DME Happenings

Jurisdiction D
March 2023

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Healthcare Solutions
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

1500 Claim Form Instructions and Tutorial

To find the 1500 claim form and the instructions to complete, select the Forms tab from the top men on the Noridian Medicare website. This Forms webpage contains most required forms which includes the CMS-1500 Claim Form Instructions, and a tutorial for each field requirement on the form.

The *CMS-1500 Form* (Health Insurance Claim Form) is sometimes referred to as the AMA (American Medical Association) form. It is the prescribed form for claims prepared and submitted by physicians or suppliers, whether or not the claims are assigned. It can be purchased in any version required by calling the U.S. Government Printing Office at 202-512-1800.

2022 1099 Tax Forms Available on NMP

The 2022 1099-INT and/or 1099-MISC are now available on the Noridian Medicare Portal (NMP). The 1099 inquiry is available through the Financials function.

1099s on the portal are a courtesy copy of the official 1099 form that was mailed to your facility. View the 1099 Inquiry section of the Portal Guide to download your copy today.

2022 Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Fee Schedule File Revisions - Resolved 12/05/22

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

Reason Codes: Not applicable.

Claim Coding Impact: Not applicable.

Description of Issue: CMS has recalculated the 2022 fees for 179 HCPCS code and modifier combinations and has issued a revised 2022 DMEPOS fee schedule file to the DME MACs. The revised payment amounts are fee increases in the non-contiguous areas of Alaska, Hawaii, Puerto Rico, and Virgin Islands. The revised 2022 fee file along with a list of the 179 HCPCS code and modifier combinations affected can be viewed at https://www.cms.gov/medicaremedicare-fee-service-paymentdmeposfeescheddmepos-fee-schedule/dme22-r

Noridian Action Required: Mass adjustments will be initiated to pay claims at the revised fee.

Provider/Supplier Action Required: Not applicable.

Proposed Resolution/Solution: Mass adjustments will be initiated to pay claims at the revised fee.

12/05/22 - Noridian initiated the mass adjustments.

Date Reported: 11/21/22

Date Resolved: 12/05/22

Additional Documentation Requests (ADR) and Appeals - Appeals Newsletter Part 2

When submitting an appeal as a result of an Additional Documentation Request (ADR):

- All fields must be completed on the Appeal form.
- If submitting ADR letter, please make it clear what it is you are appealing, and what you would like us to do.

How can the provider resolve this error?

- Complete all sections on the Appeal form
- If sending an appeal from your ADR, please include a letter telling us what you would like us to do and why
    - It is always better to submit a completed appeal form

Resource

Redetermination

Appealing Denials from Other Review Contractors

A redetermination (first level appeal) may be requested if a denial is received from another review contractor such as Comprehensive Error Rate Testing (CERT), the Office of Inspector General (OIG), Recovery Auditor (RA), Supplemental Medical Review Contractor (SMRC), or the Unified Program Integrity Contractor (UPIC). When requesting a redetermination, be specific about why the appeal is being requested. Submit medical records along with additional documentation to support the medical necessity of the item(s) denied. For more information about the appeals process refer to the Redetermination webpage on the Noridian website.

To find out more regarding why the denial may have occurred, please use the Noridian Denial Code Resolution Tool.

Avoid Receiving Inpatient Denials with Reason Code 109, Remark Code N538 and Denials for Claim Not Covered by This Payer Reason Code 109, Remark Code N418

Are you receiving inpatient denials or denials for claim not covered by this payer? Verifying **beneficiary eligibility in the Noridian Medicare Portal** is key to avoiding these types of denials. The denial code resolution tool should be utilized to find a solution to resolve denial

and/or how to avoid the same denial in the future. Reason code 109, remark code N538 Denial Code Resolution page and Reason code 109, remark code N418 Denial Code Resolution page

Beneficiary Permanent Address on File with Social Security

Just a quick reminder to ensure that when a claim is prepared for submission to the DME MAC, the beneficiary's permanent mailing address as listed with Social Security should be listed in item five of the CMS 1500 claim form or the electronic equivalent. This will ensure the correct jurisdiction is billed and avoid denials and rework for incorrect jurisdiction. The address on file with Social Security is the address where the beneficiary receives their monthly social security benefits.

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

When reviewing claims for these items, it has been identified that some suppliers have been billing with the ***supplier's cost*** of the item instead of the ***supplier's retail price***. Please ensure that the information below for the narrative is included on the claim line.

When a prefabricated custom fit orthosis is being provided directly to a beneficiary and no custom fitting is completed at the time of delivery, the corresponding prefabricated off-the-shelf HCPCS code must be billed on the claim. When there is not a corresponding prefabricated off-the-shelf HCPCS code for the HCPCS categorized as custom fitted orthotics, one of the following miscellaneous codes must be used for billing.

- L1499 - Spinal orthosis, not otherwise specified
- L2999 - Lower extremity orthoses, not otherwise specified
- L3999 - Upper limb orthosis, not otherwise specified

A narrative must be included on the claim line with the following information. Add the narrative to Item 19 of the 1500 claim form or the 2400/NTE segment of an electronic claim.

- HCPCS code of item being provided
- OTS to indicate it is off-the-shelf
- **Supplier's Retail Price (SRP)**

Example: L1820 OTS $150 SRP

News

Changes for Beneficiaries to be Aware of at Beginning of Year

- Beneficiaries change from Fee-for-Service to Medicare Advantage Plan or from Medicare Advantage Plan to Fee-for-Service - check eligibility in the Noridian Medicare Portal to ensure you are billing the correct payer, prior to providing services
- Deductible changes, Medicare Part B - $226 for 2023

Claims With CMN/DIF on File for DOS on/after 01/01/23 - Resolved 02/07/23

Provider/Supplier Type(s) Impacted: Suppliers of HCPCS that have a current CMN/DIF on file

Reason Codes: Not applicable

Claim Coding Impact: Any HCPCS that requires a CMN/DIF

Description of Issue: The Common Working File is rejecting some claims with dates of service on/after 01/01/23 when there is a current CMN/DIF on file. Claims are being held until the error is corrected at the Common Working File.

Noridian Action Required: Noridian is awaiting a fix from CWF. Noridian will provide updates as received.

Provider/Supplier Action Required: Not applicable.

Proposed Resolution/Solution: Claims are being held. No action.

02/07/23 - Claims have been released.

Date Reported: 01/26/23

Date Resolved: 02/07/23

Clinician Checklist for Pneumatic Compression Devices - Chronic Venous Insufficiency with Venous Stasis Ulcers (CVI)

Noridian has created a clinician checklist for Pneumatic Compression Devices - Chronic Venous Insufficiency with Venous Stasis Ulcers (CVI). The checklist is to help clinicians to include all coverage criteria requirements within the medical notes. For more information review the Clinician Checklist for Pneumatic Compression Devices - Chronic Venous Insufficiency with Venous Stasis Ulcers (CVI).

News

CMS Medicare Secondary Payer (MSP) Alert

To our providers, physicians, and suppliers:

CMS is encountering a severe issue where several providers, physicians and other suppliers are **denying** services and treatment to Medicare beneficiaries, due to an open MSP record on Common Working File (CWF). This practice must **not** be followed. Please share the following immediately with any billing, coding and revenue cycle staff involved.

It has come to CMS's attention again that there are some providers, physicians and other suppliers who are denying services to beneficiaries due to an open Medicare Secondary Payer record on the beneficiary Medicare record.

- Providers and suppliers shall **not deny** medical services or entry to a Skilled Nursing Facility (SNF) or hospital after you discover that there is an open or closed Group Health Plan (GHP), whether the beneficiary is entitled due to
    - Age
    - Disability
    - End Stage Renal Disease (ESRD)
    - Non-Group Health Plan (NGHP-Liability {L})
    - No-Fault (NF)
    - Workers' Compensation (WC)
- MSP record found in HIPAA Eligibility Transaction System (HETS) 270/271, or on CWF. You must continue to see Medicare beneficiaries if a claim that was previously mistakenly denied by Medicare, due to an MSP occurrence. These claims may be appealed through the appeal process.
- If services are covered under an open GHP or related to an NGHP, MSP accident or injury incident, bill the primary insurer first.
    - Situations where providers bill for services related to a new accident or injury, and not related to existing NGHP MSP record found on HETS or CWF
    - May need to use the same diagnosis codes that are found on the NGHP record in HETS and CWF
- Submit these claims to secondary Medicare, **after** you submit these claims to the appropriate GHP and/or NGHP insurer.
    - NGHP insurer may deny these claims if claim not related to the original accident or injury, or the case has not been settled
- After submitting these claims to Medicare, Medicare may mistakenly deny these services because the diagnosis codes on the claim are related to the diagnosis codes found on the NGHP MSP record on HETS and CWF.
    - Appeal inappropriately denied claims with Noridian.

- Physicians, providers, and other suppliers must provide an explanation or reason code to justify services **not related** to the accident or injury on record.
    - **Continue** to see or provide services to the beneficiary if those claims are mistakenly denied
- A Workers' Compensation Medicare Set Aside (WCMSA) MSP record is **not** a reason to deny services, but instead provides information, as to who is the **appropriate** primary payer for that situation.
- WCMSA is an agreement between the CMS and the CMS beneficiary about what value of settlement funds must be spent for care related to all settled WC injuries or illnesses before Medicare begins primary payment for those settled injuries or illnesses.
    - Must first verify, via the HETS 270/271 transaction, whether "W" WCSA record exists
    - Indication showing "W" MSP WCMSA record exists, the patient should have WCMSA that **may** pay for services, and then, the provider bills patient directly
    - If WCMSA does not pay for all of the services, due to total benefits exhaustion, provider may submit Medicare bill indicating what the WCMSA paid
    - Medicare may then pay as primary or secondary payer, dependent upon WCMSA status and how much it paid on the claim
        - Providers submits a bill with regular billing procedures indicating occurrence code 24 (insurance denied) and the date of denial in FL 31-36
        - Plus, supplementary statement calling attention that WCMSA denied payment or annotates FL 80, remarks, with the reason

Billing No-fault, Liability and Worker's Compensation Claims

When providers, physicians and other suppliers render services for beneficiaries who have an open NGHP found on CWF, and in HETS, they must bill as follows:

- NGHP record shows indicator of "Y" identifying there is Ongoing Responsibilities for Medicals (ORM), do **not** bill Medicare.
    - Bill NGHP insurer first as they are the proper primary payer for claims related to the accident or injury.
- If the NGHP record shows an indicator of "N" or "BLANK" (identifying there is no ORM), bill the NGHP insurer first. If the NGHP insurer denies the claim and identifies the reason for the denial on the remittance advice, the denial should be placed on your claim to Medicare.
    - Assists Medicare in determining to make **conditional** payment during the promptly payment period

- If there is an open employer Group Health Plan record on CWF and HETS, always bill the GHP insurer **first**, even before you bill the NGHP for both ORM and non-ORM claims.

Continuous Glucose Monitors (CGM) Procedure Code Update

- **New HCPCS Codes (Effective for DOS on or after 01/01/23)**
  - **A4239** - Supply allowance for non-adjunctive, non-implanted continuous glucose monitor (CGM), includes all supplies and accessories, one month supply = one unit of service
  - **E2103** - Non-adjunctive, non-implanted continuous glucose monitor or receiver
- **Deleted Codes (Effective for DOS prior to 01/01/23)**
  - **K0553** - Supply allowance for therapeutic CGM device

K0554 - CGM receiver/monitor

Glucose Monitors

Coverage Criteria for Intermittent Urinary Catheters A4353 - Immunosuppressed Beneficiaries Meeting Criteria 2

Immunosuppressed criteria for the A4353 (intermittent urinary catheter, with insertion supplies) are covered when a beneficiary requires catheterization and the beneficiary is immunosuppressed, for example below (**not an all-inclusive list**).

- On a regimen of immunosuppressive drugs post-transplant,
- On cancer chemotherapy,
- Has AIDS,
- Has a drug-induced state such as chronic oral corticosteroid use.

Please note that the above list indicates that it is not an all-inclusive list. For all conditions, the practitioner is required to clearly document the condition causing the immunosuppression within the beneficiary's medical records to qualify for criteria 2. These practitioner records must meet the medical necessity based on the coverage criteria listed within the Local Coverage Determination (LCD) L33803.

Determining the Maximum Quantity of Ostomy Supplies

Suppliers have often asked how to best determine the usual maximum quantity of certain ostomy supplies the beneficiary may receive within a month. Local Coverage Determination (LCD) L33828 has an extensive list of the most frequently used codes and how many are

typically considered reasonable and necessary for a beneficiary in a given month. The explanation for use of a supply quantity greater than the amounts listed must be clearly documented in the beneficiary's medical record. If adequate documentation is not provided when requested, the excess quantities will be denied as not reasonable and necessary.

Determining the Maximum Quantity of Urological Supplies

Suppliers have often asked how to best determine the usual maximum quantity of certain urological supplies the beneficiary may receive within a month. Local Coverage Determination (LCD) L33803 lists the most frequently used codes and the amount typically considered reasonable and necessary for a beneficiary in a given month. The explanation for use of a supply quantity greater than the amount listed must be clearly documented in the beneficiary's medical record. If adequate documentation is not provided when requested, the excess quantity will be denied as not reasonable and necessary.

Each Competitive Bid Area Has a Comprehensive List of Contract Suppliers

If you need to locate a competitive bid (CB) contracted supplier in a certain area, use the Supplier Directory on the Competitive Bid Contractors' webpage. Enter the Zip Code you would like to search and the type of equipment (i.e., knee brace). Then check the box next to the specific equipment. A list of supplier names, addresses, and phone numbers will be provided. The Noridian Competitive Bidding webpage also has instructions and resources.

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

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

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

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

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

News

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

External Infusion Pumps (EIP) HCPCS Codes Rejected in Error - Resolved 01/27/23

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

Reason Codes: CARC 4 and RARC N519

Claim Coding Impact: A4221, A4222, A4223, A4224, A4225, A4226, A4305, A4306, A4602, A9270, A9274, E0776, E0779, E0780, E0781, E0787, E0791, E1399, J0133, J0285, J0287, J0288, J0289, J0895, J1170, J1250, J1265, J1325, J1455, J1457, J1551, J1555, J1558, J1559, J1561, J1562, J1569, J1570, J1575, J2175, J2260, J2270, J2271, J2274, J2275, J2278, J3010, J3285, J7340, J7799, J9000, J9039, J9040, J9065, J9100, J9190, J9200, J9360, J9370, K0455, K0552, K0601, K0602, K0603, K0604, K0605

Description of Issue: Claims for EIP HCPCS Codes, as noted in above, rejected incorrectly with action code 86 when submitted with no GA, GY, GZ or KX modifier. The issue impacts claims processed between 01/01/2023 and 01/11/2023.

Noridian Action Required: Noridian has corrected the claims system logic issue.

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

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

Date Reported: 01/10/23

Date Resolved: 01/27/23

External Infusion Pump (EIP) Supplies Utilization Expectations

When an insulin infusion pump is covered, the drug and necessary supplies are also covered. When an insulin pump is beneficiary owned, the drugs and supplies are covered if the coverage criteria for the pump are met. Continued coverage for insulin infusion pumps and supplies requires that the beneficiary be seen and evaluated by the treating practitioner at least every three months.

Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Reordering of supplies and accessories is based on actual usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their beneficiaries and verify with the ordering practitioner that the atypical utilization is warranted. Regardless of utilization, a supplier must not dispense more than a three (3) - month quantity at a time.

A beneficiary or their caregiver must specifically request supply refills before they are dispensed. The supplier must not automatically dispense supplies on a predetermined basis, even if the beneficiary has "authorized" this in advance. As referenced in the Program Integrity

Manual (CMS IOM, Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.6), "Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product." Refer to the Noridian Medicare Home Page and related EIP Policy page for more information.

How to Resolve Reason Code 16, Remark Code M60 Denial

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

How to Submit Successful Appeals, or Reopenings - Appeals Newsletter Part 1

Reopening Process - Simple clerical error corrections

Do not submit a new claim to fix the error.

Utilize the Noridian Medicare Portal when a reopening is appropriate for faster results. A correction can be done instantly, whereas a paper appeal can take 60 days.

- Routine Denials - Do you need to change your diagnosis, or point to the correct diagnosis?
- Bundling Denials - Do you need to add a modifier?

Redetermination Process

Determine if you need to appeal to get paid.

- Is it paid correctly? Review your remittance advice before appealing
    - CMS Internet Only Manual (IOM) Pub 100-04 Chapter 12 Medicare Claims Processing Manual
    - CMS Internet Only Manual Pub 100-04 Chap 5 page 34 - 2022 Multiple Procedure Payment Reduction for Selected Therapy Services
    - CMS Therapy Services
- Are there any MSP issues involved? Utilize the MSP website to send to the correct team
- Are you replying to an Additional Documentation Request (ADR)
    - Where does the letter state to send documentation?

Submit a valid and complete appeal

- Make sure you use the **Redetermination** form, not the **Reopening** form
- Complete the “Action Request and Comments (paper), or Details and Explanation” on the portal form, with what, or why you are appealing
- Clear reason for the appeal not provided
    - Documentation to support your appeal
- Wrong form being submitted
- Does primary diagnosis follow the NCD/LCD for medical necessity
    - Verify your diagnosis pointer in Box 24E, or the electronic equivalent, refers to the correct primary diagnosis code in Box 21

How can the provider help?

- Make sure you are aware of what, and how many, your billing service is appealing
    - Excess appeals mean excess costs to you
- Make sure you are not submitting appeals for multiple procedure reductions or reductions for mid-level providers (Nurse Practitioner or Physician Assistant).
- Understand reductions for non-participating versus participating Medicare providers
- Confirm your place of service on the claim is correct
- Verify your diagnosis pointer in Box 24E, or the electronic equivalent, refers to the correct primary diagnosis code in Box 21
    - Review NCD/LCD for medically necessary diagnosis codes

Forms

CMS MCD Search

42 CFR 410.75 Chapter-IV Subchapter-B Part-424 Subpart-D Ssection-424.55

Inpatient Denials with Reason Code 109, Remark Code N538 Continues to be One of the Top Denials Suppliers Receive

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

News

Items That Can Be Purchased in Month One

We have received many requests for a list of DME items that can be purchased in month one, for example E0562. These items are included in the Inexpensive and Routinely Purchased (IRP) Items fee schedule category.

An IRP item can be paid as a rental or lump sum purchase. The total payment amount cannot exceed the actual charge or the fee schedule for a purchase.

- Inexpensive DME is defined as equipment where the purchase price does not exceed $150.
- Other Routinely Purchased DME consists of equipment that is purchased at least 75% of the time.

Pricing Modifiers used in this category include:

RR: Rental

NU: Purchase

UE: Purchase of used equipment.

One of these modifiers must be added to any item that falls into the IRP fee schedule category when it is submitted to Medicare. Otherwise, it will be denied, and you will need to resubmit your claim with the appropriate modifier.

Per DMEPOS Supplier Standard Number 5, a supplier must advise beneficiaries that they may rent or purchase **inexpensive or routinely purchased durable medical equipment**. Examples of IRP items include certain canes, walkers, and roll-about chairs.

To find the payment category an item falls within, please visit the PDAC website under DMECS and Fee Schedule Lookup. Enter the HCPCS Code inquiring on and the fee schedule category, the short and long description, the fee schedule (by state), and required modifiers are displayed.

It's Important to Know Which HCPCS Codes Are Included in Competitive Bid Round 2021

Not sure which off-the-shelf back and knee braces are included in the Competitive Bidding program? Enter any HCPCS code into the Competitive Bid HCPCS Lookup Tool. An answer populates. If affirmative, excellent resources will be provided to help you get educated including:

- Round 2021 Zip Code Lookup Tool
- Competitive Bid Implementation Contractor (CBIC)
- Prior Authorization webpage
- Face-to-Face and Written Order Prior to Delivery web page.

News

Medical Review After the COVID-19 Public Health Emergency: New FAQ

On November 17, 2022 CMS released a new Frequently Asked Questions about how CMS review contractors will conduct medical reviews after the COVID-19 public health emergency. Their answer states in part, “Since clinical indications for coverage were not enforced for certain DME items provided during the PHE, once the PHE ends CMS plans to primarily focus reviews on claims with dates of service outside of the PHE….” Please review the complete answer on CMS.gov at the link provided above.

Medicare Part B Premium and Deductible Changes in 2023

Each year the Medicare Part B premium, deductible, and coinsurance rates are determined according to the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be $164.90 for 2023, a decrease of $5.20 from $170.10 in 2022. The annual deductible for all Medicare Part B beneficiaries is $226 in 2023, a decrease of $7 from the annual deductible of $233 in 2022.

Since 2007, a beneficiary’s Part B monthly premium is based on his or her income. These income-related monthly adjustment amounts affect roughly 7 percent of people with Medicare Part B. Get the word out to your beneficiaries. You can find more information on this CMS.gov webpage.

New N-Modifiers for Oxygen

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **New N-Modifiers for Oxygen**, 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

Noncovered Items

We receive many questions from suppliers regarding items that are noncovered. Please refer to the Noridian Noncovered Items webpage for information regarding these items. First, in order for an item to be covered by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC), it must fall within a benefit category.

Some items may not meet the definition of a Medicare benefit or may be statutorily excluded. In order for a beneficiary to be eligible for DME, prosthetics, orthotics, and supplies reimbursement, the reasonable and necessary requirements listed in the related Local Coverage Determination (LCD) must be met. **In addition, there are statutory payment requirements specific to each policy that must be met. These criteria will be identified in individual LCD-related Policy Articles (PAs) as statutorily noncovered.**

A list of noncovered items is available on our website. The list is not all-inclusive. Some items are identified as noncovered or statutorily noncovered in the LCD or PA of individual policies.

One of the Top Denials Suppliers May Encounter is for Billing with a Date Span Overlap or Overutilization of Items

When you receive 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 for item. Determine if a self-service reopening or a redetermination is required to resolve the denial and how to initiate one on the Noridian Medicare Portal. Find resources and how to resolve denials and avoid them in the future on the Denial Code Resolution page on the Noridian Medicare website.

To avoid this denial, ensure that date spans are correct and not overlapping and that frequency guidelines are met. Check out the great tool available to assist in resolving denials.

One of the Top Denials That Suppliers Receive is Reason Code 4, Remark Code N519, HCPCS Code is Inconsistent with Modifier Used, or Required Modifier is Missing

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

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

Pharmacies Billing DMEPOS Items to DME MAC

If you are a supplier that is a pharmacy billing the DME MAC for DMEPOS items, you are to follow the same process as other DME suppliers as required by Medicare. The Noridian Medicare website provides education to suppliers on all processes to receive reimbursement. The Noridian Medicare Portal (NMP) is a free and secure, internet-based portal that allows users access to beneficiary and claim information. The portal is available for Durable Medical

Equipment (DME) users in the Noridian MAC Jurisdictions JA and JD. Noridian also provides one-on-one education to suppliers when requested. Please take advantage of all the opportunities Noridian has to offer.

Physician/Clinician Letters Available

When looking for a Physician/Clinician letter, they can be found on the Noridian website on each policy's webpage. Select the Browse by DMEPOS Category tile then click on a specific policy. All available letters can also be found under the Policies tab, then select Clinician Corner and then Clinician Resource Letters. These letters have been created by the DME Medical Directors to assist suppliers in gathering the documentation required to substantiate medical necessity for the claims submitted to the DME MACs. Utilize these letters and you are on your way to obtaining the documentation required for the items you provide.

Prior Authorization (PAR) Is Required Nationwide for Five Orthotics Codes

Five orthotics codes were added to the CMS Required Prior Authorization List. This was a phased in implementation beginning in April 2022 for four states. The implementation schedule has been completed so PAR is now a requirement nationwide. The codes requiring PAR include spinal orthotics **L0648** and **L0650** and knee orthotics **L1832, L1833,** and **L1851**. Our Prior Authorization for Orthoses webpage houses the following information:

- Codes and Descriptions
- Implementation Schedule
- Documentation to Include in Submission
    - Methods of Submission
- Expedited Request Guidelines
- Avoid Request Rejections
- Documentation and Modifier Requirements to Bypass Prior Authorization
- Affirmative and Non-Affirmative Decisions
- Decision Letter
- Many Educational Resources

Note: L0648, L0650, L1833, and **L1851** are also part of the Competitive Bid program. Comprehensive information and resources are available on the Noridian Competitive Bidding Program webpage.

Providing a Brace to a Beneficiary When the Beneficiary's Medicare Order History Indicates an Item is the Same or Similar to the Item Being Billed

The Noridian Same or Similar Chart is not just a tool but an entire webpage of guidance. This webpage contains information on:

- Replacement rules - what if the Reasonable Useful Lifetime (RUL) isn't specified in the policy?
    - RUL clarification - What's the difference between irreparable damage and irreparable wear?
- Is the item considered same or similar?
    - What questions should I consider or ask?
    - How can I verify the information I get from the beneficiary or caregiver?
- How can I avoid same/similar denials?
    - Did you check with all DME jurisdictions for a same/similar item?
        - The beneficiary may have been traveling or snow birding when brace was received
- Can I use an Advance Beneficiary Notice of Noncoverage (ABN) with a same or similar item?
- Which braces are considered the same or similar?

If a claim is denied due to same or similar claims previously paid, suppliers should submit a redetermination. Supporting documentation would need to be included with the redetermination request. Noridian encourages redeterminations/appeals be submitted using the Noridian Medicare Portal.

Examples of applicable documentation to include can be found in the Standard Written Order including:

- Signed pick-up and delivery tickets, if applicable
- Copy of medical record to substantiate change in medical condition
- If item was lost, stolen, or irreparably damaged (in a specific incident) submit applicable documentation
    - I.e., beneficiary statement, police report, fire report, insurance claim information
- Copy of ABN, if obtained

News

Reducing Appeal and Written Correspondence Workload - Appeals Newsletter Part 3

Are you aware that you can cut down on the amount of work you do by using the Noridian Medicare Portal (NMP)?

- **Claims and Appeals Status** - Check before calling about a claim or an appeal to see if it has completed processing before asking for a status update
- **Are you appealing the correct level?**
  - If appeal is finalized, you need to file a Reconsideration
  - JD DME Reconsideration
- **Written Correspondence** - check the NMP before resubmitting your communication request.

What can you do?

- Update information
- Delete claims filed in error
- Determine what stage your claim is in
- Get needed forms
- Determine if you sent in an appeal, and the status it is in

Reminder When Providing Orthoses Prior to Surgery

Orthotic devices are not covered unless they meet the coverage criteria outlined in the applicable Local Coverage Determination (LCD) and Policy Article on the date the item is provided. Medical necessity must be met, prior to providing the orthosis.

Items provided before medical necessity begins (for example, before the surgery and the brace is not required until after surgery) will not meet the coverage criteria.

For orthotic devices that require prior authorization (PA) (L0648, L0650, L1832, L1833, and L1851), a PA request should not be submitted prior to the start of medical necessity (for example, before the surgery). If the device is medically necessary after surgery and the medical record documents an emergent need for the device(s), suppliers should submit an expedited request. If an expedited (2-business day) PA request would delay necessary medical care of the beneficiary, append the ST modifier to the claim to bypass PA and provide the brace. These claims will be subject to 100% prepayment review.

For physicians/practitioners subject to non-contract exceptions for competitive bid, please refer to resources below. The KV/J5 modifiers are used if these exceptions apply.

- DMEPOS Competitive Bidding Program Physicians and Other Treating Practitioners, Physical Therapists, and Occupational Therapists

News

Reopenings Available on the Noridian Medicare Portal (NMP)

Effective June 1, 2020, Noridian began requiring that suppliers use the Noridian Medicare Portal (NMP) for all reopenings that are available through the Self-Service Reopening feature.

The reopening process allows suppliers to correct clerical errors or omissions on denials received without having to request a formal appeal.

Before submitting a reopening request, suppliers should research the claim denial reason to determine the proper way to resolve the denial and avoid it in the future. This can be accomplished in the Denial Code Resolution tool. A list of errors that must be corrected in the NMP using a self-service reopening can be found on the Noridian website.

Resolving Denials for Item Not on File in Claim History

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

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

Resolving Denials for item not on file in claim history

- Call the Supplier Contact Center to complete telephone reopening to add beneficiary owned equipment for items that require accessories or supplies. First supply claim requires narrative:
    - Beneficiary owned HCPCS; purchased month and year.
    - Good example: Bene-owned E0601 pur Jan 2021
    - Once item purchased on file, subsequent supply claims do not require narrative.
    - Examples of the items are Positive Airway Pressure (PAP) devices, BiPAPs, nebulizers, all glucose monitors, and humidifiers, etc.
- A written reopening may also be submitted with all beneficiary owned equipment information, HCPCS code of base equipment owned, and date equipment purchased. This can be accomplished through mail, fax or Noridian Medicare Portal through the appeals function.

News

Same and Similar Denials

Same or similar continues to be one of the top denials that suppliers receive. Please utilize our denial code resolution tool to assist in resolving those denials 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 the beneficiary's medical condition that supports need for a similar item
- Documentation/statement to indicate if the item was lost, stolen, or irreparably damaged and what occurred
- Advance Beneficiary Notice of Noncoverage (ABN), if applicable

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

Searching for a HCPCS Code

When searching for a HCPCS code on the Noridian Medicare website, please utilize the "Search" function. This function is at the top right of the website. When information is located, it will display under the search results. If information cannot be found, please utilize the Pricing Data Analysis and Coding (PDAC) website as this is the contractor that maintains and creates HCPCS codes for claim submission.

Stop Receiving Denials for Missing or Inappropriate Modifier on a Claim?

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

- Easy solution, correct claim line with appropriate required modifier and resubmit claim

News

Suppliers Can View a Summary of the Most Recent 100 Overpayments in the Noridian Medicare Portal

Finding overpayments for your facility can be accomplished through the Noridian Medicare Portal

- View a summary of claims that may have caused an overpayment for your facility
- Users may enter in a specific overpayment letter number and/or claim number (ICN/DCN/CCN)
- Users can view the most recent 100 overpayments or choose to download a .csv file for a specific overpayment

The “Overpayment Results” table will provide the beneficiary’s name, claim number, date of service and overpayment amount.

Suppliers Providing Spinal or Knee Orthoses That Require Prior Authorization

Suppliers who have obtained an affirmative decision on a prior authorization request (PAR) then subsequently bill with the ST modifier and include the Unique Tracking Number (UTN) received in the PAR decision letter, will receive an Additional Documentation Request (ADR) letter. 100% of claims billed with the ST modifier will be subject to prepayment review and will receive an ADR letter. This letter will be requesting all documentation again that was already submitted with the PAR. If there is no response to this letter, the claim will be denied, causing additional rework in appealing the claim.

To avoid this extra work, when suppliers have received an affirmed PAR decision and appended the UTN to the claim, the ST modifier **should not be appended**. Remember when the ST modifier is appended to a claim it causes the claim to BYPASS PA so it should never be submitted in addition to a PAR.

System Availability Notifications

The Noridian Medicare Portal (NMP) uses the Claims Processing Systems to retrieve data for various inquiries. The Claims Processing Systems go offline nightly to cycle the claim information. When these systems are offline, some inquiries on NMP are unavailable. To better serve our users, Noridian has implemented System Availability Notices that will be displayed when the systems are offline and 10 minutes prior to the system going offline.

Users will not see any disruption during our normal business hours, as these notices are provided as a courtesy to our users. Users can anticipate seeing these notices starting around 7:50 P.M. Central Time.

Users can view our Hours of Availability anytime on the Contact Us page of NMP.

News

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 October 2022 - December 2022 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Glucose Supplies
- Knee Orthosis
- Manual Wheelchairs
- 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 the CMS Website.

Therapeutic Shoes for Persons With Diabetes (TSPD) Certifying Physician

The Certifying Physician for Therapeutic Shoes for Persons with Diabetes (TSPD) is defined as a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO). A Nurse Practitioner (NP) or Physician Assistant (PA) can serve as the certifying physician if they are practicing "incident to" the MD or DO. "Incident to" requires that the NP or PA are practicing under the supervision of the certifying physician and all billing is under the certifying physician's national provider identifier (NPI). Additional information on "incident to" can be found in the Medicare Benefit Policy Manual (cms.gov) or on the Noridian Medicare website under Therapeutic Shoes.

News

The Top Reasons for Prior Authorization Non-Affirmations for All Affected Items

Suppliers can find the top reasons for non-affirmation on prior authorizations for the items they provide on the Noridian website. Select the Medical Review tab > Pre-Claim Review > Required Prior Authorization Programs > select a policy > Top Reasons for Non-Affirmation. This quarterly reporting provides the current reasons for non-affirmation to assist suppliers in avoiding these errors when requesting prior authorization.

Tools Series: Providers and Suppliers - Determine if You Are in a Competitive Bidding Area (CBA)

Suppliers and providers have asked how they can determine if they or a beneficiary are located in a CBA. Our Competitive Bid Area Zip Code Lookup Tool takes you to the Noridian Fee Schedules web page. In the right-hand column is a link to the CBIC website where the tool is housed. Simply enter a zip code and receive an instant response. If the zip code is located in a CBA, take a few minutes to look at our Competitive Bidding webpage to learn more about navigating competitive bid requirements.

Top Portal Error Checking Eligibility

One of the top errors that a supplier receives when checking eligibility on the portal is beneficiary not found or beneficiary's name or birthdate does not match. Just a quick reminder to suppliers that when utilizing the portal for eligibility, ensure all required elements are correct as listed on the Medicare Beneficiary Card. The card includes the beneficiary's legal name on file with the Social Security Administration and must be used in verifying eligibility.

Required elements when checking eligibility:

- Medicare number
- Last name
- One of the following:
    - First name
    - Date of birth

Usual Maximum Amount of Supplies

Supplies or accessories with usual maximum quantities and frequency limits are typically defined in the related Local Coverage Determination (LCD) or Policy Article (PA). Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Reordering of supplies and accessories is based upon actual beneficiary usage. Suppliers

should stay attuned to atypical utilization patterns on behalf of their clients and verify with the ordering practitioner that the atypical utilization is warranted.

A beneficiary or their caregiver must specifically request refills of supplies before they are dispensed. The supplier must not automatically dispense a quantity of supplies on a predetermined basis, even if the beneficiary has "authorized" this in advance. As referenced in the Program Integrity Manual (CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.2.6), “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.”

WatchPat Home Sleep Test

Recently we have seen an increase in questions about use of the WatchPat home sleep test in qualifying for a positive airway pressure (PAP) device. A WatchPat may be used as the qualifying sleep study, so long as the results meet the coverage criteria as indicated in the PAP LCD. For questions specific to coverage of a sleep test, please refer to your local A/B MAC.

Resources

- PAP Devices for the Treatment of Obstructive Sleep Apnea LCD
- PAP Devices for the Treatment of Obstructive Sleep Apnea Policy Article

Medical Policies and Coverage

2023 HCPCS Code Update - January Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2023 HCPCS Code Update - January 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

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

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **CMS Issues Interim Final Rules with Comment (CMS-1744-IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Correct Coding - Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding - Submitting Oxygen Claims with Modifiers KX, GA, GY, and GZ - Revised**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Medical Policies and Coverage

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 2022 DMD articles.

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

KX Modifier Use for External Infusion Pumps

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **KX Modifier Use for External Infusion Pumps**, has been created and published to our website.

View the locally hosted 2023 DMD articles.

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

LCD and Policy Article Revisions Summary for December 29, 2022

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

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Removed: Language describing “therapeutic,” “non-adjunctive,” “non-therapeutic,” and “adjunctive” terms and term usage

Removed: HCPCS code K0554

Added: HCPCS code E2103

12/29/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to CMS HCPCS coding determinations.

PA

Revision Effective Date: 01/01/2023

CODING GUIDELINES:

Added: “A4238**, A4239**” to table describing associated codes with pump codes for pump code row E0784

Added: “**For E0784 pumps, either A4238 or A4239 may be billed if used in conjunction with an integrated adjunctive or non-adjunctive CGM, respectively.” after table describing associated codes

Revised: Billing direction dates for HCPCS codes K0554 and K0553

Added: Billing direction for HCPCS codes E2103 and A4239 on or after January 1, 2023

Removed: Language describing “non-therapeutic”

Added: “NON-IMPLANTED” to the description of CGM code E2102 and CGM supply code A4238

12/29/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Glucose Monitors

LCD

Revision Effective Date: 01/01/2023

CONTINUOUS GLUCOSE MONITORS (CGM):

Removed: Statement regarding general CGM term referring to both therapeutic/non-adjunctive and non-therapeutic/adjunctive

Removed: “therapeutic” and “non-therapeutic”

Removed: HCPCS codes K0554 and K0553

Added: HCPCS codes E2103 and A4239

REFILL REQUIREMENTS:

Removed: HCPCS code K0553

Added: HCPCS code A4239

HCPCS CODES:

Revised: Long descriptor for HCPCS code E2102 in Group 1 Codes

Added: HCPCS code E2103 to Group 1 Codes

Removed: HCPCS code K0554 from Group 1 Codes

Revised: Long descriptor for HCPCS code A4238 in Group 2 Codes

Added: HCPCS codes A4239, A9277, A9276 and A9278 to Group 2 Codes

Removed: HCPCS codes A9279 and K0553 from Group 2 codes

12/29/2022: 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: 01/01/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: “(non-adjunctive)” to coverage of claims with dates of service on or after January 12, 2017

Removed: “therapeutic” and “non-therapeutic” from testing language

Added: HCPCS code A4239 to supply allowance language

Removed: HCPCS code K0553 from supply allowance language

Added: HCPCS code E2103 to coverage of a CGM supply allowance language

Removed: HCPCS code K0554 from coverage of a CGM supply allowance language

Removed: HCPCS code K0554 from the coding verification review by the PDAC language

Added: HCPCS code E2103 to the coding verification review by the PDAC language

Added: HCPCS codes A9276, A9277 and A9278 to the codes that must be utilized for products that do not meet the DME benefit category

MODIFIERS:

Removed: HCPCS codes K0553 and K0554 from the CGM language

Added: HCPCS codes E2103 and A4239 to the CGM language

Removed: HCPCS code K0554 from the CG modifier instructions for when all of the CGM criteria are met

Added: HCPCS code E2103 to the CG modifier instructions for when all of the CGM criteria are met

Removed: HCPCS code K0554 from the KF modifier instructions regarding CGMs classified by the Food & Drug Administration as Class III devices

Added: HCPCS code E2103 to the KF modifier instructions regarding CGMs classified by the Food & Drug Administration as Class III devices

CODING GUIDELINES:

Added: “through December 31, 2022” to claims with dates of service on or after July 1, 2017, that must be billed with K0554 and K0553

Added: “For claims with dates of service on or after January 1, 2023, a non-adjunctive CGM must be billed with code E2103 and code A4239 for the supply allowance."

Added: HCPCS code E2103 to description of non-adjunctive CGM that meets DME benefit requirements

Added: HCPCS code A4239 to supply allowance language

Removed: HCPCS code K0553 from supply allowance language

Added: HCPCS code A4239 to delivery and billing language

Removed: HCPCS code K0553 from delivery and billing language

Added: Billing instructions for dates of service prior to April 1, 2022, and on or after January 1, 2023, for HCPCS codes A9276 and A9277 to describe supplies used with a CGM that does not meet the definition of DME

Added: Instructions not to bill HCPCS codes A9276 and A9277 for supplies used with a non-adjunctive CGM (E2103) or adjunctive CGM supplies furnished in conjunction with an insulin infusion pump used as a CGM receiver

Added: Billing instructions to use HCPCS code A9279, for dates of service between April 1, 2022, through December 31, 2022, to describe any CGM system and/or related supplies that fail to meet the DME benefit requirement

Added: HCPCS code E2103 to "Column I"

Removed: HCPCS code K0553 from "Column I"

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."

12/29/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update(s) listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question

5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for January 12, 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 External Infusion Pumps, Intravenous Immune Globulin, Nebulizers, Oxygen and Oxygen Equipment and Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea. Please review the entire LCDs and related PAs for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 01/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: JZ modifier instructions under Drug Wastage section

CODING INFORMATION:

Added: JZ modifier

HCPCS CODES:

Added: J1574 to group 4 codes

01/12/2023: 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: 01/01/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Documented use of continuous glucose monitor meets glucose self-testing of at least 4 times per day within criterion IV. C. and D. of the related LCD

MODIFIERS:

Added: JZ modifier instructions

Revised: GA, GY, GZ and KX modifier instructions to include external infusion pumps, drugs and supplies

01/12/2023: 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.

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: JZ modifier instructions under Drug Wastage section

CODING INFORMATION:

Added: JZ modifier

01/12/2023: 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: 01/01/2023

MODIFIERS:

Added: JZ modifier instructions

01/12/2023: 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.

Nebulizers

LCD

Revision Effective Date: 01/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: JZ modifier to the DRUG WASTAGE section

SUMMARY OF EVIDENCE:

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

ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):

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

CODING INFORMATION:

Added: JZ modifier

BIBLIOGRAPHY:

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

01/12/2023: 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: 01/01/2023

MODIFIERS:

Added: JZ modifier instructions

01/12/2023: 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.

Oxygen and Oxygen Equipment

LCD

Revision Effective Date: 01/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Removed: “For all the overnight oximetry criteria described above, the 5 minutes does not have to be continuous.” under Overnight Oximetry Studies (effective 09/27/2021)

Removed: “otherwise the Group III presumption of non-coverage applies” under Overnight Oximetry Studies (effective 09/27/2021)

Removed: “for 5 minutes total (which need not be continuous)” under criterion 4 for overnight oximetry testing for beneficiaries with OSA (effective 09/27/2021)

01/12/2023: 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.

Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea

LCD

Revision Effective Date: 09/27/2021

CONCURRENT USE OF OXYGEN WITH PAP THERAPY:

Removed: “for 5 minutes total (which need not be continuous)” under criterion 4 for overnight oximetry testing for beneficiaries with OSA

01/12/2023 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.

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.

Medical Policies and Coverage

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 February 23, 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

CODING INFORMATION:

Added: N1, N2 and N3 modifiers

02/23/2023: 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

DOCUMENTATION FOR CONTINUED PAYMENT OF OXYGEN AFTER INITIAL COVERAGE:

Revised: Documentation requirements for Group II and Group III to remove re-evaluation and specify documentation of testing requirements (effective 09/27/2021)

MODIFIERS:

Added: N1, N2 and N3 modifier instructions

Revised: Direction regarding the use of the KX modifier on or after April 1, 2023

02/23/2023: 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

Open Meeting Announcement - 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 Announcement - 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.

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

Medical Policies and Coverage

Policy Article Revisions Summary for December 1, 2022

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

Pneumatic Compression Devices

PA

Revision Effective Date: 01/01/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Billing information relevant to CMNs, for DOS affected by the CMN elimination

Revised: Direction for dates of service for which a CMN is required

12/01/2022: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update(s) listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Medical Policies and Coverage

Policy Article Revisions Summary for January 19, 2023

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

External Infusion Pumps

PA

Revision Effective Date: 01/01/2023

MODIFIERS:

Revised: GA, GZ and KX modifier instructions to include external infusion pumps, drugs and supplies submitted on or after March 1, 2023 for dates of service on or after January 1, 2023

01/19/2023: 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:

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Medical Policies and Coverage

Policy Article Revisions Summary for January 26, 2023

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

Lower Limb Prostheses

PA

Revision Effective Date: 03/21/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: Language pertaining to payment of a prosthesis when provided in a Part A covered hospital stay and Part A covered skilled nursing facility (SNF) stay

Added: “The prosthesis is reasonable and necessary for a beneficiary’s use during the Medicare Part A covered SNF stay” as a criterion for payment of a prosthesis delivered to a beneficiary during a Part A covered SNF stay when eligible for DME MAC coverage and payment

Added: “The prosthetic components are classified as major category III codes under the SNFs consolidated billing” as a criterion for payment of a prosthesis delivered to a beneficiary during a Part A covered SNF stay when eligible for DME MAC coverage and payment

01/26/2023: 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.

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    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
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        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 Determinations (LCDs) Released for Comment - Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Proposed Local Coverage Determinations (LCDs) Released for Comment - Enteral Nutrition, Osteogenesis Stimulators, Parenteral Nutrition and Seat Lift Mechanisms**, 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 - Oxygen Qualification Tests and Documentation - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Reminder - Oxygen Qualification Tests and Documentation - Revised**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Video and Transcript Published - Proposed Glucose Monitors LCD (DL33822) Virtual Open Meeting

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Video and Transcript Published - Proposed Glucose Monitors LCD (DL33822) Virtual Open Meeting**, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

MLN Connects

MLN Connects - December 1, 2022

MLN Connects Newsletter: Dec 1, 2022

News

- CMS Urges Timely Patient Access to COVID-19 Vaccines, Therapeutics
- Quality Payment Program: Preview Your Performance Information by December 20
- Clinical Laboratory Fee Schedule: CY 2023 Final Payment Determinations
- HIV: Screening is Knowledge

Compliance

- LAAC & ICD National Coverage Determinations: Submit Proper Documentation

MLN Matters® Articles

- National Fee Schedule for Medicare Part B Vaccine Administration
- New Waived Tests
- New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE - Revised
- Home Health Claims: New Grouper Edits - Revised

Publications

- Checking Medicare Eligibility - Revised

From Our Federal Partners

- Biosimilars: Are They the Same Quality?

Information for Patients

- Options When ESRD Coverage with Medicare Ends

MLN Connects

MLN Connects - December 8, 2022

MLN Connects Newsletter: Dec 8, 2022

News

- CMS Proposes Rule to Expand Access to Health Information and Improve the Prior Authorization Process
- Rural Emergency Hospitals: New Institutional Provider Type Starting January 1
- Certificates of Medical Necessity & DME Information Forms Discontinued January 1
- Drugs & Biologics: Reporting Average Sales Price Data
- Provider Enrollment Application Fee: CY 2023
- Skilled Nursing Facility Value-Based Purchasing Program: December Feedback Report
- Bronchodilator Nebulizer Medications: Comparative Billing Report in December
- Short-term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Flu Shots: Help Address Disparities

Compliance

- Bill Correctly: Power Mobility Device Repairs

Claims, Pricers, & Codes

- Medicare National Correct Coding Initiative: Annual Policy Manual Update
- National Correct Coding Initiative: January Update

Events

- FY 2024 New Technology Town Hall Meeting - December 14
- Medicare Ground Ambulance Data Collection System Webinar: Data Certifier Role - December 15

MLN Matters® Articles

- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2023 Changes
- National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy
- Rural Health Clinic All-Inclusive Rate: CY 2023 Update

From Our Federal Partners

- Biosimilars & Interchangeable Products: Free Continuing Education Courses from FDA

MLN Connects

MLN Connects - December 15, 2022

MLN Connects Newsletter: Dec 15, 2022

News

- Opioid Treatment Programs: New Information for 2023
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Home Health Quality Reporting Program: Get Final OASIS-E Instrument

Compliance

- Bill Correctly: Power Mobility Devices

Claims, Pricers, & Codes

- Intravenous Immune Globulin Treatment in the Home: ICD-10 Code Update

MLN Matters® Articles

- DMEPOS Fee Schedule: CY 2023 Update
- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: April 2023
- Home or Residence Services: Billing Instructions
- National Coverage Determination 200.3: Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Publications

- Post-Acute Care Quality Reporting Program: Patient Health Questionnaire Cue Card

MLN Connects - December 22, 2022

MLN Connects Newsletter: Dec 22, 2022

Editor's Note:

Happy holidays from the MLN Connects team. We'll release the next regular edition on Thursday, January 5, 2023.

News

- HHS Proposes to Standardize Electronic Health Care Attachments Transactions and Electronic Signature Processes to Improve the Care Experience for Patients and Providers
- Long-Term Care Hospital Provider Preview Reports: Review by January 17

- Inpatient Rehabilitation Facility Provider Preview Reports: Review by January 17
- Hospital Ownership Data Release
- Clotting Factor: CY 2023 Furnishing Fee
- Medicare Diabetes Prevention Program: CY 2023 Payment Rates
- CMS Burden Reduction News & Insights

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: January Update
- Integrated Outpatient Code Editor: Version 24.0
- DMEPOS: Revised 2023 Fee Schedule Public Use File
- National Correct Coding Initiative: Annual Policy Manual Update & Information on Other Payers

MLN Matters® Articles

- Clinical Laboratory Fee Schedule: CY 2023 Annual Update
- Hospital Outpatient Prospective Payment System: January 2023 Update
- Laboratory Edit Software Changes: April 2023
- New Medicare Part B Immunosuppressant Drug Benefit
- Extension of Changes to the Low-Volume Hospital Payment Adjustment and the Medicare Dependent Hospital Program - Revised

Publications

- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier
- Rural Emergency Hospitals
- Intravenous Immune Globulin Demonstration - Revised
- Medicare Preventive Services - Revised

From Our Federal Partners

- CDC Interim Guidance: Antiviral Treatment of Influenza
- Important Updates from the CDC on COVID-19 Therapeutics for Treatment & Prevention

MLN Connects

MLN Connects - January 5, 2023

MLN Connects Newsletter: Jan 5, 2023

News

- COVID-19: Updated Vaccines for Children Ages 6 Months - 5 Years
- Advisory Panel on Hospital Outpatient Payment: Request for Nominations
- Certificates of Medical Necessity & DME Information Forms Discontinued January 1
- Cervical Health: Encourage Screening

Claims, Pricers, & Codes

- Home Oxygen: 3 New Claims Modifiers
- Home Health Prospective Payment System: CY 2023 Rural Add-on Policy
- Skilled Nursing Facility Consolidated Billing: CY 2023 HCPCS Codes

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: January 2023 Update

MLN Connects - January 9, 2023 - CMS Awards 200 New Medicare-funded Residency Slots to Hospitals Serving Underserved Communities

News

CMS Awards 200 New Medicare-funded Residency Slots to Hospitals Serving Underserved Communities

MLN Connects - January 12, 2023

MLN Connects Newsletter: Jan 12, 2023

News

- Key Dates for First Year of Inflation Reduction Act's Medicare Drug Price Negotiation Program
- Cognitive Assessment: CY 2023 Updates
- Care Compare: Telehealth Indicator for Doctors & Clinicians
- Clinical Laboratory Fee Schedule: CY 2023 Payment File
- Clinical Laboratories: PAMA Reporting & Payment Reductions Delayed

- Medicare Wellness Visits: Get Your Patients Off to a Healthy Start

Claims, Pricers, & Codes

- Drugs & Biologicals in Single-Use Containers: Using JW & JZ Modifiers

MLN Matters® Articles

- Travel Allowance Fees for Specimen Collection: 2023 Updates
- ESRD & Acute Kidney Injury Dialysis: CY 2023 Updates - Revised
- Home Health Prospective Payment System: CY 2023 Update - Revised
- National Coverage Determination 110.24: Chimeric Antigen Receptor T-cell Therapy - Revised

MLN Connects - January 19, 2023

MLN Connects Newsletter: Jan 19, 2023

News

- Additional Steps to Strengthen Nursing Home Safety and Transparency
- Increase in 2023 in Organizations and Beneficiaries Benefiting from Coordinated Care in Accountable Care Relationship
- DMEPOS: Updates to Face-to-Face Encounter & Written Order Prior to Delivery List
- Skilled Nursing Facility Provider Preview Reports: Review by February 16
- Value-Based Insurance Design Model: Learn about the Hospice Benefit Component
- Medicare Ground Ambulance Data Collection System: 5 Top Tips for Reporting
- Glaucoma Awareness Month: Act to Prevent Vision Loss

Compliance

- Home Health Rural Add-On Policy

Claims, Pricers, & Codes

- ICD-10 Code Files & MS-DRGs Version 40.1: April Update
- Integrated Outpatient Code Editor: Version 24.R1

Publications

- Post-Acute Care Quality Reporting Programs: COVID-19 Public Reporting

MLN Connects

MLN Connects - January 26, 2023

MLN Connects Newsletter: Jan 26, 2023

News

- Medicare Enrollment in PECOS: Faster & Easier Application Process - Coming Summer 2023
- Medicare Enrollment: Maintain the Same Owners in All Enrollment Records
- Hospitals: Revised Beneficiary Notices Required April 27
- Chiropractic Manipulative Treatment of the Spine: Comparative Billing Report in January
- Poverty: Help Reduce Disparities

MLN Matters® Articles

- Home Health Changes for Disaster Claims and Certain Adjustments

MLN Connects - February 2, 2023

MLN Connects Newsletter: Feb 2, 2023

News

- Aligning Quality Measures across CMS - The Universal Foundation
- Medicare Ground Ambulance Data Collection System: Portal to Report is Open
- Skilled Nursing Facilities: Care Compare January Refresh
- Expanded Home Health Value-Based Purchasing Model: January Newsletter & Performance Reports
- Therapy Services: Per-Beneficiary CY 2023 Threshold Amounts

Claims, Pricers, & Codes

- Federally Qualified Health Center Prospective Payment System: CY 2023 Pricer

Events

- Shared Savings Program & Community-Based Organization Collaboration Webinar - February 14
- Medicare Ground Ambulance Data Collection System: Q&A Session - February 23

MLN Connects

MLN Matters® Articles

- Provider Enrollment: Regulatory Changes

MLN Connects - February 9, 2023

MLN Connects Newsletter: Feb 9, 2023

News

- DMEPOS: Get Benefit Category Determinations
- Nurse Practitioners & Clinical Nurse Specialists: Update to List of National Certifying Bodies
- Help Address Heart Health Disparities

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- Home Health: Revised Editing of Telehealth Claims
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: Quarterly Update
- New Payment Adjustments for Domestic N95 Respirators
- Removal of a National Coverage Determination & Expansion of Coverage of Colorectal Cancer Screening
- Rural Health Clinic & Federally Qualified Health Center Medicare Benefit Policy Manual Update

MLN Connects Newsletter: Prescription Drug Inflation Rebate Program Guidance - February 9, 2023

News

- Medicare Part B Drug Inflation Rebates
- HHS Releases Initial Guidance for Medicare Prescription Drug Inflation Rebate Program

MLN Connects

MLN Connects - February 16, 2023

MLN Connects Newsletter: Feb 16, 2023

News

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance
- Unprecedented Efforts to Increase Transparency of Nursing Home Ownership
- CMS Proposes Benefit Expansion for Mobility Devices, Advancing Health Equity for People with Disabilities
- CMS Addresses Inequities in Rural Health in Medicare
- Medicare Shared Savings Program: Application Deadlines for January 1, 2024, Start Date

Events

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

MLN Matters® Articles

- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing: April 2023 Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: July 2023 Update

Multimedia

- Expanded Home Health Value-Based Purchasing Model: First Performance Year Quick Guide Materials

Information for Patients

- Options When ESRD Coverage with Medicare Ends

MLN Connects - February 23, 2023

MLN Connects Newsletter: Feb 23, 2023

News

- Hospital Price Transparency: Progress & Commitment to Achieving Its Potential
- Home Infusion Therapy Services Monitoring Report
- Immunosuppressive Drugs: Comparative Billing Report in February

- Expanded Home Health Value-Based Purchasing Model Resources: Submit Feedback through March 31

Claims, Pricers, & Codes

- HCPCS Level II Coding: FAQs for Single Source Drugs & Biologicals
- National Correct Coding Initiative: No April Update

Publications

- DMEPOS Quality Standards - Revised

MLN Connects Newsletter: Public Health Emergency 1135 Waivers: Updated Guidance for Providers - Feb 23, 2023

News

Public Health Emergency (PHE) 1135 Waivers: Updated Guidance for Providers

MLN Connects Newsletter: COVID-19 Public Health Emergency (PHE) New Overview Fact Sheet - Feb 27, 2023

News

COVID-19 Public Health Emergency (PHE) New Overview Fact Sheet

MLN Matters

2023 Annual Update of HCPCS Codes for SNF CB Update

Related CR Release Date: August 25, 2022

Related CR Transmittal Number: R11573CP

Related Change Request (CR) Number: 12829

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12829 identifies the changes to Healthcare Common Procedure Coding System (HCPCS) codes and explain how Medicare Physician Fee Schedule designations will be used to revise Common Working File (CWF) edits to allow A/B Medicare Administrative Contractors (MACs) to make appropriate payments in accordance with policy for Skilled Nursing Facility (SNF) Consolidated Billing (CB) in Chapter 6, Section 110.4.1 for A/B MACs (B) and Chapter 6, Section 20.6 for A/B MACs (A).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12829.

DMEPOS Fee Schedule: CY 2023 Update

MLN Matters Number: MM13006

Related CR Release Date: December 2, 2022

Related CR Transmittal Number: R11722CP

Related Change Request (CR) Number: 13006

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 13006 tells you about:

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

Make sure your billing staff knows about this annual update.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13006.

MLN Matters

International Classification of Disease (ICD-10) Code Update for Coverage of IVIG Treatment of Primary Immune Deficiency Diseases in the Home

Related CR Release Date: November 9, 2022

Related CR Transmittal Number: R11693BP

Related Change Request (CR) Number: 12973

Effective Date: October 1, 2022

Implementation Date: December 12, 2022

CR 12973 implements a maintenance coding update of Chapter 15, Section 50.6 of the Medicare Benefit Policy Manual (BPM), Publication (Pub) 100-02, Coverage of Intravenous Immune Globulin (IVIG) for Treatment of Primary Immune Deficiency Diseases in the Home.

View the complete CMS Change Request (CR)12973.

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

Related CR Release Date: September 23, 2022

Related CR Transmittal Number: September 23, 2022

Related Change Request (CR) Number: 12925

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

CR 12925 supplies the contractors with the ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The Average Sales Price (ASP) payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

View the complete CMS Change Request (CR)12925.

MLN Matters

Manual Update Pub. 100-02 Medicare Benefit Policy, Chapter 15, Section 110.8 DMEPOS Benefit Category Determinations

Related CR Release Date: December 30, 2022

Effective Date: January 31, 2023

Implementation Date: January 31, 2023

Related Change Request (CR) Number: CR 13028

Related CR Transmittal Number: R11769BP

CR 13028 updates Pub. 100-02 Medicare Benefit Policy Manual to add Chapter 15, Section 110.8 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Benefit Category Determinations. This manual section is a quick reference tool for benefit categories determinations on or after September 26, 2022, in accordance with the procedures at 42 CFR §414.114 and §414.240.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13028.

New & Expanded Flexibilities for Rural Health Clinics & Federally Qualified Health Centers during the COVID-19 PHE - Revised

MLN Matters Number: SE20016 Revised

Article Release Date: November 22, 2022

Note: CMS revised this article to add the 2023 payment rate for distant site telehealth services. You'll find substantive content updates in dark red (pages 2, 3, 5, and 6). All other information is the same.

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS have made several changes to RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE. We'll make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, view the COVID-19 FAQs on Medicare Fee-for-Service (FFS) Billing.

View the complete CMS Medicare Learning Network (MLN) Special Edition (SE)20016.

New Medicare Part B Immunosuppressant Drug Benefit - Revised

MLN Matters Number: MM12804 Revised

Related CR Release Date: December 22, 2022

Related CR Transmittal Number: R11764GI, R11764CP, and R11764BP

Related Change Request (CR) Number: 12804

Effective Date: January 1, 2023

Implementation Date: January 3, 2023

Note: CMS revised this Article due to a revised CR 12804. The CR revision didn't change the substance of the Article. CMS did revise the CR release date, transmittal numbers, and web addresses of the transmittals. All other information is the same.

CR 12804 tells you about:

- Extension of Medicare coverage for immunosuppressant drugs beyond 36 months for certain patients with kidney transplants
- Coverage of premiums and cost sharing for some of these patients

Make sure your billing staff knows about the new benefit effective January 1, 2023.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12804.

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.