Medicare B News

Jurisdiction E
January 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

2025 Annual Update of Per-Beneficiary Threshold Amounts

Noridian has updated the outpatient therapy website with the outpatient therapy KX threshold amounts for 2025. KX modifier threshold amounts are:

(a) $2,410 for PT and SLP services combined, and

(b) $2,410 for OT services.

Source: CMS Medicare Learning Network (MLN) Matters (MM)13887

2025 Medicare Physician Fee Schedule Now Available

The 2025 Medicare Physician Fee Schedule (MPFS) has been published and posted in Microsoft Excel formats. Go to the MPFS webpage under the Fees and News tab on the Noridian website for further information.

ACM B Questions and Answers - November 6, 2024

Written Pre-Q/A:

Q1. If a patient has Medicare as a secondary insurance, should we follow the billing rules as set forth by Medicare, or by the primary insurance? Similarly, if a patient has a Medicare Advantage Plan, should we follow Medicare billing rules or are the rules set by the administrator of the Advantage Plan?
A1. When Medicare is primary, follows Medicare rules and when Medicare is secondary, follow primary insurer rules first and then Medicare. Medicare Advantage plans comply with both Medicare and their own rules; however, must follow CMS National Coverage Determinations (NCDs) and their Medicare Administrative Contractor (MAC) jurisdiction Local Coverage Determination (LCD) policies.

Q2. When a patient has sleep apnea well controlled on a Continuous Positive Airway Pressure (CPAP) machine, and the provider recommends continuing with CPAP therapy, would this be 'low' risk or "moderate" on the medical decision-making (MDM) table 3rd column? What if a change was made to the settings during the visit and how about an initial prescription?
A2. This looks low risk without any other changes besides reviewing the data card. However, risk for MDM will depend on many factors, so there's no one answer. "Prescribing" is only one component of the MDM. Does the patient have other diagnoses, amount, and/or complexity of the visit? It's up to the physician's office. Make sure that the patient's condition, treatment plan, any orders, etc., are well documented.

Q3. Per Medicare's Claims Processing Manual, Publication 100-04, Chapter 8, Section 150; physicians are paid a flat fee of $500 to train patients for home dialysis. The facility is billing CPT 90989 or 90993 for home dialysis training and is reimbursed under the End Stage Renal Disease (ESRD) Prospective Payment System (PPS). How is this billed by the physician?
A3. CPT codes 90989 or 90993 are billed for the physician providing the training. When the physician is enrolled under the facility, the training is billed to Part A. If the physician is billing under a clinic, bill to Part B.

Q4. Is CPT 99459 (add on pelvic exam with E/Ms) billable with G0101 (cervical or vaginal cancer screening; pelvic and clinical breast exam) and Q0091 (pap smear)?
A4. No. 99459 would not be allowed separately for a pap and/or pelvic exams (Q0091 or G0101) as those services are bundled. Since this add-on code is a practice expense, covers speculum costs and staff time minutes (e.g., chaperone and room setup time), it should be only billed with E/M office visits. Check out the Add-on Code NCCI links on the CMS website.

Q5. Can the Continuous Glucose Monitor (CGM) CPT 95251 be completed "incident to" or can only a MD, DO, NP or PA bill this code?
A5. Yes. CPT 95251 (Ambulatory CGM of interstitial tissue fluid via a personal wear subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report) is only to be billed by an MD, DO, NP or PA. However, under "incident to", a medical assistant, nurse (both registered and licensed professional), or a Certified Diabetes Care and Education Specialist (CDCES) may only perform certain elements as they cannot bill Medicare.

Q6. What can our solo private practice for psychiatry learn to avoid future Medicare audits for CPT 90833 (psychotherapy)?
A6. For psychotherapy add on CPT 90833, the psychotherapy and medical components of the notes must be significant and separately identifiable. Make sure each requirement can be identified to determine if they are met. The E/M key components and total time must be reflected in the medical record. To assist with passing the audits, read the Mental Health pages on both Noridian and CMS; plus attend Noridian's two-part mental health annual webinars and save the PDFs for references.

The rules used for audits depend on several factors including changes in billing patterns, unusual billings on regular reviews and other items. Pre or post-pay reviews have different requirements. Some will look at the top 15 percent comparison with peers, while other reviews follow other indications. Documentation is the key to support services billed.

Q7. Would the E/M discussion of "management component" with non-health care professionals, include inpatient discussions between a physician and nurse at the

patient's bedside?
A7. No. Per the American Medical Association (AMA) E/M guidelines, this discussion would include professionals who are not health care professionals. Examples include an attorney, case manager, teacher, or parole officer.

Q8. Can CMS provide the supporting documentation on this policy around Medicare Secondary Payer (MSP) with Employer Group Health Plan (EGHP) primary discharge for dialysis clinics and Part B beneficiaries?
A8. Medicare is only secondary to an EGHP for 30 months. We are not aware of any policy of CMS restricting patient discharges from out-of-network providers to an in-network provider for the beneficiary.

Q9. Does "incident to billing" apply to both PAs and NPs in an Urgent Care setting when the Urgent Care is owned by the same provider group?
A9. Yes it could. Incident to rules apply in all appropriate allowable settings and that includes the Urgent Care setting in place of service (POS) 20 with non-facility pricing. Reminder that incident to is not allowed in a facility setting.

Q10. What is included in the global package if weight loss surgery is decided in July and not scheduled until December?
A10. If the procedure has a 90-day global, the day before is counted in the global package. A prolonged period should be billed as an E/M. The lesser 10-day global procedures only include the day of surgery.

The days included in the global package are determined based on a minor (0-10 days) or major (90 days) surgery. To reiterate, major surgeries include the day before the procedure, day of, and 90 days after.

The MLN booklet titled Global Surgery and the CMS Internet Only Manual (IOM), Claims Processing Manual, Publication 100-04, Chapter 12, Section 40 clarifies.

Q11. What is the requirement to support billing with modifier -80 for a physician (MD or DO) assistant-at-surgery?
A11. The operative note should clearly document the assistant surgeon's role during the operative session. It should include their name, credentials, and specific activities they performed.

Check Noridian's Medicare Physician Fee Schedule (MPFS) Fees and Indicators listing and descriptors for codes. For example: CPT 45385 has "Assistant Surgeon" indicator of "1", meaning "Statutory payment restriction for assistants at surgery applies to this procedure. Assistant surgeon may **not** be paid." CPT 27447 has indicator "2", meaning "Payment restriction for assistants at surgery does not apply to this procedure". Assistant surgeon may be paid "Payment restriction for assistants at surgery does not apply to this procedure. Assistant surgeon may be paid".

Q12. When a Medical Oncologist evaluates the patient, reviews labs, and orders imaging (i.e., PET scan) for re-staging the cancer disease, would a separately identifiable E/M with modifier 25 on the same day be allowed with the scheduled chemotherapy infusion?
A12. Yes, the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.5, states to bill an E/M visit with a 25 modifier, it must be a significant, separately identifiable E/M service.

Q13. Why does Noridian bundle radiation treatment services (77427-77435), although these codes have an indicator of "no global days"?
A13. Global days are not the only bundling edits. Please check the National Correct Coding Initiative (NCCI) page on the CMS website for code pair edits. Some bundled service codes cannot be unbundled.

Q14. If our mobile unit goes to a location not owned by our facility, what name and address should we have in Item 32? If the mobile unit goes to a location owned by our facility, which address should be in Item 32?
A14. When using mobile unit POS (15), a different place of service is expected to be indicated in Item 32. Indicate the address where the service was performed.

Q15. Can G2211 (complexity add-on) be billed with yearly follow-up visits for a patient in remission from cancer?
A15. Yes. G2211 may only be reported as an add-on code to E/M office or outpatient visits 99202-99205 or 99211-99215. The provider has ongoing medical care for the patient with consistency and continuity over time. Documentation would include continuous and active collaborative plan of care between the provider and the patient. If the documentation for the annual visit meets these requirements, it may be possible to use add-on code G2211.

Q16. Can a physician bill critical care services and a discharge service on the same day if the patient is transferred to another facility or expires?
A16. Depends. In situations when a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation), as long as the medical record documentation notes that: 1) the other E/M visit was provided before the critical care, and at a time when the patient did not require critical care; and 2) the services were medically necessary; and 3) the services were separate and distinct with no duplicative elements from the critical care services occurring later in the day. If so, modifier -25 should be appended to the critical care E/M on the claim for this day.

Follow-up Q16. When one provider works the day shift and another the evening shift, is critical care split and shared billing appropriate, when a physician and advanced practice provider (APP) do not work collaboratively on patient management?

Follow-up A16. CMS pays the practitioner who performs the **substantive** portion of the visit, if they are part of the same group. Read more at 2024 "Updates for Split or Shared E/M Visits".

Q17. When a patient is transferred to another physician for post-operative care, how do we report the surgical CPT with modifier 55 and what about an office visit?
A17. Physicians utilize the same global surgery CPT code and bill with modifiers -54 and/or -55. Report the same date of service the surgery was performed. In the CMS-1500 narrative field (Item 19), include the date span responsible for post-op care. Both the surgeon and postop care provider must keep a copy of the written transfer agreement in the beneficiary's medical record and add up to the 90-day global. Read more under the MLN booklet titled Global Surgery.

Follow-up Q17. If the surgeon performed one post op visit and the remaining post-operative care was managed by another physician, does the second physician report the CPT with modifier 55?
Follow-up A17. Yes, if separate medical practices. When different physicians in a group practice participate, the group bills the entire global package. The surgeon bills the surgical CPT with modifier 54 for the surgery component. On the next line, bill the same code with modifier 55, indicating one day of postop care.

The physician performing the remaining postop days bills separately with modifier 55 and dates responsible for postop care. Postop care modifier 55 is only applicable with the surgery code. Read more at Medicare Learning Network (MLN) Global Surgery Booklet.pdf.

Q18. When a medically necessary eye exam is reported as an E/M CPT, would the visual acuity testing (CPT 99173) be considered an analyzed test?
A18. No. Per the AMA, the ordering and actual performance and/or interpretation of diagnostic tests and studies during a patient encounter, are not included in determining the levels of E/M services, when the professional interpretation of those tests or studies is reported separately by the physician or other qualified health care professional reporting the E/M service.

Tests that do not require separate interpretation (e.g., results only) and are analyzed as part of the medical decision-making (MDM), do not count as an independent interpretation.

However, it may be counted as ordered or reviewed for selecting an MDM level. If a test or study is independently interpreted to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM. CPT 99173 is not separately payable.

Q19. When a patient is in a current Skilled Nursing Facility (SNF) stay and is brought to a physician clinic for an E/M visit, can the visit be reimbursed?
A19. Yes, when the patient is in a covered SNF stay and brought to physician clinic,

submit the correct level of E/M visit with the place of service 31 for the Part A covered SNF stay. If not covered under Part A, use place of service 32. Read more in the SNF Billing Reference on the CMS website.

Q20. How can we avoid our claims denying and appealing when the patient's visit diagnosis has nothing to do with their open Medicare Secondary Payer (MSP) case?
A20. Unfortunately, there may be no way around the appeal. Our systems currently reject any codes that are an exact match and/or may be related to the diagnosis code(s). Providers need to submit a completed "MSP B Correspondence" form for each claim, indicating "not related to the open file". Check that the submitted diagnosis code(s) are not related to the Non-Group Health Plan (NGHP) file, etc.

Q21. Can our mid-level providers that assist with surgery document and sign their name to the physician documentation and receive credit to bill?
A21. It depends on the surgical CPT and if Medicare allows to have an assistant surgeon bill or billed separately under the surgeon. Billers and practitioners can find all allowed codes under the Fee Schedule pages. From our Fee Schedule pages, refer to Answer 11 and consider an addendum to the medical record to include the work from the NPP.

Q22. Since the current CMS data is from 2022, what is the process to submit a request for current physician comparison data by CPT code and specialty?
A22. Check the CMS Provider Data Catalog; last modified October 11, 2024, that includes the National Downloadable File, Clinician Public Reporting, Utilization Data, etc.

Q23. If a hospital owns a clinic, but not billed as hospital-based (1206G primary care clinic), can you bill "incident to", since the expenses are not reported on the cost report for this type of clinic? Does it still apply if there's no direct expense by the physician?
A23. No. Incident to would not apply if billing on a UB04 with POS 19 or 22. If billing CMS-1500 with POS 11, then incident to may be performed. They could perform split shared services in this scenario if the criteria is met. *Note: 1206G appears to be CA designation and not Medicare*.

Verbal Q/A:

Q24. Providers are ordering bilateral facet injections, but our radiologists are only able to do one side per day and we are receiving claim denials. What type of care plan needs to be included and what we are potentially missing?
A24. Bilateral services must be performed on the same day. The policy allows a maximum of two unilateral or four bilateral per session. One spinal region is allowed per session with one or two levels unilateral or bilateral per session. When determining a level, count the number of facet joints injected, **not** the number of nerves injected. Therefore, if multiple nerves of the same facet joint are injected, it would be considered a single level.

If providers are performing a bilateral, it's considered one for both sides.

Q25. My understanding is that for minor procedures there is an inherent E/M in each procedure. Our doctor is stating that when a patient comes in for a new problem; such as right shoulder pain, and he diagnosed right shoulder osteoarthritis, then decides to perform a joint injection, we can bill an E/M service separately. Can you clarify how this would be billed for new patients?

A25. Providers would have to meet the separate E/M requirements. There is specific language in the National Correct Coding Initiative (NCCI) Manual that states just because they are a new patient, does not mean that an E/M is medically necessary on the same day as a procedure. Look at documentation to see if anything is separately identifiable from the joint injection in order to bill the E/M.

Q26. In the stereotactic radiosurgery (SRS) CPT 61796-61798 description, it mentions physician presence as a requirement for the neurosurgeon, but the type of service we provide does not require the frame placement or use that machinery. We are trying to determine whether the physician needs to be present for the treatment session in order to bill?

A26. Yes. For SRS, no **one** physician may bill **both** the neurosurgical codes and the radiation oncology 77xxx codes. Radiation oncologists and neurosurgeons have separate CPT billing codes for SRS. The comprehensive CPTs that use SRS with either particle beam, gamma ray, or linear accelerator for cranial lesions (61796, 61797, 61798, etc.), may be billed by the neurosurgeon, as one member of the team. This happens, when and only when; this "physician" is (a) present, (b) obviously the procedure is medically necessary and (c) s/he is fully participating, in the coded course.

If either the radiation oncologist or the neurosurgeon does **not fully participate** in the patient's care, that physician must code by appending the appropriate modifier 54 and then the other physician bills with appended modifier 55 to split the global procedure(s). Make sure that the date span in Box 19 narrative is reflected.

The medical record must clearly indicate the critical nature of the anatomy or other circumstances necessitating the services encompassed by this code. They must be physically present during the entire process of defining the target volume and structures at risk.

Q27. We have an urgent care with a number of providers with different specialties. What is your guidance with the new versus established patient rule? If we have a patient that sees an internal medicine provider, then three months later they see a hospitalist, could that be billed as a new patient visit as well?

A27. Depends. If the providers are completely different specialties, new patient visits could be billed for both visits. If they are the same specialty, only the first visit will be

new patient. If the doctor is covering for the doctor who saw the patient the first visit, then the second visit would be an established patient visit.

Q28. We recently opened a mobile clinic and we were billing with a 99386 (initial comprehensive preventive medicine E/M service for new patients between the ages of 40 and 64) but they are being denied as noncovered charges. Are we supposed to be using a G-code?
A28. Yes. Medicare has different codes for annual wellness visits, G0438 (initial annual wellness visit) and G0439 (subsequent annual wellness visit). We suggest checking the patient's eligibility because another provider could have previously billed.

Q29. If the provider assesses the patient's injury and determines there's a fracture, is an E/M with modifier 57 appropriate with fracture care the same day?
A29. Yes. If the procedure has a 90-day global period, the decision to determine the fracture care would be able to be billed with modifier 57.

Q30. We perform a septoplasty, CPT 30520, with additional services. The septoplasty has to be pre-authorized for Part A and our claim for additional services under Part B pays. However, it may be recouped because the hospital did not obtain this authorization. How do we get the codes that don't require authorization paid?
A30. Because all related codes to the code that requires prior authorization will be performed, if the code that requires the authorization is not approved, then all related services will be denied. Here's the current list of services *(blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, vein ablation, spinal cord neurostimulator, cervical fusion, and facet joint intervention for pain management)*. Septoplasty is not listed at this time. Check our Noridian Part A website, under Medical Review, Prior Authorization

- JE A Medical Review-Prior Authorization
- JF A Medical Review-Prior Authorization

Q31. We are a retail pharmacy and billing for oral oncology medications. Where are the requirements for patient signatures if we ship the medication to the patient?
A31. When the method of delivery is shipping (also known as Method 2), Method 2 does not require a signature. Here are the proof of delivery requirements:

- Beneficiary's name
- Delivery address
- Delivery service's package identification number, supplier invoice number, or alternative method that links the supplier's delivery documents with the delivery service's records
- Description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, long description of a HCPCS code, or a brand name and/or model number

- Quantity delivered
- Date delivered
- Evidence of delivery

Billing Tips for Psychotherapy with Evaluation & Management (E/M)

To be paid correctly for a psychotherapy visit with E/M, certain documentation is required. The psychotherapy and medical components of the notes must be significant and separately identifiable. The Comprehensive Error Rate Testing (CERT) contractor reviews medical records on samples of processed claims. Review findings may include elements necessary to improve documentation and ensure the service for psychotherapy and E/M was supported.

Psychotherapy with an eligible E/M service can be reported using an E/M code **plus** a psychotherapy add-on code when performed on the same day (review CMS NCCI add-on codes).

- E/M key components - history, examination, and medical decision-making
- Must be separately identifiable from psychotherapy service
- 90833 - Psychotherapy, 30 minutes with patient when performed with E/M
- 90836 - Psychotherapy, 45 minutes with patient when performed with E/M
- 90838 - Psychotherapy, 60 minutes with patient when performed with E/M

To bill psychotherapy on the same day as an E/M visit:

- Two services must be significant and separately identifiable
- Focus is on patient with their presence required for all or majority of time
- Time spent for each service must be clearly documented in the medical record by number of minutes, or start and stop times, for each service.

The CPT code book provides the following information on these codes:

- Type and level of E/M service selected based on medical decision-making
- Time spent on E/M activities not used to report time for psychotherapy
- Time may not be used as basis of E/M code selection
- Prolonged services may not be reported when psychotherapy with E/M services are reported

Resources

- CMS Medical Documentation for Behavioral Health Practitioners
- JE Part B Comprehensive Error Rate Testing (CERT) Documentation and Psychotherapy
- JE Part B Mental Health

News

Clinical Trials and Claim Submission

As a reminder, the following is required for a claim to be processed:

- Clinical trial number - Item 19, or electronic equivalent
- Modifier - Q0 and/or Q1
- ICD-10 code Z00.6

Note: Information included is for billing and coding purposes only and is not meant to imply guarantee of coverage and/or payment.

As of 2014, per CMS Change Request (CR) 8401, a clinical trial number is mandatory on all claims. At that time, CMS required contractors to require an eight-digit clinical trial number. More information can be found at the CMS Internet Only Manual (IOM), Publication 100-04, Claims Processing Manual, Chapter 32, Section 69.

This aligns with the CMS Clinical Trial Policy outlined in CAG-00071R2. Noridian is recommending that the current hard-coded edits be revised to better align with published guidance.

Sub-regulatory guidance on billing and payment for qualifying clinical trial services was posted in 2014, and entities billing for these services are thoroughly acquainted with the terms required for Medicare reimbursement.

Thus, the revision to the edits should not pose an extra burden to suppliers or providers.

Note: This is a reminder that clinical trials that are also investigational device exemption (IDE) trials must continue to report the associated IDE number on the claim form as well.

Resources

- Clinical Trials Coverage and Billing Guide
- CMS NCD - Routine Costs in Clinical Trials (310.1)
- HHS MM8401

DMEPOS Fee Schedules and Labor Payment - 4th Quarter 2024 Update

Updates to the DMEPOS Jurisdiction listing for 4th quarter 2024 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

Evaluation and Management: Prescription Drug Management

The American Medical Association (AMA) owns the CPT codes and CMS has an agreement with the AMA to use these codes. When CMS does not develop separate policy, Noridian will follow the AMA Evaluation and Management (E/M) guidelines.

Prescription drug management may be part of the Medical Decision Making (MDM) element when choosing the level of E/M code supported by documentation. The variables involved when determining the risk will depend on the patient's condition(s), age, co-morbidities, lifestyle, and other medications. One patient with Coronary Obstructive Pulmonary Disease (COPD) will have different risks when compared to other patients with COPD. One may be older, one may have diminished health, or one may have cancer with COPD.

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of an E/M visit. There is a mindset that because it says prescription (RX) management, if a provider prescribes, the risk level qualifies as moderate. A prescription being written or discontinued, or a decision to maintain a current medication or dosage would need to be supported in documentation that the provider evaluated the medications.

Note: Simply listing current medications is not considered "prescription drug management."

Documentation for prescription drug management would need to show the work and/or risk involved by the billing provider when managing a prescription.

- Is the prescription something that could be harmful to the patient's health?
- Will it interact with other drugs the patient is taking?
- Is the prescription a non-complex drug for a patient with no allergies or complications? Example - a patient taking anticoagulants.
- Did the patient have a stroke and is there a risk they may sustain a subsequent hemorrhage?

Additional considerations for prescription drugs that may support risk management when included in the documentation:

- Ability of a patient to self-administer the medication. Education to the patient on performing injectables or ability to open a pill bottle and take a pill out.
- Caregiver or family member at home to monitor the effects of the drug.
- Any concern about the patient's understanding with taking their medication.

Adding new or deleting drug(s) should include narrative in the medical note to explain why the change was made.

If determining the level of E/M code based on total time, the MDM elements would not apply.

AMA Publication

Appropriate documentation of prescription drug management continues to be an opportunity for many physicians. Doctors need to know that simply adding the current medication list to the progress note is not adequate. Prescription drug management is based on documented evidence that the physician has evaluated medications as part of a service that is provided. Physicians should make a direct connection between the medication that is prescribed to the patient and the work that was performed on the day of the clinic visit, such as: "Stable hypertension; continue valsartan 10 milligrams, will refill for 4 months until next follow-up visit." Simply stating that the medication list was reviewed will not meet the definition of prescription management.

AMA 2023 Webinar Questions and Answers

There is no "blanket" guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management.

Additional Resource

- AMA Evaluation and Management (E/M) Guidelines 2023

This article is written at the suggestion of the Provider Outreach and Education Advisory Group.

How to Avoid Common Appeals Mistakes Appeals Newsletter Part 13

The Appeals team has seen an increase in two common mistakes that we would like to help your office avoid.

1. Adding lines that were not submitted on the original claim through an appeal
   - If your office forgot to bill a claim line (procedure code), a new claim needs to be submitted. This cannot be added in reopenings or redeterminations.
   - Whether paper or electronic form is used, make sure that the appeal provides specific details in the comment section.
2. Timeliness for appeal levels
   There is very little room for waiving late file on an appeal. There needs to be good cause shown as the reason the appeal couldn't be submitted in the 120 days allowed. Some of those good cause reasons include:
   - Provider recoupment

- Natural disaster
- Administrative delay by the contractor
- Incorrect or incomplete information about the subject claim and/or appeal was furnished by official sources

Use the timely filing tool to determine the last day for Noridian to receive your appeal. This page has timeliness calculators for all stages through the Administrative Law Judge (ALJ) Hearing level.

Resource: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 29, Section 310.2

Incarcerated Claim Denials - Resolved 11/04/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable

Claim Coding Impact: Not applicable

Description of Issue: Noridian is aware of an issue with claims potentially denying for incarcerated status when the beneficiary does not have incarcerated record(s). Claims denying with CARC 258 "Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service."

Noridian Action: Noridian continues to work with the shared systems maintainer for a resolution. Claims identified will be suspended to reduce the volume of incorrect denials and the issue can be resolved.

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

Proposed Resolution/Solution: The shared systems maintainer is working to resolve the issue.

11/04/24 - Noridian initiated mass adjustments on or before 10/30/24.

10/15/24 - The incarcerated file was updated on 09/23/24. Noridian will initiate adjustments by 10/25/24. Noridian will provide another update when all mass adjustments are initiated.

09/20/24 - No updates. Noridian is monitoring the issue and will provide updates as they are available.

09/05/24 - No updates. Noridian is monitoring the issue and will provide updates as they are available.

Date Reported: 08/15/24

Date Resolved: 11/04/24

Influenza (Flu) Vaccine Denials - Resolved 11/01/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable.

Claim Coding Impact: Vaccine and Influenza

Description of Issue: Noridian is aware that this season's influenza codes, and their admins (G0008-G0009) not processing based on the current CMS Influenza season code list. This issue impacted claims with dates of service on/after August 1, 2024. All system updates for influenza codes are implemented during the fall of each year. All updates have been completed and all incorrectly denied or mispriced influenza codes for this season will be reprocessed.

Noridian Action Required: The system update was completed on September 12 to no longer deny the impacted procedure codes for dates of service on/after August 1, 2024. Noridian will conduct a mass adjustment for claims denied in error.

Provider/Supplier Action Required: None

Proposed Resolution/Solution:

11/01/24 - Noridian initiated mass adjustments on or before 10/31/24.

10/17/24 - Noridian started initiating mass adjustments on 09/16/24. Noridian will provide another update once all mass adjustments have been initiated.

09/27/24 - Noridian started initiating mass adjustments on 09/16/24.

Date Reported: 09/12/24

Date Resolved: 11/01/24

Intraocular Bevacizumab Denials - Resolved 12/24/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable

Claim Coding Impact: Billing and Coding: Intraocular Bevacizumab (A53008/A53009) CPT/HCPCS codes.

Description of Issue: Noridian is aware of a claims processing issue involving the Billing and Coding: Intracocular Bevacizumab article. Claims are deying incorrectly with CARC 50, "These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Noridian Action Required: Noridian is correcting the system and will be adjusting impacted claims once system updates are complete.

Provider/Supplier Action Required: None

Proposed Resolution/Solution: Noridian to correct system and adjust claims. System corrected on 12/12/24. Mass Adjustment was completed on 12/24/24. All affected claims have reentered the system for reprocessing.

Date Reported: 12/12/24

Date Resolved: 12/24/24

Medicare Billing for Physical, Occupational and, Speech Therapy Based on Minutes

What is the 8-Minute Rule? To receive payment from Medicare for a time-based CPT code, a therapist must provide direct treatment for at least eight minutes. Providers must add the total minutes of skilled, one-on-one therapy and divide by 15. If eight or more minutes remain, you can bill one more unit. For additional information see CMS IOM Medicare Claims Processing Manual 100-4, Chapter 5

New Timeframe for Prior Authorization Decisions

CMS is changing the review timeframe for standard prior authorization decisions from 10 business days to seven calendar days for requests submitted on or after January 1, 2025. The timeframe for expedited requests remains two business days.

Source: Prior Authorization for Certain Hospital Outpatient Department (OPD) Services

Notification of the 2025 Dollar Amount in Controversy Required to Sustain Appeal Rights for an ALJ Hearing or Federal District Court Review

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2025, for an Administrative Law Judge (ALJ) Hearing is **$190**.

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2025, for a Federal District Court Review is **$1,900**.

News

Submitting Documentation for Review

When sending documentation to Noridian, we wanted providers to be aware of correct practices to make sure documentation can be viewed in a timely manner.

Noridian can accept documentation by the following methods:

- Hardcopy
- Electronically by CD, DVD, or USB
- Noridian Medicare Portal (NMP)
- Fax
- esMD

Electronic documents must be in either a .pdf or .tiff format. No other format such as .jpgs or .xcl (Excel spreadsheets) can be used.

Large file sizes make it hard for our teams to open the document, so try to keep each form of media (CD, DVD, or USB) to 100 KBs.

Always place Noridian documentation request letter as the first page.

Be sure to encrypt your digital media and send the password to NHSPass@noridian.com.

- Only use one password for the entire media and not individual passwords for each file.
- Noridian will only accept CD/DVD/USBs that are encrypted using Adobe Security, WinZip, 7-Zip or Secure Zip
- Links and audio files cannot be accepted
- Information should be combined into one file

Resource

JEB Options for Submitting Documentation

System Availability Notices

The Noridian Medicare Portal (NMP) Team is proud to announce an enhancement to the Availability section of NMP. We are now able to offer a “Partial Availability” option, which will be displayed when some inquiries may not be available. This status will be indicated by a yellow banner to inform users of potential limited access and will include which inquiries may be unavailable. The following section outlines the different notifications users can expect to see regarding the status of NMP, helping ensure transparency and clarity in service availability.

Status	Banner Color	Explanation
System Normal	Green	All Functions Available
Partial Availability	Yellow	Some inquiries may not be available or delayed
Functions Unavailable	Red	All inquiries are unavailable

This enhancement ensures users are kept informed about the system's status, allowing them to manage expectations and plan accordingly. With these updates, the NMP Team aims to provide a more efficient and reliable experience, helping users navigate any potential disruptions smoothly.

Updated Trigger Point Injections Local Coverage Determination (LCD) Policy Appeals Newsletter Part 14

Effective April 2024, Noridian updated the LCD and Local Coverage Article (LCA) for trigger point injections policy. Some of the updates are highlighted below. This is a general overview and not an exhaustive list of the policy changes and coverage article. It is covered for refractory pain associated with trigger points that do not respond to conservative therapy

As the treating provider and medical record author, review the requirements included in the updated LCD to verify Medicare coverage, or possibly obtaining an Advance Beneficiary Notice of Non-coverage (ABN) from the beneficiary if a denial is expected. Make sure the billing and coding staff are aware to avoid unnecessary denials.

Medically necessary and reasonable requirements for initial trigger point injections:

1. There is a focal area of pain in the skeletal muscle.
2. There is clinical evidence of a trigger point defined as pain in a skeletal muscle that is associated with at least two of the following findings: the presence of a hyperirritable spot and/or taut band identified by palpation and possible referred pain AND
3. The physical examination identifies a focal hypersensitive bundle or nodule of muscle fiber harder than normal consistency with or without a local twitch response and referred pain AND
4. Non-invasive conservative therapy is not successful as first line treatment OR movement of a joint or limb is limited or blocked OR the TPI is necessary for diagnostic confirmation.

News

Please review the LCD for **subsequent** trigger point injection requirements.

Utilization

- No more than three trigger point injection sessions in a rolling 12 months
- 20552 - Injection(s); single or multiple trigger point(s); 1 or 2 muscles
- 20553 - Single or multiple trigger point(s); 3 or more muscles
- Pre- and post-injection pain scales must be indicated in the medical record

Medication

- Medication used is reported with a HCPCS drug code "J-code" or a revenue code
- Unclassified drugs (J3490, J9999, or C9399) must report the drug and dosage in Box 19 or its electronic equivalent
- C3999 is only for use in an Ambulatory Surgical Center (ASC)
- There are no current FDA approved biologicals for use as a trigger point injectable agent and billing these may result in a claim denial based on Internet Only Manual (IOM) Medicare Benefit Policy Manual 100-02 Chapter 16 Section 180
- No anesthesia codes should be billed in conjunction with 20552 or 20553

Resources

- Article - Billing and Coding: Trigger Point Injections (TPI) (A57701)
- LCD - Trigger Point Injections (TPI) (L34211)

2024 CPT/HCPCS Local Coverage Article (LCA) Updates

Date Posted: October 3, 2024

These Local Coverage Articles (LCA) have been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Effective Date: October 1, 2024

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

MCD Number	LCA Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A56119	Billing and Coding: Billing Limitations for Pharmacies	90684	N/A	N/A

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

2024 ICD-10 Billing and Coding Article Updates - Effective October 1, 2024

Date Posted: October 3, 2024

The following Billing and Coding Articles have been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV). All LCD LCAs are titled with "Billing and Coding: LCD title"

Effective Date: October 1, 2024

Summary of Changes: The following Billing and Coding Articles have been updated to include and/or remove ICD-10 codes.

Medical Policies and Coverage

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A57183	Billing and Coding: Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography	N/A	Q23.8	N/A
A57206	Billing and Coding: Lumbar MRI	C81.0A, C81.1A, C81.2A, C81.3A, C81.4A, C81.7A, C82.0A, C82.1A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C83.0A, C93.390, C93.398, C83.3A, C84.0A, C84.1A, C84.ZA, C85.2A, C85.8A, M62.85, T81.320A, T81.320D, T81.320S, T81.321A, T81.321D, T81.321S, T81.328A, T81.328D, T81.328S, T81.329A, T81.329D, T81.329S	C83.39, C86.0, C86.1. C86.2, C86.3, C86.4, C86.5, C86.6, C88.2, C88.3, C88.8, M51.36, M51.37, T81.32XA, T81.32XD	N/A
A55530	Billing and Coding: Peripheral Nerve Stimulation	M62.85	M62.5A2	N/A
A53008	Billing and Coding: Intraocular Bevacizumab	N/A	N/A	H44.2A3, H44.2B3, H44.2C3, H44.2D3, H44.2E3
A57224	Billing and Coding: Respiratory Care	E88.82, I26.03, I26.04, I26.95, I26.96	N/A	I26.93, I26.94

Medical Policies and Coverage

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A55001	Billing and Coding: Urine Drug Testing	N/A	M51.36, M51.37	N/A
A53026	Billing and Coding: Bariatric Surgery Coverage	M51.360, M51.361, M51.362, M51.369, M51.370, M51.371, M51.372, M51.379, M62.85	M51.36, M51.37	N/A
A55028	Billing and Coding: Lab: Bladder/Urothelial Tumor Markers	E34.00, E34.01, E34.09	E34.00	N/A
A57326	Billing and Coding: Electrocardiogram	I26.03, I26.04, I26.95, I26.96, Q23.81, Q23.82, Q23.88	Q23.8	I26.93, I26.94
A57689	Billing and Coding: Lab: Flow Cytometry	N/A	C83.39, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3. C88.4, C88.8, C88.9, E34.0	N/A
A57189	Billing and Coding: Serum Magnesium	F50.01, F50.011, F50.012, F50.013, F50.014, F50.019,F50.020, F50.021, F50.022, F50.023, F50.024, F50.029, F50.20, F50.21, F50.22, F50.23, F50.24, F50.25, F50.810, F50.811, F50.812, F50.813, F50.814, F50.819, F50.83, F50.84, I26.03, I26.04, I26.95, I26.96, Z92.26	F50.01, F50.02, F50.2, F50.81	I26.93, I26.94

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A57204	Billing and Coding: MRI and CT Scans of the Head and Neck	C81.0A, C81.1A, C81.2A, C81.3A, C81.4A, C81.7A, C81.9A, C82.0A C82.1A, C82.2A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C82.9A, C83.0A, C83.1A, C83.390, C83.398, C83.3A, C83.5A, C83.7A, C83.8A, C83.9A, C84.0A, C84.1A, C84.4A, C84.6A, C84.7B, C84.9A, C84.AA, C84.ZA, C85.1A, C85.2A, C85.8A, C85.9A, E34.00, E34.01, E34.09, G40.841, G40.842, G40.843, G48.844, G93.45, R41.85, Z86.0100, Z86.0101, Z86.0102, Z86.0109	C83.39, C86.0, C86.4, C86.5, C86.6, C88.0, C88.2, C88.4, C88.8, C88.9, E34.0, G90.8	N/A
A57342	Billing and Coding: Diagnostic and Therapeutic Colonoscopy	E34.00, E34.01, E34.09, Z86.0101, Z86.0102, Z86.0109	E34.0, Z86.010	N/A
A59175	Billing and Coding: Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-cell or T-cell Origin	N/A	C83.39, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9	N/A

Medical Policies and Coverage

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A58865	Billing and Coding: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound	M51.360, M51.361, M51.362, M51.369, M51.370, M51.371, M51.372, M51.379, M62.85, M65.90, M65.911, M65.912, M65.919, M65.921, M65.922. M65.929, M65.931, M65.932, M65.939, M65.941, M65.942, M65.949, M65.951, M65.952, M65.959, M65.971, M65.972, M65.979, M65.98, M65.99	M51.36, M51.37, M65.9	N/A
A54969	Billing and Coding: Nerve Conduction Studies and Electromyography	M51.361, M51.362, and M51.371	G90.8, M51.36, and M51.37	N/A
A57718	Billing and Coding: Vitamin D Assay Testing	C82.0A, C82.1A, C82.2A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C82.9A	N/A	N/A
A58565	Billing and Coding: Wound and Ulcer Care	T81.320A, T81.320D, T81.320S, T81.321A, T81.321D, T81.321S, T81.328A, T81.328D, T81.328S, T81.329A, T81.329D, T81.329S	T81.32XA, T81.32XD, T81.32XS	N/A

Visit the Billing and Coding Articles webpage or the Active LCD webpage to view the Billing and Coding Article or access it via the CMS Medicare Coverage Database (MCD).

2024 Q4 MolDX CPT/HCPCS Billing and Coding Article Updates - Effective October 1, 2024

Date Posted: October 10, 2024

The following MolDX Billing and Coding Articles have been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Effective Date: October 1, 2024

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

MCD Number	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A57331	Billing and Coding: MolDX: Repeat Germline Testing	0476U, 0477U, 0500U, 0516U	0078U	**NA**
A58168	Billing and Coding: MolDX: Molecular Testing for Solid Organ Allograft Rejection	0508U, 0509U	**NA**	**NA**

Visit the Active MolDX Billing and Coding Articles webpage or the Active MolDX LCD webpage to view the Billing and Coding Article or access it via the CMS Medicare Coverage Database (MCD).

2024 Q4 MolDX CPT/HCPCS Billing and Coding Article Updates - Effective October 1, 2024

Date Posted: October 10, 2024

The following MolDX Billing and Coding Articles have been revised under contractor numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Effective Date: October 1, 2024

Medical Policies and Coverage

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

MCD Number	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A57526	Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	Effective January 1, 2020- 0152U Effective April 1, 2022- 0321U Effective October 1, 2024- 0476U, 0477U, 0478U, 0480U, 0481U, 0485U, 0486U, 0487U, 0488U, 0489U, 0490U, 0491U, 0492U, 0493U, 0494U, 0495U, 0496U, 0497U, 0498U, 0499U, 0500U, 0501U, 0504U, 0505U, 0506U, 0507U, 0508U, 0509U, 0510U, 0511U, 0516U	0078U, 0396U	0403U
A58973	Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors	0485U		
A59641	Billing and Coding: MolDX: Proteomics Testing	0503U		

Visit the Active MolDX Billing and Coding Articles webpage or the Active MolDX LCD webpage to view the Billing and Coding Article or access it via the CMS Medicare Coverage Database (MCD).

Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA) Final LCD - Effective December 8, 2024

Date Posted: November 4, 2024

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
L39881	Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Medicare Coverage Database Number	Billing and Coding Article Title
A59769	Billing and Coding: Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Medicare Coverage Database Number	Response to Comments
A59935	Response to Comments: Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Effective Date: December 8, 2024

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

Billing and Coding: Cervical Fusion (A59624) - R2 - Effective September 29, 2024

Date Posted: October 10, 2024

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

Effective Date: September 29, 2024

Summary of Changes:

CPT codes 22614 and 22585 were removed from the CPT/HCPCS Codes section under Group 1.

The following ICD-10-cm codes were added to the ICD-10-CM Codes that Support Medical Necessity section under Group 1: S12.01XB, S12.01XG, S12.01XK, S12.01XS, S12.02XA, S12.02XB, S12.02XD, S12.02XG, S12.02XK, S12.02XS, S12.030A, S12.030B, S12.030D, S12.030G, S12.030K, S12.030S, S12.031B, S12.031G, S12.031K, S12.031S, S12.040A, S12.040B, S12.040D, S12.040G, S12.040K, S12.040S, S12.041B, S12.041G, S12.041K, S12.041S, S12.090A, S12.090B, S12.090G, S12.090K, S12.090S, S12.091A, S12.091B, S12.091G, S12.091K, S12.091S, S12.100A, S12.100B, S12.100D, S12.100G, S12.100K, S12.100S, S12.101B, S12.101G, S12.101K, S12.101S, S12.110A, S12.110B, S12.110G, S12.110K, S12.110S, S12.111A, S12.111B, S12.111G, S12.111K, S12.111S, S12.120A, S12.120B, S12.120G, S12.120K, S12.120S, S12.131A, S12.131B, S12.131G, S12.131K, S12.131S, S12.14XA, S12.14XB, S12.14XD, S12.14XG, S12.14XK, S12.14XS, S12.150A, S12.150B, S12.150D, S12.150G, S12.150K, S12.150S, S12.151A, S12.151B, S12.151D, S12.151G, S12.151K, S12.151S, S12.190A, S12.190B, S12.190D, S12.190G, S12.190K, S12.190S, S12.191B, S12.191G, S12.191K, S12.191S, S12.200A, S12.200B, S12.200D, S12.200G, S12.200K, S12.200S, S12.201A, S12.201B, S12.201D, S12.201G, S12.201K, S12.201S, S12.231B, S12.231G, S12.231K, S12.231S, S12.24XA, S12.24XB, S12.24XG, S12.24XK, S12.24XS, S12.250A, S12.250B, S12.250D. S12.250G, S12.250K, S12.250S, S12.251A, S12.251B, S12.251D, S12.251G, S12.251K, S12.251S, S12.290A, S12.290B, S12.290D, S12.290G, S12.290K, S12.290S, S12.291A, S12.291B, S12.291D, S12.291G, S12.291K, S12.291S, S12.300A, S12.300B, S12.300D, S12.300G, S12.300K, S12.300S, S12.301A, S12.301B, S12.301D, S12.301G, S12.301K, S12.301S, S12.331B, S12.331G, S12.331K, S12.331S, S12.34XA, S12.34XB, S12.34XD, S12.34XG, S12.34XK, S12.34XS, S12.350A, S12.350B, S12.350D, S12.350G, S12.350K, S12.350S, S12.351B, S12.351D, S12.351G, S12.351K, S12.351S, S12.390A, S12.390B, S12.390D, S12.390G, S12.390K, S12.390S, S12.391B, S12.391G, S12.391K, S12.391S, S12.400A, S12.400B, S12.400D, S12.400G, S12.400K, S12.400S, S12.401B, S12.401D, S12.401G, S12.401K, S12.401S, S12.431A, S12.431B, S12.431G, S12.431K, S12.431S, S12.44XA, S12.44XB, S12.44XD, S12.44XG, S12.44XK, S12.44XS, S12.450A, S12.450B, S12.450D, S12.450G, S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S,

S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501G, S12.501K, S12.501S, S12.531A, S12.531B, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591B, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601B, S12.601G, S12.601K, S12.601S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G, S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691B, S12.691G, S12.691K, S12.691S.

Effective Date: August 22, 2024

The following ICD-10-CM codes were added to the ICD-10-CM Codes that Support Medical Necessity section under Group 1: C41.2, G06.1, M06.88, M40.03, M40.12, M40.202, M40.292, M41.22, M43.12, M43.13, M46.21, M46.22, M46.23, M46.41, M46.42, M46.43, M46.51, M48.31, M48.32, M48.33, M48.42XA, M48.42XD, M48.42XG, M48.43XA, M48.43XG, M48.43XS, M48.51XA, M48.51XG, M48.51XS, M48.52XA, M48.52XG, M48.52XS, M48.53XA, M48.53XG, M50.10, M50.120, M50.20 - M50.33, M53.2X3, M96.0, M96.1, S12.000A, S12.000B, S12.000D, S12.000G, S12.000K, S12.000S, S12.001A, S12.001B, S12.001D, S12.001G, S12.001K, S12.001S, S12.130A, S12.130B, S12.130D, S12.130G, S12.130K, S12.130S, S12.230A, S12.230B, S12.230D, S12.230G, S12.230K, S12.230S, S12.330A, S12.330B, S12.330D, S12.330G, S12.330K, S12.330S, S12.430A, S12.430B, S12.430D, S12.430G, S12.430K, S12.430S, S12.530A, S12.530B, S12.530D, S12.530G, S12.530K, S12.530S, S12.630A, S12.630B, S12.630D, S12.630G, S12.630K, S12.630S, S12.9XXA, S12.9XXD, S12.9XXS, S13.101A, S13.101D, S13.101S, S13.110A, S13.110D, S13.110S, S13.111A, S13.111D, S13.111S, S13.120A, S13.120D, S13.120S, S13.121A, S13.121D, S13.121S, S13.130A, S13.130D, S13.130S, S13.131A, S13.131D, S13.131S, S13.140A, S13.140D, S13.140S, S13.141A, S13.141D, S13.141S, S13.150A, S13.150D, S13.150S, S13.151A, S13.151D, S13.151S, S13.160A, S13.160D, S13.160S, S13.161A, S13.161D, S13.161S, S13.170A, S13.170D, S13.170S, S13.171A, S13.171D, S13.171S, S13.180A, S13.180D, S13.180S, S13.181A, S13.181D, S13.181S, S13.20XA, S13.20XD, S13.20XS, S13.29XA, S13.29XD, S13.29XS.

Updated language for modifier GX.

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

Medical Policies and Coverage

Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP) A58223 - R3 - Effective September 15, 2024

Date Posted: October 17, 2024

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

Effective Date: September 15, 2024

Summary of Changes: Added additional ICD-10-CM codes to Group 1: G43.401, G43.409, G43.411, G43.419, G45.1, G46.0, G81.01, G81.02, G81.03, G81.04, G81.91, G81.92, G81.93, G81.94, I63.231, I63.232, I69.320, I69.321, I69.322, I69.323, I69.351, I69.352, I69.353, I69.354, I69.992, R26.0, R41.4, R47.01, R47.02, R47.1.

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

Billing and Coding: Facet Joint Interventions for Pain Management (A58403) - R6 - Effective January 1, 2025

Date Posted: December 26, 2024

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

Effective Date: January 1, 2025

Summary of Changes:

Effective: 01/01/2025

Removed Bill Type code 083X and Revenue code 049X. Added clarifying language under the levels section, laterally section, and diagnostic and therapeutic procedures section.

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R18 - Effective October 1, 2024

Date Posted: October 3, 2024

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

Effective Date: October 1, 2024

Summary of Article Changes:

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

Effective 10/01/2024 - 12/31/2024

Prialt (Ziconotide) = $9.649

Ropivacaine = $0.062

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

Billing and Coding: Lab: Cystatin C Measurement (A57643) - R5 - Effective January 1, 2023

Date Posted: October 24, 2024

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

Effective Date: January 1, 2023

Summary of Changes:

Revision Effective Date: 01/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM codes N06.0, N06.3, N06.4, N06.5, N06.6, N06.7, N06.8, N06.9, N06.A, N17.0, N17.1, N17.2, N17.8, N17.9, N18.2, N18.4, N18.5, O12.10, O12.11, O12.12, O12.13, O12.14, O12.15, O12.20, O12.21, O12.22, O12.23, O12.24, O12.25, Q61.00, Q61.01, Q61.02, Q61.11, Q61.19, Q61.2, Q61.3, Q61.4, Q61.5, Q61.8, Q61.9, R31.0, R31.1, R31.21, R31.29, R31.9, R79.89, R80.0, R80.1, R80.2, R80.3, R80.8, R80.9 to Group 1 Codes

10/24/2024: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination. This revision is due to the 2024 Annual ICD-10 updates.

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

Billing and Coding: Lab: Flow Cytometry (A57689) - R11 - Effective October 1, 2024

Date Posted: November 15, 2024

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

Effective Date: October 1, 2024

Summary of Article Changes: Under ICD-10-CM Codes that Support Medical Necessity Group 1 added:

R22.0, R22.1, R22.2, R22.31, R22.32, R22.33, R22.41, R22.42, R22.43.

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

Billing and Coding: MolDX: ApoE Genotype (A55094) Retirement - Effective September 27, 2024

Date Posted: October 3, 2024

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

Effective Date: September 27, 2024

Summary:

This article will be retiring because the information in this article has been incorporated within the Billing and Coding: MolDX: Pharmacogenomics Testing A57384.

Visit the CMS Medicare Coverage Database (MCD) to access the Retired articles.

Billing and Coding: MolDX: Genetic Testing for Hypercoagulability / Thrombophilia (Factor V Leiden, Factor II Prothrombin, and MTHFR) (A57423) - R4 - Effective November 7, 2024

Date Posted: November 7, 2024

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

Effective Date: November 7, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** revised the following regulation: 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. Under ***Article Text*** revised 3rd and 6th bullets to remove "DEX Z-Code™ " and replaced with "DEX Z-Code®". Added "NOTE: When entering the DEX Z-Code® on the SV101-7 documentation field for Part B claims please do not add additional characters and/or information on the line". Under CPT/HCPCS Codes Group 1: Codes added: 81400.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Minimal Residual Disease Testing for Hematologic Cancers (A58997)- R7 - Effective October 1, 2024

Date Posted: October 3, 2024

This Local Coverage Article (LCA) has been revised under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

Effective Date: October 1, 2024

Summary of Changes:

Updated to add C84.0A to ***Group 1 ICD-10 Codes*** table as it was missed in the previous update. This revision is effective for 10/01/2024.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Medical Policies and Coverage

Billing and Coding: MolDX: Minimal Residual Disease Testing for Hematologic Cancers (A58996) - R8 - Effective July 11, 2024

Date Posted: November 14, 2024

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

Effective Date: July 11, 2024

Summary of Changes:

Under ***Article Text*** added verbiage, "Mantle Cell Lymphoma" to the Indicated Uses and Limitations box. ***Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added*** C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, and C83.19. This revision is effective for 7/11/2024.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58718) - R4 - Effective November 28, 2024

Date Posted: December 2, 2024

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

Effective Date: November 28, 2024

Summary of Changes:

Under ***CPT/HPCS Codes Group 1: Paragraph added*** "MyProstate Score 2.0 (MPS 2.0) (PLA 0403U), performed on non-DRE urine specimens". Under ***CPT/HCPCS Codes Group 1: Codes added*** 0403U. Under ***CPT/HPCS Codes Group 2: Paragraph added*** "MyProstate Score 2.0 (MPS 2.0) (PLA 0403U), performed on non-DRE urine specimens". Under ***CPT/HCPCS Codes Group 2: Codes added*** 0403U. Formatting was corrected throughout the article. This revision is due to new covered assay that has successfully completed a TA and is effective 9/11/2024.

Under ***CPT/HPCS Codes Group 1: Paragraph added*** "ExoDX Prostate assay (PLA 0005U), performed on non-DRE urine specimens". Under ***CPT/HPCS Codes Group 2: Paragraph added*** "ExoDX Prostate assay (PLA 0005U), performed on non-DRE urine specimens". This revision is due to covered assay that has successfully completed a TA and is effective 12/27/2023.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing: (A58720) - R22 - Effective September 13, 2024

Date Posted: December 5, 2024

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

Effective Date: September 13, 2024

Summary of Changes:

Under ***CPT/HCPCS Codes Group 12: Paragraph*** added "Onychomycosis Panels: This code is only reimbursed for patients with a confirmed histopathologic diagnosis of an infiltrative/invasive fungal onychomycosis and whose culture (and antifungal susceptibility) of the nail is negative or cannot be performed." ***Under CPT/HCPCS Codes Group 12: Codes added*** 87999. ***Under CPT/HCPCS Modifiers Group 12: Codes added*** 59. ***Under ICD-10 Codes that Support Medical Necessity Group 12: Paragraph added*** "These are the diagnosis codes corresponding to coverage of CPT/ HCPCS Codes Group 12: Codes-Onychomycosis Panels." ***Under ICD-10 Codes that Support Medical Necessity Group 12: Codes added*** B35.1. This revision is effective 9/13/2024.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Pharmacogenomics Testing (A57384) - R14 - Effective August 1, 2024

Date Posted: October 24, 2024

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

Effective Date: August 1, 2024

Summary of Changes:

Under ***Article Text*** revised Table 2 to add HLA-A for afamitresgene autoleucel. This revision is due to FDA guidelines and is effective August 1, 2024.

Medical Policies and Coverage

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: Peripheral Nerve Stimulation (A55530) - R9 - Effective October 1, 2024

Date Posted: October 17, 2024

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

Effective Date: October 1, 2024

Summary of Changes:

Revision Effective Date: 10/01/2024

Under 'Article Text' Part B claims, corrected the ICD-10-CM code for Restorative Neurostimulation Therapy to M62.85. This change is effective 10/01/2024.

10/01/2024: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

Billing and Coding: Respiratory Care (A57224) - R16 - Effective October 1, 2024

Date Posted: October 10, 2024

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

Effective Date: October 1, 2024

Summary of Article Changes:

Revision Effective Date: 10/01/2024

ARTICLE GUIDANCE:

Revised: Under 'Pulmonary Function Testing codes' #4, corrected the codes listed due to typographical errors. 96417 was corrected to 94617, 96418 was corrected to 94618, and 96421 was corrected to 94621.

10/01/2024: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

MolDX: Blood Product Molecular Antigen Typing (L38331) - R5 - Effective November 7, 2024

Date Posted: November 7, 2024

This MolDX 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: November 7, 2024

Summary of Changes:

Under ***Bibliography*** revised the broken hyperlink for the twenty-fourth reference and changes were made to citations to reflect AMA citation guidelines. This revision is effective on 11/7/2024.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCD or access it via the CMS MCD.

Part B Editing for NCD 110.21 - Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions

Noridian has identified a need to update editing in relation NCD 110.21, Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions for Medicare Part B claims.

Effective January 1, 2025, system editing for Medicare Part B claims will reflect the NCD requirements in relation to the hematocrit and hemoglobin levels. The NCD states:

> "shall deny non-ESRD ESA services for HCPCS J0881, J0885, Q5106 (7/1/18) billed with modifier -EA (ESA, anemia, chemo-induced) for anemia secondary to myelosuppressive anti-cancer chemotherapy in solid tumors, multiple myeloma, lymphoma, and lymphocytic leukemia when a hemoglobin 10.0g/dL or greater or hematocrit 30.0% or greater is reported."

Please refer to the following resources for any additional guidance:

- NCD - Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21) (cms.gov)
- Oncology / Hematology

Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers Final LCD - Effective February 12, 2025

Date Posted: November 14, 2024

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
L39760	Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Medicare Coverage Database Number	Billing and Coding Article Title
A59626	Billing and Coding: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Medicare Coverage Database Number	Response to Comments
A59950	Response to Comments: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Effective Date: February 12, 2025

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

MLN Connects

MLN Connects - October 3, 2024

MLN Connects Newsletter: Oct 3, 2024

News

- HHS Releases Final Guidance for Second Cycle of Historic Medicare Drug Price Negotiation Program
- Resources & Flexibilities to Assist with the Public Health Emergency in Florida, Georgia, North Carolina, Tennessee, & South Carolina
- CMS to Provide Hurricane Helene Public Health Emergency Accelerated Payments to Medicare Fee-for-Service Providers and Suppliers
- Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision (CMS-1808-IFC)
- CMS Covers PrEP to Prevent HIV
- Clinical Laboratory Fee Schedule: Submit Comments & Reconsideration Requests by October 25
- DMEPOS: Adding New Product Categories to CMS-855S Enrollment Form on October 26
- Improve Your Search Results for CMS Content
- Help Detect Breast Cancer Early

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: October Update
- PrEP for HIV Billing: CMS Requires Diagnosis Codes
- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: October Update

Events

- Hospital Price Transparency: Encoding January 2025 Requirements in the Machine-Readable File Webinar - October 21

Publications

- Substance Use Screenings & Treatment

MLN Connects

MLN Connects - October 10, 2024

MLN Connects Newsletter: Oct 10, 2024

News

- Resources & Flexibilities to Assist with the Public Health Emergency in Florida
- CMS Roundup (October 4, 2024)
- Clinical Laboratory Fee Schedule: Reporting Delayed Until 2026
- Respiratory Viruses: Vaccinate against Flu, COVID-19, & RSV

Compliance

- Allergy & Immunology Services: Prevent Claim Denials

Claims, Pricers, & Codes

- Outpatient Skin Substitute Claims: New Codes & Updates Effective October 1
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Multimedia

- Hospice Quality Reporting Program: HOPE Tool Web-Based Training

From Our Federal Partners

- First Marburg Virus Disease Outbreak in the Republic of Rwanda
- Enroll in EFT to Get Paid for CHAMPVA Claims

Information for Patients

- 2025 Medicare & You Handbook

MLN Connects - October 17, 2024

MLN Connects Newsletter: Oct 17, 2024

News

- Inpatient Psychiatric Facilities: Guidance on All-Inclusive Cost Reporting
- No-Pay Medicare Summary Notice Mailing Frequency Changed to Every 120 Days
- Health Literacy: Help Your Patients Get Information & Services

MLN Connects

Compliance

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

Claims, Pricers, & Codes

- National Uniform Billing Committee: New Codes Effective July 1
- PrEP for HIV Billing: CMS Requires Diagnosis Codes

Events

- HCPCS Public Meeting - November 6-8

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - October 2024 - Revised

Publications

- Medicare Preventive Services - Revised

MLN Connects - October 24, 2024

MLN Connects Newsletter: Oct 24, 2024

News

- CMS Roundup (October 18, 2024)
- Rural Health Clinic & Federally Qualified Health Center: Final CY 2024 Payment Policies

Claims, Pricers, & Codes

- Home Health Consolidated Billing: New Physician Specialty Code F6 Excluded

MLN Matters® Articles

- Allowing Home Health Telehealth Services During an Inpatient Stay
- Correction for Inpatient Medicare Part B Ancillary 12X Claims & Manual Updates
- Separate Payment for Essential Medicines - New Biweekly Interim Payments for the Inpatient Prospective Payment System
- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2025 Changes - Revised

MLN Connects

From Our Federal Partners

- Biosimilars: Updated Curriculum Toolkit
- Disruptions in Availability of Peritoneal Dialysis & Intravenous Solutions from Baxter International Facility in North Carolina

MLN Connects - October 31, 2024

MLN Connects Newsletter: Oct 31, 2024

News

- Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care

Compliance

- Major Hip & Knee Replacement or Reattachment of Lower Extremity: Prevent Claim Denials
- Comprehensive Error Rate Testing Medical Record Requests: Respond Timely

Claims, Pricers, & Codes

- PrEP for HIV Billing: CMS Requires Diagnosis Codes

Publications

- Prohibition on Billing Qualified Medicare Beneficiaries - Revised
- Provider Information on Medicare Diabetes Self-Management Training - Revised

MLN Connects - November 7, 2024

MLN Connects Newsletter: Nov 7, 2024

Final Rules

- Physician Fee Schedule CY 2025 Final Rule
- Hospital Outpatient Prospective Payment System & Ambulatory Surgical Center Payment System CY 2025 Final Rule
- ESRD Prospective Payment System CY 2025 Final Rule
- Home Health Prospective Payment System CY 2025 Final Rule

MLN Connects

News

- CMS Roundup (November 1, 2024)
- Respiratory Viruses: Get Up to Date on Flu, COVID-19, & RSV Vaccines
- Diabetes: Recommend Preventive Services

Compliance

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

Claims, Pricers, & Codes

- Expanded Diabetes Screening: Claims for HCPCS Code 82947 Returned in Error
- Home Intravenous Immune Globulin Items & Services: CY 2025 Rate Update
- Discarded Drugs & Biologicals: Updated HCPCS Codes

Events

- Greenhouse Gas Reduction Fund Opportunities for the Health Sector Webinar - November 20

Publications

- Medicare Provider Compliance Tips - Revised

Information for Patients

- Medicare Prescription Payment Plan

MLN Connects - November 14, 2024

MLN Connects Newsletter: Nov 14, 2024

News

- 2025 Medicare Parts A & B Premiums and Deductibles
- Medicare Participation for CY 2025
- Ambulance Fee Schedule: CY 2025 Final Policies
- Prior Authorization Review Timeframe Change
- Skilled Nursing Facilities: Revalidation Due Date Extension
- Home Health & Hospice Resources

- Help Your American Indian & Alaska Native Patients Achieve Optimal Health

Claims, Pricers, & Codes

- PrEP for HIV Pharmacy Claims: New HCPCS Code & FAQ Update

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2025 Update
- New Waived Tests

Publications

- Checking Medicare Claim Status - Revised
- Checking Medicare Eligibility - Revised

MLN Connects - November 21, 2024

MLN Connects Newsletter: Nov 21, 2024

News

- Medicare-Funded Physician Residency Positions
- CMS Roundup (November 15, 2024)
- Hepatitis B Vaccine: Billing Requirement Update Effective January 1
- Hospitals: Use Renewed Beneficiary Notices Starting January 1
- National Rural Health Day: Address Unique Health Care Needs
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- Mechanical Ventilation: Bill Correctly for Inpatient Claims
- Enteral Nutrition: Prevent Claim Denials

Events

- Environmental Justice Thriving Communities Grantmakers Program - December 4
- Optimizing Healthcare Delivery to Improve Patient Lives Conference - December 12

MLN Connects

MLN Matters® Articles

- Home Health Prospective Payment System: CY 2025 Rate Update

Publications

- Medicare Preventive Services - Revised

From Our Federal Partners

- First Case of Clade I Mpox Diagnosed in the U.S.

MLN Connects - November 27, 2024

MLN Connects Newsletter: Nov 27, 2024

News

- Opioid Treatment Programs: CY 2025 Updates
- HIV Screening & Prevention

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update
- Clotting Factor: CY 2025 Furnishing Fee

Events

- Hospice Quality Reporting Program Webinar - December 12

MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update

MLN Connects - December 5, 2024

MLN Connects Newsletter: Dec 5, 2024

News

- Clinical Laboratory Fee Schedule: CY 2025 Final Payment Determinations
- CMS Roundup (November 29, 2024)
- Advanced Primary Care Management Services: Get Information about Billing Medicare

MLN Connects

- Flu Shots: There's Still Time to Protect Your Patients

Compliance

- Diabetic Accessories & Supplies: Prevent Claim Denials

Claims, Pricers, & Codes

- Claim Status Category & Claim Status Codes Update
- National Correct Coding Initiative: January Update

MLN Matters® Articles

- ESRD & Acute Kidney Injury Dialysis: CY 2025 Updates
- Medicare Change of Status Notice Instructions
- Medicare Physician Fee Schedule Final Rule Summary: CY 2025

Publications

- Global Surgery - Revised
- Rural Emergency Hospitals - Revised

MLN Connects - December 12, 2024

MLN Connects Newsletter: Dec 12, 2024

News

- FY 2024 Medicare Fee-for-Service Improper Payment Rate
- Revised Home Health Change of Care Notice Form Effective February 1
- Skilled Nursing Facility Value-Based Purchasing Program: December 2024 Confidential Feedback Reports
- Institutional Provider Enrollment Application Fee: CY 2025

Compliance

- Global Surgery: Bill Correctly

Claims, Pricers, & Codes

- Rural Health Clinic CY 2025 All-Inclusive Rate

Publications

- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier - Revised

MLN Connects

From Our Federal Partners

- Get Your CHAMPVA Claims Paid with EFT

MLN Connects - December 19, 2024

MLN Connects Newsletter: Dec 19, 2024

News

- MBI Lookup Tools: CMS Seeks Input by February 17
- CMS Roundup (December 13, 2024)
- Long-Term Care Hospital Provider Preview Reports: Review by January 15
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by January 15
- Medicare Advantage Organizations & Prescription Drug Plans: Comment on Draft Medicare Transaction Facilitator Agreements by January 31
- Health Professional Shortage Area: CY 2025 Bonus Payments
- Home Health Quality Reporting Program: Final OASIS-E1 Instruments & Manual
- Quarterly Credit Balance Reports No Longer Required

Compliance

- Immunosuppressive Drugs: Prevent Claim Denials

Claims, Pricers, & Codes

- HIV Pre-Exposure Prophylaxis: Coding Updates
- Coding for Appropriate Use Criteria Program for Advanced Diagnostic Imaging Ends December 31
- Federally Qualified Health Center Prospective Payment System: CY 2025 Pricer
- Skilled Nursing Facility Consolidated Billing: CY 2025 HCPCS Codes

MLN Matters® Articles

- CY 2025 Update: DMEPOS Fee Schedule
- National Coverage Determination 210.15: Pre-Exposure Prophylaxis (PrEP) for HIV Prevention

From Our Federal Partners

- CHAMPVA Policy on Weight Loss Medications Effective January 1

MLN Matters

2025 Annual Update of HCPCS Codes for SNF CB Update

Related CR Release Date: September 6, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13786

Related CR Transmittal Number: R12827CP

CR 13786 identifies the changes to Healthcare Common Procedure Coding System (HCPCS) codes and explain how Medicare Physician Fee Schedule designations will be used to revise Common Working File (CWF) edits to allow A/B Medicare Administrative Contractors (MACs) to make appropriate payments in accordance with policy for Skilled Nursing Facility (SNF) Consolidated Billing (CB) in Chapter 6, Section 110.4.1 for A/B MACs (B) and Chapter 6, Section 20.6 for A/B MACs (A).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13786.

2025 Annual Update for the HPSA Bonus Payments

Related CR Release Date: September 13, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13789

Related CR Transmittal Number: R12837CP

The purpose of this Change Request (CR) is to provide files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2025, through December 31, 2025.This recurring update notification applies to Chapter 4, Section 250.2 and Chapter 12, Section 90.4.2.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13789.

MLN Matters

Ambulatory Surgical Center Payment Update - October 2024 - Revised

Related CR Release Date: October 3, 2024

MLN Matters Number: MM13800 Revised

Effective Date: October 1, 2024

Related Change Request (CR) Number: CR 13800

Implementation Date: October 7, 2024

Related CR Transmittal Number: R12864CP

Note: CMS updated the HCPCS codes in tables 3 and 6. CMS added new subsection b in Section 5 (pages 2 & 4). CMS also revised the CR release date, transmittal number, and CR link. Substantive content changes are in dark red.

CR 13800 tells you about:

- New CPT and HCPCS codes
- Drugs and biologicals
- Skin substitutes

Make sure your billing staff knows about these changes for October.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13800.

Annual Clotting Factor Furnishing Fee Update 2025

Related CR Release Date: August 15, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13742

Related CR Transmittal Number: R12795CP

CR 13742 announces the update to the Clotting Factor Furnishing Fee. This Recurring Update Notification (RUN) applies to Chapter 17, Section 80.4.1 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13742.

MLN Matters

Changing the Frequency of No-Pay MSN Mailings from Every 90 Days to Every 120 Days - Revised

Related CR Release Date: July 16, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13627

Related CR Transmittal Number: R12718CP

Note: CMS added the VMS maintainer as a responsible party to business requirement 13627.7 and provider education to this CR. All other information remains the same

CR 13627 changes the frequency of Medicare Summary Notice (MSN) mailings from every 90 days to every 120 days, in order to conserve funding. This instruction also deletes chapter 21, section 10.1 General Requirements for the MSN in publication 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13627.

CY 2025 Update: DMEPOS Fee Schedule

Related CR Release Date: December 13, 2024

MLN Matters Number: MM13888

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13888

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12991CP

CR 13888 tells you about:

- New codes
- Updated codes
- Payment policy changes

Make sure your billing staff knows about these updates effective January 1, 2025.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13888.

MLN Matters

Disable Beneficiary Eligibility Information from MAC IVR Systems

Related CR Release Date: September 27, 2024

Effective Date: March 31, 2025

Implementation Date: October 21, 2024 - for business requirement 13754.2; March 31, 2025 - For all other business requirements

Related Change Request (CR) Number: CR 13754

Related CR Transmittal Number: R12858OTN

CR 13754 directs Medicare Administrative Contractors (MACs) to disable beneficiary eligibility information from their Interactive Voice Response (IVR) systems by March 31, 2025.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13754.

Enhancements to Home Health Consolidated Billing Edits

Related CR Release Date: May 2, 2024

Effective Date: October 1, 2024 - Claims processed on or after this date.

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13550

Related CR Transmittal Number: R12608CP

CR 13550 ensures Original Medicare systems edits enforcing home health consolidated billing are accurate and consistent with existing payment policies.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13550.

MLN Matters

ICD-10 & Other Coding Revisions to NCDs: April 2025 Update (CR 1 of 2)

Related CR Release Date: October 24, 2024

MLN Matters Number: MM13818

Effective Date: April 1, 2025, or as noted in CR 13818

Related Change Request (CR) Number: CR 13818

Implementation Date: November 26, 2024: BRs 2 & 7; April 7, 2025: BRs 1, 3, 4, 5, 6 & 8

Related CR Transmittal Number: R12903OTN

CR 13818 tells you about:

- Newly available codes
- Recent coding changes
- National Coverage Determination (NCD) coding information

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13818.

ICD-10 & Other Coding Revisions to NCDs: April 2025 Update (CR 2 of 2)

Related CR Release Date: October 24, 2024

MLN Matters Number: MM13828

Effective Date: April 1, 2025, or as noted in CR 13828

Related Change Request (CR) Number: CR 13828

Implementation Date: November 26, 2024: BRs 2, 4, 5, & 7; April 7, 2025: BRs 1, 3, & 6

Related CR Transmittal Number: R12904OTN

CR 13828 tells you about:

- Newly available codes
- Recent coding changes
- National Coverage Determination (NCD) coding information

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13828.

MLN Matters

Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update - Revised

Related CR Release Date: November 25, 2024

MLN Matters Number: MM13796 Revised

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13796

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12980GI

Note: CMS revised this Article to update the transmittal number, CR link, and CR release date. There are no substantive changes to the Article.

CR 13796 tells you about:

- Medicare Part A and Part B deductibles
- Part A and Part B coinsurance rates
- Part A and Part B premiums

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13796.

Medicare Physician Fee Schedule Final Rule Summary: CY 2025

Related CR Release Date: November 21, 2024

MLN Matters Number: MM13887

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13887

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12975CP

CR 13887 tells you about:

- Telehealth
- Caregiver training
- Therapy
- Cardiovascular risk assessment and management
- Evaluation and management (E/M)
- Behavioral Health
- Advanced primary care management (APCM)
- Global surgery payment

- Dental and oral health

Make sure your billing staff knows about changes to these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13887.

New Waived Tests

Related CR Release Date: November 1, 2024

MLN Matters Number: MM13858

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13858

Implementation Date: January 6, 2025

Related CR Transmittal Number: R129335CP

CR 13858 tells you about:

- Clinical Laboratory Improvement Amendments (CLIA) requirements
- The new waived test approved by the FDA
- The HCPCS code, effective date, and description for latest waived test

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13858.

National Coverage Determination 210.15: PrEP for HIV Prevention

Related CR Release Date: December 5, 2024

MLN Matters Number: MM13843

Effective Date: September 30, 2024

Related Change Request (CR) Number: CR 13843

Implementation Date: April 7, 2025

Related CR Transmittal Number: R12987CP & R12987NCD

CR 13843 tells you about:

- National coverage of Pre-exposure prophylaxis (PrEP) using FDA-approved antiretroviral drugs to prevent HIV
- HCPCS and diagnosis codes
- Billing and payment requirements

Make sure your billing staff knows about these changes.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13843.

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

Related CR Release Date: August 2, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13679

Related CR Transmittal Number: R12766CP

CR 13679 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)13679.

Quarterly Update to the NCCI PTP Edits, Version 31.0, Effective January 1, 2025

Related CR Release Date: September 11, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13798

Related CR Transmittal Number: R12842CP

CR 13798 updates the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. This recurring update notification applies to Chapter 23, Section 20.9.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13798.

MLN Matters

RARC, CARC, MREP and PC Print Update

Related CR Release Date: May 31, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13633

Related CR Transmittal Number: R12659CP

CR 13633 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs 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)13633.

Technical Revision Only to the MBP Manual, Pub 100-02, Chapter 15, section 50.4.2

Related CR Release Date: October 2, 2024

Effective Date: January 9, 2025

Implementation Date: January 9, 2025

Related Change Request (CR) Number: CR 13829

Related CR Transmittal Number: R12860BP

CR 13829 announces a technical change made to the Medicare Benefit Policy (MBP) Manual, Publication (Pub) 100-02, Chapter 15, section 50.4.2.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13829.

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

Contacts, Resources, and Reminders

Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

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

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

IRS-1099 Reporting

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

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

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

Contacts, Resources, and Reminders

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

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

Noridian representatives from various Part 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.

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

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

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

We look forward to your participation in these important calls.

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

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

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