DME Happenings

Jurisdiction D

September 2021

In This Issue…

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

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

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

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Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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

Correspondence	When to Use This Address	Email Address
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

Department	Address
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
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
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.

CMS Quarterly Provider Updates

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

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

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

Physician Documentation Responsibilities

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

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Refunds to Medicare

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

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

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

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

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

Question	Answer
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 submitting the correct and complete documentation for Power Mobility Devices (PMDs)?

The Comprehensive Error Rate Testing (CERT) 2020 Improper Payment report indicated the most common reasons for denial for PMDs were inadequate and missing documentation. The Noridian PMD webpage has multiple documentation and clinician checklists as well as links to all active Local Coverage Determinations (LCDs) and Policy Articles. In the left column of the page is an Educational Resources hub with links to DME on Demand tutorials, Modifier, Prior Authorization, and MUE Lookup Tools, and Pre-Claim Review Forms, among others. Spend a few minutes getting to know these great resources.

Browser Requirements and Internet Explorer Update

To view Noridian's website and portal at optimum levels, it is recommended that you use one of the browsers in the list below. Using older or non-compatible browsers, or disabling browser features such as JavaScript, may reduce functionality in our website.

Microsoft announced support of Internet Explorer will end in June 2022. It is our goal to ensure providers and suppliers are aware and prepared for this change.

- Chrome (Latest)
- Firefox (Latest)
- Microsoft Edge (Latest)

Additional information and access to the most current versions of common browsers is available in the Help section found in the footer of each page of our website.

Common errors checking eligibility on the NMP

Some common errors that are made using the HIPAA Eligibility Transaction System (HETS) to check beneficiary eligibility on the Noridian Medicare Portal (NMP) include using a beneficiary nickname (e.g., Liz instead of Elizabeth), typing errors, omitting a required suffix such as Jr or Sr, or the issuance of a new Medicare number. The beneficiary name should be entered

exactly as it appears on the beneficiary's Medicare card. More information is available on the Eligibility Benefits page in the NMP Inquiry Guide.

Earning Noridian's Continuing Education Unit (CEU) Certificate

Effective October 1, 2021 Noridian will be changing the process for webinar participants to earn American Academy of Professional Coders (AAPC) CEU's. The CEU certificate will no longer be provided with the handouts during the webinar. Our webinar protocol requires you to be logged into the GoToWebinar application and stay for the entire presentation to earn the CEU. Time in the webinar is monitored through this application.

Proceeding forward, only attendees that stay for the entire presentation will be issued the CEU with the handout following the webinar.

Informational Flyer Regarding Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP)

The Centers for Medicare & Medicaid Services (CMS) released a new printable flyer for referral agents, State Health Insurance Assistance Programs (SHIPs), suppliers, and other stakeholders to share with Medicare beneficiaries and other interested individuals. The flyer provides information regarding Round 2021 of the DMEPOS CBP and how to determine if a beneficiary is impacted by it. This flyer can be downloaded from the Competitive Bidding Implementation Contractor (CBIC) website.

MBI format on the NMP

The Medicare Beneficiary Identifiers (MBIs) are made up of numbers 0 to 9 and upper-case letters A to Z. All letters are used except S, L, O, I, B and Z. To avoid errors when entering the MBI in the Noridian Medicare Portal (NMP), always use the number zero if a "0" character is part of the MBI as the letter "O" is never used. Likewise, with the number "1" and the letters "L" or "I" as only the number 1 is a valid character for the MBI.

To learn more about how the MBI is formatted, visit the Understanding the Medicare Beneficiary Identifier (MBI) Format page on the CMS website.

Medicare Part B Qualification Required to Obtain DME Services

Medical insurance (Part B) helps pay for medically necessary services by a physician, outpatient hospital services, home health care, and a number of other medical services and supplies not covered by Part A, including Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). To qualify for DME services, a beneficiary must be enrolled in Medicare Part B. From the Eligibility tab on the Noridian Medicare Portal (NMP), suppliers can verify if the beneficiary is eligible for Part B, the deductible year, the remaining deductible and the base deductible amount. Also viewable is the beneficiary's address that is on file with the Social Security Administration. This is critical to verify billing to the correct Medicare jurisdiction particularly for beneficiaries who may be living temporarily away from home. Find additional information on the Eligibility Benefits page in the NMP Inquiry Guide.

Negative Pressure Wound Therapy (NPWT) DME on Demand Tutorials

Looking for information on the Negative Pressure Wound Therapy (NPWT) policy? 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 YouTube channel.

Negative Pressure Wound Therapy (NPWT)

- NPWT: After Month 4 - 4 minutes
- NPWT: Coding and Utilization - 6 minutes

- NPWT: Coverage Criteria - 10 minutes
- NPWT: Documentation - 4 minutes
- NPWT: Ulcer Definitions - 3 minutes

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

Noridian Medicare Portal (NMP) Security Protocols Reminder

Did you know that the Noridian Medicare Portal has security protocols it is required to follow per Federal Regulations? The following security protocols will ensure the security and integrity of data.

- Inactivity of 30 minutes or more will automatically time user out
- Always sign out when finished, user will have to wait 3 hours before logging back in
- Accounts disable after 60 days of inactivity, user will need to contact user security to get back into account Contact and Support - Portal Guide - Noridian (noridianmedicare.com)
- Accounts are deleted after 90 days of inactivity, after that the user will need to register for a new account Registration Guide - Portal Guide - Noridian (noridianmedicare.com)
- NMP passwords need to be changed every 60 days

Each portal user is responsible for their individual account registration, passwords, activity, and security awareness training. Portal users must complete Security Awareness training upon their login and annually based on their registration date. Training must be completed within the 45 day window in order to continue use of portal. If not completed the user's account will be disabled and will need to contact NMP Support to unlock it. Contact and Support - Portal Guide - Noridian (noridianmedicare.com)

The Multi-Factor Authentication (MFA) is a second layer of security to the NMP. Using the MFA helps prevent anyone other than the user from logging in. When users log into NMP, the username and password and the one-time MFA passcode is also required for all portal users. The user can choose email, text, or voice for the one-time passcode delivery. Multi-Factor Authentication (MFA) - Portal Guide - Noridian (noridianmedicare.com)

Resources: Medicare Administrative Contractor (MAC) Provider Portal Handbook (cms.gov)

Patient Status Code Lookup Available on NMP

The Noridian Medicare Portal (NMP) provides a Discharge Status Code on the Hospital/SNF section of an Eligibility inquiry response for all Hospital and Skilled Nursing Facility (SNF) stays. Currently, the description of these codes is not available within the inquiry. To assist users with determining what these codes mean, a "Patient Status Code" button has been added to the screen. This link will bring users to the Noridian Medicare page where a description of these codes are available.

Prior Authorization not Currently Required for Diabetic Supplies

Are you looking to obtain prior authorization (PA) for diabetic supplies? Diabetic supplies do not require PA. Currently only three policies require PA including Lower Limb Prosthetics, Power Mobility Devices and Pressure Reducing Support Surfaces. Instructions and resources for a successful PA submission are found on the Noridian Medicare website by selecting the Medical Review tab then Pre-Claim Review.

Providing Accessories or Supplies for Beneficiary Owned Equipment

Suppliers must ensure that the beneficiary information is on file with Medicare Fee for Service (FFS) to avoid denials. Suppliers are reminded that additional documentation is required in situations where supplies and accessories are provided for a piece of equipment not paid for by Fee-For- Service (FFS) Medicare. In addition, drugs used with a nebulizer or external infusion pump would be considered supplies to a covered piece of DME.

Claims for supplies and accessories used with beneficiary owned equipment must include all three pieces of information listed below. Claims lacking any one of the above elements will be denied for missing information with reason code 16, remark code M124. Refer to the Denial Code Resolution page on resolving and avoiding this denial in the future.

Elements required

- HCPCS code of base equipment; and,
- A notation equipment is beneficiary-owned; and,
- Date beneficiary obtained equipment (approximate)
- i.e. Beneficiary owned HCPCS; purchased month and year

Some common reasons for denials for beneficiary owned equipment not on file.

- Beneficiary purchased equipment prior to becoming Medicare eligible
- Beneficiary purchased equipment with another supplier
- Beneficiary purchased Glucose Monitor (E0607) and then purchased a Continuous Glucose Monitor (K0554) (The supplies for E0607 are not the same codes used with the K0554)
- Narrative does not match base equipment
- Base item coverage criteria not met

Service Specific Post-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting post-payment service specific reviews on the below specialties. Due to CMS direction, all post-payment reviews will be closing and TPE reviews are resuming. Final Edit Effectiveness results will be posted as they are available.

- Ankle-Foot Orthosis
- Glucose Supplies
- Knee Orthosis
- Ostomy Supplies
- Surgical Dressings
- Urological Supplies

Service Specific Post-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting post-payment service specific review for the below specialty. The final results for the below specialties from April 2021 - August 2021 can be located on the Medical Record Review Results webpage:

- Ostomy Supplies

Service Specific Post-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting post-payment service specific review for the below specialty. The following quarterly edit effectiveness results from March 2021 - May 2021 can be located on the Medical Record Review Results webpage:

- Knee Orthosis
- Urological Supplies
- Ankle-Foot Orthotics
- Surgical Dressings
- Glucose Supplies

Service Specific Post-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting post-payment service specific review for the below specialty. The final results for the below specialties from May 2021 - August 2021 can be located on the Medical Record Review Results webpage:

- Spinal Orthosis (L0457)

Submit One PTAN Per Voluntary Refund Check

When submitting a voluntary refund check, suppliers should ensure that the check involves claims for only one PTAN. There are additional steps required when a refund check involves applying the refund to claims that belong to multiple PTANs. This slows the processing of the refund. In addition, tracking the total original refund check amount is difficult as this amount will get split between the PTANs. As a result, it is in the best interest of suppliers to submit voluntary refund checks separately for each PTAN.

Surgical Dressings DME on Demand Tutorials

Looking for information on the Surgical Dressings policy?

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 YouTube channel.

Surgical Dressings

- A1-A9 Modifiers - 4 minutes
- Gradient Compression Stockings & Wraps: Coding - 3 minutes
- Gradient Compression Stockings & Wraps: Coverage Criteria - 2 minutes
- Surgical Dressings: Coverage Criteria - 2 minutes
- Surgical Dressings: Medical Records - 3 minutes
- Surgical Dressings: Orders - 3 minutes
- Surgical Dressings: Refill Requirements - 2 minutes
- L200 Surgical Dressings - Part 1 - 10 minutes
- L200 Surgical Dressings - Part 2 - 6 minutes

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

Targeted Probe and Educate (TPE) Resumption

Medical Review's Targeted Probe and Educate (TPE) program was temporarily suspended due to the COVID-19 Public Health Emergency (PHE) to help ease some of the burden on providers, facilities, and suppliers.

TPE is now set to resume. CMS has authorized the Medicare Administrative Contractors (MACs) to conduct a 10-claim preview of Round One in addition to the normal TPE process. This preview is intended to reduce burden for compliant providers, facilities, and suppliers. If the Round one preview results in zero errors, no further action is required and the TPE review will be closed.

Several webinars to review the TPE process will be held over the next few months. Registration for these events will be available on the Noridian Medicare Website

Using the KU Modifier for Wheelchair Accessories and Seat Back Cushions, Date Extended

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 is effective for dates of service from January 1, 2020 through June 30, 2021. **On July 6, 2021 per** MM12345**, this was extended to include dates of service on or after July 1, 2021**. 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.

Website Feedback and Cookies

Does it seem like you are being asked to provide feedback every day? The Noridian Website Experience survey is designed to be presented every 30 days once a survey has been completed, and every 15 days if the survey invitation is declined. These surveys use "cookies" on your internet browser to determine when the survey will be presented. A cookie is a piece of information that is sent to your browser when you access a website. Your facility's network or browser may delete these cookies daily. If this is the case, the survey cookie is no longer on your computer which causes the survey to be presented more than designed. Check with your facility's IT professionals for your company's cookie standards.

To learn more about cookies view the "Cookies" section of the Noridian Privacy Policy.

MEDICAL POLICIES AND COVERAGE .....

2020 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2020 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

2021 HCPCS Code Update - April Edition - Correct Coding

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

View the locally hosted 2021 DMD articles.

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2021 HCPCS Code Update - July Edition - Correct Coding

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

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August Revision to Glucose LCD

The Glucose Monitors Local Coverage Determination (LCD) and Policy Article (PA) has been revised. For dates of service beginning July 18, 2021, continuous glucose monitors (CGMs) now require 5 coverage criteria instead of 6. Criteria requiring that a beneficiary has been using a blood glucose monitor (BGM) and is performing frequent (four or more times a day) testing as a prerequisite for coverage of a CGM device has been removed. Please visit the LCD and PA Revision Summary for additional information.

Code Verification Review Requirement for Articulating Digit(s) and Prosthetic Hands - Revised

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

View the locally hosted 2021 DMD articles.

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Continuous Glucose Monitors (CGM) Coverage Criteria Revision - Effective July 18, 2021

The CGM Local Coverage Determination (LCD) and Policy Article (PA) have been revised. For dates of service beginning July 18, 2021, CGMs now require five coverage criteria instead of six. Visit the LCD and PA Revision Summary for additional information.

Enteral Nutrition and Parenteral Nutrition - Final LCDs and Response to Comments (RTC) Articles Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Enteral Nutrition and Parenteral Nutrition - Final LCDs and Response to Comments (RTC) Articles Published**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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- Locate/select article title

External Infusion Pumps & Glucose Monitors - Final LCDs and Response to Comments (RTC) Articles Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **External Infusion Pumps & Glucose Monitors - Final LCDs and Response to Comments (RTC) Articles Published**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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Frequently Asked Questions - Philips Respironics Respiratory Products Recall - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Frequently Asked Questions - Philips Respironics Respiratory Products Recall - 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

Incorrect Use of HCPCS Code A9279 - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Incorrect Use of HCPCS Code A9279 - 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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LCD and Policy Article Revisions Summary for June 3, 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 External Infusion Pumps and Glucose Monitors. Please review the entire LCDs and related PAs for complete information.

EXTERNAL INFUSION PUMPS

LCD

Revision Effective Date: 07/18/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: V(H) to point to Group 3 HCPCS list, instead of listing out HCPCS codes
Revised: Criteria V(H) to allow non-primary immune deficiency disorder that responds to IVIg treatment
SUMMARY OF EVIDENCE:
Added: Information related to Hizentra
ANALYSIS OF EVIDENCE:
Added: Information related to Hizentra
HCPCS CODES:
Revised: Group 3 paragraph and group 3 codes to include only subcutaneous immune globulin HCPCS codes
Added: Group 4 paragraph and codes to identify drugs for other indications
BIBLIOGRAPHY:
Added: Information related to Hizentra
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments document (A58802)

PA

Revision Effective Date: 07/18/2021
MODIFIERS:
Removed: Registered trademark symbol from first use of Cutaquig
CODING GUIDELINES:
Added: Supply codes associated with external infusion pumps HCPCS codes table
Added: Billing instruction for Hizentra for beneficiaries with CIDP using the HCPCS code J1559
Removed: Registered trademark symbol from first use of Xembify
Added: A table to identify which infusion pump is used for which specific SCIg preparations
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Group 3 paragraph to include “primary immune deficiency disorders”
Added: Group 6 listing for HCPCS code J1559, for CIDP

06/03/2021: 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.

GLUCOSE MONITORS

LCD

Revision Effective Date: 07/18/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: Four times or more per day testing with blood glucose monitor as prerequisite for CGM coverage
Revised: "injections" to "administrations" for insulin treatment regimen criterion for CGMs
Removed: "Medicare-covered" from CSII pump criterion language for CGMs
Clarified: Coding verification language for products billed as K0554
SUMMARY OF EVIDENCE:
Added: Information related to glucose testing and insulin administration
Revised: "5" to "1" minutes for measuring of interstitial fluid glucose content by CGM device
ANALYSIS OF EVIDENCE:
Added: Information related to glucose testing and insulin administration
APPENDICES:
Revised: Language of insulin-treated, by removing reference to insulin injections
BIBLIOGRAPHY:
Added: Section related to glucose testing and insulin administration
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58798)

PA

Revision Effective Date: 07/18/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Incorrect coding denial language for products billed using HCPCS that require written coding verification review
Removed: Trademark from reference to pHisohex
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Criteria references, to align with LCD criteria
Added: Clarifying language for criterion 3, frequent insulin adjustment is not a mandate if glucose levels are within target range
MODIFIERS:
Added: KF modifier instructions for Class III devices
Revised: KX modifier language "injections" to "administrations"

06/03/2021: 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.

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

LCD and Policy Article Revisions Summary for June 24, 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 Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, and Respiratory Assist Devices. Please review the entire LCDs and related PAs for complete information.

ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA

LCD

Revision Effective Date: 08/08/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: "face-to-face" to "in-person"
Removed: Not reasonable and necessary denial statement regarding custom fabricated mandibular advancement devices that do not receive written coding verification
Revised: Sleep Tests section to point to NCD 240.4.1 and applicable A/B MAC LCDs and Billing and Coding articles
SUMMARY OF EVIDENCE:
Added: Information related to diagnostic sleep testing
ANALYSIS OF EVIDENCE:
Added: Information related to diagnostic sleep testing
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58823)

PA

Revision Effective Date: 08/08/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Language regarding no aspect of a home sleep test may be performed by a DME supplier
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: "face-to-face" to "in-person"
Revised: History elements of the treating practitioners evaluation by separating the "sleep hygiene inventory" from the "duration of symptoms" bullet
MODIFIERS:
Revised: The reference to the coverage criteria within the "Coverage Indications, Limitations, and/or Medical Necessity" section of the LCD
CODING GUIDELINES:
Revised: Coding Verification Review statement for E0486 by removing "appropriate" prior to "Product Classification List"
Added: Incorrect coding denial statement for HCPCS codes that do not receive written coding verification review
Removed: Language related to the use of HCPCS code A9270 when coding verification was not received

06/24/2021: 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.

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

LCD

Revision Effective Date: 08/08/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: The CMS manual reference to CMS Pub. 100-03
Revised: Sleep Tests section to point to NCD 240.4.1 and applicable A/B MAC LCDs and Billing and Coding articles
Removed: Appendix B "List of Approved Other Devices that Indirectly Measure AHI/RDI"
SUMMARY OF EVIDENCE:
Added: Information related to diagnostic sleep testing
ANALYSIS OF EVIDENCE:
Added: Information related to diagnostic sleep testing
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58824)

PA

Revision Effective Date: 08/08/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Medicare Benefit Policy Manual reference
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Typographical error, by adding comma after "Limitations" when referencing "Coverage Indications, Limitations, and/or Medical Necessity"
CODING GUIDELINES:
Revised: Language related to HCPCS code A9279 and the incorrect use of NOC codes for monitoring technologies

06/24/2021: 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.

RESPIRATORY ASSIST DEVICES

LCD

Revision Effective Date: 08/08/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: 'etc.' from initial coverage statement for E0470 or an E0471 RAD
Revised: Situation 1 and 2 revised "Group II" to "severe COPD" beneficiaries
Revised: Situation 1 criterion B to proper LCD title, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea for E0471
Revised: Hypoventilation Syndrome criterion D to proper LCD title, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea for E0470 and E0471
Revised: Header from "VENTILATOR WITH NOINVASIVE INTERFACES" to "VENTILATOR"
Revised: The CMS manual reference to CMS Pub. 100-03
Added: HCPCS code E0467 to ventilator code listings
Revised: "Patient" to "beneficiary"
Removed: Statement of claim line rejection if billed without GA, GZ or KX modifier
Removed: "etc." from BENEFICIARIES ENTERING MEDICARE section
Revised: SLEEP TESTS section to point to NCD 240.4.1 and applicable A/B MAC LCDs and Billing and Coding articles
SUMMARY OF EVIDENCE:
Added: Information related to diagnostic sleep testing
ANALYSIS OF EVIDENCE:
Added: Information related to diagnostic sleep testing
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58822)

PA

Revision Effective Date: 08/08/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Language regarding no aspect of a home sleep test may be performed by a DME supplier
Revised: Language regarding a liner used in conjunction with a PAP mask are noncovered
Added: Language regarding monitoring devices are statutorily non-covered (previously under Coding Guidelines)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Coverage, coding and documentation requirements reference from "see below" to "see Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD"
MODIFIERS:
Removed: Reference to "Group I - IV" from KX modifier section as groups are no longer referenced in the Coverage Indications, Limitations, and/or Medical Necessity section of the related LCD
Revised: Typographical errors to add commas after "Limitations" when referencing "Coverage Indications, Limitations, and/or Medical Necessity"
Added: Statement of claim line rejection if billed without GA, GZ or KX modifier (previously noted in the LCD)

CODING GUIDELINES:
Revised: Language related to HCPCS code A9279 and monitoring devices and services

06/24/2021: 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.

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:

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        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

Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea and Respiratory Assist Devices - Final LCDs and Response to Comments (RTC) Articles Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for Obstructive Sleep Apnea and Respiratory Assist Devices - Final LCDs and Response to Comments (RTC) Articles Published**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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Policy Article Revisions Summary for July 8, 2021

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Negative Pressure Wound Therapy Pumps and Suction Pumps. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

NEGATIVE PRESSURE WOUND THERAPY PUMPS

PA

Revision Effective Date: 08/15/2021
CODING GUIDELINES:
Added: A9272 coding guideline information, to clarify all-inclusive and supplies are not separately billable
Removed: Direction for billing miscellaneous A9900

07/08/2021: 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.

SUCTION PUMPS

PA

Revision Effective Date: 08/15/2021
CODING GUIDELINES:
Removed: Trademark symbol from Winx, per AMA guidelines
Revised: A9272 coding guideline information, to clarify all-inclusive and supplies are not separately billable

07/08/2021: 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.

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

Sleep Test Requirements

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Sleep Test Requirements**, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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MLN CONNECTS

MLN Connects - June 3, 2021

MACs Resume Medical Review

MLN Connects newsletter for Thursday, June 3, 2021

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NEWS

- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 7
- Clinical Diagnostic Laboratories: Key Dates for New & Reconsidered Test Codes
- Clinical Diagnostic Laboratories: Private Payor Rate-Based CLFS Resources
- MACs Resume Medical Review on a Post-payment Basis
- CMS Celebrates Pride Month

COMPLIANCE

- Improper Payment for Intensity-Modulated Radiation Therapy Planning Services

MLN MATTERS® ARTICLES

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - October 2021
- National Coverage Determination (NCD) 110.24: Chimeric Antigen Receptor (CAR) T-cell Therapy
- National Coverage Determination (NCD) 210.3: Screening for Colorectal Cancer (CRC) - Blood-Based Biomarker Tests
- National Coverage Determination (NCD) Removal
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment

PUBLICATIONS

- Medicare Disproportionate Share Hospital - Revised

MULTIMEDIA

- Hospice Quality Reporting Program: May Forum Materials

MLN Connects Special Edition - June 9, 2021 - Biden Administration Continues Efforts to Increase Vaccinations by Bolstering Payments for At-Home COVID-19 Vaccinations for Medicare Beneficiaries

As part of President Biden's commitment to increasing access to vaccinations, CMS announced an additional payment amount for administering in-home COVID-19 vaccinations to Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach. This announcement further demonstrates continued efforts of the Biden-Harris Administration to meet people where they are and make it as easy as possible for all Americans to get vaccinated. There are approximately 1.6 million adults 65 or older who may have trouble accessing COVID-19 vaccinations because they have difficulty leaving home.

While many Medicare beneficiaries can receive a COVID-19 vaccine at a retail pharmacy, their physician's office, or a mass vaccination site, some beneficiaries have great difficulty leaving their homes or face a taxing effort getting around their communities easily to access vaccination in these settings. To better serve this group, Medicare is incentivizing providers and will pay an additional $35 per dose for COVID-19 vaccine administration in a beneficiary's home, increasing the total payment amount for at-home vaccination from approximately $40 to approximately $75 per vaccine dose. For a two-dose vaccine, this results in a total payment of approximately $150 for the administration of both doses, or approximately $70 more than the current rate.

"CMS is committed to meeting the unique needs of Medicare consumers and their communities - particularly those who are home bound or who have trouble getting to a vaccination site. That's why we're acting today to expand the availability of the COVID-19 vaccine to people with Medicare at home," said CMS Administrator Chiquita Brooks-Lasure. "We're committed to taking action wherever barriers exist and bringing the fight against the COVID-19 pandemic to the door of older adults and other individuals covered by Medicare who still need protection."

Delivering COVID-19 vaccination to access-challenged and hard-to-reach individuals poses some unique challenges, such as ensuring appropriate vaccine storage temperatures, handling, and administration. The CDC has outlined guidance to assist vaccinators in overcoming these challenges. This announcement now helps to address the financial burden associated with accommodating these complications.

The additional payment amount also accounts for the clinical time needed to monitor a beneficiary after the vaccine is administered, as well as the upfront costs associated with administering the vaccine safely and appropriately in a beneficiary's home. The payment rate for administering each dose of a COVID-19 vaccine, as well as the additional in-home payment amount, will be geographically adjusted based on where the service is furnished.

How to Find a COVID-19 Vaccine:

As this action demonstrates, a person's ability to leave their home should not be an obstacle to getting the COVID-19 vaccine. As states and the federal government continue to break down barriers - like where vaccines can be administered - resources for connecting communities to vaccination options remain key. Unvaccinated individuals and those looking to assist friends and family can:

1. Visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby
2. Text GETVAX (438829) for English or VACUNA (822862) for Spanish for near-instant access to details on three vaccine sites in the local area
3. Call the National COVID-19 Vaccination Assistance Hotline at 1-800-232-0233 (TTY: 1-888-720-7489) for assistance in English and Spanish

Coverage of COVID-19 Vaccines:

The federal government is providing the COVID-19 vaccine free of charge or with no cost-sharing for all people living in the United States. As a condition of receiving free COVID-19 vaccines from the federal government, vaccine providers cannot charge patients any amount for administering the vaccine.

Because no patient can be billed for COVID-19 vaccinations, CMS and its partners have provided a variety of information online for providers vaccinating all Americans regardless of their insurance status:

- Original Medicare and Medicare Advantage: Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance or deductible.
- Medicaid and the Children's Health Insurance Program (CHIP): State Medicaid and CHIP agencies must cover COVID-19 vaccine administration with no cost sharing for nearly all beneficiaries during the COVID-19 Public Health Emergency (PHE) and for over a year after it ends. For the very limited number of Medicaid beneficiaries who are not eligible for this coverage (and do not receive it through other coverage they might have), providers may submit claims for reimbursement for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund, administered by the Health Resources and Services Administration (HRSA), as discussed below. Under the American Rescue Plan Act of 2021 (ARP), signed by President Biden on March 11, 2021, the federal matching percentage for state Medicaid and CHIP expenditures on COVID-19 vaccine administration is currently 100% (as of April 1, 2021), and will remain 100% for more than a year after the COVID-19 PHE ends. The ARP also expands coverage of COVID-19 vaccine administration under Medicaid and CHIP to additional eligibility groups. CMS recently updated the Medicaid vaccine toolkit to reflect the enactment of the ARP at https://www.medicaid.gov/state-resource-center/downloads/covid-19-vaccine-toolkit.pdf.
- Private Plans: The vaccine is free for people enrolled in private health plans and issuers COVID-19 vaccine and its administration is covered without cost sharing for most enrollees, and such coverage must be provided both in-network and out-of-network during the PHE. Current regulations provide that out-of-network rates must be reasonable as compared to prevailing market rates, and the rules reference using the Medicare payment rates as a potential guideline for insurance companies. In light of CMS's increased Medicare payment rates, CMS will expect health insurance issuers and group health plans to continue to ensure their rates are reasonable when compared to prevailing market rates. Under the conditions of participation in the CDC COVID-19 Vaccination Program, providers cannot charge plan enrollees any administration fee or cost sharing, regardless of whether the COVID-19 vaccine is

administered in-network or out-of-network.

The Biden-Harris Administration is providing free access to COVID-19 vaccines for every adult living in the United States. For individuals who are underinsured, providers may submit claims for reimbursement for administering the COVID-19 vaccine through the COVID-19 Coverage Assistance Fund administered by HRSA after the claim to the individual's health plan for payment has been denied or only partially paid. Information is available at https://www.hrsa.gov/covid19-coverage-assistance.

For individuals who are uninsured, providers may submit claims for reimbursement for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by HRSA. Information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program is available at https://www.hrsa.gov/CovidUninsuredClaim.

More information on Medicare payment for COVID-19 vaccine administration - including a list of billing codes, payment allowances and effective dates - is available at https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment.

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 at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html.

MLN Connects - June 10, 2021

Cognitive Assessment: What's in the Written Care Plan?

MLN Connects newsletter for Thursday, June 10, 2021

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NEWS

- Cognitive Assessment: What's in the Written Care Plan?
- Hospital Outpatient Departments: Prior Authorization for Additional Services Begins July 1
- PEPPERs for Short-term Acute Care Hospitals

COMPLIANCE

- Importance of Proper Documentation: Provider Minute Video

CLAIMS, PRICERS, & CODES

- ICD-10-PCS Procedure Codes: FY 2022
- Average Sales Price Files: July 2021

EVENTS

- Physician Fee Schedule: Improving Practice Expense Data & Methods Town Hall - June 16

MLN MATTERS® ARTICLES

- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits - Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2021 Update - Revised

PUBLICATIONS

- Medicare Modernization of Payment Software
- Medicare Quarterly Provider Compliance Newsletter

MULTIMEDIA

- Medicare Shared Savings Program Webcast: Audio Recording & Transcript

MLN Connects - June 17, 2021

COVID-19: EUAs for Monoclonal Antibody Products

MLN Connects newsletter for Thursday, June 17, 2021

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NEWS

- COVID-19: EUA for Sotrovimab Monoclonal Antibody Product
- COVID-19: EUA for Regeneron Monoclonal Antibody Product Casirivimab & Imdevimab
- Men's Health: Medicare Covers Preventive Services

COMPLIANCE

- Hospice Care: Safeguards for Medicare Patients

EVENTS

- HCPCS Public Meeting - Begins July 7

MLN MATTERS® ARTICLES

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Codes 0240U, 0241U, and 87637
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2021
- Quarterly Update to Home Health (HH) Grouper
- July 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - Revised

PUBLICATIONS

- Medicare Mental Health - Revised
- Medicare Secondary Payer - Revised
- Skilled Nursing Facility 3-Day Rule Billing - Revised

MULTIMEDIA

- World of Medicare Web-Based Training - Revised

MLN Connects - June 24, 2021

2019 Quality Payment Program: Performance Information on Care Compare

MLN Connects newsletter for Thursday, June 24, 2021

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NEWS

- 2019 Quality Payment Program: Performance Information on Care Compare
- Orthoses Referring Providers: Comparative Billing Report in June

COMPLIANCE

- SNF 3-Day Rule: Bill Correctly

MLN MATTERS® ARTICLES

- July 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.2
- July 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- National Coverage Determination (NCD) 20.9.1 Ventricular Assist Devices (VADs)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge

Payment - Revised

PUBLICATIONS

- Medicare Billing for Cardiac Device Credits - Revised

MLN Connects Special Edition - June 28, 2021 - CMS to Improve Home Health Services for Older Adults and People with Disabilities

Proposed rule would accelerate shift from volume-based incentives to quality-based incentives

CMS issued a proposed rule that accelerates the shift from paying for home health services based on volume, to a system that incentivizes value and quality. The rule also seeks feedback on ways to attain health equity for all patients through policy solutions, including enhancing reports on Medicare/Medicaid dual eligible, disability status, people who are LGBTQ+; religious minorities; people who live in rural areas; and people otherwise adversely affected by persistent poverty or inequality.

The CY 2022 Home Health Prospective Payment System (HH PPS) proposed rule addresses challenges facing Americans with Medicare who receive health care at home. The proposed rule also outlines nationwide expansion of the Home Health Value-Based Purchasing (HHVBP) Model to incentivize quality of care improvements without denying or limiting coverage or provision of Medicare benefits for all Medicare consumers, and updates to payment rates and policies under the HH PPS.

"Homebound Medicare patients face a unique set of challenges and barriers to getting the care they need," said CMS Administrator Chiquita Brooks-LaSure. "Today's announcement is a reaffirmation of our commitment to these older adults and people with disabilities who are counting on Medicare for the health care they need. This proposed rule would streamline service delivery and value quality over quantity - at a time when Americans need it most."

The CMS Innovation Center (CMMI) developed the HHVBP Model, which began January 1, 2016, to determine whether payment incentives for providing better quality of care with greater efficiency would improve the quality and delivery of home health care services to people with Medicare. The HHVBP Model's current participants comprise 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% improvement in HHAs' quality scores and an average annual savings of $141 million to Medicare.

CMS announced January 8, 2021 that the HHVBP model met the statutory requirements for expansion. CMS is proposing to expand the HHVBP Model nationwide effective January 1, 2022. By expanding the HHVBP Model, CMS seeks to improve the beneficiary experience by providing incentives for HHAs to provide better quality of care with greater efficiency.

Additionally, the proposed rule would improve the Home Health Quality Reporting Program by removing or replacing certain quality measures to reduce burden and increase focus on patient outcomes. CMS would also 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 and Inpatient Rehabilitation Quality Reporting Programs effective October 1, 2022. This would position the agency with data to monitor outcomes across diverse populations and support the recent Executive Order 13985 of January 20, 2021, entitled "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government."

More Information:

- Proposed rule
- Fact Sheet

MLN Connects - July 1, 2021

Quality Payment Program: 2021 APM Incentive Payments

MLN Connects newsletter for Thursday, July 1, 2021

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NEWS

- Quality Payment Program: 2021 APM Incentive Payments

COMPLIANCE

- Inhalant Drugs: Bill Correctly

EVENTS

- Organ Procurement Organization Conditions for Coverage Webinar - July 7

MLN MATTERS® ARTICLES

- July 2021 Update of the Ambulatory Surgical Center [ASC] Payment System

PUBLICATIONS

- Medicare Preventive Services - Revised

MULTIMEDIA

- LTCH QRP: Achieving a Full APU - May 27 Webinar Materials

MLN Connects Special Edition - July 1, 2021 - CMS Proposes Changes to Reduce Health Care Disparities Among Patients with Chronic Kidney Disease and End-Stage Renal Disease

Proposed changes mark Innovation Center's first direct effort to close health equity gaps

CMS proposed actions that aim to close health equity gaps by providing Medicare patients battling End-Stage Renal Disease (ESRD) with greater access to care, through the ESRD Prospective Payment System (PPS) annual rulemaking. This proposed rule would update ESRD PPS payment rates, make changes to the ESRD Quality Incentive Program (QIP), and modify the ESRD Treatment Choices (ETC) Model. The proposed changes to the ETC Model policies would aim to encourage dialysis providers to decrease disparities in rates of home dialysis and kidney transplants among ESRD patients with lower socioeconomic status, making the model the agency's first CMS Innovation Center model to directly address health equity.

According to CMS Office of Minority Health studies on racial, ethnic, and socioeconomic factors, disadvantaged Medicare patients suffer from ESRD at higher rates. They are also more likely to experience higher hospital readmissions and costs, as well as receive in-center hemodialysis because their kidneys are no longer able to perform their function. 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.

"Health equity is at the center of our work here at CMS," said CMS Administrator Chiquita Brooks-LaSure. "Today's proposed rule is grounded in measures to ensure people with Medicare who suffer from chronic kidney disease have easy access to quality care and convenient treatment options. When CMS encourages dialysis providers to offer more options for Medicare patients to receive dialysis treatments, it can be life changing and lead to better health outcomes, greater autonomy and better quality of life for patients with kidney disease."

The proposed changes to the ETC Model build on the current model by proposing to test a new health care approach that rewards ESRD facilities and managing clinicians participating in the model for achieving significant improvement in the rates of home dialysis and kidney transplants for lower income beneficiaries. If finalized, these changes would take effect Jan. 1, 2022.

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. CMS is soliciting feedback in this proposed rule on opportunities to collect and leverage diverse sets of data. This includes race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+ and socioeconomic status. It also includes new methodological approaches to advance equity through the ESRD Quality Incentive Program (ESRD QIP).

The rule includes proposals under the ESRD QIP to address the circumstances of the COVID-19 Public Health Emergency (PHE), such as not scoring or reducing payment to any facility in 2022 based on data from 2020. Regarding COVID-19 vaccination measures, the proposed rule requests stakeholder feedback on the feasibility of incorporating COVID-19 Healthcare Provider and Patient Vaccination measures in the ESRD QIP measure set. Currently, nearly 90% of all dialysis facilities are reporting vaccination data performance to the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network

(NHSN). CMS is evaluating options for publicly reporting the data on official CMS datasets that compare the quality of care provided in Medicare-certified dialysis facilities nationwide.

CMS' proposed rule includes several requests for information for the agency to consider as part of its goal to increase access to dialysis treatments at home. Currently, Medicare will only pay for dialysis at an ESRD facility for patients with Acute Kidney Injury (AKI). CMS is soliciting comments regarding potentially modifying the site of renal dialysis services for patients with AKI and payment for AKI in the home setting.

More Information:

- Proposed rule
- Fact Sheet

MLN Connects - July 8, 2021

COVID-19 Accelerated and Advance Payments: Updated FAQs

MLN Connects newsletter for Thursday, July 8, 2021

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NEWS

- COVID-19 Accelerated and Advance Payments: Updated FAQs
- COVID-19 Snapshot: Impact on the Medicare Population

COMPLIANCE

- Hospice Aide Services: Enhancing RN Supervision

MLN MATTERS® ARTICLES

- July Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- October Quarterly Update to 2021 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement - Revised

MLN Connects Special Edition - July 13, 2021 - CMS Proposes Physician Payment Rule to Improve Health Equity, Patient Access

CMS is proposing changes to address the widening gap in health equity highlighted by the COVID-19 Public Health Emergency (PHE) and to expand patient access to comprehensive care, especially in underserved populations. In CMS's annual Physician Fee Schedule (PFS) proposed rule, the agency is recommending steps that continue the Biden-Harris Administration's commitment to strengthen and build upon Medicare by promoting health equity; expanding access to services furnished via telehealth and other telecommunications technologies for behavioral health care; enhancing diabetes prevention programs; and further improving CMS's quality programs to ensure quality care for Medicare beneficiaries and to create equal opportunities for physicians in both small and large clinical practices.

"Over the past year, the public health emergency has highlighted the disparities in the U.S. health care system, while at the same time demonstrating the positive impact of innovative policies to reduce these disparities," said CMS Administrator Chiquita Brooks-LaSure. "CMS aims to take the lessons learned during this time and move forward toward a system where no patient is left out and everyone has access to comprehensive quality health services."

CMS Seeks Feedback on Health Equity Data Collection:

CMS is committed to addressing the significant and persistent inequities in health outcomes in the U.S. by improving data collection to better measure and analyze disparities across programs and policies. In the proposed PFS rule, CMS is soliciting feedback on the collection of data, and on how the agency can advance health equity for people with Medicare (while protecting individual privacy), potentially through the creation of confidential reports that allow providers to look at patient impact through a variety of data points - including, but not limited to, LGBTQ+, race and ethnicity, dual-eligible beneficiaries, disability, and rural populations. Access to these data may enable a more comprehensive assessment of health equity and

support initiatives to close the equity gap. In addition, hospitals and health care providers may be able to use the results from the disparity analyses to identify and develop strategies to promote health equity.

Expanding Telehealth and Other Telecommunications Technologies for Behavioral and Mental Health Care:

In the proposed rule, CMS is reinforcing its commitment to expanding access to behavioral health care and reducing barriers to treatment. CMS is proposing to implement recently enacted legislation that removes certain statutory restrictions to allow patients in any geographic location and in their homes access to telehealth services for diagnosis, evaluation, and treatment of mental health disorders. Along with this change, CMS is proposing to expand access to mental health services for rural and vulnerable populations by allowing, for the first time, Medicare to pay for mental health visits when they are provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to include visits furnished through interactive telecommunications technology. This proposal would expand access to Medicare beneficiaries, especially those living in rural and other underserved areas.

To further expand access to care, CMS is proposing to allow payment to eligible practitioners when they provide certain mental and behavioral health services to patients via audio-only telephone calls from their homes when certain conditions are met. This includes counseling and therapy services provided through Opioid Treatment Programs. These changes would be particularly helpful for those in areas with poor broadband infrastructure and among people with Medicare who are not capable of, or do not consent to the use of, devices that permit a two-way, audio/video interaction for their health care visits.

"The COVID-19 pandemic has put enormous strain on families and individuals, making access to behavioral health services more crucial than ever," said Brooks-LaSure. "The changes we are proposing will enhance the availability of telehealth and similar options for behavioral health care to those in need, especially in traditionally underserved communities."

Boosting Participation in the Medicare Diabetes Prevention Program:

CMS is proposing a change to expand the reach of the Medicare Diabetes Prevention Program (MDPP) expanded model. MDPP was developed to help people with Medicare with prediabetes from developing type 2 diabetes. The expanded model is implemented at the local level by MDPP suppliers: organizations who 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.

Approximately one in three American adults (over 88 million) have prediabetes, and more than eight in 10 do not even know they have it. Many are at risk for developing type 2 diabetes within five years. Several underserved communities ?? including African Americans, Hispanic/Latino Americans, American Indians, Pacific Islanders, and some Asian Americans ?? are at particularly high risk for type 2 diabetes.

During the COVID-19 PHE, CMS has been waiving the Medicare enrollment fee for new MDPP suppliers and has observed increased supplier enrollment. CMS is proposing to waive this fee for all organizations that submit an application to enroll in Medicare as an MDPP supplier on or after January 1, 2022. Additionally, CMS is proposing changes to make delivery of MDPP services more sustainable and to improve patient access by making it easier for local suppliers to participate and reach their communities by proposing to shorten the MDPP services period to one year instead of two years. This proposal would reduce the administrative burden and costs to suppliers. CMS is also proposing to restructure payments so MDPP suppliers receive larger payments for participants who reach milestones for attendance and weight loss.

Advancing the Quality Payment Program:

CMS is taking further steps to improve the quality of care for people with Medicare through changes to the agency's 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.

CMS is proposing to require clinicians to meet a higher performance threshold to be eligible for incentives. This new threshold aligns with the requirements established for the QPP's Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act of 2015.

To ensure more meaningful participation for clinicians and improved outcomes for patients, CMS is moving forward with the next evolution of QPP and proposing its first seven MIPS Value Pathways (MVPs) - subsets of connected and complementary measures and activities, established through rulemaking, used to meet MIPS reporting requirements. The initial set of proposed 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. MVPs will more effectively

measure and compare performance across clinician types and provide clinicians more meaningful feedback. CMS is also proposing to revise the current eligible clinician definition to include clinical social workers and certified nurse-midwives, as these professionals are often on the front lines serving communities with acute health care needs.

Additionally, CMS is proposing to implement a recent statutory change that authorizes Medicare to make direct Medicare payments to Physician Assistants (PAs) for professional services they furnish under Part B. Beginning January 1, 2022, for the first time, PAs would be able to bill Medicare directly, thus expanding access to care and reducing the administrative burden that currently requires a PA's employer or independent contractor to bill Medicare for a PA's professional services.

Updating Vaccine Payment Rates:

The COVID-19 pandemic has highlighted the importance of access to vaccines. The Biden-Harris Administration has taken steps to increase American's access to COVID-19 vaccinations and is committed to meeting people where they are and making it as easy as possible for all Americans to get vaccinated. That commitment extends to other, more common vaccinations.

Medicare payments to physicians and mass immunizers for administering flu, pneumonia, and hepatitis B vaccines have decreased by around 30% over the last seven years. In the PFS proposed rule, CMS is requesting feedback to help update payment rates for administration of preventive vaccines covered under Part B. In addition to seeking information on the types of health care providers who furnish vaccines and their associated costs, CMS is looking for feedback on its recently adopted payment add-on of $35 for immunizers who vaccinate certain underserved patients in the patient's home. CMS is also seeking comments on the treatment of COVID-19 monoclonal antibody products as vaccines, and whether those products should be treated like other monoclonal antibody products after the COVID-19 PHE.

Proposal to Phase Out Coinsurance for Colorectal Screening Additional Services:

CMS is also proposing to implement a recent statutory change to provide a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps). Currently, the addition of any procedure beyond the planned colorectal screening (for which there is no coinsurance) results in a patient having to pay coinsurance.

Under the proposed change, beginning January 1, 2022, the amount of coinsurance patients will pay for such additional services would be reduced over time, so that by January 1, 2030, it would be down to zero.

More Information:

- Proposed rule
- Medicare PFS Proposed Rule fact sheet
- QPP fact sheet
- MDPP Expanded Model fact sheet

MLN Connects - July 15, 2021

Cognitive Assessment: Resources for Providers

MLN Connects newsletter for Thursday, July 15, 2021

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NEWS

- Cognitive Assessment: Resources for Providers
- CMS Opens National Coverage Determination Analysis on Treatment for Alzheimer's Disease
- PEPPERs for HHAs and PHPs

COMPLIANCE

- IRF Services: Follow Medicare Billing Requirements

CLAIMS, PRICERS, & CODES

- ICD-10-CM Codes: FY 2022

MULTIMEDIA

- Medicare Billing: Form CMS-1500 and 837 Professional Web-Based Training - Revised
- Medicare Billing: Form CMS-1450 and 837 Institutional Web-Based Training - Revised

MLN Connects Special Edition - July 19, 2021 - CMS Proposes Rule to Increase Price Transparency, Access to Care, Safety & Health Equity

CMS PROPOSES RULE TO INCREASE PRICE TRANSPARENCY, ACCESS TO CARE, SAFETY & HEALTH EQUITY

CMS is proposing actions to address the health equity gap, ensure consumers have the information they need to make fully informed decisions regarding their health care, improve emergency care access in rural communities, and use lessons learned from the COVID-19 pandemic to inform patient care and quality measurements.

In accordance with President Biden's Competition Executive Order, CMS is further strengthening its efforts to increase price transparency, holding hospitals accountable and ensuring consumers have the information they need to make fully informed decisions regarding their health care.

"As President Biden made clear in his executive order promoting competition, a key to price fairness is price transparency," said HHS Secretary Xavier Becerra. "No medical entity should be able to throttle competition at the expense of patients. I have fought anti-competitive practices before, and strongly believe health care must be in reach for everyone. With today's proposed rule, we are simply showing hospitals through stiffer penalties: concealing the costs of services and procedures will not be tolerated by this Administration."

"CMS is committed to addressing significant and persistent inequities in health outcomes in the United States and today's proposed rule helps us achieve that by improving data collection to better measure and analyze disparities across programs and policies," said CMS Administrator Chiquita Brooks-LaSure. "We are committed to finding opportunities to meet the health needs of patients and consumers where they are, whether it's by expanding access to onsite care in their communities, ensuring they have access to clear information about health care costs, or enhancing patient safety."

The proposed rule includes the following actions:

Price Transparency:

Hospital price transparency helps Americans know what a hospital charges for the items and services they provide. CMS takes seriously concerns it has 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.

CMS proposes to increase the penalty for some hospitals that do not comply with Hospital Price Transparency final rule. Specifically, CMS is proposing to set a minimum civil monetary penalty of $300/day that would apply to smaller hospitals with a bed count of 30 or fewer and apply a penalty of $10/bed/day for hospitals with a bed count greater than 30, not to exceed a maximum daily dollar amount of $5,500. Under this proposed 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.

Based on information that hospitals have made public this year, there is wide variation in prices - even within the same hospital or the same system, depending on what each insurance plan has negotiated with that hospital. CMS is committed to ensuring consumers have the information they need to make fully informed decisions regarding their health care, since health care prices can cause significant financial burdens for consumers.

Health Equity:

CMS is seeking input on ways to make reporting of health disparities based on social risk factors and race and ethnicity more comprehensive and actionable. This includes soliciting comments on potential collection of data and analysis and reporting of quality measure results by a variety of demographic data points including, but not limited to, race, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status.

Access to Emergency Care in Rural Areas:

Since 2010, 138 rural hospitals have closed - disproportionately within communities with a higher proportion of people of color and communities with higher poverty rates. Rural communities experience shorter life expectancy, higher mortality, and have fewer local providers, leading to worse health outcomes than in other communities.

Rural hospital closures deprive people living in rural areas of crucial services, including access to emergency care. To address these concerns, Congress enacted Section 125 of the Consolidated Appropriations Act of 2021 (CAA), which establishes a new provider type for Rural Emergency Hospitals (REHs). REHs will be required to furnish emergency department services and observation care and may provide other outpatient medical and health services as specified by the Secretary through rulemaking. In this proposed rule, CMS is requesting information to inform the development of requirements that would apply to REHs. This new provider designation will apply to items and services furnished on or after January 1, 2023.

CMS is seeking feedback on a wide-range of issues to help inform policy proposals for the CY 2023 rulemaking cycle, including feedback on the potential services to be provided by REHs; health and safety standards and quality measures to be established for REHs; and payment provisions for this provider type.

COVID-19 Lessons:

To incorporate lessons learned from the COVID-19 pandemic, CMS is seeking comment on the extent to which hospitals are using flexibilities offered during the COVID-19 public health emergency to provide mental health services remotely and whether CMS should consider changes to account for shifting practice patterns. In addition, CMS is proposing changes to measure how many of our nation's front-line healthcare workers in hospital outpatient departments and Ambulatory Surgical Centers (ASCs) are vaccinated against COVID-19 and to make this information available to the public so consumers know how many workers are vaccinated in different health care settings.

Improving Patient Experience and Outcomes:

The Radiation Oncology (RO) Model aims to improve the quality of care for cancer patients receiving radiotherapy and move toward a simplified and predictable payment system. The RO Model tests whether prospective, site neutral, modality agnostic, episode-based payments to physician group practices, hospital outpatient departments, and freestanding radiation therapy centers for radiotherapy episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries.

CMS is proposing changes to the RO Model, which aim to improve the experience of patients receiving radiation treatment, while incorporating evidence-based best practices to help providers improve patient outcomes.

Patient Safety:

CMS is increasing Medicare beneficiary safety by reversing changes made for 2021 regarding the care setting for which Medicare will pay for surgical procedures that may pose risk to patients.

Specifically, the agency is proposing to halt the phased elimination of the Inpatient-Only (IPO) list-procedures that Medicare will only make payment for when provided in the inpatient setting. There are some services designated as inpatient only that, given their clinical intensity, would not be expected to be performed in the outpatient setting. CMS adopted a policy for 2021 to eliminate this list over a phased period and removed musculoskeletal procedures from the list in 2021.

This change happened without individually evaluating whether the procedures met the long-standing criteria previously used to determine if a procedure could be safely removed. Some of the musculoskeletal services removed includes services like limb amputations and invasive spinal procedures.

CMS reviewed each procedure code of services that were removed and found none met criteria for removal, with insufficient supporting evidence that the service can be safely performed on the Medicare population in the outpatient setting.

CMS is proposing to add them back on to the list in 2022, and is seeking comment on whether to maintain the longer-term objective of eliminating the IPO list, maintaining the IPO list, or maintaining the list but continue to streamline the list of services. The latter would continue systematic scaling of the list back to ensure inpatient-only designations are consistent with current standards of practice.

CMS is also proposing to reinstate the patient safety criteria it uses to evaluate whether a procedure should be payable in the ASC setting that were removed in 2021. CMS is proposing to adopt a nomination process whereby the publicly can formally nominate procedures it believes are safe to perform for the Medicare population in the ASC setting.

More Information:

- Proposed rule
- Fact sheet

MLN Connects - July 22, 2021

COVID-19: EUA for Tocilizumab Monoclonal Antibody Product

MLN Connects newsletter for Thursday, July 22, 2021

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NEWS

- COVID-19: EUA for Tocilizumab Monoclonal Antibody Product
- Medicare Ground Ambulance Data Collection System FAQs
- Wound Debridement: Comparative Billing Report in July
- 3 Ways to Protect Your Medicare Enrollment Information
- Americans with Disabilities Act: 31st Anniversary
- Viral Hepatitis: Medicare Covers Preventive Services

COMPLIANCE

- Polysomnography Services: Bill Correctly

CLAIMS, PRICERS, & CODES

- ICD-10-CM Diagnosis Code Files for FY 2022

MLN MATTERS® ARTICLES

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2021
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- October 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.3, Effective October 1, 2021
- Section 50 in Chapter 30 of Publication (Pub.) 100-04 Manual Updates
- National Coverage Determination (NCD 110.24): Chimeric Antigen Receptor (CAR) T-cell Therapy - Revised

PUBLICATIONS

- Critical Access Hospital - Revised
- Medicare Advance Written Notices of Noncoverage - Revised
- Rural Health Clinic - Revised

MULTIMEDIA

- Combating Medicare Parts C and D Fraud, Waste, and Abuse Web-Based Training - Revised

MLN Connects - July 29, 2021

Hospital Price Transparency Stakeholder Webinar - August 11

MLN Connects newsletter for Thursday, July 29, 2021

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COMPLIANCE

- Ambulance Services & SNF Consolidated Billing Requirements: Avoid Improper Payments

EVENTS

- Hospice Quality Reporting Program Forum: FY 2022 Final Rule - August 4
- Price Transparency Stakeholder Webinar - August 11
- Ambulance Open Door Forum - August 12

MULTIMEDIA

- Medicare Secondary Payer Provisions Web-Based Training - Revised

MLN Connects Special Edition - July 29, 2021 - 4 Final FY 2022 Payment Rules

SNF PROSPECTIVE PAYMENT SYSTEM: FY 2022 FINAL RULE

On July 29, CMS issued a final rule updating Medicare payment policies and rates for Skilled Nursing Facilities (SNFs) under the SNF Prospective Payment System (PPS) for Fiscal Year (FY) 2022. In addition, the final rule includes several policies that update the SNF Quality Reporting Program and the SNF Value-Based Program (VBP) for FY 2022.

CMS estimates that the aggregate impact of the payment policies in this final rule would result in an increase of approximately $410 million in Medicare Part A payments to SNFs in FY 2022. This estimate reflects a $411 million increase from the update to the payment rates of 1.2%, which is based on a 2.7% SNF market basket update, less a 0.8 percentage point forecast error adjustment and a 0.7 percentage point productivity adjustment, and a $1.2 million decrease due to the proposed reduction to the SNF PPS rates to account for the recent blood-clotting factors exclusion. These impact figures do not incorporate the SNF VBP reductions that are estimated to be $184.25 million in FY 2022.

The final rule also includes:

- Methodology for recalibrating the Patient Driven Payment Model (PDPM) parity adjustment
- Section 134 of the Consolidated Appropriations Act, 2021 - New Blood Clotting Factor Exclusion from SNF Consolidated Billing
- Changes in PDPM ICD-10 code mappings

More Information:

- Full fact sheet
- Final rule

HOSPICE PAYMENT RATE UPDATE: FY 2022 FINAL RULE

On July 29, CMS issued a final rule that updates Medicare hospice payments and the aggregate cap amount for Fiscal Year (FY) 2022 in accordance with existing statutory and regulatory requirements. This rule rebases the hospice labor shares and clarifies certain aspects of the hospice election statement addendum requirements. In addition, this rule finalizes changes to the Hospice conditions of participation and Hospice Quality Reporting Program (HQRP). The final rule also finalizes a Home Health Quality Reporting Program policy that becomes effective on October 1, 2021, to prepare for public reporting beginning in January 2022.

Under the final rule, the hospices would see a 2.0 percent increase ($480 million) in their payments for FY 2022 relative to FY 2021. This is a result of the 2.7 percent market basket percentage increase reduced by a 0.7 percentage point productivity adjustment. Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual hospice payment update percentage increase for the year.

The FY 2022 hospice payment updates also include an update to the statutory aggregate cap amount, which limits the overall payments per patient that are made to a hospice annually. The cap amount for FY 2022 is $31,297.61 (FY 2021 cap amount of $30,683.93 increased by 2.0 percent). As a result of the changes mandated by Division CC, section 404 of the Consolidated Appropriations Act, 2021 (CAA 2021), this rule finalizes conforming regulation text changes at § 418.309 to reflect the new language added to section 1814(i)(2)(B) of the Act, which extends the years that the cap amount is updated by the hospice payment update percentage rather than the consumer price index.

The final rule also includes:

- Other Medicare hospice payment policies
- Closing the Health Equity Gap in the HQRP - Request for Information (RFI)
- Fast Healthcare Interoperability Resources in Support of the HQRP - RFI

More Information:

- Full fact sheet
- Final rule
- Hospice Center webpage

IRF PROSPECTIVE PAYMENT SYSTEM: FY 2022 FINAL RULE

On July 29, CMS issued a final rule that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and finalize policies under the IRF Quality Reporting Program for Fiscal Year (FY) 2022. FY 2022 IRF PPS payment rates and policies will be effective on October 1, 2021.

In addition, CMS is finalizing a Medicare Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) payment provision adopted in an interim final rule with comment period issued on May 11, 2018, as well as a provision that was included in a DMEPOS proposed rule published in the Federal Register on November 4, 2020.

For FY 2022, CMS is updating the IRF PPS payment rates by 1.9% based on the IRF specific market basket estimate of 2.6%, less a 0.7 percentage point productivity adjustment. In addition, the final rule contains an adjustment to the outlier threshold to maintain outlier payments at 3.0% of total payments. This adjustment will result in a 0.4 percentage point decrease in outlier payments. We estimate that the overall IRF payments for FY 2022 would increase 1.5% (or $130 million), relative to payments in FY 2021.

More Information:

- Full fact sheet
- Final rule

IPF PROSPECTIVE PAYMENT SYSTEM: FY 2022 FINAL RULE

On July 29, CMS issued a final rule that updates Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) for Fiscal Year (FY) 2022 and finalizes changes to the IPF Quality Reporting Program. The final rule also includes updates to the IPF teaching policy.

For FY 2022, CMS is updating the IPF PPS payment rates by 2.0% based on the final IPF market basket estimate of 2.7%, less a 0.7 percentage point productivity adjustment. In addition, the final rule updates the outlier threshold to maintain outlier payments at 2.0% of total payments. This adjustment will result in a 0.1% overall increase to aggregate payments. Total payments to IPFs are estimated to increase by 2.1% or $80 million in FY 2022 relative to IPF payments in FY 2021.

More Information:

- Full fact sheet
- Final rule

MLN Connects Special Edition - August 2, 2021 - CMS Final Rule Improves Health Equity, Access to Treatment, Hospital Readiness, and COVID-19 Vaccination Data Reporting of Hospital Workers

Hospital Inpatient Prospective Payment System Final Rule Increases Payments to Treat COVID-19 and Improves Quality of Data Collection

CMS is taking action to drive value-based, person-centered care and promote sustainability and readiness to respond to future Public Health Emergencies (PHEs) in our nation's hospitals through the Hospital Inpatient Prospective Payment System/Long Term Care Hospital (LTCH) Prospective Payment System final rule.

The final rule, effective October 1, 2021, authorizes additional payments for diagnostics and therapies to treat COVID-19 during the current PHE, and beyond. The rule revises payment policies, as well as policies under certain quality and value-based purchasing programs for hospitals to lessen the adverse impacts of the pandemic. Some of these changes will incentivize the meaningful use of certified Electronic Health Record (EHR) technology that will help public health officials monitor for future unplanned events.

"How Medicare pays for hospital care and evaluates quality, are integral pieces of achieving and addressing gaps in health equity and strengthening our health care system for a more sustainable future. CMS is moving forward to incorporate what we have learned from the COVID-19 pandemic in order to improve quality and increase transparency so that patients are positioned to make informed decisions about their care," said CMS Administrator Chiquita Brooks-LaSure. "With this final rule, we are further improving how we measure and evaluate data while investing in quality care for people that rely on Medicare for coverage."

Last week, CMS also finalized a number of other Medicare payment rules including for skilled nursing facilities, inpatient rehabilitation facilities, inpatient psychiatric facilities, and hospice providers. Using lessons learned from the COVID-19 pandemic, these final rules will enact policies that will further protect and deliver better care to Medicare beneficiaries. These payment rules finalized new quality measures to give beneficiaries and their families better insights into the quality of care rendered at hospice facilities and vaccination reporting of facility staff.

Improving Health Equity:

In an effort to advance equity through the quality reporting measurement, CMS solicited feedback on opportunities to leverage diverse data sets such as race, ethnicity, Medicare/Medicaid dual eligible status, disability status, LGBTQ+, and socioeconomic status. The agency received more than 200 comments, reflecting the importance stakeholders place on this Biden-Harris Administration priority. CMS will consider the feedback it received to inform future actions.

"Standardization of equity data to improve hospital data collection is just one more way CMS will lead the national conversation on improving health equity," said Brooks-LaSure. "CMS will use these comments and innovate on quality measures to help identify health equity data. We're also measuring hospital initiatives to improve maternal health outcomes as we work to reduce disparities in maternal morbidity."

Addressing the maternal health crisis and improving maternal health is a priority to advance health equity and a quality improvement goal for CMS. To that end, CMS is adding a Maternal Morbidity measure to the hospital quality reporting program that would require hospitals to report whether they participate in statewide or national efforts to improve perinatal health, known as Quality Improvement initiatives. Many of the factors contributing to maternal morbidity are preventable and differentially impact women of color. This measure is an important initial step toward implementation of patient safety practices to reduce maternal morbidity, and in turn, maternal mortality.

CMS is also adopting a measure that requires hospitals and LTCHs to report COVID-19 vaccination rates of workers in their facilities. Having access to information about COVID-19 vaccination rates among health care personnel will help patients, caregivers, and their communities make informed decisions when seeking care from hospitals, cancer centers, and LTCHs.

Ensuring Access to Life-Saving Diagnostics and Therapeutics:

In November 2020, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) to encourage hospitals to provide new COVID-19 treatments during the PHE. CMS is finalizing its proposal to extend the NCTAP for certain eligible technologies through the end of the fiscal year in which the PHE ends to continue to encourage these new treatments and to minimize any potential payment disruption immediately following the end of the PHE. These products include currently approved hospital treatments. Providing these therapies to COVID-19 patients early can help reduce hospital stays and deaths.

Sustaining Hospital Readiness to Respond to Future Public Health Threats:

Strengthening public health functions through methods such as early warning surveillance, case surveillance, and vaccine uptake increases information available to the public and helps hospitals better serve their patients. CMS continues its ongoing response to the PHE and future health threats by promoting the meaningful use of certified EHR IT to report data that supports public health efforts. Specifically, CMS is modifying the Promoting Interoperability Program for eligible hospitals and critical access hospitals to expand required reporting within the Public Health and Clinical Data Exchange Objective.

The final rule requires hospitals to attest they are in active engagement with public health agency to submit data for measures related to nationwide surveillance for early warning of emerging outbreaks and threats; automated case and laboratory

reporting for rapid public health response; and visibility on immunization coverage so public health agencies can tailor vaccine distribution strategies. Hospital reporting of the measures will support public health agencies as they prepare to respond to both future health threats and long-term COVID-19 recovery.

More Information:

- Final rule
- Fact sheet

MLN Connects - August 5, 2021

Coverage to Care & Connected Care

MLN Connects newsletter for Thursday, August 5, 2021

View this edition as a: Webpage | PDF

NEWS

- Clinical Diagnostic Laboratories: Private Payor Rate-Based CLFS Resources
- Coverage to Care & Connected Care

COMPLIANCE

- Hospices: Create an Effective Plan of Care

EVENTS

- Price Transparency Stakeholder Webinar - August 11
- Ambulance Open Door Forum - August 12

MLN Connects - August 12, 2021

COVID-19: Vaccinate Your Patients

MLN Connects newsletter for Thursday, August 12, 2021

View this edition as a: Webpage | PDF

NEWS

- COVID-19: Vaccinate Your Patients
- CMS Resumes Targeted Probe & Educate Program

COMPLIANCE

- Cardiac Device Credits: Medicare Billing

CLAIMS, PRICERS, & CODES

- Non-Drug & Non-Biological Items and Services: HCPCS Application Summaries & Coding Decisions

MLN MATTERS® ARTICLES

- Internet Only Manual Updates to Pub. 100-01, 100-02, and 100-04 to Implement Consolidated Appropriations Act Changes and Correct Errors and Omissions (SNF)
- Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF))
- New Waived Tests
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2022

MULTIMEDIA

- SNF Section K: Height, Weight, and Nutritional Approaches Web-Based Training

MLN Connects Special Edition - August 13, 2021 - COVID-19 Vaccine Additional Dose

Medicare stands ready to pay for administering an additional dose of COVID-19 vaccine consistent with the FDA emergency use authorization (EUA). We'll pay the same amount to administer this additional dose as we did for other doses of the COVID-19 vaccine (approximately $40 each). We'll share more information in the coming days about billing and coding.

For more information:

- View the FDA announcement
- CMS COVID-19 Provider Toolkit

MLN Connects Special Edition - August 16, 2021 - COVID-19 Vaccines Additional Doses: Codes & Payment

The FDA amended the emergency use authorizations (EUAs) for both the Pfizer BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine to allow for an additional dose in certain immunocompromised people.

Effective August 12, 2021, CMS will pay to administer additional doses of COVID-19 vaccines consistent with the FDA EUAs, using CPT code 0003A for the Pfizer vaccine and CPT code 0013A for the Moderna vaccine. We'll pay the same amount to administer this additional dose as we did for other doses of the COVID-19 vaccine (approximately $40 each).

We'll hold and then process all claims with these codes after we complete claims system updates (no later than August 27).

Learn more about Medicare COVID-19 vaccine:

- COVID-19 Vaccine Codes
- Payment

MLN Connects - August 19, 2021

Medicare Fraud & Abuse: Revised Online Course

MLN Connects newsletter for Thursday, August 19, 2021

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NEWS

- Immunization: Medicare Covers Vaccines

COMPLIANCE

- Chiropractic Services: Comply with Medicare Billing Requirements

EVENTS

- Medicare Ground Ambulance Data Collection System: Instrument Walkthrough Webinar - August 26
- Medicare Ground Ambulance Data Collection System: Q&A Session - September 14

MLN MATTERS® ARTICLES

- Implementation of the Capital Related Assets Adjustment (CRA) for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) Under the End Stage Renal Disease Prospective Payment System (ESRD PPS)
- Implementation of the GV Modifier for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for Billing Hospice Attending Physician Services
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2022
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2022
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2022
- Modifications/Improvements to Value-Based Insurance Design (VBID) Model - Implementation

- Skilled Nursing Facility (SNF) Claims Processing Updates
- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

PUBLICATIONS

- IRF & LTCH: Q&A Basics

MULTIMEDIA

- Medicare Fraud & Abuse: Prevent, Detect, Report Web-Based Training - Revised

MLN Connects Special Edition - August 24, 2021 - CMS Expands Medicare Payments for At-Home COVID-19 Vaccinations

Part of Biden-Harris Administration Vaccine Outreach, CMS Boosts Vaccine Access in Smaller Group Homes, Assisted Living Facilities, and Other Group Living Situations

As part of the Biden-Harris Administration's ongoing commitment to increasing access to vaccinations and improving health equity, CMS is expanding opportunities for people to receive COVID-19 vaccinations in their home. To ensure Medicare beneficiaries who have difficulty leaving their homes or are otherwise hard-to-reach can receive the vaccination, health care providers can now receive additional payments for administering vaccines to multiple residents in one home setting or communal setting of a home.

This announcement aims to further boost the administration of COVID-19 vaccination - including second and third doses - in smaller group homes, assisted living facilities, and other group living situations by allowing vaccine providers to receive the increased payment up to 5 times when fewer than 10 Medicare beneficiaries get the vaccine on the same day in the same home or communal setting. This policy will help ensure that at-risk patients in smaller settings have the same opportunities as others to receive the vaccination.

"We are doing everything we can to remove barriers to vaccinations, including ensuring appropriate payment levels for vaccine providers to connect with more people in their communities who are unable to receive the vaccine in a traditional setting," said CMS Administrator Chiquita Brooks-LaSure. "We've seen the difference that vaccinations have in communities, and we are calling on providers to join us as we continue to increase vaccination rates across the country. Today's actions ensure that everyone has the ability to be vaccinated against COVID-19, including older adults with mobility or transportation challenges and other at-risk individuals."

While many Medicare beneficiaries are able to receive a COVID-19 vaccine at a retail pharmacy or from a health care provider, some people have great difficulty leaving their homes or cannot easily access vaccination in these settings. These individuals are often at-risk patients who could require complex care if they contracted COVID-19 and needed to be hospitalized. To better serve this group, Medicare previously increased the total payment amount for at-home vaccination from approximately $40 to approximately $75 per vaccine dose, in certain circumstances.

Delivering COVID-19 vaccination to access-challenged and hard-to-reach individuals poses some unique challenges, such as ensuring appropriate vaccine storage temperatures, handling, and administration. Along with the CDC guidance, this announcement helps vaccine providers meet these challenges and successfully administer vaccinations.

The additional payment amount also accounts for the clinical time needed to monitor a beneficiary after the vaccine is administered, as well as the upfront costs associated with administering the vaccine safely and appropriately in a beneficiary's home. The payment rate for administering each dose of a COVID-19 vaccine, as well as the additional in-home payment amount, is geographically adjusted based on where the service is furnished.

How to Find a COVID-19 Vaccine:

As states and the federal government continue to break down barriers - like where vaccines can be administered - resources for connecting communities to vaccination options remain key. Unvaccinated individuals and those looking to assist friends and family can:

1. Visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby
2. Text GETVAX (438829) for English or VACUNA (822862) for Spanish for near-instant access to details on three vaccine sites in the local area

3. Call the National COVID-19 Vaccination Assistance Hotline at 1-800-232-0233 (TTY: 1-888-720-7489) for assistance in English and Spanish

Coverage of COVID-19 Vaccines:

The federal government is providing the COVID-19 vaccine free of charge or with no cost-sharing for Medicare beneficiaries. As a condition of receiving free COVID-19 vaccines from the federal government, vaccine providers cannot charge patients any amount for administering the vaccine.

Because no patient can be billed for COVID-19 vaccinations, CMS and its partners have provided a variety of information online for providers vaccinating all Americans regardless of their insurance status:

- Original Medicare and Medicare Advantage:Beneficiaries with Medicare pay nothing for COVID-19 vaccines or their administration, and there is no applicable copayment, coinsurance or deductible.
- Medicaid and the Children's Health Insurance Program (CHIP):State Medicaid and CHIP agencies must cover COVID-19 vaccine administration with no cost sharing for nearly all beneficiaries during the COVID-19 Public Health Emergency (PHE) and (generally) for over a year after it ends. For the very limited number of Medicaid beneficiaries who are not eligible for this coverage (and do not receive it through other coverage they might have), providers may submit claims for reimbursement for administering the COVID-19 vaccine to underinsured individuals through the COVID-19 Coverage Assistance Fund, administered by the Health Resources and Services Administration (HRSA), as discussed below. Under the American Rescue Plan Act of 2021 (ARP), signed by President Biden on March 11, 2021, the federal matching percentage for state Medicaid and CHIP expenditures on COVID-19 vaccine administration is currently 100% (as of April 1, 2021), and will remain 100% for more than a year after the COVID-19 PHE ends. The ARP also expands coverage of COVID-19 vaccine administration under Medicaid and CHIP to additional eligibility groups. CMS recently updated the Medicaid vaccine toolkit to reflect the enactment of the ARP.
- Private Plans:The vaccine is free for people enrolled in most private health plans. The COVID-19 vaccines and the administration are covered without cost sharing for most enrollees, and such coverage must be provided both in-network and out-of-network during the PHE. Current regulations provide that out-of-network rates must be reasonable as compared to prevailing market rates, and the rules reference using the Medicare payment rates as a potential guideline for insurance companies. In light of CMS's action, CMS expects health insurance issuers and group health plans to continue to ensure their rates are reasonable when compared to prevailing market rates. Under the conditions of participation in the CDC COVID-19 Vaccination Program, providers cannot charge plan enrollees any administration fee or cost sharing, regardless of whether the COVID-19 vaccine is administered in-network or out-of-network.

For individuals who are underinsured, vaccine providers may submit claims for reimbursement for administering the COVID-19 vaccine through the COVID-19 Coverage Assistance Fund administered by HRSA after the claim to the individual's health plan for payment has been denied or only partially paid.

For individuals who are uninsured, vaccine providers may submit claims for reimbursement for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by HRSA. See information on the COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured Program.

More information on Medicare payment for COVID-19 vaccine administration - including a list of billing codes, payment allowances and effective dates - is available on the Medicare COVID-19 Vaccine Shot Payment webpage.

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.

MLN Connects - August 26, 2021

Health Care Code Sets: ICD-10 - Revised

MLN Connects newsletter for Thursday, August 26, 2021

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NEWS

- Impact of the PHE on Telehealth: Comparative Billing Report in August

- COVID-19 Monoclonal Antibody EUA Updates: Casirivimab & Imdevimab

EVENTS

- FY 2022 Hospice Final Rule: What Hospices Need to Know Webinar - August 31

PUBLICATIONS

- Health Care Code Sets: ICD-10 - Revised

MLN MATTERS

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

MLN Matters Number: MM12302
Related CR Release Date: July 13, 2021
Related CR Transmittal Number: R10847CP
Related Change Request (CR) Number: 13202
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12302 tells you about Medicare system updates based on the 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 publications. Please make sure your billing staff is aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12302.

July 2021 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - Revised

MLN Matters Number: MM12244 Revised
Related CR Release Date: June 8, 2021
Related CR Transmittal Number: R10836CP
Related Change Request (CR) Number: 12244
Effective Date: July 1.2021
Implementation Date: July 6,2021

Note: CMS revised this article to reflect a revised CR 12244. The CR revision added language regarding Section 405 of the Consolidated Appropriations Act, 2021. CMS added parts of that language in red font on page 2. CMS also revised the CR release date, transmittal number, and the web address of the CR. All other information is the same.

CR 12244 informs you about the Average Sales Price (ASP) methodology, which is based on quarterly data manufacturers submit to CMS. CMS gives the MACs ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are in the Outpatient Code Editor (OCE) through separate instructions in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12244.

July Quarterly Update for 2021 DMEPOS Fee Schedule

MLN Matters Number: MM12345
Related CR Release Date: July 1, 2021
Related CR Transmittal Number: R10865CP
Related Change Request (CR) Number: 12345
Effective Date: July 1, 2021
Implementation Date: July 6, 2021

CR 12345 tells you about the changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedules that Medicare updates on a quarterly basis, when necessary. Make sure your billing staff is aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12345.

Modifications/Improvements to VBID Model - Implementation

MLN Matters Number: MM12349
Related CR Release Date: August 6, 2021
Related CR Transmittal Number: R10894DEMO
Related Change Request (CR) Number: 12349
Effective Date: January 1, 2022
Implementation Date: January 3, 2022

CR 12349 tells you about modifications to CR 11754. That CR is testing the inclusion of the Medicare hospice benefit into MA through the Value-Based Insurance Design (VBID) Model (Hospice Benefit Component) for Calendar Year (CY) 2022. Unless otherwise stated, all requirements in CR 11754 remain the same. CMS will test the Hospice Benefit Component of the Model through 2024.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12349.

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

MLN Matters Number: MM12342
Related CR Release Date: July 14, 2021
Related CR Transmittal Number: R10870CP
Related Change Request (CR) Number: 12342
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12342 tells you about the Average Sales Price (ASP) methodology, which CMS bases on quarterly data manufacturers submit to us. We give the MACs ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. We include payment allowance limits under the Outpatient Prospective Payment System (OPPS) into the Outpatient Code Editor (OCE) through separate instructions in the Medicare Claims Processing Manual, Chapter 4, Section 50. Please make sure your billing staff is aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12342.

Quarterly Update for the DMEPOS CBP - October 2021

MLN Matters Number: MM12298
Related CR Release Date: June 11, 2021
Related CR Transmittal Number: R10833CP
Related Change Request (CR) Number: 12298
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12298 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. Please make certain your billing staff is aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12298.

Section 50 in Chapter 30 of Publication (Pub.) 100-04 Manual Updates

MLN Matters Number: MM12242
Related CR Release Date: July 14, 2021
Related CR Transmittal Number: R10862CP
Related Change Request (CR) Number: 12242
Effective Date: October 14, 2021
Implementation Date: October 14, 2021

CR 12242 reorganizes, makes edits, and other changes to the Advance Beneficiary Notice of Non-coverage (ABN) section in the Medicare Claims Processing Manual, Chapter 30, Section 50. The revised chapter is part of CR 12242. Make sure your billing staff is aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12242.