Medicare A News

Jurisdiction F
July 2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACT Questions and Answers - March 22, 2023

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 its 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: Can you advise if Critical Access Hospitals (CAHs) should follow Correct Coding Initiative (CCI) guidelines for ancillary services provided in the inpatient setting? The OCE is specific to outpatient claims but since CAHs are paid by cost, I would like clarification if the CCI edits do or do not need to be followed when billing for inpatient ancillary services (radiology, labs, RT, etc.) specifically CPT 94640. The CPT book advises "for more than one inhalation treatment performed on the same date, append modifier 76", but NCCI Policy manual for Medicare specifically indicates in the outpatient setting 94640 can only be billed once per encounter. If a patient with respiratory condition is admitted, our hospital can do many units of 96460. In our case, we would be reimbursed for all of them since we are paid on cost and the CPT codes are not present in inpatient bills.
A1: NCCI edits do not apply to inpatient claims. Hospital Procedure to Procedure (PTP) edits are applied to Type of Bill "85X, and OPPS flag = 2" and is explained in the narrative in the Outpatient Code Editor (OCE) Quarterly Release Files and in the MLN article SE18012

The booklet How to Use the Medicare National Correct Coding Initiative (NCCI) Tools provides more information

Q2: What are the correct dates we should have in the "from" and "through" dates on the UB04 form field box 12? Should this date represent the first date of service from and discharge date or should it represent the admit and discharge date regardless of if this patient was in the ER the day before the admit order was written?
A2: The From date represents the first date of service which would include an ER visit the day before. A valid "from" date could be up to and including three-days (or a one day) prior to the actual inpatient admission based on the three-day/one-day payment window.

Source: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 3, Section 40.3

Q3: Our facility has a question regarding billing the standard cataract lens when a specialty lens is placed. We understand Medicare covers the standard conventional cataract lens (V2632), however, is it appropriate to report both the covered lens (V2632) and the non-covered lens on the same claim when only the specialty lens is inserted? We realize the V2632 would be reported in the covered column and the non-covered lens be reported in the non-covered column and the patient responsible for the difference between the two lenses. CMS guidance addresses Ambulatory Surgical Centers and office settings; however, our question relates to billing hospital OPPS outpatient and Critical Access Hospital Outpatient.
A3: The CAH would bill for cataract surgery (i.e., 66984, 66982, etc.), for non-covered lens, bill V2787 to report the non-covered A-C (Astigmatism-correcting) Intraocular lens (IOL) functionality charges of the inserted intraocular lens. Note: while V2788 is no longer valid to report non-covered A-C IOL charges, it's valid to report non-covered P-C (presbyopia-correcting) IOL charges. CMS will pay CAHs method II claims under current payment methodologies for conventional IOLs.

Source: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 32, Section 120.1

Q4: The Medicare Benefit Policy Manual Chapter 13 §40.1 states RHC and FQHC visits may not take place in an inpatient or outpatient department of a hospital, including a CAH. Services furnished to patients in any type of hospital setting (inpatient, outpatient, or emergency department) are statutorily excluded from the RHC/FQHC benefit and may not be billed by the RHC or FQHC. We frequently have RHC providers see patients in inpatient, observation, and outpatient encounters. Most often it is our obstetric patients who are seen for complications, sometimes requiring only a short outpatient visit but could also be held for longer observation and eventually admitted as inpatients. Are these visits by our RHC providers billable with a revenue code 0982 or is it the fact the providers are RHC providers that they are not allowed to bill for these services at all?
A4: No, the RHC cannot bill for a visit and or service in a statutorily excluded setting.

Q5: Is it appropriate to report code 77470 - Radiation special treatment procedure for the additional physician management of a patient receiving oral chemotherapy such as temodar or xeloda?
A5: 77470 is a radiation code and is intended to be used in combination of other radiation treatment codes.

Q6: During a Noridian physical therapy review, we received a coding error because we reported 97542 for a wheelchair fitting and adjustment, rather than 97162 - physical therapy evaluation. Our understanding is that a physical therapy evaluation would be included in the code for 97542. When is it appropriate to report 97542 - Wheelchair management versus 97162 - physical therapy evaluation when a wheelchair fitting and adjustment is involved?
A6: In general, the 97162 is the best basic assessment for the criteria of the wheelchair (or possible other device) use, while 97542 is the training to use the wheelchair once it has been assigned and obtained. Review your coding error for additional information.

Q7: The planned procedure was a coronary artery bypass graft (CABG), and the patient was taken to the OR and anesthesia was administered. After a transesophageal echocardiogram (TEE) was performed the CABG procedure was aborted due to patient's condition. Provider felt the patient would need extracorporeal membrane oxygenation (ECMO) to come off the pump. The patient was sent home, so, no admission occurred. The claim place of service was outpatient. We do have revenue code 360 charges, so, we coded the planned procedure of the CABG 33517 and 33533 both with modifier 74. The claim was denied as these codes are both inpatient only procedures. How should this be filed? Should we only code TEE codes with Revenue code 360?

A7: In general, we can say that it is inappropriate to bill two inpatient-only codes as outpatient. Also, modifiers 73 and 74 are modifiers specifically for Discontinued Ambulatory Surgical Center (ASC) and outpatient hospital claims so it would be inappropriate to use those modifiers on inpatient-only codes as well. If a patient is under inpatient orders and the surgery begins, it would also not be appropriate to bill the claim as outpatient as the orders reflect as inpatient. Noridian recommends reaching out to your specialty associated such as the AAPC for more specific claim submission guidance for discontinued inpatient surgeries.

Q8: My question is on leadless pacemakers and Coverage with Evidence (CED). I do not see a coverage article that has updated CPT codes for the implants, removal/replacement, programming, or interrogation. Do we need to continue to apply the Q0 modifier and other CED required codes for removals, interrogation, and programming? I can see that we need to for initial implant, but the information still lists the category III codes. It is not clear if there has been an update to each of the services.

A8: Yes, you will need to continue to apply the Q0 modifier and other CED requirements for removals, interrogation, and programming. We are reaching out to CMS regarding the outdated coding in the NCD and IOM.

Q9: If a patient was Observation Patient Class for medically necessary condition, and during the stay has an interventional procedure, does the facility need a new order for observation post the surgical procedure to report observation hours, or does the facility simply subtract the standard post op recovery time before reporting observation hours again?

A9: No, a new observation order is not needed. Observation services should not be billed along with diagnostic or therapeutic services for which active monitoring is a part of the procedure. In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. A hospital may record for each period of observation services, the beginning and ending times, during the hospital outpatient encounter and add the length of time for the periods of observation together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Source: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.2.2

Q10: If a patient is in same day surgery patient class for a medically necessary condition, has the scheduled surgical procedure, has a post op complication in one hour recovery time, where the condition prompts the provider to write an order for observation patient class at that time. Does the facility subtract the standard six hours post op recovery time, after the surgical procedure is completed before billing new observation hours?
A10: Observation services must be patient specific and not part of the facility's standard operating procedures. If observation is required after an outpatient surgical procedure and the patient meets criteria for observation monitoring after the standard surgical recovery period, you can place the patient in outpatient observation; however, the observation care will be bundled into payment for the surgical procedure.

Source: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.2.2

Q11: For all observation hours that are past the initially covered 48 hours, it has been the instruction of Noridian to place the non-covered hours in box 48 on the UB04 with instructions that one line should be REV code 0762 HCPCS G0378x 48 hours. Second line under REV code 0762 with whatever the overage of the covered 48 hours is. Could you clarify if the second line has HCPCS G0378, or should it have no HCPCS, just REV code and hours?
A11: Report all services rendered while the patient is in observation with the appropriate revenue codes, HCPCS/Current Procedure Terminology codes, and diagnosis codes. If a period of observation spans more than one calendar day, all the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.

Source: CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 290.2.2

Q12: RHC providers seen in the hospital on an outpatient status. When they see patients in an observation setting(admitted), can they charge for a visit in a hospital?
A12: No, that's not a place they can statutorily provide services as a practitioner. They can't provide service in a hospital setting, even in observation status.

Q13: Does Medicare Advantage follow the Medicare guidelines for inpatient billing, specifically the three-day rule?
A13: Medicare Advantage follow the same basic guidelines, but, have different rules and regulations that govern them. We would have to direct that question to the Medicare Advantage plan.

Q14: Is there a list of HCPCS codes for non-covered services?
A14: MLN906765 - Items & Services Not Covered Under Medicare

List for covered services: Specific Payment Codes for the Federally Qualified Health Center Prospective Payment System (FQHC PPS)

I/OCE Quarterly "Data" Files include a list of services: I/OCE Quarterly Release Files

Q15: For the OC quarterly release tabs, is it specific for all providers or only FQHC?
A15: IOCE Quarterly Data Files is not specific to FQHC , however, the FQHC section is 5.22

Q16: Can you clarify if the G0480 amount can change based on what metabolite we test or is it a fixed charge?
A16: This is priced off the clinical lab fee schedule and would price based off what CMS has published. For questions about those fee schedules see: 23CLABQ1

Q17: Regarding PHE (when no longer in effect on May 11) Will there be no telehealth services allowed or will there be a modified list for hospital outpatient departments? Is it all going away, or just some?
A17: After the PHE, there are a variety of different circumstances for different providers. Look on the CMS website under their COVID listings with fact sheets that are individual to most off the different provider types, include physicians, labs, RHCs, etc. If you look at those, they'll give you more specifics regarding what services will be available, and for how long. We highly encourage you to look at this. We do have some upcoming webinars.

Q18: I have a question about specific LCA A52966. We had a couple claims deny by Medicare. We couldn't understand the reasoning. We called our intermediary, and we were told the code from the LCA was Line #4, PCS code line #1 was coded on line #5. Because they were not on the same line, that is why our claim was denied. To get the plan processed for payment, we would need to go through the Appeals process. I wasn't understanding why they are looking at a line item. The codes came from group 1 and the group one code. It should have been covered.
A18: While we are aware of one code that is not processing correctly, we are in the process of having the correction made. Without being able to see your claim, we are not able to provide more specific information for you. Our Provider Contact Center (PCC) is your best avenue to pursue this as they can look at the claim with you.

Advance Beneficiary Notice of Noncoverage (ABN): Form Renewal

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

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

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

Resources:

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

Clinicians: Ordering Oxygen for Your Patient

Home use of oxygen and oxygen equipment is eligible for Medicare reimbursement only when a beneficiary meets all of the requirements set out in the CMS Internet Only Manual (IOM), Publication 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Section 240.2 and the corresponding DME MAC Oxygen and Oxygen equipment Local Coverage Determination (LCD). When ordering home oxygen therapy for a patient with Medicare, a blood gas study must be ordered and evaluated at the time of need. Time of need is defined as during the patient's illness when it is presumed that oxygen therapy will improve the patient's condition in the home setting. If the oxygen is initially prescribed at the time of hospital discharge, qualification testing must be performed within the 2 days prior to discharge home. Note that this 2-day prior to discharge rule does not apply to nursing facilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Share with all of your pharmacies and patients.

Holding Claims for Pricing Based on the July 2023 FISS Release

Effective July 1, 2023, Part A claims with dates of service on/after July 1, 2023 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 July 15, 2023.

News

May is Mental Health Awareness Month - Substance Use Disorder Benefits

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

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

- OTP intake add-on code (G2076) to initiate treatment with buprenorphine provided via 2-way, interactive, audio-video or audio-only technology when audio-video technology isn't available.
- Periodic patient assessments (HCPCS code G2077) via audio-video technology
- The therapy and counseling portions of weekly bundles and the add-on code for additional counseling or therapy (HCPCS code G2080) via audio-only technology when audio-video isn't available.

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

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

Post COVID Modifiers:

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

Resources

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

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

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

Education on Demand Tutorials

- The History of Medicare

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

News

Medicare Beneficiary Identifier (MBI) Retrieval and Resources

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

- Medicare Beneficiary Identifier (MBI) Retrieval and Resources

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

Mental Health Awareness Month - Week 1

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

Some of the highest demographics include:

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

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

Resources

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

News

Post-COVID 19 and Appeal Waivers, Appeals Newsletter Part 4

Due to the COVID-19 PHE expiring on May 11, 2023, many of the flexibilities will expire on May 12, 2023. One of those flexibilities is the extension of the timely filing limit for appeals. Starting on May 12. 2023 the filing deadline for Redeterminations will return to 120 days from initial determination.

Resources: Appeals Timeliness Calculators

Provider Administrator's Can Now Reactivate Users on NMP

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

Unlisted Code Billing

When billing a service or procedure, select the CPT or HCPCS code that accurately identifies the service or procedure performed. If no such code exists, report the service or procedure using the appropriate unlisted procedure code (which often ends in 99). Noridian will **not** correctly code process an unlisted procedure when a valid code is available.

For more information, please visit the Unlisted Code Billing article.

Updated Noridian On-Demand Tutorials Available

Noridian offers self-paced training tutorials to help providers and facilities better understand topics throughout Medicare. The following tutorials have been updated:

- Federally Qualified Health Centers (FQHC) Basics
- Federally Qualified Health Centers (FQHC) Location and Visit Requirements

Providers and facilities are encouraged to attend our webinars and/or to view other tutorials available to assist with proper billing and team member education. A complete listing of our tutorials can be found on the Education on Demand Tutorials webpage.

News

Venipuncture Requirements - CPT 36410 vs. 36415

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

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

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

CPT 36415 - Collection of venous blood by venipuncture

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

Resource

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

Where to Send Your Appeals - Appeals Newsletter Part 5

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

Reopenings: Written, or complete through Direct Data Entry (DDE).

Redetermination: Submit written form, or through NMP

Reconsideration: Submit through Noridian Medicare Portal (NMP) or on paper to the QIC - Maximus Federal Services

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

Medicare Appeals Council Review - Departmental Appeals Board (DAB)

Federal Court Review - Judicial Review

Resources

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

Your Feedback Matters - Education Event Surveys

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

Medical Policies and Coverage

Billing and Coding: Complex Drug Administration Coding (A58533) Retirement - Effective April 01, 2023

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: April 01, 2023

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

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

Billing and Coding: Dental Services (A59450) - Effective January 1, 2023

This coverage article has been created 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: January 1, 2023

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

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

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55323) - R13 - Effective July 1, 2023

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: July 1, 2023

Summary of Article Changes:

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

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

Prialt (Ziconotide) = $9.078

Ropivacaine = $0.074

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

Medical Policies and Coverage

Billing and Coding: Intensity Modulated Radiation Therapy (IMRT) (A58245) - R5 - Effective April 1, 2023

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 of Service: April 1, 2023

Summary of Article Changes:

Added ICD-10-cm codes C7A.1; C7A.8; C7B.8 to Group 1

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

Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999 (A55062) - R3 - Effective October 15, 2015

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 15, 2015

Summary of Article Changes:

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

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

Billing and Coding: Lab: Controlled Substance Monitoring and Drugs of Abuse Testing (A55030) - R17 - Effective July 1, 2023

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: July 1, 2023

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

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

Medical Policies and Coverage

Billing and Coding: MolDX: Abbott RealTime IDH1 and IDH2 testing for Acute Myeloid Leukemia (AML) (A55712) - R5 - Effective June 01, 2023

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: June 01, 2023

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

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

Billing and Coding: MolDX: Allomap (A54366) Retirement - Effective June 09, 2023

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: June 09, 2023

Summary: This article is being retired because the information in this article has been incorporated within MolDX: Molecular Testing for Solid Organ Allograft Rejection (A58170).

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

Billing and Coding: MolDX: AlloSure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (A57233) Retirement - Effective June 09, 2023

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: June 09, 2023

Summary: This article is being retired because the information in this article has been incorporated within MolDX: Molecular Testing for Solid Organ Allograft Rejection (A58170).

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

Medical Policies and Coverage

Billing and Coding: MolDX: bioTheranostics Cancer TYPE ID® (A54388) - R8 - Effective June 1, 2023

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: June 1, 2023

Summary of Article Changes:

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

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

Billing and Coding: MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma (A59181) Final Billing and Coding Article - Effective August 06, 2023

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 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/Contractor Determination Number: A59181

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

Effective Date: August 06, 2023

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

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

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT) (A57527) - R12 - Effective April 01, 2023

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: April 01, 2023

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

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58726) - R8 - Effective April 20, 2023

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 20, 2023

Summary of Article Changes:

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

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

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

Billing and Coding: MolDX: Next-Generation Sequencing for Solid Tumors (A57905) - R4 - Effective April 01, 2023

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: April 01, 2023

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

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

Billing and Coding: MolDX: Pharmacogenomics Testing (A57385) - R9 - Effective April 20, 2023

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: April 20, 2023

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

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

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

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

Billing and Coding: MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (A59187) Final Billing and Coding Article - Effective August 06, 2023

This Local Coverage Determination (LCD) has completed the Open Public Meeting and is now finalized under contractor numbers: 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/Contractor Determination Number: A59187

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

Effective Date: August 06, 2023

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

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

Billing and Coding: MolDX: Repeat Germline Testing (A57332) - R6 - Effective April 01, 2023

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: April 01, 2023

Summary of Article Changes:

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

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

Medical Policies and Coverage

Billing and Coding: Sacroiliac Joint Injections and Procedures (A59246) - R1 - Effective March 19, 2023

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: March 19, 2023

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

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

MolDX: AlloSure® or Equivalent Cell-Free DNA Testing for Kidney and Heart Allografts (L38380) Retirement - Effective June 09, 2023

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: L38380/A57233/A58482

Effective Date: June 09, 2023

Rationale: This LCD is being retired because the information in this policy has been incorporated within the MolDX: Molecular Testing for Solid Organ Allograft Rejection (L38671) LCD.

Visit the Retired LCDs webpage to access the retired LCDs.

MolDX: Envisia, Veracyte, Idiopathic Pulmonary Fibrosis Diagnostic Test (L37891) - R6 - Effective June 29, 2023

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: L37891

Effective Date: June 29, 2023

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

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

MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma (L39375) Final LCD - Effective August 06, 2023

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: L39375

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

Effective Date: August 06, 2023

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

Visit the Proposed LCDs webpage to access this LCD.

MolDX: Molecular Biomarker Testing for Risk Stratification of Cutaneous Squamous Cell Carcinoma - Published for Review and Comments

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

Medicare Coverage Database (MCD) Number: DL39594/DA59401

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

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

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

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

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

Medical Policies and Coverage

MolDX: Molecular Diagnostic Tests (MDT) (L36256) - R15 - Effective May 04, 2023

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).

Effective Date: May 04, 2023

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

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

MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (L38649) Final LCD - Effective August 06, 2023

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: L38649

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

Effective Date: August 06, 2023

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

Visit the Proposed LCDs webpage to access this LCD.

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

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 02101 (AK), 03101 (AZ), 02201 (ID), 03201 (MT), 03301 (ND), 02301 (OR), 03401 (SD), 03501 (UT), 02401 (WA), and 03601 (WY).

Medicare Coverage Database Number	LCD Title
L37027	Cataract Surgery in Adults
L37738	Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Medicare Coverage Database Number	Billing and Coding Article Title
A57196	Billing and Coding: Cataract Surgery in Adults
A57513	Billing and Coding: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Medicare Coverage Database Number	Response to Comments
A59414	Response to Comments: Cataract Surgery in Adults
A57420	Response to Comments: Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor and Tremor Dominant Parkinson's Disease

Effective Date: July 30, 2023

Summary: July 30, 2023

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

Medical Policies and Coverage

Multiple Proposed LCDs - Published for Review and Comments

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

- **Medicare Coverage Database (MCD) Number:** DL39118
  LCD Title: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound
- **Medicare Coverage Database (MCD) Number:** DL38301
  LCD Title: Mico-Invasive Glaucoma Surgery (MIGS)
- **Medicare Coverage Database (MCD) Number:** DL38707
  LCD Title: Transurethral Waterjet Ablation of the Prostate
- **Medicare Coverage Database (MCD) Number:** DL37293
  LCD Title: Respiratory Care

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

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

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

Self-Administered Drug Exclusion List (A53033) - R31 - Effective June 25, 2023

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: June 25, 2023

Summary of Article Changes:

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

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

Urine Drug Testing - Published for Review and Comments

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

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

Medicare Coverage Database (MCD) Number: DL36707/DA55030

LCD Title: Urine Drug Testing

LCA Title: Billing and Coding: Urine Drug Testing

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

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

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

MLN Connects

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

Proposed Rules

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

MLN Connects - April 6, 2023

MLN Connects Newsletter: Apr 6, 2023

News

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

Claims, Pricers, & Codes

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

Events

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

MLN Matters® Articles

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

MLN Connects

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

Proposed Rule

CMS Proposes Policies to Improve Patient Safety and Promote Health Equity

MLN Connects - April 13, 2023

MLN Connects Newsletter: Apr 13, 2023

News

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

Claims, Pricers, & Codes

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

Events

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

MLN Matters® Articles

- New Waived Tests

Publications

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

MLN Connects

Multimedia

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

MLN Connects - April 20, 2023

MLN Connects Newsletter: Apr 20, 2023

News

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

Compliance

- Home Health Rural Add-On Policy

Claims, Pricers, & Codes

- Grandfathered Tribal Federally Qualified Health Centers: CY 2023 Rate

Events

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

Multimedia

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

MLN Connects

MLN Connects - April 27, 2023

MLN Connects Newsletter: Apr 27, 2023

News

- Hospital Price Transparency Enforcement Updates
- For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available
- Behavioral Health Integration Services: Find Out What Medicare Covers & Who's Eligible

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- 2023 Quality Conference May 1-3

MLN Matters® Articles

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

Information for Patients

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

MLN Connects - May 4, 2023

MLN Connects Newsletter: May 4, 2023

News

- FAQs on CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency
- Guidance for the Expiration of the COVID-19 Public Health Emergency
- COVID-19 Over-the-Counter Tests
- Medicare Diabetes Prevention Program: Public Health Emergency Flexibilities Continue through December 31
- Transplant Eco-System: Role of Data in CMS Oversight of The Organ Procurement Organizations
- Expanded Home Health Value-Based Purchasing Model: April Newsletter & Performance Reports

- Religious Nonmedical Health Care Institution Benefit & COVID-19 Vaccines
- Clinical Laboratory Fee Schedule 2024 Preliminary Gapfill Rates: Submit Comments by June 26
- Mental Health: Recommend Medicare Preventive Services

Claims, Pricers, & Codes

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

Events

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

MLN Matters® Articles

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

Publications

- Electronic Cell-Signaling Treatment

MLN Connects - May 11, 2023

MLN Connects Newsletter: May 11, 2023

News

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

Compliance

- Bill Correctly: Power Mobility Devices Repairs

MLN Matters® Articles

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

MLN Connects

Publications

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

MLN Connects - May 18, 2023

MLN Connects Newsletter: May 18, 2023

News

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

Claims, Pricers, & Codes

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

Events

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

Publications

- Screening Pap Tests & Pelvic Exams - Revised

From Our Federal Partners

- Potential Risk for New Mpox Cases

MLN Connects

MLN Connects - May 25, 2023

MLN Connects Newsletter: May 25, 2023

News

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

Claims, Pricers, & Codes

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

MLN Matters® Articles

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

Publications

- Checking Medicare Claim Status

Multimedia

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

Information for Patients

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

MLN Connects - June 1, 2023

MLN Connects Newsletter: June 1, 2023

News

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

- Improve Cognitive Health: Medicare Covers Services

MLN Matters® Articles

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

Publications

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

Multimedia

- Hospice Quality Reporting Program Web-Based Training - Revised

MLN Connects - June 8, 2023

MLN Connects Newsletter: June 8, 2023

News

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

Claims, Pricers, & Codes

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

MLN Connects

MLN Matters® Articles

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

MLN Connects - June 15, 2023

MLN Connects Newsletter: June 15, 2023

News

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

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2024

MLN Matters® Articles

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

Publications

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

Information for Patients

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

MLN Connects

MLN Connects - June 22, 2023

MLN Connects Newsletter: June 22, 2023

News

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

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Codes: FY 2024

Events

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

MLN Matters® Articles

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

MLN Connects - June 29, 2023

MLN Connects Newsletter: June 29, 2023

News

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

Claims, Pricers, & Codes

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

MLN Connects

Events

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

MLN Matters® Articles

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

From Our Federal Partners

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

Information for Patients

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

MLN Matters

Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order

Related CR Release Date: March 30, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13055

Related Change Request (CR) Number: CR 13055

Related CR Transmittal Number: R11935OTN

CR 13055 tells you about:

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

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

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

Claim Status Category and Claim Status Codes Update

Related CR Release Date: March 2, 2023

Effective Date: March 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 12845

Related CR Transmittal Number: R11885CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12845.

MLN Matters

CLFS & Laboratory Services Reasonable Charge Payment: Quarterly Update

Related CR Release Date: May 4, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13195

Related Change Request (CR) Number: CR 13195

Related CR Transmittal Number: R12021CP

CR 13195 tells you about:

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

Make sure your billing staff knows about these changes.

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

DMEPOS Fee Schedule: July 2023 Quarterly Update

Related CR Release Date: June 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13235

Related Change Request (CR) Number: CR 13235

Related CR Transmittal Number: R12068CP

CR 13235 tells you about:

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

Make sure your billing staff knows about these changes.

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

MLN Matters

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

Related CR Release Date: May 18, 2023

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

MLN Matters Number: MM13192

Related Change Request (CR) Number: CR 13192

CR 13192 tells you about:

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

Make sure your billing staff knows about the updates.

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

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

Related CR Release Date: May 4, 2023 Revised

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

MLN Matters Number: MM13180

Related Change Request (CR) Number: CR 13180

Related CR Transmittal Number: R12020DEMO

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

CR13180 tells you about:

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

Make sure your billing staff knows about these adjustments.

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

MLN Matters

Hospital Outpatient Prospective Payment System: April 2023 Update - Revised

Related CR Release Date: March 31, 2023

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

MLN Matters Number: MM13136

Related Change Request (CR) Number: CR 13136

Related CR Transmittal Number: R11937CP

Note: A revision to CR 13136 changed a reference to ASP calculations based on sales price submissions from the third quarter of CY 2022 to the fourth quarter. CMS made the same change in Section 5g (page 6) of the Article. The change is in dark red.

CR 13136 tells you about payment system updates and new codes for:

- COVID-19
- Drugs, biologicals, and radiopharmaceuticals
- Devices
- Other items and services

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13136.

Hospital Outpatient Prospective Payment System: July 2023 Update

Related CR Release Date: June 13, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13210

Related Change Request (CR) Number: CR 13210

Related CR Transmittal Number: R12077CP

CR 13210 tells you about:

- COVID-19
- Drugs, biologicals and radiopharmaceuticals
- Devices
- Other items and services

Make sure your billing staff knows about the payment system updates and new codes.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13210.

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

Related CR Release Date: March 23, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13157

Related CR Transmittal Number: R11920CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13157.

Mental Health Visits via Telecommunications for RHCs & FQHCs - Revised

MLN Matters Number: SE22001 Revised

Article Release Date: May 23, 2023

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

SE22001 tells you about:

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

Make sure your billing staff knows about these changes.

View the complete CMS Special Edition (SE)22001.

MLN Matters

New JZ Claims Modifier for Certain Medicare Part B Drugs

Related CR Release Date: June 2, 2023

Effective Date: January 1, 2023

Implementation Date: July 1, 2023 - JZ modifier

MLN Matters Number: MM13056

Related Change Request (CR) Number: CR 13056

Related CR Transmittal Number: R12067CP

CR 13056 tells you about:

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

Make sure your billing staff knows about these changes.

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

Preventing Submission of Cross-Reference Document Control Numbers on Original Claims

Related CR Release Date: January 19, 2023

Effective Date: April 1, 2023

Implementation Date: April 1, 2023

Related Change Request (CR) Number: CR 13008

Related CR Transmittal Number: R11794CP

CR 13008 creates a new edit in Original Medicare systems to prevent providers from submitting unnecessary data on original claims.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13008.

MLN Matters

Quarterly Update to the ESRD PPS

Related CR Release Date: May 11, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13201

Related CR Transmittal Number: R12029CP

CR 13201 updates the list of outlier services under the End Stage Renal Disease Prospective Payment System (ESRD PPS).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13201.

Quarterly Update to the MPFSDB - July 2023 Update

Related CR Release Date: June 7, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13208

Related CR Transmittal Number: R12072CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13208.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: December 30, 2022

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

Related Change Request (CR) Number: CR 13007

Related CR Transmittal Number: R11768CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13007.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: March 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13114

Related CR Transmittal Number: R11886CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13114.

MLN Matters

Skilled Nursing Facility Prospective Payment System: Updates to Current Claims Editing

Related CR Release Date: April 21, 2023

Effective Date: October 1, 2023 - Dates of Service (DOS) October 1, 2019, and after

Implementation Date: October 2, 2023

MLN Matters Number: MM13149

Related Change Request (CR) Number: CR 13149

Related CR Transmittal Number: R11988CP

CR 13149 tells you about:

- Improved editing of claims that have interrupted stays that span 2 months
- Modified editing for occurrence span code (OSC) edits allowing for proper claims decisions

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13149.

SNF 5-Claim Probe and Educate Review

Related CR Release Date: May 15, 2023

Effective Date: June 5, 2023

Implementation Date: June 5, 2023

Related Change Request (CR) Number: CR 13164

Related CR Transmittal Number: R12037OTN

CR 13164 is an attempt to increase comprehension of correct billing practices under the PDPM by all Skilled Nursing Facility (SNF) providers that bill Medicare. CMS is implementing a 5-claim probe and educate medical review strategy that allows for maximum outreach to all SNFs and offers provider-specific education, as necessary, to prevent future improper payments. As always, if the MAC identifies an improper payment the MAC will adjust/deny the individual claim payment, as appropriate, and provide education.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13164.

MLN Matters

Update to the Payment for Grandfathered Tribal FQHCs for Calendar Year (CY) 2023

Related CR Release Date: May 9, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13174

Related CR Transmittal Number: R11942CP

CR 13174 updates the Grandfathered Tribal Federally Qualified Health Center (FQHC) PPS rate.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13174.

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

Related CR Release Date: February 9, 2023

Effective Date: January 1, 2023

Implementation Date: May 9, 2023

MLN Matters Number: MM13064

Related Change Request (CR) Number: CR 13064

CR 13064 tells you about:

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

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

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

Contacts, Resources, and Reminders

Noridian Part A Customer Service Contact

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

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

Fax Numbers - View fax numbers and submission guidelines.

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

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

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled “MLN Matters,” which will continue to be published in Noridian bulletins. The Medicare Learning

Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

Unsolicited or Voluntary Refunds Reminder

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

Background

Medicare carriers and intermediaries and 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

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

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

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

Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

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

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

IRS-1099 Reporting

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

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

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

Jurisdiction F Part A Quarterly Ask-the-Contractor Teleconferences

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

Noridian representatives from various Part 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.

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

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

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

We look forward to your participation in these important calls.

Medicare Part 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.

- Jurisdiction F Part B ACTs
- Jurisdiction D DME ACTs
- Jurisdiction A DME ACTs