does not apply to nursing facilities.

Claims for oxygen must be supported by medical documentation in the patient's record:

- A condition requiring home use of oxygen;
- The oxygen flow rate; and,
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 10 minutes per hour, 12 hours per day), and duration of need (e.g., 6 months or lifetime);and,
- Any concerns for variations in oxygen measurements that may result from such factors as the patient's age, the patient's skin pigmentation, the altitude level, or a decrease in oxygen carrying capacity (when applicable).

The type of oxygen delivery system to be used must be specified (e.g., stationary concentrator and portable gaseous tanks). If a portable system is ordered, there are specific requirements that must be included in the medical record, including that the patient is mobile within the home and that the qualifying blood gas study was performed either at rest or while exercising, but not while asleep.

In addition, for scenarios where the beneficiary has different daytime and nighttime oxygen flow requirements, these values must be documented in the patient's medical record. This information is used by the DME supplier to determine the appropriate billing information for Medicare.

Medicare can make payment for home oxygen only when the patient's medical record shows that the beneficiary has a condition expected to improve with home oxygen therapy, and meets medical documentation, test results, and health conditions required for coverage.

The Comprehensive Error Rate Testing (CERT) contractor has identified multiple errors in claims received for oxygen equipment and supplies. These errors include:

- Missing documentation of oxygen orders prior claim submission
- No documentation to support continued need for home oxygen therapy.

For continued coverage of oxygen, documentation must be included in the medical record supporting continued medical need. If oxygen is initially prescribed for short term use, an evaluation of a repeat test is required as well as a new order.

DMEPOS suppliers are your partners in caring for your patient. They will not receive payment from Medicare for the items that are ordered if you do not provide information from your medical records when it is requested. Furthermore, not providing this information may result in your patients having to pay for the item themselves. To help patients, the DME suppliers, and the Medicare program, be sure to verify that the medical documentation supports the oxygen ordered as this allows Medicare to pay claims appropriately and efficiently.

For additional information and resources on Medicare's coverage of oxygen and oxygen equipment, visit the DME MAC contractor websites.

- Jurisdiction A (CT, DE, MA, ME, MD, NH, NH, NY, PA, RI, VT, District of Columbia)
- Jurisdiction B (IL, IN, KY, MI, MN, OH, WI)
- Jurisdiction C (AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico, U.S. Virgin Islands)
- Jurisdiction D (AK, AZ, CA, HI, ID, IA, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY, American Samoa, Guam, Northern Mariana Islands)

COVID-19 Over the Counter (OTC) Test Coverage Ends May 11, 2023

With the end of the COVID-19 Public Health Emergency (PHE), CMS has instructed Medicare Administrative Contracts (MACs) the **last day** of service for coverage for COVID-19 OTC tests is May 11, 2023.

Effective May 12, 2023, COVID-19 OTC tests (HCPCS K1034) are no longer a covered benefit for Medicare. Any providers or suppliers providing monthly supplies to their patients should notify their patients of this change before providing further services.

Share with all of your pharmacies and patients.

DMEPOS Fee Schedules and Labor Payment - 2nd Quarter 2023 Update

Updates to the DMEPOS Jurisdiction listing for 2nd Quarter 2023 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

May is Mental Health Awareness Month - Substance Use Disorder Benefits

Prior to COVID, Medicare covered medications, Counseling and/or therapy, periodic assessments, and counseling through telehealth, in an office setting, or Outpatient Treatment Program (OTP).

Post-COVID Medicare will cover for patients with opioid use disorders if all other requirements are met:

- OTP intake add-on code (G2076) to initiate treatment with buprenorphine provided via 2-way, interactive, audio-video or audio-only technology when audio-video technology isn't available.
- Periodic patient assessments (HCPCS code G2077) via audio-video technology

- The therapy and counseling portions of weekly bundles and the add-on code for additional counseling or therapy (HCPCS code G2080) via audio-only technology when audio-video isn't available.

During the COVID-19 PHE and through the end of CY 2023, Medicare is allowing the following if all other requirements are met:

- Periodic patient assessments (HCPCS code G2077) via audio-only technology when audio-video technology isn't available.

Post COVID Modifiers:

- 95 - counseling and therapy using audio-visual communication
- FQ - counseling and therapy using audio-only communication

Resources

- Webinar on Demand Recordings
- Opioid Treatment Program (OTP) Billing and Payment
- CMS Internet Only Manual (IOM) Publication 100-02 Chapter-17
- CMS Internet Only Manual (IOM) Publication 100-04 Chapter-39

Medicare Basics: The History of Medicare-On-Demand Tutorials Available

Noridian will be publishing tutorials on the Basics of Medicare. This series supplements our two-day Symposium (Spring 2023) and will provide Basic Medicare education.

Education on Demand Tutorials

- The History of Medicare

Providers and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education.

Medicare Beneficiary Identifier (MBI) Retrieval and Resources

Noridian offers one self-paced training tutorial to assist providers and facilities in better understanding Medicare Beneficiary Identifier (MBI) Retrieval and Resources.

- Medicare Beneficiary Identifier (MBI) Retrieval and Resources

Providers and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education on our Education on Demand Tutorials webpage

News

Mental Health Awareness Month - Week 1

May is Mental Health Awareness Month. This week we want to highlight some information regarding Suicide Prevention. In 2020, suicide was responsible for nearly 46,000 deaths, or once every 11 minutes.

Some of the highest demographics include:

- Men over age 85 - highest suicide rate for all demographics
- American Indian and Alaska Natives
- Veterans
- Loss and Disaster Survivors

We are providing some resources to help you with your patients. As a reminder, July of 2022 the Suicide Prevention Hotline was changed to 988.

Resources

- SAMHSA Suicide Prevention Resource Center (SPRC) | SAMHSA
- CDC Suicide in Rural America | CSELS | OPHSS
- SAMHSA What is Suicide and Suicidal Behavior?
- Lifeline (988lifeline.org)
- Veterans: Lifeline (988lifeline.org)

Post-COVID 19 and Appeal Waivers, Appeals Newsletter Part 5

Due to the COVID-19 PHE expiring on May 11, 2023, many of the flexibilities will expire on May 12, 2023. One of those flexibilities is the extension of the timely filing limit for appeals. Starting on May 12. 2023 the filing deadline for Redeterminations will no longer be waived for COVID reasons. As a reminder timely filing limits are 120 days from initial determination.

Resources: Appeals Timelines Calculators

Provider Administrator's Can Now Reactivate Users on NMP

Effective June 19, 2023, Provider Administrator's (PA's) can now reactivate or deactivate End User accounts on the Noridian Medicare Portal (NMP) without having to contact User Security. View the "Manage Users" page of the Portal Guide for more details and instructions.

News

Surgery Modifiers - On-Demand Tutorials Available

Noridian offers two self-paced training tutorials to assist providers and facilities in better understanding Surgical Modifiers.

Education on Demand Tutorials

- Surgery Modifiers: Overview
- Surgery Modifiers: 62, 66, 78, 79, 80, 81, and AS

Providers and facilities are encouraged to attend our webinars and/or view other tutorials available to assist with proper billing and team member education.

Surgery Modifiers: 54, 55, 58, and 59 - On-Demand Tutorials Available

Noridian offers self-paced training tutorials to assist providers and facilities in better understanding Surgery Modifiers.

Education on Demand Tutorials

- Surgery Modifiers: 54, 55, 58, and 59

Providers and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education.

Venipuncture Requirements - CPT 36410 vs. 36415

Regardless of CPT billed and specimens drawn, only one collection fee allowed for each patient encounter.

CPT 36410 - Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (QHP), separate procedure for diagnostic or therapeutic purposes (**not** used for **routine** venipuncture)

- CPT 36410 **must** be performed by skilled physician or another non-physician practitioner (e.g., physician assistant, nurse practitioner)
- Clinical condition necessitates physician to perform venipuncture, instead of auxiliary staff
    - Medical Review saw other non-billing providers performing and billing 36410 venipuncture, when requirement is “only physicians or other QHP” may perform and bill
- MUST meet requirement of medical necessity and documentation
- Not approved reason or appropriate for physician to bill:
    - Just because physician **only** provider in the office to complete venipuncture

CPT 36415 - Collection of venous blood by venipuncture

- Used for all **routine** venipuncture for specimen collection

Resource

- CMS Internet Only Manual (IOM), Publication 100-04, Claims Processing Manual, Chapter 16, Section 60

Where to Send Your Appeals - Appeals Newsletter Part 5

Due to an increase in providers sending appeals to an incorrect department or level, we are providing you with information on where to send your appeals.

Reopenings: Written, complete on the Noridian Medicare Portal (NMP), or on the phone if cannot be done on the portal.

Redetermination: Submit written form, or through NMP

Reconsideration: Submit to the QIC - C2C

Administrative Law Judge (ALJ) - Office of Medical Hearing and Appeals

Medicare Appeals Council Review - Departmental Appeals Board (DAB)

Federal Court Review - Judicial Review

Resources

- Appeals
- C2C Welcome to C2C Innovative Solutions
- CMS Third Level of Appeal: Decision by Office of Medicare Hearings and Appeals (OMHA)
- CMS Review by the Medicare Appeals Council
- CMS Fifth Level of Appeal: Judicial Review in Federal District Court

Your Feedback Matters - Education Event Surveys

Noridian is devoted to providing solutions that put people first. Providers receive surveys at the end of every educational event and are encouraged to fill them out. Once the results are received, a select group from the appropriate team reviews the results and implements change in any way possible. Noridian sends many thanks to the provider community and looks forward to hearing from them in the future.

Billing and Coding: Complex Drug Administration Coding (A58532) Retirement - Effective April 01, 2023

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

Effective Date: April 01, 2023

Summary: This article is being retired as this is now informational for education.

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

Billing and Coding: Dental Services (A59447) - Effective January 1, 2023

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

Effective Date: January 1, 2023

Summary of Article: View guidelines that support the implementation of the CY 2023 MPFS Final Rule on Dental Services.

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

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R13 - Effective July 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: July 1, 2023

Summary of Article Changes:

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

Effective 07/01/2023 - 09/30/2023

Prialt (Ziconotide) = $9.078

Ropivacaine = $0.074

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: Intensity Modulated Radiation Therapy (IMRT) (A58236) - R5 - Effective April 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 of Service: April 1, 2023

Summary of Article Changes:

Added ICD-10-cm codes C7A.1; C7A.8; C7B.8 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: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999 (A55061) - R3 - Effective October 15, 2015

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 15, 2015

Summary of Article Changes:

Updated article to move CPT Code and ICD-10 Codes from Group 1: Paragraph to Group 1: Codes so they populate in the tables.

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) - R17 - Effective July 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: July 1, 2023

Summary of Article Changes: Under CPT/HCPCS Group 1 Codes, removed codes 0143U, 0144U, 0145U, 0146U, 0147U, 0148U, 0149U and 0150U per Q3 2023 CPT/HCPCS Updates.

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: Abbott RealTime IDH1 and IDH2 Testing for Acute Myeloid Leukemia (AML) (A55711) - R5 - Effective June 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: June 01, 2023

Summary of Article Changes: Under CMS National Coverage Policy added regulations, Title XVIII of the Social Security Act, §1833(e), CMS Internet-Only Manuals, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts With Independent Clinical Laboratories, CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, §60.1.1 Independent Laboratory Specimen Drawing, §60.2 Travel Allowance, and CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, §10 Reporting ICD Diagnosis and Procedure 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.

Billing and Coding: MolDX: Allomap (A54364) Retirement - Effective June 09, 2023

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

Effective Date: June 09, 2023

Summary: This article is being retired because the information in this article has been incorporated within MolDX: Molecular Testing for Solid Organ Allograft Rejection (A58168).

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

Billing and Coding: MolDX: AlloSure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (A57380) Retirement - Effective June 09, 2023

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

Effective Date: June 09, 2023

Summary: This article is being retired because the information in this article has been incorporated within MolDX: Molecular Testing for Solid Organ Allograft Rejection (A58168).

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

Medical Policies and Coverage

Billing and Coding: MolDX: bioTheranostics Cancer TYPE ID® (A54386) - R8 - Effective June 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: June 1, 2023

Summary of Article Changes:

Under CMS National Coverage Policy added regulations, Title XVIII of the Social Security Act, §1833(e), CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts With Independent Clinical Laboratories, CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, §60.1.1 Independent Laboratory Specimen Drawing, §60.2 Travel Allowance, and CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 23, §10 Reporting ICD Diagnosis and Procedure 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.

Billing and Coding: MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma (A59179) Final Billing and Coding Article - Effective August 06, 2023

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: A59179

Billing and Coding Article Title: Billing and Coding: MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma

Effective Date: August 06, 2023

Summary of Billing and Coding Article: The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma.

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

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT) (A57526) - R12 - Effective April 01, 2023

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

Effective Date: April 01, 2023

Summary of Article Changes:

Under CPT/HCPCS Codes Group 1: Codes added 0364U, 0368U, 0369U, 0370U, 0371U, 0372U, 0373U, 0374U, 0378U, 0379U, 0380U, and 0386U. The description was revised for 0022U. This revision is due to the 2023 Q2 CPT/HCPCS Code Update and is effective on April 1, 2023.

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R8 - Effective April 20, 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: April 20, 2023

Summary of Article Changes:

Under CPT/HCPCS Codes Group 6: Paragraph revised 2nd sentence to add “Per policy, these”. Added last sentence. Under CPT/HCPCS Codes Group 7: Paragraph revised 2nd sentence to add “Per policy, these”. Added last sentence. Under ICD-10 Codes that Support Medical Necessity Group 5: Codes added B37.89 and R30.0. Deleted N93.9 and N95.0. This revision is retroactive effective for dates of service on or after 06/02/2022.

Under CPT/HCPCS Codes Group 8: Codes added 87149, 87150, and 87513. This revision is effective on 04/20/2023.

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: Next-Generation Sequencing for Solid Tumors (A57901) - R4 - Effective April 1, 2023

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

Effective Date: April 1, 2023

Summary of Article Changes: Under CPT/HCPCS Codes Group 1: Codes added 0379U. This revision is due to the 2023 Q2 CPT/HCPCS code update and is effective on 4/1/2023.

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) - R9 - Effective April 20, 2023.

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

Effective Date: April 20, 2023

Summary of Article Changes: Under article text added the verbiage “The character maximum for loop 2400 is 80. To prevent denials/rejects when indicating more than 80 characters, please indicate the required drug names first.” under subsection heading, “Billing instructions” first paragraph.

Revised Table 1 to update to the current CPIC and FDA dates. Added new rows for ABCG2 for rosuvastatin, CYP2C19 for belzutifan, CYP2C19 for abrocitinib, CYP2C9 for nateglinide, CYP2C9 for fluvastatin, and UTGT2B17 for belzutifan.

Revised the row for SLCO1B1 to include additional generic and trade names.

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: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (A59179) Final Billing and Coding Article - Effective August 06, 2023

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: A58181

Billing and Coding Article Title: Billing and Coding: MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer

Effective Date: August 06, 2023

Summary of Billing and Coding Article: The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer.

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

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R6 - Effective April 01, 2023

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

Effective Date: April 01, 2023

Summary of Article Changes:

Under CPT/HCPCS Codes Group 1: Codes added 0378U and 0380U. This revision is due to the 2023 Q2 CPT/HCPCS Code Update and is effective on 4/1/2023.

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: Sacroiliac Joint Injections and Procedures (A59244) - R1 - Effective March 19, 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: March 19, 2023

Summary of Article Changes: Editorial/clarification changes or updates made to the Coding Guidance section.

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

MolDX: AlloSure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (L38355) Retirement - Effective June 09, 2023

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

Medicare Coverage Database (MCD) Number: L38355/A57380/A58481

Effective Date: June 09, 2023

Rationale: This LCD is being retired because the information in this policy has been incorporated within the MolDX: Molecular Testing for Solid Organ Allograft Rejection (L38629) LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (L37887) - R6 - Effective June 29, 2023

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: L37887

Effective Date: June 29, 2023

Summary of Changes: Under *CMS National Coverage Policy* updated section heading. Under *Bibliography* changes were made to citations to reflect AMA citation guidelines, removed #8, and renumbered 9-23. Formatting and punctuation errors were corrected throughout the LCD.

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

Medical Policies and Coverage

MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma (L39373) Final LCD - Effective August 06, 2023

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: L39373

LCD Title: MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma

Effective Date: August 06, 2023

Summary of LCD: The purpose of this test is to assist dermatopathologists to arrive at the correct diagnosis of melanoma versus non-melanoma when examining skin biopsies. This Medicare contractor will provide limited coverage for molecular Deoxyribonucleic acid (DNA)/Ribonucleic acid (RNA) assays that aid in the diagnosis or exclusion of melanoma from a biopsy when outlined clinical conditions are met.

Visit the Proposed LCDs webpage to access this LCD.

MolDX: Molecular Biomarker Testing for Risk Stratification of Cutaneous Squamous Cell Carcinoma - 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: DL39589/DA59386

LCD Title: MolDX: Molecular Biomarker Testing for Risk Stratification of Cutaneous Squamous Cell

LCA Title: Billing and Coding: MolDX: Molecular Biomarker Testing for Risk Stratification of Cutaneous Squamous Cell Carcinoma

Comment period: June 08, 2023 - July 22, 2023

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

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

MolDX: Molecular Diagnostic Tests (MDT) (L35160) - R16 - Effective May 04, 2023

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

Effective Date: May 04, 2023

Summary of Changes: Under CMS National Coverage Policy deleted regulation Pub 100-08 PIM, Ch. 13, Sec 13.1.3, Program Integrity Manual, and added CMS Internet-Only Manual, Pub. 100-8, Medicare Program Integrity Manual, Chapter 13, §13.5.4 Reasonable and Necessary Provisions in LCDs. Formatting, punctuation and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD.

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

MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (L38647) Final LCD - Effective August 06, 2023

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: L38647

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

Effective Date: August 06, 2023

Summary of LCD: This contractor will cover molecular diagnostic tests for use in a beneficiary with bladder cancer when all of the outlined conditions are met.

Visit the Proposed LCDs webpage to access this LCD.

Multiple Local Coverage Determinations (LCDs) Finalized - Effective July 30, 2023

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database Number	LCD Title
L34203	Cataract Surgery in Adults
L37729	Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Medicare Coverage Database Number	Billing and Coding Article Title
A57195	Billing and Coding: Cataract Surgery in Adults
A57512	Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Medicare Coverage Database Number	Response to Comments
A59413	Response to Comments: Cataract Surgery in Adults
A59419	Response to Comments: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Effective Date: July 30, 2023

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

Medical Policies and Coverage

Multiple Proposed LCDs - 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:** DL39116
  LCD Title: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound
- **Medicare Coverage Database (MCD) Number:** DL38299
  LCD Title: Micro-Invasive Glaucoma Surgery (MIGS)
- **Medicare Coverage Database (MCD) Number:** DL38705
  LCD Title: Transurethral Waterjet Ablation of the Prostate
- **Medicare Coverage Database (MCD) Number:** DL34149
  LCD Title: Respiratory Care

Comment period: June 15, 2023 to July 29, 2023

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.

Self-Administered Drug Exclusion List (A53032) - R29 - Effective June 25, 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: June 25, 2023

Summary of Article Changes:

The article has been updated to add: Adalimumab-aacf (Idacio®), Adalimumab-afzb (Abrilada™), Adalimumab-bwwd (Hadlima), Adalimumab-fkjp (Hulio®), Adalimumab-adaz (Hyrimoz), Adalimumab-aqvh (Yusimry) (C9399, J3490, J3590) effective for dates of service on or after 06/25/2023.

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.

Urine Drug Testing - Published for Review and Comments

This article has been updated to include the Billing and Coding Article which was not available at the time of the initial posting.

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: DL33368/DA55001

LCD Title: Urine Drug Testing

LCA Title: Billing and Coding: Urine Drug Testing

Comment period: April 27, 2023 - June 12, 2023

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.

MLN Connects

MLN Connects Newsletter: 4 Proposed FY 2024 Payment Rules - April 4, 2023

Proposed Rules

- FY 2024 Hospice Payment Rate Update Proposed Rule (CMS-1787-P)
- FY 2024 Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Quality Reporting (IPFQR) Updates Proposed Rule (CMS-1783-P)
- FY 2024 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule (CMS-1781-P)
- FY 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1779-P)

MLN Connects - April 6, 2023

MLN Connects Newsletter: Apr 6, 2023

News

- Resources & Flexibilities to Assist with Public Health Emergency in Mississippi Due to Recent Storms
- Program for Evaluating Payment Patterns Electronic Reports
- Advance Beneficiary Notice of Noncoverage: Form Renewal
- New Recovery Audit Contractor for Region 2 Starting Spring 2023
- Comprehensive Error Rate Testing Review Contractor Company Changed Name
- Help Improve the Health of Minority Populations

Claims, Pricers, & Codes

- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: April Update

Events

- PCG Provider Compliance Focus Group: Provider Compliance Activities Post-PHE - May 9

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: April 2023 Update – Revised

MLN Connects

MLN Connects Newsletter: CMS Proposes Policies to Improve Patient Safety and Promote Health Equity - Apr 10, 2023

Proposed Rule

CMS Proposes Policies to Improve Patient Safety and Promote Health Equity

MLN Connects - April 13, 2023

MLN Connects Newsletter: Apr 13, 2023

News

- COVID-19: End of Public Health Emergency
- CMS Roundup (Apr. 07, 2023)
- Medicare Shared Savings Program: Application Toolkit Materials
- Inpatient Rehabilitation Facility Interdisciplinary Team Meetings After the COVID-19 Public Health Emergency
- Hospital Outpatient Departments: Prior Authorization for Facet Joint Interventions Starts July 1
- Opioid Treatment Program Webpage Updates

Claims, Pricers, & Codes

- Home Health Original Claims: Don't Include Cross-Reference Document Control Numbers
- Outpatient Rehabilitation Claims with Reason Code W7072: You Might Need to Resubmit Claims

Events

- IRIS: XML Format & Duplicate Interns and Residents Full-Time Equivalents Review - May 3

MLN Matters® Articles

- New Waived Tests

Publications

- Intravenous Immune Globulin Demonstration - Revised
- Medicare Modernization of Payment Software – Revised

MLN Connects

Multimedia

- Expanded Home Health Value-Based Purchasing Model: Self-Assessment Tool Webinar Materials

MLN Connects - April 20, 2023

MLN Connects Newsletter: Apr 20, 2023

News

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance
- Medical Review & Compliance: Respond to Additional Documentation Requests
- Hospice: Comparative Billing Report in April

Compliance

- Home Health Rural Add-On Policy

Claims, Pricers, & Codes

- Grandfathered Tribal Federally Qualified Health Centers: CY 2023 Rate

Events

- Medicare Ground Ambulance Data Collection System: Office Hours Session - April 27
- Medicare Shared Savings Program: Navigating the Application Webinar - May 8
- Clinical Laboratory Fee Schedule: Present or Speak at Upcoming Meetings

Multimedia

- Medicare Home Health Prospective Payment System CY 2023: Materials from March Webinar

MLN Connects - April 27, 2023

MLN Connects Newsletter: Apr 27, 2023

News

- Hospital Price Transparency Enforcement Updates
- For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available

MLN Connects

- Behavioral Health Integration Services: Find Out What Medicare Covers & Who's Eligible

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- 2023 Quality Conference May 1-3

MLN Matters® Articles

- Home Health Claims: Telehealth Reporting
- Skilled Nursing Facility Prospective Payment System: Updates to Current Claims Editing

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Connects - May 4, 2023

MLN Connects Newsletter: May 4, 2023

News

- FAQs on CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency
- Guidance for the Expiration of the COVID-19 Public Health Emergency
- COVID-19 Over-the-Counter Tests
- Medicare Diabetes Prevention Program: Public Health Emergency Flexibilities Continue through December 31
- Transplant Eco-System: Role of Data in CMS Oversight of The Organ Procurement Organizations
- Expanded Home Health Value-Based Purchasing Model: April Newsletter & Performance Reports
- Religious Nonmedical Health Care Institution Benefit & COVID-19 Vaccines
- Clinical Laboratory Fee Schedule 2024 Preliminary Gapfill Rates: Submit Comments by June 26
- Mental Health: Recommend Medicare Preventive Services

Claims, Pricers, & Codes

- COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency Update
- Claim Status Category & Claim Status Codes

MLN Connects

Events

- Medicare Shared Savings Program: Navigating the Application Webinar - May 8
- HCPCS Public Meeting - May 30 - June 1

MLN Matters® Articles

- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI - Revised

Publications

- Electronic Cell-Signaling Treatment

MLN Connects - May 11, 2023

MLN Connects Newsletter: May 11, 2023

News

- CMS Roundup (May 5, 2023)
- Medicare Ground Ambulance Data Collection System: Report Information

Compliance

- Bill Correctly: Power Mobility Devices Repairs

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update
- Home Dialysis Payment Adjustment & Performance Payment Adjustment for ESRD Treatment Choices Model: Updated Process

Publications

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance - Revised
- Expanded Home Health Value-Based Purchasing Model: Updated Measure Calculation Resources

MLN Connects

MLN Connects - May 18, 2023

MLN Connects Newsletter: May 18, 2023

News

- COVID-19: Public Health Emergency Ended May 11
- End of COVID-19 Public Health Emergency FAQs
- Advancing Health Equity Through The CMS Innovation Center: First Year Progress And What's To Come
- Power Seat Elevation Equipment on Power Wheelchairs: Coverage, Coding, & Payment
- Medicare Shared Savings Program: Apply for January 1 Start Date by June 15
- Inpatient Rehabilitation Facility Services: Review Choice Demonstration
- Women's Health: Talk with Your Patients About Making their Health a Priority

Claims, Pricers, & Codes

- COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency - Reminder

Events

- Skilled Nursing Facility: Minimum Data Set Resident Assessment Instrument Training

Publications

- Screening Pap Tests & Pelvic Exams - Revised

From Our Federal Partners

- Potential Risk for New Mpox Cases

MLN Connects - May 25, 2023

MLN Connects Newsletter: May 25, 2023

News

- DMEPOS Competitive Bidding Program: Temporary Gap Period Starts January 1
- CMS Roundup (May 19, 2023)
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- ESRD-Related Services: Comparative Billing Report in May

MLN Connects

Claims, Pricers, & Codes

- COVID-19 Pfizer-BioNTech & Moderna Vaccines: Product & Administration Code Updates

MLN Matters® Articles

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

Publications

- Checking Medicare Claim Status

Multimedia

- J0510-J0530 Pain Interview: Understanding How a Patient Communicates Pain Video

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Connects - June 1, 2023

MLN Connects Newsletter: June 1, 2023

News

- CMS Announces Plan to Ensure Availability of New Alzheimer's Drugs
- COVID-19 Health Care Staff Vaccination Final Rule
- Medicare Secondary Payer Accident-Related Diagnosis Codes: How to Get Paid
- Hospitals: New Payment Adjustments for Domestic N95 Respirators
- Expanded Home Health Value-Based Purchasing Model: May Newsletter
- Improve Cognitive Health: Medicare Covers Services

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2023 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2023 Quarterly Update
- Updating Medicare Manual with Policy Changes in the CY 2020 & CY 2021 Final Rules

MLN Connects

Publications

- Medicare Preventive Services - Revised
- Medical Record Maintenance & Access Requirements - Revised

Multimedia

- Hospice Quality Reporting Program Web-Based Training - Revised

MLN Connects - June 8, 2023

MLN Connects Newsletter: June 8, 2023

News

- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in the Territory of Guam Due to Recent Typhoon
- CMS Roundup (June 2, 2023)
- Gender-Specific Services: Billing Correctly and Usage of the Condition Code/Modifier
- Medicare Shared Savings Program: Apply for January 1 Start Date by June 15
- Skilled Nursing Facility Value-Based Purchasing Program: June Feedback Report
- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Help Address Disparities in the LGBTQI+ Community

Claims, Pricers, & Codes

- National Correct Coding Initiative: July Update
- Integrated Outpatient Code Editor: Version 24.2

MLN Matters® Articles

- Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order

MLN Connects

MLN Connects - June 15, 2023

MLN Connects Newsletter: June 15, 2023

News

- Inflation Reduction Act Continues to Lower Out-of-Pocket Prescription Drug Costs for Drugs with Price Increases Above Inflation
- CMS Announces Multi-State Initiative to Strengthen Primary Care
- Critical Access Hospitals: Annual Average Patient Length of Stay Requirement
- Skilled Nursing Facility Probe and Educate Review
- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance
- ESRD Prospective Payment System: July Update
- Medicare Learning Network Web Refresh
- Men's Health: Encourage Your Patients to Prioritize Their Health

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2024

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2023 Quarterly Update
- Hospital Outpatient Prospective Payment System: July 2023 Update
- New JZ Claims Modifier for Certain Medicare Part B Drugs
- Ambulatory Surgical Center Payment System: July 2023 Update - Revised

Publications

- Expanded Home Health Value-Based Purchasing Model: Resource Index, FAQs, & Specifications

Information for Patients

- New Tools to Lower Prescription Drug Costs for Low-Income Seniors and People with Disabilities

MLN Connects

MLN Connects - June 22, 2023

MLN Connects Newsletter: June 22, 2023

News

- CMS Roundup (June 16, 2023)
- Lower Endoscopy: Comparative Billing Report in June
- Medicare Physician Fee Schedule Database: July Update
- Behavioral Health Integration Services: Get Information about the Codes

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Codes: FY 2024

Events

- Expanded Home Health Value-Based Purchasing Model: Overview of the Interim Performance Report Webcast - July 27

MLN Matters® Articles

- New Waived Tests
- Home Dialysis Payment Adjustment & Performance Payment Adjustment for ESRD Treatment Choices Model: Updated Process - Revised

MLN Connects - June 29, 2023

MLN Connects Newsletter: June 29, 2023

News

- CY 2024 ESRD Prospective Payment System Proposed Rule
- Transforming Medicare Coverage: A New Medicare Coverage Pathway for Emerging Technologies and Revamped Evidence Development Framework
- New Details of Plan to Cover New Alzheimer's Drugs
- Model Participants for the Enhancing Oncology Model
- Hospital Price Transparency: Volunteer for Machine-Readable File Validator Testing

Claims, Pricers, & Codes

- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: July Update

MLN Connects

Events

- Hospital Price Transparency Machine-Readable File Sample Format Webinar - July 26

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2023 Update - Revised

From Our Federal Partners

- Locally-Acquired Malaria Cases Identified in U.S.
- Measles Guidance for the Summer Travel Season

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Matters

Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order

Related CR Release Date: March 30, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13055

Related Change Request (CR) Number: CR 13055

Related CR Transmittal Number: R11935OTN

CR 13055 tells you about:

- Limited to non-acute hearing conditions and diagnostic services related to implanted auditory prosthetic devices
- Excludes audiology services that are related to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids
- Covered once per patient per 12-month period
- Unexpected discovery of an acute condition

Make sure your billing staffs knows about billing and coding requirements for these diagnostic tests using the AB modifier.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13055.

ASC Payment System: July 2023 Update - Revised

Related CR Release Date: June 22, 2023 Revised

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13216

Related Change Request (CR) Number: CR 13216

Related CR Transmittal Number: R12099CP

Note: CMS added information about a corrected payment for CPT 0697T to agree with a revised CR 13216. Substantive changes are in dark red on page 2.

CR 13216 tells you about:

- New drug, biological and procedure codes
- An Ambulatory Surgical Center (ASC) Payment Indicator (PI) correction for CPT code 0698T
- Additional skin substitute products

MLN Matters

Make sure your billing staff knows about these payment system updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13216.

Claim Status Category and Claim Status Codes Update

Related CR Release Date: March 2, 2023

Effective Date: March 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 12845

Related CR Transmittal Number: R11885CP

CR 12845 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12845.

CLFS & Laboratory Services Reasonable Charge Payment: Quarterly Update

Related CR Release Date: May 4, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13195

Related Change Request (CR) Number: CR 13195

Related CR Transmittal Number: R12021CP

CR 13195 tells you about:

- Expiration of the COVID-19 Public Health Emergency (PHE)
- Next CLFS data reporting period
- General specimen collection fee increase
- New and discontinued HCPCS codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13195.

MLN Matters

DMEPOS Fee Schedule: July 2023 Quarterly Update

Related CR Release Date: June 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13235

Related Change Request (CR) Number: CR 13235

Related CR Transmittal Number: R12068CP

CR 13235 tells you about:

- Fee schedule adjustment relief for rural and non-contiguous areas
- Supplier education on power wheelchair repair

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13235.

HCPCS Codes Used for SNF CB Enforcement: July 2023 Quarterly Update

Related CR Release Date: May 18, 2023

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

MLN Matters Number: MM13192

Related Change Request (CR) Number: CR 13192

CR 13192 tells you about:

- Updates to the list of HCPCS codes subject to the Consolidated Billing (CB) provision of the Skilled Nursing Facility (SNF) prospective payment system (PPS)
- Additions and deletions of certain chemotherapy and vaccines codes from the Medicare Part B SNF files

Make sure your billing staff knows about the updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13192.

MLN Matters

Home Dialysis Payment Adjustment & Performance Payment Adjustment for ESRD Treatment Choices Model: Updated Process - Revised

Related CR Release Date: May 4, 2023 Revised

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

MLN Matters Number: MM13180

Related Change Request (CR) Number: CR 13180

Related CR Transmittal Number: R12020DEMO

Note: CMS deleted references to condition codes 74 and 76.

CR13180 tells you about:

- Claim lines on type of bill 072X
- Monthly Capitation Payment (MCP) claims on claim lines with CPT codes 90957-90962 and 90965-90966

Make sure your billing staff knows about these adjustments.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13180.

July 2023 I/OCE Specifications Version 24.2

Related CR Release Date: May 25, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13213

Related CR Transmittal Number: R12059CP

CR 13213 provides the Integrated OCE (I/OCE) instructions and specifications for the Integrated OCE that will be utilized under the Outpatient Prospective Payment System (OPPS) and non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a nonterminal illness. The attached recurring update notification applies to publication 100-04, chapter 4, section 40.1.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13213.

MLN Matters

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

Related CR Release Date: March 23, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13157

Related CR Transmittal Number: R11920CP

CR 13157 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13157.

Mental Health Visits via Telecommunications for RHCs & FQHCs - Revised

MLN Matters Number: SE22001 Revised

Article Release Date: May 23, 2023

Note: CMS revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.

SE22001 tells you about:

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

Make sure your billing staff knows about these changes.

View the complete CMS Special Edition (SE)22001.

MLN Matters

New JZ Claims Modifier for Certain Medicare Part B Drugs

Related CR Release Date: June 2, 2023

Effective Date: January 1, 2023

Implementation Date: July 1, 2023 - JZ modifier

MLN Matters Number: MM13056

Related Change Request (CR) Number: CR 13056

Related CR Transmittal Number: R12067CP

CR 13056 tells you about:

- Using JW modifier data to show discarded amounts of drugs in a single-dose container or single-use package
- Reporting requirements for new JZ modifier starting July 1, 2023

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13056.

New Waived Tests

Related CR Release Date: April 5, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13162

Related Change Request (CR) Number: CR 13162

Related CR Transmittal Number: R11943CP

CR 13162 tells you about:

- Clinical Laboratory Improvement Amendments (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 (MM13162.

MLN Matters

New Waived Tests

Related CR Release Date: June 15, 2023

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

MLN Matters Number: MM13253

Related Change Request (CR) Number: CR 13253

Related CR Transmittal Number: R12089CP

CR 13253 tells you about:

- Clinical Laboratory Improvement Amendments (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)13253.

Quarterly Update to the MPFSDB - July 2023 Update

Related CR Release Date: June 7, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13208

Related CR Transmittal Number: R12072CP

CR 13208 amends payment files that were issued to contractors based upon the 2023 Medicare Physician Fee Schedule (MPFS) Final Rule. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.1.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13208.

MLN Matters

Quarterly Update to the NCCI PTP Edits, Version 29.2, Effective July 1, 2023

Related CR Release Date: March 16, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13145

Related CR Transmittal Number: R11909CP

CR 13145 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)13145.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: December 30, 2022

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

Related Change Request (CR) Number: CR 13007

Related CR Transmittal Number: R11768CP

CR 13007 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the Viable Information Processing Systems (ViPS) Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13007.

MLN Matters

RARC, CARC, MREP and PC Print Update

Related CR Release Date: March 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13114

Related CR Transmittal Number: R11886CP

CR 13114 updates the Remittance Advice Remark (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13114.

Updating Medicare Manual with Policy Changes in the CY 2020 & CY 2021 Final Rules

Related CR Release Date: February 9, 2023

Effective Date: January 1, 2023

Implementation Date: May 9, 2023

MLN Matters Number: MM13064

Related Change Request (CR) Number: CR 13064

CR 13064 tells you about:

- Nursing facility visits code family
- Hospital inpatient or observation care code family
- Substantive portion of a split, or shared, visit

Make sure your billing staff is aware of the updated billing instructions.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13064.

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.

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.

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