Medicare B News

Jurisdiction E
July 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACM B Questions and Answers - May 7, 2025

The following questions and answers (Q&As) are cumulative from the Part B Ask the Contractor Meeting (ACM). Some questions have been edited for clarity and answers may have been expanded to provide further details. Related questions were combined to eliminate redundancies. If a question was specific just for that office, Noridian addressed this directly with the provider. This session included pre-submitted questions and verbal questions posed during the event. Please note our disclaimer that these are accurate as of this publishing and may have future updates.

Updates and Reminders:

- For coding advice, seek external sources such as the AMA, AAPC or specialty societies
- Watch our Noridian website for CMS Telehealth updates after September 30, 2025

Written Pre-Q/A:

Q1. The CMS list does not include CPT 90480 (COVID vaccine administration). Is this an oversight or are we not allowed to bill G2211 when 90480 is performed at the same encounter as an Evaluation and Management (E/M) visit?
A1. Yes, this was an oversight. We had reached out to CMS and requested an update to the list of covered vaccine codes that would be allowed under Change Request (CR) 13705. It also includes influenza, pneumonia, and hepatitis B administrations (G0008, G0009 and G0010). This has been fixed and you may rebill or reopen the claims.

Q2. When a clinic RN or PharmD places a phone call with a patient, can we bill CPTs 98966-98968 (*phone calls for assessment and management*) that is incident-to a physician or advance practice physician (APP)? Can we append modifier 93 or could we bill CPT 99211 instead?
A2. CMS' position is that CPT codes 98966-98968 (telephone assessment and management services) may NOT be performed by nurses or Pharm D's incident to and subsequently billed by the non-physician qualified healthcare practitioner (QHP) or physician. These CPTs still fall under E/M and are intended where face-to-face encounter is not expected and require medical decision-making that must be personally performed by the physician or non-physician QHP during the encounter.

To bill CPT 99211 via telehealth, both medical necessity and incident-to rules must be met (i.e., established patient, nurse carrying out the provider's plan, direct supervision, etc.). A callback simply to provide test results from a previous visit, would be included in the previously billed visit and may not meet separate medical necessity. If audio only (with beneficiary permission), remember to bill POS 02 or 10 and append modifier 93. For more incident to information, please read the CMS Internet Only Manual (IOM)

Publication 100-02, Chapter 15, Section 60 and for Telehealth CMS Medicare Learning Network (MLN) 901705 "Telehealth & Remote Patient Monitoring" Booklet.

Q3. If moderate medical decision-making is documented and the teaching physician does not see the patient, but their participation meets the supervision requirements; do we bill a level three (99203 or 99213) with GE modifier?
A3. Yes, but only under certain circumstances. Under the primary care exception, in certain teaching hospital primary care centers, teaching physicians can bill certain services that residents provide independently without teaching physicians present, but the teaching physicians must review the care. Lower and mid-level complexity E/M services may be billed with modifier GE (service performed by a resident without presence of teaching physician; under primary care exception). CMS MLN Guidelines for "Teaching Physicians, Interns & Residents."

Q4. Per Medicare guidelines, all participants of a shared visit should be identified "in the medical record". Is it sufficient if each provider in the same clinic documents and signs their own note, and states that they saw the patient with an MD and/or Advanced Practice Provider (APP), but does not specify them by name?
A4. Yes. Since there is not split/share in the office, and the patient sees the APP and then the physician, each provider would document the portion of the visit they performed and sign the medical record to have both the physician and practitioner identified. It would not be necessary to have each provider mention the other person by name. It could be billed under the physician, where both would perform and document their portions. Read more in the CMS Internet Only Manual (IOM), Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.18.E.

Q5. When an E/M leads to a decision for a minor procedure the same day, and allows more than the procedure, would it be appropriate to report just the E/M and no procedure code, if documentation does support both?
A5. No. Providers **cannot** report the related E/M service to replace the procedure code. Related E/Ms on the same date of service as the minor surgical procedure are **included** in the payment for the procedure and shall not be reported separately. Based on CMS National Correct Coding Initiative (NCCI) Policy Manual Chapter 1.

Q6a. When documentation indicates a scenario for treatment based on test results, such as "if the test is positive, then we will prescribe Augmentin," would this be considered documented evidence that a provider is considering prescription drug management for moderate risk?
A6a. Possibly. All elements of Medical Decision-Making (MDM), per the CPT E/M Guidelines, would have to be taken into consideration before assuming that prescription drug management is always going to be moderate. Two of the three elements for the level of MDM must be met or exceeded. Therefore, we cannot say that the prescription for Augmentin, based on test results, would be considered moderate risk.

Q6b. Per the note, "If the physical therapy does not help within 3 weeks, we will proceed to major surgery". At this encounter, would we consider just the risk of performing physical therapy, or would we consider this a decision for major surgery?
A6b. No. This is not considered a decision for major surgery if the patient has not decided at this encounter. If the outcome of physical therapy is unknown, then your practice can consider the risk of physical therapy.

Q7. For E/M level, chronic condition indicates "a problem with an expected duration of at least one year or until the death of the patient". However, NCD 270.1 A, indicates "chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence". For this purpose, would a diabetic foot ulcer longer than 30 days be considered chronic rather than acute condition?
A7. Yes. For E/M purposes, the American Medical Association (AMA) CPT definitions would be followed to determine a chronic condition. CMS develops the National Coverage Determination (NCD) policies for certain procedures that are separate from CPT and two separate guidelines. For E/M, follow the CPT definitions.

Q8. For the Medicare AWV, the provider documents "Awake, Alert, and oriented x 3", as this definition would indicate there are no cognitive impairments. Does this meet requirement #5: "Detect any cognitive impairments patients may have", and if not, what additional information would be needed?
A8. No, that would not be an appropriate cognitive assessment. There are screening tools that are appropriate to determine cognitive fitness to use during the Initial Preventive Physical Exam (IPPE) or Annual Wellness Visit (AWV).

Q9. For a data analyzed E/M element, a handheld doppler ultrasound for fetal heart tones would not be billed separately with CPT 76815 (ultrasound; pelvis) when imaging is not saved. Would the analysis of the imaging by the provider be considered an independent interpretation of a test not separately reported, or review of one unique test?
A9. Possibly. Tests not separately reported and performed by another provider may meet independent interpretation. When the same provider performing the E/M service uses the handheld doppler for the ultrasound, that would be reviewing results under Category 1. Documentation of ultrasound findings would need to be indicated in the medical record to support the provider's review.

Q10. Can a Licensed Clinical Social Worker (LCSW) bill directly or incident to for CPT 96127 (Brief screening for emotional/behavioral assessment; e.g., depression, anxiety, attention-deficit, or hyperactivity disorder [ADHD], eating disorders, etc.), with scoring and documentation, per a standardized instrument?
A10. Yes for either. CPT 96127 can utilize the Patient Health Questionnaire (PHQ-9), General Anxiety Disorder scale (GAD-7) and/or Depression Anxiety Stress Scales (with 4-point Likert-type scale; DASS-21). The assessment must be provided and scored by

trained administrative staff. The LCSW could bill directly if enrolled in Medicare and working within their State guidelines and Scope of Work. Otherwise, this service would have to be performed incident to and billed by the supervising physician or other qualified health practitioner (QHP).

Q11. Sometimes, when we call the Provider Contact Center, they are closed. Is there an alternate line that can be used?
A11. No. Medicare Administrative Contractors (MACs) are unable to provide a voicemail to callers who attempt to reach Noridian outside of regular business hours. In accordance with CMS Internet Only Manual, Publication 100-09, Chapter 6, Section 30.4.6, MACs will be available 8:00 a.m. through 4:00 p.m. for all time zones of the geographical area serviced, Monday through Friday. Noridian's hours of operation are 8-5 Pacific time for JE providers and 8-6 Central time for JF providers.

CMS grants MACs 8 hours of training time per month that the contact center staff are unavailable on Fridays. Noridian has both training and holiday closures published on each of our jurisdiction pages.

Noridian receives approximately 5,000 phone calls a day. All calls are answered in order of receipt with an average wait time of 60 seconds (time may vary depending on time of day).

Q12. What needs to be documented to give credit for high toxicity? For example, provider documents vancomycin and labs are brought into the note, but doesn't document to monitor. Does this support the monitoring of high toxicity?
A12. Possibly. The purpose for ordering the lab should be documented in the medical record and would support the monitoring requirement. If the lab order does not indicate the (drug name) monitoring, this may not be considered for the E/M risk element.

Q13. Is a modifier 25 needed with an E/M when billing with CPT 95251 (Continuous Glucose Monitoring; analysis, interpretation, and report) on the same day?
A13. No. Since the NCCI does not show any coding combinations, there should be no reason to append modifier 25 on the E/M. Always check the NCCI website first before billing. A reminder that CPT 95251 services (e.g., interpretation and report of the data analysis) cannot overlap with the separate E/M visits.

Q14. Please clarify if a neurological psychologist (PhD) can bill evaluation and management (E/M) services (99202-99215)?
A14. No. Medicare only allows E/M services for specific physicians and non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS), physician assistant (PA) and certified nurse midwife (CNM)), whose Medicare benefit permits them to bill these services. Per CMS IOM, Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.4.

Q15. Can procedure CPTs 51550-51595 be used for laparoscopic cystectomy "open" procedures?
A15. Yes, the default is "open" for all of these CPT codes. If a practice wants to perform the procedure laparoscopically or with robotics, it is still the same procedure. When CPT designates the same code for a laparoscopic and open procedure, they are designating the values for the code (work, practice expense and liability) are assigned as identical. Per the NCCI Policy Manual, Chapter 1, E/M services performed, on the same date of service, as a minor surgical procedure are included in the payment for the procedure and are not reimbursed separately.

Q16. What CPT or HCPCS code should a facility report for a patient receiving dental services (under general anesthesia) in the outpatient hospital setting?
A16. HCPCS G0330 (facility services for dental rehabilitation procedure(s). This is only billing education and does not guarantee payment. CMS coverage for dental services can only be paid when medical services are inextricably linked to the clinical success of other Medicare-covered procedures CMS Medicare Dental Coverage. *"In general, ancillary services and supplies furnished incident to dental services can only be paid, if the dental services being performed during the dental rehabilitation, are considered inextricably linked. If they are* ***not*** *considered inextricably linked, they are* ***not covered*** *by Medicare under the SSA1862(a)(12). Consequently, the facility fee associated with the dental rehabilitation would then also, not be covered by Medicare."* CMS IOM, Medicare Benefit Policy Manual, Publication 100-02, Chapter 15.

Q17. Is HCPCS G2211 (E/M visit complexity add-on) ever payable for place of service Patient's Home (12) and home-based E/M visits (99348-99350)?
A17. No. CPT G2211 is only accepted with primary E/M codes (99202 - 99215). With only those new and established E/M codes, it may be added as telehealth in the patient's home. G2211 would not be allowed with home visit codes.

Q18a. How do I submit documentation that goes with an appeal, claim and or reopening?
A18a. Claims instructions are found on the Noridian Website. Sign up for the Noridian Medicare Portal (NMP) that provides a way to Reopen claims, upload appeals documentation, etc.

Q18b. How to bill for pain pump medication?
A18b. Follow the Noridian Billing and Coding Article-Implantable Infusion Pumps for Chronic Pain.

Q18c. What can be done if payment for pain pump medications do not cover cost? Can we send a copy of the invoice in appeal?
A18c. Yes, an invoice could be attached with an appeal; however, will not guarantee

additional payment. Always check the Average Sales Price (ASP) quarterly drug pricing as a couple drugs were just increased in 2025.

Q19. What code is correct to use when Cryoneurolysis is treated with the lovera system for the knee?
A19. Per the CMS Billing and Coding Article, Cryoneurolysis Instructions, bill with 0441T (*ablations, percutaneous, cryoablation, including image guidance; lower extremity, distal and/or peripheral nerve*), for the lovera system for use in the knee.

Note: Both CPTs 64640 (*destruction by neurolytic agent; other peripheral nerve or branch*) and 64624 (*destruction by neurolytic agent, genicular nerve branches including imaging guidance*) are **not** appropriate for Medicare billing, because they require destruction of the targeted nerve(s). The lovera system is temporary and not destructive. Therefore, these two CPTs are not appropriate for Medicare billing.

Q20. When an APP or non-physician practitioner (NPP) provides a service that meets all the incident-to requirements, does both the APP and supervising provider, or either one, need to sign or and date?
A20. The provider performing the visit and authoring the documentation should sign and date the medical record. CMS IOM, Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 60 states there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment, of which the service being performed by an APP is an incidental part.

Q21. What specifically needs to be documented when a patient is on high toxicity medication? Would "monitor for high toxicity" qualify for E/M credit?
A21. No. Per the AMA E/M guidelines, the monitoring may be performed by lab test, physiologic test, or imaging. The reason for ordering these tests would be supported by the need to monitor the high toxicity medication. Documenting in history and the exam does not qualify as monitoring. Noridian will not provide specific language a provider needs to document. The provider is responsible to assessing the level of risk management based on the patient's specific risk factors. Also, see QA#12 as similar.

Q22. When a consultation order is in place, can an interprofessional consultation (CPT 99451) be billed when a resident sees the patient and the teaching physician does not see the patient; but the physician reviews the record and provides recommendations to the referring provider?
A22. 99451 is considered provider-to-provider and must have the patient's consent to approve out-of-pocket coinsurance and unmet deductible expenses.

The interprofessional consultations state the consultant does not have a face-to-face visit with the patient. The resident under the teaching physician saw the patient. The interprofessional consult is reviewing medical records from the treating provider (the

one requesting the consult and not the resident) and providing a written report back to the treating/requesting provider.

If the teaching physician only reviewed the referring provider's records and provided a written report, that would qualify as interprofessional consult. The resident's medical records would not be part of the consultation. Read more *CMS MLN006347 "Guidelines for Teaching Physicians, Interns & Residents*".

Q23. According to the CMS E/M Guide (MLN 006764), members of the care team may collect information under the History and Examination section. Can you define care team in this context? If the patient is seen by a non-physician practitioner initially performs the history and exam, and a physician subsequently assumes care, would the physician need to review and agree with all the documentation?
A23. For the context of the "care team" in MLN 006764, we will check with CMS. In 2018, CMS published an FAQ regarding parts of the history can be documented by ancillary staff CMS E/M Visit FAQs Under Medicare Physician Fee Schedule (MPFS).
Documentation needs to be reviewed by the billing physician. Additionally, any information documented by others needs to be reviewed and verified to ensure accuracy and compliance with any E/M code submitted for reimbursement.

Q24. Can an APP or NPP report modifier 57 (initial decision to perform major surgery; day before or day of) if they see the patient the night before and the surgeon sees the patient the next day? Who bills the E/M with modifier 57?
A24. No. It has to come from the surgeon. CMS IOM, Claims Processing Manual, Publication 100-04, Chapter 12, Section 40.1.B states the initial consultation or evaluation of the problem is **by the surgeon** to determine the need for surgery. Modifier 57 would be appended to the E/M visit when it is the day of, or day before a major surgical procedure.

Verbal Q/A:

Q25. For the 2025 chimeric antigen receptor (CAR) T-cell therapy policy billing, we replaced the Category III code 0540T with CPT 38228 (administration, autologous). We previously billed with the 0540T and received payment. We are enrolled in the FDA Risk Evaluation and Mitigation Strategies (REMS) program and append the KX modifier to acknowledge. Why are we receiving denials?
A25. Noridian is aware of claims processing issues related to the new CPT code 38228 (which became effective 1/1/25) and are seeking further information from CMS. We will follow up once more information can be gathered. Please reach out to your jurisdiction customer service line for specific denied claims.

Q26. Is a new patient E/M bundled or allowed with modifier 25, when minor procedures and injection performed during the 10-day global period?
A26. In general, related E/Ms (new or established patients) on the same date of service as the minor surgical procedure are **included** in the payment for the procedure and shall not be reported separately. Since minor surgical procedures and XXX procedures include pre-procedure, intra-procedure, and post-procedure work inherent in the procedure, the provider/supplier shall not report an E/M service for this work.

Medicare Global Surgery Rules prevent the reporting of a separate E/M service for the work associated with the decision to perform a minor surgical procedure regardless of whether the patient is a new or established patient. Based on CMS National Correct Coding Initiative (NCCI) Policy Manual Chapter 1. Just because the patient is new does not mean the E/M can be unbundled.

Q27. Under the supervision and incident to rule for Registered Nurses (RNs), would they be covered for a surgical procedure for Vagus Nerve Stimulation (VNS) needle placement?
A27. No. Surgical procedures are not performed incident to, even in the office, and require personal supervision (i.e., performed by a qualified provider), specifically one who can demonstrate training and experience in all stages of management. An RN would not be included for the independent practice of the procedure CPT 64568 (*incision for implantation of cranial nerve [e.g., vagus nerve] neurostimulator electrode array and pulse generator*).

In this case, the issue may be an "insertion of a needle" and may be confused with an injection, which is included in the nursing scope of practice. It may be possible, once the device is in place, to allow an office nurse or clinician to regulate or test incident to the supervising qualified provider. **However**, it would be part of the E/M (unless it was at the initial install), which is part of the 64568 procedure. If it was queried or managed at a later date, it is part of that E/M.

Cardiac Rehab (CR) - POS 19 added

Change Request (CR) 13243 effective June 23, 2025, reminds cardiac providers of the update to the CMS Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 18, Section 160.2.1 and CMS Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 140.2.2.1

This reflects the additional place of service (POS) 19 (*Off Campus-Outpatient Hospital*) allowed for both Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) services.

News

Clinicians - Are You Ordering Urological Supplies for Your Patients

Urological supplies are covered as part of the Prosthetic Device benefit as outlined in the Social Security Act § 1861(s)(8). Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order.

Urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. This does not require a determination that there is no possibility that the patient's condition may improve sometime in the future. If the medical record, including the judgment of the attending physician, indicates the condition is of long and indefinite duration, the test of permanence is considered met.

Indwelling catheters are those that remain in place, and Medicare will pay for one catheter per month, barring a few exceptions (e.g., catheter is accidentally removed, there is a malfunction with the catheter, or there is a catheter obstruction). Medicare will also pay for related catheter supplies appropriate for use with indwelling catheters.

The Urological Supplies LCD also details coverage criteria for external catheters/urinary collection devices as alternatives for indwelling catheters.

Intermittent catheters are those that are changed with each episode, and the beneficiary or caregiver can perform the procedure of changing the catheter. There are three types of intermittent catheters:

1. Straight tip catheter
2. Coude (curved) tip catheter
3. Catheter with insertion supplies (please note this particular catheter, also referred to as a "sterile kit," has additional coverage criteria such as recurrent urinary tract infections, immunosuppressed, or residing in a skilled nursing facility). The preceding are examples only and not a full list of applicable conditions where this type of intermittent catheter may be medically necessary.

Medicare will cover up to 200 intermittent catheters per month as long as the medical record supports the need for the quantity ordered by the treating practitioner.

Medicare will also consider coverage of external catheter systems if the need is substantiated by information in the beneficiary's medical records. This includes male and female external catheter systems and the inFlow device. Specific coverage criteria can be found in the LCD and related Policy Article.

A standard written order (SWO) must be in the DME supplier's possession before they can submit claims to the Medicare program. A valid standard written order contains the following elements:

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

The DME supplier will likely send you a SWO for the urological supplies, which has been prepared for your review and signature. Please review and sign that SWO in a timely manner so the DME supplier can file claims to the Medicare program.

Following these coverage guidelines will help your patients and the Medicare program by verifying there is medical documentation to support the provision of urological supplies. Your assistance will allow Medicare to pay claims appropriately and ensure that your patient receives the DMEPOS items you have prescribed.

The LCD and Policy Article for urological supplies are located on the DME MAC websites.

DMEPOS Fee Schedules and Labor Payment - 2nd Quarter 2025 Update

Updates to the DMEPOS Jurisdiction listing for 2nd quarter 2025 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

News

Incorrect Rejections for Medicare Secondary Payer (MSP) Claims - Resolved 06/18/25

Provider/Supplier Type(s) Impacted: All providers

Reason Codes: Not applicable

Claim Coding Impact: Medicare Secondary Payer (MSP) Claims

Description of Issue: An issue has been identified resulting in incorrect MSP rejections related to submission errors. The claims were rejected with CARC 16, "Claim/service lacks information or has submission/billing error(s)"; RARC N245, "Incomplete/invalid plan information for other insurance" and N704, "You may not appeal this decision but can resubmit this claim/service with corrected information if warranted". The issue impacted claims processed within our system from 4/7/25 through 4/21/25.

Noridian Action Required: The system was updated on 4/22/25 so claims received on or after 4/22/25 are not impacted.

05/12/25 - The system update on 04/22/25 did not resolve the issue. Claims are being held until the issue is resolved.

05/29/25 - An additional system update is expected on 06/09/25. Noridian will validate the update works as expected prior to releasing the held claims.

06/16/25 - The system was updated on 06/09/25 and all previously held claims have been released. For guidance on how to properly resubmit any denied claims, please visit New process for MSP claims rejected with CARC 16

Provider/Supplier Action Required: None

Proposed Resolution/Solution: Noridian will conduct a mass adjustment for claims rejected in error.

05/12/25 - Noridian will provide an update when the mass adjustments are initiated.

05/29/25 - Noridian will provide an update when the mass adjustments are initiated.

06/16/25 - Noridian will provide additional updates when the mass adjustments are initiated.

06/18/25 - Noridian initiated mass adjustments on 06/17/25.

Date Reported: 04/21/25

Date Resolved: 06/18/25

News

Interactive Voice Response (IVR) Authenticate Requirements

Effective June 1, 2025, Noridian's Provider Contact Center (PCC) will be able to answer up to three separate inquiries for the same National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN) combination.

To remain in compliance with self-service and authentication requirements, Noridian will ask that all provider combinations first be authenticated through the Interactive Voice Response (IVR) system. Any inquiry for an NPI or PTAN that is different than the combination already authenticated will be asked to call back and reauthenticate through Noridian's IVR.

Medicare Portable X-Ray Survey Reminder Newsletter

Medicare Administrative Contractors (MACs), under the direction of the Centers for Medicare & Medicaid Services (CMS), are conducting a national cost analysis survey to assess the transportation components of portable X-ray services, specifically HCPCS codes R0070 and R0075. This survey is conducted every five years and will directly impact reimbursement rates starting in 2026.

With the survey deadline approaching on July 31, 2025, providers are strongly encouraged to review and submit their responses as soon as possible.

Why Is This Survey Important?

Portable X-ray services allow Medicare beneficiaries—especially those in home or nursing home settings—to receive diagnostic imaging without traveling to a healthcare facility. Billed separately under codes R0070 and R0075, the transportation component is essential to service delivery.

Key goals of this survey include:

- Evaluating current payment allowances to recognize costs incurred for portable x-ray transportation services (e.g., fuel, vehicle maintenance, staff wages).
- Addressing geographic cost differences between urban and rural service areas.
- Complying with federal payment policy updates and CMS directives.
- Responding to provider feedback regarding financial strain from outdated rates.
- Sustaining access to mobile imaging services for vulnerable Medicare populations.
- Achieve consistent cost evaluation through appropriate reporting of cost data in a singular MAC survey format.

What Is Being Collected?

MACs are gathering data on:

- Transportation expenses (fuel, insurance, maintenance)
- Labor costs for mobile X-ray staff
- Depreciation and equipment upkeep
- Administrative overhead
- Geographic variations impacting operational costs

What Providers Need to Do

If you furnish portable X-ray services and bill R0070 or R0075:

- Download and complete the survey found on the Understanding the 2026 Cost Analysis Survey for Medicare Allowances on Portable X-Ray Transportation Codes R0070 and R0075 webpage.
- Submit the completed survey via email to: medicalpolicy@noridian.com.
- Deadline for submission: July 31, 2025 - Late responses will not be accepted.

Benefits of Participation

By participating in this survey, providers will:

- Influence 2026 reimbursement levels for R0070 and R0075
- Help Medicare reflect actual cost realities
- Support continued access to care for homebound and institutionalized patients
- Stay engaged with regulatory compliance and payment policy evolution

Key Dates to Remember

- Survey Deadline: July 31, 2025
- Send completed surveys to: medicalpolicy@noridian.com.

For questions or clarification, contact your MAC contact or email the address above. Your input is essential to ensure portable X-ray services remain financially viable and widely available for Medicare beneficiaries.

Portable X-Ray Cost Analysis Survey

There is an upcoming survey for Portable X-Ray Transportation Suppliers. Please take a few minutes to review the details on this survey on the new Portable X-Ray Cost Analysis Survey webpage.

News

Psychiatric Care: Prevent Claim Denials

In 2023, the improper payment rate for outpatient psychiatry services was 13.5 percent with a projected improper payment amount of $186.1 million (see 2023 Medicare Fee-for-Service Supplemental Improper Payment Data (PDF)). Learn how to bill correctly for these services. Review the Outpatient Psychiatric Care provider compliance tip for more information, including:

- Billing codes
- Denial reasons and how to prevent them
- Covered and non-covered services
- Service frequency and duration
- Resources

Source: CMS *MLN Connects* May 22, 2025

Redetermination versus Reconsideration - Appeals Newsletter Part 17

Noridian has seen an increase of Reconsiderations sent to Noridian as second level appeals, instead of Qualified Independent Contractor (QIC) - C2C Innovative Solutions. Here are some tips to determine whether to submit a redetermination or a reconsideration, and where to send your information.

Redetermination

Did your office recently receive information on a remittance advice that the claim was denied for something other than a clerical error?

- Complete portal process for a Redetermination or;
- Fill out a Redetermination paper form

Reconsideration

Did your office recently receive a letter with an unfavorable decision or a Medicare Redetermination Notice with a decision not in your favor?

- Qualified Independent Contractor - C2C Innovative Solutions
- Reconsideration process
- Complete the QIC portal process for a reconsideration or;
- Complete a Reconsideration paper form

News

Appeals Resources

- Noridian Part A and B Appeals Tutorials
- CMS Internet Only Manual (IOM), Publication 100-04 Medicare Claims Processing Manual, Chapter 29 Appeals of Claims Decision

Reminder to Use "Browse by Specialty" for Outpatient Services on Radiation Oncology and Radiology

Ensure all necessary records are submitted to support the services rendered for Radiation Oncology and Radiology. Providers are encouraged to view these available services for assistance with proper billing, coding, and documentation requirements. Education resources can be found under "Browse by Specialty" for Radiation Oncology services and Radiology services.

Share Mental Health Screenings with Beneficiaries

During Mental Health Awareness Month, we encourage providers to be aware of preventive services available for Medicare beneficiaries.

- Alcohol Misuse Screening and Counseling
- Depression Screening
- Counseling to Prevent Tobacco Use
- Preventive Services
- CMS Medicare Preventive Services

Use the portal to check date of service beneficiary is eligible for each preventive service to avoid writing off payment amounts.

- Noridian Medicare Portal (NMP) Eligibility Benefits Portal Guide

Urine Drug Testing (UDT) Reminders

Noridian has a Local Coverage Determination (LCD) and a Billing and Coding Article that provide extensive information on UDT. The LCD policy includes purpose, definitions, drug test methods, opioid risk tool for patient self-reporting, non-covered services, etc. The Billing and Coding Article includes lab drug test codes (both presumptive and definitive) like CPTs 80305-80307 and HCPCS G0480-G0483, G0659 with 388 diagnoses covered.

2025 CPT/HCPCS Billing and Coding Article Updates - Effective July 1, 2025

Date Posted: June 26, 2025

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).

Effective Date: July 1, 2025

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	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptor changes
A56119	Billing and Coding: Billing Limitations for Pharmacies	90612, 90613, 90635	N/A	N/A
A59055	Billing and Coding: Influenza Diagnostic Tests	0556U	N/A	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).

Billing and Coding: Bariatric Surgery Coverage (A53026) - R18 - Effective October 1, 2024

Date Posted: April 24, 2025

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:

Revision Effective Date: 10/01/2024

Under ICD-10-CM Codes that Support Medical Necessity, Group 1 Paragraph, added the following codes to the second bullet:

E66.812 (Obesity, class 2), E66.813 (Obesity, class 3)

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: Billing Limitations for Pharmacies (A56119) - R10 - Effective January 1, 2025

Date Posted: April 24, 2025

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

Effective Date: January 1, 2025

Summary of Article Changes:

Under Article Guidance section, updated the Influenza Vaccine codes to remove the following codes:

- 90654: end-dated 12/31/2024
- 90659: end-dated 12/31/2003
- 90663: end-dated 12/31/2011
- 90665: end-dated 12/31/2012

Under Article Guidance section, updated the Hemophilia Clotting Factors codes to remove the following codes:

- J7184: end-dated 12/31/2011
- J7206: not a valid code and was incorrectly listed in the code range.

Under CPT/HCPCS Codes, added the following codes which were missing from the table section and were only previously listed in the Article Guidance section: 90653, 90683, J7203, J7204, J7207, J7208, J7209, J7210, J7211.

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.

Medical Policies and Coverage

Billing and Coding: Epidural Steroid Injections for Pain Management (A58993)- R5 - Effective November 15, 2023

Date Posted: June 19, 2025

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 15, 2023

Summary of Changes: Typographical and grammatical updates.

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

Billing and Coding: Immune Globulin Intravenous (IVIg) (A57187) - R9 - Effective January 1, 2025

Date Posted: April 24, 2025

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

Effective Date: January 1, 2025

Summary of Article Changes:

Revision Effective Date: 01/01/2025

Under CPT/HCPCS Codes, Group 1, added J1552 Injection, immune globulin (alyglo), 500 mg.

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: Implantable Infusion Pumps for Chronic Pain (A55239) - R20 - Effective April 1, 2025

Date Posted: April 11, 2025

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

Effective Date: April 1, 2025

Summary of Article Changes:

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

Effective 04/01/2025 - 06/30/2025

Prialt (Ziconotide) = $9.698

Ropivacaine = $0.055

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: Leadless Pacemakers (A59819) - R3 - Effective October 08, 2024

Date Posted: April 3, 2025

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

Effective Date: October 08, 2024

Summary of Article Changes: Correction made to Part B billing instructions. Eight-digit National Clinical Trial Number to be placed in Item 19 of the CMS 1500 claim form or the electronic equivalent and not in Item 23.

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

Billing and Coding: MolDX: Immunohistochemistry (IHC) Indications for Breast Pathology (A57523) Retirement - Effective June 26, 2025

Date Posted: June 26, 2025

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

Effective Date: June 26, 2025

Summary: This article is being retired because the information in this article has been incorporated within the Billing and Coding: Lab: Special Histochemical Stains and Immunohistochemical Stains Article.

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

Medical Policies and Coverage

Billing and Coding: MolDX: Minimal Residual Disease Testing for Hematologic Cancers (A58996) - R9 - Effective January 1, 2025

Date Posted: April 25, 2025

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:

Under ***Article Text*** table 1 added "assays (a bundled service) in patients with cancer." to the Test box. Under Indicated Uses and Limitations deleted last sentence. Added new row for "ClonoSeq" to Test and Indicated Uses and Limitations boxes. Revised third paragraph to add "Testing schedules are set based on the validity established for the individual test comprising the service." Added new fourth paragraph. Under ***CPT/HCPCS Codes Group 2: Paragraph*** added "Use PLA 0364U to describe the service for patients with a personal history of cancer. This code has been approved for patients with a history of Mantle Cell Lymphoma." Under ***CPT/HCPCS Codes Group 2: Codes*** added 0364U. Under ***ICD-10 Codes that Support Medical Necessity Group 2: Codes*** added C83.1A and Z85.72. This revision is due to new covered test that has successfully completed a TA and is effective for 1/29/2025.

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 Solid Tumor Cancers (A58454) - R10 - February 18, 2025

Date Posted: April 25, 2025

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: February 18, 2025

Summary of Changes:

Under ***Article Text*** revised subheading ***Additional Test-specific Indications, Limitations and Instructions*** (2) added "Non-small cell lung cancer (NSCLC) (Natera)." This revision is due to covered test that has successfully completed a TA and is effective for 2/18/2025.

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: Molecular Diagnostic Tests (MDT) (A57526) - R22 - Effective April 1, 2025

Date Posted: April 4, 2025

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: April 1, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes added*** 0531U, 0532U, 0533U, 0534U, 0536U, 0537U, 0538U, 0539U, 0540U, 0543U, 0544U and 0549U. This revision is due to the 2025 Q2 CPT/HCPCS Code Update and is effective 4/1/2025.

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) - R25 - Effective May 29, 2025

Date Posted: May 29, 2025

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: May 29, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 9: Paragraph*** revised the broken hyperlink.

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 Testing for Solid Organ Allograft Rejection (A58168) - R9 - Effective April 1, 2025

Date Posted: April 4, 2025

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: April 1, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** added 0540U and 0544U. This revision is due to the 2025 Q2 CPT/HCPCS Code Update and is effective 4/1/2025.

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 Testing for Solid Organ Allograft Rejection (A58168)- R10 - Effective November 21, 2024

Date Posted: May 22, 2025

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 21, 2024

Summary of Changes:

Under ***Article Text*** revised the table to add new row for Tutivia™. Under ***CPT/HCPCS Codes Group 1: Codes*** added 0320U. This revision is due to a new covered test that has successfully completed a TA and is effective 11/21/2024.

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

Billing and Coding: MolDX: Next-Generation Sequencing for Solid Tumors (A57901) - R7 - Effective April 1, 2025

Date Posted: April 4, 2025

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: April 1, 2025

Summary of Changes:

Updated to add **CPT/HCPCS Codes Group 1: Codes** 0391U, as it was missed in a previous update. This revision is due to the 2023 Q3 CPT/HCPCS Code Update and is effective on 7/1/2023.

Under **CPT/HCPCS Codes Group 1: Codes** added 0543U. This revision is due to the 2025 Q2 CPT/HCPCS Code Update and is effective 4/1/2025.

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: Plasma-Based Genomic Profiling in Solid Tumors (A58973) - R7 - Effective April 17, 2025

Date Posted: April 18, 2025

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: April 17, 2025

Summary of Changes:

Under ***ICD-10 Codes that Support Medical Necessity Group 1: Codes*** added C70.0 and C80.2. This revision is effective 4/17/2025.

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

Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors (A58973) - R8 - Effective February 14, 2025

Date Posted: May 1, 2025

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: February 14, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1 codes*** added 0487U. Under ***CPT/HCPCS Codes Group 2 codes*** deleted 0487U. This revision is due to successful TA and is effective 2/14/2025.

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

Billing and Coding: MolDX: Proteomics Testing (A59641) - R8 - Effective April 1, 2025

Date Posted: April 4, 2025

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: April 1, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes added*** 0541U and 0550U.This revision is due to the 2025 Q2 CPT/HCPCS Code Update and is effective 4/1/2025.

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

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R16 - Effective April 1, 2025

Date Posted: April 4, 2025

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: April 1, 2025

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** added 0532U and 0533U. This revision is due to the 2025 Q2 CPT/HCPCS Code Update and is effective 4/1/2025.

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)- R11 - Effective June 26, 2025

Date Posted: June 26, 2025

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: June 26, 2025

Summary of Changes: Effective 06/26/2025, statements referring to ReActiv8 were removed from the Article Text section. We are making these edits to clarify the article does not change coverage as specified in the LCD. Devices must follow their FDA Product Approval Order, FDA Product Code description and designation, Labeling, Safety and Effectiveness Summary and comply with current panel track Supplement(s) at the time of use.

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

Medical Policies and Coverage

MolDX: Melanoma Risk Stratification Molecular Testing (L37750) - R7 - Effective June 26, 2025

Date Posted: June 26, 2025

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: June 26, 2025

Summary of Changes:

Under ***Bibliography*** revised the broken hyperlink for the 43rd reference and changes were made to citations to reflect AMA citation guidelines.

This revision is effective on 6/26/2025.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCD or access it via the CMS Medicare Coverage Database (MCD).

Open Public Meeting Announcement - Multiple LCDs - June 26, 2025

Date Posted: May 15, 2025

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

Noridian Healthcare Solutions will be hosting an Open Public Meeting on June 26, 2025, from 2 pm - 4 pm CT.

Advance registration is required.

- Registration deadline to present comments on the LCDs will close on June 19, 2025, at 11:59 pm CDT.
- General Registration deadline to participate by listen-only mode will close on June 25, 2025, at 11:59 pm CDT.

Proposed Local Coverage Determinations (LCDs):

- Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC)
- Lab: Special Histochemical Stains and Immunohistochemical Stains

View meeting details and register now from the Open Meeting webpage.

Open Public Meeting Announcement - Transurethral Waterjet Ablation of the Prostate - June 26, 2025

Date Posted: May 29, 2025

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

Noridian Healthcare Solutions will be hosting an Open Public Meeting on June 26, 2025, from 2 pm - 4 pm CT.

Advance registration is required.

- Registration deadline to present comments on the LCDs will close on June 19, 2025, at 11:59 pm CDT.
- General Registration deadline to participate by listen-only mode will close on June 25, 2025, at 11:59 pm CDT.

Proposed Local Coverage Determinations (LCD) and Billing and Coding Article:

- Transurethral Waterjet Ablation of the Prostate
- Billing and Coding: Transurethral Waterjet Ablation of the Prostate

View meeting details and register now from the Open Meeting webpage.

Polysomnography and Other Sleep Studies Final LCD - Effective July 20, 2025

Date Posted: June 5, 2025

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

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L36861

LCD Title: Polysomnography and Other Sleep Studies

Effective Date: July 20, 2025

Summary of LCD: The LCD outlines coverage for Polysomnography and other sleep studies with specific details under Coverage Indications, Limitations and/or Medical Necessity.

Visit the Proposed LCDs webpage to access this LCD.

Medical Policies and Coverage

Proposed LCDs - Published for Review and Comments

Date Posted: May 15, 2025

The following proposed Local Coverage Determinations (LCDs) have been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database Number	LCD Title
DL40176	Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC)
DL36351	Lab: Special Histochemical Stains and Immunohistochemical Stains

Comment Period: May 15, 2025 - June 28, 2025

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

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

Proposed LCD Transurethral Waterjet Ablation of the Prostate - Published for Review and Comments

Date Posted: May 29, 2025

The following proposed Local Coverage Determinations (LCDs) have been published for review and comments for contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

Medicare Coverage Database Number	LCD Title
DL38705	Transurethral Waterjet Ablation of the Prostate

Comment Period: May 29, 2025 - July 12, 2025

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

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

Medical Policies and Coverage

Self-Administered Drug Exclusion List (A53032) - R41 - Effective June 1, 2025

Date Posted: April 17, 2025

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

Effective Date: June 1, 2025

Summary of Changes:

Added: CPT/HCPCS codes Q9999 Injection, Ustekinumab-aauz (Otulfi), biosimilar, 1 mg*; J3490, J3590, C9399 lebrikizumab-lbkz (Ebglyss); and J3490, J3590, C9399 ustekinumab-stba (SteQeyma)*

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

To view the complete listing of billing and coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Billing and Coding Articles webpage.

Self-Administered Drug Exclusion List (A53032) - R42 - Effective July 1, 2025

Date Posted: June 26, 2025

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

Effective Date: July 1, 2025

Summary of Changes:

Added: Q5098 Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg*; Q5099 Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg*; and Q5100 Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg*

Revised: Q9998 descriptor from "INJECTION, USTEKINUMAB-AEKN (SELARSDI), 1 MG" to "Injection, ustekinumab-aekn (selarsdi), biosimilar, 1 mg"

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

To view the complete listing of billing and coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Billing and Coding Articles webpage.

MLN Connects

MLN Connects - April 3, 2025

MLN Connects Newsletter: April 3, 2025

News

- Home Infusion Therapy & Intravenous Immune Globulin Services: Get Monitoring Reports
- Medicare Providers & Suppliers: Report Managing Employees
- External User Services Help Desk: New Contact Information
- Advanced Primary Care Management Services: Get Information about Billing Medicare

Claims, Pricers & Codes

- Lower Limb Orthoses: Prevent Claim Denials

MLN Matters® Articles

- Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update

MLN Connects - April 11, 2025

MLN Connects Newsletter: Apr 11, 2025

News

- Dr. Mehmet Oz Shares Vision for CMS
- Skilled Nursing Facility Value-Based Purchasing Program: March 2025 Confidential Feedback Reports
- Skilled Nursing Facilities: Revalidation Deadline is May 1

Compliance

- Pneumatic Compression Devices: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Physician Fee Schedule Database: April Update
- Integrated Outpatient Code Editor Version 26.1

MLN Connects

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: July 2025 Update
- DMEPOS Fee Schedule: April 2025 Quarterly Update
- Hospital Outpatient Prospective Payment System: April 2025 Update

MLN Connects - April 14, 2025

FY 2026 Proposed Payment Rules

- CMS Seeks Public Input on Inpatient Hospital Whole-Person Care, Proposes Updates to Medicare Payments
- Inpatient Rehabilitation Facility Prospective Payment System
- Hospice Wage Index & Payment Rate Update
- Inpatient Psychiatric Facility Prospective Payment System & Quality Reporting Updates
- Skilled Nursing Facility Prospective Payment System

MLN Connects - April 17, 2025

MLN Connects Newsletter: Apr 17, 2025

News

- Clotting Factors: Medicare Part B Pays for Alhemo & Qfitlia
- Skilled Nursing Facilities: Revalidation Deadline Extended to August 1
- Raise Awareness & Understanding of Alcohol Use and Misuse

MLN Connects - April 24, 2025

MLN Connects Newsletter: Apr 24, 2025

News

- Open Payments: Review Your Data by May 15
- Medicare Shared Savings Program: Application Toolkit Materials

MLN Connects

MLN Matters® Articles

- Inpatient Psychiatric Facilities: Return to Provider Claims with Point of Origin for Admission or Visit Code D & Charges for Emergency Department Services

MLN Connects - May 1, 2025

MLN Connects Newsletter: May 1, 2025

News

- Clinical Laboratory Fee Schedule Preliminary Gapfill Rates: Submit Comments by June 28

Compliance

- Acute Care Hospital Outpatient Services for Hospice Enrollees: Reduce Improper Payments
- Wheelchair Seating: Prevent Claim Denials

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting - June 27

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: April 2025 Update
- Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: July 2025 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2025 Quarterly Update

MLN Connects - May 8, 2025

MLN Connects Newsletter: May 8, 2025

News

- Direct Graduate Medical Education: Get Annual Update Factors

Compliance

- Walkers: Prevent Claim Denials

MLN Connects

Events

- HCPCS Public Meeting - June 2-3
- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests - July 23-24

Publications & Multimedia

- Medicare Preventive Services - Revised

MLN Connects - May 13, 2025

News

CMS Seeks Public Input on Improving Technology to Empower Medicare Beneficiaries

MLN Connects - May 22, 2025

MLN Connects Newsletter: May 22, 2025

News

- Discarded Drugs: Get Updated Lists
- Medicare Provider Payment & Utilization Public Use Files: Annual Update
- Medicare Fee-for-Service Geographic Variation Public Use Files & Interactive Dashboard: Annual Update
- CMS Fast Facts: Annual Update

Compliance

- Skilled Nursing Facilities: Identify & Prevent Improper Part D Payments for Drugs
- Psychiatric Care: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Physician Fee Schedule Database: July Update

MLN Connects

MLN Connects - May 22, 2025 - Departments of Labor, Health and Human Services, Treasury Announce Move to Strengthen Healthcare Price Transparency

Trump administration issues request for information, guidance to expand access to real prices

The departments of Labor, Health and Human Services, and the Treasury took action to advance President Trump's directive to ensure Americans have clear, accurate, and actionable information about healthcare prices.

The departments jointly issued a Request for Information (RFI) seeking public input on how to improve prescription drug price transparency. The agencies also released updated guidance for health plans and issuers that sets a clear applicability date for publishing an enhanced technical format for disclosures. These improvements are designed to eliminate meaningless or duplicative data and make cost information easier for consumers to understand and use.

Separately, CMS released new guidance, available on the Hospital Price Transparency resources website, to strengthen the Hospital Price Transparency requirements, requiring hospitals to post the actual prices of items and services, not estimates. CMS also issued its own RFI to gather public feedback on how to boost hospital compliance and enforcement and ensure data shared is accurate and complete.

See the full press release for more information.

MLN Connects - May 29, 2025

MLN Connects Newsletter: May 29, 2025

News

- Inpatient Hospital Admissions: Transferring Medical Review Responsibilities for Short Stay Claims
- Medicare Shared Savings Program: Apply Now

MLN Matters® Articles

- National Coverage Determination 20.36: Implantable Pulmonary Artery Pressure Sensors for Heart Failure Management
- Qualifications for Speech-Language Pathologists Providing Outpatient Speech-Language Pathology Services

MLN Connects

From Our Federal Partners

- Providers Accepting CHAMPVA: You Must Enroll in EFT to Get Paid

MLN Connects - June 5, 2025

MLN Connects Newsletter: June 5, 2025

News

- 2023 Doctors & Clinicians Preview Period Open Until June 25
- Hospital Price Transparency: Respond to Accuracy & Completeness RFI by July 21
- Medicare & Veteran Affairs: Adjustments for Duplicate Claims Start Next Month
- Join an Accountable Care Organization

Claims, Pricers & Codes

- RHC & FQHC Care Coordination Services: HCPCS Code G0511 Deadline Extended to September 30
- Medical Education: Submit No-Pay Bills for Programs of All-Inclusive Care for the Elderly

MLN Matters® Articles

- ESRD & Acute Kidney Injury Dialysis: CY 2025 Updates - Revised

Publications & Multimedia

- Quality in Focus Interactive Video Series: 4 New Videos to Enhance Quality of Care

MLN Connects - June 12, 2025

MLN Connects Newsletter: June 12, 2025

News

- Final National Coverage Determination: Noninvasive Positive Pressure Ventilation in Home for Treatment of Chronic Respiratory Failure Consequent to COPD
- Skilled Nursing Facility Value-Based Purchasing Program: June 2025 Confidential Feedback Reports

MLN Connects

Compliance

- Mechanical Ventilation: Bill Correctly for Inpatient Claims
- SNF Services: Prevent Claim Denials

Claims, Pricers & Codes

- ICD-10 Codes: FY 2026
- National Correct Coding Initiative: July Update

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2025 Update
- ESRD Prospective Payment System: July 2025 Update
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- 2023 Doctors & Clinicians Preview Period Open Until June 25
- Hospital Price Transparency: Respond to Accuracy & Completeness RFI by July 21
- Medicare Part B Discarded Drug Program: Get the Latest Updates
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- Updates to Colorectal Cancer Screening & Hepatitis B Vaccine Policies

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- VA Recovering Overpaid Claims from Some CHAMPVA Providers

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- Alert: Medicare Fraud Scheme Involving Phishing Fax Requests
- Medicare Diabetes Prevention Program: CY 2025 Payment Rates

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- Commodes, Bed Pans & Urinals: Prevent Claim Denials

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- Integrated Outpatient Code Editor Version 26.2
- Medical Education: Don’t Submit Claims for Programs of All-Inclusive Care for the Elderly

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2025 Quarterly Update

Publications & Multimedia

- Medicare & Mental Health Coverage - Revised
- Substance Use Screenings & Treatment - Revised

MLN Matters

Ambulatory Surgical Center Payment System: April 2025 Update

Related CR Release Date: April 24, 2025

MLN Matters Number: MM14017

Effective Date: April 1, 2025

Related Change Request (CR) Number: CR 14017

Implementation Date: April 7, 2025

Related CR Transmittal Number: R13181CP

CR 14017 tells you about:

- New HCPCS code for simulation angiogram for radioembolization of tumors
- Revised payment rates for CPT codes 0446T and 0448T
- Drug, biological, and radiopharmaceutical codes
- Skin substitute products

Make sure your billing staff knows about these payment system updates effective April 1, 2025

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14017.

ASC Payment System: July 2025 Update

Related CR Release Date: June 6, 2025

MLN Matters Number: MM14101

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14101

Implementation Date: July 7, 2025

Related CR Transmittal Number: R13259CP

CR 14101 tells you about:

- Ambulatory Surgical Center (ASC) payment indicator (PI) change and new CPT code pairs for HCPCS code C1739
- New CPT code pair for HCPCS code C1602
- New CPT category III codes
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitute products

Make sure your billing staff knows about these payment system updates effective July 1, 2025.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14101.

CLFS & Laboratory Services Subject to Reasonable Charge Payment: July 2025 Update

Related CR Release Date: April 24, 2025

MLN Matters Number: MM14055

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14055

Implementation Date: July 7, 2025

Related CR Transmittal Number: R13192CP

CR 14055 tells you about:

- When the next Clinical Laboratory Fee Schedule (CLFS) reporting period for clinical diagnostic laboratory tests (CDLTs) begins
- New and deleted CPT codes effective July 1, 2025

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14055.

DMEPOS Fee Schedule: April 2025 Quarterly Update

Related CR Release Date: April 2, 2025

MLN Matters Number: MM13990

Effective Date: April 1, 2025

Related Change Request (CR) Number: CR 13990

Implementation Date: April 7, 2025

Related CR Transmittal Number: R13122CP

CR 13990 tells you about:

- New HCPCS codes
- New fee schedule amounts
- New HCPCS codes on the fee schedule file for:
  - DMEPOS repairs and servicing
  - Complex rehabilitative power wheelchair accessories
  - Lymphedema compression treatment items

Make sure your billing staff knows about these changes.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13990.

DMEPOS Fee Schedule: July 2025 Quarterly Update

Related CR Release Date: June 20, 2025

MLN Matters Number: MM14088

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14088

Implementation Date: July 7, 2025

Related CR Transmittal Numbers: R13257CP & R13277CP

Related CR Title: July Quarterly Update for 2025 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

CR 14088 tells you about these updates effective July 1, 2025:

- No added or deleted codes
- Corrections to the 2025 fee schedule amounts for certain items provided in non-contiguous areas
- DMEPOS rural ZIP codes

Make sure your billing staff are aware of these changes.

View the complete CMS Change Request (CR) 14088.

HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2025 Quarterly Update

Related CR Release Date: April 17, 2025

MLN Matters Number: MM14049

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14049

Implementation Date: July 7, 2025

Related CR Transmittal Number: R13170CP

CR tells you about coding updates for the following categories:

- Angiography, lymphatic, venous, and related procedures
- Chemotherapy
- Radioisotopes and their administration

- Certain blood clotting factors indicated for the treatment of hemophilia and other bleeding disorders
- Customized prosthetic devices

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14049.

Hospital OPPS: April 2025 Update

Related CR Release Date: March 20, 2025

MLN Matters Number: MM13993

Effective Date: April 1, 2025

Related Change Request (CR) Number: CR 13993

Implementation Date: April 7, 2025

Related CR Transmittal Number: R13135CP

CR 13993 tells you about:

- Certain laboratory tests, COVID-19 monoclonal antibody therapy products, and Hospital Outpatient Prospective Payment System (OPPS) device categories
- Ambulatory payment classifications (APCs)
- Surgical and imaging procedures
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitute products

Make sure your billing staff knows about these updates effective April 1, 2025, including coding and billing changes

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13993.

ICD-10 & Other Coding Revisions to NCDs: July 2025 Update

Related CR Release Date: March 20, 2025

MLN Matters Number: MM13939

Effective Date: July 1, 2025 - unless noted in individual Business Requirements (BRs)

Related Change Request (CR) Number: CR 13939

Implementation Date: April 21, 2025 - BRs 1, 2, 3, 4, 5, 7 & 8; July 7, 2025 - BRs 6 & 10 only

Related CR Transmittal Number: R13097OTN

CR 13939 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)13939.

ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2025 Update

Related CR Release Date: June 6, 2025

MLN Matters Number: MM14041

Effective Date: October 1, 2025

Related Change Request (CR) Number: CR 14041

Implementation Date: July 8, 2025 - BRs 14041.2 and 14041.4; October 6, 2025

Related CR Transmittal Number: R13251OTN

CR 14041 tells you about:

- New codes
- Recent coding changes

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

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14041.

National Coverage Determination 20.36: Implantable Pulmonary Artery Pressure Sensors for Heart Failure Management

Related CR Release Date: May 22, 2025

MLN Matters Number: MM14000

Effective Date: January 13, 2025

Related Change Request (CR) Number: CR 14000

Implementation Date: October 6, 2025

Related CR Transmittal Number: R13246CP & R13246NCD

CR 14000 tells you about:

- National coverage of implantable pulmonary artery pressure sensors (IPAPS)
- Criteria for coverage
- Coverage with evidence development (CED) study criteria

- Claims processing requirements

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14000.

New Waived Tests

Related CR Release Date: May 9, 2025

MLN Matters Number: MM14025

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14025

Implementation Date: July 7, 2025

Related CR Transmittal Number: R13218CP

CR 14025 tells you about:

- Clinical Laboratory Improvement Amendments (CLIA) requirements
- New FDA-approved waived tests
- The code, effective date, and description for the latest waived tests

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14025.

Qualifications for Speech-Language Pathologists Providing Outpatient Speech-Language Pathology Services

Related CR Release Date: January 16, 2025

MLN Matters Number: MM13922

Effective Date: April 18, 2025

Related Change Request (CR) Number: CR 13922

Implementation Date: April 18, 2025

Related CR Transmittal Number: R13051BP

Related CR Title: Qualifications for Speech-Language Pathologists Furnishing Outpatient Speech Language Pathology Services

CR 13922 tells you about updates to the Medicare Benefit Policy Manual, Chapter 15, section 230.3 to match the regulatory provision for the qualifications of SLPs providing outpatient therapy services.

Make sure your billing staff knows about these changes.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13922.

Updates to CRC Screening & Hepatitis B Vaccine Policies

Related CR Release Date: May 29, 2025

MLN Matters Number: MM14031

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 14031

Implementation Date: October 6, 2025

Related CR Transmittal Number: R13248BP & R13248CP

CR 14031 tells you about:

- Coverage changes for colorectal cancer (CRC) screening tests
- Clarification of policy that applies to complete CRC screening
- Expanded coverage and changes to billing policies for the hepatitis B vaccine

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14031.

Contacts, Resources, and Reminders

Noridian Part B Customer Service Contact

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

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

Fax Numbers - View fax numbers and submission guidelines.

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for "Medicare B News" Articles

The purpose of "Medicare B News" is to educate the Noridian Medicare Part B provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it on the CMS

Manuals webpage. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

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

Unsolicited or Voluntary Refunds Reminder

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

Background

Medicare carriers and intermediaries and AB MACs receive unsolicited or voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related Change Request (CR) 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way limits the rights of the Federal Government, or any of its agencies or agents, to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to those or any other claims.

Additional Information

The official CMS CR3274 instruction may be viewed in the Medicare Learning Network (MLN) Matters article MM3274.

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

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

Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

1. "Return service requested" envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
2. "Return service requested" envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
    - Flag the provider's file DNF.
    - A/B MAC/carrier staff will notify provider enrollment team.
    - A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.
4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
5. Previously, CMS only required corrections to the "pay to" address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider's location.

IRS-1099 Reporting

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

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

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

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