DME Happenings

Jurisdiction D
June 2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

In this Issue

In this Issue

In this Issue

In this Issue

In this Issue

2023 Modifier Usage for the External Infusion Pumps (EIP) Policy

The following EIP policy modifiers are effective March 1, 2023:

For dates of service on or after January 1, 2023

KX: Coverage criteria for the DMEPOS billed is met and that documentation does exist to support the medical necessity.

GA: Item or service is expected to be denied as not medically necessary and an ABN has been properly executed.

GZ: Item or service expected to be denied as not reasonable or necessary (items are automatically denied and not subject to complex medical review).

Previously, the External Infusion Pumps LCD-related Policy Article (A52507) only required the use of the KX, GA, or GZ modifier for insulin and insulin infusion pumps (J1817 and E0784). Claims for external infusion pumps, drugs, and supplies billed without a KX, GA, or GZ modifier, with a date of receipt on or after March 1, 2023 (and a "from" date of service on or after January 1, 2023), will be rejected for missing information. Claims for infusion drugs not administered via an infusion pump must continue to be billed with a GY modifier. These changes are detailed at the path here Noridian Medicare Home page > Policies > Medical Director Articles > 2023 > KX Modifier Use for External Infusion Pumps

The following EIP policy modifiers are effective for the April 1, 2023:

For dates of service (DOS) on or after May 1, 2023

JK: One-month supply or less of drug/biological.

JL: Three-month supply of drug/biological.

These changes are based on Change Request 13014 and more information can be found Billing Medicare Part B for Insulin with New Limits on Monthly Coinsurance - Fact Sheet MLN4443820

The following EIP policy modifier is effective July 1, 2023:

For dates of service on or after January 1, 2023

JZ: Drugs from single-dose containers that are separately payable under Medicare Part B when there are no discarded amounts.

Note: Additional clarification is provided below in the frequently asked questions on use of the JW modifier (effective January 1, 2017). JW modifier: Drugs from single-dose containers that are separately payable under Medicare Part B when there are discarded amounts.

These changes are detailed in Article - Billing and Coding: JW and JZ Modifier Billing Guidelines and Discarded Drugs and Biologicals - JW Modifier and JZ Modifier Policy Frequently Asked Questions

Modifier	Descriptor	Effective Date
KX	Requirements specified in the medical policy have been met	March 1, 2023: DOS January 1, 2023 and after
GA	Item or service is expected to be denied as not medically necessary. Valid Advance Beneficiary Notice of Noncoverage (ABN) obtained.	March 1, 2023: DOS January 1, 2023 and after
GZ	Item or service expected to be denied as not reasonable or necessary. Valid ABN not issued/obtained.	March 1, 2023: DOS January 1, 2023 and after
JK	One-month supply or less of drug/biological	April 1, 2023: DOS May 1, 2023 and after
JL	Three-month supply of drug/biological	April 1, 2023: DOS July 1, 2023 and after
JZ	Discarded drug not administered	January 1, 2023: DOS July 1, 2023 and after

Advance Beneficiary Notice of Noncoverage (ABN): Form Renewal

The Office of Management and Budget approved the Advance Beneficiary Notice of Noncoverage (Form CMS-R-131) for renewal. This renewed form expires January 31, 2026.

In addition to the expiration date, CMS also updated the non-discrimination notice on the form. These changes are cosmetic only and do not impact how providers and suppliers fill out the form.

You may use the renewed form now, but you must use it beginning June 30, 2023, when the previous version expires.

Resources:

- CMS Advance Beneficiary Notice (ABN) - Renewed
- ABN Form Instructions (PDF)
- ABN Forms English and Spanish (Incl Large Print) (ZIP)
- MLN Connects April 6, 2023

News

Attention Competitive Bid Suppliers Furnishing Off-the-Shelf (OTS) Knee and Back Braces as a Non-Contract Physician or Other Treating Practitioner, Physical Therapist, or Occupational Therapist

Competitive bid non-contract physicians, other treating practitioners, physical therapists, and occupational therapists are receiving denials when there is no Part B practitioner claim on file with the same date of service as the claim for DME they provided and billed. Reason Code B15 and Remark Code M114 is the denial received on the remittance advice for this denial.

To resolve the denial:

- Ensure Part B practitioner claim has processed and paid prior to appealing
- A redetermination request may be submitted with all relevant supporting documentation
    - Noridian encourages redeterminations/appeals be submitted using the Noridian Medicare Portal
    - Review applicable Competitive Bidding requirements prior to submitting request
- The OTS back brace or OTS knee brace must be furnished by the physician/ treating practitioner to their own patient as part of their professional service.
    - Must be office visit, surgery is not included
    - Claims must have same date of service as the professional office visit or physical/occupational therapy service billed to the Part B MAC
        - The billable office visit is an absolute requirement
    - Brace must be **medically necessary** to be worn **at home prior to surgery**
    - If medical need does not exist until after surgery, a competitive bid contractor must supply brace

Billing Insulin Furnished Through an External Infusion Pump May 1, 2023 and After

Effective July 1, 2023, Medicare Part B coinsurance must not exceed $35 for a monthly supply of insulin covered under the Durable Medical Equipment (DME) benefit. This provision applies only to beneficiaries who use insulin delivered through DME insulin pumps.

Payments to suppliers and pharmacies will be adjusted to account for the balance of the reduced coinsurance. Suppliers will continue to receive the Medicare payment amount for the insulin (average sales price plus 6%) minus any applicable coinsurance, which is capped at $35 for a one-month supply or $105 for a three-month supply. If there's more than one claim for the same month, the coinsurance cap will apply to the first claim processed.

Do not bill for insulin supplies for July or subsequent months before July 2023. System updates are required to ensure beneficiaries are not charged more than the $35 maximum allowed for the month of July.

New Modifiers:

- JK - Short Descriptor: One-month supply or less of drug/biological
- JL - Short Descriptor: Three-month supply of drug/biological

The following table shows when to use the modifiers.

Claim Submission Month	Modifier	Billing Insulin Administered through DME	Modifier Utilization Date
April 2023	JK, JL	Not required	March 1, 2023: DOS January 1, 2023 and after
May 2023	JK	One-month supply	March 1, 2023: DOS January 1, 2023 and after
June 2023	JK	One-month supply	March 1, 2023: DOS January 1, 2023 and after
July 2023	JK **or** JL	One-month **or** three-month supply	April 1, 2023: DOS May 1, 2023 and after

Note: If the from date of service is in May or June 2023, suppliers must only bill a one-month supply and append the JK modifier. If the JL modifier is billed with a date of service of May or June the claim will be returned as un-processable. For the transition into July implementation, suppliers must wait to bill the supply for July until on or after July 1, 2023 or the claim will be returned as un-processable.

For more information, please refer to the Billing Medicare Part B for Insulin with New Limits on Monthly Coinsurance- Fact Sheet MLN4443820.

Certain Ankle-Foot/Knee-Ankle-Foot (AFO/KAFO) Orthotics Codes Have a New Requirement for the Order and Office Visit

Seven (7) AFO/KAFO HCPCS codes have been added to the Required Face-to-Face Encounter and Written Order Prior to Delivery List effective for dates of service **on or after April 17, 2023**.

- L1932, L1940, L1951, L1960, L1970, L2005, L2036

For items appearing on this list, the treating practitioner must document and communicate to the DMEPOS supplier that they had a face-to-face encounter with the patient **within the 6 months** before the date on the written order/prescription. The written order/prescription must be communicated to the supplier **prior to delivery**.

A face-to-face encounter means an in-person or CMS-approved telehealth encounter between the treating practitioner and the patient.

Additional information and the Required List can be found in MLN Matters SE20007, the Standard Documentation Requirements Article A55426, and the Noridian Orthotics webpage.

News

Clinician Checklist for Spinal Orthoses

Noridian has available a Clinician Checklist for Spinal Orthoses. The checklist was created to help clinicians include all coverage criteria requirements within the medical notes.

Clinician Checklist: Hospital Beds and Accessories

Suppliers have inquired on how to communicate documentation requirements to the provider community. Our clinician checklists for hospital beds and accessories located on our website provide this information in detail. The checklists are easy to print or send to providers to ensure all documentation requirements are met. Follow the path here to find this helpful resource.

Noridian Medicare Website > Browse by DMEPOS Category > Hospital Beds > Clinician Checklist for Hospital Beds and Accessories

Denials for Base Equipment Not on File/ Not Payable

This denial continues to be one of the top denials' suppliers receive. Reason Code 16/Remark Code M124 is the denial on the remittance advice suppliers receive. It can be resolved quickly by calling the Supplier Contact Center to complete a telephone reopening to add beneficiary owned equipment to the beneficiary's history. The information that is required on file is:

- Beneficiary owned HCPCS; purchased month and year.
- Good example: Bene-owned E0601 pur Jan 2021

Get your denials resolved quickly and avoid future denials by utilizing this process to put the beneficiary owned information on file.

Denials for Reason Code 50, Remark Code N115

Not sure what this denial means and how to resolve it? Follow the "Next Steps" on the Denial Code Resolution Tool. Some of the common reasons for this denial are:

- Item billed may require a specific diagnosis or modifier code based on related LCD
    - Suppliers may do a self-service reopening in the Noridian Medicare Portal to adjust diagnosis based on medical records available to supplier
- A development letter requesting additional documentation to support service billed was not received within provided timeline
- Item billed does not meet medical necessity
    - A redetermination request may be submitted with all relevant supporting documentation. Noridian encourages redeterminations/appeals be submitted using the Noridian Medicare Portal. Review applicable Local Coverage

Determination (LCD), LCD-related Policy Article, and Documentation Checklists prior to submitting request

- Noridian encourages Redeterminations be submitted using the Noridian Medicare Portal

E0776BA Denied in Error - Resolved 03/30/23

Provider/Supplier Type(s) Impacted: Not applicable.

Reason Codes: CARC CO-4, RARC N519

Claim Coding Impact: E0776BA

Description of Issue: Noridian identified an issue with HCPCS Code E0776 with Modifier BA denied in error. The issue impacted claims processed between 01/01/23 through 03/13/23.

Noridian Action Required: Noridian updated the system logic on 03/13/23.

Provider/Supplier Action Required: Suppliers may resubmit claims denied in error.

Proposed Resolution/Solution: The claims system logic issue has been corrected.

Date Reported: 03/13/23

Date Resolved: 03/30/23

E2394 Medically Unlikely Edit

Effective July 1, 2023, HCPCS E2394 (Power wheelchair accessory, drive wheel excludes tire, any size, replacement only, each) will have an updated Medically Unlikely Edit (MUE) value of 2 and a revised MUE Adjudication Indicator (MAI) of 3 (date of service level), for dates of service on or after January 1, 2023. Claims submitted for more than one unit for dates of service on or after January 1 through June 30, 2023, will be held and processed once the July 1, 2023, MUE quarterly file is in production. Prior to the implementation of the MUE quarterly update file effective July 1, 2023, suppliers may choose to delay submission of claims for this code until after the implementation of the January 1, 2023, retroactive date.

Educational Opportunities Available

Noridian Outreach and Education offers the opportunity for suppliers to receive a 60-minute individualized education session. This education would be tailored to your **specific educational needs**. Complete the Electronic Supplier Visit Data Collection Form to request education. These requests are processed in the order received. An Education Representative will contact you as time allows.

For single questions join us every **Monday** for Monday Live Chat which is a live online question and answer session from **2-3 p.m. CT**. Each session provides general information

and allows suppliers to type in questions or ask verbal questions. Attendees may join at any time during the session. No CEU is offered. Registration is required.

Enteral and Parenteral Prospective Use

For enteral and parenteral claims, no more than a 1-month quantity of nutrients, equipment, or supplies may be dispensed at one time. This means that the maximum number of supplies that can be dispensed at one time is a 31-day supply.

Suppliers are expected to be aware of the beneficiary's utilization patterns, recognize atypical use or changes to utilization patterns, and only dispense what is medically necessary. Contact with the practitioner may be necessary to ensure that the changes in patterns of use are warranted.

For the nutrients themselves, suppliers must have contact with the beneficiary prior to dispensing refills. Refills may not be automatically dispensed without a request for refill from the beneficiary. The refill request may not take place sooner than 14 calendar days before their current supply is exhausted, and the supplier may not ship or deliver the products sooner than 10 days prior to the exhaustion of supplies or nutrients on hand. Refilled items must be reasonable and necessary. Detailed records should be kept to record contact between the supplier and beneficiary. If the beneficiary has not used all of their previously delivered nutrients or supplies, the supplier should either delay delivery of the next shipment or reduce the quantity delivered so there is no more than one month's supply on hand at any one time. This may occur in situations in which the beneficiary was admitted to the hospital, or in which the beneficiary did not receive their usual nutrient intake because of an acute illness, or similar circumstance. Proof of refill for supplies picked up at the retail location may be an itemized receipt or the signed delivery slip.

Refill requirements are not applicable to the enteral daily supply allowances for HCPCS codes B4034, B4035, and B4036 or parenteral nutrition supply allowances for HCPCS codes B4220, B4222 and B4224. These codes are considered all-inclusive and include all supplies required for the administration of nutrition to the beneficiary for one day. Actual use of the supplies is expected to vary for each beneficiary. The unit of service (UOS) for the supply allowance is one (1) UOS per day (not to exceed 31 per month).

Reminder: There should not be reason to routinely bill the supply allowance 10 days earlier each month.

The supplier may deliver the nutrition and supplies directly to the beneficiary or may use a shipping service to ship the items. For items delivered by the supplier directly to the beneficiary, the "From" date of service (DOS) on the claim will be the actual date the items were received by the beneficiary. If the items are shipped to the beneficiary, the "From" DOS will be the date the items were shipped (the date the shipping label is created or the date the shipping service retrieves the items) or may be the date the items were delivered to the beneficiary. Either way, the supplier record must be linked to the shipping record by a clearly identifiable method. To determine the "To" date of service, the supplier counts the number of

days the nutrients are expected to last (example, the supplier ships a 28-day supply) and adds that number of days to the "From" date on the claim. The span dates will not always match the dates of expected use for the nutrients.

Example: Nutrition and supplies shipped via shipping service

Month One

- 02/01/2023: 28-day supply shipped
- 02/04/2023: Beneficiary receives supply of nutrients
- 02/05/2023: Beneficiary starts using nutrients
- 03/04/2023: Beneficiary finishes supply of nutrients in this shipment

Dates of service on the claim:

- “From” date = 02/01/2023 (date the nutrients were shipped)
- “To” date = 02/28/2023 (28 days after the "From" date since a 28-day supply was shipped)

Note: The span dates ("From" and "To" dates) are determined by the date the nutrients shipped and the number of days for which the quantity shipped is expected to last. The span dates do not necessarily coincide with the dates the beneficiary actually used the nutrients.

Month Two

- 02/22/2023: Supplier calls beneficiary to determine usage during the previous month and determine quantity of next shipment
- 02/24/2023: 31-day supply of nutrients shipped to beneficiary (expected dates of use; 03/01/2023 - 03/31/2023)
- 02/28/2023: Beneficiary receives shipment
- 03/01/2023: Beneficiary begins using nutrients in this shipment
- 03/13/2023 - 03/20/2023: Beneficiary admitted to inpatient hospital stay
- 04/08/2023: Beneficiary exhausts supply

Dates of service on the claim:

- “From” date: 02/24/2023 (date the nutrients were shipped)
- “To” date: 03/26/2023 (31 days after the "From" date since a 31-day supply was shipped)

Note: The next month's shipment would be delayed to account for additional supplies on hand due to the inpatient hospital stay.

- Shipping Supply Kits
- Supply kits consist of multiple items which are sometimes shipped separately. As with nutrients, the span dates on the claim will not always match the dates of expected use of the supplies.

Example: Supplier uses a shipping service

- 02/01/2023: 28-day supply of bags and tubing shipped
- 02/08/2023: 28-day supply of irrigation syringes shipped
- 02/26/2023: 28-day supply of bags and tubing shipped

Claim submission based upon above shipping example:

Month One

- HCPCS: B4035
- Units of service: 28 UOS
- From date: 02/01/2023
- To date: 02/28/2023

Month Two

- HCPCS: B4035
- Units of service: 31 UOS (expected dates of use; 03/01/2023 - 03/31/2023)
- "From" date: 02/26/2023
- "To" date: 03/28/2023

Please refer to the Enteral or Parenteral Nutrition Calculators to assist in determining the appropriate number of units for billing claims.

Glucose Monitors and Supplies L200 DME on Demands

L200 self-paced tutorials provide scenarios and resources for suppliers. Noridian offers several on glucose monitors, including high utilization, modifiers, and orders.

View these and others at Education and Outreach - DME on Demand Tutorials.

Hospitals Beds and Accessories: Billing Miscellaneous Code E1399

When suppliers are billing a product not described by a specific HCPCS code within the Hospital Beds and Accessories Policy Article (PA), use code E1399. For more information on this code and how it is used in this policy please see the policy article.

Initial Wound Evaluation for Surgical Dressings

For initial wound evaluations, the treating practitioner's medical record, nursing home, or home care nursing records must specify:

- The type of qualifying wound (see Surgical Dressings Policy Article A54563); and,

- Information regarding the location, number, and size of qualifying wounds being treated with a dressing; and,
- Whether the dressing is being used as a primary or secondary dressing or for some noncovered use (e.g., wound cleansing); and,
- Amount of drainage; and,
- The type of dressing (e.g., hydrocolloid wound cover, hydrogel wound filler, etc.); and,
- The size of the dressing (if applicable); and,
- The number/amount to be used at one time; and,
- The frequency of dressing change; and,
- Any other relevant clinical information.

This information can be found in the Surgical Dressings Policy Article A54563.

J7677 Denied in Error - Resolved 02/27/23

Provider/Supplier Type(s) Impacted: Not applicable

Reason Codes: M25, N115

Claim Coding Impact: HCPCS Code J7677

Description of Issue: Claims with billed with HCPCS code J7677 and submitted between 12/05/22 and 12/29/22 denied in error due to a claims system logic issue.

Noridian Action Required: Noridian corrected the claims system logic on 12/29/22.

Provider/Supplier Action Required: No action required at this time.

Proposed Resolution/Solution: Noridian will mass adjust the impacted claims.

01/25/23 - Further research is required to complete mass adjustments. Additional updates will be provided as they are available.

02/01/23 - The issue is still being researched. Noridian will provide additional updates as they are available.

02/14/23 - Noridian has started adjustments and expects to complete initiating adjustments the week of 02/20/23.

02/27/23 - Noridian initiated the mass adjustments.

Date Reported: 12/29/22

Date Resolved: 02/27/23

News

Knee Orthosis (KO) Code L1843 Joins Other KO Codes on the Required Face-to-Face and Written Order Prior to Delivery List

If you haven't heard already, prefab/custom fit KO code **L1843** has been added to the Required Face-to-Face Encounter and Written Order Prior to Delivery List effective for dates of service **on or after April 17, 2023**.

For items appearing on this list, the treating practitioner must document and communicate to the DMEPOS supplier that they had a face-to-face encounter with the patient **within the 6 months** before the date on the written order/prescription. Listed items require the written order/prescription to be communicated to the supplier **prior to delivery**.

A face-to-face encounter means an in-person or CMS-approved telehealth encounter between the treating practitioner and the patient.

Additional information and the Required List can be found in MLN Matters SE20007, the Standard Documentation Requirements Article A55426, and the Noridian Orthotics webpage.

Manual Wheelchair DME on Demands

Suppliers are encouraged to view the many self-paced tutorials available regarding manual wheelchairs.

Available tutorials:

- Manual Wheelchair K0001-K0003 Scenarios L200 (6 minutes)
- Manual Wheelchair Home Assessment (4 minutes)
- Manual Wheelchair Bases (14 minutes)
- Manual Wheelchair Upgrades (7 minutes)

These are available on the DME on Demands webpage under Education and Outreach.

New Documentation and Clinician Checklists for Upper Limb Orthoses

Noridian has created a Documentation Checklist and a Clinician Checklist for upper limb orthoses. The checklists were created to help suppliers and clinicians understand the requirements necessary for upper limb orthoses when providing and billing.

New Order and Face-to-Face Requirement for Certain Orthoses Now Active

In January 2023, CMS announced the addition of certain orthoses to the Required Face-to-Face Encounter & Written Order Prior to Delivery List. That requirement went into effect on April 17, 2023. The following HCPCS codes require a face-to-face (F2F) encounter with the treating practitioner within six months prior to the order.

Lumbar-Sacral Orthoses: L0631 and L0637

Knee Orthoses: L1843

Ankle Foot Orthoses: L1932, L1940, L1951, L1960 and L1970

Knee Ankle Foot Orthoses: L2005 and L2036

The written order prior to delivery (WOPD) must be communicated to the supplier prior to delivery of the item. The Standard Documentation Requirements Article (A55426) has additional information on F2F and WOPD requirements.

New Voluntary Prior Authorization (PA) of Power Mobility Device (PMD) Accessory Item(s)

CMS is implementing a voluntary PA process for accessory item(s) for PMDs. PA requests for applicable PMD accessories may be submitted for review on or after March 20, 2023, for dates of service on or after April 6, 2023. For a full listing of qualifying accessories review Voluntary Prior Authorization List.

This is a voluntary program where suppliers can request a PA review for PMD accessories when submitting on the same PA as the required base item. The PA will be rejected if accessories are submitted separate from the PMD base item PA request. If the PMD base item is denied during a PA review all accessories will be denied. If the base item has already received an affirmed PA decision and is resubmitted to review the accessories the PA will be rejected. For more information please review Prior Authorization for Power Mobility Devices.

Non-Portal Users Guide to Help with Claims Inquiries

Attention non-portal users: take advantage of the great self-service options available on the Noridian Medicare Portal. No more wasting time on the phone waiting to talk to the right person about a question you may have, the portal has those answers. The portal inquiry guide will walk you step-by-step through the functions below.

Functions available for DME users:

- Eligibility
    - MBI Lookup Inquiry
- Claim Status
    - ADR Status and Submission
    - CID Status Lookup (CERT claims)
    - Self-service Reopenings (DME)
        - Recoupment Requests
- Appeals Status

    - Begin New Appeal
- Remittance Advices
- Financials
    - Overpayments
    - 1099s
- Same or Similar (DME Only)
- Prior Authorizations (DME)
- Message Center

Noridian Customer Service Survey Launches March 27, 2023

Noridian is devoted to providing solutions that put people first. Effective March 27, 2023, providers will have the option to participate in a short survey after interacting with Noridian's interactive voice recognition (IVR) system or customer service representatives. Noridian encourages providers to participate in the survey and looks forward to hearing your thoughts.

Noridian Has a New Voluntary Prior Authorization Program

Did you know Noridian is now accepting requests for eligible PMD accessories, on a voluntary basis, when a PA request is submitted for a PMD wheelchair base? The listing of eligible PMD accessories is located in the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Items Operational Guide. For questions on the voluntary program please call the Pre-Claim Hotline at 701-433-3041.

Noridian Healthcare Solutions Logo

Here is a quick tip for navigating the Noridian Healthcare Solutions websites. When you are on the Noridian Medicare Portal (NMP) and you want a quick way to get back to the Noridian Medicare educational website, click on the Noridian Healthcare Solutions logo, in white at the top left of the website. From there you can choose the Medicare jurisdiction that provides the educational information for your business.

News

Noridian Medicare Portal vs Interactive Voice Response (IVR) - Self Service Technology

The Noridian Medicare Portal (NMP) and Interactive Voice Response (IVR) are two self-service technologies that allow Durable Medical Equipment (DME) suppliers to access beneficiary and claim information. While the NMP is a free and secure internet-based portal that is available to all DME suppliers located in the United States, access is restricted for those located outside the country due to CMS guidelines.

For those unable to register with the NMP, the IVR self-service tool is available for claim status, eligibility, same or similar, ordering remittance advice, pending claims, overpayment information, prior authorization, and phone reopenings. The IVR tool can be accessed through verbal or touch-tone commands and provides a convenient way for suppliers to access important information about their claims and beneficiaries.

It's important to note that the security regulations and policies of the NMP are governed by CMS, ensuring the protection of sensitive beneficiary and claim information. The NMP provides a comprehensive platform for DME suppliers to access and manage their claims and beneficiary information, while the IVR tool provides a quick and easy way for suppliers to obtain information when access to the NMP is restricted.

Overall, the NMP and IVR self-service technologies provide DME suppliers with flexible options to access the information they need, ensuring efficient and timely management of claim and beneficiary information.

Notification of the 2023 Dollar Amount in Controversy Required to Sustain Appeal Rights for an Administrative Law Judge (ALJ) Hearing or Federal District Court Review

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2023, for an Administrative Law Judge (ALJ) Hearing is **$180**.

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2023, for a Federal District Court Review is **$1,850**.

Pneumatic Compression Devices (PCD) Self-Paced Training

PCD has five (5) DME on Demand tutorials available totaling 35 minutes of education. Here's a snapshot of information they contain:

- Chronic Venous Insufficiency
    - Causes and signs
    - Six-month trials
    - Conservative therapy and reassessment

- Coding
  - Code characteristics
  - Appliances/sleeves
  - PDAC coding verification review
- Documentation
  - Standard Documentation Requirements
  - Who is authorized to order
  - Face-to-face requirements
- Lymphedema
  - Types
  - Coding
  - Four-week trial
- Lymphedema Extending onto Chest, Trunk, and or Abdomen
  - Types
  - Coding
  - Four-week trial

Post-COVID 19 and Appeal Waivers, Appeals Newsletter Part 4

Due to the COVID-19 PHE expiring on May 11, 2023, many of the flexibilities will expire on May 12, 2023. One of those flexibilities is the extension of the timely filing limit for appeals. Starting on May 12. 2023 the filing deadline for Redeterminations will no longer be waived for COVID reasons. As a reminder timely filing limits are 120 days from initial determination.

Resources: JDDME Appeals Timeliness Calculators

Power Seat Elevation Equipment on Power Wheelchairs: Coverage, Coding, and Payment

CMS issued a national coverage decision that establishes power seat elevation for power wheelchairs as durable medical equipment, eligible for coverage by the Medicare program.

Coverage, Coding, and Payment for Power Seat Elevation Equipment on Power Wheelchairs

CMS published a final Benefit Category Determination and National Coverage Determination (BCD NCD) for Seat Elevation Equipment (Power Operated) on Power Wheelchairs on May 16, 2023. This determination finds that power seat elevation equipment on Medicare-covered

power wheelchairs falls within the benefit category for DME. It also provides for national coverage of power seat elevation equipment on Medicare-covered complex rehabilitative power-driven wheelchairs, as defined in 42 CFR 414.202, under criteria specified in the NCD. In addition, the DME MAC has discretion to determine reasonable and necessary coverage of power seat elevation equipment for individuals who use Medicare-covered power wheelchairs other than complex rehabilitative power-driven wheelchairs.

To submit claims to the DME MACs for power seat elevation equipment beginning May 16, 2023, outside of the exceptions noted below, suppliers must use HCPCS code E2300 (wheelchair accessory, power seat elevation system, any type). Additionally, HCPCS codes K0830 (power wheelchair, Group 2 standard, seat elevator, sling/solid seat/back, patient weight capacity up to and including 300 pounds and K0831 (power wheelchair, Group 2 standard, seat elevator, captains chair, patient weight capacity up to and including 300 pounds) must be used to submit claims for individuals with Medicare using seat elevation on Group 2 power wheelchairs that are not complex rehabilitative power-driven wheelchairs. Claims submitted using HCPCS code E2300 for power seat elevation equipment on wheelchairs other than Group 5 and complex rehabilitative power-driven wheelchairs will be denied.

Effective for claims with dates of service on or after May 16, 2023, interim local fee schedule amounts for power seat elevation equipment will be established by the DME MACs for use in paying any allowed claims for power wheelchairs with power seat elevation. HCPCS coding and national fee schedule amounts for power wheelchairs with power seat elevation will be addressed as part of an upcoming HCPCS public meeting, likely later this fall. Additional details on the timing and agenda of the public meetings that will include power seat elevation coding and payment will be provided in the future on the CMS website.

Q2052 Fee Schedule Increase - Resolved 05/17/23

Provider/Supplier Type(s) Impacted: ALL

Reason Codes: N/A

Claim Coding Impact: Q2052

Description of Issue: The fee schedule for HCPCS Q2052 was updated for dates of service in 2022 and 2023 as described in the MLN article here - https://www.cms.gov/files/document/mln3191598-intravenous-immune-globulin-demonstration.pdf.

Noridian Action Required: Noridian will adjust paid claims for Q2052 to allow for the payment rate increase. All adjustments will be initiated before 05/19/23.

Provider/Supplier Action Required: N/A

Proposed Resolution/Solution: Claims will be mass adjusted by Noridian.

05/10/23 - Adjustments are continuing weekly. All adjustments will be initiated by 05/19/23.

05/17/23 - All adjustments have been initiated.

Date Reported: 04/20/23

Date Resolved: 05/17/23

Reminder About Providing Orthoses Prior to Surgery

Devices provided prior to the start of medical necessity (for example, before surgery when the brace is not required for use until after), will not meet the coverage criteria. After surgery, if there is documentation of the medical necessity for the orthotic device(s), a brace may be considered for coverage. Keep in mind there are many other payment rules related to providing braces.

For orthotic devices that require prior authorization (PA) (L0648, L0450, L1832, L1833, and L1851), do not submit PA requests prior to the start of medical necessity. After surgery, if the medical record documentation shows an emergent need for the device(s), submit an expedited request. If an expedited request is not feasible, suppliers may append the ST or KV modifier to the claim to bypass PA. These modifiers may only be used under certain circumstances. **Please review the rules concerning correct use of the ST and KV modifiers to avoid denials.** Information can be found on the Orthotics webpage, Prior Authorization for Orthoses webpage, and/or the Competitive Bidding webpage. Claims submitted with the ST or KV modifier are subject to prepayment review. **Importantly**, once a claim has been submitted with the ST or KV modifier it **should not** be submitted for PA.

If the item is subject to a competitive bid exception, refer to the Noridian Competitive Bidding webpage under “Non-Contract Suppliers and Exceptions” in the TIPS section for guidance and resources.

Repairs Page on Website Updated

Do you have questions about what is required when billing for repairs to beneficiary-owned items and when repairs can be billed? Check out our updated website page for more information, including narrative requirements and billable labor and parts codes.

Resolving Denials for a Date Span Overlap or Overutilization

If you have received a denial with Reason Code 150 or 151 and Remark Code N115 on a remittance advice, either there is a date span overlap or overutilization on the claim. Determine next steps to resolve and avoid future denials on the Denial Code Resolution page on the Noridian Medicare website.

- Review claim submitted for frequency limits listed in the LCD and Policy Article and either adjust amounts because it may be supplier liable, or appeal claim with documentation to support medical need.
- Review Medically Unlikely Edit (MUE) tool for maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.
- To adjust the date span based on medical records available to the supplier, suppliers may do a self-service reopening in the Noridian Medicare Portal.
- A redetermination request may be submitted with all relevant supporting documentation. Noridian encourages redeterminations/ appeals be submitted using the Noridian Medicare Portal. Review applicable Local Coverage Determination (LCD), LCD-related Policy Article, and Documentation Checklists prior to submitting a request. Noridian encourages redeterminations be submitted using the Noridian Medicare Portal.

Resumption of Comprehensive Error Rate Testing (CERT) Letters

The CERT team will resume sending letters for CERT claims. Letters will begin to be sent out to providers/suppliers for Non-Responders, Additional Documentation Requests (ADRs) and claims that are found to be in error. If you have any questions on the status of your review please visit the Noridian Medicare Portal.

Same and Similar Denials

Same or similar continues to be one of the top denials' suppliers receive. Our Denial Code Resolution Tool assists suppliers in resolving those denials and avoiding them in the future.

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

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

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

News

See What Parenteral Nutrition Tutorials Cover

For parenteral nutrition coverage, the treating practitioner must document that enteral nutrition (EN) has been considered and ruled out, tried, and been found ineffective, or that EN exacerbates gastrointestinal tract dysfunction. More information is available on our DME on Demand tutorials including:

- Billing
    - Prospective billing
    - Premix nutrition
    - Lipids
    - Skilled nursing facility (SNF)
- Coding
    - Homemix/premix nutrition
    - Kits
    - Pumps
- Coverage Criteria
    - PN requirements
    - Home parenteral nutrition
    - Documentation tests changes
    - 30-day evaluation

Suppliers Can View the Status and Submit Additional Documentation Requests in the Noridian Medicare Portal

By using the Claim Status function in the Noridian Medicare Portal (NMP), suppliers can see all claims that have an Additional Documentation Requests (ADR) for their Taxpayer Identification Number (TIN), National Provider Identifier (NPI), or Provider Transaction Access Number (PTAN). This provides transparency regarding the ADRs sent by Noridian, including the original letter and the specific documentation requested.

The process of uploading the required documentation through the NMP portal is designed to be user-friendly, making it easy for suppliers to comply with the ADRs. This feature can save valuable time and money by facilitating timely submission of documentation, which is crucial for claim processing and reimbursement and to avoid denials.

For more detailed information on how to use this process, suppliers are directed to consult the Inquiry Guide available on the NMP. The guide provides step-by-step instructions and further clarification on using the Claim Status function and submitting supporting documentation.

Overall, the ability for suppliers to view the status of their claims, access ADRs, and submit additional documentation through the NMP is a valuable feature. It streamlines the process, improves transparency, and promotes efficient communication between suppliers and Noridian.

Supplies for Negative Pressure Wound Therapy (NPWT) Pumps

- Coverage is provided up to a maximum of 15 dressing kits (A6550) per wound per month.
- Coverage is provided up to a maximum of ten canister sets (A7000) per month unless there is documentation evidencing a large volume of drainage (greater than 90 ml of exudate per day).
- For high volume exudative wounds, a stationary pump with the largest capacity canister must be used.
- When billing for quantities of canisters greater than those described in the policy as the usual maximum amounts, there must be clear and explicit information in the medical record that justifies the additional quantities.

This information can be found in the Negative Pressure Wound Therapy Pumps Local Coverage Determination (LCD) L33821.

Surgical Dressing Tools

Noridian offers many tools to help suppliers who provide surgical dressings: Surgical dressings exudate and wound depth lookup tool, surgical dressings HCPCS lookup tool, and surgical dressings type lookup tool. These and many others are located at Education and Outreach - Tools.

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 January 2023 - March 2023 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Enteral Nutrition
- Glucose Supplies
- Knee Orthosis

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

Ten Orthosis Codes Added to Required Face-to-Face Encounter and Written Order Prior to Delivery List

Effective April 17, 2023, ten new orthosis codes will require a face-to-face (F2F) and written order prior to delivery (WOPD) as a condition of payment. For items on this required list, a complete order is required prior to the item's delivery. (For all other DMEPOS items, the order is required prior to claim submission). A practitioner visit is required within six months of the order. More information is available on CMS.gov.

Tutorials Offer a Brush Up on Prefabricated and Custom Fabricated Knee Orthoses

Self-paced tutorials are available reviewing prefabricated (both off-the-shelf and custom fitted) and custom fabricated knee orthoses. These tutorials provide definitions of and differences between these types of orthoses among other topics. Another tutorial provides a brief overview of competitive bid. A 29-minute Collaborative Orthosis tutorial is like a mini-webinar. Come take a look at the DME on Demand tutorials we have available.

Medical Policies and Coverage

2023 HCPCS Code Update - April Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2023 HCPCS Code Update - April Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2023 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

Claim Submission Instruction Post-PHE - Continued Use of Modifier CR and COVID Narrative - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Claim Submission Instruction Post-PHE - Continued Use of Modifier CR and COVID Narrative - Revised, has been created and published to our website.

View the locally hosted 2023 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

Documentation Checklist for Negative Pressure Wound Therapy

To assist suppliers in gathering all applicable documentation, Noridian offers documentation checklists. The Negative Pressure Wound Therapy (NPWT) checklist provides documentation requirements for initial coverage, continued coverage, when coverage ends, and more.

Documentation checklists are available under Policies.

Medical Policies and Coverage

Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms - Final LCDs and Response to Comments (RTC) Articles Published

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

View the locally hosted 2023 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

Glucose Monitors - Final LCD and Response to Comments (RTC) Article Published

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

View the locally hosted 2023 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

HCPCS Codes K1018 and K1019 - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **HCPCS Codes K1018 and K1019 - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2023 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

Knee Orthoses - Correct Documentation of Knee Instability

Knee orthosis coverage for codes L1832, L1833, L1843, L1844, L1845, L1846, L1851, and L1852 requires one of two pathways to meet coverage criteria:

1. Recent injury or surgical procedure; or
2. Ambulatory beneficiary with knee instability
    a. The treating practitioner is responsible for understanding the appropriate treatment/testing necessary based on the beneficiary's condition.
    b. Medical records must include documentation of the examination and an objective description of joint laxity.
        i. Includes testing of the beneficiary (such as varus/valgus instability, anterior/posterior Drawer test, not all inclusive)
        ii. The objective test must show the test resulted in instability of the knee
        iii. A subjective statement of instability would not be sufficient documentation to support knee instability.

The Knee Orthoses Local Coverage Determination (L33318) has full coverage details.

LCD and Policy Article Revisions Summary for March 2, 2023

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 Glucose Monitors. Please review the entire LCD and related PA for complete information.

Glucose Monitors

LCD

Revision Effective Date: 04/16/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: Coverage criteria to separate initial coverage and continued coverage requirements

Removed: "with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump" from CGM coverage criterion pertaining to beneficiary being insulin-treated

Added: "The beneficiary's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription" as a CGM initial coverage criterion

Removed: "The beneficiary is insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump" from CGM coverage criteria

Removed: "The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results" from CGM coverage criteria

Revised: Initial coverage criterion language pertaining to the in-person visit, to clarify that the visit may also be a "Medicare-approved telehealth visit"

Revised: Initial coverage CGM criterion language pertaining to the in-person visit, to change notation of "criteria (1-3) above" to "criteria (1)-(4) above"

Added: Initial coverage CGM criterion pertaining to history of problematic hypoglycemia

Revised: Continued coverage CGM criterion language pertaining to the in-person visit, to clarify that the visit may also be a "Medicare-approved telehealth visit" and that the practitioner must "document" adherence to the CGM regimen and diabetes treatment plan

Removed: "K0554" and "K0553" from reference to a non-adjunctive CGM device and associated supply allowance (respectively)

Added: "E2103" and "A4239" in reference to a non-adjunctive CGM device and associated supply allowance (respectively)

SUMMARY OF EVIDENCE:

Added: Information related to the modified coverage criteria for CGM

ANALYSIS OF EVIDENCE:

Added: Information related to the modified coverage criteria for CGM

BIBLIOGRAPHY:

Added: Section related to the modified coverage criteria for CGM

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments (A59330)

PA

Revision Effective Date: 04/16/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: "or Medicare-approved telehealth" to the in-person visit requirement as part of the initial and ongoing provision of a CGM

Removed: Language from criterion 1 regarding frequent dosing of insulin

Added: Language to criterion 1 regarding appropriate training received in the use of the CGM is evidenced by a prescription

Removed: Language from criterion 2 regarding frequent adjustment of diabetes treatment regimen

Added: Language to criterion 2 regarding the CGM is prescribed in accordance with FDA indications for use

Removed: Language from criterion 3 regarding at least one daily administration of insulin

Added: Language to criterion 3 regarding the CGM prescribed to improve glycemic control for insulin treated beneficiary

Removed: Language from criterion 4 regarding insulin dose adjustments not mandatory if glucose levels in target range and documented in the medical record

Added: Language to criterion 4 regarding medical record documentation of the beneficiary's history related to problematic hypoglycemia consistent with one of the pathways to coverage

Added: The two pathways to coverage under criterion 4

Removed: "on a daily basis" from use of the CGM device documentation in the medical record to determine the beneficiary continues to adhere to diabetes treatment regimen

MODIFIERS:

Removed: "not treated with insulin administrations" from when the KX modifier must not be used

Added: "exclusively treated with oral hypoglycemic agents" to when the KX modifier must not be used

Added: Language "initial coverage of non-adjunctive" for CGM devices and supply allowance related to the use of the CG modifier when billing codes E2103 and A4239

Added: Language regarding continued coverage of a non-adjunctive CGM device and supply allowance related to the use of the CG modifier when billing codes E2103 and A4239

Added: Language regarding continued coverage of adjunctive CGM devices incorporated into an insulin infusion pump, and supply allowance, related to the use of the CG modifier when billing codes E2102 and A4238

CODING GUIDELINES:

Removed: "Effective for claims with dates of service on or after 07/01/2017, the only products that may be billed using code K0554 are those that are specified in the PCL on the PDAC contractor web site."

03/02/2023: 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

LCD and Policy Article Revisions Summary for March 30, 2023

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

External Infusion Pumps

LCD

Revision Effective Date: 04/01/2023

CODING INFORMATION:

Added: JK and JL modifiers to comply with the Inflation Reduction Act insulin coinsurance cap

03/30/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

PA

Revision Effective Date: 04/01/2023

MODIFIERS:

Added: JK and JL modifier instructions to comply with the Inflation Reduction Act insulin coinsurance cap

03/30/2023: 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

LCD and Policy Article Revisions Summary for April 13, 2023

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 Suction Pumps. Please review the entire LCD and related PA for complete information.

Suction Pumps

LCD

Revision Effective Date: 04/01/2023

HCPCS CODES:

Revised: Long descriptor for HCPCS code A4628

04/13/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are non-discretionary updates to CMS HCPCS coding determinations.

PA

Revision Effective Date: 04/01/2023

CODING GUIDELINES:

Revised: "An oropharyngeal" to "An oral and/or oropharyngeal" in reference to HCPCS code A4628

04/13/2023: 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

LCD and Policy Article Revisions Summary for April 20, 2023

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 Oxygen and Oxygen Equipment. Please review the entire LCD and related PA for complete information.

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 04/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Removed: "Beneficiaries do not change group classification when going from initial coverage to continued coverage based upon changes in blood oxygen testing results" (effective 09/27/2021)

04/20/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to updates to National Coverage Determination 240.2.

PA

Revision Effective Date: 04/01/2023

MODIFIERS:

Added: Q-modifier billing instructions for normoxemic patients

04/20/2023: 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

LCD and Policy Article Revisions Summary for April 27, 2023

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 Urological Supplies. Please review the entire LCD and related PA for complete information.

Urological Supplies

LCD

Revision Effective Date: 04/01/2023

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Revised: Reference to inFlow device to include HCPCS code A4341

SUMMARY OF EVIDENCE:

Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes

ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):

Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes

HCPCS CODES:

Added: HCPCS codes A4341 and A4342

BIBLIOGRAPHY:

Removed: Bibliography information, due to not being applicable to the non-discretionary changes

04/27/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

PA

Revision Effective Date: 04/01/2023

CODING GUIDELINES:

Revised: Billing direction for inFlow under HCPCS code A4335 for DOS April 1, 2021 through March 31, 2023

Added: Billing direction for inFlow under HCPCS A4341 and A4342 for DOS on or after 04/01/2023

Revised: Billing direction for Initial sizing and insertion to be billed to the Part B MAC

Added: Billing direction for replacement: “If a replacement of the indwelling intraurethral drainage device with valve is performed by the treating practitioner, claims for this service must be billed to the Part B MAC.”

Revised: Billing direction for activator and charging base to be billed only as replacement using HCPCS code A4342

04/27/2023: 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

Medical Policies and Coverage

LCD and Policy Article Revisions Summary for May 18, 2023

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms. Please review the entire LCDs and related PAs for complete information.

Enteral Nutrition

LCD

Revision Effective Date: 07/02/2023

SUMMARY OF EVIDENCE:

Added: Information related to GA, GY, GZ, and KX modifier addition

ANALYSIS OF EVIDENCE:

Added: Information related to GA, GY, GZ, and KX modifier addition

CODING INFORMATION:

Added: GA, GY, GZ, and KX modifiers

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments (A59397)

PA

Revision Effective Date: 07/02/2023

MODIFIERS:

Added: Section header

Added: BA, BO, GA, GY, GZ, and KX modifier instructions

Added: “As of January 1, 2023, suppliers must calculate the units of service (UOS) for each enteral product billed to Medicare, based on the treating practitioner’s order.”

Added: “Claim lines billed with codes without a KX, GA, GY or GZ modifier will be rejected as missing information” for claims with dates of service on or after July 2, 2023

CODING GUIDELINES:

Removed: “As of January 1, 2023, suppliers must calculate the units of service (UOS) for each enteral product billed to Medicare, based on the treating practitioner’s order.”

Removed: BA and BO modifier instructions

05/18/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Osteogenesis Stimulators

LCD

Revision Effective Date: 07/02/2023

SUMMARY OF EVIDENCE:

Added: Information related to GA, GZ, and KX modifier addition

ANALYSIS OF EVIDENCE:

Added: Information related to GA, GZ, and KX modifier addition

CODING INFORMATION:

Added: GA, GZ and KX modifiers

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments (A59402)

PA

Revision Effective Date: 07/02/2023

MODIFIERS:

Added: GA, GZ, KX modifier instructions

Added: “Claim lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information” for claims with dates of service on or after July 2, 2023

05/18/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Parenteral Nutrition

LCD

Revision Effective Date: 07/02/2023

SUMMARY OF EVIDENCE:

Added: Information related to GA, GY, GZ, and KX modifier addition

ANALYSIS OF EVIDENCE:

Added: Information related to GA, GY, GZ, and KX modifier addition

CODING INFORMATION:

Added: GA, GY, GZ and KX modifiers

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments (A59399)

PA

Revision Effective Date: 07/02/2023

MODIFIERS:

Added: Section header

Added: BA, GA, GY, GZ, and KX modifier instructions

Added: “Claim lines billed with codes without a KX, GA, GY or GZ modifier will be rejected as missing information” for claims with dates of service on or after July 2, 2023

CODING GUIDELINES:

Removed: BA modifier instructions

05/18/2023: 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.

Seat Lift Mechanisms

LCD

Revision Effective Date: 07/02/2023

SUMMARY OF EVIDENCE:

Added: Information related to GA, GZ, and KX modifier addition

ANALYSIS OF EVIDENCE:

Added: Information related to GA, GZ, and KX modifier addition

CODING INFORMATION:

Added: GA, GZ and KX modifiers

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments (A59403)

PA

Revision Effective Date: 07/02/2023

MODIFIERS:

Added: Section header

Added: GA, GZ, KX modifier instructions

Added: “Claim lines billed with codes without a KX, GA or GZ modifier will be rejected as missing information” for claims with dates of service on or after July 2, 2023

05/18/2023: 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

Non-Spinal Electrical Osteogenesis Stimulator Coverage Criteria

For a non-spinal electrical osteogenesis stimulator (E0747) to be covered, one of the following criteria must be met. A nonunion of a long bone fracture defined as radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the osteogenesis stimulator, there is a failed fusion of a joint other than in the spine where a minimum of nine months has elapsed since the last surgery, or there is congenital pseudarthrosis. Additional information on other types of osteogenesis stimulators can be found in the Local Coverage Determination (LCD) L33796.

Open Meeting Announcement - External Upper Limb Tremor Stimulator Therapy Proposed Local Coverage Determination (LCD)

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

View the locally hosted 2023 DMD articles.

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

Open Meeting Teleconference Information and Agenda - Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms Proposed Local Coverage Determinations (LCDs)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Open Meeting Teleconference Information and Agenda - Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms Proposed Local Coverage Determinations (LCDs)**, has been created and published to our website.

View the locally hosted 2023 DMD articles.

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- Locate/select article title

Policy Article Revisions Summary for May 4, 2023

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are High Frequency Chest Wall Oscillation Devices, Immunosuppressive Drugs and Ostomy Supplies. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

High Frequency Chest Wall Oscillation Devices

PA

Revision Effective Date: 05/04/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM code G80.0 to Group 1 Codes

05/04/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Immunosuppressive Drugs

PA

Revision Effective Date: 01/01/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: “PA” to “pancreas transplant alone”

05/04/2023: 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.

Ostomy Supplies

PA

Revision Effective Date: 01/01/2022

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: “Claims for tape and adhesive (A4450, A4452, A5120) that are billed without an AU modifier or another modifier indicating coverage under a different policy will be rejected as missing information.”

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: “Claims for tape and adhesive (A4450, A4452, A5120) that are billed without an AU modifier or another modifier indicating coverage under a different policy will be rejected as missing information.”

Removed: “Claims lines for A4450, A4452 and A5120 billed without AU modifier will be rejected as missing information.”

05/04/2023: 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

Medical Policies and Coverage

Policy Article Revisions Summary for May 25, 2023

Outlined below are the principal changes to the DME MAC Policy Article (PA) that has been revised and posted. The policy included is Mechanical In-exsufflation Devices. Please review the entire LCD and related PA for complete information.

Mechanical In-exsufflation Devices

PA

Revision Effective Date: 05/25/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM code G80.0 to Group 1 Codes

05/25/2023: 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

Medical Policies and Coverage

Proposed Local Coverage Determination (LCD) Released for Comment - External Upper Limb Tremor Stimulator Therapy

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

View the locally hosted 2023 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

PureWick Urine Collection System - Coding and Billing Instructions - Revised

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

View the locally hosted 2023 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

Reminder About Providing Orthoses Prior to Surgery

Devices provided prior to the start of medical necessity (for example, before surgery when the brace is not required for use until after), will not meet the coverage criteria. After surgery, if there is documentation of the medical necessity for the orthotic device(s), a brace may be considered for coverage. Keep in mind there are many other payment rules related to providing braces.

For orthotic devices that require prior authorization (PA) (L0648, L0450, L1832, L1833, and L1851), do not submit PA requests prior to the start of medical necessity. After surgery, if the medical record documentation shows an emergent need for the device(s), submit an expedited request. If an expedited request is not feasible, suppliers may append the ST or KV modifier to the claim to bypass PA. These modifiers may only be used under certain circumstances. **Please review the rules concerning correct use of the ST and KV modifiers to avoid**

denials. Information can be found on the Orthotics webpage, Prior Authorization for Orthoses webpage, and/or the Competitive Bidding webpage. Claims submitted with the ST or KV modifier are subject to prepayment review. **Importantly**, once a claim has been submitted with the ST or KV modifier it **should not** be submitted for PA.

If the item is subject to a competitive bid exception, refer to the Noridian Competitive Bidding webpage under “Non-Contract Suppliers and Exceptions” in the TIPS section for guidance and resources.

MLN Connects

MLN Connects - March 2, 2023

MLN Connects Newsletter: March 2, 2023

News

- The Future of Medicare Enrollment: Save Time with PECOS's Consolidated Application
- Voluntary Prior Authorization Process for Certain Power Mobility Device Accessory Items
- Expanded Home Health Value-Based Purchasing Model: February Newsletter

Events

- ICD-10 Coordination & Maintenance Committee Meeting - March 7-8
- Medicare Home Health Prospective Payment System CY 2023 Webinar - March 29
- Medicare Cost Report E-Filing System Webinar - March 30

Multimedia

- Shared Savings Program & Community-Based Organization Collaboration Webinar Materials

From Our Federal Partners

- Cannabidiol: Discuss Potential Harms with Your Patients
- Increase in Extensively Drug-Resistant Shigellosis in the U.S.

MLN Connects - March 9, 2023

MLN Connects Newsletter: Mar 9, 2023

News

- Nutrition-Related Health Conditions: Recommend Medicare Preventive Services

Compliance

- Advance Care Planning: Bill Correctly for Services

Claims, Pricers, & Codes

- Medicare Physician Fee Schedule Database: April Update
- Home Health Prospective Payment System Grouper: April Update

MLN Connects

Events

- Ambulance Open Door Forum: Medicare Ground Ambulance Data Collection System - March 16

MLN Matters® Articles

- Extension of Changes to the Low-Volume Hospital Payment Adjustment & the Medicare Dependent Hospital Program
- National Coverage Determination: Cochlear Implantation
- Patient Driven Payment Model: Claim Edit Enhancements - Revised

Publications

- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier - Revised

Information for Patients

- New Inflation Reduction Act Resources

MLN Connects Newsletter: Inflation Reduction Act Tamps Down on Prescription Drug Price Increases Above Inflation - Mar 15, 2023

News

Inflation Reduction Act Tamps Down on Prescription Drug Price Increases Above Inflation

MLN Connects - March 16, 2023

MLN Connects Newsletter: Mar 16, 2023

News

- HHS Releases Initial Guidance for Historic Medicare Drug Price Negotiation Program for Price Applicability Year 2026
- Quality Payment Program: 2021 Care Compare Performance Information
- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Skilled Nursing Facility Value-Based Purchasing Program: March Feedback Report
- Audiologists Can Furnish Certain Diagnostic Tests Without a Physician Order
- Colorectal Cancer: Screening Saves Lives

MLN Connects

Claims, Pricers, & Codes

- COVID-19: Don't Report CR Modifier & DR Condition Code After Public Health Emergency
- Split (or Shared) Critical Care Visits: Billing Correction
- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines
- HCPCS Application Summaries & Coding Decisions: Non-Drug & Non-Biological Items & Services

Events

- Home Health Value-Based Purchasing Model Webinar: Strategies for Success Self-Assessment Tool - March 30

Publications

- Medicare Secondary Payer: Don't Deny Services & Bill Correctly
- Behavioral Health Integration Services - Revised
- Medicare Preventive Services - Revised

MLN Connects - March 23, 2023

MLN Connects Newsletter: Mar 23, 2023

News

- Additional Residency Positions: Apply by March 31
- Laboratory Testing Urinalysis: Comparative Billing Report in March
- Long-Term Care Hospital Provider Preview Reports: Review by April 14
- Inpatient Rehabilitation Facility Provider Preview Reports: Review by April 14
- Make Your Voice Heard Summary: Reducing Burden & Increasing Efficiencies
- Promote Kidney Health During National Kidney Month

Compliance

- Critical Access Hospitals: Bill Correctly

Claims, Pricers, & Codes

- Integrated Outpatient Code Editor: Version 24.1

MLN Connects

Events

- Medicare Home Health Prospective Payment System CY 2023 Webinar - March 29

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: April 2023 Update
- DMEPOS Fee Schedule: April 2023 Update

MLN Connects - March 30, 2023

MLN Connects Newsletter: Mar 30, 2023

News

- COVID-19: Booster Dose for Children 6 months - 4 years
- Identity & Access Management System: Easier for Surrogates
- Medicare Advantage Value-Based Insurance Design Model Extended
- Supplemental Security Income & Medicare Beneficiary Data: FY 2021
- DMEPOS for Skilled Nursing Facility: Pre-Discharge Delivery for Fitting & Training

Claims, Pricers, & Codes

- COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency
- April 2023 Quarterly Pricing File Revisions

MLN Matters® Articles

- Medicare Part B Coverage of Pneumococcal Vaccinations
- Supervision Requirements for Diagnostic Tests: Manual Update

Publications & Multimedia

- Post-Acute Care Quality Reporting Program: Videos & Patient Cue Cards
- Expanded Home Health Value-Based Purchasing Model: March Newsletter, FAQs, & Recordings

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Connects

MLN Connects Newsletter: 4 Proposed FY 2024 Payment Rules - April 4, 2023

Proposed Rules

- FY 2024 Hospice Payment Rate Update Proposed Rule (CMS-1787-P)
- FY 2024 Medicare Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) and Quality Reporting (IPFQR) Updates Proposed Rule (CMS-1783-P)
- FY 2024 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule (CMS-1781-P)
- FY 2024 Skilled Nursing Facility Prospective Payment System Proposed Rule (CMS 1779-P)

MLN Connects - April 6, 2023

MLN Connects Newsletter: Apr 6, 2023

News

- Resources & Flexibilities to Assist with Public Health Emergency in Mississippi Due to Recent Storms
- Program for Evaluating Payment Patterns Electronic Reports
- Advance Beneficiary Notice of Noncoverage: Form Renewal
- New Recovery Audit Contractor for Region 2 Starting Spring 2023
- Comprehensive Error Rate Testing Review Contractor Company Changed Name
- Help Improve the Health of Minority Populations

Claims, Pricers, & Codes

- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: April Update

Events

- PCG Provider Compliance Focus Group: Provider Compliance Activities Post-PHE - May 9

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: April 2023 Update - Revised

MLN Connects

MLN Connects Newsletter: CMS Proposes Policies to Improve Patient Safety and Promote Health Equity - Apr 10, 2023

Proposed Rule

CMS Proposes Policies to Improve Patient Safety and Promote Health Equity

MLN Connects - April 13, 2023

MLN Connects Newsletter: Apr 13, 2023

News

- COVID-19: End of Public Health Emergency
- CMS Roundup (Apr. 07, 2023)
- Medicare Shared Savings Program: Application Toolkit Materials
- Inpatient Rehabilitation Facility Interdisciplinary Team Meetings After the COVID-19 Public Health Emergency
- Hospital Outpatient Departments: Prior Authorization for Facet Joint Interventions Starts July 1
- Opioid Treatment Program Webpage Updates

Claims, Pricers, & Codes

- Home Health Original Claims: Don’t Include Cross-Reference Document Control Numbers
- Outpatient Rehabilitation Claims with Reason Code W7072: You Might Need to Resubmit Claims

Events

- IRIS: XML Format & Duplicate Interns and Residents Full-Time Equivalents Review - May 3

MLN Matters® Articles

- New Waived Tests

Publications

- Intravenous Immune Globulin Demonstration - Revised
- Medicare Modernization of Payment Software - Revised

MLN Connects

Multimedia

- Expanded Home Health Value-Based Purchasing Model: Self-Assessment Tool Webinar Materials

MLN Connects - April 20, 2023

MLN Connects Newsletter: Apr 20, 2023

News

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance
- Medical Review & Compliance: Respond to Additional Documentation Requests
- Hospice: Comparative Billing Report in April

Compliance

- Home Health Rural Add-On Policy

Claims, Pricers, & Codes

- Grandfathered Tribal Federally Qualified Health Centers: CY 2023 Rate

Events

- Medicare Ground Ambulance Data Collection System: Office Hours Session - April 27
- Medicare Shared Savings Program: Navigating the Application Webinar - May 8
- Clinical Laboratory Fee Schedule: Present or Speak at Upcoming Meetings

Multimedia

- Medicare Home Health Prospective Payment System CY 2023: Materials from March Webinar

MLN Connects - April 27, 2023

MLN Connects Newsletter: Apr 27, 2023

News

- Hospital Price Transparency Enforcement Updates
- For the First Time, HHS Is Making Ownership Data for All Medicare-Certified Hospice and Home Health Agencies Publicly Available

- Behavioral Health Integration Services: Find Out What Medicare Covers & Who's Eligible

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- 2023 Quality Conference May 1-3

MLN Matters® Articles

- Home Health Claims: Telehealth Reporting
- Skilled Nursing Facility Prospective Payment System: Updates to Current Claims Editing

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Connects - May 4, 2023

MLN Connects Newsletter: May 4, 2023

News

- FAQs on CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency
- Guidance for the Expiration of the COVID-19 Public Health Emergency
- COVID-19 Over-the-Counter Tests
- Medicare Diabetes Prevention Program: Public Health Emergency Flexibilities Continue through December 31
- Transplant Eco-System: Role of Data in CMS Oversight of The Organ Procurement Organizations
- Expanded Home Health Value-Based Purchasing Model: April Newsletter & Performance Reports
- Religious Nonmedical Health Care Institution Benefit & COVID-19 Vaccines
- Clinical Laboratory Fee Schedule 2024 Preliminary Gapfill Rates: Submit Comments by June 26
- Mental Health: Recommend Medicare Preventive Services

MLN Connects

Claims, Pricers, & Codes

- COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency Update
- Claim Status Category & Claim Status Codes

Events

- Medicare Shared Savings Program: Navigating the Application Webinar - May 8
- HCPCS Public Meeting - May 30 - June 1

MLN Matters® Articles

- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI - Revised

Publications

- Electronic Cell-Signaling Treatment

MLN Connects - May 11, 2023

MLN Connects Newsletter: May 11, 2023

News

- CMS Roundup (May 5, 2023)
- Medicare Ground Ambulance Data Collection System: Report Information

Compliance

- Bill Correctly: Power Mobility Devices Repairs

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update
- Home Dialysis Payment Adjustment & Performance Payment Adjustment for ESRD Treatment Choices Model: Updated Process

Publications

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance - Revised

- Expanded Home Health Value-Based Purchasing Model: Updated Measure Calculation Resources

MLN Connects - May 18, 2023

MLN Connects Newsletter: May 18, 2023

News

- COVID-19: Public Health Emergency Ended May 11
- End of COVID-19 Public Health Emergency FAQs
- Advancing Health Equity Through The CMS Innovation Center: First Year Progress And What's To Come
- Power Seat Elevation Equipment on Power Wheelchairs: Coverage, Coding, & Payment
- Medicare Shared Savings Program: Apply for January 1 Start Date by June 15
- Inpatient Rehabilitation Facility Services: Review Choice Demonstration
- Women's Health: Talk with Your Patients About Making their Health a Priority

Claims, Pricers, & Codes

- COVID-19: Reporting CR Modifier & DR Condition Code After Public Health Emergency - Reminder

Events

- Skilled Nursing Facility: Minimum Data Set Resident Assessment Instrument Training

Publications

- Screening Pap Tests & Pelvic Exams - Revised

From Our Federal Partners

- Potential Risk for New Mpox Cases

MLN Connects - May 25, 2023

MLN Connects Newsletter: May 25, 2023

News

- DMEPOS Competitive Bidding Program: Temporary Gap Period Starts January 1
- CMS Roundup (May 19, 2023)

MLN Connects

- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- ESRD-Related Services: Comparative Billing Report in May

Claims, Pricers, & Codes

- COVID-19 Pfizer-BioNTech & Moderna Vaccines: Product & Administration Code Updates

MLN Matters® Articles

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

Publications

- Checking Medicare Claim Status

Multimedia

- J0510-J0530 Pain Interview: Understanding How a Patient Communicates Pain Video

Information for Patients

- States Are Restarting Medicaid & CHIP Eligibility Reviews: Tell Your Patients to Prepare Now

MLN Matters

April 2023 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: December 15, 2022

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

Related Change Request (CR) Number: CR13044

Related CR Transmittal Number: R11752CP

CR 13044 supplies the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13044.

DMEPOS Fee Schedule: April 2023 Update

Related CR Release Date: March 16, 2023

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

MLN Matters Number: MM13153

Related Change Request (CR) Number: CR 13153

Related CR Transmittal Number: R11910CP

CR 13153 tells you about:

- Fee schedule amounts for new and existing codes
- Payment policy changes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13153.

MLN Matters

Manual Update to Pub. 100-04, Chapter 20, Pre-Discharge Delivery of DMEPOS for Fitting and Training, Section 110.3

Related CR Release Date: December 21, 2022

Effective Date: March 21, 2023

Implementation Date: March 21, 2023

Related Change Request (CR) Number: CR 13005

Related CR Transmittal Number: R11760CP

CR13005 adds a note to manual section 110.3 - Pre-Discharge Delivery of DMEPOS for Fitting and Training, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13005.

Medicare Secondary Payer Don't Deny Services & Bill Correctly

MLN Number: MLN7748519

Related CR Release Date: February 23, 2023

Effective Date: March 24, 2023

Implementation Date: March 24, 2023

Related Change Request (CR) Number: CR 13085

Related CR Transmittal Number: R11874MSP

CR 13085 revises Pub. 100-05 Medicare Secondary Payer (MSP) Manual, Chapter 3 which is out of date specific to verbiage, including verbiage for MSP policy and operational procedures.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN)7748519.

MLN Matters

Mental Health Visits via Telecommunications for RHCs & FQHCs - Revised

MLN Matters Number: SE22001 Revised

Article Release Date: May 23, 2023

Note: CMS revised this Article to show a legislative change about in-person visits and added modifier 93 for reporting audio-only mental health visits. Substantive changes are in dark red on pages 1-2.

SE22001 tells you about:

- Regulatory changes for mental health visits in Rural Health Clinics (RHCs) and 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 Special Edition (SE)22001.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: December 30, 2022

Effective Date: April 1, 2023

Implementation Date: April 3, 2023

Related Change Request (CR) Number: CR 13007

Related CR Transmittal Number: R11768CP

CR 13007 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the Viable Information Processing Systems (ViPS) Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.1, and 60.2 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13007.

Technical Revisions Only to the NCD Manual

Related CR Release Date: March 9, 2023

Effective Date: April 10, 2023

Implementation Date: April 10, 2023

Related Change Request (CR) Number: CR13105

Related CR Transmittal Number: R11892NCD

CR 13105 announces technical changes that were made to the National Coverage Determination (NCD) Manual, Publication 100-03, Chapter 1, Parts 1,2,3, and 4.

View the complete CMS Change Request (CR)13105.

Contacts, Resources, and Reminders

Jurisdiction D DME MAC Supplier Contacts and Resources

Supplier Contact Center (SCC) - View hours of availability, call flow, authentication details and customer service areas of assistance.

Email Addresses - Suppliers may submit emails to Noridian for answers regarding basic Medicare regulations and coverage information. View this page for details and request form.

Fax Numbers - View fax numbers and submission guidelines.

Holiday Schedule - View holiday dates that Noridian operations, including customer service phone lines, will be unavailable for customer service.

Interactive Voice Response (IVR) - Self-Service Technology - View conversion tool and information on how to use IVR and what information is available through system. General IVR inquiries available 24/7.

Mailing Addresses - View mail addresses for submitting written correspondence, such as claims, letters, questions, general inquiries, enrollment applications and changes, written Redetermination requests and checks to Noridian.

DME MACs and Other Resources

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, 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 Medicare.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 on the CMS Manuals webpage. CMS Change Requests and the date issued will be referenced within the “Source” portion of applicable articles.

Contacts, Resources, and Reminders

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.

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

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.

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

Suppliers may call the CERT Documentation Contractor 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.

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.

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 5.5

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's 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.

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

Closures:

- Holiday Schedule
- Training Closures

What information do I need before I can initiate a Telephone Reopening?

Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed.

Verified by Customer Service Representative (CSR) or IVR:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of Tax Identification Number (TIN)

Verified by CSR:

- Caller's name
- Provider/Facility name
- Beneficiary Medicare number

- Beneficiary first and last name
- Date of Service (DOS)
- Last five digits of Claim Control Number (CCN)
- HCPCS code(s) in question
- Corrective action to be taken

Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

What may I request as a Telephone Reopening?

The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. **Note:** This list is not all-inclusive.

- Diagnosis code changes or additions
- Date of Service (DOS) changes
- HCPCS code changes
- Certain modifier changes or additions (not an all-inclusive list)

If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.

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.