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Noridian Part A Customer Service Contact

General IVR Inquiries Available 24/7

<table>
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<tr>
<th>Phone Number</th>
<th>Inquiry</th>
<th>Hours (CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>877-908-8431</td>
<td>Claim Specific</td>
<td>Monday - Friday 8 a.m. - 6 p.m.</td>
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- Interactive Voice Response (IVR)
- Provider Contact Center (PCC)
- Provider Enrollment
- EDISS
- User Security (including NMP)

Text Teletype Calls (TTY) - 877-261-4163

Monday - Friday 8 a.m. - 6 p.m. CT

MLN Matters Disclaimer Statement

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

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

Sources for “Medicare A News” Articles

The purpose of “Medicare A News” is to educate the Noridian Medicare Part A provider community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever we publish material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material.

Noridian includes “Source” following CMS derived articles to allow for those interested in the original material to research it at the CMS website, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index. The CMS Change Request (CR) and the date issued will be referenced within the “Source” portion of applicable articles.

CMS publishes a series of educational articles within their Medicare Learning Network (MLN), titled “MLN Matters.” These “MLN Matters” articles are also included in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Unsolicited or Voluntary Refunds Reminder

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

BACKGROUND

Medicare carriers and intermediaries and A/B 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**


**Effective Date:** January 1, 2005

**Implementation Date:** January 4, 2005

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

**Do Not Forward Initiative Reminder**

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

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

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

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

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

**POLICY**

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

**IMPLEMENTATION PROCESS**

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

4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.

5. Previously, CMS only required corrections to the “pay to” address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider’s location.

IRS-1099 REPORTING

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

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

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

2022 JF Part A Quarterly Ask-the-Contractor Teleconferences

Below is the listing of the 2022 Part A Quarterly Ask-the-Contractor Teleconferences (ACTs).

• March 23, 2022
• September 28, 2022

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

Noridian representatives from various Part A departments are available to address your Medicare questions and concerns. All questions are entertained and the Q&As are posted on our website for provider convenience.

To view ACT dates, times, toll-free number, and Q&As, go to https://med.noridianmedicare.com/web/jfa/education/act.

No registration is required for these calls. Please call in 10 minutes prior, all calls start promptly at the time designated in the schedule listing.

By completing and submitting the Noridian “Ask the Contractor Teleconference Question Submission Form,” providers may ask question(s), up to five (5) days prior, to be answered during the next ACT. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center. Providers will need to have Version 7 or higher of Adobe Reader to use this form.

We look forward to your participation in these important calls.

Medicare Part A ACTs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries. If you are interested in attending a Part B or a DME ACT, select the appropriate link below for more information.

JF Part B - https://med.noridianmedicare.com/web/jfb/education/act
JD DME - https://med.noridianmedicare.com/web/jddme/education/act
JA DME - https://med.noridianmedicare.com/web/jadme/education/act
2022 Medicare Physician Fee Schedule Now Available

The 2022 Medicare Physician Fee Schedule is now available in Excel format. It can be seen at: Noridian Medicare JF Part A Fee Schedules

Per CMS CR#12409, CMS has released the Medicare Physician Fee Schedule. This fee schedule takes effect January 1, 2022, so make sure your office staff are aware of the new information.

ACT Questions and Answers - September 15, 2021

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

MEDICARE PROGRAM UPDATES

1. **CMS Website:** CMS has changed the look of the home page on their website. All the information remains easily accessible.
2. **CMS Current Emergencies:** Providers can access the CMS website to access current information and any changes that may occur throughout the duration of the pandemic.

QUESTIONS AND ANSWERS

Q1: A patient is receiving treatment for cancer, however, is being admitted for something else. But the patient is scheduled for treatment during that admission. Can the patient continue his or her care while in the hospital and have their cancer treatments continued as this is being billed under Drug Related Grouping (DRG) weight or would this basically be double dipping and patient will need to discharge under 30 and register for their cancer treatment and return for continued care under new admission?

A1: Yes, treatment can continue when the inpatient admission is unrelated and be billed through the inpatient hospital provider under arrangement. Per CMS IOM, Publication 100-04, Chapter 3, Section 10.4, all items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements. Providers are also required to report all diagnosis codes on an inpatient claim as well as the Present on Admission (POA) indicators. This is used in determining the DRG grouping.

Q2: The newest version of the L34106 Local Coverage Determination (LCD) policy indicates that all patients presenting with Vertebral Compression Fracture (VCF) should be referred for evaluation of Bone Mineral Density (BMD) and osteoporosis education for subsequent treatment, as indicated, and all patients with VCF should be instructed to take part in an osteoporosis prevention/treatment program. Most patients in need of this procedure already have an established diagnosis of osteoporosis and are subsequently already on treatment with Prolia. Can you please clarify, if in these instances, the above criteria would not apply? The patient would already be following up yearly with their physician for the treatment of osteoporosis. Would this only apply to newly diagnosed patients?

A2: Performers of vertebroplasty should note that the beneficiary is under treatment and with what. The key is you cannot just do the procedure without showing that you are thinking about the treatment of the underlying disease. This must be clearly documented in the medical record.

Q3: Per CMS IOM Publication 100-04, Chapter 15, Section 220.1.2.B regarding Plans of Care for Physical Therapy (PT), Occupational Therapy (OT), or Speech-Language Pathology Services (SLP): “The duration is the number of weeks, or the number of treatment sessions, for this Plan of Care.” Per this definition, the duration would be a documented number of weeks (e.g., six weeks) or sessions (e.g., 12 sessions). Is it acceptable to document the 'duration' of the services using the end date of a certification? For example: Instead of documenting three times per week for six weeks, would it be acceptable to document three times per week through the certification end date?

A3: To reflect a clear measurable duration to meet IOM requirements it would be appropriate to note the frequency through the certification end date of XX/XX/XX. It is recommended that the end date is listed in this example.

Q4: Can we get education on the appropriateness of the KX modifier when it comes to Cardiac Rehab? According to CMS IOM Publication 100-04, Chapter 5, Section 10.3 the KX modifier should only be used if documented medically necessary services exceed the therapy cap; in this case the initial 36 sessions of cardiac rehab. Also, if a beneficiary has a new cardiac
event and needs rehab again, would this be 36 sessions without the KX modifier or is this not a lifetime max of 36 sessions?
A4: IOM Publication 100-04, Chapter 5, Section 10.3 refers to Part B Outpatient Rehabilitation and CORF/OPT Services. Comprehensive Outpatient Rehabilitation Facilities (CORF) can provide respiratory therapy services per IOM Publication 100-02, Chapter 12, Section 40.5. The respiratory plan of treatment must be wholly established by the referring physician before therapy is initiated. Respiratory therapy must be provided by a respiratory therapist. Respiratory therapy services are reported with Healthcare Common Procedure Coding System (HCPCS) G0237, G0238, and G0239 with no therapy modifiers. The plan of treatment must be reviewed upon the duration of the plan of treatment or at least every 60 days. HCPCS G0237, G0238, and G0239 are not subject to the therapy caps, therefore, the KX modifier would not be applicable. The documentation must demonstrate the medical need for skilled therapy and that the beneficiary is making progress toward one or more of the rehabilitation goals. Medicare coverage ends with respect to that aspect of the rehabilitation plan of treatment.

Coverage criteria for cardiac rehabilitation services are covered in the IOM Publication 100-02, Chapter 15, Section 232. Cardiac rehab services cannot be billed on the CORF Type of Bill (TOB) 75x. Per the IOM Publication 100-04, Chapter 32, Section 140.2.2, Cardiac Rehab (CR) and Intensive Cardiac Rehabilitation (ICR) services should be submitted on TOB 13X or 85X only for institutional claims. Contractors shall accept the inclusion of the KX modifier on the claim line(s) as an attestation by the provider of the service that documentation is on file verifying that further treatment beyond 36 sessions of CR up to a total of 72 sessions meets the requirements of the medical policy or, for ICR, that any further sessions beyond 72 sessions within a 126 day period counting from the date of the first session or for any sessions provided after 126 days from the date of the first session meet the requirements of the medical policy. Beneficiaries who switch from ICR to CR may also be eligible for up to 72 combined sessions with contractor discretion for CR sessions after 36 (to include completed ICR sessions prior to switch). In these cases, and consistent with the information above, the KX modifier must be included on the claim should the beneficiary participate in more than 36 CR sessions following the switch.

Change Request 7470, Common Working File (CWF) Editing Update for Pulmonary Rehabilitation Services (PR) states that the Common Working File (CWF) edit is set up to deny CR and ICR services that exceed 72 services provided within 18 weeks without the KX modifier.

When there is a new cardiac event beyond the 18-week time period, the coverage for CR sessions would re-start with the 36 sessions.

Q5: Please validate the billing guidelines about two different visits on same date. This is for services that overlap with revenue codes 0360 and 0450. The first service, outpatient surgery, is provided. The second visit is an emergency service follow-up on the wound. Are these two services paid separately?
A5: These claims should be combined, especially if related to the procedure. The condition code G0 (G “zero”) would not apply as they are not the same revenue center. The Integrated Outpatient Code Editor (/OCE) Specifications file in the CMS I/OCE Quarterly Files provides different examples when the G0 condition code should be applied.

Q6: I understand how to use the ET modifier for emergency room (ER) services when a patient is in-house at a Skilled Nursing Facility (SNF) and receiving emergency room services at a Part A facility spanning multiple days. Does the ET modifier apply to any emergency room services related to consolidated billing? We bill for a mental health facility and the patient is seen at an emergency room at a Part A Prospective Payment System (PPS) hospital and then is evaluated and transferred to an inpatient PPS Behavioral Health Facility. I would like to know if it is appropriate to use the ET modifier on the emergency room visit when the patient dates span 01/01/21-01/02/21 and is admitted to the Behavioral Health Facility on 01/02/21 or is the ET modifier only used when a patient is inhouse at a SNF?
A6: The ET modifier is used to exempt ER services from consolidated billing. It can be used when patient is an inpatient at a SNF in a Part A covered stay and to indicate ER-related services are excluded from End Stage Renal Disease (ESRD) consolidated billing for patients on maintenance dialysis. The ET modifier would not be appropriate for an inpatient PPS Behavioral Health Facility.

Q7: Does Noridian have any guidance in relation to billing for the donor and recipient charges for fecal transplants? Is this a covered service for the recipient; and do the donor’s charges get billed to the donor’s respective insurance, or would they be covered under the recipient? Would all charges get billed to each the donor and recipient’s respective insurance?
A7: G0455 is the correct code for Fecal Microbiota Transplant which includes the obtaining and processing of the donor specimen and is billed to the recipient. In lieu of a coverage policy, the medical record must demonstrate that the service provided is medically necessary for treatment of the beneficiary’s condition.
Q8: The current Local Coverage Article for Treatment with Yttrium-90 Microspheres (A52950) provides instruction on how to bill for Theraspheres as a product with Food and Drug Administration (FDA) Humanitarian Device Exemption (HDE) approval with the HDE number. As of March 17, 2021, Boston Scientific (the current manufacture of Theraspheres) received premarket approval for Therasphere, therefore, changing the HDE status of the product. Can you please provide instruction on how to bill future claims in which Theraspheres (C2616) is used to be able to differentiate it between the SIRTEX product, now that the HDE number will not be utilized? Both products have different covered diagnosis codes.

A8: If the product no longer had HDE status, the claim would be reported using the appropriate revenue code (not 0624) and would be coded with the correct diagnosis code per the article. The patient’s medical record would also need to reflect what product was used to ensure it matches the diagnosis codes billed.

Q9. Please refer to CMS Change Request (CR) 11792 as CPT code 12001, along with others, was removed from the Rural Healthcare Clinic (RHC) Qualifying Visit List on 07/2020. CMS does NOT update the master RHC Qualifying Visit List, they just release the change request (CR11792), and it makes it official. CPT code removed/excluded from the RHC Qualifying Visit list effective 07/2020: 10060, 11721, 12001, and 20604. How are we as a RHC to get paid for this visit? Would we automatically attach an Evaluation and Management (E&M)?

A9: No, automatically attaching an E&M code only to receive payment would be a fraudulent billing practice and you could lose the privilege to bill Medicare altogether. Per CR 12187, effective 04/01/2021 the following codes were removed from the list and are now billable/payable using the CG modifier: 10060, 11721, 11750, 11765, 12001, 20600, 20604, 29580, 69200, and 69210. Furthermore, the CMS I/OCE Quarterly Files contain a MAP_CONFLICT RHC file that determines services deemed incorrectly reported with modifier CG (Policy criteria is applied) for RHC claims are line item rejected. Complete information can be found in the CMS MLN Matters MM12187 Article.

Q10: We are a Federally Qualified Health Center (FQHC) and according to CMS guidance, COVID-19 vaccine administration payment is made at the time of cost settlement. A COVID-19 vaccine only service does not qualify as an eligible PPS visit. We submitted several COVID-19 vaccine administration claims to Noridian for report purpose, but the claims were returned to the provider with reason code: 31744. We understood that COVID-19 vaccine administration payment is made at the time of cost settlement, however, I believed that we would need to submit data to Medicare. Otherwise, how can the services be reconciled at the end of the year? As well as Medicare Advantage (MA) patients, we need to bill original Medicare since MA plans are not financially responsible for COVID-19 vaccine administration. Do we submit the claims to Part B (Medicare FFS)? We tried to submit the COVID-19 vaccine administration claims to MA Wrap-around, but the claims were returned to provider also for same reason code.

A10: The COVID 19 vaccine and its administration are paid at 100 percent of reasonable cost through the cost report. No visit is billed, and these costs should not be included on the claim. Costs for all COVID-19 vaccines should be included on the cost report information. Therefore, a claim for COVID vaccines should not be submitted.

Q11: If a CERT audit identifies an improper payment for inpatient level of care as not medically necessary, and we agree with the CERT decision, is the facility allowed to rebill for Part B charges if the DOS falls within timely filing? Please see CMS IOM 100-04, Chapter 4, Section 240.1 - Editing of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials for reference.

A11: Yes, if you are within timely filing for A-to-B Rebilling, it is appropriate to rebill those charges. Directions for A-to-B Rebilling can be found in CR8445 and CR8666. Please be aware that CMS has removed special edition, SE1333, that contained additional instructions.

Q12: The hydration billing and coding coverage article indicates that a clinical assessment would typically be performed prior to hydration being ordered for a patient’s anticipated fluid needs. In cases of nephrotoxicity, our oncology physicians order hydration based upon reviewing the patient’s lab work for elevated creatinine levels, which indicates the presence of nephrotoxicity. In these instances, would hydration still be considered medically necessary without a provider clinical assessment because the decision to order hydration for nephrotoxicity is based upon the presence of elevated labs only? Or would Noridian still expect to see a clinical assessment in the medical record for these scenarios?

A12: A clinical assessment is helpful, but not essential. The labs can provide some of the documentation for the medical necessity for why IV fluids are given but should not be the only documentation. There would also need to be notes by the provider based on what the labs reflected on why IV fluids are needed. For example, the documentation would need to show what chemo drug was given and if it is nephrotoxic, the note would indicate chemo drug is nephrotoxic and the labs are showing a need for hydration. Also, it would be expected to see fluids given on the same day as the drug.
Q13: When fluids are given at a high rate for trauma patients for treatment of shock or burns, when fluids are used for a patient with kidney stones or diabetic ketoacidosis (not dehydration) is this still considered hydration and how do we determine the time of hydration?

A13: As for the specific scenarios presented, we try and stay away from specific scenarios as the documentation would need to support each claim billed. Hydration services need to meet the definition of the CPTs as listed in the American Medical Association (AMA) coding book. Also, as indicated in the article, “In conclusion, the main question that should be asked when considering billing for 96360 and 96361 is whether IV hydration is an appropriate, accepted standard of medical practice as a diagnostic or specific treatment for a beneficiary’s condition, is one that meets, BUT does NOT exceed the beneficiary’s medical need, and cannot be met with oral hydration.” The billing and coding article also provided information on how time is calculated, “infusion time is calculated from the time the administration commences (i.e., the infusion starts dripping) to when it ends (i.e., the infusion stops dripping).” Also, if the time is less than 31 minutes, the codes cannot be reported as per the AMA since these codes reflect time.

Q14: How do we report when fluids are given for dehydration but at a slow rate as to not induce fluid overload for patients with Congestive Heart Failure (CHF) or kidney disease? How do we determine the time of hydration?

A14: The documentation needs to clearly indicate by the ordering provider, the concern of fluid overload and why the infusion was given so slowly. The billing and coding article, [A54635 for JE, A52732 for JF], provides guidance on how time is calculated “infusion time is calculated from the time the administration commences (i.e. the infusion starts dripping) to when it ends (i.e. the infusion stops dripping).”

Q15: Can Noridian please clarify if advanced practice providers (AAP) can order diagnostic mammograms? The NCD for Mammograms [220.4] reflects these can only be ordered by a doctor of medicine or osteopathy, however, the Code of Federal Regulations (CFR), title 42, section 410.32, Diagnostic x-ray tests, diagnostic laboratory test, and other diagnostic tests indicate that non-physician practitioners who furnish services that would be physician services furnished by a physician, and who are operating within their scope of their authority under State law, may be treated the same as physicians treating beneficiaries. Can APPs order diagnostic mammograms?

A15: Yes, as long as it is within the advanced practice providers scope of practice.

Q16: When a patient is seen in an RHC, and is subsequently sent to Critical Access Hospital (CAH) to be seen in the ER and possibly admitted, can the RHC bill a visit in addition to the visit that will be billed by a different provider in the ER or the admitting provider if admitted to the CAH?

A16: Yes, the RHC can bill a visit in addition to the visit that will be billed by a different provider.

Q17: When providing the drug Xolair, J2357, we are wondering how many instances of 96372 can be billed. We purchase syringes of Xolair that come in 150 and 75 mg vials. The MUE is 5. The patient has to be injected in 2 different locations. The manufacture states that no more than 150 mg can be injected in one site. Can we bill 96372 x 2 for two subcutaneous injections for two different locations on the body? Can three units of 96372 be billed for 150 mg in one site, 75 mg each in two separate sites? Which line requires a modifier 59? Is the 76 modifier applicable as this is incident to a physician service? Where are instructions published?

A17: The Current Procedural Terminology (CPT) code 96372 (Therapeutic, prophylactic, or diagnostic injection) can be billed for two units since this has to be given in two syringes at two different sites. A modifier is not needed. It would not be medically necessary to divide the dose into three syringes per the FDA guidelines, therefore, billing three units would be inappropriate. The Medically Unlikely Edits (MUE) for the administration CPT code, 96372, is five and for HCPCS code J2357 (Xolair) the MUE is 120.

Q18: Regarding therapeutic infusion coding, 96365, (Intravenous infusion). Patients come in 12 hours apart for antibiotic infusions and we are receiving denials for second infusion. We used to bill the second line item of 96365 with either the 59 or XE modifier noting the second encounter. We have received guidance to bill the second line item with 96366 (Each additional hour).

A18: Per the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 11, CPT codes 96360, 96365, 96374, 96409, and 96413 describe “initial” service codes. For a patient encounter, only one “initial” service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate
intravenous access sites. To report 2 different “initial” service codes, use National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP)-associated modifiers.

Per CPT Coding Manual: “When reporting multiple infusions of the same drug/substance on the same date of service, the initial code should be selected. The second and any subsequent infusions should be reported based on the individual times of each additionally infusion(s) of the same drug/substance using the appropriate add-on code. Example: In the outpatient observation setting, a patient receives one-hour intravenous infusions of the same antibiotic every 8 hours on the same date of service through the same IV access. The hierarchy for facility reporting permits the reporting of code 96365 for the first one-hour dose administered. Add-on 96366 would be reported twice (once for the second and third one-hour infusions of the same drug)”. The CPT manual also states that only 1 initial/primary code can be billed per date of service.

Q19: We need a definition of an encounter. When the patient leaves the facility for a period of time and they are re-registered for the second infusion, that is counted as a second encounter.
A19: For planned infusion services when the patient returns for an additional infusion of the same drug, Outpatient Perspective Payment System (OPPS) services of multiple administrations provided on the same day would be on the same claim unless they are different; and the G0 condition code would need to be reflected on the claim.

Please refer to the following resources for additional information:

CMS Change Request 7271
Jurisdiction E (JEA) Chemotherapy Administration Billing
Jurisdiction F (JFA) Chemotherapy Administration Billing

Q20: We are using Spinraza to treat patients with spinal muscular atrophy with an intrathecal administration method. We bill outpatient hospital services (UB-04 claim form) and physician services (CMS 1500 claim form). We are seeking clarity on which is the appropriate code to report for Spinraza; 96450, 62322 w/out and 62323 w/imaging guidance), or 64999 unlisted procedure code in nervous system with an inserted comment for the Spinraza administration. There is an understanding CPT codes 62322 and 62333 are in an LCD for injections into lumbar and spine which would differ for our intended use.
A20: Spinraza (nusinersen) (HCPCS code J2326) is a medication that was approved in December 2016 by the U.S. FDA for the treatment of all forms of spinal muscular atrophy (SMA). Spinraza is administered by intrathecal injection and should be billed using CPT code 96450 - Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture.

Q21: We noticed mass reprocessing of chest x-rays from 09/20/2020 through 01/07/2021. The mass reprocessing finalized on 01/17/2021. Why did this occur?
A21: Per the Local Coverage Determination (LCD), L37549 Chest X-Ray Policy, “There are thousands of diagnoses which would constitute reasonable and necessary conditions for chest X-rays. Despite that, Noridian data shows that there are a large number of chest radiographs that do NOT appear reasonable and necessary. To simplify this policy, and for physicians to be reimbursed for chest X-rays and avoiding coding errors, we are converting this to a negative policy.

Noridian is listing those diagnoses that are not reasonable and necessary based on literature from medical societies and clear community standards and for which the data analysis shows are the more common reasons for a denial. A chest X-ray that is not reasonable and necessary contributes to unneeded patient radiation exposure, patient anxiety, unnecessary visits to a medical or radiology facility, and increased costs to both patients and the Medicare Trust Fund.”

In September 2020, a system issue was identified for OPPS claims causing claims to deny incorrectly if a non-payable DX code was anywhere on the claim causing the entire claim to deny. The issue was corrected and a mass adjustment ran to correct the issue.

Q22: Tocilizumab, a monoclonal antibody treatment for hospitalized adult or pediatric patients two years and older who must have systemic corticosteroids and supplemental oxygen before you can bill the administration fee of M0249, and M0250. What is considered hospitalized? When a COVID positive patient comes into the Emergency Department (ED) and there are no hospital beds available, if an inpatient order is written and Tocilizumab monoclonal antibody treatment is ordered, is that considered hospitalization?
A22: Yes, Treatment can be provided in the hospital inpatient or outpatient setting. The hospital stay begins when there is a written order by the physician to admit.
Tocilizumab, a monoclonal antibody treatment, must be provided for patients with a positive COVID-19 test result and are at high risk for progressing to severe COVID-19, hospitalization, or both. Healthcare providers may administer monoclonal antibody therapies only in settings where they have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis and the ability to activate the emergency medical system (EMS).

Please refer to the following resources for additional information:

- CMS Monoclonal Antibody COVID-19 Infusion
- CMS Covid-19 Vaccines and Monoclonal Antibodies

**Ambulance Education-On-Demand Tutorials Available**

Noridian offers six new education-on-demand tutorials to assist ambulance suppliers. Although the tutorials are in a convenient Noridian Ambulance playlist in YouTube, each tutorial and its duration are provided for your convenience.

- Ambulance Basics: Payment Rules and Billing - 31 minutes
- Ambulance Basics: Types of Transport and Personnel - 17 minutes
- Ambulance Orders and Documentation Requirements - 19 minutes
- Ambulance Reviews - 12 minutes
- Ground Ambulance Data Collection System - 7 minutes
- Prior Authorization of Repetitive, Scheduled Non-emergent Ambulance Transport (RSNAT) - 8 minutes

Providers, suppliers, and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education. Noridian appreciates the provider feedback received through our satisfaction surveys, including the request for outreach on ambulance and the production of more tutorials.

**Ambulance Fee Schedule: CY 2022 Ambulance Inflation Factor**

According to the Social Security Act, the Ambulance Fee Schedule is updated annually by an Ambulance Inflation Factor (AIF): Consumer Price Index for All Urban Consumers (CPI-U) (June-June of the previous year) reduced by Multi-Factor Productivity (MFP). The CPI-U for 2022 is 5.4% and the MFP for Calendar Year (CY) 2022 is 0.3%. Therefore, the AIF for CY 2022 is 5.1%.

**RESOURCES**

- CMS MLN Connects Newsletter dated October 28, 2021
- CMS Change Request 12488, Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2022 and Productivity Adjustment
- CMS Ambulance Fee Schedule webpage

**ESRD Facilities: Bill Correctly for Cinacalcet Oral Drug**

Beginning January 1, 2021, the cinacalcet oral drug is eligible for consideration as an ESRD outlier service:

- Report the number of tablets or pills, not the number of units (for example, milligrams)
- Report revenue code 250 with the national drug code
- Don’t use revenue code 0636 with HCPCS code J0604

More Information:

- MLN Matters Article MM12011 (PDF), page 7
- ESRD PPS Outlier Services webpage
- Medicare Benefit Policy Manual, Chapter 11 (PDF), §20.3.C
- Medicare Claims Processing Manual, Chapter 8 (PDF), §60.2.1.2

Source: CMS MLN Connects dated September 23, 2021
**Flu Shot Disparities**

According to the [CDC](https://www.cdc.gov), people of racial and ethnic communities experience higher rates of severe flu-related illness and hospitalization, and they historically have lower vaccination rates than non-Hispanic White people.

Hospitalization Rates:
- Non-Hispanic Black people (69 per 100,000)
- Non-Hispanic American Indian or Alaskan Native people (49 per 100,000)
- Hispanic or Latino people (45 per 100,000)
- Non-Hispanic White people (38 per 100,000)
- Non-Hispanic Asian people (32 per 100,000)

Adult Flu Vaccination Percentages:
- 38.6% Hispanic or Latino people
- 40.4% non-Hispanic Black people
- 41.5 % non-Hispanic American Indian or Alaskan Native people
- 54.5% non-Hispanic Asian people
- 55.5% non-Hispanic White people

You can help reduce these disparities and increase flu shot use:
- Use each office visit to talk to your patients about why it’s important to get the flu shot
- Share handouts with patients who want additional information, have questions, or decline the flu shot
- Refer patients to a [vaccine provider](https://www.medicare.gov) if your practice doesn’t administer the flu shot

Medicare Part B covers 1 flu shot per flu season and additional flu shots, if medically necessary. Your patients pay nothing if you accept assignment.

More Information:
- [CMS Flu Shot](https://www.cms.gov) webpage
- [CDC Seasonal Influenza Vaccination Resources for Health Professionals](https://www.cdc.gov) webpage
- [Flu Shot information for your Medicare patients](https://www.medicare.gov) webpage

Source:
CMS [MLN Connects](https://www.cms.gov), Thursday, December 16, 2021

**Holding Claims for Pricing Based on the January 2022 FISS Release**

Effective January 1, 2022, Part A claims with dates of service on/after January 1, 2022 will be placed on a 15 day hold while pricing files are installed into the Fiscal Intermediary Shared System (FISS). This will allow claims to be verified for correct pricing to ensure proper payment.

All claims held during this time will be released no later than January 15, 2022.

**Implanted Spinal Neurostimulators: Document Medical Records**

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

Learn what you need to include in patient medical records to support Medicare coverage:
- [Hospital Outpatient Department (OPD) Services](https://www.medicare.gov) webpage
- [Hospital Outpatient Prospective Payment System Final Rule](https://www.cms.gov) Section XVII
Interactive Voice Response (IVR) Assistance

Noridian’s Interactive Voice Response (IVR) is available for general inquiries 24/7 by calling 1-877-908-8431. Claim-specific inquiries available: Monday-Friday: 6 a.m. - 8 p.m. CT, Saturday: 7 a.m. - 5 p.m. CT. Depending upon the type of inquiry and department, additional authentication may be required. Provider Enrollment requires National Provider Identifier (NPI), PTAN and last five of the Tax ID number. If the call relates to a claim, the following information related to the Beneficiary is required: Name, Medicare Number, and Date of Service for the claim in question.

- For Part A General Inquiries, a verbal response of General or Touch Tone Response of 1 will route call to the appropriate area based upon the NPI, TIN and PTAN entered. Once in that system, there are options to check (1) General information (1), Medicare Secondary Insurance information (2), HMO information (3), Home Health (4), Hospice (4), Preventative (6) and Eligibility Details (7).
  - For Claim Status, a verbal response of Claim Status or Touch Tone Response of 2 will route call for additional information regarding claims that have processed.
  - For Financial information, a verbal response of Financials or Touch Tone Response of 3 will route call to the appropriate area. Once in that system, the caller can verify check information (1), Offset Information (2) and Payment Summary (3)
  - For Procedure Patient Code Pricing, a verbal response of Pricing or Touch Tone Response of 4 will route call to that area.
- For EDI, a verbal response of EDI or Touch Tone Response of 2
- For Enrollment, a verbal response of Enrollment or Touch Tone Response of 3
  - If calling to verify the status of an application, the caller will be referred to the Application Status Check tool on the Noridian Medicare Website. Selecting this option in the IVR menu will refer the caller to use the Noridian Medicare website location for the tool and then disconnect the call. Once the status of the application has been verified, and there are additional questions regarding the application, select Touch Tone Response of 3 and bypass the Application Status Check prompt.
- For Reopenings, a verbal response of Reopenings or Touch Tone Response of 4
- For User Security, a verbal response of User Security or Touch Tone Response of 5. This selection is for calls related to Direct Data Entry (DDE)/Professional Provider Telecommunications Network (PPTN), Noridian Medicare Portal (NMP) registration or password assistance.

When using the IVR, we suggest calling from a quiet environment using a telephone with a handset or headset speaking clearly into the telephone. Once an option has been selected from the IVR main menu and the authentication process begins, the caller can bypass additional messages by saying “Main Menu” or pressing the # key. Saying “Main Menu” at any time will take the caller back to the beginning of the call flow. During Noridian business hours, callers may say “operator” or press the number zero. An IVR Guide is available to navigate the system to get to the correct department.

If the IVR is having trouble understanding the information that is spoken, there is a tone feature for entering letters using either the chart listed in the IVR section or the IVR conversion Tool. This will convert the PTAN/Medicare Number and/or the patient’s first and last names. For example, PTAN GT4165 would be converted to: *41*814165, Patient Name: John Smith would be: *51*63*42*62*74*61*43*81*42.

Level 2 Appeal Submission for Part A Providers

The Noridian Medicare Portal (NMP) now offers Part A providers to submit Level 2 Reconsiderations directly to the Qualified Independent Contractor (QIC). This new functionality will allow providers to not only submit your reconsiderations, but also be able to check the status, view the reconsideration decisions and view and print the reconsideration letters.
To begin using NMP to submit the Level 2 appeals, users will perform a Claim Status Inquiry to find the claim wanting to be appealed. The Claim Status Details page will provide a summary of the Level 1 appeal previously submitted. Once the Level 1 Appeal has been finalized, the Level 2 Appeal form will then be available.

For instructions and to begin submitting Level 2 Appeals today, view the Part A Response section of the Claim Status Inquiry of the NMP Inquiry Guide.

**Medicare FFS Claims 2 Percent Payment Adjustment (Sequestration) Changes**

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims:

- No payment adjustment through March 31, 2022
- 1% payment adjustment April 1 - June 30, 2022
- 2% payment adjustment beginning July 1, 2022

Source
- CMS MLN Connects dated December 16, 2021

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**Opioid Treatment Programs New Information, Billing, and Payment**

**NEW INFORMATION FOR 2022**

The Calendar Year (CY) 2022 Physician Fee Schedule final rule includes information for Medicare-enrolled Opioid Treatment Programs (OTPs):

- After the end of the COVID-19 public health emergency (PHE), CMS will allow audio-only interactions (like telephone calls) when audio-video communication isn’t available to the patient or the patient can’t or won’t agree to 2-way audio-video communication
- CMS established HCPCS code G1028 for a higher dose of naloxone hydrochloride nasal spray in response to the increase in overdoses from illicitly-manufactured fentanyl, which can require a more potent overdose reversal drug

After the PHE ends, CMS expects OTPs to add the following modifiers on claims for HCPCS code G2080:

- Modifier 95: for counseling and therapy provided using audio-video telecommunications
- Modifier FQ: for counseling and therapy provided using audio-only telecommunications

Additionally, CMS issued an interim final rule with comment period to keep the methadone payment amount at the CY 2021 rate for the duration of CY 2022. CMS encourages OTPs to review the rule and submit formal comments by January 3, 2022.

CMS updated the OTP webpages and the Billing & Payment (PDF) booklet with this and other new information.

**MEDICARE BILLING AND PAYMENT - REVISED**

Learn about new HCPCS codes and modifiers (PDF):

- Use HCPCS code G1028 - Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray
- Use HCPCS code G2215 - Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray
- Add Modifier 95 to your claim for counseling and therapy you provide by audio-video telecommunications using HCPCS code G2080 after the Public Health Emergency (PHE) ends
- Add Modifier FQ if you provide audio-only counseling or therapy services after the PHE ends
• See updated Table 1: MAT Codes, Descriptors, & National Medicare Payment Rates to include updated rates, new HCPCS code G1028 and revised definition of HCPCS code G2215

Source
• CMS MLN Connects dated December 16, 2021

Pneumococcal Conjugate Vaccine, 15 Valent

Medicare began covering pneumococcal conjugate vaccine, 15 valent on July 16. CMS suggests submitting separate claims for this vaccine (HCPCS code 90671). CMS MLN Matters Number: MM12439 Revised added instructions for vaccine code 90671 and changed the effective date for code 90677 (Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use).

• Part A and B Medicare Administrative Contractors will hold claims for vaccines provided after December 31 until pricing is set
• CMS will deny claims for vaccines provided before July 16

Sources:
CMS MLN Connects dated December 23, 2021
CMS MLN Connects dated December 16, 2021

Provider Enrollment Application Fee Amount for CY 2022

On October 25, CMS issued a notice in the Federal Register, Provider Enrollment Application Fee Amount for Calendar Year 2022, establishing the CY 2022 provider enrollment application fee. Effective January 1 - December 31, 2022, the application fee is $631 for institutional providers (as defined in 42 CFR § 424.502) that are:

• Initially enrolling in the Medicare or Medicaid program or the Children’s Health Insurance Program (CHIP)
• Revalidating their Medicare, Medicaid, or CHIP enrollment
• Adding a new Medicare practice location

You must pay this fee when you submit any of these enrollment applications in CY 2022.

Webinar Recordings on Demand Coming Soon

Noridian Healthcare Solutions will provide access to live webinar recordings in the coming months. These recordings will be available for a limited time and will be accessed through our Education and Outreach page on the Noridian website. Recordings will be viewed through GoToStage. Please note that not all webinars will be posted. Continuing Education Units (CEU) will not be available for recorded webinars. Watch for the announcement once they are available.

Webinar Registration Allows Pre-Submitted Questions

Providers, when you are registering to attend a webinar, you will be asked "What question do you hope to have answered by attending this event?" By talking with your peers and billing office staff members prior to registering, you can help ensure Noridian delivers tailored outreach to meet your needs.

The Provider Outreach and Education team hopes to tailor our presentations to best fit your training needs. Having you submit your question(s) during the registration process provides us the opportunity to research and streamline the question-and-answer portion at the end of each webinar.

Noridian appreciates the provider feedback received through our satisfaction surveys, including the compliments and recommendations regarding the question-and-answer portion of events.
MEDICAL POLICIES AND COVERAGE

2021 ICD-10 Local Coverage Determination (LCD) and Local Coverage Article (LCA) Updates

The following LCA’s have 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: October 1, 2021

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

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<th>LCD/LCA Number</th>
<th>ICD-10 Added</th>
<th>ICD-10 Deleted</th>
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<td>R05.1 - Acute cough</td>
<td>R05 - Cough</td>
<td>M35.02 - Sjogren syndrome with lung involvement</td>
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<td>R05.3 - Chronic cough</td>
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<td>R05.8 - Other specified cough</td>
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<td>Peripheral Nerve Stimulation / Billing and Coding: Peripheral Nerve Stimulation</td>
<td>L37360/A55531</td>
<td>G44.86 - Cervicogenic headache</td>
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<td>Nerve Conduction Studies and Electromyography / Billing and Coding: Nerve Conduction Studies and Electromyography</td>
<td>L36526/A54992</td>
<td>M35.06 - Sjogren syndrome with peripheral nervous system involvement</td>
<td>N/A</td>
<td>M35.03 - Sjogren syndrome with myopathy</td>
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<td>Nerve Blockade for Treatment of Chronic Pain and Neuropathy</td>
<td>L35457/A52725</td>
<td>M54.51 - Vertebrogenic low back pain</td>
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<td>MRI &amp; CT Scans of the Head and Neck / Billing and Coding: MRI &amp; CT Scans of the Head and Neck</td>
<td>L35175/A57215</td>
<td>C84.7A E75.244</td>
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<td>G92 - Toxic encephalopathy</td>
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<td>F78.A9 G04.82</td>
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<td>M31.1 - Thrombotic microangiopathy</td>
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<td>Lumbar Epidural Injections / Billing and Coding: Lumbar Epidural Injections</td>
<td>L34980/A57203</td>
<td>M54.51 - Vertebrogenic low back pain</td>
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<td>Immune Globulin Intravenous (IVIg) / Billing and Coding: Immune Globulin Intravenous (IVIg)</td>
<td>L34074/A57194</td>
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<td>Billing and Coding: Positron Emission Tomography Scans Coverage</td>
<td>A56668</td>
<td>Group 4: C56.3 - Malignant neoplasm of bilateral ovaries</td>
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<td>Group 5: C79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
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<td>Group 17 - added coverage for infection and inflammation</td>
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<td>Billing and Coding: Posterior Tibial Nerve Stimulation Coverage</td>
<td>A52965</td>
<td>R35.81 - Nocturnal polyuria&lt;br&gt;R35.89 - Other polyuria</td>
<td>N/A</td>
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<td>Billing and Coding: Routine Foot Care</td>
<td>A57957</td>
<td>Group 2: E75.244 - Niemann-Pick disease type A/B&lt;br&gt;M35.06 - Sjogren syndrome with peripheral nervous system involvement&lt;br&gt;Group 3: M35.0B - Sjogren syndrome with Vasculitis</td>
<td>N/A</td>
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<td>Controlled Substance Monitoring and Drugs of Abuse Testing</td>
<td>L36707/A55030</td>
<td>R45.88&lt;br&gt;T70.711A&lt;br&gt;T70.711D&lt;br&gt;T70.711S&lt;br&gt;T40.712A&lt;br&gt;T40.712D&lt;br&gt;T40.712S&lt;br&gt;T40.713A&lt;br&gt;T40.713D&lt;br&gt;T40.713S&lt;br&gt;T40.714A&lt;br&gt;T40.714D&lt;br&gt;T40.714S&lt;br&gt;T40.721A&lt;br&gt;T40.721D&lt;br&gt;T40.721S&lt;br&gt;T40.722A&lt;br&gt;T40.722D&lt;br&gt;T40.722S&lt;br&gt;T40.723A&lt;br&gt;T40.723D&lt;br&gt;T40.723S&lt;br&gt;T40.724A&lt;br&gt;T40.724D&lt;br&gt;T40.724S</td>
<td>M54.5 - Low back pain&lt;br&gt;T40.7X1A - Poisoning by cannabis (derivatives), accidental (unintentional) initial encounter&lt;br&gt;T40.7X2A - Poisoning by cannabis (derivatives), intentional self-harm, initial encounter&lt;br&gt;T40.7X3A - Poisoning by cannabis (derivatives), assault, initial encounter&lt;br&gt;T40.7X4A - Poisoning by cannabis (derivatives), undetermined initial encounter</td>
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<td>Lumbar MRI / Billing and Coding: Lumbar MRI</td>
<td>L37281/A57207</td>
<td>C56.3 - Malignant neoplasm of bilateral ovaries</td>
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<td>M54.50 - Low back pain, unspecified</td>
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<td>M54.51 - Vertebrogenic low back pain</td>
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<td>MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease / Billing and Coding: MolDX: Genetic Testing for BCR-ABL Negative Myeloproliferative Disease</td>
<td>L36186/A57422</td>
<td>D75.838 - Other thrombocytosis</td>
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<td>MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels / Billing and Coding: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels</td>
<td>L37315/A57340</td>
<td>R05.1</td>
<td>R05 - Cough</td>
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<td>MolDX: NRAS Genetic Testing / Billing and Coding: MolDX: NRAS Genetic Testing</td>
<td>L36339/A57487</td>
<td>C79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
<td>C79.9 - Secondary malignant neoplasm of unspecified site</td>
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<td>MolDX: Next-Generation Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies / Billing and Coding: MolDX: Next-Generation Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies</td>
<td>L38125/A57892</td>
<td>D75.838 - Other thrombocytosis</td>
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<td>Trigger Point Injections / Billing and Coding: Trigger Point Injections</td>
<td>L36859/A57702</td>
<td>M54.59 - Other low back pain</td>
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<td>Billing and Coding: Bariatric Surgery Coverage</td>
<td>A53028</td>
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<td>Billing and Coding: MolDX: Avise PG Assay</td>
<td>A54378</td>
<td>N/A</td>
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<td>Z92.25 - Personal history of immunosuppression therapy</td>
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<td>Billing and Coding: MolDX: FDA-Approved KRAS Tests</td>
<td>A54500</td>
<td>C79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
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<td>Billing and Coding: MolDX: bioTheranostics Cancer TYPE ID®</td>
<td>A54388</td>
<td>C56.3 - Malignant neoplasm of bilateral ovaries</td>
<td>M79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
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<td>Billing and Coding: B-Type Natriuretic Peptide (BNP) Testing</td>
<td>A57084</td>
<td>I5A - Non-ischemic myocardial injury (non-traumatic)</td>
<td>N/A</td>
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<td>Billing and Coding: Chest X-Ray</td>
<td>A57498</td>
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<td>Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)</td>
<td>A58245</td>
<td>C56.3 - Malignant neoplasm of bilateral ovaries</td>
<td>C79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
<td>C84.7A - Anaplastic large cell lymphoma, ALK-negative, breast</td>
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<td>Billing and Coding: Vitamin D Assay Testing</td>
<td>A57719</td>
<td>N/A</td>
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<td>Z68.30 - Body mass index [BMI] 30.0-30.9, adult</td>
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<td>R63.3 - Feeding difficulties</td>
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<td>M35.06</td>
<td>M35.08</td>
<td>T40.7X5A - Adverse effect of cannabis (derivatives), initial encounter</td>
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<td>T40.7X5D - Adverse effect of cannabis (derivatives), subsequent encounter</td>
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<td>M35.0A</td>
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<td>T40.7X5S - Adverse effect of cannabis (derivatives), sequela</td>
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<td>M35.0B</td>
<td>P00.80</td>
<td>M35.04 - Sjogren syndrome with tubulo-interstitial nephropathy</td>
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<td>Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea / Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea</td>
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<td>Z68.30 - Body mass index [BMI] 30.0-30.9, adult</td>
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## MEDICAL POLICIES AND COVERAGE

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<td>Lab: Flow Cytometry / Billing and Coding: Lab: Flow Cytometry</td>
<td>L34215/A57689</td>
<td>C79.63 - Secondary malignant neoplasm of bilateral ovaries</td>
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<td>C84.7A - Anaplastic large cell lymphoma ALK-negative breast</td>
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Visit the [Noridian](#) website to view all LCDs and LCAs or access them via the CMS [MCD](#).

### 2022 HCPC/CPT Policy Revision(s) for Local Coverage Determinations and Associated Billing and Coding Articles - Effective January 1, 2022

The following Local Coverage Determinations (LCDs) and associated Billing and Coding Articles (LCAs) have been revised under contractor numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY). Responses to comments received may be found as a link at the bottom of the final LCD.

**Effective Date:** January 1, 2022  
**Summary:** The below LCDs along with their associated Billing and Coding Articles have had CPT/HCPCS updates:

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<th>LCD/LCA Numbers</th>
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| L37283/A57327   | Lab: Flow Cytometry  
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| L34315/A57326   | Electrocardiogram/Billing and Coding: Electrocardiogram | Add:  
93319 - 3D ultrasound imaging of heart for evaluation of heart structure performed during ultrasound imaging of congenital heart defects.  
93593 - Insertion of catheter into right side of heart for evaluation of congenital heart defect in heart with normal native blood vessel connections, using imaging guidance.  
93594 - Insertion of catheter into right side of heart for evaluation of congenital heart defect in heart with abnormal native blood vessel connections, using imaging guidance.  
93595 - Insertion of catheter into left side of heart for evaluation of congenital heart defect, using imaging guidance.  
93596 - Insertion of catheter into right and left sides of heart for evaluation of congenital heart defect in heart with abnormal native blood vessel connections, using imaging guidance.  
93597 - Insertion of catheter into right and left sides of heart for evaluation of congenital heart defect in heart with normal native blood vessel connections, using imaging guidance.  
93598 - Measurement of output of blood from heart, performed during cardiac catheterization for evaluation of congenital heart defects. |
| L38312/A57949   | Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea/Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea | Add:  
64582 - Insertion of hypoglossal nerve neurostimulator electrode and generator and breathing sensor electrode.  
64583 - Revision or replacement of hypoglossal nerve neurostimulator electrode and breathing sensor electrode with connection to existing generator.  
64584 - Removal of hypoglossal nerve neurostimulator electrode and generator and breathing sensor electrode.  
Delete:  
0466T - Insertion of breathing sensor electrode or electrode array into chest wall.  
0467T - Revision or replacement of breathing sensor electrode or electrode array in chest wall.  
0468T - Removal of breathing sensor electrode or electrode array from chest wall. |
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<td>L38301/A57964</td>
<td>Micro-Invasive Glaucoma Surgery (MIGS)/Billing and Coding: Micro-Invasive Glaucoma Surgery</td>
<td>Add: 0671T - Insertion of drainage device into drainage tissue within eye (trabecular meshwork). 66989 - Complex extracapsular removal of cataract with insertion of artificial lens and insertion of drainage device in front chamber of eye. 66991 - Extracapsular removal of cataract with insertion of artificial lens and insertion of drainage device in front chamber of eye. 68841 - Insertion of drug delivery implant into tear duct of eye. Delete: 0191T - Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion. 0367T - Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)</td>
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<td>L37027/A57196</td>
<td>Cataract Surgery in Adults</td>
<td>Add: 66989 - Complex extracapsular removal of cataract with insertion of artificial lens and insertion of drainage device in front chamber of eye. 66991 - Extracapsular removal of cataract with insertion of artificial lens and insertion of drainage device in front chamber of eye.</td>
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<tr>
<td>L37293/A57225</td>
<td>Respiratory Care (Respiratory Therapy) / Billing and Coding: Respiratory Care (Respiratory Therapy)</td>
<td>Add: 94625 - Professional services for outpatient pulmonary rehabilitation, per session. 94626 - Professional services for outpatient pulmonary rehabilitation with continuous monitoring of blood oxygen, per session.</td>
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<td>L38826/A58438</td>
<td>Colon Capsule Endoscopy (CCE); Billing and Coding: Colon Capsule Endoscopy (CCE)</td>
<td>Add: 91113 - Imaging of colon using capsule endoscope, with interpretation and report Delete: 0355T - X-ray of large bowel with interpretation and report</td>
</tr>
<tr>
<td>A56668</td>
<td>Billing and Coding: Positron Emission Tomography Scans Coverage</td>
<td>Add: A9595 - Piflufolastat f-18, diagnostic, 1 millicurie to Group 17</td>
</tr>
<tr>
<td>A58533</td>
<td>Billing and Coding: Complex Drug Administration Coding</td>
<td>Added: J2506 - pegfilgrastim, excludes biosimilar (Neulasta®) in the Subcutaneous and Intramuscular Injection Non-Chemotherapy Generic/Trade Names table and Group 1 Codes J3590 - Anifrolumab-fnia (SaphneloTM ) in the Infusions Non-Chemotherapy Generic/Trade Names table and to Group 2 Codes Deleted: J2505 - pegfilgrastim (Neulasta®) in the Subcutaneous and Intramuscular Injection Non-Chemotherapy Generic/Trade Names table and Group 1 Codes</td>
</tr>
</tbody>
</table>
Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices - R7- Effective October 1, 2021

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

Effective Date: 10/01/2021

Summary of Article: The following updates were made to this coverage article.

- Added I5A - Non-ischemic myocardial injury (non-traumatic) to the list of payable Group 1 percutaneous endovascular cardiac assist devices diagnosis codes effective 10/01/2021 per CR 12480.
- Moved R57.0 - Cardiogenic Shock to the to the list of payable Group 1 diagnosis codes also. This code was just list in the Group 1 Paragraph.
- Correction to the previous Revision History includes changing the Title of the article from Billing and Coding: Percutaneous Endovascular Cardiac Assist Procedures and Devices to Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices to include coverage for artificial hearts.

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

Billing and Coding: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices - R8- Effective October 1, 2021

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

Effective Date: 10/01/2021

Summary of Article: The following update was made to this coverage article. Added I5A - Non-ischemic myocardial injury (non-traumatic) to the list of payable Group 2 percutaneous endovascular cardiac assist devices diagnosis codes effective 10/01/2021 missed with previous update.

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

Billing and Coding: Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification (NAATs) - R4 - Effective November 08, 2021

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

Effective Date: November 08, 2021

Summary of Article Changes:
Effective 11/08/2021: Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added A41.9, R65.20, and R65.21.
Effective 10/21/2021: Under Article Text added “This contractor expects that critically ill patients will be tested and managed in the appropriate inpatient facility. As such, for critically ill patients, only Part A claims should be submitted.” Under CPT/HCPCS Codes Group 2: Paragraph revised to “This code is covered in beneficiaries with immunodeficiency AND/OR critical illness.” Under ICD-10 Codes that Support Medical Necessity Group 2: Paragraph revised to “For immunosuppressed patients, to bill for 87507 or 0097U, an ICD-10 diagnosis code from Group 2 must be on the claim in addition to an ICD-10 diagnosis code from Group 1.” Under ICD-10 Codes that Support Medical Necessity Group 2: Codes deleted A04.9, A09, K56.0, R10.0, and R19.7.
Effective 10/01/2021: Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added M31.19. Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added D89.44, T80.82XS, Z92.850, Z92.858, and Z92.86. This revision is due to the Annual ICD-10 Code Update and is effective on 10/1/2021.

Effective 08/05/2021: Under CMS National Coverage Policy removed regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests. Added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.2 A/B MAC (B) Contacts with Independent Clinical Laboratories. Under CPT/HCPCS Codes Group 1: Codes moved 0097U from Group 1 codes to Group 2 codes. Under ICD-10 Codes that Support Medical Necessity Group 1: Paragraph deleted 0097U. Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added A00.0, A00.1, A00.9, A01.09, A01.1, A01.2, A01.3, A02.8, A05.4, A05.5, A06.0, A06.1, A06.2, A07.1, A07.2, A07.4, A08.0, A08.11, A08.2, A08.32, A32.11, A32.12, A32.7, K56.0, and R10.0. Deleted A02.9, B20, D80.0, D80.1, D80.2, D80.3, D80.4, D80.5, D80.6, D80.7, D80.8, D80.9, D81.0, D81.1, D81.2, D81.30, D81.31, D81.32, D81.39, D81.4, D81.5, D81.6, D81.7, D81.810, D81.818, D81.819, D81.89, D81.9, D82.0, D82.1, D82.2, D82.3, D82.4, D82.8, D82.9, D83.0, D83.1, D83.2, D83.8, D83.9, D84.0, D84.1, D84.89, D84.9, D89.0, D89.1, D89.2, D89.3, D89.40, D89.41, D89.42, D89.43, D89.49, D89.49, D89.810, D89.811, D89.812, D89.813, D89.82, D89.89, D89.9, Y92.239, Z94.0, Z94.1, Z94.2, Z94.3, Z94.4, Z94.5, Z94.6, Z94.81, Z94.82, Z94.82, and Z94.83. Under ICD-10 Codes that Support Medical Necessity Group 2: Paragraph revised to “To bill for 87507 or 0097U, an ICD-10 diagnosis code from Group 2 must be on the claim in addition to an ICD-10 diagnosis code from Group 1”. Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added A04.9, A09, D61.09, D61.1, D61.2, D61.3, D61.810, D61.811, D61.812, D61.819, D61.9, D64.81, D64.89, D70.0, D70.1, D70.2, D70.3, D70.4, D70.9, D84.821, D84.822, K56.0, R10.0, and R19.7. Deleted D80.7, D81.819, D82.9, D84.9, D89.2, D89.40, D89.49, and Y92.239. Formatting, punctuation, and typographical errors were corrected throughout the article.

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

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

**Billing and Coding Implantable Automatic Defibrillators - R5 - Effective October 1, 2021**

The coverage requirements for the Billing and Coding Implantable Automatic Defibrillators National Coverage Determination (NCD) have been revised and published under contract numbers: 02101 (AK), 02201 (ID), 02301(OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

**NCD:** Implantable Automatic Defibrillators 20.4  
**Effective Date:** October 1, 2021  
**Summary of Article Changes:** Added diagnosis code I5A - Non-ischemic myocardial injury (non-traumatic) to number 1 of the Nationally Covered Indications in the Article Text and the Group 1 ICD-10 diagnosis codes effective 10/01/2021 per CR12480. Also, the end date for ICD-10-PCS code 02PAXMZ is 09/30/2021 instead of 10/31/2021 stated in the Article Revision History number 2.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

**Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55323) - R6 - Effective October 1, 2021**

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

**Effective Date:** October 1, 2021  
**Summary of Article Changes:** Updated prices for Prialt (Ziconotide) and Ropivacaine per quarterly ASP Drug file update:

Effective 10/01/2021 - 12/31/2021  
• Prialt (Ziconotide) = $8.686
• Ropivacaine = $0.080

Visit the Noridian website to view the full LCA or through the CMS MCD.

Billing and Coding: Lab: Special Stains and Immunohistochemistry (IHC) Indications for Gastric Pathology (A55802) Retirement - Effective December 29, 2021

This coverage article has been retired 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: December 29, 2021
Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

This article has been incorporated within the Lab: Special Histochemical Stains and Immunohistochemical Stains LCD.

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

Billing and Coding: MolDX: Biomarkers in Cardiovascular Risk Assessment (A57055) - R2 - Effective October 1, 2021

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

Effective Date: October 1, 2021
Summary of Article Changes:
Under ICD-10 Codes that Support Medical Necessity Group 1: Codes deleted I48.91, I63.00, I63.019, I63.039, I63.10, I63.119, I63.139, I63.20, I63.219, I63.239, I63.30, I63.319, I63.329, I63.339, I63.349, I63.40, I63.419, I63.429, I63.439, I63.449, I63.49, I63.50, I63.519, I63.529, I63.539, I63.549, I70.209, I70.219, I70.229, I70.239, I70.249, I70.269, I70.299, I70.309, I70.319, I70.329. This revision will become effective 10/1/21.

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added E75.244. This revision is due to the Annual ICD-10 update and is effective on 10/1/21.


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

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

Billing and Coding: MolDX: BRCA1 and BRCA2 Genetic Testing (A57355) - R5 - Effective January 06, 2022

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

Effective Date: January 06, 2022
Summary of Article Changes:
Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C25.9, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911,
C50.912, C50.919, C50.921, C50.922, C50.929, C56.9, and C57.00. The deletion of these codes with Revision 4 was done in error and is retroactive effective for dates of service on or after 4/29/2021.

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

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

**Billing and Coding: MoLDX: Breast Cancer Index™ (BCI) Gene Expression Test - R10 - Effective October 09, 2021**

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

**Effective Date:** October 09, 2021

**Summary of Article Changes:**

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes deleted C50.911 and C50.912. Under article text added the information in this article contains billing, coding, or other guidelines that complement the Local Coverage Determination (LCD) for MoLDX: Breast Cancer Index® (BCI) Gene Expression Test.

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

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

**Billing and Coding: MoLDX: BRCA1 and BRCA2 Genetic Testing - R4 - Effective October 1, 2021**

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

**Effective Date:** October 1, 2021

**Summary of Article Changes:**

Effective 10/01/2021: Under ICD-10 Codes that Support Medical Necessity Group 1: Code added C56.3


Under CPT/HCPCS Codes Group 3: Codes deleted 81445 and 81455. CPT® code 81162 was moved from CPT/HCPCS Codes Group 3: Codes to CPT/HCPCS Codes Group 1: Codes.

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes deleted C25.9, C50.019, C50.029, C50.119, C50.129, C50.219, C50.229, C50.319, C50.329, C50.419, C50.429, C50.519, C50.529, C50.619, C50.629, C50.819, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C56.9, and C57.00. Typographical errors were corrected throughout the article.

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

To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.
Billing and Coding: MolDX: Genetic Testing for Lynch Syndrome - R7 - Effective October 01, 2021

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

Effective Date: October 01, 2021
Summary of Article Changes:
Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C56.3. This revision is due to the Annual ICD-10 update and is effective on 10/1/21. Under article text added the information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for MolDX: Genetic Testing for Lynch Syndrome.

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

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

Billing and Coding: MolDX: MammaPrint (A54447) - R6 - Effective October 08, 2021

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

Effective Date: October 08, 2021
Summary of Article Changes:
10/08/2021: Under Article Text revised the first sentence to read, “MammaPrint®, a next-generation sequencing (NGS)-based diagnostic test that uses gene expression profiling to analyze the gene activity of the identified tumor, has been assigned a unique identifier” and revised the third sentence to read, “MammaPrint® was prospectively validated as a microarray assay in the 6,693 patient MINDACT trial in early stage breast cancer, <5cm up to 3 positive lymph nodes and independent of receptor status. The MammaPrint® NGS test has demonstrated technically equivalent performance to the predicate microarray test”.

Under CPT/HCPCS Codes Group 1: Codes added 81479. MammaPrint® was inserted throughout the article where applicable.

Effective 10/01/2015: Under Does the CPT 30% Coding Rule Apply: changed to yes.

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

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

Billing and Coding: MolDX: Myriad’s BRACAnalysis CDx - R6 - Effective October 1, 2021

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

Effective Date: October 1, 2021
Summary of Article Changes:
Effective 10/01/2021: Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C56.3 and C79.63.

Effective 04.29.021: Under CMS National Coverage Policy added regulation Title XVIII of the Social Security Act (SSA) §1833(e), prohibits Medicare payment for any claim lacking the necessary documentation to process the claim. Under ICD-10 Codes that Support Medical Necessity Group 1: Codes deleted C25.9, C48.2, C50.911, C50.912, C50.921, C50.922, C56.9, and C79.9. Typographical errors were corrected throughout the article.
Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.

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

**Billing and Coding: MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™) - R1-Effective November 25, 2021**

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

**Effective Date:** November 25, 2021

**Summary of Article Changes:** Under CMS National Coverage Policy moved CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15 §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, §80.1.1 Certification Changes to the related LCD.

Under article text added Select PLA code 0045U

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

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

**Billing and Coding: MolDX: Pharmacogenomics Testing - R2 - Effective August 23, 2021**

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

**Effective Date:** August 23, 2021

**Summary of Article Changes:**

08.23.2021: Under Article Text subheading Billing instructions added the verbiage, “The use of the generic name is strongly preferred.” to the end of the second paragraph. Under the third and fourth paragraph deleted the verbiage, “Multigene panels can be performed when (as defined in the policy):

- More than one gene is reasonable and necessary for the safe use of the drug being considered or in use; or
- More than one drug is in consideration or use that is associated with a gene-drug interaction

A multigene panel must include all relevant genes and variants for its intended use to be reasonable and necessary. If, after the initial test is completed and additional testing is warranted and is reasonable and necessary as stated in the associated policy and as defined in the Repeat Germline Testing policy, an additional test may be subsequently performed.” Under subheading Gene/CPT coding/Drug information revised the first sentence to read, “Table 1 represents relevant gene/drug associations from CPIC and FDA sources”. Table 1 and Table 2 were deleted and a new Table 1 was added. Under subheading Covered multigene panels the verbiage, “with intended uses” was added to the subheading. Table 3 was renamed Table 2 and added the verbiage, “Table 2 represents covered multigene panels with specified uses that have successfully completed a TA. These tests must fulfill all the criteria above and may be further limited to specific indications listed by ICD-10 codes, when applicable”. Rows 3 and 5 were added to the table. Under CPT/HCPCS Codes Group 1: Codes added 0029U. This revision is retroactive effective for dates of service on or after 8/23/2021.

01.01.2021: Under Article Text subheading Billing instructions: added registered mark after CPT and added the verbiage, “If multiple drugs are being used/considered for the specified beneficiary on the claim, they should be added to the comment line separated by a ‘/’ (example Drug 1/Drug 2). Do not list the same drug more than once”. Under subheading Gene/CPT coding/Drug information revised the two tables to include CPT® code 81479 where N/A was previously listed. Under subheading Covered multigene panels revised table to update the intended use of each test. Under subheading ICD-10 codes associated with intended uses revised table to update intended use, added additional ICD-10 codes, and deleted unspecified codes for each gene.
codes. Under CPT/HCPCS Codes Group 1: Paragraph added the verbiage, “CPT® code 81479 is used to describe multi-gene panels and single genes not otherwise classified”. Under CPT/HCPCS Codes Group 1: Codes added 81479. Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F31.0, F31.11, F31.12, F31.13, F31.2, F31.31, F31.32, F31.4, F31.5, F31.61, F31.62, F31.63, F31.64, F31.71, F31.73, F31.75, F31.77, F40.11, F41.0, F41.1, F41.3, F41.8, F43.11, F43.12, F60.5, F90.0, F90.1, F90.2, F90.8 and deleted F32.9, F33.40, F33.9. This revision is retroactive effective for dates of service on or after 1/1/2021.

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

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

Billing and Coding: MolDX: Prostate Cancer Genomic Classifier Assay for Men with Localized Disease - R3 - Effective December 06, 2020

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

Effective Date: December 06, 2020

Summary of Article Changes: Under CPT/HCPCS Codes Group 1: Codes added 0047U. This revision is retroactive effective for dates of service on or after 12/06/2020.

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

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

Billing and Coding: MolDX: Targeted and Comprehensive Genomic Profile Next-Generation Sequencing Testing in Cancer - R4 - Effective November 08, 2021

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

Effective Date: November 08, 2021

Summary of Article Changes:
11/08/2021: Under ICD-10 Codes that Support Medical Necessity Group 1: Codes deleted D46.9
10/01/2021: Under CPT/HCPCS Codes Group 2: Codes added 0250U. This revision is due to the Q3 2021 CPT/HCPCS Code Update and is effective for dates of service on or after 7/1/2021.

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added D75.838. Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added C56.3. This revision is due to the Annual ICD-10 Update and will become effective on 10/1/2021.

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

To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.
Billing and Coding: MolDX: Trugraf Blood Gene Expression Test Retirement - September 22, 2021

This coverage article has been retired 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: September 22, 2021
Summary: Articles may be retired due to changes in coding, coverage, and/or documentation requirements. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage policy, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not an article is in place.

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

Billing and Coding Outpatient Cardiac Rehabilitation - R6 - Effective October 1, 2021

The following Noridian coverage requirements for the Billing and Coding Outpatient Cardiac Rehabilitation National Coverage Determination (NCD) have been revised and published for notice under contract numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

NCD: Outpatient Cardiac Rehabilitation 20.10.1
Effective Date: October 1, 2021
Summary of Changes: Added diagnosis code I5A - Non-ischemic myocardial injury (non-traumatic effective 10/01/2021) and converted this article to a Billing and Coding article.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

Billing and Coding: MolDX: Phenotypic Biomarker Detection from Circulating Tumor Cells (A58185) - R1 - Effective November 08, 2021

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

Effective Date: November 08, 2021
Summary of Article Changes:
Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C78.89, C79.11, C79.19, C79.82, and Z19.2. Deleted C78.00, C78.30, and C79.40. Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added C78.01, C78.02, and C78.39. Deleted C78.00 and C78.30.

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.71, C79.72, C79.81, C79.89, Z85.3, and deleted C50.819 and C50.829. The addition and deletion of these codes is due to coding that is applicable to the related LCD and is retroactive effective for dates of service on or after 7/25/2021.

Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added C79.63. This revision is due to the Annual ICD-10 Update and will become effective on 10/1/2021.

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

To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.
Billing and Coding: Polysomnography and Other Sleep Studies (A57698) - R1 - Effective December 01, 2019

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

Effective Date: December 01, 2019

Summary of Article Changes: Group 4 Paragraph was updated to reflect CPT codes 95800, 95801, 95806 will be allowed when performed in a home or a facility.

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

Billing and Coding: Positron Emission Tomography Scans Coverage - R28 - Article effective October 01, 2021

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

Effective Date: October 01, 2021

Summary of Article Changes: Added the statement "Effective 09/10/2021, the NCCN Guidelines have been updated to allow PMSA-PET/CT or PMSA-PET/MRI with Ga-68 PSMA-11 to be considered effective for initial bone imaging with the use of the ‘PI’ modifier." to the Group 15 Paragraph and "Effective 09/10/2021, the National Comprehensive Cancer Network® (NCCN®) Guidelines have been updated to allow PMSA-PET/CT or PMSA-PET/MRI with F 18 piflufolastat PSMA to be considered effective for initial bone imaging with the use of the ‘PI’ modifier." to the Group 16 Paragraph. Also effective 9/10/2021, added the information for the tracers C-11 Choline from Group 10 and Fluciclovine F18 from Group 12 PET/CT or PET/MRI and the ‘PI’ modifier are allowed when equivocal results are on initial bone imaging per the updated NCCN Guidelines for Prostate Cancer.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

Billing and Coding: Positron Emission Tomography Scans Coverage - R29 - Article effective October 01, 2021

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

Effective Date: October 01, 2021


Changed Group 3 Paragraph and Codes to the coverage & diagnosis codes criteria for NCD 220.6.9 FDG PET for Refractory Seizures and added the diagnosis codes from Group 2 that apply to this NCD. These are G40.011, G40.019, G40.111, G40.119, G40.211, G40.219, G40.301, G40.311, G40.319, G40.A01, G40.A09, G40.A11, G40.A19, G40.B11, G40.B19, G40.411, G40.419, G40.803, G40.804, G40.813, G40.814, G40.823, G40.824, G40.89, G40.911 and G40.919.

Renumber the succeeding Groups to 4-18.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.
Billing and Coding: Positron Emission Tomography Scans Coverage - R30 - Article effective October 29, 2021

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

Effective Date: October 29, 2021

Summary of Article Changes: For the effective dates stated for A9591 in Group 14, A9592 in Group 15 and A9593 and A9594 in Group 16, added a statement indicating the tracer will be paid to Part A facilities when billed with one of the diagnosis codes listed for the specific group.

Added the NCD number for FDG Refractory Seizures in the Group 3 Paragraph.

Deleted G31.1, from the JF AB article as this was missed with the previous update effective 10/29/2021.

Correction to Revision History 26: C7B.01-C7B.09 when billed with A9592 were added effective for DOS 04/01/2021.

Visit the National Coverage Determination (NCD) webpage to view the NCD coverage articles.

Billing and Coding: ProMark® Risk Score (A57609) - R2 - Effective December 30, 2021

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

Effective Date: December 30, 2021

Summary of Article Changes:


Under Article Text revised title to ProMark® Risk Score. Formatting, punctuation, and typographical errors were corrected throughout the article. ProMark® was inserted throughout the article where applicable.

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

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

Billing and Coding: ProMark® Risk Score - R2 - Effective December 30, 2021

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

Effective Date: December 30, 2021


Under Article Text revised title to ProMark® Risk Score. Formatting, punctuation, and typographical errors were corrected throughout the article. ProMark® was inserted throughout the article where applicable.

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

To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.
Billing and Coding: Prospera™ Retirement - September 22, 2021

This coverage article has been retired 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: September 22, 2021

Summary: Articles may be retired due to changes in coding, coverage, and/or documentation requirements. Where providers have adjusted their billing and coding practices to correspond to the guidance in a coverage policy, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not an article is in place.

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

Billing and Coding: Routine Foot Care - R6 - Effective October 1, 2021

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

Effective Date: October 1, 2021

Summary of Article: Asterisks added to I82.501-I82.503, I82.531-I82.533, and I82.591-I82.593 in Group 3, which were missed in previous updates per the Medicare Benefit Policy Manual, Chapter 15 Section 290 - Foot Care; subsection D-Systemic Conditions That Might Justify Coverage. Also moved the Primary diagnosis codes for the treatment of mycotic nails, or onychogryphosis, or onychauxis to the Group 5 Codes section and added a Group 6 Paragraph and Codes section for the covered secondary diagnosis.

The prior Revision History had an incorrect code. E41.0 should have been E08.41. E08.41 was already asterisked, however N18.30-N18.6 was asterisked according to Medicare Benefit Policy Manual, Chapter 15 Section 290 - Foot Care; subsection D-Systemic Conditions That Might Justify Coverage. This manual section pre-dates this Local Coverage Article.

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

Billing and Coding: Routine Foot Care - R7- Effective November 28, 2021

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

Effective Date: November 28, 2021

Summary of Article: Made the following updates to this article.

• Changed the reference for coverage for symptomatic hyperkeratoses to the new Wound and Ulcer Care Local Coverage Determination (LCD) and associated Billing and Coding Local Coverage Article (LCA) L8902/A58565 effective 11/28/21 in Group 1 Paragraph.
• Updated the statement “For treatment of painful mycotic nails, or onychogryphosis, or onychauxis, see Group 5” to include Group 6 too in the Group 1 Paragraph.
• Clarified the statement regarding when to bill the asterisked diagnosis code L60.8 to read “L60.8 is to be billed with 11719 only if one of the systemic conditions from Group 2, 3 or 4 below is present AND the patient does not have dystrophic nails” in Group 1: Medical Necessity ICD-10-CM Codes Asterisk Explanation.

Visit the Noridian Medicare Coverage Articles webpage to view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD.
**Colon Capsule Endoscopy (CCE) Final LCD - R1 - Effective December 19, 2021**

This Local Coverage Determination (LCD) has completed the Open Public Meeting comment period and is now finalized under contractor numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY).

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<td>L38826</td>
<td>Colon Capsule Endoscopy (CCE)</td>
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**Effective Date:** December 19, 2021

**Summary:** This LCD provides limited coverage for a Diagnostic Colon Capsule endoscopy (CCE). Colon capsule endoscopy (CCE) is a noninvasive procedure that does not require air inflation or sedation and allows for minimally invasive and painless colonic evaluation. CCE utilizes a tiny wireless camera that takes pictures of the gastrointestinal tract. The wireless camera is housed inside a vitamin-size capsule that is swallowed with water. As the capsule travels through the digestive tract, the camera system takes pictures. The images are then transmitted to a computer with special software where the images are strung together to create a video. The provider reviews the video to look for any abnormalities within the gastrointestinal tract. The LCD was updated to acknowledge FDA approved blood-based biomarker testing that could be used for screening purposes.

Visit the [CMS Medicare Coverage Database (MCD)](https://www.cms.gov) to access this LCD.

**Final Wound and Ulcer Care LCD and Associated Billing and Coding: Wound and Ulcer Care- Effective November 28, 2021**

This Local Coverage Determination (LCD) has completed the Open Public Meeting comment period and is now finalized under contractor numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY).

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<td>Wound and Ulcer Care</td>
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**Effective Date:** November 28, 2021

**Summary:** The LCD & Billing and Coding article describe the coding, documentation and utilization criteria needed to support the medical necessity for the treatment of acute wounds and chronic ulcers

Visit the [CMS Medicare Coverage Database (MCD)](https://www.cms.gov) to access this LCD.

**Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification Tests (NAATs) LCD - R5 - Effective August 05, 2021**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L37368

**LCD Title:** Foodborne Gastrointestinal Panels Identified by Multiplex Nucleic Acid Amplification Tests (NAATs)
Effective Date: August 05, 2021
Summary of Changes: Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests. Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were defined and inserted where appropriate throughout the LCD.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

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

Local Coverage and Determination (LCD) and Associated Billing and Coding Local Coverage Article (LCA) - Treatment of Ulcers and Symptomatic Hyperkeratoses Billing and Coding Treatment of Ulcers and Symptomatic Hyperkeratoses LCA - Retirement - Effective November 27, 2021

This LCD and the associated Billing and Coding LCA have been retired under contractor numbers: 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

Medicare Coverage Database (MCD) Numbers: L34199/A57460
LCD/LCA Title: Treatment of Ulcers and Symptomatic Hyperkeratoses/Billing and Coding Treatment of Ulcers and Symptomatic Hyperkeratoses
Effective Date: November 27, 2021
Rationale: This LCD is retired and is replaced with Noridian’s Wound and Ulcer Care LCD L38904 and Billing and Coding Wound and Ulcer Care A58567 effective 11/28/2021.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Algorithm Definition as a Component of a Laboratory Test (A58674) - R1 - Effective April 22, 2021

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

Effective Date: April 22, 2021
Summary of Article Changes:
Under Article Title changed title to read, “MolDX: Algorithm definition as a component of a laboratory test”. Under Article Text deleted the first sentence and added the verbiage, “The aim of this article is to promote a shared understanding of the term "algorithm" within the context of a clinical laboratory test. The objective of this article is to communicate the attributes of an algorithm as defined by this contractor within the stated context. The presence or absence of an algorithm as part of a lab service may be relevant to understanding the components of that service for coding or valuation purposes” and revised the second sentence to read, “An algorithm may be considered a meaningful and independent component of a laboratory process when ALL the following conditions are met”

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

To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.
MolDX: Breast Cancer Index® (BCI) Gene Expression Test (L37824) - R4 - Effective October 28, 2021

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L37824  
**LCD Title:** MolDX: Breast Cancer Index® (BCI) Gene Expression Test  
**Effective Date:** October 28, 2021  
**Summary of Changes:**  
Under Summary of Evidence Table 4 in-text citation changed from 27 to 18.  

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.  

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

MolDX: Inivata™, InVisionFirst®, Liquid Biopsy for Patients with Lung Cancer - R3 - Effective October 14, 2021

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

**Medicare Coverage Database (MCD) Number:** L37899  
**LCD Title:** MolDX: Inivata™, InVisionFirst®, Liquid Biopsy for Patients with Lung Cancer  
**Effective Date:** October 14, 2021  
**Summary of Changes:** Under LCD Title added trademark symbol to Inivata and registered symbol to InVisionFirst. Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests and §80.1.1 Certification Changes and updated descriptions to regulations.  

Under Bibliography changes were made to citations to reflect AMA citation guidelines and source #33 was updated to the correct citation. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were inserted and defined where appropriate throughout the LCD. Inivata™, InVision®, Oncomine™, FoundationOne®, Tam-Seq™ and InVisionFirst® were inserted throughout the LCD where applicable.  

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

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

MolDX: MGMT Promoter Methylation Analysis - R5 - Effective October 14, 2021

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

**Medicare Coverage Database (MCD) Number:** L36192  
**LCD Title:** MolDX: MGMT Promoter Methylation Analysis  
**Effective Date:** October 14, 2021  
**Summary of Changes:** Under CMS National Coverage Policy added regulation CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.1.1 Certification Changes and updated descriptions to regulations.  

Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD.
Visit the [Molecular Diagnostic Services (MolDX)] webpage to access the locally hosted MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.

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

**MolDX: Minimal Residual Disease Testing for Cancer Final LCD - Effective January 02, 2022**

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY). 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:** L38816

**LCD Title:** MolDX: Minimal Residual Disease Testing for Cancer

**Effective Date:** January 02, 2022

**Summary of LCD:** Limited coverage for minimally invasive molecular deoxyribonucleic acid (DNA) and ribonucleic acid (RNA) tests that detect minimal residual disease (MRD) in patients with a personal history of cancer.

Visit the [Proposed LCDs] webpage to access this LCD.

**MolDX: myPath® Melanoma Assay LCD - R4**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L37881

**Effective Date:** November 4, 2021

**Summary of Changes:** Under LCD Title added registered mark symbol to myPath. Under CMS National Coverage Policy updated section headings for regulations and removed CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §80.2. Under Bibliography changes were made to citations to reflect AMA citation guidelines and the broken hyperlink for the second reference was corrected. myPath® was inserted throughout the LCD where applicable. Punctuation and typographical errors were corrected throughout the LCD.

Visit the [Molecular Diagnostic Services (MolDX)] webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

Visit the [Active LCDs] webpage to view the locally hosted Active LCD or access it via the CMS MCD.

**MolDX: NRAS Genetic Testing LCD - R6 - Effective October 07, 2021**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L36339

**LCD Title:** MolDX: NRAS Genetic Testing

**Effective Date:** October 07, 2021

**Summary of Changes:** Under CMS National Coverage Policy added regulations Title XVIII of the Social Security Act (SSA), §1862(a)(1)(A) and 42 CFR 410.32(a).

Under Sources of Information moved all citations to the Bibliography section. Changes were made to citations to reflect AMA citation guidelines. Punctuation and typographical errors were corrected throughout the LCD. Acronyms were defined and inserted where appropriate throughout the LCD. This revision is retroactive effective for dates of service on or after 10/1/2021.

Visit the [Molecular Diagnostic Services (MolDX)] webpage to access the locally hosted MolDX Medicare Coverage Article from the “Covered Tests” or the “Excluded Tests” webpage.
To view the complete listing of locally hosted coverage articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Medicare Coverage Articles webpage.

**MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™) (L36947) - R6 - Effective November 25, 2021**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L36947  
**LCD Title:** MolDX: Oncotype DX® Breast Cancer for DCIS (Genomic Health™)  
**Effective Date:** November 25, 2021

**Summary of Changes:**
Under CMS National Coverage Policy updated section headings for regulations and added CMS Internet Only Manuals, Pub 100-02 Medicare Beneficiary Policy Manual chapter 15, §80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests, §80.1.1 Certification Changes.

Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting and punctuation were corrected throughout the LCD. Acronyms were defined and inserted where appropriate throughout the LCD. Oncotype DX® was inserted throughout the LCD where applicable.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

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

**MolDX: Repeat Germline Testing (L38353) - R1 - Effective December 30, 2021**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L38353  
**LCD Title:** MolDX: Repeat Germline Testing  
**Effective Date:** December 30, 2021

**Summary of Changes:**

Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

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

**MolDX: TruGraf Blood Gene Expression Test LCD Retirement - Effective September 22, 2021**

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

**Medicare Coverage Database (MCD) Number:** L38137  
**LCD Title:** MolDX: TruGraf Blood Gene Expression Test  
**Effective Date:** September 22, 2021  
**Rationale:** This LCD is being retired because the information in this policy has been incorporated within the MolDX: Molecular Testing for Solid Organ Allograft Rejection.
Visit the Retired LCDs webpage to access the retired LCDs.

**Policy Revision for Nerve Conduction Studies and Electromyography Local Coverage Determination and Associated Billing and Coding Nerve Conduction Studies and Electromyography Local Coverage Article - R4 - Effective October 1, 2021**

The following Local Coverage Determinations (LCD) and associated Billing and Coding Article (LCA) have been revised under contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY).

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<td>Nerve Conduction Studies and Electromyography</td>
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<td>A54992</td>
<td>Billing and Coding: Nerve Conduction Studies and Electromyography</td>
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**Effective Date:** October 1, 2021

**Summary of Changes:** ICD-10-CM codes added and deleted were missed with the prior ICD-10-CM Annual update to the Billing and Coding LCA only. No updates to the LCD were made.

- **Added:**
  - M35.81 - Multisystem inflammatory syndrome
  - M35.89 - Other specified systemic involvement of connective tissue
- **Deleted:**
  - M35.8 - Other specified systemic involvement of connective tissue

Visit the Noridian Active LCDs webpage or Noridian Medicare Coverage Articles webpages to view the locally hosted document or access it via the CMS MCD.


This Local Coverage Determination (LCD) has completed the Open Public Meeting comment period and is now finalized under contractor numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY). Responses to comments received may be found as a link at the bottom of the final LCD.

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<tr>
<th>Medicare Coverage Database Number</th>
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<tr>
<td>L39060</td>
<td>Platelet Rich Plasma Injections for Non-Wound Injections</td>
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<tr>
<td>A58790</td>
<td>Billing and Coding: Platelet Rich Plasma Injections for Non-Wound Injections</td>
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**Effective Date:** January 23, 2022

**Summary:** The LCD and associated Billing and Coding Article outline the non-coverage policy for Platelet Rich Plasma Injections for Non-Wound Injections.
Visit the CMS Medicare Coverage Database (MCD) to access this LCD.

**Policy Revision for Nerve Conduction Studies and Electromyography Local Coverage Determination and Associated Billing and Coding Nerve Conduction Studies and Electromyography Local Coverage Article - R5 - Effective October 1, 2021**

The following Local Coverage Determinations (LCD) and associated Billing and Coding Article (LCA) have been revised under contract numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY).

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<td>Nerve Conduction Studies and Electromyography</td>
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<td>A54992</td>
<td>Billing and Coding: Nerve Conduction Studies and Electromyography</td>
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**Effective Date:** October 1, 2021

**Summary of Changes:** Corrected the typographical error in the definition of Physician Supervision of Diagnostic Procedures Indicator 77 from general physician supervision to direct supervision for a PT that is not ABPTS certified in the Article Text. No changes to the LCD were made.

Visit the Noridian Active LCDs webpage or Noridian Medicare Coverage Articles webpages to view the locally hosted document or access it via the CMS MCD.

**ProMark® Risk Score (L36706) - R5 - Effective December 30, 2021**

This Local Coverage Determination (LCD) 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).

**Medicare Coverage Database (MCD) Number:** L36706

**LCD Title:** ProMark® Risk Score

**Effective Date:** December 30, 2021

**Summary of Changes:**
Under LCD Title added registered symbol to ProMark and revised to ProMark® Risk Score.


Under Bibliography changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. Acronyms were inserted where appropriate throughout the LCD. ProMark® was inserted throughout the LCD were applicable.

Visit the Molecular Diagnostic Services (MolDX) webpage to access the locally hosted MolDX Medicare Local Coverage Determination from the “Active LCD” Webpage.

Visit the Active LCDs webpage to view the locally hosted Active LCD or access it via the CMS MCD.
MLN Connects - October 7, 2021

Enter Your Digital Contact Information Into NPPES Now

MLN Connects newsletter for Thursday, October 7, 2021

View this edition as a: Webpage | PDF

NEWS
- Medicare-Dependent Hospital COVID-19 Waiver: Modification
- Organ Procurement Organization Performance Report
- NPPES: Add Digital Contact Information
- Hospice QRP Claims-Based Measures: FAQs
- Breast Cancer: Talk to Your Patients about Screening

CLAIMS, PRICERS, & CODES
- Drugs & Biologics: HCPCS Level II Application Summaries & Coding Decisions

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- Medicare Ground Ambulance Data Collection System Webinar: Labor Costs - October 7
- Medicare Ground Ambulance Data Collection System: Q&A Session - October 12
- Hospice Quality Reporting Program Forum - October 19

MLN MATTERS® ARTICLES
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022 - Revised

PUBLICATIONS
- Medicare DMEPOS Payments While Inpatient - Revised

MULTIMEDIA
- Modernizing Health Care to Improve Physical Accessibility

MLN Connects - October 14, 2021

Pneumococcal Conjugate Vaccine, 20 Valant

MLN Connects newsletter for Thursday, October 14, 2021

View this edition as a: Webpage | PDF

NEWS
- Pneumococcal Conjugate Vaccine, 20 Valant

COMPLIANCE
- Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

EVENTS
- Medicare Ground Ambulance Data Collection System Webinar: Volunteer Organizations - October 14
- Medicare Ground Ambulance Data Collection System Webinar: Public Safety Organizations - October 21
MLN MATTERS® ARTICLES

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2022
- January 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files & Revisions to Prior Quarterly Pricing Files
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2022
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 28.0, Effective January 1, 2022
- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy - This CR Rescinds and Fully Replaces CR 11783 - Revised

MULTIMEDIA

- Health Equity Web-Based Trainings
- SNF Quality Reporting Program: Section O: O0100. Special Procedures, Treatments, and Programs Web-Based Training

MLN Connects - October 21, 2021

Cognitive Assessment: Resources to Answer Patient Questions

MLN Connects newsletter for Thursday, October 21, 2021

View this edition as a: Webpage | PDF

CLAIMS, PRICERS, & CODES

- LTCH: New Web Pricer Released

EVENTS

- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model National Expansion Special ODF - October 28

MLN MATTERS® ARTICLES

- Claim Status Category and Claim Status Codes Update
- New/Modifications to the Place of Service (POS) Codes for Telehealth

PUBLICATIONS


INFORMATION FOR MEDICARE PATIENTS

- Cognitive Assessment: Resources to Answer Patient Questions


COVID-19: Moderna & Jansen (J&J) Booster Shots

Effective October 20, 2021, FDA amended the emergency use authorizations for the Moderna and Jansen (Johnson & Johnson) COVID-19 vaccines to allow for use of a single booster dose for certain populations.

Get the most current list of billing codes, payment allowances and effective dates.

More Information:
CMS News Alert
COVID-19 provider toolkit including:
- Payment rates for administering vaccines
- How to bill correctly
MLN Connects - October 28, 2021

Make a Strong Flu Shot Recommendation - it’s Critical

MLN Connects newsletter for Thursday, October 28, 2021

NEWS

• Make a Strong Flu Shot Recommendation - it’s Critical
• Make Health Information Understandable During Health Literacy Month
• Ambulance Fee Schedule: CY 2022 Ambulance Inflation Factor

COMPLIANCE

• Home Health LUPA Threshold: Bill Correctly

EVENTS

• Medicare Ground Ambulance Data Collection System Webinar: Reporting Revenue - October 28
• Medicare Ground Ambulance Data Collection System Webinar: Hospitals & Other Providers - November 4

MLN MATTERS® ARTICLES

• April 2022 Update to the Java Medicare Code Editor (MCE) for New Edit 20 - Unspecified Code Edit
• Skilled Nursing Facility (SNF) Claims Processing Update to Fiscal Year End (FYE) Edits

MLN Connects Special Edition - October 29, 2021 - CMS Takes Decisive Steps to Reduce Health Care Disparities Among Patients with Chronic Kidney Disease and End-Stage Renal Disease

CMS is taking action to close health equity gaps by providing Medicare patients living with End-Stage Renal Disease (ESRD) with greater access to care. Through the ESRD Prospective Payment System (PPS) annual rulemaking, CMS is making changes to the ESRD Quality Incentive Program (QIP) and the ESRD Treatment Choices (ETC) Model, and updating ESRD PPS payment rates. The changes to the ETC Model policies aim to encourage dialysis facilities and health care providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status, making the model one of the agency’s first CMS Innovation Center models to directly address health equity.

“Today’s final rule is a decisive step to ensure people with Medicare with chronic kidney disease have easy access to quality care and convenient treatment options,” said CMS Administrator Chiquita Brooks-LaSure. “Enabling dialysis providers to offer more dialysis treatment options for Medicare patients will catalyze better health outcomes, greater autonomy and better quality of life for all patients with kidney disease.”

According to CMS Office of Minority Health’s studies on racial, ethnic and socioeconomic factors, disadvantaged people with Medicare have higher rates of ESRD. They are also more likely to experience higher hospital readmissions and costs, as well as more likely to receive in-center hemodialysis (vs. home dialysis). Studies also indicate non-white ESRD patients are less likely to receive pre-ESRD kidney care, become waitlisted for a transplant, or receive a kidney transplant.

CMS is improving access to home dialysis for patients of all socioeconomic backgrounds. For example, CMS is finalizing changes to the ETC Model to test a new payment incentive that rewards ESRD facilities and clinicians who manage dialysis patients for achieving significant improvement in the home dialysis rate and kidney transplant rate for lower-income beneficiaries. In addition, CMS is approving the first ever technology under a recently established policy that allows for enhanced payments for innovative technologies that represent a substantial clinical improvement relative to existing options. This approval will help ESRD facilities offer an additional option to beneficiaries for home dialysis at this critical time in the pandemic.

Consistent with President Biden’s Executive Order 13985 on “Advancing Racial Equity and Support for Underserved Communities through the Federal Government,” CMS is addressing health inequities and improving patient outcomes in the U.S. through improved data collection for better measurement and analysis of disparities across programs and policies. In response to the proposed rule, CMS received valuable feedback on potential opportunities to collect and leverage diverse sets of data such as race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+ and socioeconomic status, to
better measure disparities. CMS also received feedback on various methodical approaches to advance equity through the ESRD Quality Incentive Program (ESRD QIP). This valuable stakeholder feedback will help guide future rulemaking to improve health equity.

The rule finalizes policies for the ESRD QIP that address the circumstances of the COVID-19 public health emergency and functionality challenges relating to the implementation of a new data collection system. These challenges include a special scoring and payment policy under which no facility will receive a payment reduction under the ESRD QIP for the upcoming year, especially since such payment reductions would have been based on performance during the height of the pandemic in 2020.

CMS’ proposed rule included several requests for information (RFIs) for the agency to consider as part of its goal to increase access to dialysis treatments at home. Commenters’ responses to the RFIs included specific suggestions for improving Acute Kidney Injury (AKI) payment and the ESRD PPS.

More Information:
- Fact sheet
- Final rule

MLN Connects Special Edition - November 2, 2021 - 3 Final Payment Rules

CMS PHYSICIAN PAYMENT RULE PROMOTES GREATER ACCESS TO TELEHEALTH SERVICES, DIABETES PREVENTION PROGRAMS

Final Rule Advances Health Equity, Person-Centered Care

On November 2, CMS is announcing actions that will advance its strategic commitment to drive innovation to support health equity and high quality, person-centered care. CMS’ Calendar Year (CY) 2022 Physician Fee Schedule (PFS) final rule will promote greater use of telehealth and other telecommunications technologies for providing behavioral health care services, encourage growth in the diabetes prevention program, and boost payment rates for vaccine administration. The final rule also advances programs to improve the quality of care for people with Medicare by incentivizing clinicians to deliver improved outcomes.

"Promoting health equity, ensuring more people have access to comprehensive care, and providing innovative solutions to address our health system challenges are at the core of what we do at CMS," said CMS Administrator Chiquita Brooks-LaSure. "The Physician Fee Schedule final rule advances all these strategic priorities and helps build a better Medicare program for the future."

Expanding Use of Telehealth and Other Telecommunications Technologies for Behavioral Health Care

The final rule makes significant strides in expanding access to behavioral health care - especially for traditionally underserved communities - by harnessing telehealth and other telecommunications technologies. In line with legislation enacted last year, CMS is eliminating geographic barriers and allowing patients in their homes to access telehealth services for diagnosis, evaluation, and treatment of mental health disorders.

"The COVID-19 pandemic has highlighted the gaps in our current health care system and the need for new solutions to bring treatments to patients, wherever they are," said Brooks-LaSure. "This is especially true for people who need behavioral health services, and the improvements we are enacting will give people greater access to telehealth and other care delivery options."

CMS is bringing care directly into patients' homes by providing certain mental and behavioral health services via audio-only telephone calls. This means counseling and therapy services, including treatment of substance use disorders and services provided through Opioid Treatment Programs, will be more readily available to individuals, especially in areas with poor broadband infrastructure.

In addition, for the first time outside of the COVID-19 public health emergency (PHE), Medicare will pay for mental health visits furnished by Rural Health Clinics and Federally Qualified Health Centers via telecommunications technology, including audio-only telephone calls, expanding access for rural and other vulnerable populations.
Promoting Growth in Medicare Diabetes Prevention Program

Prediabetes impacts over 88 million American adults, with many at risk for developing type 2 diabetes within five years. Many traditionally underserved communities - including African Americans, Hispanic/Latino Americans, American Indians, Pacific Islanders, and some Asian Americans - face an elevated risk of developing type 2 diabetes.

As the U.S. marks Diabetes Awareness Month this November, CMS is taking steps to improve its Medicare Diabetes Prevention Program (MDPP) expanded model, which was developed to help people with Medicare with prediabetes from developing type 2 diabetes.

Under the expanded model, local suppliers provide structured, coach-led sessions in community and health care settings using a Centers for Disease Control and Prevention-approved curriculum to provide training in dietary change, increased physical activity, and weight loss strategies. CMS is waiving the Medicare enrollment fee for all organizations that apply to enroll as an MDPP supplier on or after January 1, 2022. CMS has been waiving this fee during the COVID-19 PHE for new MDPP suppliers and has witnessed increased supplier enrollment. Next, CMS is shortening the MDPP services period to one year instead of two years. This change will make delivery of MDPP services more sustainable, reduce the administrative burden and costs to suppliers, and improve patient access by making it easier for local suppliers to participate and reach their communities. Finally, CMS is restructuring payments so MDPP suppliers receive larger payments for participants who reach milestones for attendance.

CMS expects these changes will result in more MDPP suppliers, increased access to MDPP services for people with Medicare in rural areas, and a decrease in the number of individuals with diabetes in both urban and rural communities.

Increased Access to Medical Nutrition Therapy Services

The PFS final rule also streamlines access to Medical Nutrition Therapy (MNT), which includes services provided by registered dietitians or nutrition professionals to help people with Medicare better manage their diabetes or renal disease. MNT establishes goals, a care plan, and interventions, as well as plans for follow-up over multiple visits to assist with behavioral and lifestyle changes relative to help address an individual’s nutrition needs and medical condition or disease(s).

CMS removed a requirement that limited who could refer people with Medicare to MNT services, allowing any physician (M.D. or D.O.) to do so. This change should particularly benefit people living in rural areas as the MNT services are provided to eligible individuals with no out of pocket costs and may be provided via telehealth.

Encouraging Proven Vaccines to Protect Against Preventable Illness

As the COVID-19 pandemic has so starkly demonstrated, access to safe and effective vaccines is vital to public health. CMS will maintain the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective January 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines. CMS will also continue to facilitate vaccinations for common diseases such as influenza, pneumonia, and hepatitis B.

This year Medicare reviewed payments for vaccinations to ensure doctors and other health professionals are paid appropriately for providing vaccinations. This final rule will nearly double Medicare Part B payment rates for influenza, pneumococcal, and hepatitis B vaccine administration from roughly $17 to $30. CMS hopes this change will increase access to these potentially life-saving injections and lead to greater vaccination uptake.

Expanded Pulmonary Rehabilitation Coverage Under COVID

As part of CMS’ continuing efforts to address the current PHE, the agency finalized expanded coverage of outpatient pulmonary rehabilitation services, paid under Medicare Part B, to individuals who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks. This goes beyond CMS’ PFS proposed rule which would have focused the expanded coverage to those hospitalized with COVID-19. CMS also finalized a temporary extension of certain cardiac and intensive cardiac rehabilitation services available via telehealth for people with Medicare until the end of December 2023.
Advancing the Quality Payment Program and MIPS Value Pathways

To further improve the quality of care for people with Medicare, the PFS final rule makes several key changes to CMS’ Quality Payment Program (QPP), a value-based payment program that promotes the delivery of high-value care by clinicians through a combination of financial incentives and disincentives.

For example, CMS finalized a higher performance threshold that clinicians will be required to exceed in 2022 to be eligible for positive payment incentives. This new threshold was determined in accordance with statutory requirements for the QPP’s Merit-based Incentive Payment System (MIPS).

CMS is also moving forward with the next evolution of QPP and officially introducing the first seven MIPS Value Pathways (MVPs) - subsets of connected and complementary measures and activities, established through rulemaking, that clinicians can report on to meet MIPS requirements. MVPs are designed to ensure more meaningful participation for clinicians and improved outcomes for patients by more effectively measuring and comparing performance within different clinician specialties and providing clinicians more meaningful feedback. This initial set of MVP clinical areas include: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia.

To incentivize high-quality care for professionals that are often a key point of contact for underserved communities with acute health care needs, CMS has also revised the current eligible clinician definition to include clinical social workers and certified nurse-midwives among those participating in MIPS.

Ensuring Accurate Payments Through Clinical Labor Update

CMS recognizes the importance of making accurate payments for services provided under Medicare to ensure the integrity of the program as well as to support continued access to care. For the first time in nearly 20 years, CMS is updating the clinical labor rates that are used to calculate practice expense under the PFS. As a result, payments to primary care specialists that involve more clinical labor, such as family practice, geriatrics, and internal medicine specialties, are expected to increase. This increase will to drive greater person-centered care for these services particularly for disadvantaged groups and underserved communities. There will be a four-year transition period to implement the clinical labor pricing update, which will help maintain payment stability and mitigate any potential negative effects on health care providers by gradually phasing in the changes over time.

Increasing Access to Physician Assistants’ Services

Finally, CMS is implementing a recent statutory change that authorizes Medicare to make direct Medicare payments to Physician Assistants (PAs) for professional services they furnish under Part B. For the first time, beginning January 1, 2022, PAs will be able to bill Medicare directly. As a result, more individuals with Medicare will have access to these services as PAs will have the same opportunity as certain other Medicare practitioners to bill Medicare for professional services.

More Information:

- CY 2022 Physician Fee Schedule Final Rule
- CY 2022 Physician Fee Schedule Final Rule fact sheet
- CY 2022 Quality Payment Program final changes fact sheet
- Medicare Diabetes Prevention Program final changes fact sheet

CMS OPPS/ASC FINAL RULE INCREASES PRICE TRANSPARENCY, PATIENT SAFETY AND ACCESS TO QUALITY CARE

On November 2, in keeping with President Biden’s Competition Executive Order, CMS is releasing a final rule that will further advance its commitment to increasing price transparency, holding hospitals accountable and ensuring consumers have the information they need to make fully informed decisions regarding their health care. The Calendar Year (CY) 2022 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule with Comment Period will strengthen enforcement of price transparency requirements for hospitals, and increase Medicare beneficiary quality and safety by halting the phased elimination of the Inpatient Only (IPO) list for surgical procedures.

"CMS is committed to promoting and driving price transparency, and we take seriously concerns we have heard from consumers that hospitals are not making clear, accessible pricing information available online, as they have been required to do since January 1, 2021," said CMS Administrator Chiquita Brooks-LaSure. "We are also taking actions to enhance patient safety and quality care."
Price Transparency

Beginning January 1, 2022, CMS will increase the penalty for some hospitals that do not comply with the Hospital Price Transparency final rule. Specifically, CMS is setting a minimum civil monetary penalty of $300 per day that will apply to smaller hospitals with a bed count of 30 or fewer, and a penalty of $10 per bed per day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this approach, for a full calendar year of noncompliance, the minimum total penalty amount would be $109,500 per hospital, and the maximum total penalty amount would be $2,007,500 per hospital.

Hospital price transparency helps people know what a hospital charges for the items and services they provide, an important factor given that health care costs can cause significant financial burdens for consumers. While enforcement activities are necessary to drive compliance with price transparency, CMS is also committed to working with hospitals to help them meet those requirements.

Enhancing Beneficiary Protections

CMS is also enhancing beneficiary protections by finalizing policies that will allow for a more evidence-based approach in determining whether procedures should be payable in the outpatient setting. In the CY 2021 OPPS/ASC final rule, CMS finalized a policy to eliminate the IPO list over a three-year period, removing 298 services in the first phase of the elimination. A large number of stakeholder comments opposed elimination of the list, primarily due to safety concerns with performing certain procedures in an outpatient setting.

For CY 2022, CMS is halting the elimination of the IPO list and, after clinical review of the services removed from the list in CY 2021, CMS is adding all but a small number of procedures back to the list. CMS is also reinstating the ASC Covered Procedures List (CPL) criteria that were in effect in CY 2020 and adopting a process for stakeholders to nominate procedures they believe meet the requirements to be added to the ASC CPL.

Health Equity, Access to Emergency Care in Rural Areas and Lessons from COVID-19

In the OPPS/ASC Payment System proposed rule, CMS also issued Requests for Information (RFIs) and solicited comments on a number of potential proposals and actions to further the vision of advancing health equity, driving high-quality, person-centered care, and promoting affordability and sustainability. The comments will help inform future rulemaking around these topics. Future rulemaking will include additional opportunities for public comments.

- Health equity: CMS received input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable by including additional demographic data points (e.g., race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status).
- Access to emergency care in rural areas: the proposed rule included an RFI on Rural Emergency Hospitals (REHs). CMS received robust comments in response to this RFI and looks forward to taking each of those comments into consideration during the rulemaking process for the development of the REH requirements.
- Lessons from COVID-19: CMS solicited comments on the extent to which hospitals are using flexibilities offered during the COVID-19 public health emergency (PHE) to provide mental health services remotely and whether CMS should consider changes to account for shifting practice patterns. In addition, comments were received on the collection and reporting of COVID-19 vaccination status of hospital outpatient department and ASC staff, and making this information available to the public so consumers know how many workers are vaccinated in different health care settings.

More Information:

- OPPS/ASC Payment System Final Rule
- CY 2022 OPPS/ASC Payment System Final Rule fact sheet

BIDEN-HARRIS ADMINISTRATION IMPROVES HOME HEALTH SERVICES FOR OLDER ADULTS AND PEOPLE WITH DISABILITIES

Final rule accelerates shift from volume-based incentives to quality-based incentives and advances coordination of care through Quality Reporting Programs

On November 2, CMS issued a final rule that furthers CMS’ strategic commitment to drive innovation that promotes comprehensive, person-centered care for older adults and people with disabilities by accelerating the shift from paying for home health services based on volume, to a system that incentivizes value and quality. The final rule will also strengthen CMS’ data collection efforts to identify and address health disparities and use of care among people who are dually eligible for...
Medicare and Medicaid, people with disabilities, people who identify as LGBTQ+, religious minorities, people who live in rural areas, and people otherwise adversely affected by persistent poverty or inequality.

The Calendar Year 2022 Home Health Prospective Payment System (PPS) Final Rule addresses challenges facing Medicare beneficiaries who receive health care at home. The final rule finalizes nationwide expansion of the successful Home Health Value-Based Purchasing (HHVBP) Model to incentivize quality of care improvements.

"CMS is committed to helping people get the care they need, where they need it," said CMS Administrator Chiquita Brooks-LaSure. "This final rule will improve the delivery of home health services for people with Medicare. It will also improve our data collection efforts, helping us to identify health disparities and advance health equity."

The CMS Innovation Center (Innovation Center) launched the original HHVBP Model on January 1, 2016, to determine whether CMS could improve the quality and delivery of home health care services to people with Medicare by offering financial incentives to providers that offer better quality of care with greater efficiency. The original HHVBP Model comprised all Medicare-certified home health agencies (HHAs) providing services across nine randomly selected states. The Third Annual Evaluation Report of the participants' performance from 2016-2018 showed an average 4.6 percent improvement in HHAs' quality scores and an average annual savings of $141 million to Medicare.

The final policies promulgated in this rule expand the HHVBP Model nationally, with the first performance year beginning January 1, 2023. The HHVBP Model is one of four Innovation Center models that have met the requirements to be expanded in duration and scope since 2010. Starting in 2025, CMS will adjust fee-for-service payments to Medicare-certified HHAs based on the quality of care provided to beneficiaries during the CY 2023 performance year. Throughout 2022, CMS will provide technical assistance to HHAs to ensure they understand how performance will be assessed. Overall, these policies support the Agency's commitment to advancing value-based care by providing incentives for HHAs to improve the beneficiary experience and quality of care.

Additionally, the final rule will advance CMS' coordination of care efforts through improvements to the Home Health Quality Reporting Program, Long-Term Care Hospital Quality Reporting Program, and Inpatient Rehabilitation Facility Quality Reporting Program and finalizes the mandatory COVID-19 reporting requirements for Long Term Care facilities (nursing homes) established as a part of the May 2020 and May 2021 Interim Final Rules beyond the current COVID-19 public health emergency (PHE) until December 31, 2024. The rule removes or replaces several quality measures to reduce burden and increase focus on patient outcomes. CMS is also finalizing its proposals to begin collecting data on two measures promoting coordination of care in the Home Health Quality Reporting Program effective January 1, 2023 as well as measures under Long-Term Care Hospital Quality Reporting Program and Inpatient Rehabilitation Quality Reporting Program effective October 1, 2022. The effective dates position the agency to support the recent Executive Order 13985 of January 20, 2021, Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

Finally, this rule implements provisions of the Consolidated Appropriations Act, 2021 that establish survey and enforcement requirements for hospice programs serving Medicare beneficiaries. These provisions will require the use of multidisciplinary survey teams, prohibition of surveyor conflicts of interest, and expansion of surveyor training to include accrediting organizations (AOs). The provisions also establish a hospice program complaint hotline and create the authority for CMS to impose enforcement remedies for noncompliant hospice programs. These changes will strengthen oversight, enhance enforcement, and establish consistent and transparent survey requirements in hospice care.

More Information:

- [HH PPS proposed rule](#)
- [HH PPS proposed rule](#) fact sheet

**MLN Connects - November 4, 2021**

COVID-19: Changes for Medicare Advantage Plan Claims Starting January 1

MLN Connects newsletter for Thursday, November 4, 2021

NEWS

- COVID-19 Vaccines for Children
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Starting January 1, 2022
Biden-Harris Administration Issues Emergency Regulation Requiring COVID-19 Vaccination for Health Care Workers

National requirement protects patients at nearly 76,000 providers and covers more than 17 million health care workers

The Biden-Harris Administration is requiring COVID-19 vaccination of eligible staff at health care facilities that participate in the Medicare and Medicaid programs. The emergency regulation issued by the Centers for Medicare & Medicaid Services (CMS) today protects those fighting this virus on the front lines while also delivering assurances to individuals and their families that they will be protected when seeking care.

“Ensuring patient safety and protection from COVID-19 has been the focus of our efforts in combatting the pandemic and the constantly evolving challenges we’re seeing,” said CMS Administrator Chiquita Brooks-LaSure. “Today’s action addresses the risk of unvaccinated health care staff to patient safety and provides stability and uniformity across the nation’s health care system to strengthen the health of people and the providers who care for them.”

The prevalence of COVID-19, in particular the Delta variant, within health care settings increases the risk of unvaccinated staff contracting the virus and transmitting the virus to patients. When health care staff cannot work because of illness or exposure to COVID-19, the strain on the health care system becomes more severe and further limits patient access to safe and essential care. These requirements will apply to approximately 76,000 providers and cover over 17 million health care workers across the country. The regulation will create a consistent standard within Medicare and Medicaid while giving patients assurance of the vaccination status of those delivering care.

Facilities covered by this regulation must establish a policy ensuring all eligible staff have received the first dose of a two-dose COVID-19 vaccine or a one-dose COVID-19 vaccine prior to providing any care, treatment, or other services by December 5, 2021. All eligible staff must have received the necessary shots to be fully vaccinated - either two doses of Pfizer or Moderna or one dose of Johnson & Johnson - by January 4, 2022. The regulation also provides for exemptions based on recognized medical conditions or religious beliefs, observances, or practices. Facilities must develop a similar process or plan for permitting exemptions in alignment with federal law.

CMS accelerated outreach and assistance efforts encouraging individuals working in health care to get vaccinated following the Administration’s announcement that it would expand the requirement for staff vaccination beyond nursing homes to include additional providers and suppliers. Since the Administration’s announcement, nursing home staff vaccination rates have increased by approximately nine percentage points - from 62 to 71 percent. This increase is encouraging, and this regulation will help to ensure even greater improvement in the vaccination rate among health care workers.

A recent White House report describes the evidence that vaccine requirements work. An analysis of health care systems, educational institutions, public-sector agencies, and private businesses shows that organizations with vaccination requirements have seen their vaccination rates increase by more than 20 percentage points and have routinely seen their share of fully vaccinated workers rise above 90%.
States and individual health systems have historically addressed vaccination requirements for diseases such as influenza and hepatitis B. Today, more than 2,500 hospitals, or 40 percent of all U.S. hospitals, have announced COVID vaccination requirements for their workforce. They span all 50 states, the District of Columbia, and Puerto Rico. The report also found that vaccination requirements have not led to widespread resignations in the health care workforce and that the requirements are an essential tool to protect patients and health care personnel.

CMS will ensure compliance with these requirements through established survey and enforcement processes. If a provider or supplier does not meet the requirements, it will be cited by a surveyor as being non-compliant and have an opportunity to return to compliance before additional actions occur. CMS’s goal is to bring health care providers into compliance. However, the Agency will not hesitate to use its full enforcement authority to protect the health and safety of patients.

The requirements apply to: Ambulatory Surgical Centers, Hospices, Programs of All-Inclusive Care for the Elderly, Hospitals, Long Term Care facilities, Psychiatric Residential Treatment Facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities, Home Health Agencies, Comprehensive Outpatient Rehabilitation Facilities, Critical Access Hospitals, Clinics (rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services), Community Mental Health Centers, Home Infusion Therapy suppliers, Rural Health Clinics/Federally Qualified Health Centers, and End-Stage Renal Disease Facilities.

CMS is taking necessary action to establish critical safeguards for the health of all people, their families, and the providers who care for them. CMS knows that everyone working in health care wants to do what is best to keep their patients safe. Yet, unvaccinated staff pose both a direct and indirect threat to the very patients that they serve. Vaccines are a crucial scientific tool in preserving and restoring efficient operations across the nation’s health care system while protecting individuals. This new requirement presents an opportunity to continue driving down COVID-19 infections, stabilize the nation’s health care system, and ensure safety for anyone seeking care.

To view the interim final rule with comment period, visit: https://www.federalregister.gov/public-inspection/2021-23831/medicare-and-medicaid-programs-omnibus-covid-19-health-care-staff-vaccination

To view a list of frequently asked questions, visit: https://www.cms.gov/files/document/cms-omnibus-staff-vax-requirements-2021.docx

MLN Connects - November 11, 2021

Diabetes Resources for You & Your Patients

MLN Connects newsletter for Thursday, November 11, 2021

NEWS

- Provider Enrollment Application Fee for CY 2022
- LTCH & IRF: CY 2022 QRP Updates
- Critical Care E/M Services: Comparative Billing Report in November
- Diabetes Resources for You & Your Patients

COMPLIANCE

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

CLAIMS, PRICERS, & CODES

- HCPCS Application Summaries & Coding Decisions: 510(k)-Cleared Wound Care Products

EVENTS

- HCPCS Public Meeting - December 1 & 2

MLN MATTERS® ARTICLES

- Medicare Part B CLFS: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System
MLN Connects - November 18, 2021

COVID-19: Changes to Nursing Home Visitation & Survey Activities

MLN Connects newsletter for Thursday, November 18, 2021

NEWS

• CMS Repeals MCIT/R&N Rule; Will Consider Other Coverage Pathways to Enhance Access to Innovative Medical Devices
• Changes to Nursing Home Visitation COVID-19 (Revised) & COVID-19 Survey Activities
• Annual Medicare Participation Open Enrollment Period
• It’s Not Too Late to Vaccinate
• Post-Acute Care QRP: Job Aids & Pocket Guides
• Quality Payment Program: 2020 Doctors & Clinicians Preview Period Open Until December 14
• Lung Cancer Awareness: Help Your Patients Reduce Their Risk

CLAIMS, PRICERS, & CODES

• Upcoming Quarterly Update to Home Health Grouper

EVENTS

Medicare Ground Ambulance Data Collection System: Q&A Session - December 14

MLN MATTERS® ARTICLES

• 2022 Annual Update of Per-Beneficiary Threshold Amounts
• Low Utilization Payment Adjustment (LUPA) Add-on Amounts for Home Health (HH) Occupational Therapy Visits

INFORMATION FOR MEDICARE PATIENTS

• CMS Announces 2022 Medicare Part B Premiums

MLN Connects - November 24, 2021

Provider Relief Fund Reporting Deadline

MLN Connects newsletter for Wednesday, November 24, 2021

NEWS

• Provider Relief Fund Reporting Deadline: November 30, 2021
• HIV: Talk to Your Patients About Prevention & Screening
• Home Health & Hospice: Medicare Provider Resources
• COVID-19: Pfizer & Modena Booster Shots for 18 Years and Older

COMPLIANCE

• DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

• IPPS, IRF & LTCH: New Web Pricer Released for FY 2022

MLN MATTERS® ARTICLES

• Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
• The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2019 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long-Term Care Hospitals (LTCHs)
• Claims Processing Instructions for the New Pneumococcal 20-valent Conjugate Vaccine Code 90677
• New Waived Tests
• International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - April 2022

PUBLICATIONS
• Medicare Provider Compliance Tips
• National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) Prior Authorization Model

MULTIMEDIA
• CLFS Data Reporting Clinical Diagnostic Laboratory Tests Webinar Materials

MLN Connects - December 2, 2021

National Influenza Vaccination Week
MLN Connects newsletter for Thursday, December 2, 2021

NEWS
• National Influenza Vaccination Week
• Clinical Laboratory Fee Schedule: CY 2022 Final Payment Determinations
• Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder
• Ambulance Prior Authorization Model Expands February 1

CLAIMS, PRICERS, & CODES
• Hospital Inpatient EHR Reductions
• ICD-10: New Diagnosis & Procedure Codes Effective April 1, 2022

MLN MATTERS® ARTICLES
• 2022 Annual Update to the Therapy Code List
• Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2022
• Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2022
• Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

PUBLICATIONS
• Ordering External Breast Prostheses & Supplies - Revised
• Checking Medicare Eligibility - Revised

MLN Connects Special Edition - December 2, 2021 - CMS Encourages People with Medicare to get COVID-19 Vaccine Booster Shot

As part of the Biden-Harris Administration’s ongoing efforts to ensure that Americans are vaccinated against COVID-19 and to reduce stress across the nation’s health care system, the Centers for Medicare & Medicaid Services (CMS) is encouraging those with Medicare who are fully vaccinated to get a booster dose of the COVID-19 vaccine. Data shows that a COVID-19 vaccine booster dose increases immune response, which improves protection against COVID-19.

CMS is doing the following to encourage those with Medicare to get fully vaccinated and get their booster dose:

• **Sending a letter to people with Medicare:** All of the 63 million people who currently have Medicare will receive a letter encouraging them to get their COVID-19 vaccine booster as soon as possible.

• **Conducting campaigns and paid advertising:** This outreach will focus on those with Medicare who are not fully vaccinated against COVID-19 and will include reminders about getting the annual flu shot.

• **Including 1-800 MEDICARE reminders:** Approximately two million people call 1-800-MEDICARE each month. They will hear a reminder to get their COVID-19 boosters at the beginning of their call.
• Including a message in Medicare Summary Notices: For people with Original Medicare, CMS will include a COVID-19 booster message in their Medicare Summary Notice (the explanation of benefits people receive when a claim is filed) over the next several months.

• Sending email reminders: CMS will send COVID-19 vaccine booster reminder emails to the more than 14 million people that receive Medicare emails.

• Delivering consistent communication via social media: The @MedicareGov Twitter handle will continue to tweet about the importance of COVID-19 vaccine boosters.

• Engaging local and national partners: CMS is contacting more than 500 organizations, with a potential reach of more than five million members, and supplying them resources from Department of Health & Human Services (HHS) and the Centers for Disease Control and Prevention (CDC). The agency is also offering webinars to allow partners to interact with experts on encouraging COVID-19 vaccination.

• Conducting outreach to health plans: CMS and CDC are continuing their outreach to health plans to help them understand best practices for encouraging COVID-19 vaccinations and parameters for coverage of COVID-19 vaccines and boosters.

• Conducting outreach to nursing homes: CMS continues to work with nursing homes to increase COVID-19 vaccine and booster uptake. These efforts include deploying Quality Improvement Organizations (QIOs)—operated under the Medicare Quality Improvement Program—to assist nursing homes with low rates of initial and booster vaccinations and disparities in access to vaccinations. CMS will continue to explore additional outreach efforts to further support nursing homes.

• Conducting media outreach: CMS Administrator Chiquita Brooks-LaSure and other CMS leaders are encouraging COVID-19 vaccine boosters as part of their Medicare open enrollment outreach.

People with Medicare pay nothing when they get the COVID-19 vaccine and booster and there is no applicable copayment, coinsurance, or deductible. In addition, thanks to the American Rescue Plan (ARP), nearly all Medicaid and CHIP beneficiaries must receive coverage of COVID-19 vaccines and boosters without cost-sharing. COVID-19 vaccines and boosters will also be covered without cost-sharing for eligible consumers of most health insurance issuers in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.


MLN Connects Special Edition - December 6, 2021 - Provider Requirements Under the No Surprises Act Special ODF - December 8

Wednesday, December 8 from 2 - 3 pm ET

CMS will host a Special Open Door Forum (SODF) to explain provider requirements under the No Surprises Act. Starting January 1, 2022, consumers will have new billing protections when getting emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers. These requirements generally apply to items and services provided to people enrolled in group health plans, group or individual health insurance coverage, Federal Employees Health Benefits plans, and the uninsured.

These requirements don’t apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE that have other protections against high medical bills.

This SODF will include:

- Background and purpose
- Requirements for providers, facilities, and providers of air ambulance services starting January 1
- Enforcement provisions
• Resources and definitions
• Q&A session

How to Participate:
• Dial: 1-888-455-1397; conference ID # 8604468
• TTY services: Dial 7-1-1 or 800-855-2880

More Information:
• Presentation
• Provider Requirements and Resources webpage
• Questions: mailto:provider_enforcement@cms.hhs.gov

MLN Connects - December 9, 2021

CY 2022 Medicare Deductible, Coinsurance, & Premium Rates

MLN Connects newsletter for Thursday, December 9, 2021

NEWS
• PECOS: Multi-Factor Authentication Requirement Delayed
• HHS Seeks Public Comments to Advance Equity & Reduce Disparities in Organ Transplantation, Improve Life-Saving Donations, and Dialysis Facility Quality of Care
• Orthoses Referring Providers: Comparative Billing Report in December

COMPLIANCE
• Implanted Spinal Neurostimulators: Document Medical Records

MLN MATTERS® ARTICLES
• Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or in Part by a Physical Therapist Assistant or an Occupational Therapy Assistant
• Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2022

PUBLICATIONS
• Independent Diagnostic Testing Facility (IDTF) - Revised

MLN Connects - December 16, 2021

2% Payment Adjustment (Sequestration) Changes

MLN Connects newsletter for Thursday, December 16, 2021

NEWS
• Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes
• Flu Shot Disparities
• Opioid Treatment Programs: New Information for 2022
• Medicare Clinical Laboratory Fee Schedule Private Payor Data Reporting - Delayed until 2023
• PEPPERs for Short-Term Acute Care Hospitals
• COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Starting January 1, 2022

CLAIMS, PRICERS, & CODES
• Pneumococcal Conjugate Vaccine, 15 Valent
• Average Sales Price Files: January 2022
• Skin Substitute Codes
• National Correct Coding Initiative Medicare Policy Manual: Annual Update
MLN Connects Special Edition - December 17, 2021

CMS Funding 1,000 New Residency Slots for Hospitals Serving Rural & Underserved Communities

Administration takes action to address access to care, workforce shortages in high-need areas

On December 17, CMS took a critical step to advance health equity and access, issuing a final rule that will enhance the health care workforce and fund additional medical residency positions in hospitals serving rural and underserved communities.

The Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) final rule with comment period establishes policies to distribute 1,000 new Medicare-funded physician residency slots to qualifying hospitals, phasing in 200 slots per year over five years. CMS estimates that funding for the additional residency slots, once fully phased in, will total approximately $1.8 billion over the next 10 years. In implementing a section of the Consolidated Appropriations Act (CAA), 2021, this is the largest increase in Medicare-funded residency slots in over 25 years. Other sections of the CAA being implemented further promote increasing training in rural areas and increasing graduate medical education payments to hospitals meeting certain criteria.

Read the full Press Release.

MLN Connects - December 23, 2021

COVID-19 Vaccine Access in Long-Term Care Settings

Editor's Note: Happy holidays from the MLN Connects team! We'll release the next regular edition on Thursday, January 6, 2022.

NEWS

• COVID-19 Vaccine Access in Long-Term Care Settings
• DMEPOS Final Rule
• NPPES: Public Reporting of Digital Contact Information
• VBID Model: Hospice Benefit Component
• Federally Qualified Health Center CY 2022 PPS
• RHC: AIR Payment Limit for CY 2022

COMPLIANCE

• Surgical Dressings: Medicare Requirements

CLAIMS, PRICERS, & CODES

• January 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.0
MLN MATTERS® ARTICLES

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 86328
- January 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 - Revised
- Intravenous Immune Globulin Demonstration - Revised
MLN MATTERS

2022 Annual Update of Per-Beneficiary Threshold Amounts

MLN Matters Number: MM12470
Related CR Release Date: November 5, 2021
Related CR Transmittal Number: R11107CP
Related Change Request (CR) Number: 12470
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12470 tells you about:
- The updates to the annual per-beneficiary incurred expenses amounts now called the KX modifier thresholds and related policy for calendar year 2022 (CY 2022)
- The CY 2022 KX modifier threshold amounts are:
  - $2,150 for Physical Therapy (PT) and Speech-Language Pathology (SLP) services combined
  - $2,150 for Occupational Therapy (OT) services

Make sure your billing staff knows about these changes.
View the complete CMS Medicare Learning Network (MLN) Matters (MM)12470.

2022 Annual Update to the Therapy Code List

MLN Matters Number: MM12446
Related CR Release Date: November 10, 2021
Related CR Transmittal Number: R11118CP
Related Change Request (CR) Number: 12446
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12446 informs you about:
- The updated Calendar Year (CY) 2022 therapy code list
- The 5 CPT codes added to the list
- Some of the requirements for using those codes

Make sure your billing staff knows about these updates.
View the complete CMS Medicare Learning Network (MLN) Matters (MM)12446.

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2022

MLN Matters Number: MM12468
Related CR Release Date: October 1, 2021
Related CR Transmittal Number: R11013CP
Related Change Request (CR) Number: 12468
Effective Date: January 1, 2022
Implementation Date: January 3, 2022
CR 12468 tells you about changes in the January 2022 quarterly release of the edit module for clinical diagnostic laboratory services. According to the Medicare Claims Processing Manual, Chapter 16, Section 120.2, CMS updates the laboratory edit module as necessary to reflect coding updates and substantive changes to the NCDs. Make sure that your billing staff knows of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12468.

**Claim Status Category and Claim Status Codes Update**

MLN Matters Number: MM12299
Related CR Release Date: October 14, 2021
Related CR Transmittal Number: R11034CP
Related Change Request (CR) Number: 12299
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12299 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staff knows about the updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12299.

**Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 - Revised**

MLN Matters Number: MM12439 Revised
Related CR Release Date: December 14, 2021
Related CR Transmittal Number: R11163CP
Related Change Request (CR) Number: 12439
Effective Date: July 1, 2021 for 90677, July 16, 2021 for 90671
Implementation Date: April 4, 2022

Note: CMS revised this Article due to a revised CR 12439. The revised CR added instructions for vaccine code 90671 and changed the effective date for code 90677. CMS made those same changes in the Article as they show in dark red font. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 12439 informs you of:
- A new code for a pneumococcal vaccine
- Where to find pricing for the code
- The basis for Medicare’s payment to institutional providers for this code

Make sure your billing staff knows about new vaccine code:
- 90677, which is effective for Dates of Service (DOS) on or after July 1, 2021
- 90671, which is effective for DOS on or after July 16, 2021

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12439.
CY 2022 Update for DMEPOS Fee Schedule

MLN Matters Number: MM12521
Related CR Release Date: December 2, 2021
Related CR Transmittal Number: R11137CP
Related Change Request (CR) Number: 12521
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12521 informs you of:
- The Calendar Year (CY) 2022 annual update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule
- Fee schedule amounts for new and existing codes, as applicable
- Changes to DMEPOS payment policies

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12521.

Fiscal Year (FY) 2022 IPPS and LTCH PPS Changes

MLN Matters Number: MM12373
Related CR Release Date: September 16, 2021
Related CR Transmittal Number: R10995CP
Related Change Request (CR) Number: 12373
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12373 informs you of:
- FY 2022 Inpatient Prospective Payment System (IPPS) updates
- FY 2022 Long Term Care Hospital (LTCH) PPS updates
- Update to those hospitals that CMS excludes from the IPPS

Make sure your billing staff knows about the FY 2022 changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12373.

ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) -- April 2022 (CR 1 of 2)

MLN Matters Number: MM12480
Related CR Release Date: October 21, 2021
Related CR Transmittal Number: R11068OTN
Related Change Request (CR) Number: 12480
Effective Date: April 1, 2022
Implementation Date: November 23, 2021-Medicare Administrative Contractors (MACs); April 4, 2022, Medicare Shared Systems

CR 12480 tells you about updates of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These changes result from:
- Newly available codes
• Separate NCD coding revisions
• Coding feedback

CMS isn’t including any policy changes in this ICD-10 quarterly update. CMS covers NCD policy changes using the current, longstanding NCD process. Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12480.

ICD-10 and Other Coding Revisions to National Coverage Determinations (NCDs) -- April 2022 (CR 2 of 2)

MLN Matters Number: MM12482
Related CR Release Date: October 29, 2021
Related CR Transmittal Number: R11083OTN
Related Change Request (CR) Number: 12482
Effective Date: April 1, 2022
Implementation Date: December 2, 2021–Medicare Administrative Contractors (MACs) - April 4, 2022 - Medicare Shared Systems

CR 12482 tells you about updates of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to National Coverage Determinations (NCDs). These changes result from:

• Newly available codes
• Separate NCD coding revisions
• Coding feedback received

CMS isn’t including any policy changes in this ICD-10 quarterly update. CMS covers NCD policy changes using the current, longstanding NCD process. Make sure your billing staff knows of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12482.

Implementation of Changes in the ESRD PPS and Payment for Dialysis Furnished for AKI in ESRD Facilities for CY 2022

MLN Matters Number: MM 12499
Related CR Release Date: November 15, 2021
Related CR Transmittal Number: R11120BP
Related Change Request (CR) Number: 12499
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12499 informs you about:

• Updates for Calendar Year (CY) 2022 to the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) base rate, budget neutrality factor, and outlier threshold
• Updates to the Acute Kidney Injury (AKI) dialysis payment rate
• Updates for the Capital Related Assets (CRA) for Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12499.
Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08

MLN Matters Number: MM12502  
Related CR Release Date: December 2, 2021  
Related CR Transmittal Number: R1142PI  
Related Change Request (CR) Number: 12502  
Effective Date: January 1, 2022  
Implementation Date: January 3, 2022

CR 12502 informs you of:

- A summary of changes to the Medicare Program Integrity Manual, Chapter 10 - Medicare Enrollment
- Changes affecting a variety of provider types, including PA enrollment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12502.

Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022

MLN Matters Number: MM12417 Revised  
Related CR Release Date: October 5, 2021  
Related CR Transmittal Number: R11039CP  
Related Change Request (CR) Number: 12417  
Effective Date: October 1, 2021  
Implementation Date: October 4, 2021

Note: CMS revised this Article due to a revised CR 12417, which corrected the fixed dollar loss threshold amount to $16,040. CMS changed the CR release date, transmittal number, and the web address of the CR. CMS shows the revised fixed dollar loss threshold amount in dark red font on page 3. All other information remains the same.

CR 12417 is for Inpatient Psychiatric Facilities (IPFs) submitting claims to Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Make sure that your billing staff knows about the changes that apply to discharges occurring from October 1, 2021, through September 30, 2022.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12417.

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

MLN Matters Number: MM12469  
Related CR Release Date: October 1, 2021  
Related CR Transmittal Number: R11012CP  
Related Change Request (CR) Number: 12469  
Effective Date: January 1, 2022  
Implementation Date: January 3, 2022

CR 12469 tells you about the quarterly updates to Medicare’s Average Sales Price (ASP) and Not Otherwise Classified (NOC) Part B drug pricing files. Make sure that your billing staff knows of these changes.
January 2022 Update of the Hospital OPPS

MLN Matters Number: MM12552
Related CR Release Date: December 10, 2021
Related CR Transmittal Number: R11150CP
Related Change Request (CR) Number: 12552
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12552 informs you of:

- New Covid-19 CPT vaccines and administration codes
- Outpatient Prospective Payment System (OPPS) updates for January 2022
- New Drugs, Biologicals, and Radiopharmaceuticals

Make sure your billing staff knows about these changes.

Medicare Part B CLFS: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System - Revised

MLN Matters Number: SE19006 Revised
Article Release Date: November 4, 2021

Note: CMS revised this article to note that for CDLTs that aren’t ADLTs, the data reporting is delayed by one year and must now be reported from January 1, 2022, through March 31, 2022 (previously January 1, 2021, through March 31, 2021). All references to the 2021 data reporting period have been changed to 2022. In addition, CMS included information about the Online Data Collection System. You’ll find substantive content updates in dark red font (see pages 2,13-15 and 21-24). There are no other changes to the substance of the article.

SE 19006 will help laboratories meet the requirements under Section 1834A of the Social Security Act (the Act) for the Medicare Part B Clinical Laboratory Fee Schedule (CLFS). It covers:

- Clarifications for deciding whether a hospital outreach laboratory meets the requirements to be an “applicable laboratory”
- Applicable information (private payor rate data) that you must collect and report to us
- The entity responsible for reporting applicable information to us
- The data collection and reporting periods
- Information about our online data collection system
- Our schedule for implementing the next private payor-rate based CLFS update
- Information about the condensed data reporting option for reporting entities

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12469.
National Coverage Determination (NCD 110.24): CAR T-cell Therapy - This CR Rescinds and Fully Replaces CR 11783 - Revised

MLN Matters Number: MM12177 Revised
Related CR Release Date: July 20, 2021
Related CR Transmittal Number: R10891CP and R10891NCD
Related Change Request (CR) Number: 12177
Effective Date: August 7, 2019
Implementation Date: September 20, 2021

Note: CMS revised the Article to add information on the use of the KX modifier on professional claims. You’ll find the substantive content update in dark red font on page 4. All other information is the same.

CR 12177 tells you that, effective for claims with dates of service on or after August 7, 2019, CMS covers autologous treatment for cancer with T-cells expressing at least 1 Chimeric Antigen Receptor (CAR) when administered at healthcare facilities:

- Enrolled in the FDA Risk Evaluation and Mitigation Strategies (REMS)
- Meets specified CMS/FDA criteria

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12177.

Quarterly Update to the ESRD PPS

MLN Matters Number: MM12307
Related CR Release Date: August 10, 2021
Related CR Transmittal Number: R10920CP
Related Change Request (CR) Number: 12307
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12307 updates the diagnosis codes eligible for the End-Stage Renal Disease Prospective Payment System (ESRD PPS) co-morbidity payment adjustment, effective October 1, 2021. Make sure your billing staff knows about these code updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12307.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM12478
Related CR Release Date: November 17, 2021
Related CR Transmittal Number: R11111CP
Related Change Request (CR) Number: 12478
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12478 informs you about:

- The latest update of the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) code sets
- What you must do if you use Medicare Remit Easy Print (MREP) or PC Print
- Where to find the official code lists

Make sure your billing staff knows about these changes. If you use MREP or PC Print, be sure to get the latest version when available.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12478.
Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or In Part by a PTA or an OTA

MLN Matters Number: MM12397
Related CR Release Date: November 22, 2021
Related CR Transmittal Number: R11129CP
Related Change Request (CR) Number: 12397
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12397 is for physical and occupational therapists and therapy providers billing Medicare administrative Contractors (MACs) for services of physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) provided to Medicare patients.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12397.

Summary of Policies in the CY 2022 MPFS Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List - Revised

MLN Matters Number: MM12519 Revised
Related CR Release Date: December 2, 2021
Related CR Transmittal Number: R11146CP
Related Change Request (CR) Number: 12519
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

Note: CMS revised this Article due to a revised CR 12519. In the Article, CMS added language to show that the originating site facility fee doesn’t apply to Medicare telehealth services when the originating site is the patient’s home. For mental telehealth services, CMS shows there must be a non-telehealth service every 12 months (instead of 6 months) after initiating telehealth. These changes are in dark red font on page 2. CMS also changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.

CR 12519 informs you of:

- Updates to payment policies and Medicare payment rates for services physicians and Non-Physician Practitioners (NPPs) provide that Medicare pays for with the Medicare Physician Fee Schedule (MPFS) in Calendar Year (CY) 2022
- Updates to Medicare Telehealth Services and Telehealth origination site facility fee payment amounts
- Billing for Physician Assistant (PA) Services and other policy changes related to Medicare Part B

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12519.

Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2019 for IPPS Hospitals, IRFs, and LTCHs

MLN Matters Number: MM12516
Related CR Release Date: November 16, 2021
Related CR Transmittal Number: R11127COM
Related Change Request (CR) Number: 12516
Effective Date: December 17, 2021
Implementation Date: December 17, 2021
CR 12516 informs you of:

- Updated data that decides the Disproportionate Share (DSH) adjustment for Inpatient Prospective Payment System (IPPS) hospitals
- The Low-Income Patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs)
- Payments, as applicable, for Long Term Care Hospitals (LTCH) discharges

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12516.

**Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2022**

MLN Matters Number: MM12507
Related CR Release Date: November 30, 2021
Related CR Transmittal Number: R11136Gi
Related Change Request (CR) Number: 12507
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12507 is for new Calendar Year (CY) 2022:

- Medicare rates
- Part A and B Deductible and Coinsurance Rates
- Part A and B Premium Amounts

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12507.