DME Happenings

Jurisdiction D

December 2021

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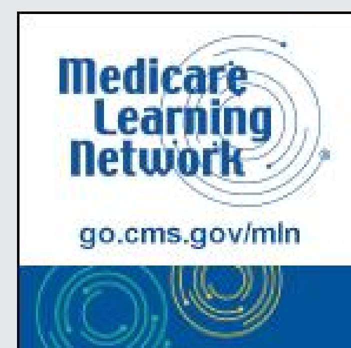

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo

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NEWS

Jurisdiction D DME MAC Supplier Contacts and Resources

PHONE NUMBERS

Department/System	Phone Number	Availability
Interactive Voice Response System (IVR)	877-320-0390	General IVR inquiries: 24/7 Claim-specific inquiries: Monday - Friday 6 a.m. - 8 p.m. CT Saturday 6 a.m. - 3 p.m. CT
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. - 6:00 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

Correspondence	When to Use This Address	Email Address
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
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
• Correspondence
• Medical Review Documentation
  ○ Complex Medical Review Response
  ○ Non-Complex Medical Review Response
• Redetermination Requests
  ○ Overpayment Redetermination and Rebuttal Requests
  ○ Recovery Auditor Redeterminations
• Refunds
• Written Reopening Requests
• Electronic Funds Transfer (EFT)
	Noridian JD DME
	Attn: __________
	PO Box 6727
	Fargo, ND 58108-6727

• Extended Repayment Schedule (ERS) • Refund Checks	Noridian JD DME Attn: Refunds PO Box 511531 Los Angeles, CA 90051-8086
Administrative Simplification Compliance Act (ASCA)	Noridian JD DME Attn: ASCA PO Box 6736 Fargo, ND 58108-6736
Benefit Integrity	Noridian JD DME Attn: Benefit Integrity PO Box 6736 Fargo, ND 58108-6736
Congressional Inquiries	Noridian JD DME Attn: Congressional PO Box 6727 Fargo, ND 58108-6727
Education	Noridian JD DME Attn: DME Education PO Box 6727 Fargo, ND 58108-6727
Freedom of Information Act (FOIA)	Noridian JD DME Attn: FOIA PO Box 6727 Fargo, ND 58108-6727
LCD: New LCD Request	Noridian JD DME Attn: New LCD Request PO Box 6742 Fargo, ND 58108-6742

Department	Address
LCD Reconsideration Request	Noridian JD DME Attn: DME LCD Reconsiderations PO Box 6742 Fargo, ND 58108-6742
Medical Review - Prior Authorization Requests (PAR)	Noridian JD DME Attn: DME MR-PAR PO Box 6742 Fargo, ND 58108-6742
Recovery Auditor Overpayments	Noridian JD DME Attn: Recovery Auditor Overpayments PO Box 6727 Fargo, ND 58108-6727

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
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare

Organization	Phone Number	Types of Inquiries
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. 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.

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

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.
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.

Question	Answer
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.

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.

Are You Aware That When Billing for a CPM Device There Are Certain Data Elements Required?

We have a CPM Device Billing Span Dates Calculator on our website that provides the first and last day Medicare can be billed and the maximum number of units. It is also important to remember that the first date available for billing may be the discharge date, but suppliers may not bill for the CPM device prior to application.

CMS Updates Advance Beneficiary Notice of Non-coverage (ABN) Chapter of Medicare Claims Processing Manual effective October 14, 2021

The Centers for Medicare & Medicaid Services (CMS) recently revised the ABN Section 50 in Chapter 30 of Pub. 100-04. Most notably, this Change Request (CR) 12242 altered the period of effectiveness for repetitive or continuous non-covered care from one year to a baseline of criteria. Please visit the Noridian ABN webpage including the Educational Resources links to view updates and guidelines. You can also view the complete (CR)12242 on the bottom of the webpage or on the MLN Matters Articles List.

Competitive Bid 2021 Modifier Chart - OTS Knee and Back Braces

When an off the shelf (OTS) knee or back brace is provided under Round 2021 of the DMEPOS Competitive Bidding Program, certain modifiers are required per the policy and others per Competitive Bid. Definitions for these specific Competitive Bid modifiers are also identified in the tips section of Noridian's Competitive Bidding webpage. Please refer to Noridian' new Competitive Bid 2021 Modifier Chart - OTS Knee and Back Braces for more information.

Consolidated Billing Questions Answered

Do you have questions about items included in Consolidated Billing? Refer to our Consolidated Billing page and utilize our Consolidated Billing tool to determine if a specific Healthcare Common Procedure Coding System (HCPCS) code is considered under consolidated billing.

PART A COVERED STAY

Medicare does not pay for individual items furnished during an inpatient Part A stay. These items are paid to hospitals and Skilled Nursing Facilities (SNFs) through the Inpatient Prospective Payment System (IPPS) under Medicare Part A. The facility must furnish all inpatient services and DMEPOS items during the stay or arrange for a supplier to furnish them. If necessary, the supplier will work out a payment arrangement with the facility as they are the ones receiving reimbursement from Medicare for items provided.

It is the supplier's responsibility to check with the facility to determine if their beneficiary is a resident in a covered Part A stay. If so, all items must be billed to Medicare by the SNF except for certain excluded items. A complete list of these excluded items (listed by HCPCS) may be found on the CMS SNF Consolidated Billing webpage > [YEAR] Part B MAC Update > Downloads > File 1 - Part A Stay (Physician services). **If a HCPCS code appears on this list, it may be billed to the DME MAC for reimbursement, even if the beneficiary is in a covered Part A SNF stay.**

NOT IN A PART A STAY

Coverage consideration for DMEPOS items in a Skilled Nursing Facility (31) or a Nursing Facility (32) for beneficiaries **not** in a Part A covered stay is limited to the following:

- Prosthetics, orthotics, and related supplies
- Urinary incontinence supplies
- Ostomy supplies
- Surgical dressings
- Oral anticancer drugs
- Oral antiemetic drugs
- Therapeutic shoes for diabetics
- Parenteral/enteral nutrition (including E0776BA, the IV pole used to administer parenteral/enteral nutrition)
- ESRD - dialysis supplies only
- Immunosuppressive drugs

HOME HEALTH EPISODE

The Balanced Budget Act of 1997 requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, billing for all such items and services will be made to a single home health agency (HHA) overseeing that plan.

Types of services that are subject to the Home Health Prospective Payment System (PPS) include routine and non-routine medical supplies.

When a beneficiary is in a 60-day home health episode, these items are included in the PPS episode payment. HHAs must bill for all supplies provided during the 60-day episode including those not related to the plan of care because of the consolidated billing requirements. Items such as urological supplies, ostomy supplies, and surgical dressings are included in Home Health Consolidated billing and cannot be separately billed to the DME MAC. **If a HCPCS code appears on this list, it may not be billed to the DME MAC when the beneficiary is in a home health episode**.

ELIGIBILITY

Suppliers are encouraged to check beneficiary eligibility either through the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR).

Denials for Beneficiary-owned Equipment

Have you experienced denials for beneficiary-owned equipment, Reason code 16, Remark code M124? Visit our Denial Code Resolution tool for common reasons for denial, the next steps to take to resolve and how to avoid future denials.

Enteral Nutrition Documentation Checklist

An updated Documentation Checklist has been posted to the Noridian Medicare website to ensure suppliers gather all required documentation for persons receiving enteral nutrition. This checklist provides guidance for all documentation that may be requested for review. It specifies what is required on the signed and dated statement from the certifying physician and a detailed description of what should be contained in the medical records.

Find Out Next Steps to Resolving Denials

View the most common claim submission denials using reason and remark codes on our Denial Code Resolution page. Also find information on common reasons for the denial, instructions for resolving denials and how to avoid the same denial in the future.

Glucose Monitors and Testing Supplies DME on Demand Tutorials

Noridian offers many self-paced training tutorials for DMEPOS. These items are available 24/7 to meet your training needs. These can be accessed on our website by selecting Education and Outreach, DME on Demand Tutorials.

Glucose Monitors and Testing Supplies:

- Continuous Glucose Monitors
- Continuous Glucose Monitors and Supplies Prior to July 18, 2021
- Continuous Glucose Monitors and Supplies July 18, 2021 and After
- Glucose Monitors and Supplies: Coverage
- Glucose Monitors and Supplies: Documentation
- Glucose Monitors and Supplies: Overutilization
- Glucose Monitors and Supplies L200 - High Utilization
- Glucose Monitors and Supplies L200 - Modifiers
- Glucose Monitors and Supplies L200 - Orders

For a complete list of tutorials, visit DME On Demand Tutorials Page.

How to Sign Up for the Noridian Medicare Weekly Updates (Listserv)

Noridian posts a weekly email with the latest Medicare updates, changes, education events and time-sensitive information. The email can be customized to choose which information you want to receive at the top of the email, but you will still receive all updates. Email sign up is available at the bottom of every page on our website, and a brochure is available with instructions on how to sign up.

Never Miss an Online Event

Register and participate in GoToWebinar events by downloading and using the GoToWebinar product applications for your smart phone, iPad, or tablet.

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Now Available - Parenteral Nutrition Modifier Tool

Noridian now has a Parenteral Nutrition Pricing Calculator which will allow suppliers to determine the correct number of units to submit for Parenteral Nutrition claims. Many pricing and Parenteral HCPCS codes can be found by utilizing this tool. Visit the Parenteral Calculator webpage to access the resources, related articles, and the Manual Parenteral Pricing Tool.

Off-the-Shelf vs Custom-Fitted Orthotic Lookup Tool - Now Available

A new tool has been created to help suppliers and billers determine the correct HCPCS code when billing prefabricated orthotics. Is the orthotic off-the-shelf or custom-fitted or is there a corresponding code that may be billed depending on the action taken at time of delivery? Find the answer on our website with our new Off-The-Shelf vs Custom-Fitted Orthotic Lookup Tool.

QIC Telephone Discussion and Reopening Process Demonstration Ending

All activities related to Qualified Independent Contractor (QIC) Telephone Discussion and Reopening Process Demonstration will be ending December 31, 2021. This includes activities conducted by both the Durable Medical Equipment (DME) and Part A East QIC contractors. We thank you for your interest and participation. For more information visit the QICs website at https://www.medicaredmeappeals.com/.

The Power of the Policy Article

While local coverage determinations (LCDs) provide policy coverage criteria, policy articles provide much more specific guidelines for the successful provision and billing of DME items and services. Take a look at some of the topics that are found in the policy articles.

- Non-medical necessity
- Payment rules
- Final Rule 1713 (face-to-face, written order prior to delivery (WOPD) requirements)
- Policy specific documentation requirements
- General requirements (specific to the policy)
  - Correct billing instructions
- Modifiers (general and policy specific)
- Miscellaneous information
- Coding guidelines and instructions
  - Diagnosis codes
  - HCPCS codes
  - Group codes
  - Codes that include multiple products
- Revision history information (check changes to the policy)
- Medical need

At the bottom of the policy article, is an Associated Documents section. Here you will find links to items including necessary attachments like certification documents, Certificate of Medical Necessity (CMN), the LCD, Standard Documentation Requirements article (A55426), and the National Coverage Determination (NCD).

Reason Code 16, Remark Code M60, How to Resolve?

If you have received Reason Code 16, Remark Code M60 on a remittance advice, an initial Certificate of Medical Necessity (CMN) or DME Information Form (DIF) was not submitted with the claim or is not on file with Noridian. Find a list of next steps and how to avoid future denials on the Reason Code 16 | Remark Code M60 page on the Noridian Medicare website.

Reason Code 151, Remark Code N115, what to do?

If you have received Reason Code 151, Remark Code N115 on a remittance advice, either there is a date span overlap or overutilization. Find out if a self-service reopening or a redetermination is needed and how to initiate one in the Noridian Medicare Portal. Find resources and how to avoid future denials on this denial resolution page on the Noridian Medicare website.

Replacement Equipment

Does the beneficiary need a replacement piece of equipment due to irreparable damage? If the item billed is same or similar to an item already received in the beneficiary's history within the Reasonable Useful Lifetime (RUL) it may need the appropriate modifier appended. The RA modifier indicates a replacement of a DME, Orthotic or Prosthetic item that have been lost, stolen or irreparably damaged. Find more information on replacements.

Resources and Assistance With Your Overpayment Demand Letter

Many situations may cause a supplier to owe Medicare money on previously paid claims. It could be a Noridian initiated claim edit correction, contractor claim reviews, or changes to a beneficiary's eligibility among others. Noridian's Overpayments web page provides links to related information such as:

- Bankruptcy
- Extended Repayment Schedule (ERS)
- Immediate Offset
- Limitation on Recoupment
- Overpayment Interest Rates
- Overpayment Monetary Threshold
- Overpayment Rebuttal
- Recovery Auditor Overpayments
- Surety Bond
- Voluntary Refund
- Resources

In addition, don't miss the Educational Resources located in the left panel of the Overpayments page. In the *Elements of a Demand Letter*, each section of the letter is explained, and resource links are provided. Take advantage of the Decision Tree and Interest Calculator tools. Find *Refunds/Overpayment Forms*, field descriptions for a remittance advice and the CMS article, *New Repayment Terms for Medicare Loans made to Providers during COVID-19*.

Searching for a Fee Schedule and Fee Schedule Category for a Certain HCPCS Code?

That information can be found on the PDAC website Fee Schedule Lookup tab with the current source data from the CMS fee schedule. Once you enter a HCPCS code in the lookup, the following displays for the code entered:

Fee Schedule Category
Short Description
Long Description

Here you can find the Fee Schedule Category for the specific HCPC code, modifiers used with the DMEPOS Payment Categories, each states' rural and non-rural fee allowable, and a Rural Zip Code Checker.

Visit our website today for this and many other tools to assist in providing service to Medicare beneficiaries.

Top Activities a New Supplier, Biller, or Website Visitor Should Complete

This table of activities will help you become familiar with the website through a site tour and site map, understand the benefits of electronic claim submissions, and how to use self-service options like the Interactive Voice Response (IVR) system and Noridian Medicare Portal (NMP). Become a Noridian email subscriber to receive latest updates, find and register for training events and create favorites and bookmarks. View them all today, including the New Supplier Training Opportunity Checklist that includes a comprehensive list of pre-recorded tutorials available by accessing our DME on Demand webpage.

Understanding the Provider Adjustment Details of Remittance Advice

Do you need more resources and assistance in understanding the provider adjustment details section of the remittance advice?

Noridian's Remittance Advice Field Descriptions and the Remittance Advice Tutorial have both been updated to provide guidance for those fields, specifically the WO PLB Reason Code used for offsets. View these today for more information.

WO PLB REASON CODE DESCRIPTION

Offset: As a result of a previous overpayment (A/R accounts receivable). Used to recover previous overpayment. A reference number (the original ICN and Medicare ID) is applied for tracking purposes.
Important Note: In HIGLAS when two or more providers are affiliated and have the same Tax Identification Number (TIN), payments may be withheld from one provider (PTAN) to collect another provider's (PTAN) overpayments.
When money is taken back by TIN, if supplier cannot determine the PTAN who money is being taken back on, call the Provider Contact Center for your Jurisdiction to obtain that information.
Example: Supplier 123 PTAN in California receives remittance advice. An offset is taken back from supplier 345 PTAN in Florida. Both suppliers under same TIN but supplier 123 is unable to locate account in their accounts receivable to balance account. Contact the Provider Contact Center to obtain this information.

Updated Overpayment Decision Tree Tool

Check out our updated Overpayment Decision Tree tool.

We have enhanced this tool by adding links to:

- The new Elements of a Demand Letter page when a demand letter is received
- Noridian's address for refund checks
- The Noridian Medicare Portal User Guide to complete a DME Recoupment Request through Self-Service Reopenings for Non-MSP overpayments
- The MSP Overpayment Refund Form when refunding an MSP claim overpayment

Check out the tool today.

Using the KU Modifier for Wheelchair Accessories and Seat Back Cushions

The KU modifier is used to receive the unadjusted fee schedule amount and was implemented for a variety of wheelchair accessories and seat back cushions used with complex rehabilitative manual wheelchairs and certain manual wheelchairs. The use of the KU modifier started for claims submitted on July 6, 2020 and was extended on July 6, 2021 per MM12345 . The impacted accessories and wheelchair codes include K0005, E1161, E1231-E1238 and K0008. Previously paid claims with dates of service on or after January 1, 2020 can be reopened to add the KU modifier.

On October 1, 2021, implementation Date: October 4, 2021, MLN Matters Article MM12453 was published. This indicates to continue including the KU modifier when billing the manual and power wheelchair accessories and seat and back cushion codes given with the wheelchairs discussed above. A list of the wheelchair accessory and seat and back cushion codes given with Group 3 power wheelchairs (HCPCS codes K0848-K0864) is available in Attachment A of CR 12453.

Written Reopenings Special Project Process Change

Effective January 1, 2022, Noridian will be changing the process for Written Reopenings Special Project Request. Suppliers will need to call the Telephone Reopenings Contact Center to obtain a reference number and the appropriate fax number for all special projects and any spreadsheet requests. Any spreadsheet received after January 1, 2022 without the correct information obtained will be dismissed and sent back to the supplier for corrections. There must be a contact person and phone number included with all requests. For further information you can check out Reopenings page on the Noridian's website.

MEDICAL POLICIES AND COVERAGE ....

2021 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2021 HCPCS Code Update - October Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2021 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

Articulating Digit(s) and Prosthetic Hands - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Articulating Digit(s) and Prosthetic Hands - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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- Locate/select article title

Clinician Checklist and Knee Orthosis Documentation Checklist

Noridian offers a Clinician Checklist Ankle-Foot/Knee-Foot Orthosis. The checklist will assist clinicians with coverage and documentation requirements. If you are having trouble getting the needed documentation from a Clinician, you can direct that Clinician to the Noridian Medicare website, and you can also use the site to access a Knee Orthosis Documentation Checklist to ensure that you have gathered all required documentation.

Correct Coding, Billing and Code Verification of HCPCS Code E0467 (Multi-Functional Ventilator)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding, Billing and Code Verification of HCPCS Code E0467 (Multi-Functional Ventilator)**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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

Correct Coding of Elbow, Shoulder, Shoulder-Elbow-Wrist-Hand and Shoulder- Elbow-Wrist-Hand-Finger Braces (Orthoses)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding of Elbow, Shoulder, Shoulder-Elbow-Wrist-Hand and Shoulder- Elbow-Wrist-Hand-Finger Braces (Orthoses)**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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Correct Coding of Finger, Hand, Hand-Finger and Wrist-Hand- Finger Braces (Orthoses) - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding of Finger, Hand, Hand-Finger and Wrist-Hand- Finger Braces (Orthoses) - Revised**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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Insulin Used with Continuous External Insulin Infusion Pumps Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Insulin Used with Continuous External Insulin Infusion Pumps Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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

LCD and Policy Article Revisions Summary for October 7, 2021

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 High Frequency Chest Wall Oscillation Devices, Mechanical In-exsufflation Devices, Oral Anticancer Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), Transcutaneous Electrical Nerve Stimulators (TENS) and Wheelchair Seating. Please review the entire LCDs and related PAs for complete information.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2021
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: ICD-10-CM code G71.20 and M35.03 descriptions in Group 1 Codes, due to annual ICD-10-CM code updates

10/07/2021: At this time the 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: 10/01/2021
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: ICD-10-CM code description for G71.20 due to annual ICD-10-CM Code updates

10/07/2021: 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.

ORAL ANTICANCER DRUGS

PA

Revision Effective Date: 10/01/2021
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM C56.3 to groups 1, 2, 3, 4, 6, 7, 9, ICD-10-CM C79.63 to groups 2, 3, 4, 6, 7, 8, 9, ICD-10-CM C84.7A to groups 1, 3, 4, 5, 7 due to annual ICD-10-CM code updates

10/07/2021: At this time the 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.

ORAL ANTIEMETIC DRUGS (REPLACEMENT FOR INTRAVENOUS ANTIEMETICS)

PA

Revision Effective Date: 10/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: “multiple codes” after “netupitant/palonosetron” and replaced with J8655
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: References of “Q0181” and “depending on date of service” after palonosetron and netupitant/palonosetron
Added: Instructions for billing Q0181
CODING GUIDELINES:
Added: Directions for billing rolapitant based on multiple codes for the appropriate date of service
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM C56.3, C79.63 and C84.7A to Group 1 due to annual ICD-10-CM code updates

10/07/2021: At this time the 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.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

LCD

Revision Effective Date: 11/20/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Removed: Criterion III Chronic Lower Back Pain (CLBP) due to coverage expired June 7, 2015 under NCD 160.27
Added: Not reasonable and necessary statement in accordance with NCD 160.27
CODING INFORMATION:
Removed: Modifier Q0 under HCPCS Modifiers section
APPENDICES:
Removed: CLBP clinical trial references

10/7/2021: In accordance with NCD 160.27, coverage of TENS for CLBP is no longer available under Coverage with Evidence Development. Per the NCD, TENS is not reasonable and necessary for the treatment of CLBP under section 1862(a)(1)(A) of the Act. As a result, the DME MACs are removing this requirement as a non-discretionary change to the LCD, per the Program Integrity Manual, Chapter 13, §13.2.4.

PA

Revision Effective Date: 11/20/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Language regarding supply allowances during the rental period for clarification
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: Medical records statement for Criterion III as coverage expired June 7, 2015 for CLBP under NCD 160.27
MODIFIERS:
Removed: Q0 modifier statements regarding Criterion III as coverage expired June 7, 2015 for CLBP under NCD 160.27
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: ICD-10-CM codes used for CLBP as coverage expired June 7, 2015 for CLBP under NCD 160.27
ICD-10-CM CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Removed: Statement under paragraph 1 regarding CLBP and all codes not specified

10/07/2021: 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: 10/01/2021
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: ICD-10-CM code G71.20 description in Group 2 and Group 4 Codes, due to annual ICD-10-CM code updates
Added: ICD-10-CM code G04.82 to Group 2 and Group 4 Codes, due to annual ICD-10-CM code updates

10/07/2021: At this time the 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(s) 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

Local Coverage Determination Release for Notice - Transcutaneous Electrical Nerve Stimulators (TENS)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Local Coverage Determination Release for Notice - Transcutaneous Electrical Nerve Stimulators (TENS)**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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

Medicare Coverage for Shoes - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Medicare Coverage for Shoes - Correct Coding - Revised**, has been created and published to our website.

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- Locate/select article title

Open Meeting Announcement - Nebulizers Proposed Local Coverage Determination (LCD)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Open Meeting Announcement - Nebulizers Proposed Local Coverage Determination (LCD)**, has been created and published to our website.

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Open Meeting Announcement - Pneumatic Compression Devices Proposed Local Coverage Determination (LCD)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Open Meeting Announcement - Pneumatic Compression Devices Proposed Local Coverage Determination (LCD)**, has been created and published to our website.

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Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L33797 and Related Policy Article (PA) A52514 Update

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Oxygen and Oxygen Equipment Local Coverage Determination (LCD) L33797 and Related Policy Article (PA) A52514 Update**, has been created and published to our website.

View the locally hosted 2021 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

Policy Article Revisions Summary for November 11, 2021

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Oxygen and Oxygen Equipment, Nebulizers, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, High Frequency Chest Wall Oscillation Devices, Mechanical In-exsufflation Devices, Oral Appliances for Obstructive Sleep Apnea, Respiratory Assist Devices, and Suction Pumps. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2021
CODING GUIDELINES:
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review (CVR) information
Added: CVR requirement for products coded E0467

11/11/2021: At this time the 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: 10/01/2021
CODING GUIDELINES:
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review (CVR) information
Added: CVR requirement for products coded E0467

11/11/2021: At this time the 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.

NEBULIZERS

PA

Revision Effective Date: 05/17/2020
CODING GUIDELINES:
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review (CVR) information
Added: CVR requirement for products coded E0467

11/11/2021: At this time the 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.

ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA

PA

Revision Effective Date: 08/08/2021
CODING GUIDELINES:
Moved: E0486 code verification review (CVR) language to coding verification review section
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC CVR information
Added: CVR requirement for products coded E0486 and E0467

11/11/2021: At this time the 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.

OXYGEN AND OXYGEN EQUIPMENT

PA

Revision Effective Date: 08/02/2020
CODING GUIDELINES:
Moved: E1405 and E1406 coding verification review (CVR) language to coding verification review section
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC CVR information
Added: CVR requirement for products coded E1405, E1406 and E0467

11/11/2021: At this time the 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.

POSITIVE AIRWAY PRESSURE (PAP) DEVICES FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA

PA

Revision Effective Date: 08/08/2021
CODING GUIDELINES:
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review (CVR) information
Added: CVR requirement for products coded E0467

11/11/2021: At this time the 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.

RESPIRATORY ASSIST DEVICES

PA

Revision Effective Date: 08/08/2021
CODING GUIDELINES:
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review (CVR) information
Added: CVR requirement for products coded E0467.

11/11/2021: At this time the 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.

SUCTION PUMPS

PA

Revision Effective Date: 08/15/2021
CODING GUIDELINES:
Moved: K0743 coding verification review (CVR) language to coding verification review section
Revised: Coding instructions for multifunction ventilators (E0467) (Effective 01/01/2019)
CODING VERIFICATION REVIEW:
Added: Section header and PDAC CVR information
Added: CVR requirement for products coded K0743 and E0467

11/11/2021: At this time the 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.

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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

Proposed Local Coverage Determinations (LCDs) Released for Comment - Nebulizers and Pneumatic Compression Devices

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Proposed Local Coverage Determinations (LCDs) Released for Comment - Nebulizers and Pneumatic Compression Devices**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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- Locate/select article title

PureWick Urine Collection System - Coding and Billing Instructions

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **PureWick Urine Collection System - Coding and Billing Instructions**, has been created and published to our website.

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- Locate/select article title

Reminder: Enteral Nutrition (L38955) and Parenteral Nutrition (L38953) final LCDs and related Policy Articles - Effective for Claims with Dates of Service on or after September 5, 2021

The DME MACs are reminding stakeholders that the Enteral Nutrition (L38955) and Parenteral Nutrition (L38953) final LCDs and LCD-related Policy Articles (A58833 and A58836, respectively) will go into effect for claims with dates of service on or after September 5, 2021. These LCDs and related Policy Articles were published on July 22, 2021, in the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Database and are accessible on individual DME MAC websites. More information, regarding LCDs and related Policy Articles, is available at Local Coverage Determination (LCD).

Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Warranty, Reasonable Useful Lifetime (RUL), and the Minimum Lifetime Requirement (MLR) for Durable Medical Equipment - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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- Locate/select article title

MLN CONNECTS

MLN Connects - September 2, 2021

Ambulance Prior Authorization Model Implementation Dates

MLN Connects newsletter for Thursday, September 2, 2021

View this edition as a: Webpage | PDF

NEWS

- Ambulance Prior Authorization Model Implementation Dates
- In Response to Hurricane Ida PHE, CMS Announces Support for Residents of Louisiana & Mississippi
- Provider Enrollment Activities Resume in October
- Hospice Quality Reporting Program: Public Reporting Key Dates
- DME Suppliers: Payment for Respiratory Equipment Affected by Recent Recall
- Healthy Aging: Recommend Services for Your Patients

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- HCPCS Level II Application Submission: Launch of MEARISTM
- HCPCS Level II Application Submission Deadlines

MLN MATTERS® ARTICLES

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2022

PUBLICATIONS

- Medicare Provider Enrollment - Revised

MLN Connects - September 9, 2021

SNF: WBT & COVID-19 Reminder

MLN Connects newsletter for Thursday, September 9, 2021

View this edition as a: Webpage | PDF

NEWS

- PEPPERs for Short-term Acute Care Hospitals
- Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments: Payment Update
- Prostate Cancer: Talk to Your Patients about Screening

COMPLIANCE

- DMEPOS Items: Medical Record Documentation

EVENTS

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

MLN MATTERS® ARTICLES

- Medicare FFS Response to the PHE on the COVID-19 - Revised

PUBLICATIONS

- Medicare Mental Health - Revised

MULTIMEDIA

- SNF Consolidated Billing Web-Based Training - Revised

MLN Connects Special Edition - September 9, 2021 - Biden-Harris Administration to Expand Vaccination Requirements for Health Care Settings

New action will protect patients of the 50,000 providers and over 17 million health care workers in Medicare and Medicaid certified facilities

The Biden-Harris Administration will require COVID-19 vaccination of staff within all Medicare and Medicaid-certified facilities to protect both them and patients from the virus and its more contagious Delta variant. Facilities across the country should make efforts now to get health care staff vaccinated to make sure they are in compliance when the rule takes effect.

The Centers for Medicare & Medicaid Services (CMS), in collaboration with the Centers for Disease Control and Prevention (CDC), announced that emergency regulations requiring vaccinations for nursing home workers will be expanded to include hospitals, dialysis facilities, ambulatory surgical settings, and home health agencies, among others, as a condition for participating in the Medicare and Medicaid programs. The decision was based on the continued and growing spread of the virus in health care settings, especially in parts of the U.S. with higher incidence of COVID-19.

"There is no higher priority for us than patient health and safety. As the Delta variant strengthens, the Biden-Harris Administration is committed to doing everything we can to keep patients, and those who care for them, safe," said U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra. "There is no question that staff, across any health care setting, who remain unvaccinated pose both direct and indirect threats to patient safety and population health. Ensuring safety and access to all patients, regardless of their entry point into the health care system, is essential."

Nursing homes with an overall staff vaccination rate of 75% or lower experience higher rates of preventable COVID infection. In CMS's review of available data, the agency is seeing lower staff vaccination rates among hospital and End Stage Renal Disease (ESRD) facilities. To combat this issue, CMS is using its authority to establish vaccine requirements for all providers and suppliers that participate in the Medicare and Medicaid programs. Vaccinations have proven to reduce the risk of severe illness and death from COVID-19 and are effective against the Delta variant. CMS will continue to work closely with all Medicare and Medicaid certified facilities to ensure these new requirements are met.

"We know that those working in health care want to do what is best for their patients in order to keep them safe," said CMS Administrator Chiquita Brooks-LaSure. "As the Delta variant continues to spread, we know the best defense against it lies with the COVID-19 vaccine. Data show that the higher the level of vaccination rates among providers and staff, the lower the infection rate is among patients who are dependent upon them for care. Now is the time to act. I'm urging everyone, but especially those fighting this virus on the front lines, to get vaccinated and protect themselves, their families, and their patients from COVID-19."

CMS is developing an Interim Final Rule with Comment Period that will be issued in October. CMS expects certified Medicare and Medicaid facilities to act in the best interest of patients and staff by complying with new COVID-19 vaccination requirements. Health care workers employed in these facilities who are not currently vaccinated are urged to begin the process immediately. Facilities are urged to use all available resources to support employee vaccinations, including employee education and clinics, as they work to meet new federal requirements.

MLN Connects - September 16, 2021

COVID-19 Vaccines: Act Now

MLN Connects newsletter for Thursday, September 16, 2021

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NEWS

- COVID-19 Vaccines: Act Now
- IRF Review Choice Demonstration: Submit Comments by October 8

COMPLIANCE

- Medicare Quarterly Provider Compliance Newsletter
- Surgical Dressings: Medicare Requirements

CLAIMS, PRICERS, & CODES

- Average Sales Price Files: October 2021

EVENTS

- National Stakeholder Call with the CMS Administrator - September 17

MLN MATTERS® ARTICLES

- 2022 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Annual Clotting Factor Furnishing Fee Update 2022
- Home Health Notices of Admission - Additional Manual Instructions
- 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 Health Care (CAQH) CORE
- Influenza Vaccine Payment Allowances - Annual Update for 2021-2022 Season
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to Home Health (HH) Grouper
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2021 Update

PUBLICATIONS

- DMEPOS Accreditation - Revised
- Independent Diagnostic Testing Facility (IDTF) - Revised

MULTIMEDIA

- Part D Coverage Determinations, Appeals, & Grievances Web-Based Training - Revised

MLN Connects Special Edition - September 20, 2021 - Help CMS Improve Your Experience with Provider Resources

CMS is conducting a study to help us improve your experience with resources about the Medicare program and correct billing. Please share your thoughts with us by taking this survey. Responses are confidential, and the survey should take about 10 minutes to complete. Thank you for your time.

MLN Connects - September 23, 2021

COVID-19: Compare Nursing Homes by Vaccination Rate

MLN Connects newsletter for Thursday, September 23, 2021

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NEWS

- CMS Launches New Medicare.gov Feature to Compare Nursing Homes by Vaccination Rate
- Drugs of Abuse Testing: Comparative Billing Report in September
- Cardiovascular Disease: Talk to your Patients about Screening

COMPLIANCE

- DMEPOS Items: Ordering or Referring Practitioner Requirements

CLAIMS, PRICERS, & CODES

- ESRD Facilities: Bill Correctly for Cinacalcet Oral Drug

MLN MATTERS® ARTICLES

- Claims Processing Instructions for National Coverage Determination 20.33 - Transcatheter Edge-to-Edge Repair (TEER) for Mitral Valve Regurgitation
- National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds
- October 2021 Update of the Ambulatory Surgical Center (ASC) Payment System
- Medicare Clarifies Recognition of Interstate License Compact Pathways - Revised

PUBLICATIONS

- Medicare Vision Services - Revised
- Power Mobility Devices - Revised
- Transitional Care Management Services - Revised

MLN Connects Special Edition - September 24, 2021 - CMS Will Pay for COVID-19 Booster Shots, Eligible Consumers Can Receive at No Cost

CMS Will Pay for COVID-19 Booster Shots, Eligible Consumers Can Receive at No Cost

Coverage without cost-sharing available for eligible people with Medicare, Medicaid, CHIP, and Most Commercial Health Insurance Coverage

Following the FDA's recent action that authorized a booster dose of the Pfizer COVID-19 vaccine for certain high-risk populations and a recommendation from the CDC, CMS will continue to provide coverage for this critical protection from the virus, including booster doses, without cost sharing.

Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance, or deductible. In addition, thanks to the American Rescue Plan Act of 2021, nearly all Medicaid and CHIP beneficiaries must receive coverage of COVID-19 vaccines and their administration, without cost-sharing. COVID-19 vaccines and their administration, including boosters, will also be covered without cost-sharing for eligible consumers of most issuers of health insurance in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

"The Biden-Harris Administration has made the safe and effective COVID-19 vaccines accessible and free to people across the country. CMS is ensuring that cost is not a barrier to access, including for boosters," said CMS Administrator Chiquita Brooks-LaSure. "CMS will pay Medicare vaccine providers who administer approved COVID-19 boosters, enabling people to access these vaccines at no cost."

CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available on the CDC COVID-19 Vaccination Program Provider Requirements and Support webpage and through the CMS COVID-19 Provider Toolkit.

MLN Connects Special Edition - September 27, 2021 - Flu & Pneumococcal Vaccines: Expanded SNF Enforcement Discretion for Certain Pharmacy Billing

Effective September 20, 2021, CMS exercised enforcement discretion for Skilled Nursing Facility (SNF) consolidated billing provisions related to flu and pneumococcal vaccines. This allows Medicare-enrolled immunizers, including pharmacies, to bill directly and get direct reimbursement from the Medicare program (including vaccine administration and product), whether these vaccines are administered at the same time (co-administered) with a COVID-19 vaccine or at different times. Visit the SNF: Enforcement Discretion Relating to Certain Pharmacy Billing webpage.

Vaccinations for respiratory illnesses reduce the impact and resulting burdens on the health care system during the COVID-19 PHE. The CDC recommends that patients in post-acute care facilities get the flu vaccine during the COVID-19 pandemic.

MLN Connects - September 30, 2021

Flu Season is Here: Protect Your Patients, Yourself, & Your Loved Ones

MLN Connects newsletter for Thursday, September 30, 2021

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NEWS

- Flu Season is Here: Protect Your Patients, Yourself, & Your Loved Ones
- Clinical Laboratory Fee Schedule Updates

COMPLIANCE

- Post-Acute Care Transfers: Bill Correctly

MLN MATTERS® ARTICLES

- October 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.3
- October 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- October Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

MULTIMEDIA

- Part C Organization Determination, Appeals, & Grievances - Revised

MLN Connects - October 7, 2021

Enter Your Digital Contact Information Into NPPES Now

MLN Connects newsletter for Thursday, October 7, 2021

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NEWS

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

CLAIMS, PRICERS, & CODES

- Drugs & Biologics: HCPCS Level II Application Summaries & Coding Decisions

EVENTS

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

MLN MATTERS® ARTICLES

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

PUBLICATIONS

- Medicare DMEPOS Payments While Inpatient - Revised

MULTIMEDIA

- Modernizing Health Care to Improve Physical Accessibility

MLN Connects - October 14, 2021

Pneumococcal Conjugate Vaccine, 20 Valent

MLN Connects newsletter for Thursday, October 14, 2021

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NEWS

- Pneumococcal Conjugate Vaccine, 20 Valent
- DATA 2000 Waiver Training Payments Still Available for Rural Health Clinics

COMPLIANCE

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

EVENTS

- Medicare Ground Ambulance Data Collection System Webinar: Volunteer Organizations - October 14
- Medicare Ground Ambulance Data Collection System Webinar: Public Safety Organizations - October 21

MLN MATTERS® ARTICLES

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

MULTIMEDIA

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

MLN Connects - October 21, 2021

Cognitive Assessment: Resources to Answer Patient Questions

MLN Connects newsletter for Thursday, October 21, 2021

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CLAIMS, PRICERS, & CODES

- LTCH: New Web Pricer Released

EVENTS

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

MLN MATTERS® ARTICLES

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

PUBLICATIONS

- A Prescriber’s Guide to Medicare Prescription Drug (Part D) Opioid Policies

INFORMATION FOR MEDICARE PATIENTS

- Cognitive Assessment: Resources to Answer Patient Questions

MLN Connects Special Edition - October 22, 2021 - COVID-19: Moderna & Jansen (J&J) Booster Shots

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

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

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

More Information:
CMS News Alert
COVID-19 provider toolkit including:

- Payment rates for administering vaccines
- How to bill correctly

MLN Connects - October 28, 2021

Make a Strong Flu Shot Recommendation - it's Critical

MLN Connects newsletter for Thursday, October 28, 2021

NEWS

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

COMPLIANCE

- Home Health LUPA Threshold: Bill Correctly

EVENTS

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

MLN MATTERS® ARTICLES

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

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

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

"Today's final rule is a decisive step to ensure people with Medicare with chronic kidney disease have easy access to quality care and convenient treatment options," said CMS Administrator Chiquita Brooks-LaSure. "Enabling dialysis providers to offer

more dialysis treatment options for Medicare patients will catalyze better health outcomes, greater autonomy and better quality of life for all patients with kidney disease."

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

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

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

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

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

More Information:

- Fact sheet
- Final rule

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

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

Final Rule Advances Health Equity, Person-Centered Care

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

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

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

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

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

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

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

Promoting Growth in Medicare Diabetes Prevention Program

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

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

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

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

Increased Access to Medical Nutrition Therapy Services

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

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

Encouraging Proven Vaccines to Protect Against Preventable Illness

As the COVID-19 pandemic has so starkly demonstrated, access to safe and effective vaccines is vital to public health. CMS will maintain the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective January 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of

other Part B preventive vaccines. CMS will also continue to facilitate vaccinations for common diseases such as influenza, pneumonia, and hepatitis B.

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

Expanded Pulmonary Rehabilitation Coverage Under COVID

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

Advancing the Quality Payment Program and MIPS Value Pathways

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

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

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

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

Ensuring Accurate Payments Through Clinical Labor Update

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

Increasing Access to Physician Assistants' Services

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

More Information:

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

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

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

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

Price Transparency

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

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

Enhancing Beneficiary Protections

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

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

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

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

- Health equity: CMS received input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable by including additional demographic data points (e.g., race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status).
- Access to emergency care in rural areas: the proposed rule included an RFI on Rural Emergency Hospitals (REHs). CMS received robust comments in response to this RFI and looks forward to taking each of those comments into consideration during the rulemaking process for the development of the REH requirements.

- Lessons from COVID-19: CMS solicited comments on the extent to which hospitals are using flexibilities offered during the COVID-19 public health emergency (PHE) to provide mental health services remotely and whether CMS should consider changes to account for shifting practice patterns. In addition, comments were received on the collection and reporting of COVID-19 vaccination status of hospital outpatient department and ASC staff, and making this information available to the public so consumers know how many workers are vaccinated in different health care settings.

More Information:

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

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

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

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

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

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

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

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

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

Finally, this rule implements provisions of the Consolidated Appropriations Act, 2021 that establish survey and enforcement requirements for hospice programs serving Medicare beneficiaries. These provisions will require the use of multidisciplinary

survey teams, prohibition of surveyor conflicts of interest, and expansion of surveyor training to include accrediting organizations (AOs). The provisions also establish a hospice program complaint hotline and create the authority for CMS to impose enforcement remedies for noncompliant hospice programs. These changes will strengthen oversight, enhance enforcement, and establish consistent and transparent survey requirements in hospice care.

More Information:

- HH PPS proposed rule
- HH PPS proposed rule fact sheet

MLN Connects - November 4, 2021

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

MLN Connects newsletter for Thursday, November 4, 2021

NEWS

- COVID-19 Vaccines for Children
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for MA Plan Claims Starting January 1, 2022
- Multi-Factor Authentication Requirement for PECOS

EVENTS

- Medicare Clinical Laboratory Fee Schedule Private Payor Data Collection & Reporting Webinar - November 10
- COVID-19 Vaccine Webinar for Rural Communities - November 15

MLN MATTERS® ARTICLES

- Manual Updates for Clarification on the Election Statement Addendum and Extension of the Hospice Cap Calculation Methodology
- Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) PPS Changes

PUBLICATIONS

- Medicare Billing: 837P & Form CMS-1500

MULTIMEDIA

- PAC Quality Reporting Programs: Updated 3-Course Training Series for Section GG

MLN Connects Special Edition - November 4, 2021

Biden-Harris Administration Issues Emergency Regulation Requiring COVID-19 Vaccination for Health Care Workers

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

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

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

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

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

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

A recent White House report describes the evidence that vaccine requirements work. An analysis of health care systems, educational institutions, public-sector agencies, and private businesses shows that organizations with vaccination requirements have seen their vaccination rates increase by more than 20 percentage points and have routinely seen their share of fully vaccinated workers rise above 90%.

States and individual health systems have historically addressed vaccination requirements for diseases such as influenza and hepatitis B. Today, more than 2,500 hospitals, or 40 percent of all U.S. hospitals, have announced COVID vaccination requirements for their workforce. They span all 50 states, the District of Columbia, and Puerto Rico. The report also found that vaccination requirements have not led to widespread resignations in the health care workforce and that the requirements are an essential tool to protect patients and health care personnel.

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

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

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

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

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

MLN Connects - November 11, 2021

Diabetes Resources for You & Your Patients

MLN Connects newsletter for Thursday, November 11, 2021

NEWS

- Provider Enrollment Application Fee for CY 2022
- LTCH & IRF: CY 2022 QRP Updates

- Critical Care E/M Services: Comparative Billing Report in November
- Diabetes Resources for You & Your Patients

COMPLIANCE

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

CLAIMS, PRICERS, & CODES

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

EVENTS

- HCPCS Public Meeting - December 1 & 2

MLN MATTERS® ARTICLES

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

MLN Connects - November 18, 2021

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

MLN Connects newsletter for Thursday, November 18, 2021

NEWS

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

CLAIMS, PRICERS, & CODES

- Upcoming Quarterly Update to Home Health Grouper

EVENTS

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

MLN MATTERS® ARTICLES

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

INFORMATION FOR MEDICARE PATIENTS

- CMS Announces 2022 Medicare Part B Premiums

MLN Connects - November 24, 2021

Provider Relief Fund Reporting Deadline

MLN Connects newsletter for Wednesday, November 24, 2021

NEWS

- Provider Relief Fund Reporting Deadline: November 30, 2021
- HIV: Talk to Your Patients About Prevention & Screening
- Home Health & Hospice: Medicare Provider Resources

- COVID-19: Pfizer & Modena Booster Shots for 18 Years and Older

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

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

MLN MATTERS® ARTICLES

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

PUBLICATIONS

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

MULTIMEDIA

- CLFS Data Reporting Clinical Diagnostic Laboratory Tests Webinar Materials

MLN MATTERS

Additional Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics. Update to Change Request (CR) 3959, CR 8390, and CR 8730

Release Date: September 13, 2021
CR Transmittal Number: R11002OTN
Change Request (CR) Number: 12282
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

Note: Transmittal 10896, dated July 21, 2021, is being rescinded and replaced by Transmittal 11002, dated, September 13, 2021 to make additional updates to the OR01 and OR02 HCPCS Codes Attachment. All other information remains the same.

CR 12282 communicates the addition of HCPCS codes which require the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics under the following product and service codes:

1. OR01 Orthoses: Custom Fabricated
2. OR02 Orthoses: Prefabricated (Custom Fitted)

View the complete CMS Change Request (CR) 12282.

Claim Status Category and Claim Status Codes Update

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

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

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

Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from CAQH CORE

MLN Matters Number: MM12428
Related CR Release Date: September 8, 2021
Related CR Transmittal Number: R10967CP
Related Change Request (CR) Number: 12428
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12428 tells you Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) will publish the next version of the Code Combination List on or about October 1, 2021. Make sure your billing staff knows of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12428.

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

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

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

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12469.

Medicare FFS Response to the PHE on COVID-19

MLN Matters Number: SE20011 Revised
Article Release Date: September 8, 2021

Note: CMS revised this Article to add more information about the SNF waivers. You'll find substantive content updates in dark red font on page 13. All other information remains the same.

The Secretary of the HHS declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020, HHS 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.

New/Modifications to the POS Codes for Telehealth

MLN Matters Number: MM12427
Related CR Release Date: October 13, 2021
Related CR Transmittal Number: R11045CP
Related Change Request (CR) Number: 12427
Effective Date: January 1, 2022
Implementation Date: April 4, 2022

CR 12427 provides updates to the current Place of Service (POS) code set by revising the description of existing POS code 02 and adding new POS code 10. Make sure your billing staff knows of the updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12427.

October Quarterly Update for 2021 DMEPOS Fee Schedule

MLN Matters Number: MM12453
Related CR Release Date: September 17, 2021
Related CR Transmittal Number: R11005CP
Related Change Request (CR) Number: 12453
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12453 is the October quarterly update for the 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule. Make sure your billing staff knows about the changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12453.

Quarterly Update for the DMEPOS CBP - January 2022

MLN Matters Number: MM12445
Related CR Release Date: October 1, 2021
Related CR Transmittal Number: R11022CP
Related Change Request (CR) Number: 12445
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12445 provides specific instruction for implementing the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) files. Medicare updates the DMEPOS CBP files on a quarterly basis to implement necessary changes to HCPCS codes, ZIP codes, and single payment amounts. Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12445.