DME Happenings

Jurisdiction D

December 2020

In This Issue…

This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://med.noridianmedicare.com

Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Subscribe" on the bottom right-hand corner of any page.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

FYI

Jurisdiction D DME MAC Supplier Contacts and Resources

PHONE NUMBERS

Department/System	Phone Number	Availability
Interactive Voice Response System (IVR)	877-320-0390	24/7 for Eligibility 6 a.m. - 8 p.m. CT for all other inquiries
Supplier Contact Center	877-320-0390	Monday - Friday 8 a.m. - 6 p.m. CT
Telephone Reopenings	877-320-0390	Monday - Friday 8 a.m. - 4:30 p.m. CT
Beneficiary Customer Service	800-633-4227	24/7

FAX NUMBERS

Department	Fax Number
Reopenings/Redeterminations Recovery Auditor Redeterminations	701-277-7886
Recoupment • Refunds to Medicare • Immediate Offsets	701-277-7894
MSP Refunds	701-277-7892
Recovery Auditor Offsets	701-277-7896
MR Medical Documentation	701-277-7888

EMAIL ADDRESSES

Correspondence	When to Use This Address	Email Address
Customer Service	Suppliers can submit emails to Noridian for answers regarding basic supplier information regarding Medicare regulations and coverage	See webpage https://med.noridianmedicare.com/web/jddme/contact/email-customer-service
Comprehensive Error Rate Testing (CERT)	Use this address for CERT related inquiries, such as outcomes and status checks. *Include the CID within the message*	jddmecert@noridian.com
Congressional Inquiries or FOIA Requests	Use this address when submitting Freedom of Information Act (FOIA) requests or if the request is coming from a Congressional office. *Emails sent to this address require specific information. Review the Freedom of Information Act or Congressional Inquiries webpages for a full listing of required items to include*	DMEDCongressional.FOIA@noridian.com

Correspondence	When to Use This Address	Email Address
LCD: New LCD Request	Use this address to request the creation of a new LCD. *Emails sent to this address require specific information. Review the New LCD Request Process webpage for a full listing of required items to include*	DMERecon@noridian.com
LCD Reconsideration Request	Use this address to request a revision to an existing LCD. *Emails sent to this address require specific information. Review the LCD Reconsideration Process webpage for a full listing of required items to include*	DMERecon@noridian.com
Recoupment	Use this address to submit requests for immediate offsets of open debt(s)	dmemsprecoupment@noridian.com
Reopenings and Redeterminations	Use this address with questions regarding: Timely Filing Inquiries, Appeal Rights and Regulations, Coverage Questions, Redetermination Documentation Requirements, Social Security Laws, Interpretation of Redetermination Decisions and Policies	dmeredeterminations@noridian.com
Website Questions	Use this form to report website ease of use or difficulties	See webpage https://med.noridianmedicare.com/web/jddme/help/website-feedback
CMS Comments on Noridian	Use this contact information to send comments to CMS concerning Noridian's performance	See webpage https://med.noridianmedicare.com/web/jddme/contact/cotr

MAILING ADDRESSES

Department	Address
• Advance Determination of Medicare Coverage Requests • Claim Submission • Congressional Inquiries • Correspondence • Education • Electronic Funds Transfer (EFT) • Freedom of Information Act (FOIA) • Medical Review Documentation • Overpayment Redetermination and Rebuttal Requests • Recovery Auditor Overpayments • Recovery Auditor Redeterminations • Redetermination Requests • Refunds • Written Reopening Requests	Noridian JD DME Attn: _____ PO Box 6727 Fargo, ND 58108-6727

Department	Address
• Administrative Simplification Compliance Act Exception Requests (ASCA) • Benefit Integrity	Noridian JD DME Attn: _____ PO Box 6736 Fargo, ND 58108-6736
• LCD: New LCD Request • Medical Review - Prior Authorization Requests (PAR)	Noridian JD DME Attn: _____ PO Box 6742 Fargo, ND 58108-6742
• Extended Repayment Schedule (ERS) • Refund Checks	Noridian JD DME Attn: _____ PO Box 511531 Los Angeles, CA 90051-8086
Qualified Independent Contractor (QIC)	MAXIMUS Federal DME - QIC Project 3750 Monroe Avenue, Suite 777 Pittsford, NY 14534

DME MACS AND OTHER RESOURCES

MAC/Resource	Phone Number	Website
Noridian: Jurisdiction A	866-419-9458	https://med.noridianmedicare.com/web/jadme
Noridian: Jurisdiction D	877-320-0390	https://med.noridianmedicare.com/web/jddme
CGS: Jurisdiction B	877-299-7900	https://www.cgsmedicare.com/
CGS: Jurisdiction C	866-238-9650	https://www.cgsmedicare.com/
Pricing, Data Analysis and Coding (PDAC)	877-735-1326	https://www.dmepdac.com/
National Supplier Clearinghouse	866-238-9652	https://www.palmettogba.com/nsc
Common Electronic Data Interchange (CEDI) Help Desk	866-311-9184	https://www.ngscedi.com
Centers for Medicare and Medicaid Services (CMS)		https://www.cms.gov/

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits

Organization	Phone Number	Types of Inquiries
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits - Benefits Coordination & Recovery Center (BCRC)	1-855-798-2627	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, https://www.medicare.gov/, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for and access MyMedicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

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 "DME Happenings" Articles

The purpose of "DME Happenings" is to educate Noridian's Durable Medical Equipment supplier 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 at CMS's website, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index. 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.

CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund 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."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Clarifying The Use of As-Needed/PRN Orders for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

Release Date: November 25, 2020
CR Transmittal Number: 10492
Change Request (CR) Number: 11997
Effective Date: January 1, 2020
Implementation Date: December 29, 2020

Effective for dates of service on or after January 1, 2020, CMS amended its order requirements for items of DMEPOS via recent regulation CMS-1713-F. The rule provides a standard written order with set elements required to be included for payment purposes. Since frequency is no longer a required element, CMS is updating section 5.11 in Chapter 5 of Pub. 100-08 to remove the language stating that "PRN" or "as-needed" are not acceptable frequencies to be included on a Standard Written Order.

View the complete CMS Change Request (CR)11997.

Formal Telephone Discussion Demonstration Implements Zoom for Healthcare Audio Conference Calls

The Qualified Independent Contractor (QIC) recently transitioned to conducting the formal telephone discussion demonstration using Zoom for Healthcare audio conference calls. Previously, Maximus contacted the supplier participants directly for the telephone discussion. Zoom allows participants to dial into an audio-only conference call, utilizing a telephone number and meeting ID provided by the QIC.

This change has resulted in several efficiencies to this process with the two most prominent being:

- Improved call clarity during the discussion and playback of the recordings;
- QICs ability to conduct multi-case calls within one recorded phone discussion.

The conference line details are provided via email in advance of the call. There is no video conferencing utilized or any software application to download or log into.

Any questions concerning the use of Zoom for Healthcare should be directed to Maximus at the following address: DMEInfo@maximus.com.

GoToWebinar Access Issues Utilizing Internet Explorer

Recently it has been identified that some of our users are having difficulties registering for our events when utilizing Internet Explorer (IE) as their web browser. LogMeIn (GoToWebinar) is aware of the issues and suggests that users use other browsers such as Edge, Chrome, Firefox, etc. By utilizing a different web browser, users should be able to register for all events provided by Noridian.

GW Modifier Billing Reminder

Effective for claims submitted on or after December 1, 2020, with a date of service on or after September 7, 2020, if a beneficiary is currently enrolled in hospice and is provided a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) item not related to their hospice condition, the GW modifier must be appended to the applicable HCPCS codes.

When a claim is submitted after December 1, 2020, with a date of service on or after September 7, 2020, without the GW modifier for a beneficiary enrolled in hospice, the claim will be denied. These claims can be corrected through the Noridian Medicare Portal or resubmitted with the GW modifier.

If there are more than four modifiers required to be appended to the same HCPCS code, replace the fourth modifier with modifier 99 and add the excess modifiers to Item 19 of the CMS-1500 claim form.

Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN Matters Number: MM11881
Related CR Release Date: August 28, 2020
Related CR Transmittal Number: R10324CP
Related Change Request (CR) Number: 11881
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 11881 informs you that Medicare will update its claims processing systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the CORE, Code Combination List, which will be published on or about October 1, 2020. Make sure that your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11881.

Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN Matters Number: MM11988
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10474CP
Related Change Request (CR) Number: 11988
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

CR 11988 informs you of Medicare system updates based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claims Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Reason Code (CAGC) rule publications. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2021. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11988.

Intravenous Immune Globulin Demonstration Ending: Important Information for IVIG and Infusion Suppliers

This notice contains important information for suppliers that bill for beneficiaries receiving immune globulin in their home through the IVIG demonstration program. Each of your IVIG demonstration beneficiaries will be calling you for guidance on obtaining their IVIG in 2021, so please be prepared to discuss the options and help them by reading the below information.

The **Medicare IVIG Demonstration will end as of December 31, 2020**. This date is based on date of service (DOS) so any **claims for Q2052 billed with DOS after December 31, 2020 will be denied**. Suppliers are reminded that they have one year to file claims from the date of service to avoid a timely filing denial.

Noridian will **stop enrollment in the demonstration as of November 16, 2020**. For mailed applications, the post mark date must be on/before November 15 for us to process the IVIG application. Faxes received by 11:59 pm Central Time on November 15 will be processed.

Since the demonstration ends on December 31, 2020, no payment will be made for demonstration services (supplies and related nursing services to administer IVIG in the home) provided after that date. The traditional Medicare fee-for-service program will continue to pay for IVIG based on coverage requirements, but once the demonstration ends, it will no longer pay for the services and supplies to administer the drug in the home, **unless** the beneficiary is receiving covered Medicare home health services. Beneficiaries currently receiving IVIG in their home must transition to other options for receiving IVIG, as further explained below.

Receive the IVIG treatment in a doctor's office or other outpatient setting.

1. If medically appropriate, transition to a subcutaneous form of immune globulin that can be self-administered.
2. In 2021, Medicare also pays for professional services (nursing services) for certain forms of immune globulin, when administered through a pump in your home, under the Home Infusion Therapy benefit. Suppliers must meet certain requirements to bill under this new benefit.

Therefore, **suppliers will need to transition each patient receiving IVIG through the demonstration to another method of receiving IVIG**, as discussed above, for Medicare to consider payment for the administration of the IVIG and related services and supplies. For more information on the Home Infusion Therapy benefit, see https://www.cms.gov/files/document/mm11880.pdf and https://www.cms.gov/files/document/se19029.pdf.

If you have questions regarding this, call the IVIG call center at 1-844-625-6284, Monday - Friday 8:30 a.m. - 4 p.m. CT.

KE Modifier Adjustments to the Fully Adjusted Payment Rates for CARES Act

Noridian is ready to accept KE reopenings for claims with dates of service March 6, 2020 through April 22, 2020 for finalized claims. As part of the fee schedule update for the CARES Act for the length of the public health emergency, the KE modifier was added to the fee schedule for use on items bid under the initial Round 1 of Competitive Bidding but used with non-competitive bid base equipment.

For information on how to submit these reopenings, see the Special Project Section on the Reopenings Webpage.

Nationwide Expansion of the Condition of Payment Prior Authorization Program for Lower Limb Prosthetics

In December 2016, CMS issued a final rule that established a Condition of Payment Prior Authorization (COPPA) process for certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) that are frequently subject to unnecessary utilization. This process was implemented in March 2017 for two HCPCS codes and expanded to include 45 items as of July 2019.

The COPPA program expanded September 1, 2020 to include six lower limb prosthetic (LLP) HCPCS codes for beneficiaries residing in California, Michigan, Pennsylvania and Texas.

Effective December 1, 2020 prior authorization will be required for the six LLP HCPCS codes L5856, L5857, L5858, L5973, L5980, and L5987 in all U.S. states and territories. DME MACs will begin accepting LLP prior authorization requests under the COPPA program November 17, 2020 for planned dates of service on/after December 1, 2020.

See the Required Prior Authorization Programs webpage for information on prior authorization request submission and education resources.

New Physician Specialty Code for MDS and ACHD and a New Supplier Specialty Code for Home Infusion Therapy Services - Revised

MLN Matters Number: MM11750 Revised
Related CR Release Date: September 25, 2020
Related CR Transmittal Numbers: R10374CP and R10374FM
Related Change Request (CR) Number: 11750
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: CMS revised this article to reflect the revised CR 11750, issued on September 25, 2020. In the article, CMS revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.

CR 11750 informs you of new physician specialty codes for Micrographic Dermatologic Surgery (MDS) (D7), and Adult Congenital Heart Disease (ACHD) (D8), and a new supplier specialty code for Home Infusion Therapy Services (D6). Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11750.

Noridian Medicare Portal (NMP) Overpayments-Recoupment Requests

Did you know DME suppliers may submit a request for an overpayment on the Noridian Medicare Portal (NMP)? It is fast and easy to access and is available 24/7. To learn more about this functionality visit the NMP website for full details.

Appeals

Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

Question	Answer
How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-877-320-0390.
What are the hours for Telephone Reopenings?	Monday - Friday 8 a.m. - 6 p.m. CT Holiday and Training Closures can be found at https://med.noridianmedicare.com/web/jddme/contact/holiday-schedule and https://med.noridianmedicare.com/web/jddme/contact/training-closures
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have ***all*** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. Verified by Customer Service Representative (CSR) or IVR • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digits of Tax Identification Number (TIN) Verified by CSR • Caller's name • Provider/Facility name • Beneficiary Medicare number • Beneficiary first and last name • Date of Service (DOS) • Last five digits of Claim Control Number (CCN) • HCPCS code(s) in question • Corrective action to be taken Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

Question	Answer
What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive. • Diagnosis code changes or additions • Date of Service (DOS) changes • HCPCS code changes • Certain modifier changes or additions (not an all-inclusive list) If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.
What is not accepted as a Telephone Reopening?	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation. • Overutilization denials that require supporting medical records • Certificate of Medical Necessity (CMN) issues (applies to Telephone Reopenings only) • Durable Medical Equipment Information Form (DIF) issues (applies to both Written and Telephone Reopenings) • Oxygen break in service (BIS) issues • Overpayments or reductions in payment. Submit request on Overpayment Refund Form • Medicare Secondary Payer (MSP) issues • Claims denied for timely filing (older than one year from initial determination) • Complex Medical Reviews or Additional Documentation Requests (ADRs) • Change in liability • Recovery Auditor-related items • Certain modifier changes or additions: EY, GA, GY, GZ, K0 - K4, KX, RA (cannot be added), RB, RP • Certain HCPCS codes: E0194, E1028, K0108, K0462, L4210, All HCPCS in Transcutaneous Electrical Nerve Stimulator (TENS) LCD, All National Drug Codes (NDCs), miscellaneous codes and codes that require manual pricing The above is not an all-inclusive list.
What do I do when I have a large amount of corrections?	If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 13 • Reopening webpage • CMS IOM, Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Emails containing Protected Health Information (PHI) will be returned as unprocessable.

Claim Reviews.....

CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Documentation Contractor for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates the reason for the appeal is due to "no submission of documentation" and "submitting incorrect documentation."

Suppliers are reminded the CERT program produces national, contractor-specific and service-specific paid claim error rates, as well as a supplier compliance error rate. The paid claim error rate is a measure of the extent to which the Medicare program is paying claims correctly. The supplier compliance error rate is a measure of the extent to which suppliers are submitting claims correctly.

The CERT Documentation Contractor sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT Documentation Contractor will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT Operations Center via fax, the preferred method, or mail at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is 804-261-8100.

Mail all requested documentation to:
AdvanceMed
CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT Documentation Contractor at 888-779-7477 with questions regarding specific documentation to submit.

Suppliers must submit medical records within 75 days from the receipt date of the initial letter or claims will be denied. The supplier agreement to participate in the Medicare program requires suppliers to submit all information necessary to support the services billed on claims.

Also, Medicare patients have already given authorization to release necessary medical information in order to process claims. Therefore, Medicare suppliers do not need to obtain a patient's authorization to release medical information to the CERT Documentation Contractor.

Suppliers who fail to submit medical documentation will receive claim adjustment denials from Noridian as the services for which there is no documentation are interpreted as services not rendered.

Knee Orthoses (HCPCS L1833 & L1851) Notification of Service Specific Post-Payment Review

Noridian Jurisdiction D, DME MAC, Medical Review is initiating service specific post-payment medical record review of claims for the following HCPCS codes:

- **L1833**: KNEE ORTHOSIS, ADJUSTABLE KNEE JOINTS (UNICENTRIC OR POLYCENTRIC), POSITIONAL ORTHOSIS, RIGID SUPPORT, PREFABRICATED, OFF-THE SHELF
- **L1851**: KNEE ORTHOSIS (KO), SINGLE UPRIGHT, THIGH AND CALF, WITH ADJUSTABLE FLEXION AND EXTENSION JOINT (UNICENTRIC OR POLYCENTRIC), MEDIAL-LATERAL AND ROTATION CONTROL, WITH OR WITHOUT VARUS/VALGUS ADJUSTMENT, PREFABRICATED, OFF-THE-SHELF

Service specific reviews are initiated to prevent improper payments for services which present possible sustained or high-level payment errors. This review is being initiated based on data analysis identifying probable vulnerabilities.

Please see the Medical Record Review Results page for further information.

Ostomy Supplies (HCPCS A4407 & A4409) Notification of Service Specific Post-Payment Review

Noridian Jurisdiction D, DME MAC, Medical Review is initiating service specific post-payment medical record review of claims for the following HCPCS codes:

- **A4407**: OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE, OR ACCORDION), EXTENDED WEAR, WITH BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH
- **A4409**: OSTOMY SKIN BARRIER, WITH FLANGE (SOLID, FLEXIBLE OR ACCORDION), EXTENDED WEAR, WITHOUT BUILT-IN CONVEXITY, 4 X 4 INCHES OR SMALLER, EACH

Service specific reviews are initiated to prevent improper payments for services which present possible sustained or high-level payment errors. This review is being initiated based on data analysis identifying probable vulnerabilities.

Please see the Medical Record Review Results page for further information.

Urological Supplies (HCPCS A4352 & A4353) Notification of Service Specific Post-Payment Review

Noridian Jurisdiction D, DME MAC, Medical Review is initiating service specific post-payment medical record review of claims for the following HCPCS codes:

- **A4352**: INTERMITTENT URINARY CATHETER; COUDE (CURVED) TIP, WITH OR WITHOUT COATING (TEFLON, SILICONE, SILICONE ELASTOMERIC, OR HYDROPHILIC, ETC.), EACH
- **A4353**: INTERMITTENT URINARY CATHETER; WITH INSERTION SUPPLIES

Service specific reviews are initiated to prevent improper payments for services which present possible sustained or high-level payment errors. This review is being initiated based on data analysis identifying probable vulnerabilities.

Please see the Medical Record Review Results page for further information.

Claim Submission

Billing for Home Infusion Therapy Services on or After January 1, 2021 - Revised

MLN Matters Number: MM11880
Related CR Release Date: November 13, 2020
Related CR Transmittal Number: R10463BP, R10463CP
Related Change Request (CR) Number: 11880
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Note: CMS revised this article to reflect a revised CR 11880 issued on November 13. In the article, CMS added statements related to the status indicator for the G codes on the Physician Fee Schedule and noting that MACs will post the HIT fees on their websites as soon as possible. Also, CMS revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.

CR 11880 provides guidance to providers and suppliers about claims processing systems changes necessary to implement Section 5012(d) of the 21st Century Cures Act. These changes are effective on and after January 1, 2021. Make sure that your billing staff is aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11880.

Claim Status Category and Claim Status Codes Updates

MLN Matters Number: MM11796
Related CR Release Date: August 28, 2020
Related CR Transmittal Number: R10322CP
Related Change Request (CR) Number: 11796
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 11796 informs you of updates to the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11796.

Coverage

Ankle-Foot Orthoses - Arizona-Type - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Ankle-Foot Orthoses - Arizona-Type - Correct Coding - REVISED, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Billing of Powered L-Coded Items - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Billing of Powered L-Coded Items - Correct Coding - Revised, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Correct use of Not Otherwise Specified L-codes for Orthoses and Prostheses - Billing Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Correct use of Not Otherwise Specified L-codes for Orthoses and Prostheses - Billing Reminder, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Enteral Nutrition - Correct Coding and Billing

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Enteral Nutrition - Correct Coding and Billing, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
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- Locate/select article title

Incorrect Use of HCPCS Codes for Custom Fit Orthotics

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Incorrect Use of HCPCS Codes for Custom Fit Orthotics, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

L1005 - Tension Based Scoliosis Orthosis And Accessory Pads, Includes Fitting And Adjustment - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, L1005 - TENSION BASED SCOLIOSIS ORTHOSIS AND ACCESSORY PADS, INCLUDES FITTING AND ADJUSTMENT - Correct Coding, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

L1686 Prefabricated Hip Abduction Orthosis - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, L1686 Prefabricated Hip Abduction Orthosis - Correct Coding, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

L1690 Prefabricated Bilateral Lumbo-sacral Hip Orthosis - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, L1690 PREFABRICATED BILATERAL LUMBO-SACRAL HIP ORTHOSIS - Correct Coding - Correct Coding, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
  - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Nurse Practitioners and Physician Assistants as Certifying Physicians for Therapeutic Shoes and Inserts

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Nurse Practitioners and Physician Assistants as Certifying Physicians for Therapeutic Shoes and Inserts, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Parenteral Nutrition - Correct Coding and Billing

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Parenteral Nutrition - Correct Coding and Billing, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Primary Care First Model Demonstration Project - Nurse Practitioners as Certifying Physicians for Therapeutic Shoes and Inserts

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Primary Care First Model Demonstration Project - Nurse Practitioners as Certifying Physicians for Therapeutic Shoes and Inserts, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Retirement of Enteral Nutrition Local Coverage Determination (LCD) and Related Policy Article - Effective November 12, 2020

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Retirement of Enteral Nutrition Local Coverage Determination (LCD) and Related Policy Article - Effective November 12, 2020, has been created and published to our website.

View the locally hosted 2020 DMD articles.

- Go to Noridian Medical Director Articles webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Retirement of Parenteral Nutrition Local Coverage Determination (LCD) and Related Policy Article - Effective November 12, 2020

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Retirement of Parenteral Nutrition Local Coverage Determination (LCD) and Related Policy Article - Effective November 12, 2020, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select article title

Educational

Address All Redetermination Denial Reasons in Reconsideration Request

Suppliers are reminded to review all elements of the redetermination letter to understand the reasons for denial of the appeal. The "Explanation of Decision" section of the letter outlines the reasons for denial and the policies that must be met for the item to be considered for payment. All denial reasons within the redetermination letter must be addressed when submitting to reconsiderations, the next level of appeal. Addressing all denial reasons will assist in receiving a favorable outcome at the next level of appeal. See Elements of a Redetermination Letter for full details.

Appeals Converted to Reopenings

Noridian receives a large number of appeal requests for corrections that should be completed through the Noridian Medicare Portal (NMP) Self-Service Reopenings function. These appeals will be processed as reopenings. Providers looking for information through the NMP on an appeal that has been converted to a reopening will find the claim information on their Remittance Advice (RA).

Providers will still have appeal rights on claims that have been processed as reopenings. The appeals timeframe of 120 days from the initial determination will remain regardless.

The Reopening process allows providers to correct clerical errors or omissions without having to request a formal appeal. Most reopenings can be initiated through Self-Service Reopenings via the NMP. Services considered too complex that cannot be completed through the NMP Self-Service Reopening function should be submitted as either a written reopening or redetermination in the NMP.

The CMS Internet Only Manual (IOM), Publication 100-09, Chapter 6, Section 50 mandates that all providers first access inquiries through self-service technology. This process change will allow Noridian to meet CMS requirements.

Eligibility Inquiry and Eligibility Tutorials Available within NMP - Save Time and Resources

Save time and resources on phone calls by resolving claim denials utilizing the Noridian Medicare Portal (NMP). This self-service tool provides users the ability to check eligibility and offers self-paced, online tutorials, for all functions available in the NMP.

Check out NMP today.

The Wheelchair Cushion Lookup Tool is Now Available

A new tool has been created to assist in determining the specialty wheelchair cushion(s) a beneficiary meets coverage criteria for when providing a manual or power wheelchair. The user will be provided a short series of questions to determine whether the beneficiary qualifies for a general use, skin protection, positioning, combination skin and positioning, or a custom fabricated wheelchair cushion. The tool is located on our education and outreach webpage under Tools.

Emergencies and Disasters.....

Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised

MLN Matters Number: SE20011 Revised
Article Release Date: November 9, 2020

Note: CMS revised the article to clarify the billing instructions in the Skilled Nursing Facility (SNF) Benefit Period Waiver - Provider Information section. All other information remains the same.

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)20011.

Medical Policies

LCD and Policy Article Revisions Summary for September 17, 2020

Posted September 17, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is External Infusion Pumps. Please review the entire LCD and related PA for complete information.

EXTERNAL INFUSION PUMPS

LCD

Revision Effective Date: 09/15/2020
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: Information related to HCPCS code E0787, which is invalid for Medicare submission for DOS on or after 9/15/2020
Added: Information regarding external ambulatory insulin infusion pumps that incorporate dose rate adjustment using therapeutic continuous glucose sensing

CODING INFORMATION:
Removed: HCPCS code E0787 from Group 1 HCPCS Codes
Removed: HCPCS code A4226 from Group 2 HCPCS Codes

09/17/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are due to Non-Discretionary HCPCS code changes rendering them invalid for submission to Medicare.

PA

Revision Effective Date: 09/15/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Information related to HCPCS code E0787, which is invalid for Medicare submission for DOS on or after 09/15/2020

MODIFIERS:
Removed: HCPCS code E0787

CODING GUIDELINES:
Removed: Guidelines for HCPCS codes E0787 and A4226
Added: Coding guidelines for insulin infusion pumps with integrated continuous glucose sensing capabilities

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: HCPCS code E0787 from Group 1 Paragraph

09/17/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)

4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for October 15, 2020

Posted October 15, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Refractive Lenses, Surgical Dressings, and Urological Supplies. Please review the entire LCDs and related PAs for complete information.

REFRACTIVE LENSES

LCD

Revision Effective Date: 10/01/2020
HCPCS CODES:
Added: HCPCS Code V2524 to Group 3 codes (effective for DOS on or after October 1, 2020)

10/15/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to add CMS HCPCS coding determinations.

PA

Revision Effective Date: 10/01/2020
CODING GUIDELINES:
Added: Guideline information for HCPCS code V2524

10/15/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

SURGICAL DRESSINGS

PA

Revision Effective Date: 01/01/2020
QUALIFYING DRESSING REQUIREMENTS:
Revised: Indication that eligible products “include both” to “are defined as”
Revised: Eligible product information, to include definitions of primary and secondary dressings

CODING GUIDELINES:
Added: Coding guidelines for Alginate or Other Fiber Gelling Dressings (A6196, A6197, A6198)
Revised: Clarified wound fillers as primary dressings
Revised: Clarified wound covers as primary or secondary dressings
Added: Clarification regarding sizing related to adhesive borders

10/15/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

UROLOGICAL SUPPLIES

LCD

Revision Effective Date: 10/01/2020
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: HCPCS A4335 from inFlow device reference due to new HCPCS codes as of 10/01/2020

HCPCS CODES:
Added: K1010, K1011 and K1012 (effective DOS on or after 10/01/2020)

10/15/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to add CMS HCPCS coding determinations.

PA

Revision Effective Date: 10/01/2020
MODIFIERS:
Removed: inFlow A4335 code from directions

CODING GUIDELINES:
Revised: inFlow HCPCS billing direction, HCPCS A4335 for DOS 07/26/2020 through 9/30/2020 and HCPCS K1010, K1011 and/or K1012 for DOS on or after 10/01/2020
Added: Billing direction for K1010, K1011 and K1012

10/15/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for September 24, 2020

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthoses, High Frequency Chest Wall Oscillation Devices, Mechanical In-exsufflation Devices and Wheelchair Seating. Please review the entire LCDs and related PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES

PA

Revision Effective Date: 10/01/2020
MISCELLANEOUS:
Clarified: Custom fabricated items that do not have specific HCPCS codes require additional information in claim narrative
Added: Statement referring to the LCD-related Standard Documentation Requirements article for more information

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: Non-specific ICD-10 codes M24.573 and M24.576 from Group 1 codes
Removed: Non-specific ICD-10 code M14.679 from Group 2 codes

09/24/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2020
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: ICD-10 code G71.2 from Group 1 codes, due to annual ICD-10 Code updates
Added: ICD-10 codes G71.20, G71.21, G71.220, G71.228, and G71.29 to Group 1 codes, due to annual ICD-10 Code updates

09/24/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

MECHANICAL IN-EXSUFFLATION DEVICES

PA

Revision Effective Date: 10/01/2020
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: ICD-10 code G71.2 from Group 1, due to annual ICD-10 Code updates

Added: ICD-10 codes G71.20, G71.21, G71.220, G71.228, G71.29 to Group 1 codes, due to annual ICD-10 Code updates

09/24/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

WHEELCHAIR SEATING

PA

Revision Effective Date: 10/01/2020
CODING GUIDELINES:
Added: RT and LT modifier billing instructions, for use when applicable

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: ICD-10 codes G11.1 and G71.2 from Group 2 and Group 4 codes, due to annual ICD-10 Code updates
Added: ICD-10 codes G11.10, G11.11, and G11.19 to Group 2 and Group 4 codes, due to annual

ICD-10 Code updates
Added: ICD-10 codes G71.20, G71.21, G71.220, G71.228, and G71.29 to Group 2 and Group 4 codes, due to annual ICD-10 Code updates

09/24/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for October 8, 2020

Outlined below are the principal changes to the DME MAC Policy Article (PA) that has been revised and posted. The policy included is Wheelchair Options/Accessories. Please review the entire LCD and related PA for complete information.

WHEELCHAIR OPTIONS/ACCESSORIES

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Removed: Reference to ICD-10 codes for replacement of E2398
Revised: Column II of table, removing E2398 for manual wheelchair bases and power wheelchair bases

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: Group 1 paragraph information, HCPCS code E2398 reference, and Group 1 ICD-10 Codes

10/08/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

- Open the currently effective policy on the Medical Coverage Database (MCD)
    - Links to the MCD can be found on the Active LCDs page on the Noridian website
        - There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        - There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
- Scroll down to the bottom of the policy
- Find the section labeled Public Version(s)
- Look for the link to the policy that was effective on the dates of service in question
- Click on hyperlink to go to the policy

Policy Article Revisions Summary for November 19, 2020

Posted November 19, 2020

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthoses, Knee Orthoses, Spinal Orthoses: TLSO and LSO and Therapeutic Shoes for Persons with Diabetes. Please review the entire LCDs and related PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES

PA

Revision Effective Date: 02/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Prefabricated orthoses (OTS or custom-fit) incorrect coding denial language, by removing "with a statutory denial"
Added: Definitions of prefabricated and custom fabricated orthoses
Clarified: Billing of custom fabricated additions

CODING GUIDELINES:
Added: Coding guideline information for HCPCS code L2005

11/19/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

KNEE ORTHOSES

PA

Revision Effective Date: 02/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Denial language for custom fitted orthoses to remove “with a statutory denial”

11/19/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

SPINAL ORTHOSES: TLSO AND LSO

PA

Revision Effective Date: 02/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Prefabricated orthoses (OTS or custom-fit) incorrect coding denial language, by removing “with a statutory denial”
Added: Definitions of prefabricated and custom fabricated orthoses
Clarified: Billing of custom fabricated additions

11/19/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

THERAPEUTIC SHOES FOR PERSONS WITH DIABETES

PA

Revision Effective Date: 11/05/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Certifying physician information, to clarify NPs or PAs practicing ‘incident to’ supervising physician

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: “detailed written order” to “SWO”
Revised: Certifying physician information, to clarify NPs or PAs practicing ‘incident to’ supervising physician

11/19/2020: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the ‘LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Reminder - Prosthetic Feet and Additions to Lower Limb Extremity Prostheses - Coding Verification Review Requirement

Posted September 3, 2020

Prosthetic manufacturers are reminded that the Pricing, Data Analysis and Coding (PDAC) contractor is conducting Coding Verification Reviews of the prosthetic components subject to Lower Limb Prostheses (LLP) Prior Authorization. Effective for claims with dates of service on or after January 1, 2021, the only products which may be billed using codes L5856, L5857, L5858, L5973, L5980, and L5987 are those for which a written Coding Verification Review has been made by the Pricing, Data Analysis and Coding (PDAC) Contractor and subsequently published on the appropriate Product Classification List. For more information please see the following article, published June 25, 2020: Prosthetic Feet and Additions to Lower Limb Extremity Prostheses - Correct Coding and Coding Verification Review Requirement.

Updated Clinician Checklists

Have you provided the Clinician Checklists to your practitioners recently? All checklists have been updated with the requirements of the Standard Documentation Requirements Policy Article and the Standard Written Order (SWO) requirements. Utilizing these checklists for practitioners provides a one stop shop for the requirements including coverage guidelines. Check out these Clinician Checklists created for most policy groups.

MLN Connects.....

MLN Connects Special Edition - Wednesday, September 2, 2020 - CMS Advancing Seniors' Access to Cutting-edge Therapies and Technology in Medicare Hospital Rule

FINALIZED POLICY CHANGES EXPAND NEW TECHNOLOGY ADD-ON PAYMENT PATHWAY FOR CERTAIN ANTIMICROBIALS

On September 2, CMS issued the FY 2021 Medicare Hospital Inpatient Prospective Payment System and Long Term Acute Care Hospital (LTCH) final rule, which includes important provisions designed to ensure access to potentially life-saving diagnostics and therapies for hospitalized Medicare beneficiaries. The changes will affect approximately 3,200 acute care hospitals and approximately 360 LTCHs. CMS estimates that total Medicare spending on acute care inpatient hospital services will increase by about $3.5 billion in FY 2021, or 2.7 percent.

"President Trump is committed to ensuring that seniors on Medicare have access to the latest life-saving diagnostics and therapies," said CMS Administrator Seema Verma. "This rule is another critical step in our effort to modernize the program and strip away bureaucratic barriers between our seniors and the latest innovative treatments."

CMS' rule creates a new Medicare Severity Diagnostic Related Group (MS-DRG) that provides a predictable payment to help adequately compensate hospitals for administering Chimeric Antigen Receptor (CAR) T-cell therapies. The current FDA-approved CAR-T-cell cancer therapies use a patient's genetically modified immune cells to treat specific types of cancer.

Also in the final rule, CMS approved a record number of 24 New Technology Add-on Payments (NTAPs), which is an additional payment to hospitals for cases involving eligible new and relatively high cost technologies. Last year, to remove barriers to innovation, CMS established alternative streamlined pathways for FDA Breakthrough Devices and FDA Qualified Infectious Disease Products (QIDPs) to qualify for NTAPs. Among CMS' approval of these 24 additional NTAPs are two technologies for new medical devices that are part of the FDA's Breakthrough Devices Program and six technologies that received FDA QIDP designation. This will provide additional Medicare payment for these technologies while real-world evidence is emerging, giving Medicare beneficiaries timely access to the latest innovations.

CMS is also expanding the add-on payment alternative pathway for antimicrobial products approved under FDA's Limited Population Pathway for Antibacterial and Antifungal Drugs (LPAD pathway), which encourages the development of safe and effective drug products that address unmet needs of patients with serious bacterial and fungal infections. Specifically, an antibacterial or antifungal drug approved under the LPAD pathway is used to treat a serious or life-threatening infection in a limited population of patients with unmet needs.

CMS is also taking steps to ensure that the Medicare Fee-for-Service (FFS) program adopts pricing strategies based on real world market forces. Medicare generally pays hospitals a rate that is weighted by the relative cost of providing certain services based on a patient's diagnosis. These weights are currently based in large part on the charges that hospitals report to the federal government, which often have little relevancy to the actual rates paid by insurance companies. Hospitals are already required to report these negotiated rates as part of the Trump Administration's efforts to promote price transparency, and CMS is now finalizing a requirement for hospitals to report to CMS the median rate negotiated with Medicare Advantage Organizations for inpatient services to use instead of the charge based data. CMS will begin to collect this data in 2021 and will use it in the methodology for calculating inpatient hospital payments beginning in 2024. These provisions will introduce the influences of market competition into hospital payment and help advance CMS's goal of utilizing market- based pricing strategies in the Medicare FFS program.

For More Information:

- Final Rule
- Fact Sheet

MLN Connects - September 3, 2020

CMS Acts to Spur Innovation for America's Seniors

MLN Connects® for Thursday, September 3, 2020
View this edition as a PDF

NEWS

- CMS Acts to Spur Innovation for America's Seniors
- Hospital Opioid Toolkit
- CMS Offers Comprehensive Support for California due to Wildfires
- PEPPERs for Short-term Acute Care Hospitals
- Office Visits by Nurse Practitioners: Comparative Billing Report

EVENTS

- Dementia Care Call - September 22

MLN MATTERS® ARTICLES

- 2021 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Annual Clotting Factor Furnishing Fee Update 2021
- Claim Status Category and Claim Status Codes Update
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2021
- The Intravenous Immune Globulin (IVIG) Demonstration: Demonstration is ending on December 31, 2020
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3
- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised
- Update to the International Classification of Diseases, Tenth Revision (ICD-10) Diagnosis Codes for Vaping Related Disorder and Diagnosis and Procedure Codes for the 2019 Novel Coronavirus (COVID-19) - Revised

PUBLICATIONS

- Medicare Preventive Services - Revised
- Medicare Preventive Services Poster - Revised

MLN Connects - September 10, 2020

CMS Care Compare Empowers Patients

MLN Connects® for Thursday, September 10, 2020
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NEWS

- CMS Care Compare Empowers Patients When Making Important Health Care Decisions
- Open Payments: Adding 5 Provider Types in 2021
- Breast Re-Excision: Comparative Billing Report in September

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - September 10
- Dementia Care Call - September 22

MLN MATTERS® ARTICLES

- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2021
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2021
- Internet Only Manual Update to Pub. 100-04, Chapter 16, Section 60.1.2 and Pub. 100-04, Chapter 26, Section 10.4, Item 19
- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries
- National Coverage Determination (NCD 30.3.3): Acupuncture for Chronic Low Back Pain (cLBP) - Revised

PUBLICATIONS

- Understanding Your Remittance Advice Reports
- Home Health, Hospice, IRF, LTCH, & SNF Quality Reporting Programs: COVID-19 Public Reporting

MULTIMEDIA

- Pain Management Listening Session: Audio Recording & Transcript
- Introduction to the LTCH Quality Reporting Program Web-Based Training
- Introduction to the Home Health Quality Reporting Program Web-Based Training

MLN Connects Special Edition - September 11, 2020 - Community Health Access and Rural Transformation Model

COMMUNITY HEALTH ACCESS AND RURAL TRANSFORMATION MODEL

The CMS Innovation Center announced the Community Health Access and Rural Transformation (CHART) Model.

The approximately 57 million Americans living in rural communities, including millions of Medicare and Medicaid beneficiaries, face unique challenges when seeking health care services, such as limited transportation options, shortages of health care services, and an inability to fully benefit from technological and care-delivery innovations.

Current regulations and volume-based payment structures perpetuate these challenges, with unsustainable financial models leading to over 130 rural hospitals closing since 2010. The constellation of reduced access to care and patients not seeking or delaying care leads to rural Americans facing worse health outcomes and having higher rates of preventable diseases than those living in urban areas.

CMS remains focused on the transformation of rural health care delivery and enabling local community collaboration to redesign their systems of care and align across providers and payers based on their unique needs. As part of that rural transformation, including transforming a system built on fee-for-service and volume to one based on value, CMS is testing the CHART Model.

Through the Model, CMS is directly providing a pool of $75M in upfront, seed funding, with 15 rural communities applying for up to $5M to develop local transformation plans. With this upfront seed funding, CMS is also providing regulatory and operational flexibility for updated service delivery models as well as changing how participating hospitals in these communities are paid, from a system based on volume to stable, monthly payments. In additional to supporting these 15 rural communities, CMS is also looking for 20 rural Accountable Care Organizations (ACOs) to participate in the model, paying shared savings upfront so that ACOs have infrastructure funding to be successful on the move towards achieving better outcomes. Taken together, these are substantial and tangible actions to support health care in our rural communities.

Specifically, the CHART Model will:

- Increase financial stability for rural health care providers through multiple new funding approaches, including the use of up-front investments and predictable, capitated payments that pay for quality and patient outcomes over volume
- Provide the necessary operational and regulatory flexibilities to allow health care providers and CMS to test the Model in their local communities and successfully transform themselves
- Support local rural communities' transformation efforts by being directly engaged at CMS, offering real-time technical expertise and other learning when needed to foster success

If successful, beneficiaries' access to health care services should be improved, rural provider's financial sustainability should increase for years to come, and communities can align with payers and other stakeholders to address both their health care service delivery ecosystem and the necessary social support structures, such as food and housing, to deliver improved health. Ultimately, the CHART Model aims to improve quality and health, while reducing Medicare and Medicaid expenditures, in rural communities over the long-term.

CMS is providing funding, regulatory and operational flexibilities, and technical assistance for rural communities to transform their systems of care through a Community Transformation Track. Further, CMS is enabling providers to participate in value-based payment models where they are paid for quality and outcomes, instead of volume, through an ACO Transformation Track.

CMS anticipates the Notice of Funding Opportunity for the Community Transformation Track will be available in September on the Model website. The Request for Application for the ACO Transformation Track will be available in early 2021 on the CHART Model website.

See the full text of this excerpted CMS Fact Sheet (issued August 11).

MLN Connects - September 17, 2020

Participate in Medical Documentation Interoperability Pilot

MLN Connects® for Thursday, September 17, 2020
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NEWS

- SNF Healthcare-Associated Infections Measure: Submit Comments by October 14
- Participate in Medical Documentation Interoperability Pilot
- COVID-19 Lessons Learned & Infectious Disease Surge Annex Template
- Healthy Aging® Month: Discuss Preventive Services with Your Patients
- Prostate Cancer Awareness Month

EVENTS

- Dementia Care Call - September 22

MLN MATTERS® ARTICLES

- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act - Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 - Revised

MLN Connects Special Edition - September 17, 2020 - Nursing Home COVID-19 Commission Findings, Oregon Wildfires, & Flu

INDEPENDENT NURSING HOME COVID-19 COMMISSION FINDINGS VALIDATE UNPRECEDENTED FEDERAL RESPONSE

On September 16, CMS received the final report from the independent Coronavirus Commission for Safety and Quality in Nursing Homes (Commission), which was facilitated by MITRE. CMS also released an overview of the robust public health actions the agency has taken to date to combat the spread of the Coronavirus Disease 2019 (COVID-19) in nursing homes. The Commission's findings align with the actions the Trump Administration and CMS have taken to contain the spread of the virus and to safeguard nursing home residents from the ongoing threat of the COVID-19 pandemic. This announcement delivers on the Administration's commitments to keeping nursing home residents safe and to transparency for the American people in the face of this unprecedented pandemic.

"The Trump Administration's effort to protect the uniquely vulnerable residents of nursing homes from COVID-19 is nothing short of unprecedented," said CMS Administrator Seema Verma. "In tasking a contractor to convene this independent Commission comprised of a broad range of experts and stakeholders, President Trump sought to refine our approach still

further as we continue to battle the virus in the months to come. Its findings represent both an invaluable action plan for the future and a resounding vindication of our overall approach to date. We are grateful for the Commission's important contribution."

As the capstone to the Commission's extensive report, on September 17, Administrator Verma will join Vice President Mike Pence and CDC Director Dr. Robert R. Redfield, some members of the Commission, and other public health and elder care experts at the White House. The Vice President, Dr. Redfield, and Administrator Verma will lead the group in a discussion regarding the Commission's findings and general issues facing the nation's elder care system.

Nursing homes and other shared or congregate living facilities have been severely affected by COVID-19, as these facilities often house older individuals who suffer from multiple medical conditions, making them particularly susceptible to complications from the virus. To help CMS inform immediate and future actions as well as identify opportunities for improvement, the Commission was created to conduct an independent review and comprehensive assessments of confronting COVID-19. The Commission's report contains best practices that emphasize and reinforce CMS strategies and initiatives to ensure nursing home residents are protected from COVID-19.

As outlined in the overview released on September 16, the Trump Administration has already taken significant steps to implement many of the Commission's findings. The Administration has worked to support nursing homes financially during this challenging time, distributing over $21 billion to America's nursing homes - more than $1.5 million each on average. To ensure nursing homes had access to supplies, the Trump Administration shipped a 14-day supply of personal protective equipment to more than 15,000 nursing homes across the Nation in May.

The Administration has also required facilities to report data about COVID-19 cases, deaths, and supply levels, with 99.3 percent of facilities currently reporting. CMS took action to keep COVID-19 out of nursing homes by requiring them to test staff, a requirement that was paired with the Administration's distribution of 13,850 point-of-care testing devices to America's nursing homes. The Administration has also deployed federal Task Force Strike Teams in six waves, in 18 states so far, to 61 facilities particularly affected by COVID-19 to share best practices and gain a deeper understanding of how the virus spreads. CMS also required states to conduct focused infection control inspections at their nursing homes; between June and July, states completed these inspections at 99.8 percent of Medicare and Medicaid certified nursing homes.

Additionally, since March, CMS has conducted weekly calls with nursing homes, issued over 22 guidance documents and established a National Nursing Home COVID-19 Training program focused on infection control and best practices. CMS is also using COVID-19 data to target support to the highest risk nursing homes. In May, CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to nursing homes. The toolkit is a catalogue of resources dedicated to addressing the specific challenges facing nursing homes as they combat COVID-19. CMS updates the toolkit on a biweekly basis.

For More Information:

- Coronavirus Commission for Safety and Quality in Nursing Homes Report
- Trump Administration Response to Commission findings
- COVID-19 Guidance and Updates for Nursing Homes during COVID-19

See the full text of this excerpted CMS Press Release (issued September 16), including a list of CMS public health actions for nursing homes on COVID-19 to date.

CMS OFFERS COMPREHENSIVE SUPPORT FOR OREGON DUE TO WILDFIRES

On September 17, CMS announced efforts underway to support Oregon in response to wildfires across the state. On September 16, HHS Secretary Alex Azar declared a Public Health Emergency (PHE) in Oregon, retroactive to September 8. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of the wildfires. CMS provided numerous waivers to health care providers during the current Coronavirus Disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. These waivers will continue be available to health care providers to use for the duration of the COVID-19 PHE and for the wildfires PHEs. CMS will be waiving certain Medicare, Medicaid, and Children's Health Insurance Program requirements; creating special enrollment opportunities for individuals to access health care quickly; and taking steps to ensure dialysis patients obtain critical life-saving services.

For More Information, visit https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/EPRO-Home. See the full text of this excerpted CMS Press Release (issued September 17).

PROTECT YOURSELF & YOUR PATIENTS FROM FLU THIS SEASON

Do your part to prevent the spread of seasonal flu. The CDC published flu vaccine recommendations for the 2020-2021 season. Because of the COVID-19 pandemic, reducing the spread of respiratory illness, like flu, this fall and winter is more important than ever.

Frequency and Coverage:

- Medicare Part B covers one flu shot per flu season and additional flu shots if medically necessary
- Flu shots are free for your Medicare patients if you accept assignment

You can give pneumonia and flu shots during the same office visit; see CDC recommendations.

The CDC, the Advisory Committee on Immunization Practices, and the Healthcare Infection Control Practices Advisory Committee recommend that all U.S. health care workers get annual flu shots.

For More Information:

- CMS Flu Shot webpage
- CDC Flu website
- CDC Information for Health Professionals webpage
- CDC Fight Flu Toolkit webpage
- Vaccines.gov

MLN Connects Special Edition - September 18, 2020 - New COVID-19 Nursing Home Visitation Guidance, Kidney Disease Care Model, & Radiation Oncology Payment Model

CMS ANNOUNCES NEW GUIDANCE FOR SAFE VISITATION IN NURSING HOMES DURING COVID-19 PUBLIC HEALTH EMERGENCY

On September 17, CMS issued revised guidance providing detailed recommendations on ways nursing homes can safely facilitate visitation during the coronavirus disease 2019 (COVID-19) pandemic. After several months of visitor restrictions designed to slow the spread of COVID-19, CMS recognizes that physical separation from family and other loved ones has taken a significant toll on nursing home residents. In light of this, and in combination with increasingly available data to guide policy development, CMS is issuing revised guidance to help nursing homes facilitate visitation in both indoor and outdoor settings and in compassionate care situations. The guidance also outlines certain core principles and best practices to reduce the risk of COVID-19 transmission to adhere to during visitations.

See the full text of this excerpted CMS Press Release (issued September 17).

CMS ANNOUNCES TRANSFORMATIVE NEW MODEL OF CARE FOR MEDICARE BENEFICIARIES WITH CHRONIC KIDNEY DISEASE

Model focuses on reducing costs and improving quality of care for patients

On September 18, CMS announced it has finalized the End-Stage Renal Disease (ESRD) Treatment Choices (ETC) Model, to improve or maintain the quality of care and reduce Medicare expenditures for patients with chronic kidney disease. The ETC Model delivers on President Trump's Advancing Kidney Health Executive Order and encourages an increased use of home dialysis and kidney transplants to help improve the quality of life of Medicare beneficiaries with ESRD. The ETC Model will impact approximately 30 percent of kidney care providers and will be implemented on January 1, 2021 at an estimated savings of $23 million over five and a half years.

"Over the past year, the Trump Administration has taken more action to advance American kidney health than we've seen in decades," said HHS Secretary Alex Azar. "This new payment model helps address a broken set of incentives that have prevented far too many Americans from benefiting from enjoying the better lives that could come with more convenient dialysis options or the possibility of a transplant."

For More Information:

- Full Press Release
- Fact Sheet

CMS ANNOUNCES INNOVATIVE PAYMENT MODEL TO IMPROVE CARE, LOWER COSTS FOR CANCER PATIENTS

Radiation Oncology Model will modernize Medicare payments for radiotherapy services

On September 18, CMS finalized a new Innovation Center model expected to improve the quality of care for cancer patients receiving radiotherapy and reduce Medicare expenditures through bundled payments that allow providers to focus on delivering high-quality treatments. The new Radiation Oncology (RO) Model allows this focus on value-based care by creating simpler, more predictable payments that incentivize cost-efficient and clinically effective treatments to improve quality and outcomes. The RO Model, part of a final rule on specialty care models issued by CMS, will begin on January 1, 2021 and is estimated to save Medicare $230 million over 5 years.

"President Trump knows that, for cancer patients, what matters is their quality of life and beating their cancer. But today, Medicare payment for radiotherapy is based on the number of treatments a patient receives and where they receive it, which can lead to spending more time traveling for treatment with little clinical value," said CMS Administrator Seema Verma. "That's why the Trump administration has developed a new innovative model that allows patients and providers to focus on better outcomes for patients."

For More information:

- Full Press Release
- Fact Sheet
- Radiation Oncology Model webpage

These Models are a part of a CMS final rule on Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures (CMS-5527-F).

MLN Connects - September 24, 2020

Need Help Checking Medicare Eligibility?

MLN Connects® for Thursday, September 24, 2020
View this edition as a PDF

NEWS

- CMS to Expand Successful Ambulance Program Integrity Payment Model Nationwide
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- COVID-19: Maintaining Safety, Critical Care Load-Balancing, & Behavioral Health
- National Cholesterol Education Month & World Heart Day

CLAIMS, PRICERS & CODES

- Medicare Diabetes Prevention Program: Valid Claims

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - September 24

MLN MATTERS® ARTICLES

- 2021 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update
- National Coverage Determination (NCD 90.2): Next Generation Sequencing (NGS) for Medicare Beneficiaries with Germline (Inherited) Cancer
- Update to the Medicare Claims Processing Manual
- Update to the Model Admission Questions for Providers to Ask Medicare Beneficiaries - Revised

PUBLICATIONS

- Checking Medicare Eligibility

MLN Connects - October 01, 2020

Hospital Price Transparency: Requirements Effective January 1

MLN Connects® for Thursday, October 1, 2020
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Editor's Note:

This edition includes a new section, Information for Your Medicare Patients, which mirrors information your patients get from Medicare. We'll include occasional messages to help you answer questions from your patients.

NEWS

- Hospital Price Transparency: Requirements Effective January 1
- IRF Provider Preview Reports: Review Your Data by October 26
- LTCH Provider Preview Reports: Review Your Data by October 26
- Therapeutic Injections and Infusions: Comparative Billing Report
- SNF Healthcare-Associated Infections Confidential Dry Run Report
- COVID-19: Optimizing Health Care PPE and Supplies
- Hospice Quality Reporting Program News
- October is National Breast Cancer Awareness Month

MLN MATTERS® ARTICLES

- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.0, Effective January 1, 2021
- Change to the Payment of Allogeneic Stem Cell Acquisition Services - Revised
- New Physician Specialty Code for Micrographic Dermatologic Surgery (MDS) and Adult Congenital Heart Disease (ACHD) and a New Supplier Specialty Code for Home Infusion Therapy Services - Revised
- October 2020 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised
- October 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation - Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised

MULTIMEDIA

- ICD-10 Coordination and Maintenance Committee Meeting Materials
- SNF Consolidated Billing Web-Based Training Course - Revised

INFORMATION FOR MEDICARE PATIENTS

- Making Insulin More Affordable for Medicare Patients Beginning January 1

MLN Connects - October 08, 2020

17 Provider Compliance Tips Fact Sheets

MLN Connects® for Thursday, October 8, 2020
View this edition as a: Webpage | PDF

NEWS

- Hospice Quality Reporting Program: Successful Facilities for FY 2021

- Laboratories: Pay Your CLIA Certification Fees Online
- Institutional Providers: Give Us Your Feedback on the Provider Specific File by November 1
- Submit Medicare GME Affiliation Agreements during COVID-19 PHE by January 1
- COVID-19: Optimizing PPEand Child Health and Wellness
- Ostomies are Life-Savers

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - October 8

PUBLICATIONS

- Laboratory Quick Start Guide for CLIA Certification
- Provider Compliance Tips - Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets - Revised
- DMEPOS Accreditation - Revised
- SNF and LTCH Quality Reporting Programs: COVID-19 Public Reporting - Revised

MULTIMEDIA

- Dementia Care Call: Audio Recording and Transcript

MLN Connects Special Edition - October 08, 2020 - CMS Announces New Repayment Terms for Medicare Loans Made to Providers During COVID-19

NEW RECOUPMENT TERMS ALLOW PROVIDERS AND SUPPLIERS ONE ADDITIONAL YEAR TO START LOAN PAYMENTS

CMS announced amended terms for payments issued under the Accelerated and Advance Payment (AAP) Program as required by recent action by President Trump and Congress. This Medicare loan program allows CMS to make advance payments to providers, which are typically used in emergency situations. Under the Continuing Appropriations Act, 2021 and Other Extensions Act, repayment will now begin one year from the issuance date of each provider or supplier's accelerated or advance payment. CMS issued $106 billion in payments to providers and suppliers in order to alleviate the financial burden health care providers faced while experiencing cash flow issues in the early stages of combating the Coronavirus Disease 2019 (COVID-19) public health emergency.

"In the throes of an unprecedented pandemic, providers and suppliers on the frontlines needed a lifeline to help keep them afloat," said CMS Administrator Seema Verma. "CMS' advanced payments were loans given to providers and suppliers to avoid having to close their doors and potentially causing a disruption in service for seniors. While we are seeing patients return to hospitals and doctors providing care we are not yet back to normal," she added.

CMS expanded the AAP Program on March 28, 2020, and gave these loans to health care providers and suppliers in order to combat the financial burden of the pandemic. CMS successfully paid more than 22,000 Part A providers, totaling more than $98 billion in accelerated payments. This included payments to Part A providers for Part B items and services they furnished. In addition, more than 28,000 Part B suppliers, including doctors, non-physician practitioners, and durable medical equipment suppliers received advance payments totaling more than $8.5 billion.

Providers were required to make payments starting in August of this year, but with this action, repayment will be delayed until one year after payment was issued. After that first year, Medicare will automatically recoup 25% of Medicare payments otherwise owed to the provider or supplier for 11 months. At the end of the 11-month period, recoupment will increase to 50% for another 6 months. If the provider or supplier is unable to repay the total amount of the AAP during this time-period (a total of 29 months), CMS will issue letters requiring repayment of any outstanding balance, subject to an interest rate of 4%.

The letter also provides guidance on how to request an Extended Repayment Schedule (ERS) for providers and suppliers who are experiencing financial hardships. An ERS is a debt installment payment plan that allows a provider or supplier to pay debts over the course of 3 years, or, up to 5 years in the case of extreme hardship. Providers and suppliers are encouraged to contact their MAC for information on how to request an ERS. To allow even more flexibility in paying back the loans, the $175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans. CMS will be communicating

with each provider and supplier in the coming weeks as to the repayment terms and amounts owed as applicable for any accelerated or advance payment issued.

For More Information:

- Fact Sheet
- FAQs

MLN Connects - October 15, 2020

COVID-19 Testing: Protecting Integrity

MLN Connects® for Thursday, October 15, 2020
View this edition as a: Webpage | PDF

NEWS

- CMS Takes Action to Protect Integrity of COVID-19 Testing
- Protect Your Patients: Give Them a Flu Shot

EVENTS

- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast - October 29

MLN MATTERS® ARTICLES

- New Waived Tests
- January 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- October 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.3 - Revised
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2021 - Revised

PUBLICATIONS

- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies - Revised

MULTIMEDIA

- Coverage of an Annual Wellness Visit Video

INFORMATION FOR MEDICARE PATIENTS

- Medicare Health and Drug Plans Receive Star Ratings

MLN Connects Special Edition - October 15, 2020 - Trump Administration Drives Telehealth Services in Medicaid and Medicare

On October 14, CMS expanded the list of telehealth services that Medicare Fee-for-Service will pay for during the COVID-19 Public Health Emergency (PHE). CMS is also providing additional support to state Medicaid and Children's Health Insurance Program (CHIP) agencies in their efforts to expand access to telehealth. The actions reinforce President Trump's Executive Order on Improving Rural Health and Telehealth Access to improve the health of all Americans by increasing access to better care.

"Responding to President Trump's Executive Order, CMS is taking action to increase telehealth adoption across the country," said CMS Administrator Seema Verma. "Medicaid patients should not be forgotten, and today's announcement promotes telehealth for them as well. This revolutionary method of improving access to care is transforming health care delivery in America. President Trump will not let the genie go back into the bottle."

Expanding Medicare Telehealth Services:

For the first time using a new expedited process, CMS added 11 new services to the Medicare telehealth services list since the publication of the May 1 COVID-19 Interim Final Rule with comment period (IFC). Medicare will begin paying eligible practitioners who furnish these newly added telehealth services effective immediately and for the duration of the PHE. These new telehealth services include certain neurostimulator analysis and programming services, and cardiac and pulmonary rehabilitation services. The list of these newly added services is available on the List of Telehealth Services webpage.

In the May 1 COVID-19 IFC, CMS modified the process for adding or deleting services from the Medicare telehealth services list to allow for expedited consideration of additional telehealth services during the PHE outside of rulemaking. This update to the Medicare telehealth services list builds on the efforts CMS has already taken to increase Medicare beneficiaries' access to telehealth services during the COVID-19 PHE.

Since the beginning of the PHE, CMS added over 135 services to the Medicare telehealth services list - such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services. With this action, Medicare will pay for 144 services performed via telehealth. Between mid-March and mid-August, over 12.1 million Medicare beneficiaries - over 36% - of people with Medicare Fee-for-Service received a telemedicine service.

Preliminary Medicaid and CHIP Data Snapshot on Telehealth Utilization and Medicaid & CHIP Telehealth Toolkit Supplement:

In an effort to provide greater transparency on telehealth access in Medicaid and CHIP, CMS released, for the first time, a preliminary Medicaid and CHIP data snapshot on telehealth utilization during the PHE. This snapshot shows, among other things, that there have been more than 34.5 million services delivered via telehealth to Medicaid and CHIP beneficiaries between March and June of this year, representing an increase of more than 2,600% when compared to the same period from the prior year. The data also shows that adults ages 19-64 received the most services delivered via telehealth, although there was substantial variance across both age groups and states.

To further drive telehealth, CMS released a new supplement to its State Medicaid & CHIP Telehealth Toolkit: Policy Considerations for States Expanding Use of Telehealth, COVID-19 Version that provides numerous new examples and insights into lessons learned from states that implemented telehealth changes. The updated supplemental information is intended to help states strategically think through how they explain and clarify to providers and other stakeholders which policies are temporary or permanent. It also helps states identify services that can be accessed through telehealth, which providers may deliver those services, the ways providers may use in order to deliver services through telehealth, as well as the circumstances under which telehealth can be reimbursed once the PHE expires.

The toolkit includes approaches and tools states can use to communicate with providers on utilizing telehealth for patient care. It updates and consolidates in one place the FAQs and resources for states to consider as they begin planning beyond the temporary flexibilities provided in response to the pandemic.

View the Medicaid and CHIP data snapshot on telehealth utilization during the PHE.

MLN Connects Special Edition - October 16, 2020 - Enforcement Discretion Relating to Certain Pharmacy Billing

The Centers for Medicare & Medicaid Services ("CMS") appreciates its long-standing partnership with immunizers, including pharmacies, to facilitate the efficient administration of vaccinations, particularly for vulnerable populations in long-term care facilities and other congregate care settings across America. Leveraging immunizers' capabilities and expertise will play an important role in the Department's ability to broadly distribute and administer COVID-19 vaccinations, including Medicare beneficiaries.

America is facing an unprecedented challenge. Quickly, safely, and effectively vaccinating our most vulnerable citizens in settings that have accounted for about 30 percent of U.S. COVID-19 deaths is a top-priority mission for the Trump Administration. Unfortunately, many long-term care facilities may not have sufficient capacity to receive, store, and administer vaccines. And some long-term care facility residents cannot safely leave the facility to receive vaccinations.

Outside immunizers can help fill that urgent need and provide onsite vaccinations at skilled nursing facilities ("SNFs"). But to do so during this global emergency, Medicare-enrolled vaccinators must be able to bill directly and receive direct reimbursement from the Medicare program. However, the Social Security Act requires SNFs to bill for certain services, including vaccine administration, even when SNFs rely on an outside vendor to perform the service. See Social Security Act §§ 1862(a)(18), 1842(b)(6)(E).

Therefore, in order to facilitate the efficient administration of COVID-19 vaccines to SNF residents, CMS will exercise enforcement discretion with respect to these statutory provisions as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance (collectively, "SNF Consolidated Billing Provisions"). Through the exercise of that discretion, CMS will allow Medicare-enrolled immunizers, including but not limited to pharmacies working with the United States, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare SNF residents.

CMS will exercise such discretion (1) during the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. § 1320b-5(g)) and ending on the last day of the calendar quarter in which the last day of such emergency period occurs; or (2) so long as CMS determines that there is a public health need for mass COVID-19 vaccinations in congregate care settings-whichever is later. While CMS exercises this enforcement discretion, compliance with SNF Consolidated Billing Provisions is not material to CMS' decision to reimburse for COVID-19 vaccine administration. If CMS decides in the future to cease exercising this enforcement discretion, CMS will provide public notice in advance and allow at least 60 days for affected outside immunizers to modify their business practices.

MLN Connects - October 22, 2020

Medicare Coverage for Opioid Use Disorder Treatment

MLN Connects® for Thursday, October 22, 2020
View this edition as a: Webpage | PDF

NEWS

- Opioid Use Disorder Treatment: Medicare Coverage
- Clinical Diagnostic Laboratory Tests Advisory Panel: Request for Nominations
- Medicare Diabetes Prevention Program: Become a Medicare-Enrolled Supplier

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - October 22
- Medicare Part A Cost Report: New Bulk e-Filing Feature Webcast - October 29

MLN MATTERS® ARTICLES

- Ambulance Inflation Factor (AIF) for Calendar Year (CY) 2021 and Productivity Adjustment
- Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised
- New Waived Tests - Revised

MULTIMEDIA

- Nursing Home COVID-19 Preparedness for Fall & Winter Web-Based Training

INFORMATION FOR MEDICARE PATIENTS

- Diabetes Management Resources

MLN Connects Special Edition - October 27, 2020

NEW CMS PROPOSALS STREAMLINE MEDICARE COVERAGE, PAYMENT, AND CODING FOR INNOVATIVE NEW TECHNOLOGIES AND PROVIDE BENEFICIARIES WITH DIABETES ACCESS TO MORE THERAPY CHOICES

Durable Medical Equipment (DME) proposed rule would reduce administrative burden for new innovative technologies

On October 27, under the leadership of President Trump, CMS proposed new changes to Medicare Durable Medical Equipment, Prosthetics, Orthotic Devices, and Supplies (DMEPOS) coverage and payment policies. This rule would provide more choices for beneficiaries with diabetes, while streamlining the process for innovators in getting their technologies approved for coverage, payment, and coding by Medicare.

The proposed rule would expand the interpretation regarding when external infusion pumps are appropriate for use in the home and can be covered as DME under Medicare Part B, increasing access to drug infusion therapy services in the home. The proposed rule also drastically reduces administrative burdens - such as complicated government coverage, payment, and coding processes - that block innovators from getting their products to Medicare beneficiaries in a timely manner. This action aligns with President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors.

"With the policies outlined in this proposed rule, innovators have a much more predictable path to understanding the kinds of products that Medicare will pay for," said CMS Administrator Seema Verma. "For manufacturers, bringing a new product to market will mean they can get a Medicare payment amount and billing code right off the bat, resulting in quicker access for Medicare beneficiaries to the latest technological advances and the most, cutting-edge devices available. It's clearly a win-win for patients and innovators alike."

Due to administrative constraints, the process for making Medicare benefit classifications, pricing determinations, and creating billing codes for DMEPOS used to routinely take up to 18 months to complete. Last year, CMS changed this process through sub-regulatory guidance to reduce that timeframe to six months in many cases, and is now proposing to establish a streamlined process for coding, coverage, and payment in regulation. Under this accelerated process, benefit classification and pricing decisions could happen on the same day the billing codes used for payment of new items take effect, which would facilitate seamless coverage and payment for new DMEPOS and services. If finalized, this proposed rule would allow innovators to bring their products to Medicare beneficiaries quicker giving them more choices and increased access to the latest, cutting-edge devices.

If finalized, this proposed rule will also expand Medicare coverage and payment for Continuous Glucose Monitors (CGMs) that provide critical information on blood glucose levels to help patients with diabetes manage their disease. Currently, CMS only covers therapeutic CGMs or those approved by the FDA for use in making diabetes treatment decisions, such as changing one's diet or insulin dosage based solely on the readings of the CGM.

CMS is proposing to classify all CGMs (not just limited to therapeutic CGMs) as DME and establish payment amounts for these items and related supplies and accessories. CGMs that are not approved for use in making diabetes treatment decisions can be used to alert beneficiaries about potentially dangerous glucose levels while they sleep and that they should further test their glucose levels using a blood glucose monitor. With one in every three Medicare beneficiaries having diabetes, this proposal would give Medicare beneficiaries and their physicians a wider range of technology and devices to choose from in managing diabetes. This proposal will improve access to these medical technologies and empower patients to make the best health care decisions for themselves.

In addition, the proposed rule would expand classification of external infusion pumps under the DME benefit making home infusion of more drugs possible for beneficiaries. An external infusion pump is a medical device used to deliver fluids such as nutrients or medications into a patient's body in a controlled manner. The proposal would expand classification of external infusion pumps as DME in cases where assistance from a skilled home infusion therapy supplier is necessary for safe infusion in the home, allowing beneficiaries more choices to get therapies at home instead of traveling to a health care facility.

Lastly, in the proposed rule, CMS proposes to continue to pay higher amounts to suppliers for DMEPOS items and services furnished in rural and non-contiguous areas to encourage suppliers to provide access and choices for beneficiaries living in those areas. CMS is making this proposal based on previous stakeholder feedback that indicate unique challenges and higher costs for providing for DMEPOS items for beneficiaries in rural and remote areas.

For More Information:

- Proposed Rule
- Fact Sheet

MLN Connects Special Edition - October 28, 2020 - Trump Administration Acts to Ensure Coverage of Life-Saving COVID-19 Vaccines & Therapeutics

Under President Trump's leadership, CMS is taking steps to ensure all Americans, including the nation's seniors, have access to the coronavirus disease 2019 (COVID-19) vaccine at no cost when it becomes available. On October 28, the agency released a comprehensive plan with proactive measures to remove regulatory barriers and ensure consistent coverage and payment for the administration of an eventual vaccine for millions of Americans. CMS released a set of toolkits for providers, states and

insurers to help the health care system prepare to swiftly administer the vaccine once it is available. These resources are designed to increase the number of providers that can administer the vaccine, ensure adequate reimbursement for administering the vaccine in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover the vaccine at no charge to beneficiaries. In addition, CMS is taking action to increase reimbursement for any new COVID-19 treatments that are approved or authorized by the FDA.

"Under President Trump's leadership, we have developed a comprehensive plan to support the swift and successful distribution of a safe and effective vaccine for COVID-19," said CMS Administrator Seema Verma. "As Operation Warp Speed nears its goal of delivering the vaccine in record time, CMS is acting now to remove bureaucratic barriers while ensuring that states, providers and health plans have the information and direction they need to ensure broad vaccine access and coverage for all Americans."

To ensure broad access to a vaccine for America's seniors, CMS released an Interim Final Rule with Comment Period (IFC) that establishes that any vaccine that receives Food and Drug Administration (FDA) authorization, either through an Emergency Use Authorization (EUA) or licensed under a Biologics License Application (BLA), will be covered under Medicare as a preventive vaccine at no cost to beneficiaries. The IFC also implements provisions of the CARES Act that ensure swift coverage of a COVID-19 vaccine by most private health insurance plans without cost sharing from both in and out-of-network providers during the course of the public health emergency (PHE).

In anticipation of the availability of new COVID-19 treatments, the IFC also establishes additional Medicare hospital payment to support Medicare patients' access to these potentially life-saving COVID-19 therapies. In Medicare, hospitals are generally reimbursed a fixed payment amount for the services they provide during an inpatient stay, even if their costs exceed that amount. Under current rules, hospitals may qualify for additional "outlier payments," but only when their costs for a particular patient exceed a certain threshold. Under this IFC, hospitals would qualify for additional payments when they treat patients with innovative new products approved or authorized to treat COVID-19 to mitigate any losses they may experience from making these therapies available, even if they do not reach the current outlier threshold. The IFC also makes changes to reimbursement for outpatient hospital services to ensure payment for certain innovative treatments for COVID-19 that occur outside of bundled arrangements and are paid separately. In addition, CMS released information to prepare hospitals to bill for the outpatient administration of a monoclonal antibody product in the event one is approved under an emergency use authorization (EUA).

This rule also allows states to employ a broad range of strategies - based on local needs - to appropriately manage their Medicaid program costs. The guidance and flexibility provided to states in the IFC will help them maintain Medicaid beneficiary enrollment while receiving the temporary increase in federal funding in the Families First Coronavirus Response Act (FFCRA).

CMS is also taking continued steps to ensure that price transparency extends to COVID-19 testing during the PHE. Provisions in the IFC require that any provider who performs a COVID-19 diagnostic test post their cash prices online. Providers that are non-compliant may face civil monetary penalties.

In addition to these provisions, the IFC:

- Provides an extension of Performance Year 5 for the Comprehensive Care for Joint Replacement (CJR) model; and
- Creates flexibilities in the public notice requirements and post-award public participation requirements for a State Innovation Waiver under Section 1332 of the Patient Protection and Affordable Care Act during the COVID-19 PHE.

Along with these regulatory changes, CMS is issuing three toolkits aimed at state Medicaid agencies, providers who will administer the vaccine, and health insurance plans. Together, these toolkits will help ensure the health care system is prepared to successfully administer a safe and effective vaccine by addressing issues related to access, billing and payment, and coverage.

Increasing Access to Vaccines for Medicare & Medicaid Beneficiaries

The toolkits issued today give health care providers not currently enrolled in Medicare the information needed to administer and bill vaccines to Medicare patients. CMS is working to increase the number of providers that will administer a COVID-19 vaccine to Medicare beneficiaries when it becomes available, to make it as convenient as possible for America's seniors. New providers are now able to enroll as a "Medicare mass immunizers" through an expedited 24-hour process. The ability to easily enroll as a mass immunizer is important for some pharmacies, schools, and other entities that may be non-traditional providers or otherwise not eligible for Medicare enrollment. To further increase the number of providers who can administer

the COVID -19 vaccine, CMS will continue to share approved Medicare provider information with states to assist with Medicaid provider enrollment efforts. CMS is also making it easier for newly enrolled Medicare providers to also enroll in state Medicaid programs to support state administration of vaccines for Medicaid recipients.

Coverage

As a condition of receiving free COVID-19 vaccines from the federal government, providers will be prohibited from charging consumers for administration of the vaccine. To ensure broad and consistent coverage across programs and payers, the toolkits have specific information for several programs, including:

Medicare: Beneficiaries with Medicare pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicare Advantage (MA): For calendar years 2020 and 2021, Medicare will pay directly for the COVID-19 vaccine and its administration for beneficiaries enrolled in MA plans. MA plans would not be responsible for reimbursing providers to administer the vaccine during this time. Medicare Advantage beneficiaries also pay nothing for COVID-19 vaccines and their copayment/coinsurance and deductible are waived.

Medicaid: State Medicaid and CHIP agencies must provide vaccine administration with no cost sharing for most beneficiaries during the public health emergency. Following the public health emergency, depending on the population, states may have to evaluate cost sharing policies and may have to submit state plan amendments if updates are needed.

Private Plans: CMS, along with the Departments of Labor and the Treasury, is requiring that most private health plans and issuers cover a recommended COVID-19 vaccine and its administration, both in-network and out-of-network, with no cost sharing. The rule also provides that out-of-network rates cannot be unreasonably low, and references CMS's reimbursement rates as a potential guideline for insurance companies.

Uninsured: For individuals who are uninsured, providers will be able to be reimbursed for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by the Health Resources and Services Administration (HRSA).

Billing and Payment

The toolkits also address issues related to billing and payment. After the FDA either approves or authorizes a vaccine for COVID-19, CMS will identify the specific vaccine codes, by dose if necessary, and specific vaccine administration codes for each dose for Medicare payment. CMS and the American Medical Association (AMA) are working collaboratively on finalizing a new approach to report use of COVID-19 vaccines, which include separate vaccine-specific codes. Providers and insurance companies will be able to use these to bill for and track vaccinations for the different vaccines that are provided to their enrollees.

Medicare Payment

CMS also released new Medicare payment rates for COVID-19 vaccine administration. The Medicare payment rates will be $28.39 to administer single-dose vaccines. For a COVID-19 vaccine requiring a series of two or more doses, the initial dose(s) administration payment rate will be $16.94, and $28.39 for the administration of the final dose in the series. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. Medicare beneficiaries, those in Original Medicare or enrolled in Medicare Advantage, will be able to get the vaccine at no cost.

CMS is encouraging state policymakers and other private insurance agencies to utilize the information on the Medicare reimbursement strategy to develop their vaccine administration payment plan in the Medicaid program, CHIP, the Basic Health Program (BHP), and private plans. Using the Medicare strategy as a model would allow states to match federal efforts in successfully administering the full vaccine to the most vulnerable populations.

The IFC (CMS-9912-IFC) is scheduled to display at the Federal Register as soon as possible with an immediate effective date and a 30-day comment period.

For More Information:

- Fact Sheet
- COVID-19 vaccine resources for providers, health plans and State Medicaid programs
- FAQs on billing for therapeutics

MLN Connects - October 29, 2020

Quality Payment Program APMs: Update Billing Information to Get Paid

MLN Connects® for Thursday, October 29, 2020
View this edition as a: Webpage | PDF

NEWS

- Quality Payment Program APMs: Update Billing information by November 13

COMPLIANCE

- Hospice Aide Services: Enhancing RN Supervision

MLN MATTERS® ARTICLES

- Change to the Payment of Allogeneic Stem Cell Acquisition Services - Revised

PUBLICATIONS

- Medicare Quarterly Provider Compliance Newsletter

MLN Connects Special Edition - November 3, 2020 - ESRD & Home Health Payment Rules

ESRD PPS: CY 2021 PAYMENT POLICIES AND RATES

On November 2, CMS issued a final rule that updates payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries enrolled in Original Medicare on or after January 1, 2021. This rule also updates the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI and finalizes changes to the ESRD Quality Incentive Program.

The final CY 2021 ESRD PPS base rate is $253.13, which represents an increase of $13.80 to the current base rate of $239.33. This amount reflects the application of the updated wage index budget-neutrality adjustment factor (.999485), the addition to the base rate of $9.93 to include calcimimetics, and a productivity-adjusted market basket increase, as required by section 1881(b)(14)(F)(i)(I) of the Act (1.6 percent), equaling $253.13 (($239.33 x .999485) + $9.93 x 1.016 = $253.13).

CMS finalized the following:

- Update to the ESRD PPS wage index to adopt the 2018 Office of Management and Budget delineations with a transition period
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- Change to the low-volume payment adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency

For More Information:

- Final rule
- Press release
- Full text of fact sheet

HOME HEALTH AGENCIES: CY 2021 PAYMENT AND POLICY CHANGES AND HOME INFUSION THERAPY BENEFIT

On October 29, CMS issued a final rule that finalizes routine updates to the home health payment rates for Calendar Year (CY) 2021 in accordance with existing statutory and regulatory requirements. This rule also finalizes the regulatory changes related to the use of telecommunications technology in providing care under the Medicare home health benefit.

CMS estimates that Medicare payments to Home Health Agencies (HHAs) in CY 2021 will increase in the aggregate by 1.9 percent, or $390 million, based on the finalized policies. This increase reflects the effects of the 2.0 percent home health payment update percentage ($410 million increase) and a 0.1 percent decrease in payments due to reductions in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018 for CY 2021 ($20 million decrease). This rule also updates the home health wage index including the adoption of revised Office of Management and Budget statistical area delineations and limiting any decreases in a geographic area's wage index value to no more than 5 percent in CY 2021.

This final rule also:

- Finalizes Medicare enrollment policies for qualified home infusion therapy suppliers
- Updates the home infusion therapy services payment rates for CY 2021
- Finalizes a policy excluding home infusion therapy services from home health services as required by law
- Finalizes policies under the Home Health Value Based Purchasing Model published in the interim final rule with comment period, as required by law

For More Information:

- Final rule
- Home Health Prospective Payment System website
- HHA Center webpage
- Home Health Patient-Driven Groupings Model webpage
- Home Infusion Therapy Services website
- Full text of Fact Sheet

CMS' NEW ONE-STOP NURSING HOME RESOURCE CENTER ASSISTS PROVIDERS, CAREGIVERS, RESIDENTS

On October 30, CMS launched a new online platform - the Nursing Home Resource Center - to serve as a centralized hub bringing together the latest information, guidance, and data on nursing homes that is important to facilities, frontline providers, residents, and their families, especially as the fight against COVID-19 continues.

The Resource Center consolidates all nursing home information, guidance, and resources into a user-friendly, one-stop-shop that is easily navigable so providers and caregivers can spend less time searching for critical answers and more time caring for residents. Moreover, the new platform contains features specific to residents and their families, ensuring they have the information needed to make empowered decisions about their health care.

With the new page, people can efficiently navigate all facility inspection reports and data - including COVID-19 pandemic and Public Health Emergency (PHE) information. This tool will remain active through and beyond the COVID-19 PHE.

Full text of News Alerts.

MLN Connects - November 5, 2020

COVID-19 Vaccine: Find Out How to Prepare

MLN Connects® for Thursday, November 5, 2020
View this edition as a: Webpage | PDF

NEWS

- COVID-19 Vaccine: Find Out How to Prepare
- Hospital Price Transparency: Requirements Effective January 1
- SNF Quality Reporting Program: October Refresh
- Flu Shots: Each Visit is an Opportunity

COMPLIANCE

- Inhalant Drugs: Bill Correctly

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - November 5

MLN MATTERS® ARTICLES

- Special Provisions for Radiology Additional Documentation Requests
- Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers
- October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule - Revised
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission -- Implementation - Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2020 Update - Revised

PUBLICATIONS

- Medicare Wellness Visits

MULTIMEDIA

- SNF Quality Reporting Program: Confusion Assessment Method Video Tutorial
- SNF Quality Reporting Program: Brief Interview for Mental Status Video Tutorial

MLN Connects Special Edition - November 11, 2020 - CMS Takes Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment

COVERAGE AVAILABLE AT NO COST TO BENEFICIARIES ACROSS VARIETY OF SETTINGS IN HEALTH CARE SYSTEM

CMS announced that starting November 10, Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost-sharing during the Public Health Emergency (PHE). CMS' coverage of monoclonal antibody infusions applies to bamlanivimab, which received an Emergency Use Authorization (EUA) from the FDA on November 9.

"Today, CMS is announcing a historic, first-of-its kind policy that drastically expands access to COVID-19 monoclonal antibodies to beneficiaries without cost sharing," said CMS Administrator Seema Verma. "Our timely approach means beneficiaries can receive these potentially life-saving therapies in a range of settings - such as in a doctor's office, nursing home, infusion centers, as long as safety precautions can be met. This aggressive action and innovative approach will undoubtedly save lives."

CMS anticipates that this monoclonal antibody product will initially be given to health care providers at no charge. Medicare will not pay for the monoclonal antibody products that providers receive for free but this action provides for reimbursement for the infusion of the product. When health care providers begin to purchase monoclonal antibody products, Medicare anticipates setting the payment rate in the same way it set the payment rates for COVID-19 vaccines, such as based on 95% of the average wholesale price for COVID-19 vaccines in many provider settings. CMS will issue billing and coding instructions for health care providers in the coming days.

CMS anticipates the announcement will allow for a broad range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the EUA, and bill Medicare to administer these infusions.

Under section 6008 of the Families First Coronavirus Response Act (FFCRA), state and territorial Medicaid programs may receive a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), through the end of the quarter in which the COVID-19 PHE ends. A condition for receipt of this enhanced federal match is that a state or territory must cover COVID-19 testing services and treatments, including vaccines and their administration, specialized equipment, and therapies for Medicaid enrollees without cost sharing. This means that this monoclonal antibody infusion is expected to be covered when furnished to Medicaid beneficiaries, in accordance with the EUA, during this period, with limited exceptions.

View the Monoclonal Antibody COVID-19 Infusion Program Instruction.

MLN Connects - November 12, 2020

COVID-19: Non-Physician Practitioner Billing for Audio Services

MLN Connects® for Thursday, November 12, 2020
View this edition as a: Webpage | PDF

NEWS

- Critical Care: Comparative Billing Report in November
- Raising Awareness of Diabetes in November

COMPLIANCE

- SNF 3-Day Rule Billing

CLAIMS, PRICERS & CODES

- COVID-19: Non-Physician Practitioner Billing for CPT Codes 98966-98968

MLN MATTERS® ARTICLES

- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021
- Manual Updates Related to the Hospice Election Statement and the Implementation of the Election Statement Addendum
- Updates to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims

PUBLICATIONS

- Provider Compliance Tips - Revised

INFORMATION FOR MEDICARE PATIENTS

- 2021 Medicare Part B Premiums Remain Steady

MLN Connects Special Edition - November 12, 2020 - COVID-19 Vaccine Codes and PC-ACE Software Update

In anticipation of the availability of a vaccine(s), for the novel coronavirus (SARS-CoV-2) in response to the coronavirus disease 2019 (COVID-19), the American Medical Association (AMA), working with the Centers for Medicare & Medicaid Services (CMS), created new codes for the vaccine and the administration of the vaccine. To prepare for the vaccine administration claims, the PC-ACE software is also updated and ready for providers to download.

If you intend to administer the COVID-19 vaccines when they become available, or the new monoclonal antibody bamlanivimab, especially if you intend to roster bill these codes, please download and install the new release of PC-ACE. This release includes the coding structure, currently comprised of both a HCPCS Level I CPT code structure issued by the American Medical Association (AMA) and a HCPCS Level II code structure issued by CMS. Together, these codes support the administration of the COVID-19 vaccines and the monoclonal antibody infusions, as they become available; this structure includes the codes for bamlanivimab. This code structure was developed to facilitate efficient claims processing for any COVID-19 vaccines and monoclonal antibody infusions that receive FDA EUA or approval. CMS and the AMA are working collaboratively regarding which codes to submit for COVID-19 vaccines and administration. Most of these codes are not currently effective and not all codes will be used. We will issue specific code descriptors in the future. Effective dates for the codes for Medicare purposes will coincide with the date of the FDA EUA or approval.

MLN Connects - November 19, 2020

Nursing Homes: Take COVID-19 Training

MLN Connects® for Thursday, November 19, 2020
View this edition as a: Webpage | PDF

NEWS

- CMS Releases Nursing Home COVID-19 Training Data with Urgent Call to Action
- Medicare FFS Estimated Improper Payments Decline by $15 Billion Since 2016
- CMS Retiring Original Compare Tools on December 1
- COVID-19: Health Care Operations Lessons and Fostering Professional Resilience
- Medicare Diabetes Prevention Program: Become a Medicare-Enrolled Supplier
- Recognizing Lung Cancer Awareness Month and the Great American Smokeout

COMPLIANCE

- Hospice Care: Safeguards for Medicare Patients

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - November 19
- Hospital Price Transparency Webcast - December 8

MULTIMEDIA

- Part A Cost Report Webcast: Audio Recording and Transcript

MLN Connects - November 25, 2020

Hospital Price Transparency Webcast on 12/8

MLN Connects® for Wednesday, November 25, 2020
View this edition as a: Webpage | PDF

NEWS

- CMS Announces Historic Changes to Physician Self-Referral Regulations
- Policy Will Increase Number of Lifesaving Organs by Holding OPAs Accountable through Transparency and Competition
- Prescription Drug Payment Model to Put American Patients First
- DMEPOS Competitive Bidding Program: Contract Suppliers for Round 2021
- Quality Payment Program APMs: Extended Deadline to Update Billing information - December 13
- Clinical Laboratory Fee Schedule: CY 2021 Final Payment Determinations
- Hospice Quality Reporting Program: November Refresh
- November is Home Care & Hospice Month
- World AIDS Day is December 1

COMPLIANCE

- Polysomnography Services: Bill Correctly

CLAIMS, PRICERS & CODES

- Medicare Diabetes Prevention Program: Valid Claims

EVENTS

- Long-Term Services and Supports Open Door Forum - December 1
- Hospital Price Transparency Webcast - December 8
- Interoperability and Patient Access Final Rule Call - December 9

MLN MATTERS® ARTICLES

- Changes to the End-Stage Renal Disease (ESRD) PRICER to Accept the New Outpatient Provider Specific File Supplemental Wage Index Fields, the Network Reduction Calculation and New Value Code for Time on Machine
- Claim Status Category and Claim Status Codes Update
- Implementation of Two (2) New NUBC Condition Codes. Condition Code "90", "Service provided as Part of an Expanded Access Approval (EA)" and Condition Code "91", "Service Provided as Part of an Emergency Use Authorization (EUA)"
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- National Coverage Determination (NCD 90.3): Chimeric Antigen Receptor (CAR) T-cell Therapy
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021
- Update to Vaccine Services Editing
- Overview of the Repetitive Scheduled Non-emergent Ambulance Prior Authorization Model - Revised
- Billing for Home Infusion Therapy Services on or After January 1, 2021 - Revised
- Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2021 - Revised
- Update to Chapter 10 of Publication (Pub.) 100-08 - Enrollment Policies for Home Infusion Therapy (HIT) Suppliers - Revised

PUBLICATIONS

- DMEPOS Information for Pharmacies - Revised
- DMEPOS Quality Standards - Revised
- Advance Care Planning - Revised

Noridian Medicare Portal.....

Overpayment Inquiry and Overpayment Tutorials Available within NMP - Save Time and Resources

Save time and resources on phone calls by resolving overpayment questions utilizing the Noridian Medicare Portal (NMP). This self-service tool provides users the ability to check overpayments and offers self-paced, online tutorials, for all functions available in the NMP.

Check out NMP today.

Pneumococcal Vaccine Codes Available in Noridian Medicare Portal

The Noridian Medicare Portal (NMP) provides the previous service history for Pneumococcal Vaccine (PPV) HCPCS codes 90670 and 90732 in the "Preventive" section of the Eligibility inquiry response. The service history will display up to 10 previous dates of service and provide the rendering NPI.

If no PPV information is available, the HCPCS codes will not be viewable in the "Preventive" section of the Eligibility inquiry response.

Updates

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11957
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10473CP
Related Change Request (CR) Number: 11957
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

CR 11957 informs you of updates, as needed, to the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgment transactions. Make sure your billing staffs are aware of this update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11957.

HCPCS Codes for SNF CB - 2021 Annual Update

MLN Matters Number: MM11968
Related CR Release Date: September 11, 2020
Related CR Transmittal Number: R10349CP
Related Change Request (CR) Number: 11968
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 11968 makes changes to Healthcare Common Procedure Coding System (HCPCS) codes and Medicare Physician Fee Schedule (MPFS) designations that Medicare uses to revise its Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for Skilled Nursing Facility (SNF) Consolidated Billing (CB) in Chapter 6, Section 110.4.1 and Chapter 6, Section 20.6 in the Medicare Claims Processing Manual (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c06.pdf). Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11968.

January 2021 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM12020
Related CR Release Date: October 9, 2020
Related CR Transmittal Number: R10391CP
Related Change Request (CR) Number: 12020
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 12020 informs you of updates to the Quarterly Average Sales Price (ASP) Medicare Part B Pricing Files and informs providers of revisions, if needed, to prior quarterly pricing files. Please make sure your billing staffs are aware of these updates and revisions.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12020.

October Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule - Revised

MLN Matters Number: MM11956 Revised
Related CR Release Date: October 27, 2020
Related CR Transmittal Number: R10410CP
Related Change Request (CR) Number: 11956
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: CMS revised this article to reflect the revised CR11956, issued on October 27, 2020. The CR revision clarified the claims processing jurisdiction for code K1009 and CMS made that clarification in this article. Also, CMS revised the CR release date, the transmittal number, and the web address of the CR. All other information remains the same.

CR 11956 informs DME MACs about the changes to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedules that Medicare updates quarterly, when necessary, to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11956.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM11943
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10472CP
Related Change Request (CR) Number: 11943
Effective Date: April 1, 2021
Implementation: April 5, 2021

CR 11943 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the Medicare's system maintainers to update Medicare Remit Easy Print (MREP) and PC Print. Make sure billing staffs are aware of these updates. If you use the MREP or PC Print software, be sure to get the updated software.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11943.

Update to Medicare Deductible, Coinsurance and Premium Rates for Calendar Year (CY) 2021

MLN Matters Number: MM12024
Related CR Release Date: November 20, 2020
Related CR Transmittal Number: R10469GI
Related Change Request (CR) Number: 12024
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 12024 informs you of the new Calendar Year (CY) 2021 Medicare premium, coinsurance, and deductible rates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12024.