DME Happenings

Jurisdiction D

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

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

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.

Ankle-Foot Orthosis (AFO) Top Denials

Noridian's Medical Review Department just released the second quarter Targeted Probe and Educate review results. The top AFO denial reasons apply to suppliers across the board. It's good to know what to do to avoid these denials. Here they are:

Top Medical Necessity Denial Reasons

- Medical record documentation does not support the beneficiary requires stabilization for medical reasons.
- Medical record documentation does not support the beneficiary is ambulatory.
- Medical record documentation does not support the beneficiary has the potential to benefit functionally.

Top Technical Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.

Beneficiaries Entering Medicare With Equipment From Another Payer

- Does Medicare automatically continue coverage for an item obtained by another payer?
- What requirements does the beneficiary or equipment need to meet?
- Is a proof of delivery (POD) required?
- What about billing rental of a beneficiary-owned device and/or accessories and supplies?

So many questions. We've got answers under the Beneficiaries Entering Medicare heading on the Billing Situations webpage.

Break in Need or Service and Break in Billing Questions

Break in need or service and break in billing are the most common situations for questions on what type of CMN/DIF/order or information should be obtained/submitted on claims. The Noridian Break in Need or Service and Break in Billing webpage defines the two situations and provides guidance including what is required when billing a claim.

CERT Documentation Deadline August 22, 2022

The end to the Comprehensive Error Rate Testing (CERT) Review Year (RY) 2022 is quickly coming to an end. In order to give sufficient time for the CERT Review Contractor (RC) to complete the review of your claims, all documentation and additional documentation must be received by **August 22, 2022** to be considered for review. A favorable CERT decision restores recouped money and lowers the provider or supplier error rate. Any questions can be sent to the Noridian CERT team at the following email addresses.

Part A JE and JF: CERTPartAQuestion@noridian.com

Part B JE and JF: CERTQuestion@noridian.com

DME JA: JADMECERT@noridian.com

DME JD: JDDMECERT@noridian.com

CERT Redetermination Deadline September 13, 2022

The end to the Comprehensive Error Rate Testing (CERT) Review Year (RY) 2022 is quickly coming to an end. The deadline for redetermination submission is September 13, 2022 to be considered for the CERT RY. Noridian requests redeterminations be submitted by September 6, 2022 to allow time for processing. A favorable redetermination decision restores recouped money and lowers the provider or supplier error rate. Any questions can be sent to the Noridian CERT team the following email addresses.

Part A JE and JF: CERTPartAQuestion@noridian.com

Part B JE and JF: CERTQuestion@noridian.com

DME JA: JADMECERT@noridian.com

DME JD: JDDMECERT@noridian.com

Continued Coverage of Negative Pressure Wound Therapy (NPWT)

What do you do if a beneficiary needs NPWT after three months of initial therapy? The Clinician Checklist for continuous coverage is there for you. In a nutshell:

- Document continuing problems with the wound
    - Include additional measures being taken
- Directly evaluate/document wound measures and healing progress monthly
    - Provide this documentation to the supplier
- Review the LCD for supply allowables.

The NPWT webpage has links, tips, and educational resources. They're just waiting for you.

Continued Medical Need - Urological and Ostomy Supplies

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered. Beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription.

Once initial medical need is established, unless continued coverage requirements are specified in the LCD, ongoing need is assumed to be met. There is no requirement for further documentation of continued medical need as long as the beneficiary continues to meet the Prosthetic Devices benefit. For more information please review the policy articles for Urological Supplies A52521 or Ostomy Supplies A52487.

Correct Use of Not Otherwise Classified (NOC) Codes

A NOC code should only be used when another HCPCS code is not available. Some codes have a description that indicates "miscellaneous, NOC, unlisted, or non-specified." If so, a NOC code can be used but additional information must be included in the Narrative field of the claim. The Noridian Billing Not Otherwise Classified (NOC) HCPCS Code webpage lists the required elements to include in the narrative and the location of that field on the claim form. Don't let your claim get rejected and cause you rework.

DME On Demand Tutorial Policy Refresher

Noridian offers self-paced educational materials. Our tutorials are available 24/7 so you can view them anytime, anywhere. Here's just a sample:

- External Infusion Pump (EIP)
  - EIP: Inotropic Drugs Revised: Coverage Criteria - 4 minutes
  - EIP: Insulin Pump - 7 minutes
- External Breast Prothesis (EBP)
  - External Breast Prothesis: Coverage Criteria, Refills and Replacements - 8 minutes
  - External Breast Prothesis: Modifiers, Upgrades, and Documentation - 7 minutes
- Knee Orthoses
  - Knee Orthoses: Prefabricated - 8 minutes
  - Knee Orthoses: Custom Fabricated - 6 minutes

Don't Forget the Order When Documentation is Requested

If you receive an additional documentation request (ADR) letter, remember to include the standard written order (SWO) with the requested documentation. Noridian sees frequent denials for this easily remedied issue. Our How to Respond to ADR webpage has helpful information or try our Tips for ADR Responses webpage.

Electronic Signatures

Is the electronic signature you have obtained acceptable? Check out the listing of acceptable electronic signatures on the bottom of our Medical Documentation Signature Requirements webpage. Have other questions on signatures? Check other resources on the page like the CMS Complying with Medicare Signature Requirements Fact Sheet, plus much more.

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.

Common Electronic Data Interchange (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.

Get Paid for Accessories and Supplies Used With Beneficiary-Owned Equipment

Noridian has a valuable Billing Situations webpage. Find out how to correctly bill accessories and supplies used with beneficiary-owned equipment. If you don't include a claim narrative, you may not get paid. Find out how to resolve a denial, or better yet, avoid one. If you do receive a denial, please contact the Supplier Contact Center to place the beneficiary-owned information on file with Medicare.

Glucose Monitor Modifiers: CG, KF, KS, and KX

BLOOD GLUCOSE MONITORS

- (E0607, E2100, E2101) and related supplies (A4233, A4234, A4235, A4236, A4244, A4245, A4246, A4247, A4250, A4253, A4255, A4256, A4257, A4258, A4259)

CONTINUOUS GLUCOSE MONITOR (CGM) DEVICES

- (K0554 or E2102) and supply allowance (K0553 or A4238)

MODIFIERS REQUIRED ON EVERY CLAIM SUBMITTED (APPLY TO CLAIM LINE)

- **KX** - Use if the beneficiary is insulin treated
- **KS** - Use if the beneficiary is non-insulin treated
- **CG** - Must be added for CGM device (K0554) and supply allowance (K0553)
    - Only if all CGM coverage criteria (1-5) in the Glucose Monitors LCD (L33822) are met
- **CG** - Must be added for an adjunctive CGM (E2102) incorporated into an insulin infusion pump and supply allowance (A4238) ONLY if all CGM coverage criteria (1-5) in the Glucose Monitors LCD, and coverage criteria for an insulin infusion pump outlined in External Infusion Pumps LCD (L33794) are met
- **KF** - Must be added for devices classified by Food & Drug Administration as Class III for CGMs (K0554, E2102) and related supplies (A4238, K0553)

This information on can be found in the Glucose Monitors Policy Article (A52464).

Inpatient Denials With Reason Code 109, Remark Code N538 on Your Remittance Advice

There's more information for the exception to delivery rules when the beneficiary is in a Part A inpatient stay. Checking beneficiary eligibility, acceptable time of delivery, and billing the discharge date are key. For more information review the Standard Documentation Requirements for All claims Submitted to DME MACS and to assist in resolving denials and avoiding denials in the future, check out our Denial Code Resolution page on the Noridian Medicare website.

Make the Noridian Billing Situations Webpage Your New Best Friend

The Noridian Billing Situations webpage should be your work best friend. Have questions on topics like these? Your answers are waiting:

- Accessories and Supplies Used with Beneficiary-Owned Equipment
- Beneficiaries Entering Medicare
- Billing Not Otherwise Classified (NOC) HCPCS Code
- Break in Need or Service and Break in Billing
- Consolidated Billing
- DMEPOS and Inpatient Stays
- New Capped Rental Period

Multi-Factor Authentication (MFA) Passcode Valid for 8 Hours

Noridian has enhanced the Multi-Factor Authentication (MFA) passcode on the Noridian Medicare Portal (NMP) to be valid for an 8-hour time period. Users will continue to request the passcode at each log in but will be able to just enter in the same passcode for 8 hours instead of receiving a new passcode at each log in. A text message or email will still be received at each log in with the same passcode.

Note: If a different MFA method is selected during the 8-hour time period, a new passcode will be provided.

Noridian recognizes that users have been asking for this enhancement and we strive to provide the best user experience possible. Thank you for your continued support of the Noridian Medicare Portal.

New Knee Orthosis Codes Require Coding Verification Review (CVR) October 10, 2022

The only products which may be billed using the following list of HCPCS codes are those for which a written CVR has been made by the PDAC contractor and published on their Product Classification List (PCL). Information concerning the documentation that must be submitted for a CVR can be found on the PDAC website by selecting the Topics dropdown menu, then Coding Verification; or by contacting PDAC. Products which have received a coding verification can be found on the PDAC web site by first selecting the DMECS tile, then the Product Classification List bubble. The effective date of the CVR is included for each code.

Required CVR effective dates:

- Effective for claims with dates of service on or after July 01, 2008: **Knee orthosis** L1845
- Effective for claims with dates of service on or after January 1, 2017: **Knee orthosis** L1852
- **Effective for claims with dates of service on or after October 10, 2022: Knee orthoses L1832, L1833, and L1851**
- Effective for claims with dates of service on or after July 1, 2010: Spinal orthoses L0450, L0454, L0456, L0458, L0460, L0462, L0464, L0466, L0468, L0470, L0472, L0488, L0490, L0491, L0492, L0625, L0626, L0627, L0628, L0630, L0631, L0633, L0635, L0637, L0639
- Effective for claims with dates of service on or after January 1, 2014: **Spinal orthoses** L0455, L0457, L0467, L0469, L0641, L0642, L0643, L0648, L0649, L0650, L0651

If a product is billed to Medicare using a HCPCS code that requires a written CVR, but the product is not on the PCL for that particular HCPCS code, the claim line will be denied as incorrect coding.

Noridian Medicare Portal (NMP) Self Service Reopenings

The NMP offers the ability to complete a self service reopening through the portal for all Place of Service (POS) denials with the exception of 31 or 32 which must be completed through a telephone reopening. The place of service for DMEPOS claims is considered the location where a beneficiary will primarily use the DMEPOS item. It's simple and saves time with a quick turnaround time for your payment. Start saving time and money now.

Learn more about this important feature on the NMP Inquiry Guide webpage.

Noridian Medicare Portal (NMP) Written Reopenings

The NMP offers the ability to complete a written reopening through the appeal process and there's no need to mail or fax a request. To begin a new appeal, follow the steps to indicate a reopening on the NMP Inquiry Guide webpage.

Ostomy Supplies Refill Requirements

For Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS items supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that:

- The refilled item remains reasonable and necessary; and,
- Existing supplies are approaching exhaustion; and,
- To confirm any changes or modifications to the order.

Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product. This is regardless of which delivery method is utilized.

Additional information on ostomy supplies can be found in the Local Coverage Determination (LCD) L33828 and Policy Article A52487 on the Noridian website.

Parenteral Nutrition Tutorials

Spend 3-9 minutes feeding your knowledge. There are four parenteral nutrition DME on Demand tutorials can provide quick refreshment:

- Billing - 5 minutes
- Coding - 3 minutes
- Completing the DME Information Form (DIF) - 5 minutes
- Coverage Criteria - 9 minutes

Phase 2 of Prior Authorization for Orthotics Beginning Soon

Do you supply orthotics codes L0648, L0650, L1832, L1833, or L1851? Phase 2 of Prior Authorization begins soon for dates of service on or after July 12, 2022. The following states are part of phase 2: Maryland, Pennsylvania, New Jersey, Michigan, Ohio, Kentucky, Texas, North Carolina, Georgia, Missouri, Arizona, and Washington. Noridian will begin accepting prior authorization requests on June 28, 2022. The Noridian Prior Authorization for Orthoses webpage has details and additional resources.

Prior Authorization Requests Cannot Be Submitted Retroactively

The Prior Authorization Requests (PAR) program is a condition of claim payment. HCPCS codes that were selected by CMS for prior authorization are frequently subject to unnecessary utilization based on prior payment experience. Codes requiring PAR that are submitted for payment without a PAR decision and assigned a Unique Tracking Number (UTN) will be denied.

Providing Accessories or Supplies for Beneficiary-Owned Equipment

A top denial on remittance advices continues to be Reason Code 16/Remark Code M124. As a reminder:

- Beneficiary-owned information must be on file with Medicare Fee-for-Service (FFS) to avoid denials.

Claims for supplies and accessories used with beneficiary-owned equipment must include three pieces of information with claim submission in the narrative section.

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

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 continue to receive denials because the information still is not on file, please utilize the following options to ensure the information has been added to the beneficiary's record.

- Call telephone reopening through the Supplier Contact Center
- Submit a written reopening using the Noridian Medicare Portal appeals process
- Mail
- Fax

Questions With Different Billing Situations

Do you have questions about any of the following subjects? The The billing situations page on our website will provide guidance on these subjects. Check out the page today.

- Accessories and Supplies Used with Beneficiary-Owned Equipment
- Back-Up Equipment
- Beneficiaries Entering Medicare
- Billing Not Otherwise Classified (NOC) HCPCS Code
- Break in Need or Service and Break in Billing
- Certificates of Medical Necessity (CMNs) or DME Information Forms (DIFs)
- Common Scenario Chart Requirement for Type of CMN/DIF/Order and Additional Information When Billing Claims
- Consolidated Billing
- DMEPOS and Inpatient Stays
- Federal Black Lung
- Hospice
- Indian Health Services (IHS)
- Informational Unsolicited Response (IUR)
- Medicare Advantage Plan
- Medicare HMO Beneficiaries Transferring to Fee-For-Service Medicare
- New Capped Rental Period

Receiving Denials for Beneficiary With an HMO

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 please utilize the Denial Code Resolution webpage on the Noridian Medicare website

Receiving Denials for Beneficiary With An HMO, Reason Code 109, Remark Code N418

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 would send the claim to the HMO plan listed on the NMP under Expanded Denial Details. Please utilize the Denial Code Resolution webpage on the Noridian Medicare website for more information.

Receiving Denials for HCPCS Code Is Inconsistent With Modifier Used or Required Modifier Is Missing

Rework for correcting claims and rebilling when required modifiers are missing or procedure code does not require modifier that was appended to claim line. This is one of the most frequent denials that suppliers receive. We have the solution, utilize the Noridian Modifier Lookup Tool to ensure all potential modifiers are included on the claim along with referring to the appropriate Local Coverage Determination (LCD) and LCD Policy Article. To resolve denial:

- **Correct claim line with appropriate required modifier and resubmit claim**

Receiving Denials for Missing or Inappropriate Modifier on a Claim

Tired of rework for correcting claims and rebilling when required modifiers are missing or procedure code does not require modifier that was appended to claim line? This is one of the most frequent denials that suppliers receive. We have the solution, utilize the Noridian Modifier Lookup Tool to ensure all potential modifiers are included on the claim.

- **Correct claim line with appropriate required modifier and resubmit claim**

Receiving Inpatient Denials with Reason Code 109, Remark Code N538 on Your Remittance Advice

Are you receiving inpatient denials? Check out the exception to delivery rules when the beneficiary is in a Part A inpatient stay. Checking beneficiary eligibility, acceptable time of delivery, and billing the discharge date are key. For more information review the Standard Documentation Requirements for All claims Submitted to DME MACS and to assist in resolving denials and avoiding denials in the future, check out our Denial Code Resolution page on the Noridian Medicare website.

Resolving Denials for Reason Code 16 and Remark Code MA83

Did you know that block 11 on the 1500 claim form must be completed to indicate whether Medicare is the primary or secondary payer?

- Item 11 on the 1500 claim form must be completed and cannot be left blank.
- If there is insurance primary to Medicare for the service date(s), enter the insured's policy or group number within the box.
- If there is no insurance primary to Medicare, do not enter "n/a," "not," etc., ***enter the word NONE*** within the confines of the box.

If item 11 is left blank, the claim will be denied as unprocessable with reason code 16, remark code MA83 on the remittance advice. The claim must be corrected and resubmitted.

Round 2021 Competitive Bid

Competitive Bid Questions? Competitive Bid Round 2021 product categories only includes Off-The-Shelf (OTS) Knee Braces and OTS Back Braces. Visit our website for resources on the DMEPOS Competitive Bidding Program.

The Medicare DMEPOS CBP was established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act" or "MMA") after the conclusion of successful demonstration projects.

- Under the MMA, the DMEPOS CBP was to be phased-in so that competition under the program would first occur in 10 MSAs in 2007
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) temporarily delayed the program in 2008 and made certain limited changes
- CMS successfully implemented the Round 1 Rebid in 2011 in select markets and expanded in 2013 for a total of 130 CBAs
- After recompeting DMEPOS CBP contracts in these markets, CMS announced plans for Round 2019 in all 130 CBAs
- In February 2017, CMS announced that Round 2019 was delayed allowing for reforms to the DMEPOS CBP
- The Centers for Medicare & Medicaid Services (CMS) competed 16 product categories in 130 competitive bid areas (CBAs) in Round 2021
- The product category for non-invasive ventilators was removed in April 2020 due to the coronavirus disease 2019 (COVID-19) public health emergency (PHE)
- Of the remaining 15 product categories that were bid for Round 2021, 13 of the product categories have been in previous rounds of the CBP, while off-the-shelf (OTS) back and knees braces were competed for the first time in Round 2021
- CMS did not award competitive bidding contracts for any of the 13 product categories for Round 2021 that were previously competed so only off-the-shelf (OTS) back and knees braces are included in the current competitive bid round

Round 2021 Zip Code Update

The following ZIP codes have been added to Round 2021 of the **Competitive Bidding Program (CBP)** to conform with United States Postal Service ZIP code changes within the identified competitive bidding areas (CBAs) for the **3rd Quarter 2022 ZIP Code Updates**.

- 56980 Washington, DC CBA
- 56981 Washington, DC CBA
- 56982 Washington, DC CBA
- 56983 Washington, DC CBA
- 56984 Washington, DC CBA
- 56985 Washington, DC CBA
- 85288 Phoenix-Mesa-Scottsdale, AZ CBA

The ZIP code lookup tool can be used to identify when a specific item furnished to a beneficiary is subject to the CBP.

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 April 2022 - June 2022 can be located on the Medical Record Review Results webpage:

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

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.

You Spoke, We Listened - August 5, 2022

Our webinar (MCE) survey comments reflect that some suppliers aren't able to follow the content quickly enough. We also know suppliers don't often take time (or have time) to read the PowerPoint before the event, so we approached this from two angles. First, we agreed as a team to send the presentation via email the night before the event to allow more time for review. Second, we wrote a Facebook (FB) post, *Get a Leg Up on the Webinar You Are Attending*, inviting suppliers to consider if reviewing the presentation before the webinar would reduce their questions, increase their understanding and ability to capture concepts, and **save** them time in the end. Find a sample of other changes we have made on the Noridian You Spoke We Listened webpage.

Your Webinar Survey Comments Making a Difference

You have helped us improve your education. We review every survey comment from our suppliers. Look what we did in response to your webinar surveys.

- To help suppliers get their questions answered, some webinars have introduced additional opportunities to ask verbal questions throughout the webinar right when the content is fresh.
- We read your comments on the challenges of repair and replacement rules and correctly using modifiers. So, we took on the assignment of adding more content about these rules to our policy specific webinars.
- Are we hearing what you're seeing? We are taking a close look at the content on our webinar slides. Is there enough information there? Does it make sense? Does what we are saying enhance what you are seeing? Your comments encourage us to keep looking for improvements.
- In small groups, we review your webinar survey comments and written questions. We use them to add/change slide information. We do additional research. We have discussions about policy criteria and challenges our suppliers face.

Thank you for taking the time to come to our events, use our website, and ask questions. We want to do what we can to help you serve your communities.

MEDICAL POLICIES AND COVERAGE .....

2022 HCPCS Code Update - July Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, 2022 HCPCS Code Update - July 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

CMS Issues Interim Final Rules with Comment (CMS-1744- IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, CMS Issues Interim Final Rules with Comment (CMS-1744- IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - 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

Dear Clinician Letter for AIRWAY CLEARANCE: HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES & MECHANICAL IN-EXSUFFLATION DEVICES

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Dear Clinician Letter for **AIRWAY CLEARANCE: HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES & MECHANICAL IN-EXSUFFLATION DEVICES** has been created and published to our website.

View the locally hosted Dear Clinician Letters.

- Go to Clinician Resource Letters webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select letter title

Dear Clinician Letter for ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Dear Clinician Letter for **ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES** has been created and published to our website.

View the locally hosted Dear Clinician Letters.

- Go to Clinician Resource Letters webpage
    - The End User Agreement for Providers will appear if you have not recently visited the website. Select "Accept" (if necessary)
- Locate/select letter title

LCD and Policy Article Revisions Summary for July 28, 2022

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

EXTERNAL INFUSIONS PUMPS

LCD

Revision Effective Date: 07/01/2022
HCPCS CODES:
Added: J1551 to group 3 codes, effective for billing on or after July 1, 2022

07/28/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to CMS HCPCS coding determinations.

PA

Revision Effective Date: 07/01/2022
MODIFIERS:
Revised: J7799 (Cutaquig) to HCPCS code J1551 in JB modifier requirements
CODING GUIDELINES:
Revised: Billing direction dates for Cutaquig under HCPCS code J7799
Added: Billing direction for Cutaquig for HCPCS Code J1551, effective on or after July 1, 2022
Revised: specific SCIg preparations table to list HCPCS J1551, instead of J7799 (Cutaquig)
CODING INFORMATION:
Revised: Cutaquig HCPCS code to J1551 under Group 3

07/28/2022: 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 July 7, 2022

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

SPINAL ORTHOSES: TLSO AND LSO

PA

Revision Effective Date: 07/07/2022
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “coding guideline” and “Coding Guidelines” to “CODING GUIDELINES” in reference to section
Removed: Statement that pertained to the effective date for coding verification review requirement and to statutory denial
Revised: “CAD-CAM” to “computer-aided design/computer-aided manufacturing (CAD/CAM)”
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: “off-the-shelf” to “OTS”
Revised: “Coding Guidelines” to “CODING GUIDELINES” in reference to section
Removed: Information pertaining to that which suppliers must do when providing these items
CODING GUIDELINES:
Revised: “three point” to “three-point”
Revised: “L codes” to “L-codes”
Removed: Statement that referred to Documentation Requirements section of the LCD for instructions concerning use of the CG modifier
Removed: Statement that pertained to billing when CAD/CAM technology used to fabricate an orthosis
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review information
Revised: Reference to the coding verification review effective date for HCPCS codes L0455, L0457, L0467, L0469, L0641, L0642, L0643, L0648, L0649, L0650, L0651

07/07/2022: 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.

THERAPEUTIC SHOES FOR PERSONS WITH DIABETES

PA

Revision Effective Date: 11/05/2020
CODING GUIDELINES:
Removed: Reference of HCPCS codes for inserts and modifications used with L-coded footwear
Added: Language referring to the Orthopedic Footwear LCD and LCD-related Policy Article for more information
Added: Language referring to the Lower Limb Prostheses LCD and LCD-related Policy Article for information pertaining to coverage of devices under the prosthetic devices benefit category

07/07/2022: 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/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

MLN CONNECTS

MLN Connects - June 2, 2022

ICD-10-PCS Procedure Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 2, 2022

NEWS

- Medicare Shared Savings Program: Application Deadlines for January 1 Start Date

CLAIMS, PRICERS, & CODES

- ICD-10-PCS Procedure Codes: Fiscal Year 2023
- July 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.2

MULTIMEDIA

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program - Part 1

MLN Connects - June 9, 2022

Learn about the CMS National Quality Strategy

MLN Connects newsletter for Thursday, June 9, 2022

NEWS

- CMS National Quality Strategy: A Person-Centered Approach to Improving Quality
- Strategy to Strengthen Behavioral Health Care
- Program for Evaluating Payment Patterns Electronic Reports for Short-Term Acute Care Hospitals
- Interns and Residents Information System (IRIS) XML Format
- LGBTQ+ Community: Help Address Disparities

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

MLN MATTERS® ARTICLES

- Update to 'J' Drug Code List for Billing Home Infusion Therapy (HIT) Services
- July 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)

PUBLICATIONS

- Medicare Preventive Services - Revised

MLN Connects - June 16, 2022

ICD-10-CM Diagnosis Codes: Fiscal Year 2023

MLN Connects newsletter for Thursday, June 16, 2022

NEWS

- Comprehensive Error Rate Testing Program Report: Sample Reduced for Reporting Year 2023
- Men’s Health: Talk to Your Patients About Preventive Services

COMPLIANCE

- Implanted Spinal Neurostimulators: Document Medical Records

CLAIMS, PRICERS, & CODES

- ICD-10-CM Diagnosis Codes: Fiscal Year 2023
- July 2022 Quarterly Average Sales Price [ASP] Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN MATTERS® ARTICLES

- July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

MLN Connects Special Edition - June 21, 2022 - Home Health and ESRD Proposed CY 2023 Payment Rules

Home Health & ESRD Proposed CY 2023 Payment Rules

HOME HEALTH AGENCIES: CALENDAR YEAR 2023 PROPOSED RULE - SUBMIT COMMENTS BY AUGUST 16

CMS issued a Calendar Year (CY) 2023 Home Health Prospective Payment System (HH PPS) Rate Update proposed rule to update Medicare payment policies and rates for home health agencies. See a summary of key provisions. Proposals include:

- Routine updates to the Medicare HH PPS and home infusion therapy services payment rates for CY 2023
- Permanent prospective payment adjustment to the home health 30-day period payment rate
- Requests for input on how best to implement a temporary payment adjustment for CYs 2020 and 2021, and collecting telehealth data on home health claims

We encourage you to review the rule, and submit formal comments by August 16, 2022.

ESRD FACILITIES: CALENDAR YEAR 2023 PROPOSED RULE-SUBMIT COMMENTS BY AUGUST 22

CMS issued a Calendar Year 2023 ESRD Prospective Payment System (PPS) proposed rule to update Medicare payment policies and rates for renal dialysis services. See a summary of key provisions. Proposals include:

- Rebase and revise ESRD Bundled market basket to a 2020 base year and update the labor-related share
- Change ESRD PPS methodology for calculating the outlier threshold for adult patients
- Apply a permanent 5% cap on decreases in the ESRD PPS wage index and increase the wage index floor
- Change definition of "oral-only drug" beginning January 1, 2025, and clarify ESRD PPS functional category definitions
- Request comments on whether 3 products meet eligibility criteria for the Transitional Add-on Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Request input on a potential add-on payment adjustment for new renal dialysis drugs and biological products and health equity issues under the ESRD PPS, with a focus on pediatric dialysis payment
- Update requirements and input requests for the ESRD Quality Incentive Program

We encourage you to review the rule, and submit formal comments by August 22, 2022.

MLN Connects - June 23, 2022

Medical Records Correspondence Address

MLN Connects newsletter for Thursday, June 23, 2022

NEWS

- Ambulance Prior Authorization Model Expands August 1
- Orthoses Referring Providers: Comparative Billing Report in June
- Medical Records Correspondence Address
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by July 15
- Long-Term Care Hospital Provider Preview Report: Review by July 15
- Cognitive Assessment: What's in the Written Care Plan?

CLAIMS, PRICERS, & CODES

- Quarterly Update to the National Correct Coding Initiative [NCCI] Procedure-to-Procedure [PTP] Edits, Version 28.2, Effective July 1, 2022

MLN MATTERS® ARTICLES

- July Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule

PUBLICATIONS

- Medicare Diabetes Self-Management Training - Revised

MLN Connects - June 30, 2022

No Surprises Act: Fact Sheets for Your Patients

MLN Connects newsletter for Thursday, June 30, 2022

NEWS

- CMS Issues Significant Updates to Improve the Safety and Quality Care for Long-Term Care Residents & Calls for Reducing Room Crowding
- COVID-19: Pfizer-BioNTech Vaccines for Children as Young as 6 Months - New Codes
- New Model to Improve Cancer Care for Medicare Patients: Apply by September 30
- Internet-Only Manual Update to Publication 100-04, Chapter 16, Sections 70.5, 70.8, and 70.9 to Remove References to the Clinical Laboratory Improvement Amendments (CLIA) Files
- Provide Ostomy Supplies Promptly

EVENTS

- Cancelled - CMS National Provider Enrollment Conference in Boston

MLN MATTERS® ARTICLES

- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP), and PC Print Update
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2022
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2 - Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - July 2021 - Revised

PUBLICATIONS

- Hospital Price Transparency - Updated Resources
- Medicare Provider Enrollment - Revised

INFORMATION FOR MEDICARE PATIENTS

- No Surprises Act: Fact Sheets for Your Patients

MLN Connects - July 7, 2022

Expanding Access to Emergency Care Services in Rural Communities

MLN Connects newsletter for Thursday, July 7, 2022

NEWS

- Taking Action to Expand Access to Emergency Care Services in Rural Communities
- People with Disabilities: Help Address Disparities

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- Long COVID: Use ICD-10 Code U09.9

MLN MATTERS® ARTICLES

- July 2022 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised

PUBLICATIONS

- Teaching Physicians, Interns, & Residents Guidelines - Revised

MLN Connects Special Edition - July 7, 2022 - CMS Proposes Physician Payment Rule to Expand Access to High-Quality Care

On July 7, CMS issued the Calendar Year 2023 Physician Fee Schedule (PFS) proposed rule, which would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care - particularly in rural and underserved areas. These proposed changes play a key role in the Biden-Harris Administration's Unity Agenda - especially its priorities to tackle our nation's mental health crisis, beat the overdose and opioid epidemic, and end cancer as we know it through the Cancer Moonshot - and ensure CMS continues to deliver on its goals of advancing health equity, driving high-quality, whole-person care, and ensuring the sustainability of the Medicare program for future generations.

"At CMS, we are constantly striving to expand access to high quality, comprehensive health care for people served by the Medicare program," said CMS Administrator Chiquita Brooks-LaSure. "Today's proposals expand access to vital medical services like behavioral health care, dental care, and cancer treatment options, all while promoting access, innovation, and cost savings in the Medicare program."

"Integrated coordinated, whole-person care - which addresses physical health, behavioral health, and social determinants of health - is crucial for people with Medicare, especially those with complex needs," said Dr. Meena Seshamani, CMS Deputy Administrator and Director of the Center for Medicare. "If finalized, the proposals in this rule will advance equity, lead to better care, support healthier populations, and drive smarter spending of the Medicare dollar.

The proposed CY 2023 PFS conversion factor is $33.08, a decrease of $1.53 to the CY 2022 PFS conversion factor of $34.61. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in Relative Value Units.

Modernizing Coverage for Behavioral Health Services

In the 2022 CMS Behavioral Health Strategy, CMS set goals to remove barriers to care and improve access to, and the quality of, mental health and substance use care. To help address the acute shortage of behavioral health practitioners, the agency is proposing to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. Additionally, CMS is proposing to pay for clinical psychologists and licensed clinical social workers to provide integrated behavioral health services as part of a patient's primary care team.

CMS is also proposing to bundle certain chronic pain management and treatment services into new monthly payments, improving patient access to team-based comprehensive chronic pain treatment. Lastly, CMS is proposing to cover opioid

treatment and recovery services from mobile units, such as vans, to increase access for people who are homeless or live in rural areas.

Expanding Access to Accountable Care Organizations

ACOs are groups of health care providers who come together to give coordinated, high-quality care to their Medicare patients. The Medicare Shared Savings Program covers more than 11 million people with Medicare and includes more than 500,000 providers.

CMS is proposing changes to the Medicare Shared Savings Program that, if finalized, represent some of the most significant reforms since the final rule that established the program was finalized in November 2011 and ACOs began participating in 2012. Building on the CMS Innovation Center's successful ACO Investment Model, CMS is proposing to incorporate advance shared savings payments to certain new Medicare Shared Savings Program ACOs that could be used to address Medicare beneficiaries' social needs. This is one of the first times Traditional Medicare payments would be permitted for such uses and is expected to be an opportunity for providers in rural and other underserved areas to make the investments needed to become an ACO and succeed in the program. CMS is also proposing that smaller ACOs have more time to transition to downside risk, further helping to grow participation in rural and underserved communities. CMS is also proposing a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations. Finally, CMS is proposing benchmark adjustments to encourage more ACOs to participate and succeed, which would help achieve the goal of having all people with Traditional Medicare in an accountable care relationship with a healthcare provider by 2030.

Improving Access to Colon Cancer Screening

Colon and rectal cancer were the second-leading cause of cancer deaths in the United States in 2020, with higher colorectal cancer death rates for Black Americans, American Indians, and Alaska Natives. To reduce barriers to getting a colonoscopy, CMS is proposing that a follow-up colonoscopy to an at-home test be considered a preventive service, which means that cost sharing would be waived for people with Medicare. Additionally, Medicare is proposing to cover the service for individuals 45 years of age and above, in line with the newly lowered age recommendation (down from 50) from the United States Preventive Services Task Force.

Proposing Payment for Dental Services that are Integral to Covered Medical Services

Medicare Part B currently pays for dental services when that service is integral to medically necessary services required to treat a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following accidental injury or tooth extractions done in preparation for radiation treatment for jaw cancer. CMS is proposing to pay for dental services, such as dental examination and treatment preceding an organ transplant. In addition, CMS is seeking comment on other medical conditions where Medicare should pay for dental services, such as for cancer treatment or joint replacement surgeries, as well as on a process to get public input when additional dental services may be integral to the clinical success of other medical services.

More Information:

- PFS fact sheet
- Quality Payment Program fact sheet
- Medicare Shared Savings Program Proposals fact sheet
- Blog
- Proposed rule

MLN Connects - July 14, 2022

COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits

MLN Connects newsletter for Thursday, July 14, 2022

NEWS

- COVID-19: FDA Authorizes Pharmacists to Prescribe PAXLOVID with Certain Limits
- COVID-19: Moderna Vaccines for Children as Young as 6 Months - New Codes

- Establishing the Framework for Health Equity at CMS
- Post-Acute Care Report to Congress: Prototype Unified Payment for Medicare
- Long Term Care Facilities: Nursing Home Five Star Rating Changes
- Program for Evaluating Payment Patterns Electronic Reports for Home Health Agencies & Partial Hospitalization Programs
- Home Health Quality Reporting Program: Final OASIS Data Specifications

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

CLAIMS, PRICERS, & CODES

- Claims Processing Instructions for the New Hepatitis B Vaccine Code 90759
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- New Edit for Prospective Payment System (PPS) Outpatient and Inpatient Bill Types Receiving an Outlier Payment When a Device Credit is Reported

EVENTS

- Medicare Ground Ambulance Data Collection System Webinar: Allocating Expenses & Revenue - July 21

INFORMATION FOR PATIENTS

- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

MLN Connects Special Edition - July 15, 2022 - CMS Proposes Rule to Advance Health Equity, Improve Access to Care, & Promote Competition and Transparency

CMS is proposing actions to advance health equity and improve access to care in rural communities by establishing policies for Rural Emergency Hospitals (REH) and providing for payment for certain behavioral health services furnished via communications technology. Additionally, in line with President Biden's Executive Order on Promoting Competition in the American Economy, the calendar year 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center Payment System proposed rule includes proposed enhanced payments under the OPPS and the Inpatient Prospective Payment System for the additional costs of purchasing domestically made NIOSH-approved surgical N95 respirators and a comment solicitation on competition and transparency in our nation's health care system.

More Information:

- Press release
- Proposed rule fact sheet
- REH fact sheet
- Proposed rule

MLN Connects - July 21, 2022

988 Suicide & Crisis Lifeline Available Nationwide

MLN Connects newsletter for Thursday, July 21, 2022

NEWS

- 988 Suicide & Crisis Lifeline Available Nationwide
- COVID-19: Novavax Vaccine, Adjuvanted - New Codes
- Allergy & Immunology: Comparative Billing Report in July
- Inpatient Rehabilitation Facilities: Care Compare July Refresh
- Long-Term Care Hospitals: Care Compare July Refresh

- Hospices & Home Health Agencies: Submit Technical Expert Panel Nominations by August 12
- Skilled Nursing Facility Provider Preview Reports: Review by August 15
- Opioid Treatment Programs: Comment by September 6

COMPLIANCE

- Implanted Spinal Neurostimulators: Document Medical Records

INFORMATION FOR PATIENTS

- Medicare Savings Programs Help Pay Premiums

MLN Connects Special Edition - July 27, 2022 - 3 Final FY 2023 Payment Rules: Hospices, Inpatient Psychiatric Facilities, & Inpatient Rehabilitation Facilities

HOSPICES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued a Fiscal Year (FY) 2023 Hospice Payment Rate Update final rule to update Medicare hospice payments, wage index, quality reporting programs, and policies. See a summary of key provisions effective October 1, 2022:

- Routine annual rate setting changes resulting in a 3.8% increase in payments for FY 2023
- Permanent 5% cap on negative wage index changes
- Hospice Quality Reporting Program (HQRP) updates, including the new Hospice Outcomes and Patient Evaluation Tool, the Consumer Assessment of Healthcare Providers and Systems hospice survey, quality measures for FY 2023, and a summary of public comments from the request for information to inform future efforts related to HQRP health equity

INPATIENT PSYCHIATRIC FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the Fiscal Year 2023 Inpatient Psychiatric Facilities (IPF) Prospective Payment System final rule to update IPF payments, wage index, and policies. See a summary of key provisions effective October 1, 2022:

- Updated payment rates by 3.8% with estimated payments to increase by 2.5% after productivity adjustment
- Applied a permanent 5% cap on wage index decreases

INPATIENT REHABILITATION FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the Fiscal Year 2023 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) final rule to update Medicare payment policies and rates. See a summary of key provisions effective October 1, 2022:

- Updated IRF PPS payment rates by 3.9% with estimated overall payments to increase by 3.2% after productivity and outlier adjustments
- Applied a permanent 5% cap on annual wage index decreases
- Expanded quality data reporting on all IRF patients, regardless of payer

MLN Connects - July 28, 2022

Enhanced Nursing Home Rating System

MLN Connects newsletter for Thursday, July 28, 2022

NEWS

- CMS Enhances Nursing Home Rating System with Staffing & Turnover Data
- Clinical Laboratory Improvement Amendments Proposed Rule: Submit Comments by August 25
- Hospices: Submit Technical Expert Panel Nominations by August 12
- Viral Hepatitis: Talk to Your Patients about Screening

CLAIMS, PRICERS, & CODES

- Integrated Outpatient Code Editor: Java Beta File Release

EVENTS

- Medicare Ground Ambulance Data Collection System Webinar: Using Facilities & Vehicles Templates - August 4

MLN Connects Special Edition - July 29, 2022 - Skilled Nursing Facilities: Final FY 2023 Payment Rule

SKILLED NURSING FACILITIES: LEARN WHAT'S NEW FOR FISCAL YEAR 2023

CMS issued the Fiscal Year (FY) 2023 Skilled Nursing Facility (SNF) Prospective Payment System final rule to update payment policies and rates. See a summary of key provisions effective October 1, 2022:

- 2.7% net payment rate increase for skilled nursing facilities
- Patient Driven Payment Model parity adjustment recalibration (use the FY 2023 proposed rule calculator to learn more) and changes in ICD-10 code mappings
- Permanent 5% cap on annual wage index decreases
- SNF Quality Reporting Program: compliance date revisions for certain requirements, new influenza vaccination coverage for health care personnel measure, and regulation text revisions
- SNF Value Based Purchasing: not apply the SNF 30-Day All Cause Readmission Measure for the FY 2023 program year and add 3 new measures for FY 2026 & 2027 program expansion years

CMS SEEKS PUBLIC FEEDBACK TO IMPROVE MEDICARE ADVANTAGE

The Centers for Medicare & Medicaid Services (CMS) released a Request for Information seeking public comment on the Medicare Advantage program. CMS is asking for input on ways to achieve the agency's vision so that all parts of Medicare are working towards a future where people with Medicare receive more equitable, high quality, and person-centered care that is affordable and sustainable.

CMS encourages the public to submit comments to the Request for Information. Feedback from plans, providers, beneficiary advocates, states, employers and unions, and other partners to this Request for Information will help inform the Medicare Advantage policy development and implementation process.

More Information:

- Press release
- Request for Information

MLN Connects Special Edition - August 1, 2022 - New CMS Rule Increases Payments for Acute Care Hospitals & Advances Health Equity, Maternal Health

On August 1, CMS issued a final rule for inpatient and long-term care hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. As required by statute, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule updates Medicare payments and policies for hospitals, drives high-quality, person-centered care, and promotes fiscal stewardship of the Medicare program. In addition, the rule finalizes new measures to encourage hospitals to build health equity into their core functions. These actions will improve care for people and communities who are disadvantaged or underserved by the health care system.

The rule includes three health equity-focused measures in hospital quality programs and establishes a "Birthing-Friendly" hospital designation. CMS will award this new designation to hospitals that participate in a statewide or national perinatal quality improvement collaborative program and have implemented the recommended quality interventions.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting (IQR) Program and are meaningful electronic health record users, the final rule will result in an increase in operating payment rates of 4.3%. This reflects a FY 2023 projected hospital market basket update of 4.1%, reduced by a statutorily required productivity adjustment of a 0.3 percentage point and plus a 0.5 percentage point adjustment required by statute. This is the

highest market basket update in the last 25 years and is primarily due to higher expected growth in compensation prices for hospital workers. Under the LTCH PPS, CMS expects payments in FY 2023 to increase by approximately 2.4% or $71 million.

"CMS is taking action to support hospitals, including updating payments to hospitals by a significantly higher rate than in the proposed IPPS rule. This final rule aligns hospital payments with CMS' vision of ensuring access to health care for all people with Medicare and maintaining incentives for our hospital partners to operate efficiently," said CMS Administrator Chiquita Brooks-LaSure. "It also takes important steps to advance health equity by encouraging hospitals to implement practices that reduce maternal morbidity and mortality."

Advancing Health Equity:

Consistent with the agency's definition of health equity, CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

To address health care disparities in hospital inpatient care and beyond, CMS is adopting three health equity-focused measures in the IQR Program. The first measure assesses a hospital's commitment to establishing a culture of equity and delivering more equitable health care by capturing concrete activities across five key domains, including strategic planning, data collection, data analysis, quality improvement, and leadership engagement. The second and third measures capture screening and identification of patient-level, health-related social needs - such as food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety. By screening for and identifying such unmet needs, hospitals will be in a better position to serve patients holistically by addressing and monitoring what are often key contributors to poor physical and mental health outcomes.

In the near future, CMS is also interested in using measures focused on connecting patients with identified social needs to community resources or services. CMS sought comment on the proposed rule. In the final rule, CMS acknowledges the robust comments received on key considerations that inform our approach to improving data collection, to better measure and analyze disparities across programs and policies, and approaches for updating the Hospital Readmissions Reduction Program (HRRP) that encourage providers to improve performance for socially at-risk populations.

CMS is also discontinuing the use of proxy data for uncompensated care costs in determining uncompensated care payments for Indian Health Service and Tribal hospitals, and hospitals in Puerto Rico, and we are establishing a new supplemental payment to prevent undue long-term financial disruption for these hospitals and to promote long-term payment stability. CMS is also finalizing new flexibilities for graduate medical education for rural hospitals participating in rural track programs, which will help promote workforce development in rural areas.

Improving Maternal Health Outcomes:

CMS is creating a new hospital designation to identify "Birthing-Friendly" hospitals and additional quality measure reporting to drive improvements in maternal health outcomes. CMS is finalizing this designation following the release of the comprehensive CMS Maternity Care Action Plan.

The Biden-Harris Administration has championed policies to improve maternal health and equity since taking office. Earlier this year, Vice President Harris convened a first-ever White House meeting with Cabinet Secretaries and agency leaders, including Secretary Becerra and CMS Administrator Chiquita Brooks-LaSure, to discuss the Administration's whole-of-government approach to reducing maternal mortality and morbidity. In December 2021, Vice President Harris announced a historic call to action to improve health outcomes for parents and their young children in the United States. Implementing this new hospital designation is part of the Biden-Harris Administration's continued response to that call to action, as noted in the CMS Maternity Care Action Plan.

The "Birthing-Friendly" hospital designation will provide important information to consumers about hospitals with a demonstrated commitment to reducing maternal morbidity and mortality by implementing best practices that advance health care quality and safety for pregnant and postpartum patients.

Conditions of Participation Pandemic Reporting for Hospital and Critical Access Hospitals (CAH):

CMS proposed to continue the current COVID-19 reporting requirements for hospitals and CAHs as well as establish new reporting requirements for future public health emergencies (PHE). Based on public feedback, CMS is finalizing the proposed

requirements for continued COVID-19-related reporting for hospitals and CAHs with a reduced number of data categories as an off ramp to the current PHE. CMS is not finalizing the proposed reporting requirements for future PHEs.

Continued Public Reporting of Patient Safety Metrics:

CMS uses quality measures to ensure safety and quality within the health care system and to pay providers through value-based programs. For the FY 2023 Hospital-Acquired Condition (HAC) Reduction Program, CMS proposed to pause - meaning not calculate and subsequently not publicly report - the data for the PSI-90 measure, which is a composite measure that covers multiple patient safety indicators, such as pressure sores, falls, and sepsis. CMS' proposal reflected concerns about the impact COVID-19 would have on the ability to interpret data and was also sensitive to the risks of financially penalizing hospitals for factors potentially out of their control. CMS recognizes the importance of this measure for patients and providers and is finalizing the calculation and public reporting of the CMS PSI-90 measure results. CMS will include the measure in Star Ratings in alignment with the feedback we received. Although this measure will be publicly reported, it will not be used in payment calculations in the HAC to avoid unintentional penalties related to the uneven impacts of COVID-19 across the country.

More Information:

- Final Rule fact sheet
- Maternal Health fact sheet
- Final Rule

MLN Connects - August 4, 2022

ICD-10-CM Code Files: Fiscal Year 2023

MLN Connects newsletter for Thursday, August 4, 2022

NEWS

- Hospices: Volunteer to Test Hospice Outcomes & Patient Evaluation Instrument
- Immunization: Protect Your Patients

CLAIMS, PRICERS, & CODES

- ICD-10-CM Code Files: Fiscal Year 2023
- ICD-10 Medicare Severity Diagnosis-Related Group Version 40

EVENTS

- ICD-10 Coordination & Maintenance Committee Meeting - September 13-14

PUBLICATIONS

- Items & Services Not Covered Under Medicare - Revised

MLN Connects - August 11, 2022

Monkeypox & Smallpox Vaccines: New Product Codes

MLN Connects newsletter for Thursday, August 11, 2022

NEWS

- Monkeypox & Smallpox Vaccines: New Product Codes
- Payment Allowance Update for COVID-19 Monoclonal Antibody Therapy Q0222 Injection, Bebtelovimab, 175 mg
- CMS Announces Resources & Flexibilities to Assist Kentucky Due to Recent Storms
- Hospice Quality Reporting Program: Measure Change

COMPLIANCE

- What's the Comprehensive Error Rate Testing Program?

CLAIMS, PRICERS, & CODES

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2022
- Integrated Outpatient Code Editor: Java Beta File Release

MLN MATTERS® ARTICLES

- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2023
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2023
- New Waived Tests
- Implementation of the Capital Related Assets (CRA) Adjustment 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) - Revised

PUBLICATIONS

- Skilled Nursing Facility Billing Reference - Revised

MULTIMEDIA

- Hospice Quality Reporting Program Videos

MLN Connects - August 18, 2022

Discontinuing Use of Certificates of Medical Necessity & Durable Medical Equipment Information Forms

MLN Connects newsletter for Thursday, August 18, 2022

NEWS

- CMS Discontinuing the Use of Certificates of Medical Necessity and Durable Medical Equipment Information Forms to Increase Efficiency and Reduce Burden for Clinicians, DME Suppliers, and Beneficiaries
- Quality Payment Program: Comment on Proposed Changes by September 6
- Skilled Nursing Facilities: Participate in Interoperability Survey
- Home Health: Revised Guide to Help Desks

CLAIMS, PRICERS, & CODES

- Claim Status Category and Claim Status Codes Update

EVENTS

- Home Health OASIS-E Virtual Workshops - September 13 & 14

MLN MATTERS® ARTICLES

- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - January 2023 Update
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) - January 2023 Update - 2 of 2
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2023
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update – Revised

MLN Connects Special Edition - August 18, 2022 - Creating a Roadmap for the End of the COVID-19 Public Health Emergency

NEWS

- Creating a Roadmap for the End of the COVID-19 Public Health Emergency
- Health Care System Resiliency

Preparing the Health Care System for Operation After the Public Health Emergency: Secretary of Health and Human Services (HHS) Xavier Becerra extended the existing COVID-19 public health emergency (PHE) through October 15, 2022 - and has committed to providing states, health care providers, and other stakeholders a 60-day notice before ending the PHE.

MLN Connects - August 25, 2022

Medicare Secondary Payer: Manual Updates

MLN Connects newsletter for Thursday, August 25, 2022

NEWS

- Interns and Residents Information System XML Format: Updated Vendor List

CLAIMS, PRICERS, & CODES

- Integrated Outpatient Code Editor: Java Beta File Release

MLN MATTERS® ARTICLES

- Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 5

INFORMATION FOR PATIENTS

- Coverage to Care: Updated Resources

MLN MATTERS

Claim Status Category and Claim Status Codes Update

Related CR Release Date: August 10, 2022
Related CR Transmittal Number: R11552CP
Related Change Request (CR) Number: 12778
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

CR 12778 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12778.

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

Related CR Release Date: March 29, 2022
Related CR Transmittal Number: R11318CP
Related Change Request (CR) Number: 12685
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12685 tell you that the Average Sales Price (ASP) methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in chapter 4, section 50 of the Internet Only Manual.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12685.

July Quarterly Update for 2022 DMEPOS Fee Schedule

MLN Matters Number: MM12772
Related CR Release Date: June 9, 2022
Related CR Transmittal Number: R11451CP
Related Change Request (CR) Number: 12772
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12772 tells you about:

- The July 2022 quarterly update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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)12772.

Mental Health Visits via Telecommunications for RHCs & FQHCs

MLN Matters Number: SE22001 Revised
Article Release Date: June 6, 2022

SE22001 tells you about:

- Regulatory changes for mental health visits in Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)
- Billing information for mental health visits done via telecommunications

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)22001.

Pub. 100-08, Chapter 5 Update - Planned Elimination of CMN and DIF Forms

Related CR Release Date: May 26, 2022
Related CR Transmittal Number: R11431PI
Related Change Request (CR) Number: 12726
Effective Date: June 28, 2022
Implementation Date: June 28, 2022

CR 12726 makes an update to Chapter 5 of Publication (Pub.) 100-08. Other Pubs. that include instructions on Certificates of Medical Necessity (CMN) and Durable Medical Equipment Information (DIF) will also be updated in other Change Requests (CRs).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12726.

RARC, CARC, MREP and PC Print Update - Revised

MLN Matters Number: MM12774 Revised
Related CR Release Date: August 10, 2022
Related CR Transmittal Number: R11549CP
Related Change Request (CR) Number: 12774
Effective Date: October 1, 2022
Implementation Date: October 3, 2022

Note: CMS revised this Article due to a revised CR 12774. CMS changed a date in the Background section from July 1 to August 1. CMS shows this in dark red font on page 2. CMS also changed the CR release date, transmittal number and the CR web address. All other information is the same.

CR 12774 tells you about:

- The latest update of the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) code sets
- What you must do if you use Medicare Remit Easy Print (MREP) or PC Print
- Where to find the official code lists

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12774.

Significant Updates to Internet Only Manual (IOM) Publication (Pub.) 100-05 MSP Manual, Chapter 5

MLN Matters Number: MM12765
Related CR Release Date: August 12, 2022
Related CR Transmittal Number: R11550MSP
Related Change Request (CR) Number: 12765
Effective Date: October 13, 2022
Implementation Date: October 13, 2022

CR 12765 tells you about:

- Updates to Chapter 5 of the Medicare Secondary Payer (MSP) Manual
- Sending claims to primary payers before billing Medicare

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12765.