DME Happenings

Jurisdiction D

December 2022

In This Issue…

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

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

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

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

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
Congressional Inquiries or FOIA Requests	Use this address when submitting Freedom of Information Act (FOIA) requests or if the request is coming from a Congressional office. *Emails sent to this address require specific information. Review the Freedom of Information Act or Congressional Inquiries webpages for a full listing of required items to include*	DMEDCongressional.FOIA@noridian.com

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

MAILING ADDRESSES

Department	Address

• Advance Determination of Medicare Coverage Requests
• Claim Submission
• Correspondence
• Medical Review Documentation
  ○ 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

Department	Address
Benefit Integrity	Noridian JD DME Attn: Benefit Integrity PO Box 6736 Fargo, ND 58108-6736
Congressional Inquiries	Noridian JD DME Attn: Congressional PO Box 6727 Fargo, ND 58108-6727
Education	Noridian JD DME Attn: DME Education PO Box 6727 Fargo, ND 58108-6727
Freedom of Information Act (FOIA)	Noridian JD DME Attn: FOIA PO Box 6727 Fargo, ND 58108-6727
LCD: New LCD Request	Noridian JD DME Attn: New LCD Request PO Box 6742 Fargo, ND 58108-6742
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.

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 Schedule and Training Closures
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have **all** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. Verified by Customer Service Representative (CSR) or IVR • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digits of Tax Identification Number (TIN) Verified by CSR • Caller's name • Provider/Facility name • Beneficiary Medicare number • Beneficiary first and last name • Date of Service (DOS) • Last five digits of Claim Control Number (CCN) • HCPCS code(s) in question • Corrective action to be taken Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

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

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.

Beneficiary Owned Information Missing

Denials for missing information on claim, specific to missing indication of whether the patient owns the equipment that requires the part or supply that is being billed continues to be at the top of denials that suppliers receive.

The denial on the remittance advice displays as Reason Code 16/Remark Code M124. This denial will be received if the beneficiary owns a base item that requires supplies used with the base item and the item is not on file in the claim history with Medicare.

Resolving Denials for item not on file in claim history

- Call the Supplier Contact Center to complete telephone reopening to add beneficiary owned equipment for items that require accessories or supplies. First supply claim requires narrative:
    - Beneficiary owned HCPCS; purchased month and year.
    - Good example: Bene-owned E0601 pur Jan 2021
    - Once item purchased on file, subsequent supply claims do not require narrative.
    - Examples of the items are Positive Airway Pressure (PAP) devices, BiPAPs, nebulizers, all glucose monitors, and humidifiers, etc.

- A written reopening may also be submitted with all beneficiary owned equipment information, HCPCS code of base equipment owned, and date equipment purchased. This can be accomplished through mail, fax or Noridian Medicare Portal through the appeals function.

Billing for Custom Fitted Orthotics When no Custom Fitting is Completed With no Off-the-Shelf Equivalent

Have you billed a claim for an orthotic item that is classified as a custom fit brace, but no custom fitting was performed and there is no equivalent off-the-shelf brace? The medical directors for Noridian and CGS, along with the PDAC published an article titled, *Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding*. The article provides instructions on billing with a miscellaneous code when this scenario occurs. Another article was published titled, *Correct Billing for Custom Fitted Orthotics when no Custom Fitting is Completed with no Off the Shelf Equivalent* that provides detailed instructions on information that should be included in the narrative when billing these claims.

If you have claims that have denied with an MA130 remark code, that means the claim contains incomplete and/or invalid information, and **no appeal rights are afforded**. If the claim did not include the correct narrative as indicated in the articles' instructions, add the narrative, and resubmit the claim. If the narrative was included and still denied, please contact the Supplier Contact Center to request a reopening.

Claim Information Can be Found on the Noridian Medicare Portal

One of the most common reasons suppliers call into the Supplier Contact Center is to find out why a claim denied or information about the status of a claim. All this information is available using our self-service tool on the Noridian Medicare Portal under Claim Status, saving time and money. Utilize this great resource for efficiency in your business. Check it out today.

Electronic Supplier Visits are Available Once Again

Noridian offers suppliers one-on-one virtual education. This education is tailored specifically for your company and is created to answer any policy specific or general Medicare questions you may have. If you or your team are interested in this opportunity, please fill out this e-visit form found on our website and a Provider Outreach and Education Representative will contact you. Suppliers are encouraged to fill out this form and take advantage of this wonderful opportunity.

Eliminating Certificates of Medical Necessity & Durable Medical Equipment Information Forms - January 1, 2023

All Certificates of Medical Necessity (CMNs) and Durable Medical Equipment (DME) Information Forms (DIFs) will be discontinued effective for dates of service January 1, 2023 and after.

If CMNs or DIFs are included on any claims with dates of service on or after January 1, 2023, the claims will be rejected. Claims with dates of service prior to January 1, 2023 should still include CMN and DIF information in accordance with DME MAC processing and policy guidelines.

CEDI recommends contacting your vendor or programmer to verify your claims software product will be ready for this change.

CEDI will provide updates when changes will be implemented to the PC-ACE software and the CEDI Claims Portal.

Please contact the CEDI Help Desk regarding any questions at ngs.cedihelpdesk@anthem.com or at 866-311-9184.

Enteral Nutrition - Oral Intake

It is important to know that enteral nutrition is covered when a beneficiary cannot adequately meet nutritional needs through oral consumption or oral supplementation. Oral intake of food for gratification purposes would not necessarily preclude the beneficiary from coverage for enteral nutrition. The medical records need to support the reason for oral intake. Enteral

nutrition products and related supplies that are administered orally are noncovered, no benefit. If you are billing for products that are only administered orally, these should be coded as A9270.

Refer to the Noridian Medicare Enteral Nutrition webpage for additional resources.

External Infusion Pumps - Medical Record Documentation Requirements

Suppliers should obtain documentation from the patient's medical record to ensure that coverage criteria have been met. It is expected that the beneficiary's medical records will reflect the need for the care provided and support that the coverage criteria have been met.

The medical records must:

- Support utilization
- Address
    - Symptoms
    - Continuing response/need for therapy
    - Diagnosis
    - Duration of condition
    - Clinical course (worsening or improvement)
    - Prognosis
    - Nature and extent of functional limitations
    - Other therapeutic interventions (and results)
    - Previous experiences with related items
- Support that item continues to remain reasonable and necessary
    - Continued medical need must be timely for DOS under review and is defined as a record within the preceding 12 months

Continued coverage for external insulin pumps and supplies require:

- An evaluation by the treating practitioner every 3 months

Administration of parenteral inotropic therapy requires:

- An evaluation every 3 months by prescribing provider or heart failure team with oversight by a cardiologist with training in management of advanced heart failure

Refer to the Noridian Medicare External Infusion Pumps webpage for additional resources.

Face-to-Face Encounter Must Occur Prior to Written Order Prior to Delivery (WOPD)

For all items requiring a WOPD and **face-to-face encounter**, a practitioner visit is required **within six months preceding the WOPD**. A WOPD is a completed Standard Written Order (SWO) that is communicated to the DMEPOS supplier before delivery of the item(s).

The WOPD follows the same documented requirements as the SWO; the only difference is the timeliness requirements of the order, prior to dispensing versus prior to claim submission.

The face-to-face encounter must be documented in the pertinent portion of the medical record (for example, history, physical examination, diagnostic tests, summary of findings, progress notes, treatment plans) or other sources of information that may be appropriate. The supporting documentation must include subjective and objective beneficiary-specific information used for diagnosing, treating, or managing a clinical condition for which the DMEPOS is ordered.

Find Upper Limb Correct Coding in a Joint Medical Director Article

Upper limb orthotics don't have their own Local Coverage Determination (LCD) or Policy Article. But the DME medical directors created this upper limb joint publication to provide guidance on correctly coding these orthoses. Come take a look.

If You Supply Off-the-Shelf Back or Knee Braces, You May Be in a Competitive Bid Area

The current Round 2021 Competitive Bidding Program only includes off-the-shelf (OTS) back and knee braces. You can determine if your facility or your beneficiaries are in a competitive bid area (CBA) by using this Zip Code Lookup tool. If you or your beneficiaries are, please spend some time on our Competitive Bid webpage. It's packed with information and resources.

Important Place of Service Information for Physician/Practitioner Who is Also a Supplier

If you are a physician/practitioner who is also a supplier, it is important to remember that place of service (POS) is different for an office visit versus providing an item for use in the home. When submitting claims for DME items to use in the home, POS is 12. Denials for these types of claims are denied for wrong POS and require rework through the self-service reopening function on the Noridian Medicare Portal. So, save time and money by billing with the correct POS on the initial claim filing.

Inpatient Denials with Reason Code 109, Remark Code N418 Continues to be One of the Top Denials

A dedicated tab can be found in the Noridian Medicare Portal (NMP) eligibility tab for Health Maintenance Organization (HMO) and Managed Care Organization (MCO) information to ensure billing to the correct payor the first time and avoiding rework.

Obtain the following information regarding beneficiaries by selecting the Eligibility tab on the NMP.

- Insurer name
- Policy number
- Effective and termination dates
- Plan type
- Bill option code
- Plan address
- Plan phone number

To resolve denials suppliers should send the claim to the HMO plan listed on the NMP under Expanded Denial Details. Please utilize the Denial Code Resolution webpage for more information.

Medically Unlikely Edit for J1559

CMS plans to increase the current Medically Unlikely Edit (MUE) units allowed per day for HCPCS code J1559 (Injection, immune globulin (Hizentra), 100 mg), currently set at 1600 to 2400. This update is scheduled with the implementation of the January 2023 quarterly MUE file and will be retroactive to July 1, 2022.

Until the change is implemented, Medicare contractors will hold claims submitted with J1559 with units of service >1500 and ≤2400 for dates of service on or after July 1, 2022, through September 30, 2022, and hold claims submitted with units of service >1600 and ≤2400 for dates of service on or after October 1, 2022, through December 31, 2022.

Noridian will be adjusting claims that have already processed during this time that were denied. Adjustments will be processed within 60 business days following the MUE update in January 2023.

Prior to the implementation of the MUE quarterly update file for January 1, 2023, providers may choose to delay submission of claims until after the January 1, 2023 implementation of the July 1, 2022 retroactive date.

Note: Appeals will not be necessary for denials as the claims will be adjusted as listed above.

Nebulizer Drug Calculator Tool Does All the Work

The Noridian website houses a useful tool to calculate nebulizer drugs. Suppliers can enter a drug, drug strength, size of the vial dispensed (if applicable), and the medication frequency. The tool then determines the maximum number of units that can be billed in a 31 or 90-day period. Put away your calculator and let us do the work for you.

Noridian Enteral and Parenteral Nutrition Self-Paced Tutorials

Do you have a new hire who could use some additional education? Are you a Medicare expert who could use a quick refresher? Our self-paced DME on Demand tutorials provide education reviews in just a few valuable minutes. Here are what is available today.

ENTERAL NUTRITION

- Completing the DIF for Enteral Nutrition - 6 minutes
- Enteral Nutrition: Administration - 4 minutes
- Enteral Nutrition: Billing and Documentation - 6 minutes
- Enteral Nutrition: Coding - 10 minutes
- Enteral Nutrition: Coverage Criteria - 6 minutes

PARENTERAL NUTRITION

- Parenteral Nutrition: Billing - 5 minutes
- Parenteral Nutrition: Coding - 4 minutes
- Parenteral Nutrition: Completing the DME Information Form (DIF) - 5 minutes
- Parenteral Nutrition: Coverage Criteria - 9 minutes

Noridian Offers a Buffet of Surgical Dressings Self-Paced Tutorials

Our offering of 10 tutorials covers a variety of helpful topics. You can spend as little as 3 minutes or take 25 minutes to review content relevant to your billing/education needs. See what's available below.

- A1-A9 Modifiers - 5 minutes
- Collaborative Surgical Dressings and Supplies - 25 minutes
- Gradient Compressing Stockings & Wraps: Coding - 4 minutes
- Gradient Compressing Stockings & Wraps: Coverage Criteria - 3 minutes
- Surgical Dressings: Coverage Criteria - 3 minutes
- Surgical Dressings: Medical Records - 4 minutes
- Surgical Dressings: Orders - 3 minutes
- Surgical Dressings: Refill Requirements - 3 minutes
- L200 Surgical Dressings: Part 1 - 12 minutes
- L200 Surgical Dressings: Part 2 - 7 minutes

Only One “Claim” Can Be Processed Through the Noridian Medicare Portal at One Time

The Noridian Medicare Portal is a fast and efficient way to submit a redetermination. Save time and money by accessing the Portal to quickly submit appeals. As a reminder, attachments with additional claims are not allowed within the documentation submitted on the portal to bypass having to do more than one appeal per “claim” at a time. A single claim may include multiple dates of service; however, an appeal must be submitted for each "single claim". You must utilize the mail or fax option when submitting multiple claims for appeal.

Oxygen Equipment Cannot Be Purchased

Noridian is seeing an increase in beneficiary complaints regarding the sale of oxygen equipment.

Suppliers are reminded that Medicare will only consider an oxygen claim for payment when the equipment is rented. If a beneficiary wishes to purchase oxygen equipment, the beneficiary will be financially responsible for the entire purchase price and a claim should not be filed to Medicare.

Arrangements where the beneficiary pays up front and then the supplier files a “rental” claim until the purchase price is paid by Medicare is not an acceptable arrangement.

Suppliers may issue a voluntary Advance Beneficiary Notice (ABN) to notify the beneficiary that oxygen equipment that is purchased is statutorily non-covered. Though the beneficiary is not required to sign the voluntary ABN, we encourage suppliers to point out Option 2 to help the beneficiary understand their financial responsibility and that a claim will not be filed. In this situation, the ABN is used to provide notification of financial liability for items that Medicare never covers.

Parenteral Nutrition- Documentation Requirements

In order to justify payment for DMEPOS items, suppliers must meet the following requirements:

- Standard Written Order (SWO)
- Medical Record Information (including continued need/use if applicable)
- Correct Coding
- Proof of Delivery

No more than one month's supply of parenteral nutrients, equipment or supplies is allowed for one month's prospective billing. Claims submitted retroactively, may include multiple months.

The treating practitioner expectations:

- Evaluate the beneficiary within 30 days prior to initial certification/required recertification (but not revised certifications)
- If treating practitioner does not see beneficiary within this timeframe, he/she must;
    - Document reason why beneficiary was not seen; and
    - Describe what other monitoring methods were used to evaluate beneficiary's parenteral nutrition need

The medical records must include enough information to support that coverage criteria have been met, including, but not limited to:

- Beneficiary’s diagnosis
- Duration of beneficiary’s condition
- Clinical course (worsening or improvement)
- Prognosis
- Nature and extent of functional limitations
- Other therapeutic interventions and results
- Previous experience with related items
- Any other pertinent information related to use of parenteral nutrition

Refer to the Noridian Medicare Parenteral Nutrition webpage for additional resources.

Phase 3 of Prior Authorization is Right Around the Corner

Phase three of prior authorization (PAR) for HCPCS codes L0648, L0650, L1832, L1833, and L1851 begins nationwide for dates of service on/after October 10, 2022. PARs from all states can be submitted as of now. Find more information on our Required Prior Authorization Programs webpage.

Providing Items Prior to Surgery

- Determining need prior to surgery - Items can be provided and billed prior to surgery when item is medically necessary and the brace is **required to be worn prior to surgery**, coverage criteria is met, and documentation to substantiate the need is included in ordering physician's medical record.
- Determining need after surgery - If there is no medical need to wear the item until after surgery, item should not be provided until after the surgery has been performed and medical need is clearly established per Medicare guidelines.

Resources to Help Bill Knee Orthotics Correctly

Are you finding it hard to understand what documentation you need from the practitioner for knee orthoses? A Clinician Letter written by the medical directors for Noridian and CGS has detailed information regarding expectations from the clinician. This letter is a great resource to provide to clinicians in order to obtain the information required in the medical record.

Would a Documentation Checklist for Knee Orthoses at a glance be helpful? The one on our website provides hyperlinks to many resources for this policy including the LCD, Policy Article, Standard Written Order, Face-to-Face and Written Order Prior to Delivery (WOPD), Prior Authorization, Continued Need, and on. It also provides a succinct list of what should be in the medical record for each code. And just a reminder, medical necessity must be supported by one of the specific ICD-10-CM codes listed in the Knee Orthoses LCD-related Policy Article (A52465) and that code must be included on the claim.

The Clinician Checklist for Knee Orthoses - Custom and Prefabricated is a short document indicating the medical documentation required for these two categories of orthotics.

We hope these resources, including our Orthotics webpage, can help you bill successfully.

Same and Similar Denials

Same or similar continues to be one of the top denials that suppliers receive. Please utilize our denial code resolution tool to assist in resolving those denials.

Same or similar denials can be identified with reason code 151, remark code M3 on the remittance advice. To resolve the denial, an appeal/redetermination request may be submitted with all relevant supporting documentation, such as:

- Documentation to support change in the beneficiary's medical condition that supports need for a similar item
- Documentation/statement to indicate if the item was lost, stolen, or irreparably damaged and what occurred
- Advance Beneficiary Notice of Noncoverage (ABN), if applicable

Prior to providing an item, suppliers should verify if a beneficiary has received a same or similar item. That can be accomplished in the Noridian Medicare Portal. If a same or similar item is on file in the beneficiary's claim history, an Advance Beneficiary Notice of Noncoverage (ABN) should be obtained prior to providing the item.

Security Acknowledgement on NMP

Effective October 1, 2022, the Noridian Medicare Portal (NMP) will have an additional Security Acknowledgment that all users will need to accept in order to continue when logging in. This additional security acknowledgment is required by CMS for all MACs to maintain standards and minimize potential security risks.

The additional acknowledgment will be presented after the Multi-Factor Authentication (MFA) code is entered. This security acknowledgment will only be presented to users once every two weeks. If a user declines the acknowledgment, they will be logged out of the Portal and will have the opportunity to log back in.

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from July 2022 - September 2022 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Glucose Supplies
- Manual Wheelchairs
- Ostomy Supplies
- Pneumatic Compression Devices
- Therapeutic Shoes
- Spinal Orthotics
- Surgical Dressings
- Urological Supplies

Tools Series Coming in November and December

Tools are the backbone of good business from pens to keyboards to nuts and bolts. They make our life easier and help us do our job. That's why we're going to write a series of pieces highlighting ways you can use our tools for the items/services you supply. How many of Noridian's 58 tools have you used? They have their own webpage, but you can also find tools under "Educational Resources" on the left-hand side of every policy page. They don't all have the word "tool" in the title. The *Same or Similar Chart and Denial Code Resolution* are definitely tools. We're looking forward to showing you just how valuable our tools can be.

Tools Series: External Infusion Pump Drug Calculator

The External Infusion Pump (EIP) Drug Calculator is used to assist suppliers in determining the correct units of service (UOS) to bill for EIP drugs. Once the tool is open, select a drug and enter the requested elements. For example:

- Drug: Acyclovir (HCPCS will also display)
- Vial Strength: 200
- Vial Size: 5 (ml)
- Number of ml dispensed to patient: 10
- Hit Calculate
- Billable units of service displays: 80

Find this and many more useful tools on our website.

Tools Series: External Infusion Pumps (EIP) C-Peptide Calculator

The C-Peptide Calculator tool calculates c-peptide results for beneficiaries with or without renal insufficiency and helps determine whether the c-peptide levels meet the LCD requirements.

BENEFICIARIES WITHOUT RENAL INSUFFICIENCY

- **Insulin Infusion Pump Criterion A1:** C-peptide level is less than or equal to 110 percent of the lower limit of normal of the laboratory's measurement method.

BENEFICIARIES WITH RENAL INSUFFICIENCY

- **Insulin Infusion Pump Criterion A2:** Beneficiaries with renal insufficiency and a creatinine clearance (actual or calculated from age, weight, and serum creatinine) less than or equal to 50 ml/minute, a fasting C-peptide level is less than or equal to 200 percent of the lower limit of normal of the laboratory's measurement method.

This slick calculator can be found on the Noridian Tools and EIP webpages.

Tools Series: Understanding Consolidated Billing (CB) for DMEPOS

Do you know if your beneficiary is in a Part A covered stay? If not, always ask the beneficiary or their family member/caregiver. It could also be beneficial to ask the ordering physician's office. It's always important to check eligibility in the Noridian Medicare Portal (NMP) but be aware Part A has a year to bill their claims so the stay may not be visible.

To help POS suppliers navigate CB, Noridian created a Consolidated Billing/SNF/Home Health/Hospice Lookup tool. A code can be entered in the tool to assist suppliers/providers with determining if a specific HCPCS is considered under consolidated billing for SNF, Home Health (HH), and Hospice. The tool provides information on the specific HCPCS code entered and whether the item is payable in each of the situations under CB (i.e., SNF, HH, or Hospice). The tool also provides guidance when an item is payable in a SNF after the Part A stay has ended. In this scenario some prosthetics, orthotics and supplies are covered when billing for a place of service (POS) 31 Skilled Nursing Facility or POS 32 Nursing Facility. Please visit our Consolidated Billing page on our website for more information.

Top Denial Is Base Equipment Not on File/Not Payable

One of the top denials suppliers continue to receive is the base equipment not on file or not payable. The denial on the remittance advice displays as Reason Code 16/Remark Code M124. As a reminder:

- If a beneficiary owns a base item that requires supplies used with the base, the base item must be on file, in the claim history, with Medicare to avoid denials.

If you are billing claims with this requirement the claim narrative must include three pieces of information:

- HCPCS code of base equipment; and,
- A notation equipment is beneficiary-owned; and,
- Date beneficiary obtained equipment (approximate)

Good example: Bene-owned E0601 pur Jan 2021

Once the beneficiary-owned item is placed on file, subsequent supply claims do not require a narrative.

If you have added the narrative but continue to receive denials indicating the information is not on file, please utilize the following options to ensure the information has been added to the beneficiary's record.

- Call Telephone Reopenings through the Supplier Contact Center
- Submit a Written Reopening using the Noridian Medicare Portal appeals process
- Mail
- Fax

Two New Contracts for DMEPOS Medicare Enrollment

Starting November 7, 2022, the Medicare enrollment application process for DMEPOS suppliers will be transitioned from the NSC to two regional contracts held by Novitas Solutions, Inc., and Palmetto GBA:

- Novitas Solutions (NPEAST): Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, District of Columbia, Puerto Rico, US Virgin Islands
- Palmetto GBA (NPWEST): Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands

No action is required at this time. Please continue to work with the NSC through November 6.

Use Prior Authorization Look Up Tool for Required Pressure Reducing Support Surfaces (PRSS) Codes

Pressure Reducing Support Surfaces (PRSS) suppliers have had questions regarding which codes require prior authorization (PA). Our Prior Authorization Look Up Tool has the answers. Enter any PRSS HCPCS code into the tool for an instant response. Just for your reference, only Group II codes E0193, E0277, E0371, E0372, and E0373 require PA. No Group I or III codes require PA.

Use Prior Authorization Resources for Orthoses

Please use the Noridian Orthotics webpage and the Prior Authorization for Orthoses webpage to understand this requirement. Note the Educational Resources on the left-hand side of these pages for tools, comparison charts, and additional information. Scroll to the bottom of the pages for articles that have been written on the subject. The recording of the Prior Authorization - Orthoses webinar held on 9/8/2022 is available on our Webinar on Demand page until 11/15/2022. You may also attend our upcoming webinar on 11/30/2022 from 1:30-3:00 PM CT.

Zip Code Added to the Competitive Bidding Program (CBP)

The following ZIP code has been added to Round 2021 of the DMEPOS CBP to conform with United States Postal Service ZIP code changes within the identified competitive bidding area (CBA):

56964 Washington, DC CBA

The Zip Code Lookup tool can be used to identify when a specific item furnished to a beneficiary is subject to the CBP.

MEDICAL POLICIES AND COVERAGE .....

2022 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2022 HCPCS Code Update - October Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2022 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

Basics of Choosing the Correct HCPCS Code - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Basics of Choosing the Correct HCPCS Code - Correct Coding**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Billing Instructions - Parenteral and Enteral Nutrition

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

View the locally hosted 2022 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

CMN and DIF Elimination - Correct Coding and Billing

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

View the locally hosted 2022 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

Comment Period Closes November 19, 2022 for the Proposed Glucose Monitors LCD

The Comment Period will close on **Saturday, November 19, 2022 at 5:00 p.m. ET** for the proposed Glucose Monitors LCD (DL33822). Additional information related to the written comment process is available at Proposed Local Coverage Determination (LCD) Released for Comment - Glucose Monitors.

LCD Revisions Summary for September 8, 2022

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

SURGICAL DRESSINGS

LCD

Revision Effective Date: 05/01/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Comma at Collagen Dressing or Wound Filler section in the first sentence after parentheses

09/08/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive corrections.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or 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 November 17, 2022

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

Enteral Nutrition, External Infusion Pumps, High Frequency Chest Wall Oscillation Devices, Immunosuppressive Drugs, Osteogenesis Stimulators, Oxygen and Oxygen Equipment, Parenteral Nutrition, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea,

Seat Lift Mechanisms, and Transcutaneous Electrical Nerve Stimulators (TENS). Please review the entire LCDs and related PAs for complete information.

ENTERAL NUTRITION

LCD

Revision Effective Date: 01/01/2023
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Language pertinent to the feeding supply allowance corresponding to the method of administration
Revised: Reference to DIF question 5, to clarify it is for dates of services prior to January 1, 2023
SUMMARY OF EVIDENCE:
Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes
ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):
Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes
BIBLIOGRAPHY:
Removed: Bibliography information, due to not being applicable to the non-discretionary changes

11/17/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to CMS Change Request (CR) 12734: Elimination of Certificates of Medical Necessity and DME Information Forms.

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to DIFs, for DOS affected by the DIF elimination
CODING GUIDELINES:
Added: Information pertaining to the need for calculation of UOS based on the treating practitioner's order

11/17/2022: 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.

EXTERNAL INFUSION PUMPS

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to DIFs, for DOS affected by the DIF elimination

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

LCD

Revision Effective Date: 10/01/2022
HCPCS CODES:
Revised: E0483 HCPCS long descriptor

11/17/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to CMS HCPCS coding determinations.

PA

Revision Effective Date: 10/01/2022
CODING GUIDELINES:
Revised: E0483 HCPCS long descriptor

11/17/2022: 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.

IMMUNOSUPPRESSIVE DRUGS

PA

Revision Effective Date: 01/01/2023
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Medicare entitlement statement to include coverage beyond 36 months for beneficiaries eligible and enrolled in the Part B immunosuppressive drug benefit (PBID)

11/17/2022: 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.

OSTEOGENESIS STIMULATORS

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to CMNs, for DOS affected by the CMN elimination

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

OXYGEN AND OXYGEN EQUIPMENT

LCD

Revision Effective Date: 01/01/2023
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Language in regard to CMS' codification of nationally covered and non-covered indications for home oxygen and oxygen equipment within the NCD Manual section 240.2 and section 1862(a)(1)(A) of the SSA (effective 09/27/2021)
Added: "therapy and oxygen equipment" after statements of "oxygen" and "home oxygen"
Added: "and oxygen equipment" after statements of "oxygen therapy" and "home oxygen therapy"
Added: "Initial coverage" of home oxygen therapy (effective 09/27/2021)
Revised: Reasonable and necessary criteria for Groups I and II home oxygen therapy and oxygen equipment (effective 09/27/2021)
Removed: References to "chronic stable state" (effective 09/27/2021)
Added: Coverage criteria for Group III home oxygen therapy and oxygen equipment (effective 09/27/2021)
Added: Group IV criteria
Removed: Long Term Oxygen Therapy (LTOT) Clinical Trials
Removed: "CLUSTER HEADACHES (CH)" section and related information
Added: "cluster headaches" as a medical condition example in Group III
Removed: All references and instructions for the Certificate of Medical Necessity
Added: Group I, II or III for high litter flow allowance criteria
SUMMARY OF EVIDENCE:
Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes
ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):
Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes
CODING INFORMATION:
Removed: Q0 modifier
APPENDICES:
Removed: Cluster headaches and LTOT special coverage rules
SOURCES OF INFORMATION:
Added: Home use of Oxygen and Home Oxygen Use to Treat Cluster Headaches Decision Memorandum (CAG-00296R2)
Added: Home Use of Oxygen Decision Memo (CAG-00296R3)
Removed: "CR7235 for cluster headache trial"
BIBLIOGRAPHY:
Removed: Bibliography information, due to not being applicable to the non-discretionary changes

11/17/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to updates to National Coverage Determination 240.2, removal of National Coverage Determination 240.2.2 and CMS Change Request (CR) 12734: Elimination of Certificates of Medical Necessity and DME Information Forms.

PA

Revision Effective Date: 01/01/2023
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Reference to Social Security Act §1834(a)(5)(E)
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: References to chronic stable state (effective 09/27/2021)
Revised: Documentation requirements to align with information in the Coverage Indications, Limitations, and/or Medical Necessity section of the related Oxygen and Oxygen Equipment LCD (effective 09/27/2021)
Removed: ”LONG TERM OXYGEN THERAPY TRIALS (LTOT)” section and related information (effective 09/27/2021)
Removed: "CLUSTER HEADACHES” section and related information (effective 09/27/2021)
REPLACEMENT EQUIPMENT:
Removed: References to "Recertification" and "Certification of Medical Necessity"
CERTIFICATE OF MEDICAL NECESSITY (CMN):
Removed: Section and related information
CODING GUIDELINES:
Removed: Clinical trial information for cluster headaches
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: Group 1 Paragraph information
Removed: ICD-10-CM codes from Group 1 Codes
Removed: Group 2 Paragraph information
Removed: ICD-10-CM code from Group 2 Codes
ICD-10-CM CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Removed: Group 1 Paragraph information

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

PARENTERAL NUTRITION

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to DIFs, for DOS affected by the DIF elimination
CODING GUIDELINES:
Added: Information pertaining to the need for calculation of UOS based on the treating practitioner’s order

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

LCD

Revision Effective Date: 09/27/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Removed: References to “chronic stable state” from CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Removed: “severe lung disease” from CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Added: “condition resulting in hypoxemia” to CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Added: “therapy and oxygen equipment” after statements of “oxygen” and “home oxygen” to CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Added: “and oxygen equipment” after statements of “oxygen therapy” and “home oxygen therapy” to CONCURRENT USE OF OXYGEN WITH PAP THERAPY

Added: Ineligibility for coverage of home oxygen with overnight oximetry as part of home sleep testing or any other home testing to CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Added: "Beneficiaries that qualify for oxygen therapy based on testing conducted only during the course of a sleep test are eligible only for reimbursement of stationary equipment." to CONCURRENT USE OF OXYGEN WITH PAP THERAPY
Removed: Duplicate instruction for suppliers to refer to the Oxygen and Oxygen Equipment LCD and related Policy Article for additional coverage, coding and documentation requirements from CONCURRENT USE OF OXYGEN WITH PAP THERAPY
SUMMARY OF EVIDENCE:
Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes
ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):
Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes

11/17/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to updates to National Coverage Determination 240.2 and removal of National Coverage Determination 240.2.2.

SEAT LIFT MECHANISMS

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to CMNs, for DOS affected by the CMN elimination

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

PA

Revision Effective Date: 01/01/2023
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Billing information relevant to CMNs, for DOS affected by the CMN elimination

11/17/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or 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

Open Meeting Agenda - Glucose Monitors Proposed Local Coverage Determination

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

View the locally hosted 2022 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

Open Meeting Announcement - Glucose Monitors Proposed Local Coverage Determination (LCD)

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

View the locally hosted 2022 DMD articles.

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

Panzyga® (Immunoglobulin Intravenous (Human), 10%) Correct Coding and Coverage - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Panzyga® (Immunoglobulin Intravenous (Human), 10%) Correct Coding and Coverage - Revised**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Policy Article Revisions Summary for September 22, 2022

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, External Infusion Pumps, High Frequency Chest Wall Oscillation Devices, Mechanical In-exsufflation Devices, Oral Anticancer Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) and Wheelchair Seating. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

AUTOMATIC EXTERNAL DEFIBRILLATORS

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Removed: ICD-10-CM code I47.2 from Group 1 and Group 2 Codes due to ICD-10-CM code updates
Added: ICD-10-CM codes I47.20, I47.21 and I47.29 to Group 1 and Group 2 Codes due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

EXTERNAL INFUSION PUMPS

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM code D81.82 to Group 3 Codes due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM codes D81.82, G71.031, G71.032, G71.033, G71.0340, G71.0341, G71.0342, G71.0349, G71.035, G71.038, and G71.039 to Group 1 Codes, due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

MECHANICAL IN-EXSUFFLATION DEVICES

PA

Revision Effective Date: 10/01/2022
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM codes G71.031, G71.032, G71.033, G71.0340, G71.0341, G71.0342, G71.0349, G71.035, G71.038, G71.039 to Group 1 Codes due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

ORAL ANTICANCER DRUGS

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: ICD-10-CM code descriptor for C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49 in Groups 1, 3, 4, 5, 7 Codes due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

ORAL ANTIEMETIC DRUGS (REPLACEMENT FOR INTRAVENOUS ANTIEMETICS)

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: ICD-10-CM code descriptor for C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C94.6 in Group 1 Codes due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

WHEELCHAIR SEATING

PA

Revision Effective Date: 10/01/2022
CODING GUIDELINES:
Added: CAD/CAM technology details to the fabrication technique information
Revised: Format of language pertaining to fabrication techniques for cushions
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM codes F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, G31.83, G60.0, Q79.60, Q79.61, Q79.62, Q79.63, Q79.69, Q90.0, Q90.1, Q90.2, and Q90.9 to Group 2 Codes
Added: ICD-10-CM codes Q72.01, Q72.02, Q72.03, Q72.11, Q72.12, and Q72.13 to Group 3 Codes
Added: ICD-10-CM codes F03.90, F03.911, F03.918, F03.92, F03.93, F03.94, F03.A11, F03.A18, F03.A2, F03.A3, F03.A4, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, G31.83, G60.0, Q72.01, Q72.02, Q72.03, Q72.11, Q72.12, Q72.13, Q79.60, Q79.61, Q79.62, Q79.63, Q79.69, Q90.0, Q90.1, Q90.2, and Q90.9 to Group 4 Codes
Added: ICD-10-CM codes G71.031, G71.032, G71.033, G71.0340, G71.0341, G71.0342, G71.0349, G71.035, G71.038, and G71.039 to Group 2 and Group 4 Codes, due to ICD-10-CM code updates

09/22/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or 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

Policy Article Revisions Summary for November 24, 2022

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and will be posted November 24, 2022. The policies included are Intravenous Immune Globulin and Standard Documentation Requirements for All Claims Submitted to DME MACs. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

INTRAVENOUS IMMUNE GLOBULIN

PA

Revision Effective Date: 10/01/2022
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10-CM code D81.82 to Group 1 codes per update to Medicare Benefit Policy Manual, Chapter 15, section 50.6

11/24/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

STANDARD DOCUMENTATION REQUIREMENTS FOR ALL CLAIMS SUBMITTED TO DME MACS

PA

Revision Effective Date: 01/01/2023
MEDICAL RECORD DOCUMENTATION:
Added: “(for DOS prior to 01/01/2023)” after “CMN”
Added: “prior to DOS 01/01/2023” in the second reminder bullet after “CMN”
CONTINUED MEDICAL NEED:
Added: "of supplies" to the end of the first bullet after "refills"
Added: Bullet justifying continued medical need to include an order/prescription for repairs
Added: “obtained prior to DOS 01/01/2023,” in the fourth bullet of items that justify continued need after “CMN or DIF”
CERTIFICATE OF MEDICAL NECESSITY (CMN) & DME INFORMATION FORM (DIF):
Added: Billing information relevant to CMNs and DIFs, for DOS affected by the CMN and DIF elimination
REPLACEMENT:
Added: “(prior to DOS 01/01/2023)” after “CMN”

11/24/2022: 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

Click on hyperlink to go to the policy

Proposed Local Coverage Determination (LCD) Released for Comment - Glucose Monitors

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Proposed Local Coverage Determination (LCD) Released for Comment - Glucose Monitors**, has been created and published to our website.

View the locally hosted 2022 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

MLN CONNECTS

MLN Connects - September 1, 2022

Payment Allowances for Influenza Vaccine

MLN Connects newsletter for Thursday, September 1, 2022

NEWS

- CORRECTION: Monkeypox & Smallpox Vaccines: Include Product Code on Claims
- COVID-19: Novavax Vaccine Authorized for Patients 12-17 Years Old
- Medicare Shared Savings Program Saves Medicare More Than $1.6 Billion in 2021 & Continues to Deliver High-quality Care
- Increased Use of Telehealth for Opioid Use Disorder Services During COVID-19 Pandemic Associated with Reduced Risk of Overdose
- Sickle Cell Disease: What You Need to Know Video
- Healthy Aging: Recommend Services for Your Patients

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- Influenza Vaccine Payment Allowances - Annual Update for 2022-2023 Season
- Quarterly Update to Home Health (HH) Grouper

MULTIMEDIA

- Introduction to Language Access Plans Web-Based Training
- Combating Medicare Parts C and D Fraud, Waste, & Abuse Web-Based Training - Revised

INFORMATION FOR PATIENTS

- How to Report a Medicare Complaint

MLN Connects - September 8, 2022

Prostate Cancer: Talk to Your Patients about Screening

MLN Connects newsletter for Thursday, September 8, 2022

NEWS

- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Prostate Cancer: Talk to Your Patients about Screening

MLN MATTERS® ARTICLES

- Exceptions to Average Sales Price (ASP) Payment Methodology - Claims Processing Manual Changes

MLN Connects - September 12, 2022 - Updated COVID-19 Vaccines Providing Protection Against Omicron Variant Available at No Cost

The Department of Health & Human Services (HHS), through CMS announced that people with Medicare, Medicaid, Children's Health Insurance Program coverage, private insurance coverage, or no health coverage can get COVID-19 vaccines, including the updated Moderna and Pfizer-BioNTech COVID-19 vaccines, at no cost, for as long as the federal government continues purchasing and distributing these COVID-19 vaccines.

The FDA has authorized the Moderna and Pfizer-BioNTech updated vaccines that target the original COVID-19 viral strain and two Omicron variants (BA.4/BA.5) that are currently the most prevalent in the U.S. Individuals are eligible for their updated vaccine shot at least two months after completing at least their primary vaccination series (two doses of Pfizer-BioNTech, Moderna, or Novavax, or one dose of Johnson & Johnson)-regardless of how many monovalent COVID-19 boosters they have received to date.

CMS issued 4 new CPT codes effective August 31, 2022:

Code 91312 for Pfizer-BioNTech COVID-19 Vaccine, Bivalent Product:

- Long descriptor: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use
- Short descriptor: SARSCOV2 VAC BVL 30MCG/0.3ML

Code 91313 for Moderna COVID-19 Vaccine, Bivalent Product:

- Long descriptor: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use
- Short descriptor: SARSCOV2 VAC BVL 50MCG/0.5ML

Code 0124A for Pfizer-BioNTech COVID-19 Vaccine, Bivalent - Administration - Booster Dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, booster dose
- Short descriptor: ADM SARSCV2 BVL 30MCG/.3ML B

Code 0134A for Moderna COVID-19 Vaccine, Bivalent - Administration - Booster Dose:

- Long descriptor: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, booster dose
- Short descriptor: ADM SARSCV2 BVL 50MCG/.5ML B

Visit the COVID-19 Vaccine Provider Toolkit for more information, and get the most current list of billing codes, payment allowances, and effective dates. Note: You may need to refresh your browser if you recently visited this webpage.

See the full news alert.

MLN Connects - September 15, 2022

Make Your Voice Heard

MLN Connects newsletter for Thursday, September 15, 2022

NEWS

- Make Your Voice Heard Request for Information Seeks Public Comment to Promote Efficiency, Reduce Burden, & Advance Equity within CMS Programs
- Enhancing Oncology Model to Improve Cancer Care: Apply by September 30
- Revision to National Coverage Determination (NCD) 240.2 (Home Use of Oxygen) to Align to 1834(a)(5)(E) of the Social Security Act

CLAIMS, PRICERS, & CODES

- Billing for Hospital Part B Inpatient Services
- National Correct Coding Initiative: October Quarterly Update

MLN MATTERS® ARTICLES

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment - Revised

MLN Connects - September 22, 2022

Encourage Preferred Flu Vaccines for Patients 65+

MLN Connects newsletter for Thursday, September 22, 2022

NEWS

- Flu Shot: Encourage Preferred Vaccines for Patients 65+
- Cataract Surgery: Comparative Billing Report
- Do You Only Order or Certify Services? Use Revised Enrollment Form CMS-855O by January 1
- Cardiovascular Disease: Talk with Your Patients about Screening

CLAIMS, PRICERS, & CODES

- October 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN MATTERS® ARTICLES

- October 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

PUBLICATIONS

- Hospice Quality Reporting Program: New Resources

MLN Connects - September 29, 2022

MLN Connects Newsletter: Sept 29, 2022

NEWS

- Resources & Flexibilities to Assist with Public Health Emergency in Puerto Rico
- Resources & Flexibilities to Assist with Public Health Emergency in Florida
- 2023 Medicare Parts A & B Premiums and Deductibles
- Clinical Laboratory Fee Schedule Payment Determinations & Voting Results: Submit Comments by October 24
- DMEPOS: Change to Enrollment Contractor After November 6
- Hispanic or Latino Patients: Help Address Disparities

CLAIMS, PRICERS, & CODES

- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines
- HCPCS Application Summary for Non-Drug & Non-Biological Items and Services

MLN Connects - October 6, 2022

MLN Connects Newsletter: Oct 6, 2022

NEWS

- Resources & Flexibilities to Assist with Public Health Emergency in South Carolina
- Implementation of Inflation Reduction Act Provision Addressing Medicare Payments for Biosimilars
- CMS Asks for Public Input on Establishing First, National Directory of Health Care Providers and Services
- Inflation Reduction Act Lowers Health Care Costs for Millions of Americans
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4
- Inpatient Rehabilitation Facilities: IRF-PAI & September Care Compare Release
- Long-Term Care Hospitals: September Care Compare Release
- Help Detect Breast Cancer Early

CLAIMS, PRICERS, & CODES

- October 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.3

MLN MATTERS® ARTICLES

- Ambulatory Surgical Center Payment System: October 2022 Update
- DMEPOS Fee Schedule: October 2022 Quarterly Update
- Inpatient Prospective Payment System Hospitals in the 9th Circuit: Updated Fiscal Years 2019 and 2020 Supplemental Security Income Medicare Beneficiary Data

INFORMATION FOR PATIENTS

- 2023 Medicare & You Handbook

MLN Connects - October 13, 2022

MLN Connects Newsletter: Oct 13, 2022

NEWS

- Protect Your Patients in October: Give Them a Flu Shot & COVID-19 Vaccine
- Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period
- Clinical Laboratory Fee Schedule: Final Gapfill Recommendations

CLAIMS, PRICERS, & CODES

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update Fiscal Year (FY) 2023

MLN MATTERS® ARTICLES

- Home Health Claims: New Grouper Edits
- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI

PUBLICATIONS

- Medicare Preventive Services - Revised
- National Expansion of the Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model - Revised

FROM OUR FEDERAL PARTNERS

- Outbreak of Ebola Virus Disease in Central Uganda

MLN Connects - October 27, 2022

MLN Connects Newsletter: Oct 27, 2022

NEWS

- COVID-19 Updated Booster Vaccines Covered Without Cost-Sharing for Eligible Children Ages 5-11
- Oversight of Nation's Poorest-Performing Nursing Homes
- Initial Nursing Facility Evaluation & Management Visits: Comparative Billing Report in October
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4

MLN MATTERS® ARTICLES

- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program
- Patient Driven Payment Model: Claim Edit Enhancements

MLN Connects - October 31, 2022

MLN CONNECTS NEWSLETTER: FINAL RULES

Final Rules

- CY 2023 Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Requirements
- Calendar Year 2023 End-Stage Renal Disease (ESRD) Prospective Payment System (PPS)
- Finalized Policies to Simplify Enrollment and Expand Access to Coverage

MLN Connects - November 1, 2022

MLN CONNECTS NEWSLETTER: OPPS/ASC & PFS FINAL PAYMENT RULES

Final Rules

- HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule
- HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care

MLN Connects - November 3, 2022

MLN Connects Newsletter: Nov 3, 2022

NEWS

- COVID-19 Vaccine: Novavax Booster Authorized
- Medicare Part B Immunosuppressive Drug: Get Information on New Benefit
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Skilled Nursing Facilities: October Care Compare Release
- Clinical Diagnostic Laboratories: Report Private Payor Rate Data Beginning January 1
- Diabetes: Recommend Preventive Services

CLAIMS, PRICERS, & CODES

- Home Health Consolidated Billing Enforcement: CY 2023 HCPCS Codes

PUBLICATIONS

- Medicare Provider Compliance Tips - Revised

MULTIMEDIA

- Hospice Quality Reporting Program: September Forum Materials

MLN Connects - November 10, 2022

MLN Connects Newsletter: Nov 10, 2022

NEWS

- Teaching Hospitals: Phase 2 Section 131 Reviews - Submission Deadline November 18
- Medicare Participation for CY 2023
- CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care
- DMEPOS: Appeals & Rebuttals Contractor Clarification
- Lung Cancer: Help Your Patients Reduce Their Risk

COMPLIANCE

- What's the Comprehensive Error Rate Testing Program?

CLAIMS, PRICERS, & CODES

- Home Health Prospective Payment System Grouper: January Update
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- HCPCS Application Summary for Continuous Glucose Monitoring: Updated

MLN MATTERS® ARTICLES

- Telehealth Home Health Services: New G-Codes

FROM OUR FEDERAL PARTNERS

- Increased Respiratory Virus Activity, Especially Among Children
- Ebola Virus Disease Outbreak in Central Uganda: Update

MLN Connects - November 17, 2022

MLN Connects Newsletter: Nov 17, 2022

NEWS

- Hospital Price Transparency: Download Machine-Readable File Sample Formats & Data Dictionaries
- Medical Review After the COVID-19 Public Health Emergency: New FAQ
- Flu Shots & COVID-19 Vaccines: Each Visit is an Opportunity

CLAIMS, PRICERS, & CODES

- DMEPOS: Corrected 2022 Fee Schedule Amounts
- Hospital Part B Inpatient Services Billing
- Outpatient Prospective Payment System Payment Rate for HCPCS Code Q5124

EVENTS

- HCPCS Public Meeting: November 29 - December 1

MLN MATTERS® ARTICLES

- Provider Enrollment Instructions: Seventh General Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations (NCDs): April 2023 Update

PUBLICATIONS

- Home Health & Hospice: Medicare Provider Resources
- Independent Diagnostic Testing Facility (IDTF) - Revised

MULTIMEDIA

- Quality in Focus Videos to Increase Quality of Care

MLN Connects - November 23, 2022

MLN Connects Newsletter: Nov 23, 2022

NEWS

- Colorectal Cancer Screening Test: Reduced Coinsurance for Related Procedures Begins January 1
- Ambulance Fee Schedule: CY 2023 Inflation Factor & Productivity Adjustment
- Medicare Ground Ambulance Data Collection System: Information to Help You Report
- Health Professional Shortage Area: CY 2023 Bonus Payments
- Rural Health: Help Address Disparities

MLN MATTERS® ARTICLES

- ESRD & Acute Kidney Injury Dialysis: CY 2023 Updates
- Home Health Prospective Payment System: CY 2023 Update
- Medicare Physician Fee Schedule Final Rule Summary: CY 2023

PUBLICATIONS

- Federally Qualified Health Center - Revised

FROM OUR FEDERAL PARTNERS

- Managing Monkeypox in Patients Receiving Therapeutics: CDC Update

MLN MATTERS

DMEPOS Fee Schedule: October 2022 Quarterly Update

MLN Matters Number: MM12918
Related CR Release Date: September 29, 2022
Related CR Transmittal Number: R11619CP
Related Change Request (CR) Number: 12918
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12918 tells you about:

- The October 2022 quarterly update for the DMEPOS fee schedule
- Fee schedule amounts for new and existing codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12918.

Exceptions to ASP Payment Methodology - Claims Processing Manual Changes

MLN Matters Number: MM12854
Related CR Release Date: August 25, 2022
Related CR Transmittal Number: R11572CP
Related Change Request (CR) Number: 12854
Effective Date: October 26, 2022
Implementation Date: October 26, 2022

CR 12854 tells you about:

- Updates to Chapter 17 of the Medicare Claims Processing Manual
- Exceptions to Average Sales Price (ASP) payment methods

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12854.

Medicare Deductible, Coinsurance & Premium Rates: Calendar Year 2023 Update

MLN Matters Number: MM12903
Related CR Release Date: October 13, 2022
Related CR Transmittal Number: R11641GI
Related Change Request (CR) Number: 12903
Effective Date: January 1, 2023
Implementation Date: January 3, 2023

CR 12948 tells you about:

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

Make sure your billing staff knows about these Calendar Year (CY) 2023 rate changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12903.

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

Related CR Release Date: July 14, 2022
Related CR Transmittal Number: July 14, 2022
Related Change Request (CR) Number: 12788
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12788 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12788.

Revision to NCD 240.2 (Home Use of Oxygen) to Align to 1834(a)(5)(E) of the Social Security Act

Related CR Release Date: September 8, 2022
Related CR Transmittal Number: September 8, 2022
Related Change Request (CR) Number: 12877
Effective Date: September 27, 2021
Implementation Date: January 3, 2023

CR 12877 tells you that on September 27, 2021, the Centers for Medicare & Medicaid Services (CMS) revised

National Coverage Determination (NCD) 240.2 (Home Use of Oxygen) and NCD 240.2.2 (Home Oxygen Use for Cluster Headache). On February 10, 2022, CMS issued Transmittal 11263 to implement the revised coverage policies in Change Request (CR) 12607. On May 23, 2022, CMS rescinded Transmittal 11263 and replaced it with Transmittal 11429, to extend the implementation date of CR 12607 to January 3, 2023. All other information in Transmittal 11429 remained the same as in Transmittal 11263.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12877.