Medicare B News

Jurisdiction F
January 2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACM Questions and Answers - October 11, 2023

Note: 2024 Final Rule released November

Pre-Questions:

Q1. How do we define the difference between minimal versus low risk, as the AMA has not defined the difference? Can over-the-counter (OTC) medications be considered low risk?
A1. The table of risk indicates the level of MDM for low risk may not be part of the assessment selection; however, the use of OTCs for treatment is part of the decision process for the patient. Each patient may be different depending on conditions, age, and other medications. OTC recommendations may or may not be a risk factor. This would depend on dosage changes that differ from packaging instructions and consider patient's medical status.

The American Medical Association (AMA) has published guidance on determining the level of risk. The risk would be determined by the physician or qualified health care professional based on their evaluation of the patient's condition.

Source: American Medical Association CPT® Evaluation and Management (E/M) Revisions FAQs.

Q2. When the patient is provided Zofran IV push in the ER for nausea, would this be considered Moderate Risk for the Evaluation and Management (E/M) medical decision-making (MDM)?
A2. Moderate risk could apply, because the patient was being temporarily monitored for the decision results to use the type and dose of medication. Overall, the risk will be determined by the patient's overall medical status and if the medication risk to the patient would be low or moderate.

Q3. We've heard that Medicare and many other payers cannot be billed when a Physician or Advanced care provider (ARNP, PA-C, etc.) meets and consults with a patient's family and/or caregiver(s) when the patient is not present. Does Medicare allow all E/M services to be reported when the provider only meets with the family or caregiver when the patient is not present?
A3. No. Medicare follows most of the AMA guidelines when counting time for E/M services. The patient would need to be present for the majority of the encounter. Time meeting with the family or caregiver may be counted if medically necessary for the patient's treatment. When billing based on time, include all time related to the patient on the date of the encounter, when managing the patient's treatment and discussing with family or caregivers, as that time would count. See Medicare Learning Network (MLN) 006764 Evaluation and Management Services Guide Aug 2023.

Under IOM 100-02, Chapter 15, Section 30.A; Physician Services, General, a service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment.

Q4. Can a physician bill for chemotherapy education?
A4. No. There is not a billable CPT or HCPCS code and Medicare does not pay separately for chemotherapy education. If performed during the same visit as a chemotherapy infusion, the education would be bundled into the drug infusion code. If there is a separate, medically necessary

E/M service performed, chemotherapy education may be factored into the medical decision-making for the time spent on that day. See also Answers 10 and 17.

Q5. Is there a Local Coverage Determination (LCD) available for radiation therapy use in the treatment of benign conditions? Is treating osteoarthritis with external beam radiation therapy (EBRT) considered experimental using HCPCS G6003-G6016?

A5. No. Noridian's External Beam Therapy policy retired in 2016. We are not aware of coverage for benign conditions; however, treating osteoarthritis should be covered. For the conventional EBRT delivery, Medicare will not cover for routine follow-up care during the three months after completion of external beam therapy since this is considered part of the treatment management.

Q6. Our Cardiology practice has denials that another physician was reimbursed. We provided the professional component for some facility-based CPT 93306-26 (Echocardiography). Our redetermination was also unfavorable. How do we prove that there was only one study that day and our provider read?

A6. Hospital claims billed under claim UB04 should be Revenue code 04X or 073X imaging and place of service 22 (hospital outpatient department). If the physician is not working under arrangement for the hospital; in which case both the technical and professional components fall under global services, the hospital is the only entity that can bill for the diagnostic test (which includes interpretation).

Note: During the ACM call, it was incorrectly indicated the hospital should bill with TC modifier. After the call, we discussed with Part A, that stated the hospital should be using the indicated revenue code to allow the professional component to be billed separately.

Q7. Psychiatric Collaborative Care Management (CPT add-on code 99494) has a Medically Unlikely Edit (MUE) of '2' per date of service. Since the code is per month, how can additional time be allowed for complex patients? Would an appeal allow additional time?

A7. An appeal would be allowed with supporting documentation of medically necessary time from the care management team. Review the CMS Medicare Learning Network (MLN) 909432 title "Behavioral Health Integration Services" booklet to verify time is totaled correctly by the care management team.

If a provider believes the MUE value should be modified, email the CMS NCCI mailbox:?NCCIPTPMUE@cms.hhs.gov. Include code(s), an alternative MUE value, the rationale for the alternative MUE value, and any supporting documentation. Do not include any Protected Health Information (PHI).

Q8. Can audio only visits (CPTs 99441-99443) be provided to new and established patients thru the end of 2023 or just established patients after the 05/11/2023 (end of Public Health Emergency-PHE)?

A8. Effective 5/12/2023, these codes will only be allowed for established patients per the CPT code description and guidelines.

Q9. Since there is no policy on how to bill unlisted surgical CPT codes, what is needed in the narrative or comment field in Box 19?

A9. Noridian does address "Unlisted and Not Otherwise Classified (NOC) Code Billing" under Noridian's Browse by Topics, Documentation Requirements. An unlisted CPT must have a "concise description of

the procedure" with how procedure performed (e.g., laparoscopic, transnasal, infusion), body area treated and why performed.

It may assist to reflect to the closest CPT (e.g., 22899 billed) and add comments like this example: "*removed prominent spinous process-no lesion, like code 22101*".

Use checklists to assist and no need to send documentation unless requested. When requested, providers can fax, mail, or utilize the electronic additional documentation Paperwork (PWK). Read more under Noridian's Jurisdiction E or F:

- JEB Browse by Topic, Claims, Claim Submission Billing, Errors and Solutions, Unlisted Procedures
- JFB Browse by Topic, Claims, Claim Submission Billing, Errors and Solutions, Unlisted Procedures

Q10. Is it acceptable when chemotherapy begins in three days, following the first appointment, to bill a second appointment to Medicare for chemotherapy education (no other chief complaint) provided by a Registered Nurse (RN), Physician Assistant (PA) or Nurse Practitioner (NP)? Does it make a difference between oral medication and IV medication?

A10. As noted in Answer 4 and 17, there is not a billable CPT or HCPCS code, as Medicare does not pay separately for chemotherapy education. If performed during the same visit as a chemotherapy infusion, the education would be bundled into the drug infusion code.

If there is a separate, medically necessary E/M service performed, chemotherapy education may be factored into the medical decision-making for the time spent on that day. It makes no difference on the type of medication (oral or IV) and would not affect this reply for chemotherapy education.

Q11. Are physicians, NPs, and PAs allowed to be reimbursed for depression screening (G0444) in the home when performed at the same time of the subsequent AWV (G0439)? Our providers are billing G0439 for homebound patients and also perform a depression screening, but it's denied for place of service (12), as not allowed in the home.

A11. No. HCPCS G0444 can be reimbursed on the same day as subsequent AWV only when provided in primary care settings. Since home is not considered a primary care setting (Office, Outpatient Hospital, Independent Clinic, and State or Local Public Health Clinic), Noridian recommends working with your specialty societies and reaching out to your CMS regional office.

Q12. Following a surgery, we may see patients that have transferred to ICU, with frequent neuro checks, etc., but that doesn't necessarily warrant critical care or transfer of care. Can other specialties bill for other services when the surgeon is not performing the follow-up care?

A12. If the patient is stable after surgery, even in ICU, it is not considered critical care. Critical care services related to the surgery are included in the reimbursement when performed during the global period. If the critical care or other care is unrelated to the surgery, append modifiers **24** *(unrelated E/M by the same physician or other qualified health care professional during a post-operative period)* and **FT** *(E/M visit furnished within the global period, unrelated, or when one or more additional E/M visits furnished on the same day are unrelated)*.

If the surgeon is not performing the post-op portion of the global period, it will be necessary to have a transfer of care in the documentation and bill with correct modifiers. The surgeon would submit the

surgery with modifier **54** and the provider performing the post-op care would submit the same surgery code with modifier **55**. The number of post-op days the provider is responsible for would be indicated in the Box 19 comments section of the claim. See IOM 100-04, Chapter 12, Section 30.6.12.7

When the specialist is **not** in the same group and they're managing the patient's condition, non-related to the surgery; bill appropriately and no modifiers are needed for that specialist (e.g., neurologist and endocrinologist).

Q13. Can extensive neuroplasty (CPTs 64708-64727) be reported separately from a soft tissue tumor excision (e.g., CPT 27632), or is that considered a standard surgical procedure and not separately reported?
A13. Yes, a neuroplasty is a separate procedure. Soft tissue tumor excision does not entail revision, moving or restoring a nerve in the area. However, removal of a benign tumor would not be expected to injure a named nerve in the area; so, if the nerve had to be restored or moved, it should be coded as a complication.

Q14. If a new problem is also addressed during a follow up visit, can the nurse practitioner (NP) speak with the physician to get an updated plan of care or does the physician have to see the patient in order to bill as incident to?
A14. CMS Internet Only Manual (IOM) Publication 100-02, Chapter 15, Section 60.2, states there must have been a direct, personal, professional service furnished by the physician to **initiate the course of treatment**, of which the service being performed by a non-physician practitioner or (NPP) is an incidental part.

There must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in the management of the course of treatment. New problems would not be part of the provider's established plan of care.

Verbal Q/A:

Q15. Do providers have to perform history and physical, or just one for E/M billing?
A15. Yes. CMS states for all E/M visits; history and physical exam must be performed in accordance with the code descriptors, but history and exam no longer impact visit level selection. Medical Decision Making (MDM) or time would determine the level of E/M service that is submitted. See IOM Publication 100-04, Chapter 12, Section 30.6.1.B.

Q16. Do providers have to follow 2023 E/M billing guidelines? Is it appropriate to use a table of risk from the E/M 1995 or 1997 when billing for 2023 services?
A16. Yes. Providers must follow the current 2023 guidelines when billing 2023 E/Ms.

Q17. If the only service provided was chemotherapy education, can providers bill an E/M?
A17. No. To bill an E/M, there service must be medically necessary and meet all coding criteria. As noted in both Answers 4 and 10, please see additional information.

Q18. Is there an 8-hour rule regarding for billing with chemotherapy and administration?
A18. No. Noridian is unaware of any rule except in observation. Stay tuned for an upcoming Observation webinar on December 12, 2023.

Q19. What can we do when another provider is billing services they didn't render, resulting in duplicate denials?
A19. Medicare pays the first incoming claim. Medicare would only recoup the paid provider's claim if there was clear evidence it was billed wrong. The providers should work together to determine how the services need to be billed. If one of them disagrees with how the claims process, they may appeal. If there is an error in billing, and the provider refuses to correct it, the provider may report possible abusive billing by following the process on either Noridian's JE B Fraud and Abuse or JF B Fraud and Abuse page.

ACO Lookup Available in NMP

The Noridian Medicare Portal (NMP) has added a new feature for users to verify if a provider is enrolled in a demonstration program using the ACO Lookup inquiry. Accountable Care Organizations (ACO) are one of the many innovation models created by the Centers for Medicare and Medicaid Services (CMS). Participation in these programs is voluntary and allows providers and patients to work together to deliver faster and more efficient healthcare treatment and reimbursement. This new feature is available under the Provider Enrollment function on the ACO Lookup tab.

To view more information on the ACO Lookup inquiry, visit the ACO Lookup section of the NMP Inquiry Guide.

Additional Self-Service Requirements Effective November 6, 2023

In accordance with Internet Only Manual (IOM), Publication 100-09, CMS requires the use of self-service tools to verify all claim status and patient eligibility information. The use of these tools prevents unnecessary denials for providers and helps ensure proper payment of claims. To assist providers with these requirements, Noridian has created education about the following self-service tools.

- Noridian Medicare Portal (NMP)
- Interactive Voice Response (IVR)
- Provider Enrollment, Chan and Ownership System (PECOS)
- Remittance Advice (RA)
- National Plan and Provider Enumeration System (NPPES)
- Part B Noridian Custom Edits (NCE)

To further assist providers, Noridian has also published weekly updates and hosted webinars. Examples of information available on these tools include:

- Claim Status information for all processed and pending claims (E.g., claim number, receipt date, and patient responsibility for denied and paid claims)
- Appeal rights, status, and letters
- Patient's insurance and eligibility information
- Duplicate and overlapping claim information
- Provider's enrollment information
- Local Coverage Determination (LCD) and National Coverage Determination (NCD) numbers.

To remain in compliance with CMS guidelines, effective November 6, 2023, Noridian representatives assist with a single claim denial that can be resolved via the use of a self-service tool. (e.g., the patient having another insurance to Medicare) as a courtesy. This will help providers to better understand what specific claim adjustment reason codes (CARC) and Remittance advice remark codes (RARC) mean and how to resolve those claims going forward.

Noridian requests this information be shared with all provider staff to ensure they abide by Medicare's requirements.

Resources

- Denial Code Resolution
- NMP vs. IVR Self Service Elements Comparison
- CMS Internet Only Manual (IOM), Publication 100-09, Medicare Contractor Beneficiary and Provider Communications Manual, Chapter 6, Section 50.

Advanced Beneficiary Notice of Non-coverage (ABN) and Appeals - Appeals Newsletter Part 7

Noridian's Appeals team has seen an increase in appeals that do not have the ABN form with the request, Without the ABN, the appeal decision will cause the liability to change to the providers. Frequently, we receive the ABN once the providers receive the shift in liability notice.

- Noridian can no longer treat this as a Redetermination, and it must be sent to the Reconsideration contractor.
- This increases the amount of time for your appeals to be finalized.
- Adds work unnecessarily for our Appeals team and the Reconsideration contractor.

Action

Make sure you have your documentation available when creating an appeal. When a service is appealed that has a previously signed ABN, include a copy in the appeal request.

Annual Participation Program

CMS Manual 100-04 Chapter 1 Section 30.3.12 outlines an annual open enrollment process, to provide eligible practitioners and suppliers with the opportunity to enroll in or terminate enrollment in the participation program.

For providers (including physicians and suppliers) who have enrolled in Medicare, to sign participation agreement (Form CMS-460) is to agree to accept assignment for all covered services that are provided to Medicare patients. The benefits of signing a participation agreement include:

- No 5 percent reduction in the Medicare approved amount.
- Beneficiaries with Medigap coverage (private supplemental insurance) may assign the payment on the supplemental claim to the provider or supplier. Under the current mandatory Medigap (claim-based) crossover process, beneficiaries must assign payment on their claims to a participating provider or supplier as a condition for their claims to be forwarded to their Medigap insurer for payment of all coinsurance and deductible amounts due under the Medigap policy. The Medigap insurer, in turn, must pay the participating provider or supplier directly, thereby relieving the need of having to file a second claim. (Refer to the Medicare Claims Processing Manual, Chapter 28, Section 70.6, for more information regarding the eligibility-file based crossover process.)
- Listing in the Medicare Participation Physicians/Suppliers Directory (MEDPARD) that is posted on the MAC Web site.
- Participants receive direct and timely reimbursement from Medicare.

Eligibility

All practitioners and suppliers eligible to receive payments under Part B of Medicare may choose to enter into a participation agreement. This includes practitioners whose services are subject to mandatory assignment. The reason why it could still be appropriate for such practitioners to enter into a participation agreement is because the mandatory assignment provisions apply only to the particular practitioner service benefit (e.g., nurse practitioner services). Thus, for example, if a nurse practitioner is eligible to bill for, and is indeed billing under, Part B for something other than a nurse practitioner service (e.g., an EKG tracing), the mandatory assignment provision of the law does not apply to that other service. However, if the nurse practitioner has entered into a participation agreement, that agreement requires that the nurse practitioner accept assignment for any service for which he or she submits a Medicare Part B claim.

Hold billing until notified of status change. Noridian is unable to submit claims revisions on your behalf for this reason. This open enrollment cycle runs from November 15, 2023 through December 31, 2023.

We encourage you to visit the noridianmedicare.com website if you would like more information on 2024 Open Enrollment.

Behavioral Health and Opioid Treatment Reminders

Medicare pays for services beneficial to the mental well-being of Medicare beneficiaries. Those services include Psychotherapy for Crisis, Behavioral Health Integration, and Opioid Use Disorder.

Psychotherapy for Crisis

- 90839 - Psychotherapy for crisis; first 60 minutes
- 90840 - Each additional 30 minutes
    - Includes urgent assessment and history of crisis state, mental status exam and psychotherapy, resources to reduce the crisis and restore safety, and providing interventions to minimize potential of psychological trauma.
    - Cannot bill other psychotherapy codes on same day.
- Services can be provided by physician and non-physician practitioners who are eligible to furnish services for the diagnosis and treatment of mental illnesses.

Resources

- CMS Psychotherapy for Crisis
- CMS MLN1986542 - Medicare & Mental Health Coverage

Behavioral Health Integration (BHI) Services

- 99484 - Behavioral Health Integration
    - Initial assessment, behavioral care planning, facilitating, coordinating treatment, Pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated team member (at least 15 minutes).
- G0323 - Care Management Services for Behavioral Health Conditions
    - Clinical Psychologist (CP), or Licensed Clinical Social Worker (LCSW) serves as focal point of care for integration of mental health services.
    - At least 20 minutes of CP or LCSW time per calendar month
    - Who can provide counseling, individual, and group therapy included in the bundled payment - LCSW, Licensed professional counselors, or mental health counselor, Licensed marriage and family therapists, Licensed clinical alcohol and drug counselors, certified

peer specialists or others permitted to give this type of therapy or counseling by state law and scope of practice.

Resources

- CMS MLN909432 Behavioral Health Integration Services Booklet

Opioid Use Disorder (OUD) Screening and Treatment Reminders

- Medicare pays OUD screenings performed by physicians and non-physician practitioners.
    - OUD screening required element of Medicare's Initial Preventive Physical Exam (IPPE) and Annual Wellness Visit (AWV)
    - During physician office and outpatient hospital settings, Medicare pays for Screening, Brief Intervention, & Referral to Treatment (SBIRT) treatment services.
        - Evidence-based, early intervention approach for people with non-dependent substance use **before** they need more specialized treatment.
        - Depending on service duration, bill:
        - **G2011** (5-14 minutes),
        - **G0396** (15-30 minutes), or;
        - **G0397** (greater than 30 minutes)
        - Evaluation & Management (E/M) visits (99202-99499) for medication management (like buprenorphine) involving evaluating and managing patient health as part of recovery process.
- Monthly office-based only services bundle beneficiary overall management, treatment plan, coordinated care, individual and group psychotherapy, and substance use counseling.
    - Includes office-based Substance Use Disorder (SUD) Treatment Billing with three HCPCS for patient monthly bundling
        - **G2086** (first calendar month; at least 70 minutes)
        - **G2087** (subsequent month; at least 60 minutes)
        - **G2088** (coordinated care; more than 120 minutes)
        - For patients prescribed buprenorphine or naltrexone in office setting
- Opioid Treatment Program (OTP) provide medications for opioid use disorder (MOUD), including methadone, buprenorphine, and naltrexone, as well as a range of other services including:
    - Individual and group therapy, substance use counseling, and toxicology testing for patients diagnosed with OUD.
    - Consider referring your patient to an OTP if specific MOUD helpful to their recovery

- Learn more about covered OUD screening and treatment options which includes a list of Medicare-enrolled OTPs

Resources

- Opioid Treatment Programs (OTP) | CMS

Billing Health Provider Shortage Area (HPSA) Claims - Appeals Newsletter Part 6

Section 1833(m) of the Act provides bonus payments for physicians and psychiatrists serving areas designated as primary medical care HPSAs under section 332(a)(1)(A) of the Public Health Service (PHS) Act. Make sure your billing staff understand how to bill these claims to make sure you get paid properly.

- As of January 1, 2005, no modifier is needed for services in HPSA zip codes.
- If services provided are in zip code that does not fall entirely within a full, or partial HPSA county, the AQ modifier must be added to the claim.
- MACs will continue to accept the AQ modifier for partially designated HPSA claims.
- Use the following link to determine if you are in a HPSA area:
    - CMS Physician Bonuses

Resource

- CMS MM11852 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments)
- CMS Physician Bonuses in Health Provider Shortage Areas (HPSA)

Broader Medicare Coverage of Leqembi: Claims Processing

The drug lecanemab (Leqembi™) was granted traditional approval by the FDA on July 6, 2023. Leqembi will now be covered under National Coverage Determination (NCD) 200.3, Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's.

For dates of service beginning July 6, 2023, Medicare will pay for Leqembi when you submit a valid claim and coding information to provide treatment included in a qualifying clinical study.

Include the following on your Leqembi-related drug and/or PET Scan clinical trial claims:

- HCPCS code: **Leqembi** J0174 (Injection, lecanemab-irmb, 1mg)
- Registry trial number (8-digit number): Use the temporary # **99999999** or the dedicated NCT # **6058234**
- One of these modifiers:

  - Q0 (Investigational clinical service provided in a clinical research study that is an approved clinical research study), or
  - Q1 (Routine clinical service provided in a clinical research study that is an approved clinical research study)
- Diagnosis Codes: **Z00.6** (noting a registry) AND one of the following dx codes:
  - G30.0 Alzheimer's disease w/early onset
  - G30.1 Alzheimer's disease w/late onset
  - G30.8 Other Alzheimer's disease
  - G30.9 Alzheimer's disease, unspecified
  - G31.84 mild cognitive impairment, so stated
- Condition code 30 (For institutional claims only)

For more information:

- CMS Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)
- Provider Fact Sheet - Alzheimers Treatment (PDF)
- CMS Statement: Broader Medicare Coverage of Lecembi Available Following FDA Traditional Approval

Clarification on Payment for Monoclonal, Complex Biological, and Rheumatological Therapies

Monoclonal, complex biological, and rheumatological therapy agents should be coded as complex drug administration and claims will not be adjusted based solely on the specific drug.

Claims that involve administration of monoclonal, complex biological, and rheumatological therapies should be coded as complex drug administration and will be paid as complex administration, so long as all elements of these codes that are required for appropriate billing are met. Complex drug administration codes use the same service codes as chemotherapy administration. Physician work related to complex drug administration involves the affirmation of the treatment plan and the supervision (pursuant to incident to requirements) of nonphysician clinical staff.

Physicians should follow the CPT coding instructions and Medicare guidance to report complex drug administration. Noridian will not make claims adjustments or edits to codes 96401-96549 based solely on the specific drug or agent administered.

For additional Medicare guidance, refer to CMS Change Request (CR) 13468 and CMS Internet Only Manual (IOM), Publication 100-04, Chapter 12, Section 30.5: Payment for Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions.

News

CMS' New Tool for Exchanging Healthcare Documentation - Healthcare Information Handler

Recently, CMS updated how providers submit documentation to the Medicare Administrative Contractor (MAC), or other contractors. It is called the Health Information Handler (HIH), and it is hosted on CMS' Amazon Web Services (AWS) environment.

There is no cost to providers submitting directly to CMS, regardless of the number of transactions sent monthly. HIH meets all security and privacy requirements, and there is no Information Technology (IT) expertise required.

Providers still have the option to contract with an HIH through their existing Gateway services, or they can build a gateway of their own (and sign up as an HIH).

Providers and suppliers can use for:

- Prior authorization requests and supporting documentation for Parts A/B and DME
- Paperwork (PWK) documentation for claims
- First and second level appeal requests
- Advanced Determination of Medicare Coverage Requests (ADMC)
- Durable Medical Equipment (DME) phone discussion requests

Resources

- CMS Health Information Handler
- CMS esMD for Health Information Handlers (HIH) - Getting Started and Frequently Asked Questions (FAQ's)

DMEPOS Fee Schedules and Labor Payment - 3rd Quarter 2023 Update

Updates to the DMEPOS Jurisdiction listing for 3rd Quarter 2023 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

EDI Claim Submission Available in NMP

The Noridian Medicare Portal (NMP) now allows Part A and B users to upload EDI compatible claim files to EDI Support Services for processing. This is available under the Claim Status function on the Batch Claims Submit tab. The EDI generated reports will also be viewable in NMP once the file has been processed.

To view more information on claim submission in NMP, visit the Batch Claims Submit Request section of the NMP Inquiry Guide.

Ensure Your Medical Records Correspondence Address is Correct

We encourage all providers and suppliers to ensure your enrollment record in PECOS has a Medical Records Correspondence Address (MRCA) on file that is kept up-to-date. This address is used by your Medicare Administrative Contractor (MAC) to request medical records.

Although the MRCA has been on the enrollment forms for some time, the use of addresses by MACs is relatively new, so we would encourage all providers to make sure that an address is present in this field. Note that if this field is blank, the payee address is used for medical records requests.

The MRCA may also be used by other Medicare contractors doing claim reviews to request medical documentation, but the following contractors are not doing so at this time, as explained below. When applicable, we have provided ways you can control which address is used for your medical records requests.

CERT (Comprehensive Error Rate Testing program): Call CERT Customer Service at 888-779-7477 to request that records requests be mailed to a specific address.

SMRC (Supplemental Medical Review Contractor): This contractor uses the mailing address for requesting records.

RAC (Recovery Audit Contractor): This contractor uses the payee address or physical address for requesting records. Log into the Cotiviti provider portal to update contact information.

CMS Provider Portal 2.0

UPIC (Unified Program Integrity Contractor): For pre-payment reviews, the UPIC uses the MRCA for records request, with the default to the payee address if the MRCA is not present. For post-payment review requests, the payee address is used.

Hospital and Skilled Nursing Facility (SNF) Stays Impacting Part B Claims

Each month providers receive over $100,000.00 in part B denials or recoupments because a service was inappropriately billed to Part B when a patient was in a Part A stay. This is in accordance with CMS Internet Only Manual (IOM), Publication 100-04, Claims Processing Manual, Chapter 26, Section 10.5, *"physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, shall, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter."*

If a patient is in a SNF or inpatient hospital stay, the claim will deny with the following remark codes:

- CO-109: Claim/service not covered by this payer/contractor.

- N193-Alert: Specific federal/state/local program may cover this service.

To avoid delays in payment, Noridian has the following tips:

1 Verify all patient eligibility status on the Noridian Medicare Portal (NMP)
2 Ensure there is open communication between ordering providers
    - If ordering a service for a patient, ensure your order includes the patient's status (e.g., under hospital care)
    - When receiving an order or referral from another provider, confirm the ordering or referring provider has provided patient's status
3 Bill only the professional component of global services to Medicare Part B
4 Confirm the place of service (POS) code is appropriate based on patient status

Resources

- Noridian Portal Claim Status Guide
- Denial Code Resolution Tool
- CMS IOM, Publication 100-04, Claims Processing Manual, Chapter 26, Section 10.5

Independent Diagnostic Testing Facility (IDTF) Updates

Recently CMS updated information on supervising physicians, interpreting physicians, and technicians. This includes supervising physicians enrolling only to supervise, and not provide medical services. It also includes information on how to change an interpreting physician, or technician.

Make sure your staff are informed of these updates.

Resource

- CMS MLN909060 - Independent Diagnostic Testing Facility (IDTF)

Noridian Duplicate Denials

Each month Noridian receives several thousand duplicate claims. When a duplicate claim is submitted, it will reject through Noridian's Part B Noridian Custom Edits (NCE) with the follow message:

"Smart Edit DCP: This line is a possible duplicate of a claim performed by the same provider on the same day. If you feel you have received this message in error or if you need to resubmit the claim without making any changes, please resubmit your claim on the next business day."

If a duplicate claim continues to be submitted and passes through Noridian's upfront edits, one of three possible denials will occur:

1 Duplicate to another claim on the same date of service:
   - CO-97: The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF),
   - N111: No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated,

2 Exact duplicate to another claim on same date of service:
   - OA-18: Exact duplicate claim/service,
   - N522: Duplicate of a claim processed, or to be processed, as a crossover claim.

3 Duplicate to another provider's claim on the same DOS:
   - B20: Procedure/service was partially or fully furnished by another provider.

When a claim denies for duplicate, the Noridian Medicare Portal (NMP) will provide the duplicate claim information. When viewing the status of a claim on NMP, there will be a button on the right side of the screen that says, "related claim details". By clicking on that button, a provider can view the previously processed claim and provider information.

Resources

- Noridian Portal Claim Status Guide
- Part B Noridian Custom Edits (NCE) - EDI Support Services
- Denial Code Resolution Tool

Notification of the 2024 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, 2024, for an Administrative Law Judge (ALJ) Hearing is **$180**.

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2024, for a Federal District Court Review is **$1,840**.

News

Patients Receiving New Medicare Numbers

When a patient reports their Medicare card lost or stolen, they will receive a new Medicare Beneficiary Identifier (MBI) number. When a patient receives a new MBI number, providers must immediately switch to billing with the new MBI. Billing with the old MBI may result in receiving the below CARC and RARC rejection codes:

- CO16: Claim/Service lack information or has submission/billing error(s).
- N382: Missing/Incomplete/Invalid patient identifier

If you receive a denial with the above remark codes, please verify the patient's MBI using the NMP MBI Lookup Tool.

Resources

- Denial Code Resolution

Receive Faster Claim Notifications with Noridian Smart Edits.

To assist providers with faster claim resolutions, Noridian has installed multiple Custom Smart Edits (NCEs) to give upfront notifications when a claim is billed with incorrect information. This rapid response allows providers to immediately review their claim responses and correct them without having to wait for a remittance response. For example, if a procedure that bundles with another submitted code for the date will receive the below message:

"SMARTEDIT PATTERN 24078 PROCEDURE CODE (DENIED) CODE HAS AN UNBUNDLED RELATION WITH HISTORY PROCEDURE (PROCESSED PROCEDURE) BILLED ON THE SAME DATE OF SERVICE PER CCI GUIDELINES."

Providers are advised to thoroughly review these upfront edits before resubmitting electronic claims. The only time a rejected claim should be resubmitted without corrections is if provider needs a denied remit.

Resources

- https://www.edissweb.com/cgp/reports/nce.html

News

Transitional Care Management (TCM) Direct Contact

It is important to note what is meant by 'direct contact' when submitting CPT codes 99495 and 99496. The term 'direct contact' does not include the use of digital assistants such as chat bots, Siri, or Alexa for the required interactive communication.

CPT guidelines state, "TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional or licensed clinical staff under his or her direction."

For codes 99495 and 99496, 'direct contact' is referred to as one of three types of communication with the patient or caregiver within 2 business days of discharge. The other two types of communication would be telephone and electronic. Both codes may be reported through synchronous (real-time) interactive audio-video telemedicine services when appended by modifier 95.

The CPT guidelines provide additional information for interactive contact:

- "TCM requires an interactive contact with the patient or caregiver, as appropriate, within two business days of discharge. The contact may be direct (face-to-face), telephonic, or by electronic means. Medication reconciliation and management must occur no later than the date of the face-to-face visit."
- The required contact with the patient or caregiver, as appropriate, may be by the physician or qualified health care professional or clinical staff. 'Within two business days' of discharge is Monday through Friday except holidays without respect to normal practice hours or date of notification of discharge. The contact must include capacity for prompt interactive communication addressing patient status and needs beyond scheduling follow-up care.

The Transitional Care Management Services MLN Booklet corresponds with the CPT guidelines.

See Noridian's TCM webpage

Welcome to the New NoridianMedicare.com

In response to survey feedback, Noridian has recently updated the look and feel of NoridianMedicare.com. This new design provides a wider view of content to better utilize common screen resolutions, more white space to remove distractions, and updated font sizing and spacing to allow users to easily focus on reading.

Our site may look different but navigation remains the same. All webpages are still in the same place, so bookmarks will work as they always have, and users will continue to follow the same menu selections to get to the sections they need.

You spoke. We Listened. Many of these changes were driven by user comments, and Noridian thanks everyone for their feedback. Please continue to use our survey and feedback tab to leave messages and suggestions about future changes for us to review.

Written Reopenings Available on the Noridian Medicare Portal (NMP)

Effective January 1, 2024, Noridian will be requiring that providers use the Noridian Medicare Portal (NMP) for all written reopenings that are available through the Self-Service Reopening feature.

The reopening process allows suppliers to correct clerical errors or omissions on denials received without having to request a formal appeal.

Before submitting a reopening request, suppliers should research the claim denial reason to determine the proper way to resolve the denial and avoid it in the future. This can be accomplished in the Denial Code Resolution tool. A list of errors that must be corrected in the NMP using a self-service reopening can be found on the Noridian website.

2023 ICD-10 Local Coverage Article (LCA) Updates

The following LCAs have been revised under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY). All LCAs are titled with "Billing and Coding: LCD title"

Effective Date: October 1, 2023

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

Medicare Coverage Database (MCD) Number:

MCD Number	LCA Title	New ICD-10 Codes	Deleted ICD-10 Codes	Revised ICD-10 Codes
A58245	Billing and Coding: Intensity Modulated Radiation Therapy (IMRT)	D481.10, D481.11, D481.12	D48.1	N/A
A57719	Billing and Coding: Vitamin D Assay	E20.810, E20.811, E20.812, E20.818, E20.819, E20.89	E20.8	N/A
A54668	Billing and Coding: Positron Emission Tomography Scans Coverage	N/A	I20.8, I24.8, D48.1, G20	N/A
A57513	Magnetic Resonance Guided Focused Ultrasound Surgery (MRGfUS)	G20.A1, G20.A2, G20.B1, G20.B2, G20.C	G20	N/A
A54992	Nerve Conduction Studies and Electromyography	G20.A1, G20.A2, G20.B1, G20.B2, G37.89	G20, G37.8	N/A

Visit the Noridian Website to view all LCDs and LCAs or access it via the CMS MCD.

2024 CPT/HCPCS Local Coverage Article (LCA) Updates

These Local Coverage Articles (LCA) have been revised under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: January 01, 2024

Medical Policies and Coverage

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
A58097	Billing and Coding: Non-Invasive Fractional Flow Reserve (FFR) for Stable Ischemic Heart Disease	75580	0501T, 0502T, 0503T, 0504T	N/A
A55531	Billing and Coding: Peripheral Nerve Stimulation	64596, 64597, 64598	N/A	64585, 64590, 64595
A57162	Billing and Coding: Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)	N/A	N/A	11200, 11201
A57957	Billing and Coding: Routine Foot Care	N/A	N/A	11055, 11056, 11057
A57614	Billing and Coding: Lab: Special Histochemical Stains and Immunohistochemical Stains	N/A	N/A	88341, 88342, 88344
A56515	Billing and Coding: MOHS Micrographic Surgery	N/A	N/A	88331, 88332
A52725	Billing and Coding: Nerve Blockade for Treatment of Chronic Pain and Neuropathy	N/A	N/A	97032

MCD Number	LCA Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptors changes
A53046	Billing and Coding: Wound Care and Debridement - Provided by a Therapist, Physician, NPP, or as Incident-to Services	N/A	N/A	97597, 97598
A54992	Billing and Coding: Nerve Conduction Studies and Electromyography	N/A	N/A	92265
A58567	Billing and Coding: Wound and Ulcer Care	N/A	N/A	11000, 11001, 11004, 11005, 11006, 11008, 11042, 11043, 11044, 11045, 11046, 11047, 11055, 11056, 11057, 97597, 97598, 97605, 97606, 97607, 97608
A53017	Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence	N/A	N/A	64585, 64590, 64595
A57792	Billing and Coding: Spinal Cord Stimulators for Chronic Pain	N/A	N/A	63685

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

Billing and Coding: Amniotic and Placental-Derived Product Injections and/or Applications for Musculoskeletal Indications, Non-Wound (A58867) - R2 - Effective November 12, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 12, 2023

Summary of Article Changes:

- In the CPT/HCPCS Codes section, HCPCS codes Q4112 and Q4149 were removed from Group 1.
- ICD-10 codes M80.0B1A, M80.0B1D, M80.0B1G, M80.0B1K, M80.0B1P, M80.0B1S, M80.0B2A, M80.0B2D, M80.0B2G, M80.0B2K, M80.0B2P, M80.0B2S, M80.0B9A, M80.0B9D, M80.0B9G, M80.0B9K, M80.0B9P, M80.0B9S, M80.8B1A, M80.8B1D, M80.8B1G, M80.8B1K, M80.8B1P, M80.8B1S, M80.8B2A, M80.8B2D, M80.8B2G, M80.8B2K,M80.8B2P, M80.8B2S, M80.8B9A, M80.8B9D, M80.8B9G, M80.8B9K, M80.8B9P, M80.8B9S were added to Group 1 in the ICD-10-CM Codes that DO NOT Support Medical Necessity section.

Visit the Noridian Active LCDs 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: Artificial Hearts and Percutaneous Endovascular Cardiac Assist Procedures and Devices (A52967) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Medical Policies and Coverage

Billing and Coding: Botulinum Toxin Types A and B (A57186) - R6 - Effective October 1, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 1, 2023

Summary of Article Changes:

Per Annual ICD-10 Updates:

The following codes were added to Group 1: G43.E01, G43.E09, G43.E11, G43.E19.

These updates are effective 10/01/2023.

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

Billing and Coding: Cataract Surgery in Adults (A57196) - R7 - Effective January 1, 2024

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: January 1, 2024

Summary of Article Changes:

Under ***ICD-10-CM Codes that Support Medical Necessity***, added the following codes effective 01/01/2024:

H52.31, H52.32

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

Billing and Coding: Dental Services (A59450) Retirement - Effective December 19, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: December 19, 2023

Summary: The Dental Services coverage article is being retired pending 2024 updates.

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

Medical Policies and Coverage

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

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database (MCD) Number: A58245

Effective Date: November 1, 2023

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

Visit the Retired LCDs webpage to access the retired LCDs.

Billing and Coding: MolDX: Molecular Assays for the Diagnosis of Cutaneous Melanoma (A59181) - R1 - Effective August 06, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: August 06, 2023

Summary of Article Changes: Under Article Text revised the 8th and 11th bullets to remove “DEX Z-Code™” and replaced with “DEX Z-Code®”. Under ICD-10 Codes that Support Medical Necessity Group 1: Codes added D48.5. This revision is effective 8/6/2023.

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

Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58724) - R1 - Effective November 02, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 02, 2023

Summary of Article Changes: Under Article Text revised the 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 subheading Additional information deleted third sentence and Table 1. This revision is effective 11/2/2023.

Under CPT/HPCS Codes Group 2: Paragraph added "The following test may be billed in the pre-biopsy setting as defined in the policy: SelectMDx assay (PLA 0339U), performed on post-digital rectal exam (DRE) urine specimens". Under CPT/HCPCS Codes Group 2: Codes added 0339U. Under ICD-10 Codes that Support Medical Necessity Group 2: Paragraph added "The following codes are covered". Under ICD-10 Codes that Support Medical Necessity Group 2: Codes added D29.1, D40.0, N40.2, N40.3, and R97.20. The revision is due to new covered assay that has successfully completed a TA and is effective 2/17/2023.

Under Article Text removed the sentence: Medical record documentation must indicate the rationale for performance of such diagnostic biomarker tests as Noridian has modified certain language in the articles to mirror the language used presently by the MolDX team at Palmetto GBA as part of an annual review. Revision history dates and language may not exactly match the MolDX PGBA revision history. However, these revisions do not change coverage or guidance.

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58726) - R12 - Effective October 01, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 01, 2023

Summary of Article Changes: Under CPT/HCPCS Group 5: Codes added 0402U. This revision is due to the 2023 Q4 CPT/HCPCS Code Update and is effective 10/1/2023.

Under CPT/HCPCS Codes Group 9: Paragraph added "Arthropod Infection Panels: This code is reimbursed under limited circumstances. Note also the additional diagnostic guidance provided by the

Centers for Disease Control and Prevention (CDC): https://www.cdc.gov/ticks/tickbornediseases". Under CPT/HCPCS Group 9: Codes added 87999. Under CPT/HCPCS Modifiers Group 9: Codes added 59. Under ICD-10 Codes that Support Medical Necessity Group 9: Paragraph added "These are the diagnosis codes corresponding to coverage of CPT/HCPCS Codes Group 9: Codes - Arthropod Infection Panels". Under ICD-10 Codes that Support Medical Necessity Group 9: Codes added A77.40, A77.41, A77.49, A79.82, A79.9, A84.89, A84.9, A85.2, A85.8, A86, A93.8, A94, B60.00, B60.09, B60.01, B60.02, B60.03, G04.81, G04.90, R41.82, W57.XXXA, W57.XXXD, and W57.XXXS. This revision is effective 5/8/2023.

Under CPT/HCPCS Codes Group 10: Paragraph added "Joint Infection Panels: This code is reimbursed under limited circumstances". Under CPT/HCPCS Group 10: Codes added 87999. Under CPT/HCPCS Modifiers Group 10: Codes added 59. Under ICD-10 Codes that Support Medical Necessity Group 10: Paragraph added "These are the diagnosis codes corresponding to coverage of CPT/HCPCS Codes Group 10: Codes - Joint Infection Panels". Under ICD-10 Codes that Support Medical Necessity Group 10: Codes added A01.04, A02.23, A54.42, M00.00, M00.011, M00.012, M00.019, M00.021, M00.022, M00.029, M00.031, M00.032, M00.039, M00.041, M00.042, M00.049, M00.051, M00.052, M00.059, M00.061, M00.062, M00.069, M00.071, M00.072, M00.079, M00.08, M00.09, M00.10, M00.111,M00.112, M00.119, M00.121, M00.122, M00.129, M00.131, M00.132, M00.139, M00.141, M00.142, M00.149, M00.151, M00.152, M00.159, M00.161, M00.162, M00.169, M00.171, M00.172, M00.179, M00.18, M00.211, M00.212, M00.219, M00.221, M00.222, M00.229, M00.231, M00.232, M00.239, M00.241, M00.242, M00.249, M00.251, M00.252, M00.259, M00.261, M00.262, M00.269, M00.271, M00.272, M00.279, M00.28, M00.29, M00.80, M00.811, M00.812, M00.819, M00.821, M00.822, M00.829, M00.831, M00.832, M00.839, M00.841, M00.842, M00.849, M00.851, M00.852, M00.859, M00.861, M00.862, M00.869, M00.871, M00.872, M00.879, M00.88, M00.89, M00.9, M01.X0, M01.X11, M01.X12, M01.X19, M01.X21, M01.X22, M01.X29, M01.X31, M01.X32, M01.X39, M01.X41, M01.X42, M01.X49, M01.X51, M01.X52, M01.X59, M01.X61, M01.X62, M01.X69, M01.X71, M01.X72, M01.X79, M01.X8, M01.X9, T84.50XS, T84.50XA, T84.50XD, T84.51XA, T84.51XD, T84.51XS, T84.52XA, T84.52XD, T84.52XS, T84.53XA, T84.53XD, T84.53XS, T84.54XA, T84.54XD, T84.54XS, T84.59XA, T84.59XD, T84.59XS, T84.60XA, T84.60XD, T84.60XS, T84.610A, T84.610D, T84.610S, T84.611A, T84.611D, T84.611S, T84.612A, T84.612D, T84.612S, T84.613A, T84.613D, T84.613S, T84.614A, T84.614D, T84.614S, T84.615A, T84.615D, T84.615S, T84.619A, T84.619D, T84.619S, T84.620A, T84.620D, T84.620S, T84.621A, T84.621D, T84.621S, T84.622A, T84.622D, T84.622S, T84.623A, T84.623D, T84.623S, T84.624A, T84.624D, T84.624S, T84.625A, T84.625D, T84.625S, T84.629A, T84.629D, T84.629S, T84.63XA, T84.63XD, T84.63XS, T84.69XA, T84.69XD, T84.69XS, T84.7XXA, T84.7XXD, and T84.7XXS. This revision is effective 8/19/2022.

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

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58726) - R14 - Effective October 1, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 1, 2023

Summary of Article Changes:

Under Group 9: Paragraph, replaced the broken link with the correct link: https://www.cdc.gov/ticks/tickbornediseases/

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

Billing and Coding: MolDX: Pharmacogenomics Testing (A57385) - R11 - Effective October 01, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 01, 2023

Summary of Article Changes: Under CPT/HCPCS Group 1: Codes added 0411U and 0419U. This revision is due to the 2023 Q4 CPT/HCPCS Code Update and is effective on October 1, 2023.

Under Article Text revised Table 2 to delete row for CFTR as this is not relevant to the general Medicare population. Under subheading Covered multigene panels with intended uses revised verbiage to read "Panels with a specific intended use such as major depressive disorder (MDD) or neuropsychiatric must include relevant ICD-10 codes." and deleted Table 3. Under CPT/HCPCS Codes Group 1: Codes deleted 81220. This revision is effective on October 1, 2023.

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

Billing and Coding: MolDX: Plasma-Based Genomic Profiling in Solid Tumors (A58975) - R2 - Effective October 01, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 01, 2023

Summary of Article Changes: Under CPT/HCPCS Codes Group 1: Codes added 0409U. This revision is due to the 2023 Q4 CPT/HCPCS Code Update and is effective for dates of service on or after 10/1/2023.

Under Article Text revised the 3rd and 6th bullets to remove "DEX Z-Code™" and replaced with "DEX Z-Code®". This revision is effective on 10/1/2023.

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

Billing and Coding: Outpatient Cardiac Rehabilitation (A54070) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Billing and Coding: Physician Supervision of Dialysis for Acute Kidney Injury (A55996) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Billing and Coding: Positron Emission Tomography Scans Coverage (A54668) Retirement - Effective October 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database (MCD) Number: A54668

Effective Date: October 1, 2023

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

Visit the Retired LCDs webpage to access the retired LCDs.

Billing and Coding: Posterior Tibial Nerve Stimulation Coverage (A52965) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Billing and Coding: Pulmonary Rehabilitation Services (A52770) - R7 - Effective May 11, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: May 11, 2023

Summary of Article Changes:

Within the Article Text section 'Public Health Emergency Telehealth Services', added the following statement:

"Due to the Public Health Emergency (PHE) ending on May 11, 2023, this exception is no longer in effect as of May 11, 2023."

This update was effective 05/11/2023.

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

Billing and Coding: Remote Imaging of the Retina to Screen for Retinal Diseases (A58914) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Billing and Coding: Treatment with Yttrium-90 Microspheres (A52950) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

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

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

Billing and Coding: Urine Drug Testing (A55030) - R21 - Effective October 1, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 1, 2023

Summary of Article Changes:

Revision History R19 should have also included the following:

Under ICD-10 Codes that support Medical Necessity Group 1 Codes added: E87.20 and deleted: F11.21, F12.20, F15.20, F19.10, F19.14, M25.59, M54.50, M54.59, Z91.141, Z91.148, Z91.151, Z91.158.

These updates are effective 10/08/2023.

The following ICD-10 Codes were previously mentioned as deleted in R19 but were listed incorrectly: F10.21, F10.230, F10.280, F10.288. They were not deleted as they were not in the policy.

Revision History R20 should have indicated the ICD-10 Annual Updates were effective 10/01/2023.

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

Micro-Invasive Glaucoma Surgery (MIGS)

The proposed Local Coverage Determination (LCD) and associated Local Coverage Article (LCA) are being updated under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database (MCD) Number: DL38301

LCD Title: Micro-Invasive Glaucoma Surgery (MIGS)

Effective Date: December 28, 2023

Rationale:

The Micro-Invasive Glaucoma Surgery (MIGS) Local Coverage Determination (LCD) L38301, and Billing and Coding Article A57864, will not become Final and therefore have been removed from the Medicare Coverage Database. Accordingly, at this time there will be no change in the current status of coverage for MIGS.

Micro-Invasive Glaucoma Surgery (MIGS) (LCDs) Finalized - Effective December 24, 2023

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database Number	LCD Title
L38301	Micro-Invasive Glaucoma Surgery (MIGS)

Medicare Coverage Database Number	Billing and Coding Article Title
A57864	Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS)

Medicare Coverage Database Number	Response to Comments
A59572	Response to Comments: Micro-Invasive Glaucoma Surgery (MIGS)

Effective Date: December 24, 2023

Multiple Local Coverage Determinations (LCDs) Finalized - Effective January 28, 2024

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database Number	LCD Title
L39644	Intraosseous Basivertebral Nerve Ablation
L38707	Transurethral Waterjet Ablation of the Prostate

Medicare Coverage Database Number	Billing and Coding Article Title
A59468	Billing and Coding: Intraosseous Basivertebral Nerve Ablation
A58229	Billing and Coding: Transurethral Waterjet Ablation of the Prostate

Medicare Coverage Database Number	Response to Comments
A59599	Response to Comments: Intraosseous Basivertebral Nerve Ablation
A59597	Response to Comments: Transurethral Waterjet Ablation of the Prostate

Effective Date: January 28, 2024

Visit the Medicare Coverage Database webpage to access these LCD.

Parenteral Iron Administration Coverage in Non-Dialysis Usage (A55734) Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: November 1, 2023

Summary: Coverage articles may be retired due to lack of evidence of current problems or CMS may have issued guidance regarding national coverage. The Noridian guidance in the retired article may still be helpful in assessing medical necessity. Where providers have adjusted their billing and coding

practices to correspond to the guidance in a coverage article, they will want to be very careful in departing from these practices just because the article is retired. Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a coverage article in place.

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

Pegfilgrastim (Neulasta) J2505 and Q5122 - (Injection, pegfilgrastim-apgf, biosimilar, (Nyvepria)) Article A55447 Retirement - Effective November 1, 2023

This coverage article has been retired under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database (MCD) Number: A55447

Effective Date: November 1, 2023

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

Visit the Retired LCDs webpage to access the retired LCDs.

Proteomics

As many stakeholders are aware, requests for new LCDs or reconsideration of existing LCDs have been on pause due to questions regarding scope and jurisdiction. All requests for new LCDs, revisions of existing LCDs, and general information regarding Proteomics, should be directed to Palmetto GBA starting in January of 2024.

If any other specific questions or concerns, please do not hesitate to contact us at: mpreconsideration@noridian.com

More specific contact information will be forthcoming at a future date.

Respiratory Care (L37293) - R7 - Effective November 5, 2023

This Local Coverage Determination (LCD) has been revised under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database (MCD) Number: L37293

Effective Date: November 5, 2023

Summary of Changes: Updated #7 under Sources of Information to remove broken link.

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

Respiratory Care Local Coverage Determination (LCD) Finalized - Effective November 5, 2023

The following Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contractor numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Medicare Coverage Database Number	LCD Title
L37293	Respiratory Care

Medicare Coverage Database Number	Billing and Coding Article Title
A57225	Billing and Coding: Respiratory Care

Medicare Coverage Database Number	Response to Comments
A59532	Response to Comments: Respiratory Care

Effective Date: November 5, 2023

Self-Administered Drug Exclusion List - R33 - Effective October 1, 2023

This coverage article has been revised and published for notice under contract numbers: 02102 (AK), 02202 (ID), 02302 (OR), 02402 (WA), 03102 (AZ), 03202 (MT), 03302 (ND), 03402 (SD), 03502 (UT), and 03602 (WY).

Effective Date: October 1, 2023

Summary of Changes: This article has been updated to delete: J0800 and was replaced with J0801 and J0802 effective 10/01/2023.

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

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

MLN Connects

MLN Connects - October 5, 2023

MLN Connects Newsletter: Oct 5, 2023

News

- Administration Moves Forward with Medicare Drug Price Negotiations to Lower Prescription Drug Costs for People with Medicare
- CMS Requests Public Input on Coverage of Over-the-Counter Preventive Services, Including Contraception, Tobacco Cessation, and Breastfeeding Supplies
- Action Plan for Sickle Cell Disease Month
- CMS Burden Reduction News & Insights Fall Newsletter
- New COVID-19 Treatments Add-On Payment Ended September 30
- Clinical Laboratory Fee Schedule: Submit Your Comments
- DMEPOS: New Provider Enrollment Appeals & Rebuttals Contractor Starts October 9
- Help Detect Breast Cancer Early

Claims, Pricers, & Codes

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

Publications

- Medicare Provider Compliance Newsletter

Multimedia

- Post-Acute Care Quality Reporting Programs: Brief Interview for Mental Status Video

MLN Connects Newsletter: COVID-19: Updated Novavax COVID-19 Vaccine, Adjuvanted for Patients 12 & Older - Oct 6, 2023

News

COVID-19: Updated Novavax COVID-19 Vaccine, Adjuvanted for Patients 12 & Older

MLN Connects

MLN Connects - October 12, 2023

MLN Connects Newsletter: Oct 12, 2023

News

- CMS Roundup (Oct 6, 2023)
- Protect Your Patients: Give Them a Flu Shot

Publications

- Direct Data Entry: 10-Digit Screen Expansion
- Medicare Preventive Services - Revised
- Medicare Provider Compliance Tips - Revised

MLN Connects - October 19, 2023

MLN Connects Newsletter: Oct 19, 2023

News

- 2024 Medicare Parts A & B Premiums and Deductibles
- Help CMS Improve Provider Resources - Respond by November 9
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Health Literacy: Help Your Patients Get Information & Services

Claims, Pricers, & Codes

- Discarded Drugs & Biologicals: When to Use JW & JZ Modifiers

Events

- Provider Compliance Focus Group Meeting - November 2
- Expanded Home Health Value-Based Purchasing Model: Preparing for CYs 2024 & 2025 Webinar - November 9

MLN Matters® Articles

- Update for Blood Clotting Factor Add-on Payments

MLN Connects

Publications

- Complying with Medical Record Documentation Requirements - Revised
- Expanded Home Health Value-Based Purchasing Model Resource Index - Updated

From Our Federal Partners

- Health Care Preparedness Resources

MLN Connects - October 26, 2023

MLN Connects Newsletter: Oct 26, 2023

News

- Help CMS Improve Provider Resources - Respond by November 9
- CMS Roundup (Oct 20, 2023)
- Nursing Facility Evaluation and Management Visits: Comparative Billing Report in October

Claims, Pricers, & Codes

- Conditional Payment Claims: Continue to Submit to Your Medicare Administrative Contractor
- Home Health Consolidated Billing Enforcement: CY 2024 HCPCS Code
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29

MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update
- Processing Claims Affected by Retroactive Entitlement

Publications

- Medicare Secondary Payer: Don’t Deny Services & Bill Correctly - Revised

Information for Patients

- 2024 Medicare & You Handbook

MLN Connects

MLN Connects Newsletter: Take Our Provider Survey Today - Nov 1, 2023

News

Take Our Provider Survey Today

MLN Connects - November 2, 2023

MLN Connects Newsletter: Nov 2, 2023

News

- CY 2024 Home Health Prospective Payment System Final Rule
- CY 2024 End-Stage Renal Disease Prospective Payment System Final Rule
- Behavioral Health: Medicare Pays for 3 Services
- Lymphedema Compression: Medicare Pays for Treatment Items
- Diabetes: Recommend Preventive Services
- Flu Shots Can Take Flu from Wild to Mild

Claims, Pricers, & Codes

- Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827

Publications

- Interns & Residents Duplicate FTEs Audit Reviews
- Expanded Home Health Value-Based Purchasing Model: October Newsletter
- Medicare Payment Systems - Revised

MLN Connects Newsletter: PFS, OPPS/ASC, & OPPS 340B-Acquired Drug Final Rules - Nov 2, 2023

Final Rules

- CMS Finalizes Physician Payment Rule that Advances Health Equity
- CMS Makes Hospital Prices More Transparent and Expands Access to Behavioral Health Care
- Hospital Outpatient Prospective Payment System (OPPS): Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule (CMS 1793-F)

MLN Connects

MLN Connects - November 9, 2023

MLN Connects Newsletter: Nov 9, 2023

News

- CMS Roundup (Nov 3, 2023)
- Marriage and Family Therapists & Mental Health Counselors: Enroll in Medicare Now
- American Indians or Alaska Natives: Help Your Patients Achieve Optimal Health

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update

Events

- CMS Hospice Forum - November 14
- Optimizing Healthcare Delivery to Improve Patient Lives Conference - November 15
- HCPCS Public Meeting - November 28-30
- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2024 Update
- Removal of a National Coverage Determination & Expansion of Coverage of Colorectal Cancer Screening - Revised

Publications

- Home Health & Hospice Resources
- Independent Diagnostic Testing Facility - Revised

MLN Connects - November 16, 2023

MLN Connects Newsletter: Nov 16, 2023

News

- Unprecedented Efforts to Increase Transparency of Nursing Home Ownership
- Hospital Price Transparency: Use Required CMS Template Layout to Encode Hospital Standard Charge Information

MLN Connects

- Quality Payment Program: Preview Your Performance Information by December 12
- Medicare Participation for CY 2024
- Hospice: New Requirement for Physicians Who Certify Patient Eligibility
- Medicare Ground Ambulance Data Collection System: CY 2024 Final Policies, Printable Instrument, & FAQs
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- National Rural Health Day: Address Unique Health Care Needs
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- Skilled Nursing Facility: Appropriate Use of Place-Of-Service Codes

Claims, Pricers, & Codes

- Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827 - Updated

MLN Matters® Articles

- Home Health Prospective Payment System: CY 2024 Update
- Provider Enrollment Changes to the Medicare Program Integrity Manual
- Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims
- Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order - Revised

Multimedia

- Home Health Agency Perspectives on Innovation: Panel Materials

MLN Connects - November 22, 2023

MLN Connects Newsletter: Nov 22, 2023

News

- CMS Roundup (Nov 17, 2023)
- Provider Enrollment Application Fee: CY 2024
- Clinical Laboratory Fee Schedule: CY 2024 Final Payment Determinations & Reporting Delay

- Medicare Ground Ambulance Data Collection System: 5 Top Tips
- Respiratory Virus Season: Protect Your Patients

Events

- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29
- Ambulance Open Door Forum - November 30

MLN Matters® Articles

- Lymphedema Compression Treatment Items: Implementation
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2024 Update - Revised

Publications

- New Ownership Reporting Requirements for Providers Using the Form CMS-855A
- Intravenous Immune Globulin Demonstration - Revised
- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model - Revised

MLN Connects - November 30, 2023

MLN Connects Newsletter: Nov 30, 2023

News

- Quality Payment Program: Preview Your Performance Information by December 12
- HIV: Screening is Knowledge

Claims, Pricers, & Codes

- Resubmit Telehealth Claims with Modifier CS
- Federally Qualified Health Center Prospective Payment System: CY 2024 Pricer
- Rural Health Clinic CY 2024 All-Inclusive Rate

MLN Matters® Articles

- Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease
- ESRD & Acute Kidney Injury Dialysis: CY 2024 Updates
- Medicare Physician Fee Schedule Final Rule Summary: CY 2024

MLN Connects

Information for Patients

- Medicaid and CHIP Renewals: Patient-Centered Messaging for Clinical Offices and Health Care Settings

MLN Connects - December 7, 2023

MLN Connects Newsletter: Dec 7, 2023

News

- Citrix Bleed Vulnerability: Act Now
- Marriage and Family Therapists & Mental Health Counselors: Enroll in Medicare Now
- Health Professional Shortage Area: CY 2024 Bonus Payments
- Skilled Nursing Facility Value-Based Purchasing Program: December Confidential Feedback Reports
- Flu Shots: There's Still Time to Protect Your Patients

Claims, Pricers, & Codes

- Medicare Physician Fee Schedule: New CPT Codes for RSV Vaccine Administration
- Discarded Drugs & Biologicals: JZ Modifier Use for Pharmacies
- National Correct Coding Initiative: Annual Policy Manual Update
- ICD-10: New Procedure Codes Effective April 1

MLN Matters® Articles

- Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25
- New Waived Tests
- Update for Blood Clotting Factor Add-on Payments – Revised

MLN Connects

MLN Connects - December 14, 2023

MLN Connects Newsletter: December 14, 2023

News

- CMS Releases Revised Guidance for Medicare Prescription Drug Inflation Rebate Program
- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier - Revised
- Billing for Flu, Pneumococcal, & COVID-19 Vaccines
- Expanded Home Health Value-Based Purchasing Model: October 2023 Interim Performance Reports

Claims, Pricers, & Codes

- New Place of Service Code 27 for Outreach Site/Street
- National Correct Coding Initiative: January Update

MLN Matters® Articles

- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System - Revised
- Clinical Laboratory Fee Schedule: 2024 Annual Update
- Medicare Program Integrity Manual: CY 2024 Home Health Prospective Payment System Updates
- Activation of Validation Edits for Providers with Multiple Service Locations - Revised

Publications

- Medicare Diabetes Prevention Program Expanded Model - Revised
- Rural Emergency Hospitals - Revised

Multimedia

- Expanded Home Health Value-Based Purchasing Model: Agency Perspectives Video Series

From Our Federal Partners

- Severe & Fatal Confirmed Rocky Mountain Spotted Fever among People with Recent Travel to Tecate, Mexico

MLN Connects

MLN Connects - December 21, 2023

MLN Connects Newsletter: Dec 21, 2023

Editor's Note:

Happy holidays from the MLN Connects team. We'll release the next regular edition on Thursday, January 4, 2024.

News

- CMS Roundup (Dec 15, 2023)
- Opioid Use Disorder Screenings & Treatment: Medicare Pays for Services
- Opioid Treatment Programs: New Information for 2024
- Skilled Nursing Facility Consolidated Billing: Are You Following the Requirements?

Compliance

- Global Surgery: Bill Correctly

Claims, Pricers, & Codes

- Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827 - Updated

MLN Matters® Articles

- DMEPOS Fee Schedule: CY 2024 Update

Multimedia

- Medicare Diabetes Prevention Program Orientation Video

From Our Federal Partners

- Urgent Need to Increase Immunization Coverage for Influenza, COVID-19, and RSV & Use of Authorized/Approved Therapeutics in the Setting of Increased Respiratory Disease Activity During the 2023-2024 Winter Season

MLN Matters

2024 Annual Update for the HPSA Bonus Payments

Related CR Release Date: September 21, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13384

Related CR Transmittal Number: R12260CP

CR 13384 provides files for the automated payments of Health Professional Shortage Area (HPSA) bonuses for dates of service January 1, 2024. through December 31, 2024. 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)13384.

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

Related CR Release Date: October 27, 2023 - Revised

Effective Date: July 1, 2023, except January 1, 2024, as noted in the Article

Implementation Date: July 3, 2023

MLN Matters Number: MM13055

Related Change Request (CR) Number: CR 13055 & CR 13279

Related CR Transmittal Number: R12091OTN & R12335OTN

Note: CMS added 2 new CPT codes effective January 1, 2024, based on CR 13279.

CR 13055 tells you about:

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

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

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

MLN Matters

Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Related CR Release Date: August 10, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13295

Related CR Transmittal Number: R12197CP

CR 13295 provides the January 2024 annual update to the list of Healthcare Common Procedure Coding System (HCPCS) codes used by Medicare systems to enforce consolidated billing of home health services. The attached recurring update notification applies to chapter 10, section 20.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13295.

Beta Amyloid PET in Dementia and Neurodegenerative Disease

Related CR Release Date: November 16, 2023

Effective Date: October 13, 2023

Implementation Date: December 19, 2023, (MACs); April 1, 2024 (CWF, MCS, FISS)

MLN Matters Number: MM13429

Related Change Request (CR) Number: CR 13429

Related CR Transmittal Numbers: R12364CP and R12364NCD

CR 13429 tells you:

- CMS removed NCD 220.6.20 from the Medicare National Coverage Determination (NCD) Manual, effective October 13, 2023
- Your MACs will make coverage determinations for Positron Emission Tomography (PET) beta amyloid imaging for dementia and neurodegenerative disease

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13429.

MLN Matters

Changes to Value-Based Insurance Design Model: CY 2024

Related CR Release Date: June 29, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13236

Related Change Request (CR) Number: CR13236

Related CR Transmittal Number: R12111DEMO

CR 13236 tells you about:

- Changes in the VBID Model's hospice benefit component for CY 2024
- The business requirements in CR 11754, CR 12349, CR 12688 and CR 12964

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13236.

Clinical Laboratory Fee Schedule: 2024 Annual Update

Related CR Release Date: November 30, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13467

Related Change Request (CR) Number: CR 13467

Related CR Transmittal Number: R12389CP

CR 13467 tells you about:

- Delay in Clinical Laboratory Fee Schedule (CLFS) data reporting period and the phase-in of payment reductions
- Mapping for new test codes
- Updates for costs subject to the reasonable charge payment

Make sure your billing staff knows about changes and instructions effective January 1, 2024.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13467.

MLN Matters

DMEPOS Fee Schedule: CY 2024 Update

Related CR Release Date: December 7, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13463

Related Change Request (CR) Number: CR 13463

Related CR Transmittal Number: R12398CP

CR 13463 tells you about:

- CY 2024 fee schedule amounts for new and existing codes
- Payment policy changes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13463.

Edits to Prevent Payment of G2211 with O/O E/M Visit and Modifier 25

Related CR Release Date: November 21, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13272

Related Change Request (CR) Number: CR 13272

Related CR Transmittal Number: R12370CP

CR 13272 tells you that:

- Medicare pays separately starting January 1, 2024
- CMS won't pay when you report an associated Office/Outpatient Evaluation and Management (O/O E/M) visit with modifier 25
- CMS won't pay Method II Critical Access Hospitals on the same encounter for type of bill 85X

Make sure your billing staff knows about complexity add-on code G2211.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13272.

MLN Matters

ICD-10 & Other Coding Revisions to NCDs: January 2024 Update - Revised

Related CR Release Date: November 9, 2023, Revised

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13278

Related Change Request (CR) Number: CR 13278

Related CR Transmittal Number: R12355OTN

Note: CMS added information about CPT codes 0359U, 81455, and 81479 on page 2

CR 13278 tells you about:

- Newly available codes
- Recent coding changes
- How to find 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)13278.

ICD-10 & Other Coding Revisions to NCDs: April 2024 Update (CR 1 of 2)

Related CR Release Date: October 19, 2023

Effective Date: April 1, 2024 or as noted in CR 13390

Implementation Date: November 21, 2023:

BRs 2,4,11, MACs, April 1, 2024: Other BRs

MLN Matters Number: MM13390

Related Change Request (CR) Number: CR 13390

Related CR Transmittal Number: R12318OTN

CR 13390 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)13390.

MLN Matters

ICD-10 & Other Coding Revisions to NCDs: April 2024 Update (CR 2 of 2)

Related CR Release Date: November 3, 2023 Revised

Effective Date: April 1, 2024 or as noted in CR 13391

Implementation Date: November 21, 2023: BRs 2,6,7,12-MACs, January 2, 2024: BR 11, April 1, 2024: Remaining BRs

MLN Matters Number: MM13391

Related Change Request (CR) Number: CR 13391

Related CR Transmittal Number: R12350OTN

CR 13391 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)13391.

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

Related CR Release Date: September 21, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13380

Related CR Transmittal Number: R12258CP

CR 13380 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)13380.

MLN Matters

Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update

Related CR Release Date: October 19, 2023

Effective Date: January 1, 2024

Implementation Date: January 1, 2024

MLN Matters Number: MM13365

Related Change Request (CR) Number: CR 13365

Related CR Transmittal Number: R12307GI

CR 13365 tells you about:

- Medicare Part A and Medicare Part B deductible and coinsurance rates
- Part A and Part B premium amounts

Make sure your billing staff knows about CY 2024

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13365.

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

MLN Matters Number: SE19006 Revised

Article Release Date: December 4, 2023

Note: CMS revised this Article to note that for CDLTs that aren't ADLTs, the data reporting period is delayed and resumes starting January 1, 2025 - March 31, 2025. Also, CMS extended the 0% limit on laboratory payment reductions to the end of CY 2024 and the 15% limit on payment reductions per year to CY 2025 - 2027 (see pages 2, 14, 15, and 20-24).

SE 19006 tells you about:

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

Make sure your billing staff knows about these changes.

View the complete CMS Special Edition (SE)19006.

Medicare Physician Fee Schedule Final Rule Summary: CY 2024

Related CR Release Date: November 22, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13452

Related Change Request (CR) Number: CR 13452

Related CR Transmittal Number: R12372CP

CR 13452 tells you about:

- Telehealth services
- Evaluation and management (E/M) visits
- Behavioral health services
- Dental and oral health services
- Therapy services
- Diabetes self-management training (DSMT) services
- Community Health Integration (CHI) services
- Principal Illness Navigation (PIN) services
- Social Determinants of Health (SDOH)
- Caregiver training

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13452.

MLN Matters

Medicare Program Integrity Manual: CY 2024 Home Health Prospective Payment System Updates

Related CR Release Date: December 7, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13333

Related Change Request (CR) Number: CR 13333

Related CR Transmittal Number: R12393PI

CR 13333 tells you about:

- Expanding the HHA 36-month rule
- Moving hospices into the high level of categorical risk-screening
- Other updates to Chapter 10 of the Medicare Program Integrity Manual

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13333.

New POS Code 27 - "Outreach Site/Street" - Rescinded

Related CR Release Date: December 14, 2023

Effective Date: October 1, 2023

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13314

Related CR Transmittal Number: R12411CP

Note: Transmittal 12254 issued September 20, 2023, is being rescinded and replaced by Transmittal 12411, dated December 14, 2023, to add a new business requirement (13314.3) providing direction on how to treat claims submitted with POS 27. All other information remains the same.

CR 13314 creates a new place of service (POS) code 27 for "Outreach Site/Street" - A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13314.

MLN Matters

Payment of Codes for Chemotherapy Administration and Nonchemotherapy Injections and Infusions

Related CR Release Date: December 7, 2023

Effective Date: December 21, 2023

Implementation Date: December 21, 2023

Related Change Request (CR) Number: CR 13468

Related CR Transmittal Number: R12397OTN

CR 13468 provides clarification to the A/B MACs regarding the Medicare guidance/policy as described in Chapter 12, section 30.5 of the Medicare Claims Processing Manual that relates to the complex administration of CPT codes 96401-96549.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13468.

Provider Enrollment Changes to the Medicare Program Integrity Manual

Related CR Release Date: November 9, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13331

Related Change Request (CR) Number: CR 13331

Related CR Transmittal Number: R12356PI

CR 13331 tells you about:

- Medicare enrollment of MFTs and MHCs
- Other provider enrollment policy updates like denial reasons and revocations

Make sure your billing staff knows about these changes effective January 1, 2024.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13331.

Quarterly Update to the NCCI PTP Edits, Version 30.0, Effective January 1, 2024

Related CR Release Date: September 15, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13366

Related CR Transmittal Number: R12246CP

CR 13366 updates the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to Publication 100-04, Chapter 23, Section 20.9.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13366.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: May 18, 2023

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

Related Change Request (CR) Number: CR 13207

Related CR Transmittal Number: R12043CP

CR 13207 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason (CARC) lists and to instruct the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13207.

Removal of a NCD & Expansion of Coverage of CRC - Revised

Related CR Release Date: October 12, 2023

Effective Date: January 1, 2023

Implementation Date: February 27, 2023, November 13, 2023, for requirements subject to revision in the amended CR

MLN Matters Number: MM13017 Revised

Related Change Request (CR) Number: CR 13017

Related CR Transmittal Numbers: R12299CP, R12299BP, and R12299NCD

Note: CMS added clarifying information about the -KX modifier for screening colonoscopy claims in the context of a complete colorectal cancer screening. Substantive changes are in dark red (pages 2-3).

CR 13017 tells you about:

- Removal of National Coverage Determination (NCD) 160.22 - Ambulatory Electroencephalographic (EEG) Monitoring
- Lowering the minimum age for colorectal cancer screening (CRC) from age 50 to 45 for certain tests
- Expanding the definition of CRC screening tests and new billing instructions for colonoscopies under certain scenarios
- Medicare manual updates

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13017.

Contacts, Resources, and Reminders

Noridian Part B Customer Service Contact

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

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

Fax Numbers - View fax numbers and submission guidelines.

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

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

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

Medicare Learning Network Matters Disclaimer Statement

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

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

Sources for “Medicare B News” Articles

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

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

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

Unsolicited or Voluntary Refunds Reminder

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

Background

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

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

Additional Information

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

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

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

Do Not Forward Initiative Reminder

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

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

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

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

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

Policy

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

Implementation Process

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

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

IRS-1099 Reporting

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

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

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

Jurisdiction F Part B Quarterly Ask-the-Contractor Teleconferences

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

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

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

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

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

We look forward to your participation in these important calls.

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

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

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