Medicare A News

Jurisdiction F
January 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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2025 Annual Update of Per-Beneficiary Threshold Amounts

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

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

(b) $2,410 for OT services.

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

ACM Questions and Answers - August 28, 2024

Written Questions

Q1. CPT code 0499T (Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed) was changed to new code 52284 (Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed) as of January 1, 2024. Is this new code, 52284, considered investigational?

A1. The American Medical Association's (AMA's) new code 52284 was implemented in 2024 as a Category I code. As a Category I code, 52284 satisfies additional AMA criteria over the Category III. However, the AMA's assignment of Category I coding, does not affect CMS' nor a Medicare Administrative Contractor's (MAC's) determination as to the investigational or experimental nature of a service, nor does it determine coverage and payment.

Q2. Can a Rural Health Clinic (RHC) perform annual wellness visits via a telephone encounter?

A2. Through December 31, 2024, all providers who are eligible to bill Medicare for professional services, including RHCs, can provide distant site telehealth.

Practitioners can provide telehealth from any distant site location, including their home, during the time they're working for the RHC, and they can provide any distant site-approved telehealth under the Physician Fee Schedule (PFS). You can't bill the visit's cost or include it on the cost report. Note: Section 4113 of the CAA 2023 extends the telehealth policies enacted in the CAA 2022 through December 31, 2024.

Q3. Do we need to do a refund before rebilling with corrected charges? What are the parameters to send a corrected claim if we do it in Direct Data Entry (DDE)? How do we do it to have it proceed rather than be rejected?

A3. In some cases, you do not have to initiate a refund. In the Direct Data Entry (DDE) system, you can submit an adjusted claim using Type of Bill XX7, which in this example,

would allow you to make a correction to the billed amount(s). If you are correcting to lessen charges on an already-paid line or claim, the system is able to initiate a partial takeback on an amount that had already been paid without new claim action initiated by you. Make sure that you utilize the correct Condition Codes during this process, as they indicate the reason for the change on the paid claim. Our Condition Codes page is located within the Quick Reference Billing Guide on the Noridian website. (Note, medically denied claims or lines can't be adjusted with this process. They must go through the Appeals process.) Noridian does have tutorials and the DDE User Manual available online for the DDE claim adjustment process.

Q4. What are the guidelines billing an emergency room (ER) visit or office visit 72 hours before inpatient stays? Is it included on the inpatient claim? Do we need to add a modifier? Does it have to be related to the inpatient stay?

A4. Medicare's three-day (or one-day) payment window applies to outpatient services that hospitals and hospital wholly-owned or wholly-operated Part B entities furnish to Medicare beneficiaries. Any item or service that is related to the upcoming inpatient stay, including the ER or office visit you mention, will be bundled into the inpatient bill. Using a modifier on the code would not specifically make this correlation. CMS does publish a lot of information on the 3-day (and 1-day) pre-admission windows. A great resource for this topic is MLN Matters SE20024.

CMS Medicare Learning Network (MLN) Matters Special Edition (SE) 20024 - FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients

Q5. Are providers allowed to apply intent-to-order when an inpatient or observation order is missing or ambiguous? It is my understanding that only the MAC may utilize intent-to-order guidance for inpatient orders and intent-to-order does not apply to observation orders.

A5. According to 42 CFR 412.3, an inpatient admission order must be in the medical record for payment. If the order is unclear, but the intent to admit as an inpatient is evident and shown as medically necessary, then it could be considered acceptable. The same principle would apply for the intent to "admit to observation."

These conclusions will align with the admitting physician's documentation. In such situations, hospitals should include a separate attestation, with the admitting physician documenting why inpatient (or observation) care is required. Medical records must support coverage criteria (including medical necessity) and meet Medicare's Conditions of Participation. The order must be authenticated before discharge or billing Medicare.

Q6. On April 25, 2024, you published the Billing and Coding: Cryoneurolysis Instructions article (A59752/A59753) in the CMS Medicare Coverage Database, but it was not included on your website, so we had to use Google to find it. Our question pertains to code 0441T. CPT Assistant from April 2019, page 9, states that this code is used ablation and that cryoneurolysis is reported with codes 64640 or 64624. Was there a reason this instruction was not included on your website? We want to clarify which code should be used for cryoneurolysis. Please clarify if the instructions are current and how they should be followed.

A6. While the Billing and Coding: Cryoneurolysis Instructions article was posted to the Medicare Coverage Database (MCD), we missed adding it to the Noridian Billing and Coding Articles webpages. We apologize for the error and can confirm this has been added as of August 27, 2024.

Noridian guidance indicates CPT 64640 and 64624 require the destruction of target nerve(s). Noridian would look to using 0440T, 0441T, or 0442T, depending on the location, for Cryoneurolysis when billing Medicare until a permanent CPT is provided.

Q7. Can the hospital bill a G0463 (hospital outpatient clinic visit for assessment and management of a patient) for an in-person, medically necessary medication management service provided by a pharmacist that is within scope and state of Montana licensure?

A7. Yes, the hospital may use this code in the billing of that service. It represents the hospital's resources (overhead expenses) used for the clinic visit. Making sure that the service is within state scope of practice and aligns with your hospital's best practice.

Q8. Can you please explain how to properly build G codes with $0.00 charge? I have claims that will not go through to Medicare and so we need to add a G code and then the claim returns to provider (RTPs) in the Common Working File (CWF) for a G code with $0.00 charge.

A8. We do hear of this issue from time to time. Some billing software programs don't always like zero-dollar values in the Amount fields. In these cases, we usually advise to try billing the line for a nominal charge ($0.01) to allow the claim to pass by those types of edits.

Q9. Regarding imaging orders, if the treating physician orders a 2-Views Chest X-ray, and a 3-Views Chest X-ray is instead performed or if a 2-view chest x-ray is ordered and a single-view chest x-ray is performed by the radiology technician, would a new order be required, or is documentation by the radiologist as to why the procedure was not fully performed sufficient?

A9. Yes, a new order should be written, and it should also be documented in the medical record the reason for the change in order. For services performed in a hospital, the CMS Conditions of Participation: Radiology Service Rules (42 CFR 482.26) apply. These rules state that "Radiologic services must be provided only on the order of practitioners with

clinical privileges or, consistent with state law, of other practitioners authorized by the medical staff and the governing body to order the services." Since radiologists generally meet these qualifications, no effort has been made to exclude them from rights and privileges granted others.

The radiology report should explain the reason for change in order and the revised order must be authorized by ordering physician or by the hospital's governing body, can be authorized by radiologist. The key to this would be communication with the ordering provider and an updated order.

Q10. What date is populated for occurrence code 29? The date the therapist evaluated the patient and created the plan of care OR the date the ordering provider (MD, ARNP, etc.) signed and certified the plan of care? The UB Editor, Claims Processing Manual, and all guidance we can find simply say "Date Outpatient Physical Therapy Plan Established or Last Reviewed." This is a poorly defined occurrence code as the term "reviewed" does not translate to therapist evaluation date or ordering provider certification date.

A10. The provider has the option to use the date the therapist evaluates patient and creates the plan of care (POC) or the date the ordering provider reviewed/signed and certified POC. CMS does not elaborate on the who does the reviewing, however for a physician or nonphysician practitioner (NPP) to certify a POC, they would certainly need to review it first.

An exception is for Comprehensive Outpatient Rehabilitation Facility (CORF). (CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.1.2.A. - Establishing the plan). Only a physician may establish a plan of care in a CORF.

Q11. Regarding the delivery of the Medicare Important Message (IM), in the Medical Claims Processing Manual, Chapter 30, Section 200.3.3, it states the beneficiary must be given the option of requesting paper issuance over electronic issuance if that is what the beneficiary prefers. However, the next sentence then states, "Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the IM."
Does the beneficiary have a choice of paper or electronic issuance, if it states a paper copy of the IM must be given? Note: The verbiage in Section 200.3.3 also states "…as specified in 200.3.9," however, there is no Section 200.3.9.

A11. Yes, a paper copy of the Medicare Important Message (IM) needs to be given to beneficiary. They do have a choice on how to read the IM, either electronically or by paper, but the beneficiary must receive a paper copy of notice so that they always have access to it.

Q12. Some of our mental health providers are MDs. They submit evaluation and management (E&M) codes for behavioral health services when there are medical and mental health visits on the same day, both reported with E&M codes. How do we submit them both on the claim? Can the mental health visit be submitted with Revenue Code 0900?
A12. Yes, qualified mental health visits billed under revenue code 0900 receive an additional payment when billed on the same day as a medical visit (051X or 052X). Revenue code 0900 is used to report certain behavioral health, psychiatric, and psychological treatment and services.

Verbal Questions

Q13. Regarding cardiac rehabilitation program, is there a time limit between when the evaluation is completed and when the first treatment session is performed?
A13. There is not a set timeline between the evaluation and the initiation of cardiac rehabilitation. There are recommendations for certain events, but there are not set guidelines.

Q14. Regarding cardiac rehabilitation program, do the treatment sessions need to be completed within one year of the qualifying event or the when the condition happened that qualified them for the cardiac program?
A14. The order for treatment sessions is only good for one year. Sessions would need to be completed within that timeframe.

Q15. If a patient came into the emergency department one night with a Medicare Advantage (MA) plan, and then the next day or two days later, became Fee-for-Service (FFS) Medicare-eligible, who should the claim be billed to? Is it based on the admit order?
A15. In the case of Inpatient Prospective Payment System (IPPS), the CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 90, outlines that it is based on the admission: "If the provider is an inpatient acute care hospital, inpatient rehabilitation facility or a long term care hospital, and the patient changes MA status during an inpatient stay for an inpatient institution, the patient's status at admission or start of care determines liability."

Clinical Trials and Claim Submission

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

- Condition code 30
- Modifier - Q0 and/or Q1(outpatient claims only)
- ICD-10 code Z00.6
- Value code D4

- Eight-digit National Clinical Trial number

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

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

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

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

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

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

Resources

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

Evaluation and Management: Prescription Drug Management

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

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

Prescription drug management is based on documented evidence that the provider has evaluated the patient's medications as part of an E/M visit. There is a mindset that because it says prescription (RX) management, if a provider prescribes, the risk level

qualifies as moderate. A prescription being written or discontinued, or a decision to maintain a current medication or dosage would need to be supported in documentation that the provider evaluated the medications.

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

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

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

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

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

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

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

AMA Publication

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

AMA 2023 Webinar Questions and Answers

There is no "blanket" guidance for services to represent specific levels of risk. The physician is responsible for assessing (and documenting) the level of risk of the services to be performed including medicine management, (prescription or OTC), based on a

specific patient's risk factors and the risks typically seen with the drug. For example, an NSAID in a person with kidney disease or on anticoagulant is of greater concern than most prescription drugs. Simply reviewing a medication list does NOT constitute prescription drug management.

Additional Resource

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

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

How to Avoid Common Appeals Mistakes Appeals Newsletter Part 11

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

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

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

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

News

Incarcerated Claim Denials - Resolved 11/04/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: U538H

Claim Coding Impact: Not applicable.

Description of Issue: Noridian is aware of an claims processing issue with claims potentially denying for incarcerated status when the beneficiary does not have incarcerated record(s). Claims denying incorrectly with reason code U538H for "SERVICES BILLED WHILE BENEFICIARY IS INCARCERATED."

Noridian Action Required: Noridian continues to work with the shared system maintainer for a resolution.

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

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

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

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

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

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

Date Reported: 08/15/24

Date Resolved: 11/04/24

Inpatient Psychiatric Facilities: Guidance on All-Inclusive Cost Reporting

CMS made an edit to the Hospital and Hospital Health Care Complex Cost Report (CMS-2552-10) for inpatient psychiatric facilities to ensure you're using an appropriate cost reporting methodology for periods starting on or after October 1, 2024. Read Guidance for Inpatient Psychiatric Facilities (IPFs) about All-Inclusive Cost Reporting on all-inclusive cost reporting, including:

- Description of new cost reporting edit
- Temporary use of an alternate cost reporting methodology
- FAQs

Source: MLN Connects dated October 17, 2024

News

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

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

New "Browse by Provider Type" sections: Radiation Oncology and Radiology

Radiation Oncology and Radiology services has a new location.

Providers and facilities are encouraged to view these services available to assist with proper billing, coding, and documentation requirements education found on the Radiation Oncology and Radiology services.

New Timeframe for Prior Authorization Decisions

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

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

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

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

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

News

Skilled Nursing Facilities: Report Expanded Ownership, Management, & Related Party Data

CMS will revalidate enrolled skilled nursing facilities (SNFs) from October - December 2024 to collect data on ownership, managerial, and related party information. Your Medicare Administrative Contractor will send you a revalidation notice:

- One-third of SNFs will get notices in October
- Two-thirds will get notices in November or December

Providers must report this data on the revised Medicare Provider Enrollment Application Form (CMS-855A). View the Guidance for SNF Attachment on Form CMS-855A for detailed information on the parties to be reported. ***Please note that CMS will not be updating the online Medicare Revalidation List to include the SNF off-cycle revalidation schedule.***

Resources: Provider Enrollment and Certification Revalidations (Renewing Your Enrollment)

Submitting Documentation for Review

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

Noridian can accept documentation by the following methods:

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

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

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

Always place Noridian documentation request letter as the first page.

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

- Only use one password for the entire media and not individual passwords for each file.
- Noridian will only accept CD/DVD/USBs that are encrypted using Adobe Security, WinZip, 7-Zip or Secure Zip

- Links and audio files cannot be accepted
- Information should be combined into one file

Resource

JFA Options for Submitting Documentation

System Availability Notices

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

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

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

Understanding Replacement in Medicare Durable Medical Equipment (DME) Coverage: Key Definitions and Guidelines

Medicare provides coverage for Durable Medical Equipment (DME) to help beneficiaries with specific healthcare needs. A crucial aspect of DME coverage is the concept of "replacement." Replacement refers to the provision of a new or nearly identical item when the original DME item has been lost, stolen, or irreparably damaged. The Centers for Medicare & Medicaid Services (CMS) outlines these rules in the CMS Internet Only Manual (IOM), Publication 100-02, Benefit Policy Manual, Chapter 15, Section 110.2.C

that defines the conditions under which replacement is covered and explains the requirements for healthcare providers.

Key Definitions and Criteria for Replacement

Replacement of DME is covered under specific circumstances, as outlined by CMS. These circumstances include:

- **Loss or Theft:** If a beneficiary's equipment is lost or stolen, Medicare may cover the cost of a replacement item.
- **Irreparable Damage:** When an item is damaged beyond repair due to accidents, natural disasters (e.g., fire, flood), or other incidents, a replacement may be authorized.

Suppliers may be required to submit documentation confirming details of the incident (e.g., police report, insurance claim report or beneficiary statement).

However, replacement is not typically covered for items in the **frequent and substantial servicing payment category** or for **inexpensive and routinely purchased rental items**.

Replacement Due to Irreparable Wear: The Role of Reasonable Useful Lifetime (RUL)

Medicare also covers replacement for items at the end of the RUL. The **Reasonable Useful Lifetime (RUL)** of the equipment determines when a replacement is justified. The RUL refers to the estimated period during which an item remains useful before it should be replaced.

- **RUL Calculation:** The RUL is determined based on the **date the equipment was delivered to the beneficiary**, not its age. This ensures that the RUL reflects the actual use of the equipment by the beneficiary.
- **Replacement During RUL:** Medicare does not cover replacement of items within their RUL period, except for a documented change in medical condition to substantiate the medical need. However, repairs may be covered, provided the repair costs do not exceed the cost of replacing the item. Once the RUL has been reached, Medicare may approve a replacement.

If no program instructions provide specific guidance on the RUL of an item, Medicare Administrative Contractors (MACs) are responsible for setting the RUL, which cannot be less than **five years**.

Steps to Determine If Replacement is Covered

Before proceeding with replacing an item, healthcare providers should ask several key questions to determine if the replacement is covered under Medicare.

1. **Has the beneficiary previously had a similar item?**

- If the beneficiary has never had a similar item, the claim can proceed without further documentation. If the beneficiary has had a similar item, further steps must be followed:
  - **Check the RUL:** Determine if the equipment has reached its RUL.
  - **If RUL has been reached:** The replacement can be billed without an Advance Beneficiary Notice (ABN).
  - **If RUL has not been reached:** An ABN should be obtained to inform the beneficiary of the potential noncoverage, and the claim must be billed with the appropriate modifier.

2. **Has there been a change in the beneficiary's medical condition?**
   - A change in the beneficiary's medical condition may require a different or more advanced item. If necessary, a similar or the same item can be replaced. There must be documentation in the ordering practitioner's record to substantiate the need of replacement item.
3. **Has the original item been lost, stolen, or irreparably damaged?**
   - In cases of loss, theft, or irreparable damage, the supplier may provide a replacement. Suppliers should ensure they have documentation on file confirming details of the incident (e.g., police report, insurance claim report or beneficiary statement).

Importance of a Treating Practitioner's Order

In many cases, Medicare requires an order from the treating practitioner to confirm the medical necessity for the replacement. This order ensures that the replacement item is appropriate for the beneficiary's health needs and complies with Medicare's coverage guidelines.

By carefully adhering to these guidelines and evaluating each case individually, healthcare providers can ensure compliance with Medicare's DME replacement policies and help beneficiaries receive the appropriate coverage for their Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) needs.

Resolving Denials

A common cause of denials in DMEPOS claims is when the billed item is considered the "same as" or "similar to" an item the beneficiary already possesses and is still within its RUL. To resolve denials in such cases, suppliers should submit a Redetermination Request with supporting documentation. This may include:

- Evidence that the item was lost or stolen or was irreparably damaged.
- Medical records from the prescribing physician or practitioner, particularly if there has been a change in the beneficiary's condition that justifies the need for a new item.

Same or Similar Denials: Claims are often denied when an item is deemed the same or similar to one already in the beneficiary's possession. Some common examples of "same or similar" items include:

- **E0196 (gel pressure mattress)** vs. **E0277 (powered pressure-reducing air mattress)**
- **E0250 (hospital bed, fixed height)** vs. **E0261 (semi-electric hospital bed)**

Before providing an item, it is essential for healthcare providers to check for same or similar using the **Same or Similar** functionality in the **Noridian Medicare Portal (NMP)**. This will help in determining whether an ABN should be obtained or if further documentation is necessary.

Updated Trigger Point Injections Local Coverage Determination (LCD) Policy Appeals Newsletter Part 12

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

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

Medically necessary and reasonable requirements for initial trigger point injections:

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

Please review the LCD for subsequent trigger point injection requirements.

News

Utilization

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

Medication

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

Resources

- Article - Billing and Coding: Trigger Point Injections (TPI) (A57702)
- LCD - Trigger Point Injections (TPI) (L36859)

2024 CPT/HCPCS Local Coverage Article (LCA) Updates

Date Posted: October 3, 2024

These Local Coverage Articles (LCA) 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 Date: October 01, 2024

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

MCD Number	LCA Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A56124	Billing and Coding: Billing Limitations for Pharmacies	90684	N/A	N/A

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

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

Date Posted: October 3, 2024

The following Billing and Coding Articles have been revised under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY). All LCD LCAs are titled with “Billing and Coding: LCD title”

Effective Date: October 1, 2024

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

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A57184	Billing and Coding: Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography	N/A	Q23.8	N/A
A57207	Billing and Coding: Lumbar MRI	C81.0A, C81.1A, C81.2A, C81.3A, C81.4A, C81.7A, C82.0A, C82.1A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C83.0A, C93.390, C93.398, C83.3A, C84.0A, C84.1A, C84.ZA, C85.2A, C85.8A, M62.85, T81.320A, T81.320D, T81.320S, T81.321A, T81.321D, T81.321S, T81.328A, T81.328D, T81.328S, T81.329A, T81.329D, T81.329S	C83.39, C86.0, C86.1. C86.2, C86.3, C86.4, C86.5, C86.6, C88.2, C88.3, C88.8, M51.36, M51.37, T81.32XA, T81.32XD	N/A
A55531	Billing and Coding: Peripheral Nerve Stimulation	M62.85	M62.5A2	N/A
A53009	Billing and Coding: Intraocular Bevacizumab	N/A	N/A	H44.2A3, H44.2B3, H44.2C3, H44.2D3, H44.2E3
A57225	Billing and Coding: Respiratory Care	E88.82, I26.03, I26.04, I26.95, I26.96	N/A	I26.93, I26.94

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A55030	Billing and Coding: Urine Drug Testing	N/A	M51.36, M51.37	N/A
A53028	Billing and Coding: Bariatric Surgery Coverage	M51.360, M51.361, M51.362, M51.369, M51.370, M51.371, M51.372, M51.379, M62.85	M51.36, M51.37	N/A
A55029	Billing and Coding: Lab: Bladder/Urothelial Tumor Markers	E34.00, E34.01, E34.09	E34.00	N/A
A57327	Billing and Coding: Electrocardiogram	I26.03, I26.04, I26.95, I26.96, Q23.81, Q23.82, Q23.88	Q23.8	I26.93, I26.94
A57690	Billing and Coding: Lab: Flow Cytometry	N/A	C83.39, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3. C88.4, C88.8, C88.9, E34.0	N/A
A57198	Billing and Coding: Serum Magnesium	F50.01, F50.011, F50.012, F50.013, F50.014, F50.019,F50.020, F50.021, F50.022, F50.023, F50.024, F50.029, F50.20, F50.21, F50.22, F50.23, F50.24, F50.25, F50.810, F50.811, F50.812, F50.813, F50.814, F50.819, F50.83, F50.84, I26.03, I26.04, I26.95, I26.96, Z92.26	F50.01, F50.02, F50.2, F50.81	I26.93, I26.94

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A57215	Billing and Coding: MRI and CT Scans of the Head and Neck	C81.0A, C81.1A, C81.2A, C81.3A, C81.4A, C81.7A, C81.9A, C82.0A C82.1A, C82.2A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C82.9A, C83.0A, C83.1A, C83.390, C83.398, C83.3A, C83.5A, C83.7A, C83.8A, C83.9A, C84.0A, C84.1A, C84.4A, C84.6A, C84.7B, C84.9A, C84.AA, C84.ZA, C85.1A, C85.2A, C85.8A, C85.9A, E34.00, E34.01, E34.09, G40.841, G40.842, G40.843, G48.844, G93.45, R41.85, Z86.0100, Z86.0101, Z86.0102, Z86.0109	C83.39, C86.0, C86.4, C86.5, C86.6, C88.0, C88.2, C88.4, C88.8, C88.9, E34.0, G90.8	N/A
A57343	Billing and Coding: Diagnostic and Therapeutic Colonoscopy	E34.00, E34.01, E34.09, Z86.0101, Z86.0102, Z86.0109	E34.0, Z86.010	N/A
A59177	Billing and Coding: Allogeneic Hematopoietic Cell Transplantation for Primary Refractory or Relapsed Hodgkin's and Non-Hodgkin's Lymphoma with B-cell or T-cell Origin	N/A	C83.39, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9	N/A

Medical Policies and Coverage

MCD Number	Billing and Coding Article Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A58867	Billing and Coding: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound	M51.360, M51.361, M51.362, M51.369, M51.370, M51.371, M51.372, M51.379, M62.85, M65.90, M65.911, M65.912, M65.919, M65.921, M65.922. M65.929, M65.931, M65.932, M65.939, M65.941, M65.942, M65.949, M65.951, M65.952, M65.959, M65.971, M65.972, M65.979, M65.98, M65.99	M51.36, M51.37, M65.9	N/A
A54992	Billing and Coding: Nerve Conduction Studies and Electromyography	M51.361, M51.362, and M51.371	G90.8, M51.36, and M51.37	N/A
A57719	Billing and Coding: Vitamin D Assay Testing	C82.0A, C82.1A, C82.2A, C82.3A, C82.4A, C82.5A, C82.6A, C82.8A, C82.9A	N/A	N/A
A58567	Billing and Coding: Wound and Ulcer Care	T81.320A, T81.320D, T81.320S, T81.321A, T81.321D, T81.321S, T81.328A, T81.328D, T81.328S, T81.329A, T81.329D, T81.329S	T81.32XA, T81.32XD, T81.32XS	A58565

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

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

Date Posted: October 10, 2024

The following MolDX Billing and Coding Articles have been revised under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

Effective Date: October 1, 2024

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

MCD Number	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A57332	Billing and Coding: MolDX: Repeat Germline Testing	0476U, 0477U, 0500U, 0516U	0078U	**NA**
A58170	Billing and Coding: MolDX: Molecular Testing for Solid Organ Allograft Rejection	0508U, 0509U	**NA**	**NA**

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

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

Date Posted: October 10, 2024

The following MolDX Billing and Coding Articles have been revised under contractor numbers: 02101 (AK), 02201 (ID), 02301 (OR), 02401 (WA), 03101 (AZ), 03201 (MT), 03301 (ND), 03401 (SD), 03501 (UT), and 03601 (WY).

Effective Date: October 1, 2024

Medical Policies and Coverage

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

MCD Number	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A57527	Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)	Effective January 1, 2020- 0152U Effective April 1, 2022- 0321U Effective October 1, 2024- 0476U, 0477U, 0478U, 0480U, 0481U, 0485U, 0486U, 0487U, 0488U, 0489U, 0490U, 0491U, 0492U, 0493U, 0494U, 0495U, 0496U, 0497U, 0498U, 0499U, 0500U, 0501U, 0504U, 0505U, 0506U, 0507U, 0508U, 0509U, 0510U, 0511U, 0516U	0078U, 0396U	0403U
A58975	Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors	0485U		
A59642	Billing and Coding: MolDX: Proteomics Testing	0503U		

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

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

Date Posted: November 4, 2024

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 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
L39883	Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Medicare Coverage Database Number	Billing and Coding Article Title
A59771	Billing and Coding: Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Medicare Coverage Database Number	Response to Comments
A59936	Response to Comments: Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA)

Effective Date: December 8, 2024

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

Billing and Coding: Cervical Fusion (A59645) - R2 - Effective September 29, 2024

Date Posted: October 10, 2024

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

Effective Date: September 29, 2024

Summary of Changes:

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

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

S12.450K, S12.450S, S12.451A, S12.451B, S12.451D, S12.451G, S12.451K, S12.451S, S12.490A, S12.490B, S12.490D, S12.490G, S12.490K, S12.490S, S12.491A, S12.491B, S12.491G, S12.491K, S12.491S, S12.500A, S12.500B, S12.500D, S12.500G, S12.500K, S12.500S, S12.501A, S12.501B, S12.501G, S12.501K, S12.501S, S12.531A, S12.531B, S12.531G, S12.531K, S12.531S, S12.54XA, S12.54XB, S12.54XD, S12.54XG, S12.54XK, S12.54XS, S12.550A, S12.550B, S12.550D, S12.550G, S12.550K, S12.550S, S12.551A, S12.551B, S12.551D, S12.551G, S12.551K, S12.551S, S12.590A, S12.590B, S12.590D, S12.590G, S12.590K, S12.590S, S12.591B, S12.591G, S12.591K, S12.591S, S12.600A, S12.600B, S12.600D, S12.600G, S12.600K, S12.600S, S12.601B, S12.601G, S12.601K, S12.601S, S12.631A, S12.631B, S12.631D, S12.631G, S12.631K, S12.631S, S12.64XA, S12.64XB, S12.64XD, S12.64XG, S12.64XK, S12.64XS, S12.650A, S12.650B, S12.650D, S12.650G, S12.650K, S12.650S, S12.651A, S12.651B, S12.651D, S12.651G, S12.651K, S12.651S, S12.690A, S12.690B, S12.690D, S12.690G, S12.690K, S12.690S, S12.691B, S12.691G, S12.691K, S12.691S.

Effective Date: August 22, 2024

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

Updated language for modifier GX.

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

Medical Policies and Coverage

Billing and Coding: Computed Tomography Cerebral Perfusion Analysis (CTP) A58225 - R3 - Effective September 15, 2024

Date Posted: October 17, 2024

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

Effective Date: September 15, 2024

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

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

Billing and Coding: Facet Joint Interventions for Pain Management (A58405) - R6 - Effective January 1, 2025

Date Posted: December 26, 2024

This Billing and Coding Article 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: January 1, 2025

Summary of Changes:

Effective: 01/01/2025

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

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

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55323) - R18 - Effective October 1, 2024

Date Posted: October 3, 2024

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, 2024

Summary of Article Changes:

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

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

Prialt (Ziconotide) = $9.649

Ropivacaine = $0.062

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

Billing and Coding: Lab: Cystatin C Measurement (A57644) - R5 - Effective January 1, 2023

Date Posted: October 24, 2024

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

Effective Date: January 1, 2023

Summary of Changes:

Revision Effective Date: 01/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

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

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

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

Billing and Coding: Lab: Flow Cytometry (A57690) - R11 - Effective October 1, 2024

Date Posted: November 15, 2024

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, 2024

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

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

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

Billing And Coding: MolDX: ApoE Genotype (A55095) Retirement - Effective September 27, 2024

Date Posted: October 3, 2024

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 27, 2024

Summary:

This article will be retiring because the information in this article has been incorporated within the Billing and Coding: MolDX: Pharmacogenomics Testing A57385.

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

Billing and Coding: MolDX: Genetic Testing for Hypercoagulability / Thrombophilia (Factor V Leiden, Factor II Prothrombin, and MTHFR) (A57424) - R4 - Effective November 7, 2024

Date Posted: November 7, 2024

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

Effective Date: November 7, 2024

Summary of Changes:

Under ***CMS National Coverage Policy*** revised the following regulation: CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 16, §50.5 Jurisdiction of Laboratory Claims, §60.1.1 Independent Laboratory Specimen Drawing, §60.2 Travel Allowance. Under ***Article Text*** revised 3rd and 6th bullets to remove "DEX Z-Code™ " and replaced with "DEX Z-Code®". Added "NOTE: When entering the DEX Z-Code® on the SV101-7 documentation field for Part B claims please do not add additional characters and/or information on the line". Under CPT/HCPCS Codes Group 1: Codes added: 81400.

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

Billing and Coding: MolDX: Minimal Residual Disease Testing for Hematologic Cancers (A58997) - R8 - Effective July 11, 2024

Date Posted: November 14, 2024

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

Effective Date: July 11, 2024

Summary of Changes:

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

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

Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58724) - R4 - Effective November 28, 2024

Date Posted: December 2, 2024

This Billing and Coding article 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: November 28, 2024

Summary of Changes:

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

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

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing: (A58726) - R22 - Effective September 13, 2024

Date Posted: December 5, 2024

This Billing and Coding Article 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: September 13, 2024

Summary of Changes:

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

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

Billing and Coding: MolDX: Pharmacogenomics Testing (A57385) - R14 - Effective August 1, 2024

Date Posted: October 24, 2024

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

Effective Date: August 1, 2024

Summary of Changes:

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

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

Billing and Coding: Peripheral Nerve Stimulation (A55531) - R9 - Effective October 1, 2024

Date Posted: October 17, 2024

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

Effective Date: October 1, 2024

Summary of Changes:

Revision Effective Date: 10/01/2024

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

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

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

Billing and Coding: Respiratory Care (A57225) - R15 - Effective October 1, 2024

Date Posted: October 10, 2024

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, 2024

Summary of Article Changes:

Revision Effective Date: 10/01/2024

ARTICLE GUIDANCE:

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

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

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

Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence (A53107) - R12 - Effective October 1, 2024

Date Posted: November 15, 2024

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: January 1, 2024

Summary of Article Changes: Revision due to CR 13828 - added the following ICD-10 codes to Group 1, T85.111A, T85.113A, T85.121A, T85.193A, T85.840A and Z45.42

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

MolDX: Blood Product Molecular Antigen Typing (L38333) - R5 - Effective November 7, 2024

Date Posted: November 7, 2024

This MolDX 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: November 7, 2024

Summary of Changes:

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

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

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

Date Posted: November 14, 2024

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

Medical Policies and Coverage

Medicare Coverage Database Number	LCD Title
L39764	Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Medicare Coverage Database Number	Billing and Coding Article Title
A59628	Billing and Coding: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Medicare Coverage Database Number	Response to Comments
A59952	Response to Comments: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers

Effective Date: February 12, 2025

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

MLN Connects

MLN Connects - October 3, 2024

MLN Connects Newsletter: Oct 3, 2024

News

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

Claims, Pricers, & Codes

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

Events

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

Publications

- Substance Use Screenings & Treatment

MLN Connects

MLN Connects - October 10, 2024

MLN Connects Newsletter: Oct 10, 2024

News

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

Compliance

- Allergy & Immunology Services: Prevent Claim Denials

Claims, Pricers, & Codes

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

Multimedia

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

From Our Federal Partners

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

Information for Patients

- 2025 Medicare & You Handbook

MLN Connects - October 17, 2024

MLN Connects Newsletter: Oct 17, 2024

News

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

MLN Connects

Compliance

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

Claims, Pricers, & Codes

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

Events

- HCPCS Public Meeting - November 6-8

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - October 2024 - Revised

Publications

- Medicare Preventive Services - Revised

MLN Connects - October 24, 2024

MLN Connects Newsletter: Oct 24, 2024

News

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

Claims, Pricers, & Codes

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

MLN Matters® Articles

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

MLN Connects

From Our Federal Partners

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

MLN Connects - October 31, 2024

MLN Connects Newsletter: Oct 31, 2024

News

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

Compliance

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

Claims, Pricers, & Codes

- PrEP for HIV Billing: CMS Requires Diagnosis Codes

Publications

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

MLN Connects - November 7, 2024

MLN Connects Newsletter: Nov 7, 2024

Final Rules

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

MLN Connects

News

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

Compliance

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

Claims, Pricers, & Codes

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

Events

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

Publications

- Medicare Provider Compliance Tips - Revised

Information for Patients

- Medicare Prescription Payment Plan

MLN Connects - November 14, 2024

MLN Connects Newsletter: Nov 14, 2024

News

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

MLN Connects

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

Claims, Pricers, & Codes

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

MLN Matters® Articles

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

Publications

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

MLN Connects - November 21, 2024

MLN Connects Newsletter: Nov 21, 2024

News

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

Compliance

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

Events

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

MLN Connects

MLN Matters® Articles

- Home Health Prospective Payment System: CY 2025 Rate Update

Publications

- Medicare Preventive Services - Revised

From Our Federal Partners

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

MLN Connects - November 27, 2024

MLN Connects Newsletter: Nov 27, 2024

News

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

Claims, Pricers, & Codes

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

Events

- Hospice Quality Reporting Program Webinar - December 12

MLN Matters® Articles

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

MLN Connects - December 5, 2024

MLN Connects Newsletter: Dec 5, 2024

News

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

MLN Connects

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

Compliance

- Diabetic Accessories & Supplies: Prevent Claim Denials

Claims, Pricers, & Codes

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

MLN Matters® Articles

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

Publications

- Global Surgery - Revised
- Rural Emergency Hospitals - Revised

MLN Connects - December 12, 2024

MLN Connects Newsletter: Dec 12, 2024

News

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

Compliance

- Global Surgery: Bill Correctly

Claims, Pricers, & Codes

- Rural Health Clinic CY 2025 All-Inclusive Rate

Publications

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

MLN Connects

From Our Federal Partners

- Get Your CHAMPVA Claims Paid with EFT

MLN Connects - December 19, 2024

MLN Connects Newsletter: Dec 19, 2024

News

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

Compliance

- Immunosuppressive Drugs: Prevent Claim Denials

Claims, Pricers, & Codes

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

MLN Matters® Articles

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

From Our Federal Partners

- CHAMPVA Policy on Weight Loss Medications Effective January 1

MLN Matters

2025 Annual Update of HCPCS Codes for SNF CB Update

Related CR Release Date: September 6, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13786

Related CR Transmittal Number: R12827CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13786.

2025 Annual Update for the HPSA Bonus Payments

Related CR Release Date: September 13, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13789

Related CR Transmittal Number: R12837CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13789.

MLN Matters

Annual Clotting Factor Furnishing Fee Update 2025

Related CR Release Date: August 15, 2024

Effective Date: January 1, 2025

Implementation Date: January 6, 2025

Related Change Request (CR) Number: CR 13742

Related CR Transmittal Number: R12795CP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13742.

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

Related CR Release Date: July 16, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13627

Related CR Transmittal Number: R12718CP

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

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13627.

MLN Matters

Correction for Inpatient Medicare Part B Ancillary 12X Claims & Manual Updates

Related CR Release Date: October 10, 2024

MLN Matters Number: MM13812

Effective Date: April 1, 2025

Related Change Request (CR) Number: CR 13812

Implementation Date: April 7, 2025

Related CR Transmittal Number: R12888CP

CR 13810 tells you about:

- Editing correction for certain inpatient Part B ancillary 12X claims
- Processing of service dates outside the inlier portion of the stay with occurrence span code 70
- Billing provisions for all items and non-physician services inpatients receive

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13810.

CY 2025 Update: DMEPOS Fee Schedule

Related CR Release Date: December 13, 2024

MLN Matters Number: MM13888

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13888

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12991CP

CR 13888 tells you about:

- New codes
- Updated codes
- Payment policy changes

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

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

MLN Matters

Disable Beneficiary Eligibility Information from MAC IVR Systems

Related CR Release Date: September 27, 2024

Effective Date: March 31, 2025

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

Related Change Request (CR) Number: CR 13754

Related CR Transmittal Number: R12858OTN

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13754.

ESRD & AKI Dialysis: CY 2025 Updates

Related CR Release Date: November 22, 2024

MLN Matters Number: MM13686

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13686 and CR 13865

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12962BP, and R12979CP

CR 13865 tells you about:

- Finalized policies for the ESRD Prospective Payment System (PPS)
- Payment for renal dialysis services you provide to patients with Acute Kidney Injury (AKI) in ESRD facilities

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

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13686.

MLN Matters

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

Related CR Release Date: October 24, 2024

MLN Matters Number: MM13818

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

Related Change Request (CR) Number: CR 13818

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

Related CR Transmittal Number: R12903OTN

CR 13818 tells you about:

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

Make sure your billing staff knows about these changes.

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

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

Related CR Release Date: October 24, 2024

MLN Matters Number: MM13828

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

Related Change Request (CR) Number: CR 13828

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

Related CR Transmittal Number: R12904OTN

CR 13828 tells you about:

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

Make sure your billing staff knows about these changes.

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

MLN Matters

Inpatient & Long-Term Care Hospital IPPS: FY 2025 Changes - Revised

Related CR Release Date: October 8, 2024

MLN Matters Number: MM13734 Revised

Effective Date: October 1, 2024

Related Change Request (CR) Number: CR 13734

Implementation Date: October 7, 2024

Related CR Transmittal Number: R12869CP

Note: CMS deleted a bullet point in Section I on page 4 and added language to the 2nd bullet point in the same section. CMS also updated the CR link, related CR transmittal number, & CR release date. All other information is the same. Substantive content changes are in dark red.

CR 13734 tells you about:

- FY 2025 Inpatient Prospective Payment System (IPPS) updates
- FY 2025 LTCH Prospective Payment System (PPS) updates
- Updates to certain hospitals that CMS excludes from the IPPS

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13734.

Medicare Change of Status Notice Instructions (Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services)

Related CR Release Date: November 21, 2024

MLN Matters Number: MM13846

Effective Date: November 15, 2024

Related Change Request (CR) Number: CR 13846

Implementation Date: February 14, 2025

Related CR Transmittal Number: R12934CP

CR13846 tells you about:

- Appeal rights for eligible Medicare patients reclassified from inpatient to outpatient receiving observation services
- Medicare Change of Status Notice (MCSN) delivery requirements
- Adding Section 450 to the Medicare Claims Processing Manual, Chapter 30

Make sure your billing staff knows about these changes.

MLN Matters

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13846.

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

Related CR Release Date: November 25, 2024

MLN Matters Number: MM13796 Revised

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13796

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12980GI

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

CR 13796 tells you about:

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

Make sure your billing staff knows about these changes.

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

Medicare Physician Fee Schedule Final Rule Summary: CY 2025

Related CR Release Date: November 21, 2024

MLN Matters Number: MM13887

Effective Date: January 1, 2025

Related Change Request (CR) Number: CR 13887

Implementation Date: January 6, 2025

Related CR Transmittal Number: R12975CP

CR 13887 tells you about:

- Telehealth
- Caregiver training
- Therapy
- Cardiovascular risk assessment and management
- Evaluation and management (E/M)

- Behavioral Health
- Advanced primary care management (APCM)
- Global surgery payment
- Dental and oral health

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

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

National Coverage Determination 210.15: PrEP for HIV Prevention

Related CR Release Date: December 5, 2024

MLN Matters Number: MM13843

Effective Date: September 30, 2024

Related Change Request (CR) Number: CR 13843

Implementation Date: April 7, 2025

Related CR Transmittal Number: R12987CP & R12987NCD

CR 13843 tells you about:

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

Make sure your billing staff knows about these changes.

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

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

Related CR Release Date: August 2, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13679

Related CR Transmittal Number: R12766CP

CR 13679 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The

ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13679.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: May 31, 2024

Effective Date: October 1, 2024

Implementation Date: October 7, 2024

Related Change Request (CR) Number: CR 13633

Related CR Transmittal Number: R12659CP

CR 13633 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13633.

RHC and FQHC Medicare Benefit Policy Manual Chapter 13 Update

Related CR Release Date: September 12, 2024

Effective Date: January 1, 2024

Implementation Date: October 14, 2024

Related Change Request (CR) Number: CR 13493

Related CR Transmittal Number: R12832BP

CR 13493 updates Chapter 13 to reflect payment policies finalized for 2024. Chapter 13 of the Medicare Benefit Policy Manual has been revised to include payment policy for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) as finalized in the Calendar Year (CY) 2024 Physician Fee Schedule and CY 2024 Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rules.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13493.

MLN Matters

Separate Payment for Essential Medicines - New Biweekly Interim Payments for the IPPS

Related CR Release Date: May 2, 2024

MLN Matters Number: MM13590

Effective Date: October 1, 2024 - For cost reporting periods beginning on or after October 1, 2024

Related Change Request (CR) Number: CR 13590

Implementation Date: October 7, 2024

Related CR Transmittal Number: R12615CP

CR 13590 tells you about the following for the Inpatient Prospective Payment System (IPPS):

- Payment adjustments for establishing and maintaining access to essential medicines
- How providers can be paid (biweekly or annually)
- How future payments will be determined

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13590.

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

Related CR Release Date: October 2, 2024

Effective Date: January 9, 2025

Implementation Date: January 9, 2025

Related Change Request (CR) Number: CR 13829

Related CR Transmittal Number: R12860BP

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

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13829.

Contacts, Resources, and Reminders

Noridian Part 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

Contacts, Resources, and Reminders

Jurisdiction F Part A Quarterly Ask the Contractor Meetings (ACM)

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

Noridian representatives from various Part 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.

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

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

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

We look forward to your participation in these important calls.

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

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

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