DME Happenings

Jurisdiction D
September 2023

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Ankle-Foot/Knee-Ankle-Foot Orthoses (AFO/KAFO) Top Denial - What to Do Next and How to Avoid It

The most common denial for AFOs/KAFOs is Reason Code 151 | Remark Code M3. To avoid this denial in the future, it's important to understand the reasons behind it.

This denial occurs when the item billed is considered the same as or similar to an item the beneficiary previously received that appears in their history. It's crucial to determine whether the initial item was lost, stolen, irreparably damaged, or if there was a change in the beneficiary's medical condition requiring a different type of orthosis.

To appeal this denial, a redetermination (first-level appeal) request can be submitted with all relevant supporting documentation to justify the need for a new orthosis. The Noridian Medicare Portal (NMP) is recommended for this submission, as it's the quickest and easiest method.

To prevent this denial in the future, it's recommended to check if the beneficiary already has a same or similar item using the NMP or by calling the IVR. If they do, and the end of the reasonable useful lifetime (RUL) hasn't been reached, an Advance Beneficiary Notice of Noncoverage (ABN) should be provided to the beneficiary.

Additionally, Noridian's Denial Code Resolution webpage and tool can be used to look up any reason and remark code, understand what went wrong with the claim submission, how to resolve the denial, and how to avoid it in the future.

Avoiding Denials for Inconsistent or Missing Modifiers

A significant challenge faced by suppliers in Medicare billing is the occurrence of denials due to billing invalid modifiers. This issue can lead to disruptions in claim processing and delayed reimbursement. To help suppliers prevent these denials and ensure accurate billing practices, Noridian offers a valuable tool and resources.

Utilizing the Modifier Lookup Tool: Noridian provides a user-friendly tool designed to empower suppliers with information about potential, pricing, and informational modifiers for specific HCPCS codes. To access this tool, suppliers simply enter a HCPCS code and click "check" to retrieve results. Effectively using this tool can play a pivotal role in avoiding denials attributed to an invalid combination of HCPCS modifiers when submitting claims.

Preventing Denials with Denial Code Resolution: In the event of a Reason Code 4 | Remark Code N519 denial, suppliers can turn to the Denial Code Resolution webpage for guidance. This resource offers insights into common reasons for the denial, step-by-step instructions on how to resolve the issue, and strategies to prevent similar denials in the future.

By leveraging Noridian's Modifier Lookup Tool and utilizing the resources provided on the Denial Code Resolution webpage, suppliers can proactively address inconsistent or missing modifiers and effectively

prevent denials related to the “invalid modifier billed” denial. These tools empower suppliers to navigate modifier-related challenges and enhance the accuracy of their Medicare billing practices, leading to smoother claim processing and improved reimbursement outcomes.

Helpful Links: To make the process even more accessible, Noridian provides direct links to the Denial Code Resolution webpage and the Modifier Lookup Tool.

Reason Code 4: The procedure code is inconsistent with the modifier used

Remark Code N519: Invalid combination of HCPCS modifiers

Modifier Lookup Tool

Billing Multiple Units for 60- or 90-Day Supply Items - Narrative Required to Avoid Denials

When submitting a claim for a 60- or 90-day supply, when permitted by the policy, of items with a single HCPCS code and identical modifiers, it is crucial to ensure that all units of service are consolidated on one claim line. Additionally, a narrative indicating the specific supply duration (60-day or 90-day) must be included in the NTE segment of the electronic claim. This is necessary to prevent denials related to policy frequency limits, as stated in the Standard Documentation Requirements under claim narratives. A similar scenario can arise when submitting duplicate claim lines with the same HCPCS code, provided there is a valid justification - for example, different strengths (J codes) that necessitate the inclusion of a narrative for explanation.

In the event that the claim lacks the required narrative specifying the number of months being billed or the reason multiple claim lines are being billed, it may be denied, and further action will be needed to resolve the issue. This could involve reopening the claim through a telephone or written request. To illustrate, when billing a three-month supply of PAP accessories (e.g., mask, tubing, or cushions), a narrative must be included in the claim narrative in Item 19 of the 1500 hard copy claim form or the 2400/NTE segment of an electronic claim "90-day supply" or "three-month supply", when permitted by the specific policy.

It is essential to note that this requirement applies only to claims that have the exact same modifiers and does not impact claims with bilateral modifiers. To avoid denials, it is strongly recommended to refrain from billing one HCPCS code with the exact same modifiers on multiple claim lines.

By adhering to these guidelines and ensuring the inclusion of accurate narratives, the DME MACs can process claims correctly without encountering denials, providing smoother and more efficient claim processing. Denials arising from failure to meet these requirements will be accompanied by reason code 150 (information submitted does not support this level of service, remark code N115 (decision based on an LCD).

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Checking for Same or Similar in the Noridian Medicare Portal (NMP) to Avoid Denials

Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims often deny when the billed equipment or item is considered the "same as" or "similar to" what the beneficiary already possesses, and it falls within its Reasonable Useful Lifetime (RUL). Suppliers encountering such denials can take specific steps to address them effectively.

Addressing Denials: In cases where a DMEPOS claim is denied due to equipment/item similarity, suppliers should proceed with a redetermination request. This submission must include comprehensive documentation, such as evidence of lost or stolen items if applicable, or medical records from the prescribing physician/practitioner indicating a change in need. Such documentation should support the necessity for a different item, especially when a change in the beneficiary's medical condition justifies it.

Key Considerations Before Replacement: Before proceeding with an equipment/item replacement, it's crucial to consider the following questions:

1. **Change in Medical Condition:** Has the beneficiary's medical condition changed to support the need for an item that is the "same as" or "similar to" the existing one?
2. **Loss, Theft, or Irreparable Damage:** Has the original item been lost, stolen, or suffered irreparable damage? Answering these questions helps determine whether obtaining an Advance Beneficiary Notice of Noncoverage (ABN) is necessary.
3. **History of Same or Similar Items:** Has the beneficiary previously received a "same as" or "similar" item? Suppliers should verify these details using the Same or Similar functionality in the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR) system.

Answering these questions helps determine whether obtaining an Advance Beneficiary Notice of Noncoverage (ABN) is necessary.

Appropriate Action Steps: Based on the responses to the above questions, suppliers should take the following actions:

- If no previous history of a "same as" or "similar" item exists, suppliers can bill the claim without obtaining an ABN (Advance Beneficiary Notice of Noncoverage).
- If a history of a "same as" or "similar" item exists, suppliers should determine if the item has reached its RUL. If the RUL has been reached, the claim can be billed without an ABN.
- If the item has not reached its RUL, suppliers should obtain an ABN and proceed with billing the claim while applying the appropriate modifier.

Effectively utilizing the Same or Similar functionality in the Noridian Medicare Portal (NMP) and adhering to the outlined steps can help suppliers avoid denials and ensure proper billing practices for DMEPOS claims. By proactively addressing the criteria for replacements and ABN requirements, suppliers contribute to smoother claim processes and improved beneficiary care.

Resources: Suppliers can access further guidance and instructions for managing ABN requirements and the Same or Similar functionality through the provided links:

- NMP Same or Similar Inquiry Guide
- Interactive Voice Response (IVR) system
- ABN Instructions

CMS-588 Electronic Funds Transfer (EFT) Authorization Agreement Form Submission - Important Changes Effective August 21, 2023

Effective August 21, 2023, CMS-588 Electronic Funds Transfer (EFT) Authorization Agreements must be sent to the applicable National Provider Enrollment (NPE) contractor for the supplier's physical location. Please refer to the below map to determine your correct NPE contractor.

Bank information must be applicable for all four jurisdictions. The **Part III Financial Institution Information** listed on the EFT agreement must be the same for all jurisdictions, regardless of the supplier's physical address.

CMS-588 forms received by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) between August 21, 2023, through November 19, 2023, will be forwarded to the correct NPE contractor. EFT forms received by the DME MAC on or after November 20, 2023, will be rejected and returned to the supplier.

EFT Inquiries

Effective August 21, 2023, suppliers must contact the appropriate NPE contractor for all inquiries related to electronic funds transfers. This includes questions about all other EFT correspondence sent to suppliers by the DME MACs or the NPE contractors, status of EFT requests, and changes in EFT information.

This is supported by *42 Code of Federal Regulations (CFR) § 424.510* - *Requirements for enrolling in the Medicare program*:

(e) Providers and suppliers must -

(1) Agree to receive Medicare payment via electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors where the provider or supplier was already receiving payments via EFT or submission of an enrollment change request. and

(2) Submit the CMS-588 form to receive Medicare payment via electronic funds transfer.

The enrollment contractors will notify you when you must transition from paper checks to EFT.

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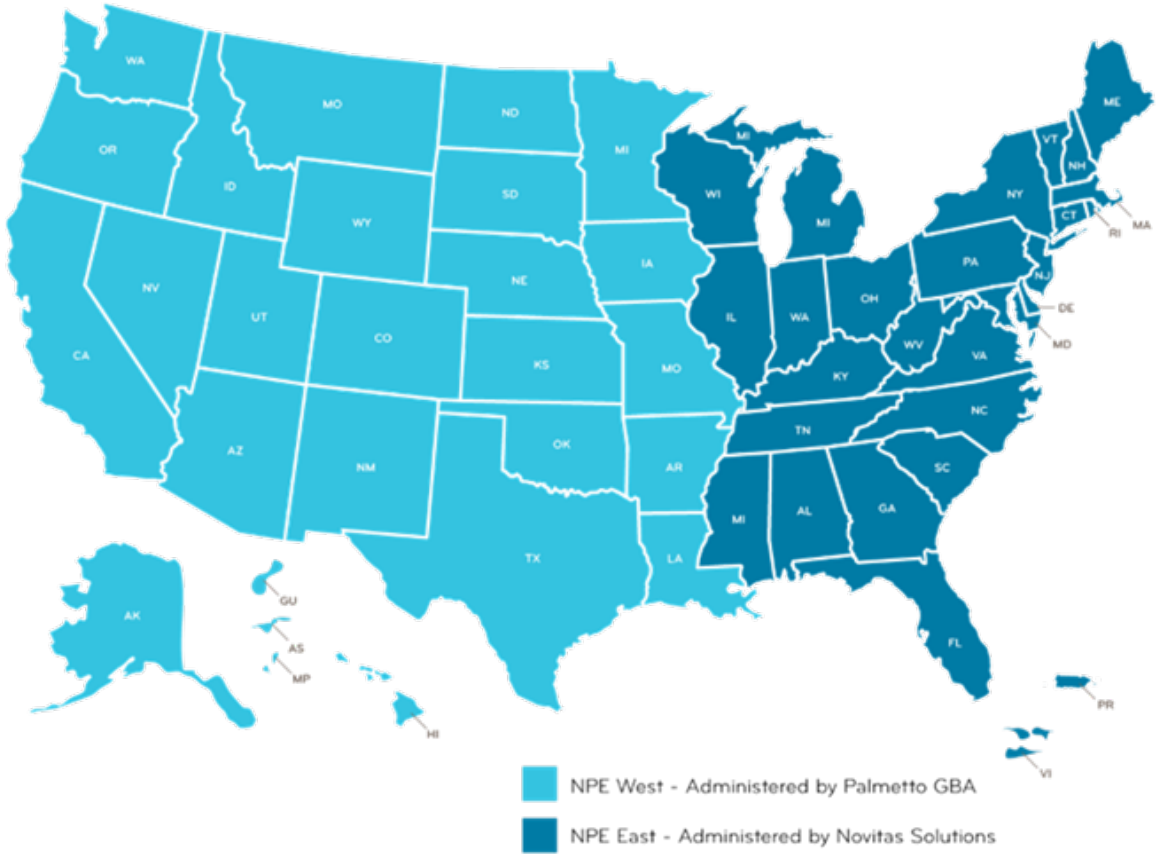
NPE Contact Information:

NPE East Contractor (NPEAST): Novitas Solutions, Inc.

- PO Box 3704
  Mechanicsburg PA 17055-1863
- Telephone 866-520-5193 9 a.m. to 5 p.m. ET

NPE West Contractor (NPWEST): Palmetto GBA

- PO Box 100142
  Columbia SC 29202-3142
- Telephone 866-238-9652 10 a.m. to 6 p.m. ET



Correct Billing of Power Seat Elevation Equipment on Power Wheelchairs

CMS published a final Benefit Category Determination and National Coverage Determination (NCD) for seat elevation equipment (power operated) on power wheelchairs for dates of service May 16, 2023, and after. For more information, review the National Coverage Analysis and Coverage, Coding and Payment for Power Seat Elevation Equipment on Power Wheelchairs.

Suppliers must use HCPCS E2300 (wheelchair accessory, power seat elevation system, any type) when billing to Medicare. Additionally, HCPCS codes K0830 (Power Wheelchair, Group 2 Standard, Seat Elevator, Sling/Solid Seat/Back, Patient Weight Capacity Up to and Including 300 Pounds) or K0831 (Power Wheelchair, Group 2 Standard, Seat Elevator, Captains Chair, Patient Weight Capacity Up To and Including 300 Pounds) must be used to submit claims for individuals with Medicare using seat elevation on Group 2 power wheelchairs that are not complex rehabilitative power-driven wheelchairs. Claims submitted using HCPCS code E2300 for power seat elevation equipment on wheelchairs other than Group 5 and complex rehabilitative power-driven wheelchairs will be denied.

Modifiers

Pricing modifiers must be added to the claim when billing the E2300 and K0830 and K0831. The capped rental modifiers KH, KI, or KJ and/or rent/purchase modifiers BP or BR apply depending on the billed month and rental/purchase option chosen. For more information review our website on Modifiers.

Gap-Filling

CMS has not set a fee schedule for E2300, K0830, and K0831. Allowed amounts for these HCPCS will be calculated based on gap-filling regulations. For additional information on gap-filling, review Pricing on our website.

E2394 Medically Unlikely Edit

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

MUE denied claims will be reprocessed for dates of service on or after January 1, 2023.

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

Enteral Nutrition Targeted Probe and Educate Webpage

The DME MAC Medical Review department conducts a Targeted Probe and Educate (TPE) review of improperly paid claims. The quarterly results from January 2023 - March 2023 for Enteral Nutrition show that 21% of Jurisdiction D enteral claims for HCPCS codes B4150 and B4152 were improperly paid. The TPE webpage explains the top denial reasons and provides educational resources to keep the supplier community up-to-date.

News

High Utilization for Home Blood Glucose Monitors (BGM) Supplies

To be eligible for coverage of home blood glucose monitors and related accessories and supplies, the beneficiary must meet both of the following basic criteria (1)-(2):

1. The beneficiary has diabetes (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses); and,
2. The beneficiary's treating practitioner has concluded that the beneficiary (or the beneficiary's caregiver) has sufficient training using the particular device prescribed as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing.

For a beneficiary who is not currently being treated with insulin administrations, more than 100 test strips and more than 100 lancets every 3 months are covered if criteria (a)-(c) below are met.

For a beneficiary who is currently being treated with insulin administrations, more than 300 test strips and more than 300 lancets every 3 months are covered if criteria (a)-(c) below are met.

a. Basic coverage criteria (1)-(2) listed above for all home glucose monitors and related accessories and supplies are met; and,
b. Within six (6) months prior to ordering quantities of strips and lancets that exceed the utilization guidelines, the treating practitioner has had an in-person visit with the beneficiary to evaluate their diabetes control and their need for the specific quantity of supplies that exceeds the usual utilization amounts described above; and,
c. Every six (6) months, for continued dispensing of quantities of testing supplies that exceed the usual utilization amounts, the treating practitioner must verify adherence to the high utilization testing regimen.

If neither basic coverage criterion (1) or (2) is met, all testing supplies will be denied as not reasonable and necessary. If quantities of test strips or lancets that exceed the utilization guidelines are provided and criteria (a)-(c) are not met, the amount in excess will be denied as not reasonable and necessary.

This information can be found in the Glucose Monitors Local Coverage Determination (LCD) L33822

Importance of Reviewing Front-End Electronic Claim Reports

Have you ever experienced delays in claims processing, called the Provider Contact Center or checked claim status on the Noridian Medicare Portal (NMP), only to discover that Noridian does not have the claim? Despite transmitting the claim electronically, it seems to have gone missing.

To address this situation and ensure smoother processing, the Common Electronic Data Interchange (CEDI) contractor, National Government Services (NGS), offers a unified electronic front-end solution for all Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) suppliers. CEDI collaborates closely with DME MAC software vendors, billing services, clearinghouses, and electronic submitters (trading partners) to fulfill electronic front-end requirements.

CEDI handles several essential electronic transactions, including:

- Electronic claims using American National Standards Institute (ANSI) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats
- Delivery of electronic Front-End Acknowledgements and Reports
- Electronic Remittance Advices (ERAs)
- 276/277 Claim Status Request/Response

To ensure smooth processing and timely reception of claims within the DME claims processing system, suppliers must diligently review and address the Front-End Acknowledgements and Reports. Failure to act on these reports means Noridian will not receive the claim until it is corrected and resolved. Until CEDI accepts and processes the claim, transmitting it to Noridian, the claim will not be visible in the DME claim system.

By promptly reviewing Front-End Acknowledgement Reports and resolving any issues, suppliers can help expedite the electronic billing process, minimizing delays, and ensure efficient claim handling.

InFlow Device Use with Initial and Continued Coverage

An inFlow device (Intraurethral Valve-Pump and Activator) (HCPCS Code A4335) is a urinary catheter used as an alternative to clean intermittent catheterization (CIC) in patients with impaired detrusor contractility (IDC). The inFlow device consists of a silicone tube containing a miniature valve and pump and a separate remote control "activator" wand. The tube is inserted with a disposable introducer and remains inside the urethra for about a month. To empty the bladder, the patient sits on the toilet, holds the remote-control wand over the lower pelvic area, and presses a button that magnetically activates a small valve pump in the inserted urethral tube. Once the pump is activated, the bladder drains at a normal rate. Once the button is released, a valve closes, and urine flow stops. The inFlow device is sized for the urethra and initially inserted by a treating practitioner. Normally, the user or caregiver can replace the inFlow device, as insertion is like a urinary catheter.

Initial Coverage

The inFlow device is considered reasonable and necessary as an alternative to intermittent catheterization for beneficiaries with permanent urinary retention (PUR) due to IDC.

One (1) inFlow device will be covered no more than once every 29 days. Claims for the inFlow device billed more than once every 29 days will be denied as not reasonable and necessary.

Continued coverage (beyond the first three months of therapy)

For continued coverage of the inFlow device lasting longer than three months, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary continues to use and is

benefiting from the device. This clinical re-evaluation must be done no sooner than the 31st day but no later than the 91st day after initiating therapy.

Documentation of use and clinical benefit is demonstrated by:

1. An in-person encounter by the treating practitioner showing that urinary symptoms are improved; and,
2. The treating practitioner must verify the beneficiary's adherence to the use of the inFlow device.

If the above criteria are not met, continued coverage of the inFlow device and related accessories will be denied as not reasonable and necessary.

If the practitioner's re-evaluation does not occur until after the 91st day but the evaluation demonstrates that the beneficiary is benefiting from the inFlow device as defined in criteria 1 and 2 above, continued coverage of the inFlow device will commence with the date of that re-evaluation.

If there is a discontinuation of usage of the inFlow device at any time, the supplier is expected to stop billing for the equipment and related accessories and supplies.

Please refer to the Urological Supplies Local Coverage Determination and related Policy Article for additional information on coverage, coding, and documentation.

For questions about correct coding, contact the Pricing, Data Analysis, and Coding (PDAC) contractor contact center.

July 2023 HCPCS Updates

CMS has released the July 2023 Healthcare Common Procedure Coding System (HCPCS) File. Inclusion on this list does not indicate coverage. All HCPCS code changes are effective and should be used for claims with dates of service on or after July 1, 2023. Please watch the Noridian website for additional policy updates regarding HCPCS codes.

Added HCPCS Codes

Effective for dates of service on and after July 1, 2023

HCPCS	Description
J0137	Injection, acetaminophen (hikma) not therapeutically equivalent to j0131, 10 mg
J0206	Injection, allopurinol sodium, 1 mg
J0216	Injection, alfentanil hydrochloride, 500 micrograms
J0457	Injection, aztreonam, 100 mg

News

HCPCS	Description
J0665	Injection, bupivicaine, not otherwise specified, 0.5 mg
J0736	Injection, clindamycin phosphate, 300 mg
J0737	Injection, clindamycin phosphate (baxter), not therapeutically equivalent to j0736, 300 mg
J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
J1805	Injection, esmolol hydrochloride, 10 mg
J1806	Injection, esmolol hydrochloride (wg critical care) not therapeutically equivalent to j1805, 10 mg
J1811	Insulin (fiasp) for administration through dme (i.e., insulin pump) per 50 units
J1812	Insulin (fiasp), per 5 units
J1813	Insulin (lyumjev) for administration through dme (i.e., insulin pump) per 50 units
J1814	Insulin (lyumjev), per 5 units
J1836	Injection, metronidazole, 10 mg
J1920	Injection, labetalol hydrochloride, 5 mg
J1921	Injection, labetalol hydrochloride (hikma) not therapeutically equivalent to j1820, 5 mg
J1941	Injection, furosemide (furoscix), 20 mg
J1961	Injection, lenacapavir, 1 mg
J2249	Injection, remimazolam, 1 mg
J2305	Injection, nitroglycerin, 5 mg
J2329	Injection, ublituximab-xiiy, 1mg
J2371	Injection, phenylephrine hydrochloride, 20 micrograms
J2372	Injection, phenylephrine hydrochloride (biorphen), 20 micrograms

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HCPCS	Description
J2427	Injection, paliperidone palmitate extended release (invega hafyera, or invega trinza), 1 mg
J2561	Injection, phenobarbital sodium (sezaby), 1 mg
J2598	Injection, vasopressin, 1 unit
J2599	Injection, vasopressin (american regent) not therapeutically equivalent to j2598, 1 unit
J2806	Injection, sincalide (maia) not therapeutically equivalent to j2805, 5 micrograms
J9029	Injection, nadofaragene firadenovec-vncg, per therapeutic dose
J9056	Injection, bendamustine hydrochloride (vivimusta), 1 mg
J9058	Injection, bendamustine hydrochloride (apotex), 1 mg
J9059	Injection, bendamustine hydrochloride (baxter), 1 mg
J9063	Injection, mirvetuximab soravtansine-gynx, 1 mg
J9259	Injection, paclitaxel protein-bound particles (american regent) not therapeutically equivalent to j9264, 1 mg
J9322	Injection, pemetrexed (bluepoint) not therapeutically equivalent to j9305, 10 mg
J9323	Injection, pemetrexed (hospira) not therapeutically equivalent to j9305, 10 mg
J9347	Injection, tremelimumab-actl, 1 mg
J9350	Injection, mosunetuzumab-axgb, 1 mg
J9380	Injection, teclistamab-cqyv, 0.5 mg
J9381	Injection, teplizumab-mzwv, 5 mcg
Q5131	Injection, adalimumab-aacf (idacio), biosimilar, 20 mg

News

Deleted HCPCS Code

Invalid for billing for dates of service July 1, 2023 and after

HCPCS	Description
J2370	INJECTION, PHENYLEPHRINE HCL, UP TO 1 ML

Description Update

The long description of the HCPCS code has been updated as of July 1, 2023

HCPCS	Description
J2426	Injection, paliperidone palmitate extended release (invega sustenna), 1 mg

Knee Orthoses Reasonable Useful Lifetime (RUL) Guidance in Policy Article A52465

When an RUL for an item is absent from the policy article, the RUL is considered five (5) years per Standard Documentation Requirements Article A55426. Refer to the Knee Orthoses - Policy Article A52465 for HCPCS that do not follow the five (5) year RUL.

Negative Pressure Wound Therapy Webpage Features Tips and Tools

The Negative Pressure Wound Therapy (NPWT) webpage offers valuable tips and resources for healthcare professionals dealing with billing exclusions and denials related to pumps and supplies. Do you need help resolving a denial? The Denial Code Resolution tool located in the Educational Resources section is particularly useful. It provides details of the reason for denial, actions to take and how to avoid future denials. The Tips section offers the requirements for continued coverage to ensure all beneficiaries receive the necessary ongoing care. Additionally, the clinician checklists and letters offer concise summaries of requirements related to NPWT.

October 2023 HCPCS Updates

CMS has released the October 2023 Healthcare Common Procedure Coding System (HCPCS) File. Inclusion on this list does not indicate coverage. All HCPCS code changes are effective and should be used for claims with dates of service on or after October 1, 2023. Please watch the Noridian website for additional policy updates regarding HCPCS codes.

Added HCPCS Codes

Effective for dates of service on and after October 1, 2023

HCPCS	Description
A9156	Oral mucoadhesive, any type (liquid, gel, paste, etc.), per 1 ml
A9268	Programmer for transient, orally ingested capsule
A9269	Programable, transient, orally ingested capsule, for use with external programmer, per month
B4148	Enteral feeding supply kit; elastomeric control fed, per day, includes but not limited to feeding/flushing syringe, administration set tubing, dressings, tape
E0490	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by hardware remote
E0491	Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by hardware remote, 90-day supply
J0349	Injection, rezafungin, 1 mg
J0801	Injection, corticotropin (acthar gel), up to 40 units
J0802	Injection, corticotropin (ani), up to 40 units
J0874	Injection, daptomycin (baxter), not therapeutically equivalent to J0878, 1 mg
J0889	Daprodustat, oral, 1 mg, (for ESRD on dialysis)
J2359	Injection, olanzapine, 0.5 mg
J2781	Injection, pegcetacoplan, intravitreal, 1 mg
J7353	Anacaulase-bcdb, 8.8% gel, 1 gram
J7519	Injection, mycophenolate mofetil, 10 mg
J9051	Injection, bortezomib (maia), not therapeutically equivalent to J9041, 0.1 mg
J9064	Injection, cabazitaxel (sandoz), not therapeutically equivalent to J9043, 1 mg
J9345	Injection, retifanlimab-dlwr, 1 mg

HCPCS	Description
K1036	Supplies and accessories (e.g., transducer) for low frequency ultrasonic diathermy treatment device, per month
L1681	Hip orthosis, bilateral hip joints and thigh cuffs, adjustable flexion, extension, abduction control of hip joint, postoperative hip abduction type, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
L5991	Addition to lower extremity prostheses, osseointegrated external prosthetic connector
V2526	Contact lens, hydrophilic, with blue-violet filter, per lens

Deleted HCPCS Code

Invalid for billing for dates of service October 1, 2023 and after

HCPCS	Description
J0800	Injection, Corticotropin, up to 40 units

Description Update

The long description of the HCPCS code has been updated as of October 1, 2023

HCPCS	Description
A4344	Indwelling catheter, foley type, two-way, all silicone or polyurethane, each
J1921	Injection, labetalol hydrochloride (hikma) not therapeutically equivalent to J1920, 5 mg
K1004	Low frequency ultrasonic diathermy treatment device for home use
K1028	Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application

Pneumatic Compression Devices E0650 and E0651 Four-Week Trial

One of the top denials for pneumatic compression devices is an incomplete four-week trial. Noridian has created clinician checklists that outline the requirements of the four-week trial. For more information, visit Clinician Checklist for Pneumatic Compression Devices E0650-E0651.

News

Primary Care First Model Demonstration Project

Effective January 1,2021, through December 31, 2025, a nurse practitioner (NP) is allowed to certify an order for diabetic shoes under the Primary Care First (PCF) Model Demonstration Project. Only NPs participating in the PCF demonstration are eligible to serve as the certifying physician. Additional information on the PCF model can be found here: Primary Care First Model Options | CMS Innovation Center.

Prior Authorization Required for Spinal Orthoses

Lumbar-sacral orthoses coded L0648 and L0650 require prior authorization prior to claim submission. For more information on documentation requirements, methods of submission, expedited guidelines, decisions, and much more, refer to our Prior Authorization for Orthoses webpage.

Provider Administrator's Can Now Reactivate Users on NMP

Effective June 19, 2023, Provider Administrator's (PA's) can now reactivate or deactivate End User accounts on the Noridian Medicare Portal (NMP) without having to contact User Security. View the "Manage Users" page of the Portal Guide for more details and instructions.

Qualifying for Continued Coverage of Negative Pressure Wound Therapy (NPWT)

For qualifying wounds to receive continued coverage, a licensed clinician must:

- Directly assess the wound(s) being treated with the negative pressure wound therapy (NPWT) pump on a regular basis; and
- Perform or supervise the dressing changes; and
- At least monthly, document changes in the ulcer's dimensions and characteristics.

The NPWT webpage has this information, documentation resources, the LCD and Policy Article, and useful tools.

Reduce Calls to the Provider Contact Center: Utilize the Noridian Medicare Portal (NMP)

To streamline operations and improve efficiency, the Noridian Medicare Portal (NMP) is a quick and reliable resource to address common inquiries and minimize the need for calls to the Provider Contact Center. The NMP offers self-service tools that reduce wait times and provide answers to frequently encountered questions.

The NMP is a secure, internet-based platform accessible free of charge to all Durable Medical Equipment (DME) users within the Noridian MAC Jurisdictions A and D. It grants users access to beneficiary and claim information, empowering suppliers to resolve various issues independently.

By taking advantage of the NMP, suppliers can find resolutions to many of the top reasons for contacting the Provider Contact Center. A few of the topics that can be found on the NMP include:

1. Claim Denial Inquiry
2. Claim Status
3. Eligibility
4. Appeals
5. Remittance Advice Information

We encourage suppliers to utilize the portal for inquiries, claim reopenings, appeals, or any other function available, as it saves valuable time and resources.

Together, we can reduce the volume of calls to the Provider Contact Center, improving efficiency and ensuring that our resources are dedicated to addressing more complex issues that require direct assistance. Thank you for your cooperation in making the most of the NMP.

Reminder: Replacement and Warranties for Power Mobility Devices

Replacements

A supplier that transfers title to a capped rental item, such as a power wheelchair, to a beneficiary remains responsible for furnishing replacement equipment at no cost to the beneficiary or Medicare program for the 5-year reasonable useful lifetime of the equipment. In making this determination, the DME MACs may consider whether the accumulated costs of repair exceed 60 percent of the cost to replace the item.

Warranties

Payment may be made for reasonable and necessary charges for maintenance and servicing of beneficiary-owned equipment. Reasonable and necessary charges are those made for parts and labor not otherwise covered under a manufacturer or supplier warranty. Suppliers must maintain copies of any manufacturer or supplier warranties for equipment being repaired and furnish this documentation upon request. For more information, review the Repairs, Maintenance and Replacement webpage.

News

Rules for Who Can Order DME, Prosthetics, Orthotics, and Supplies (DMEPOS)

The question about who can order DMEPOS and what Medicare requires of them is asked often.

Q1: Who can order DME, prosthetics, orthotics, and supplies?
A1: All claims for items billed to Medicare require a written order/prescription from the treating practitioner as a condition of payment.

Q2: Who is considered a "treating practitioner"?
A2: The term "treating practitioner" refers to a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) as defined in section 1861(aa)(5) of the Social Security Act.

Physicians

- Doctor of medicine
- Doctor of osteopathy (including osteopathic practitioner) - must be licensed to practice medicine and surgery
- Doctor of dental medicine or dental surgery
- Doctor of podiatric medicine
- Doctor of optometry (optometrists can only order and refer DMEPOS products/services and laboratory or x-ray services payable under Medicare Part B)

Non-Physician Practitioners

These practitioners must follow the requirements set forth in the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Sections 5.2.3, 5.7, and 5.8

- Physician Assistants
- Clinical Nurse Specialists
- Nurse Practitioners

To qualify as an ordering provider, you must:

- Have an individual National Provider Identifier (NPI)
- Be enrolled in Medicare in either an "approved" or an "opt-out" status
- Be of an eligible specialty type

Items and services you can order and certify will depend on your **specialty type**. Contact your MAC if you have questions about what you can order and certify.

Q3: Does the treating practitioner have to fill out everything on the order?
A3: For DMEPOS items other than PMDs, someone other than the treating practitioner may complete certain required elements of the Standard Written Order (SWO); however, the SWO must be signed by the treating practitioner per the Standard Documentation Requirements Article A55426.

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 April 2023 - June 2023 can be located on the Medical Record Review Results webpage:

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

Temporary Gap Period for DMEPOS Competitive Bidding Program

The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) contracts for off-the-shelf (OTS) back braces and OTS knee braces will expire on December 31, 2023. Beginning January 1, 2024 there will be a temporary gap in the DMEPOS CBP.

To ensure the continued effectiveness of the CBP, the Centers for Medicare & Medicaid Services (CMS) plans to conduct bidding for the next round of the program. This will involve undergoing notice and comment rulemaking to further strengthen the CBP.

For more details regarding the temporary gap period, please refer to the Temporary Gap Period fact sheet. Refer to the CMS.gov and Competitive Bidding Implementation Contractor (CBIC) websites regularly for updates.

Use Knee Orthoses Tutorials to Improve Your Understanding and Expertise

Noridian provides a wide selection of self-paced tutorials on YouTube that are highly beneficial for knee orthoses suppliers. These tutorials cover crucial topics and aspects of knee orthoses, which can significantly improve your understanding and expertise in the field. Below are some key tutorials that we recommend considering:

1. Competitive Bid Round 2021 Off-the-Shelf Back and Knee Braces (Duration: 9 minutes) - This tutorial provides insights into this round of competitive bid. It can help you understand the bidding process and requirements associated with these items.
2. Knee Orthoses: Prefabricated (Duration: 13 minutes) - This tutorial covers essential information regarding the selection, fitting, and usage of prefabricated knee orthoses.
3. Knee Orthoses: Custom Fabricated (Duration: 7 minutes) - This tutorial offers guidance on the process of fitting and supplying custom orthoses to meet the specific needs of beneficiaries.
4. Prior Authorization: Orthoses (Duration: 14 minutes) - This tutorial provides the necessary steps and documentation required to obtain prior authorization for orthoses.

In addition to these specific tutorials, Noridian offers several other tutorials that can enhance your billing knowledge. Some of these include:

- Seven Standard Documentation Requirements tutorials every supplier should be familiar with
- Before You Bill
- Self Service Tools
- Advance Beneficiary Notice of Noncoverage (ABN)
- Claim Submission
- Noncovered Items

Noridian recommends reviewing these tutorials to ensure you have a comprehensive understanding of knee orthoses and the related DME processes. This will not only make you a more knowledgeable supplier but also enable you to provide better service to beneficiaries in need of knee orthoses.

Medical Policies and Coverage

2023 HCPCS Code Update - July Edition - Correct Coding

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

LCD and Policy Article Revisions Summary for June 15, 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 and Standard Documentation Requirements for All Claims Submitted to DME MACs. Please review the entire LCDs and related PAs for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 04/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: Instructions to DRUG WASTAGE section to see MODIFIERS section of LCD-related Policy Article (effective 01/01/2023)

Removed: JW and JZ modifier instructions from DRUG WASTAGE section (effective 01/01/2023)

06/15/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

PA

Revision Effective Date: 04/01/2023

MODIFIERS:

Revised: JW and JZ modifier instructions to align with the CMS 2023 Physician Fee Schedule final rule (effective 01/01/2023)

06/15/2023: 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: Instructions to DRUG WASTAGE section to see MODIFIERS section of the LCD-related Policy Article

Removed: JW and JZ modifier instructions from DRUG WASTAGE section

06/15/2023: 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:

Revised: JW and JZ modifier instructions to align with the CMS 2023 Physician Fee Schedule final rule

06/15/2023: 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: Instructions to DRUG WASTAGE section to see MODIFIERS section of the LCD-related Policy Article

Removed: JW and JZ modifier instructions from DRUG WASTAGE section

06/15/2023: 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:

Revised: JW and JZ modifier instructions to align with the CMS 2023 Physician Fee Schedule final rule

06/15/2023: 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.

Standard Documentation Requirements for All Claims Submitted to DME MACs

PA

Revision Effective Date: 01/01/2023

ORDERS:

Revised: Reference to "1861(r)(1)" which refers to physicians by removing "(1)" to reflect the full statutory definition of treating practitioner

WRITTEN ORDERS PRIOR TO DELIVERY (WOPD):

Added: Statutory definition of treating practitioner for PMDs

FACE-TO-FACE ENCOUNTER:

Removed: "For example, the National Coverage Determination § 240.2 "Home use of Oxygen" requires a face-to-face examination within a month of starting home oxygen therapy." (effective 09/27/2021)

06/15/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

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

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

LCD and Policy Article Revisions Summary for June 22, 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 and Intravenous Immune Globulin. Please review the entire LCDs and related PAs for complete information.

External Infusion Pumps

LCD

Revision Effective Date: 07/01/2023

CODING INFORMATION:

Added: J1811 and J1813 to Group 4 Codes

06/22/2023: 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: 07/01/2023

MODIFIERS:

Added: HCPCS codes J1811 and J1813 to the JK and JL modifier instructions to comply with the Inflation Reduction Act insulin coinsurance cap

CODING GUIDELINES:

Added: J1811 and J1813 to instruction for billing insulin administered through an external insulin pump (E0784)

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: HCPCS codes J1811 and J1813 to Group 1 Paragraph

06/22/2023: 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: 07/01/2023

HCPCS CODES:

Added: J1576

06/22/2023: 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: 07/01/2023

CODING GUIDELINES:

Added: Direction for billing Panzyga

06/22/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

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

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

LCD and Policy Article Revisions Summary for August 17, 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 Power Mobility Devices and Wheelchair Options/Accessories. Please review the entire LCDs and related PAs for complete information.

Power Mobility Devices

LCD

Revision Effective Date: 05/16/2023

CMS NATIONAL COVERAGE POLICY:

Added: "280.16"

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: "Wheelchair Options and Accessories" to "Wheelchair Options/Accessories"

Removed: "Refer to the related Policy Article for information concerning coverage of Group 2 PWCs with seat elevators (K0830, K0831). "

08/17/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to development of National Coverage Determination (NCD) 280.16.

PA

Revision Effective Date: 05/16/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: "A seat elevator is a statutorily noncovered option on a power wheelchair. If a PWC with a seat elevator (K0830, K0831) is provided, it will be denied as non-covered. "

CODING GUIDELINES:

Revised: "Wheelchair Options and Accessories" to "Wheelchair Options/Accessories"

08/17/2023: 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.

Wheelchair Options/Accessories

LCD

Revision Effective Date: 05/16/2023

CMS NATIONAL COVERAGE POLICY:

Added: "280.16"

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: Coverage information for the power seat elevation system (E2300) when the beneficiary meets coverage criteria for either a Group 2 single power option or multiple power option power-driven wheelchair, or a Group 3 power-driven wheelchair and meets the coverage criteria for seat elevation equipment as described in the National Coverage Determination (NCD) 280.16.

08/17/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates due to development of National Coverage Determination (NCD) 280.16.

PA

Revision Effective Date: 05/16/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Revised: "POWER SEATING SYSTEMS" to "POWER STANDING SYSTEM"

Removed: Language that specified a power seat elevation feature (E2300) is non-covered

08/17/2023: 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.

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 Revisions Summary for July 13, 2023

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

Pneumatic Compression Devices

LCD

Revision Effective Date: 06/07/2022

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Removed: "At the end of the four-week trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. Only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, may the lymphedema be considered unresponsive to conservative therapy, and coverage for a PCD considered."

Removed: "At a minimum, re-assessments conducted for a trial must include detailed measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate."

07/13/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates based on CMS direction as a result of the

United States District Court, District of Columbia decision in Greenwald v. Becerra (Decided June 7, 2022)

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 Revisions Summary for July 27, 2023

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

Pneumatic Compression Devices

LCD

Revision Effective Date: 06/07/2022

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:

Removed: "At the end of the four-week trial, if there has been improvement of the lymphedema extending onto the chest, trunk and/or abdomen, then reimbursement for an E0652 is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. When and only when no significant improvement has occurred in the most recent four weeks and the coverage criteria above are still met, an E0652 is eligible for reimbursement."

07/27/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due to non-discretionary coverage updates based on CMS direction as a result of the

United States District Court, District of Columbia decision in Greenwald v. Becerra (Decided June 7, 2022)

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

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

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

View the locally hosted 2023 DMD articles.

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

Policy Article Revisions Summary for July 6, 2023

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

Oral Anticancer Drugs

PA

Revision Effective Date: 07/06/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10 codes C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.8, E34.0, Z85.020, Z85.030, Z85.040, Z85.060, Z85.230 to Group 2 Codes

Added: ICD-10 codes C75.5, C7B.8 to Group 3 Codes

Added: ICD-10 codes C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.5, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.8, C7B.8, E34.0, Z85.020, Z85.030, Z85.040, Z85.060, Z85.110, Z85.230 to Group 8 Codes

07/06/2023: 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)
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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

Policy Article Revisions Summary for July 20, 2023

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Knee Orthoses and Pneumatic Compression Devices. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

Knee Orthoses

PA

Revision Effective Date: 07/20/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Revised: ICD-10-CM Code range in the Group 2 and Group 4 Codes, from “S83.221A - S83.222A” to “S83.221A - S83.222S”

07/20/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Pneumatic Compression Devices

PA

Revision Effective Date: 01/01/2023

GENERAL:

Removed: "The documentation for each of the above must include careful, detailed records of measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to, at periodic times during and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate." (effective June 7, 2022)

07/20/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

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

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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

Policy Article Revisions Summary for August 3, 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: 07/01/2023

CODING GUIDELINES

Revised: Non-associated supply HCPCS codes for E0781 to remove duplicate HCPCS code A4224 and replace with A4225

08/03/2023: 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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        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

MLN Connects

MLN Connects - June 1, 2023

MLN Connects Newsletter: June 1, 2023

News

- CMS Announces Plan to Ensure Availability of New Alzheimer's Drugs
- COVID-19 Health Care Staff Vaccination Final Rule
- Medicare Secondary Payer Accident-Related Diagnosis Codes: How to Get Paid
- Hospitals: New Payment Adjustments for Domestic N95 Respirators
- Expanded Home Health Value-Based Purchasing Model: May Newsletter
- Improve Cognitive Health: Medicare Covers Services

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2023 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2023 Quarterly Update
- Updating Medicare Manual with Policy Changes in the CY 2020 & CY 2021 Final Rules

Publications

- Medicare Preventive Services - Revised
- Medical Record Maintenance & Access Requirements - Revised

Multimedia

- Hospice Quality Reporting Program Web-Based Training - Revised

MLN Connects - June 8, 2023

MLN Connects Newsletter: June 8, 2023

News

- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in the Territory of Guam Due to Recent Typhoon
- CMS Roundup (June 2, 2023)
- Gender-Specific Services: Billing Correctly and Usage of the Condition Code/Modifier
- Medicare Shared Savings Program: Apply for January 1 Start Date by June 15

MLN Connects

- Skilled Nursing Facility Value-Based Purchasing Program: June Feedback Report
- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Help Address Disparities in the LGBTQI+ Community

Claims, Pricers, & Codes

- National Correct Coding Initiative: July Update
- Integrated Outpatient Code Editor: Version 24.2

MLN Matters® Articles

- Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order

MLN Connects - June 15, 2023

MLN Connects Newsletter: June 15, 2023

News

- Inflation Reduction Act Continues to Lower Out-of-Pocket Prescription Drug Costs for Drugs with Price Increases Above Inflation
- CMS Announces Multi-State Initiative to Strengthen Primary Care
- Critical Access Hospitals: Annual Average Patient Length of Stay Requirement
- Skilled Nursing Facility Probe and Educate Review
- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance
- ESRD Prospective Payment System: July Update
- Medicare Learning Network Web Refresh
- Men's Health: Encourage Your Patients to Prioritize Their Health

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2024

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2023 Quarterly Update
- Hospital Outpatient Prospective Payment System: July 2023 Update
- New JZ Claims Modifier for Certain Medicare Part B Drugs

- Ambulatory Surgical Center Payment System: July 2023 Update - Revised

Publications

- Expanded Home Health Value-Based Purchasing Model: Resource Index, FAQs, & Specifications

Information for Patients

- New Tools to Lower Prescription Drug Costs for Low-Income Seniors and People with Disabilities

MLN Connects - June 22, 2023

MLN Connects Newsletter: June 22, 2023

News

- CMS Roundup (June 16, 2023)
- Lower Endoscopy: Comparative Billing Report in June
- Medicare Physician Fee Schedule Database: July Update
- Behavioral Health Integration Services: Get Information about the Codes

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Codes: FY 2024

Events

- Expanded Home Health Value-Based Purchasing Model: Overview of the Interim Performance Report Webcast - July 27

MLN Matters® Articles

- New Waived Tests
- Home Dialysis Payment Adjustment & Performance Payment Adjustment for ESRD Treatment Choices Model: Updated Process – Revised

MLN Connects

MLN Connects - June 29, 2023

MLN Connects Newsletter: June 29, 2023

News

- CY 2024 ESRD Prospective Payment System Proposed Rule
- Transforming Medicare Coverage: A New Medicare Coverage Pathway for Emerging Technologies and Revamped Evidence Development Framework
- New Details of Plan to Cover New Alzheimer's Drugs
- Model Participants for the Enhancing Oncology Model
- Hospital Price Transparency: Volunteer for Machine-Readable File Validator Testing

Claims, Pricers, & Codes

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

Events

- Hospital Price Transparency Machine-Readable File Sample Format Webinar - July 26

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2023 Update - Revised

From Our Federal Partners

- Locally-Acquired Malaria Cases Identified in U.S.
- Measles Guidance for the Summer Travel Season

Information for Patients

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

MLN Connects - July 6, 2023

MLN Connects Newsletter: July 6, 2023

News

- CY 2024 Home Health Prospective Payment System Proposed Rule
- HHS Announces Actions to Lower Health Care Costs and Allow Medicare to Negotiate Lower Drug Prices

- CMS Roundup (June 30, 2023)
- Skilled Nursing Facility: COVID-19 Enforcement Discretion for Pharmacy Billing Ended June 30
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Help People with Disabilities Get the Care They Need

MLN Matters® Articles

- Corrections to Home Health Claims Edits

Publications

- Medicare & Mental Health Coverage - Revised

From Our Federal Partners

- Wildfire Smoke Exposure Poses Threat to At-Risk Populations

MLN Connects Newsletter: Broader Medicare Coverage of Leqembi Available Following FDA Traditional Approval - July 7, 2023

News

Broader Medicare Coverage of Leqembi Available Following FDA Traditional Approval

Broader Medicare coverage is now available for Biogen and Eisai's Leqembi (the brand name for lecanemab) following the Food and Drug Administration's (FDA) move to grant traditional approval to the drug that treats individuals with Alzheimer's disease. The Centers for Medicare & Medicaid Services had previously announced this would be the case and released more details on coverage.

MLN Connects - July 13, 2023

MLN Connects Newsletter: July 13, 2023

News

- Hospital Outpatient Prospective Payment System: Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022
- National Coverage Determination: Pre-exposure Prophylaxis Using Antiretroviral Drugs to Prevent HIV Infection
- Medicare Dental Services: Learn What's Covered

MLN Connects

Claims, Pricers, & Codes

- Institutional Providers: Resubmit Audiology Claims Returned with Reason Code 34963
- Inpatient Prospective Payment System-Excluded Hospitals: Correcting Issue with Excluded Units
- ICD-10-CM Diagnosis Codes: FY 2024 Coding Guidelines & Conversion Table

Events

- Expanded Home Health Value-Based Purchasing Model: Overview of the Interim Performance Report Webcast - July 27

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to Laboratory National Coverage Determinations: October 2023 Update
- Ambulatory Surgical Center Payment System: July 2023 Update - Revised
- New Fiscal Intermediary Shared System Edit to Validate Attending Provider NPI - Revised

Publications & Multimedia

- Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, & Texas
- Expanded Home Health Value-Based Purchasing Model: New Resources

From Our Federal Partners

- Rural Emergency Hospitals: Requirements in CMS Emergency Preparedness Final Rule

MLN Connects Newsletter: PFS & OPPS/ASC Proposed Payment Rules - July 13, 2023

Proposed Rules

- CMS Physician Payment Rule Advances Health Equity
- CMS Proposes Policies to Expand Behavioral Health Access and Further Efforts to Increase Hospital Price Transparency

MLN Connects

MLN Connects - July 20, 2023

MLN Connects Newsletter: July 20, 2023

News

- Percutaneous Transluminal Angioplasty of Carotid Artery Concurrent with Stenting: Proposed National Coverage Determination
- Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease: Proposed National Coverage Determination
- CMS Posts Program Year 2022 Open Payments Data to CMS.gov
- Value-Based Insurance Design Model: CY 2024
- DMEPOS Suppliers: When & Where to Submit Electronic Funds Transfer Authorization Agreement Form
- New Domestic N95 Respirator Payment Adjustments
- Medicare Providers: Deadlines for Joining an Accountable Care Organization

Compliance

- Inpatient Admission Before Part A Entitlement: Bill Correctly

MLN Matters® Articles

- Activation of Validation Edits for Providers with Multiple Service Locations - Revised

Publications

- Telehealth Services - Revised

Multimedia

- Post-Acute Care: Brief Interview for Mental Status Video

MLN Connects - July 27, 2023

MLN Connects Newsletter: July 27, 2023

News

- CMS Continues Work on Behavioral Health
- Discarded Drugs and Biologicals: Updated FAQs on JW & JZ Modifiers
- Expanded Home Health Value-Based Purchasing Model: July 2023 Interim Performance Reports

MLN Connects

- Subsequent Annual Wellness Visits: Comparative Billing Report in July
- Medicare Ground Ambulance Data Collection System: Submit Comments by September 11
- Clinical Laboratories: New Diagnostic Tests & Reporting Reminder
- Viral Hepatitis: Talk with Your Patients about Shots & Screenings

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

From Our Federal Partners

- Biosimilars: Free Continuing Education Courses, Videos, & Resources from FDA

MLN Connects Newsletter: 5 Final FY 2024 Payment Rules - Aug 1, 2023

Final FY 2024 Payment Rules

- New CMS Rule Promotes High-Quality Care and Rewards Hospitals that Deliver High-Quality Care to Underserved Populations
- Hospice Payment Rate Update
- Medicare Inpatient Psychiatric Facility Prospective Payment System & Quality Reporting
- Inpatient Rehabilitation Facility Prospective Payment System
- Skilled Nursing Facility Prospective Payment System

MLN Connects - August 3, 2023

MLN Connects Newsletter: Aug 3, 2023

News

- Medicare Dementia Care Model
- Your Patient's Medicare Beneficiary Identifier (MBI) May Change
- CMS Roundup (July 28, 2023)
- Building on CMS's Accountable Care Vision to Improve Care for Medicare Beneficiaries
- Home Health Agencies & Partial Hospitalization Programs: Program for Evaluating Payment Patterns Electronic Reports
- Skilled Nursing Facility Value-Based Purchasing Program: August Performance Score Report

- Expanded Home Health Value-Based Purchasing Model: Revised July Interim Performance Reports

MLN Matters® Articles

- ESRD Prospective Payment System: October 2023 Update
- Patient Driven Payment Model Claim Edits
- Processing Services During Disenrollment from the Program of All-Inclusive Care for the Elderly

MLN Connects - August 10, 2023

MLN Connects Newsletter: Aug 10, 2023

News

- Immunization: Protect Your Patients

Claims, Pricers, & Codes

- Outpatient Rehabilitation Claims with Reason Code W7072: Do You Need to Resubmit Claims?

MLN Matters® Articles

- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: October 2023 Update

Publications

- Expanded Home Health Value-Based Purchasing Model: New Resource & Updated FAQs

Multimedia

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

MLN Connects - August 17, 2023

MLN Connects Newsletter: Aug 17, 2023

News

- CMS.gov Website Refresh - Test Website Available for Feedback
- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in Hawaii Due to Recent Wildfires

- Clotting Factor: CY 2024 Furnishing Fee

Claims, Pricers, & Codes

- COVID-19: CPT Codes for Vaccines No Longer Authorized
- Inpatient Rehabilitation Facility Prospective Payment System: FY 2024 Pricer Update
- Skilled Nursing Facility Prospective Payment System: FY 2024 Pricer Update

MLN Matters® Articles

- Hospice Payments: FY 2024 Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2024 Update
- National Coverage Determination 30.3.3 - Acupuncture for Chronic Low Back Pain
- Power Seat Elevation Equipment on Power Wheelchairs

Publications

- Medicare Provider Enrollment - Revised

MLN Connects - August 24, 2023

MLN Connects Newsletter: Aug 24, 2023

News

- Seasonal Flu Vaccine Pricing for 2023-2024 Season
- Expanded Home Health Value-Based Purchasing Model: July 2023 Interim Performance Reports, Post-Event Materials, & Comment on CY 2024 Proposals
- Behavioral Health Integration Services: Are Your Patients Eligible?

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Non-Drug & Non-Biological Items & Services
- New Place of Service Code 27 - Outreach Site/Street

Events

- ICD-10 Coordination & Maintenance Committee Meeting - September 12-13
- Optimizing Healthcare Delivery to Improve Patient Lives Conference - November 15

MLN Connects

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update
- Activation of Validation Edits for Providers with Multiple Service Locations - Revised

MLN Connects - August 31, 2023

MLN Connects Newsletter: Aug 31, 2023

News

- HHS Selects the First Drugs for Medicare Drug Price Negotiation
- Medicare Shared Savings Program Saves Medicare More Than $1.8 Billion in 2022 and Continues to Deliver High-quality Care
- CMS Issues Draft Guidance on New Program to Allow People with Medicare to Pay Out-of-Pocket Prescription Drug Costs in Monthly Payments
- CMS Roundup (Aug. 25, 2023)
- CMS.gov Website Refresh - Provide Feedback on Test Website by September 5

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Non-Drug & Non-Biological Items and Services
- Home Health Prospective Payment System Grouper: October Update
- Updated ICD-10 Medicare Severity Diagnosis-Related Group Version 41

From Our Federal Partners

- Locally Acquired Malaria Cases Identified in Florida, Texas, & Maryland - Important Updates

MLN Matters

Claim Status Category and Claim Status Codes Update

Related CR Release Date: March 2, 2023

Effective Date: March 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 12845

Related CR Transmittal Number: R11885CP

CR 12845 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions. This Recurring Update Notification (RUN) can be found in chapter 31, section 20.7 of Publication (Pub.) 100-04

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12845.

DMEPOS Fee Schedule: July 2023 Quarterly Update

Related CR Release Date: June 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

MLN Matters Number: MM13235

Related Change Request (CR) Number: CR 13235

Related CR Transmittal Number: R12068CP

CR 13235 tells you about:

- Fee schedule adjustment relief for rural and non-contiguous areas
- Supplier education on power wheelchair repair

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13235.

MLN Matters

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

Related CR Release Date: March 23, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13157

Related CR Transmittal Number: R11920CP

CR 13157 supplies the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13157.

New JZ Claims Modifier for Certain Medicare Part B Drugs

Related CR Release Date: June 2, 2023

Effective Date: January 1, 2023

Implementation Date: July 1, 2023 - JZ modifier

MLN Matters Number: MM13056

Related Change Request (CR) Number: CR 13056

Related CR Transmittal Number: R12067CP

CR 13056 tells you about:

- Using JW modifier data to show discarded amounts of drugs in a single-dose container or single-use package
- Reporting requirements for new JZ modifier starting July 1, 2023

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13056.

MLN Matters

New Place of Service (POS) Code 27 - "Outreach Site/Street"

Related CR Release Date: August 10, 2023

Effective Date: October 1, 2023

Implementation Date: January 2, 2024

Related Change Request (CR) Number: CR 13314

Related CR Transmittal Number: R12202CP

CR 13314 creates a new place of service code 27 for "Outreach Site/Street" - A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Make sure your billing staffs are aware of these changes.

View the complete CMS Change Request (CR)13314.

Power Seat Elevation Equipment on Power Wheelchairs

Related CR Release Date: August 3, 2023

Effective Date: May 16, 2023

Implementation Date: September 4, 2023

MLN Matters Number: MM13277

Related Change Request (CR) Number: CR 13277

Related CR Transmittal Number: R12183NCD

CR 13277 tells you about:

- NCD 280.16 for power seat elevation equipment on power wheelchairs
- Coding requirements for this equipment

Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13277.

MLN Matters

RARC, CARC, MREP and PC Print Update

Related CR Release Date: March 2, 2023

Effective Date: July 1, 2023

Implementation Date: July 3, 2023

Related Change Request (CR) Number: CR 13114

Related CR Transmittal Number: R11886CP

CR 13114 updates the Remittance Advice Remark (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13114.

Technical Revisions Only to the NCD Manual, Pub 100-03

Related CR Release Date: June 29, 2023

Effective Date: June 29, 2023

Implementation Date: July 31, 2023

Related Change Request (CR) Number: CR 13220

Related CR Transmittal Number: R12112NCD

CR 13220 announces technical changes that were made to the National Coverage Determination (NCD) Manual, Publication (Pub)100-03, Chapter 1 Parts 1, 3, and 4. Proposed manual changes include: (1) In Chapter 1, Part 1, Section 20.33 Transcatheter Edge-To-Edge (TEER) for Mitral Valve Regurgitation title was corrected to align with the title of the NCD. (2) In Chapter 1, Part 1, Section 20.4 Implantable Cardioverter Defibrillators (ICDs), in Part B number 4 added verbiage ‘or cardiac arrest due to VF’ to align with Section I of the Final Decision Memo. (3) In Chapter 1, Part 3, Section 190.1 Histocompatibility Testing, removed 4 bullets and replaced them with letters to align with the original Coverage Issues Manual language. (4) In Chapter 1, Part 4, Section 280.1, in the DME reference list, the Muscle Stimulator hyperlink is being changed from 250.4 to 160.12 to refer back to the correct section in the manual.

Make sure your billing staffs are aware of these changes.

View the complete CMS Change Request (CR)13220.

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

Contacts, Resources, and Reminders

Organization	Phone Number	Types of Inquiries
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."

Contacts, Resources, and Reminders

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.

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.