# DME Happenings

## Jurisdiction D
## December 2024

Healthcare Solutions

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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# News

## Ankle-Foot Orthoses/Knee-Ankle-Foot Orthoses Same or Similar Tip

Same or similar denials are a top denial for the Ankle-Foot Orthoses (AFO)/Knee-Ankle-Foot Orthoses (KAFO) policy. This may be due to beneficiaries requiring an AFO/KAFO initially, then later, during the reasonable useful lifetime (RUL), as the beneficiary's medical condition changes, they require another orthosis to treat the change in medical condition. For example, many beneficiaries initially require a boot and then later move on to a long-term orthosis.

When providing a brace for a change in medical condition, suppliers should obtain an Advance Beneficiary Notice of Noncoverage (ABN) if the previous orthosis has not reached its RUL and submit the claim with the KX modifier when all requirements specified in the policy have been met. When the claim denies as same or similar, appeal the claim, and include documentation justifying the change in medical condition, including all medical records to support the change. Be sure to include the valid ABN with the appeal request.

**Note:** The KX and GA modifiers may not be appended to the same claim line. This will cause a rejection of the claim for incorrect modifiers.

## Ask the Contractor Meeting (ACM) Questions and Answers - November 7, 2024

The following questions and answers (Q&As) are cumulative from the DMEPOS Ask the Contractor Meeting (ACM). Some questions have been edited for clarity and answers may have been expanded to provide further details. Similar questions were combined to eliminate redundancies. If a question was specific just for one supplier, Noridian addressed directly with the supplier.

### Questions Received Prior to ACM

**Q: There is lacking details on the new PureWick system (E2001). The National Coverage Determination (NCD) is vague. When is criteria coming out?**
A: The only information Noridian has on the PureWick system may be found in the coding and billing article at the path below. This is a joint publication with Noridian and CGS.

Noridian Medicare website > Policies > Medical Director Articles > 2024 > PureWick Urine Collection System - Coding and Billing Instructions - Revised

**Q: How does regular Medicare enrollment differ from durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) enrollment?**

A: In order to bill Medicare for DMEPOS items, suppliers must enroll with the National Provider Enrollment (NPE) East or NPE West. More information on enrollment and links to the NPE East and NPE West contractor websites may be found at the path below.

Noridian Medicare website > Browse by Topic > Enrollment

**Q: Are there any upcoming policy changes for the ventilator policy?**
A: There are not any upcoming changes to ventilator coverage. You can learn more about ventilator coverage at the next webinar, scheduled for December 19th at 1 p.m. CT.

Noridian Medicare website > Education and Outreach > Schedule of Events

**Q: What kind of documentation is Medicare looking for to justify specialty enteral nutrition formulas (B4149)?**
A: The medical records from the treating practitioner must support the level of care provided. If the beneficiary requires a special formula, there must be a determination that a standard formula is insufficient to meet nutritional requirements. While a diagnosis alone is not sufficient to support medical necessity of an item, perhaps the medical records discuss the beneficiary having an allergy or medical condition which prohibits the use of a standard formula or eliminates the standard formula as an option.

**Q: We have a patient demanding pickup of equipment that is under the five-year reasonable useful lifetime (RUL). The power wheelchair was purchased 18 months ago and has been repaired, and the reason for pickup is the beneficiary doesn't like the manufactured chair.**
A: The beneficiary owns the wheelchair and therefore is responsible for the item. If the beneficiary is requesting the item to be returned that would be up to your own business practices. However, Medicare will only replace the wheelchair in certain instances such as lost, stolen, or irreparably damaged items. For more information on replacement, review the Noridian Medicare website > Browse by Topic > Repairs, Maintenance and Replacement > Replacement

**Q: Could you please show what documentation is required for Therapeutic Shoes for Persons with Diabetes (TSPD) and give suggestions on what information is needed per the 2024 guidelines?**
A: Noridian offers a documentation checklist for TSPD that is up to date. It provides guidance on all the documentation needed as well as what information needs to be provided. Please follow the pathway to view the documentation checklist: Noridian Medicare website > Browse by DMEPOS Category > Therapeutic Shoes > Therapeutic Shoes for Persons with Diabetes Documentation Checklist

**Q: If the beneficiary has a significant weight loss but has a bariatric wheelchair that has not reached the 5-year reasonable useful lifetime (RUL), can we bill another wheelchair of an appropriate size?**

A: If there is a change in medical need a different wheelchair may be billed for payment. Issuing an Advance Beneficiary Notice of Noncoverage (ABN) to the beneficiary would be appropriate in this scenario. The claim will deny as same or similar, and all documentation requirements can be submitted to redeterminations for review.

### Verbal Questions Asked During ACM

**Q: What is the best practice for billing Foley catheters and bundled billing when beneficiaries are overutilizing? They are requiring more than one per month but we're getting two bundled codes that populate because we provide, for example, two of the drainage bags, 12 Foleys, and 12 insertion trays.**
A: Only one foley catheter is allowed per month unless there is documentation that supports the need for additional units (e.g., obstruction, sludging, clotting of blood, or chronic, recurrent urinary tract infection). The supplier will bill for the units ordered, which will populate with A4311 and A4314 in this case. After the first denial, the supplier should complete a redetermination to be reviewed by medical review. If the documentation supports it, a note will be put in the system to allow further claims to be processed for payment.

**Q: Medicare extended telehealth visits for the face-to-face (F2F) through December 31, 2024. Is there any clarification on if this will be extended past 2024?**
A: Yes, valid telehealth visits will continue to be acceptable. Some flexibilities for valid telehealth visits are scheduled through December 31, 2024. CMS has a list of what would be considered a valid telehealth visit.

**Q: Is the August 2024 required face-to-face and written order prior to delivery list on the CMS website a comprehensive list?**
A: Yes, the complete list is located on the CMS website.

**Q: Regarding a positive airway pressure (PAP) mask, it doesn't matter where the fitting happened (such as a doctor's office or another location), the supplier can still bill for it, correct?**
A: Correct, the DME supplier who provides the mask must bill for the mask.

### Written Questions Asked During ACM

**Q: Can you please review the different role between nurse practitioner, physician assistants and certifying physicians regarding the therapeutic shoes?**
A: There are different ways that these can be the certifying physician. One way a nurse practitioner can be a certifying physician is if they are participating in the Primary Care First (PCF) Demonstration Project. A nurse practitioner and a physician assistant can act as a certifying physician if they are practicing "incident to" a supervising physician (M.D. or D.O.). For "incident to", the supervising physician must sign and date (indicating

agreement) the nurse practitioner's or the physician assistant's records. All billing must be done under the supervising physician's National Provider Identifier (NPI) for "incident to" requirements to be met.

**Q: Can you clarify acceptable addendums to diagnostic testing or medical records, specifically computed tomography (CT) of chest or chest x-ray?**
A: All addendums to medical records must be done according to the requirements in the Internet Only Manual, Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.

**Q: With the ABN, the beneficiaries want to electronically sign and date. I have seen Medicare come back and state that the beneficiary cannot electronically date, handwritten only. The beneficiary has to print it out, sign it, and then scan it back. Is there an easier way that this can be done? Not all beneficiaries have the equipment to do this.**
A: Nothing prohibits electronic signing or dating of the ABN. Electronic issuance of ABNs is not prohibited. If a healthcare provider or supplier elects to issue an ABN that is viewed on an electronic screen before signing, the beneficiary has the option of requesting paper issuance over electronic if that is what s/he prefers. Also, regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary should be given a paper copy of the signed ABN to keep for his/her own records. For more information, see the IOM, Publication 100-04, Chapter 30.

**Follow-up Question: I received a denial stating the signature must be handwritten. Can this be looked into?**
A: If a claim was denied, the appeals process must be followed.

**Q: We have a new Medicare beneficiary who just entered Medicare on October 1, 2024. His F2F visit and testing are all prior to this date. Does he still need a F2F visit after becoming Medicare eligible if he was not set up prior to eligibility?**
A: Another F2F visit is not required if this is regarding oxygen or PAP.

**Q: We recently received some denials where a clinician is PECOS-enrolled but somehow not for Part B. How can we check for this for DME?**
A: PECOS enrollment may be verified on the CMS website.

**Q: Regarding power mobility devices (PMDs), do we know if the telehealth F2F and specialty evaluation that was mandated during the health crisis will be extended past December 31, 2024?**
A: Valid telehealth visits do continue to be acceptable for PMDs when done by the treating practitioner with the requirement met for both audio and video. A listing of valid telehealth services can be found on the CMS website.

**Q: How does Medicare view lumpectomy vs mastectomy? Do chart notes need to specify mastectomy or is a substantial lumpectomy sufficient? If the record stated**

**lumpectomy, but described size (removed measurement, cup size change, etc.) that could be described as partial mastectomy but doesn't state mastectomy, could the beneficiary qualify for breast prosthesis or does the record need to include the word mastectomy?**
A: The medical records need to reflect what medical procedure took place. A lumpectomy wouldn't necessarily mean a mastectomy, so the medical records need to be specific. Also, a breast prosthesis and garments are covered for a beneficiary who has had a mastectomy with a diagnosis code that is listed in the Local Coverage Determination (LCD)-related Policy Article. The medical record would need to support the need for a prosthesis.

**Q: Is there an LCD or National Coverage Determination (NCD) for urine suction pumps (PureWick)?**
A: There is not a policy; however, the Medical Directors discuss the PureWick system and coding guidelines in an article on our website under Policies > Medical Director Articles > 2024 > PureWick Urine Collection System - Coding and Billing Instructions - Revised.

**Q: Would having a comment on the physician written order saying "Refer to RT Determination" satisfy the requirement that the treating practitioner has evaluated the results of the blood gas study as long as we have a copy of the testing in the medical records or would we have to prove the provider actually seen the testing?**
A: We are unable to provide pre-approval of specific documentation examples. However, we do have a recently published article titled "Treating Practitioner Evaluation of the Blood Gas Study for Oxygen" which describes what may be used to meet this requirement. Examples include notation of the results on the order or reference to evaluation of testing performed on a specific date. In the example provided, "Refer to RT Determination" may not be sufficient in case of review to meet this requirement. This article is found under Browse by DMEPOS Category > Oxygen > Related Articles section.

**Q: When will there be training and updated materials (checklists, etc.) for Pneumatic Compression Devices with the change from LCD to NCD?**
A: Training materials will be released when more information is available. Thank you for your patience.

**Q: If a prior authorization (PA) is needed and the item is dispensed, is the authorization date from the prescription date or is it the approval "affirmed" date on the letter?**
A: The prior authorization becomes valid starting on the date the affirmed Unique Tracking Number (UTN) is provided.

**Q: Does Noridian do retroactive authorizations?**
A: Retroactive prior authorizations are not appropriate except in scenarios where the beneficiary is retroactively eligible for Medicare. More information on prior authorization

can be found on the Noridian Medicare website under Medical Review > Pre-Claim Review > Required Prior Authorization Programs. Also, the operational guide can be found on the CMS website.

**Q: Can an order have the verbiage of a letter of medical necessity (LMN) and that count as both forms from the provider?**
A: A separate order is required unless the supplier is also the treating practitioner. Supplier-prepared statements and physician attestations by themselves do not provide sufficient documentation of medical necessity, even if signed by the ordering physician. An LMN itself is not enough to meet coverage criteria. The information must come from the medical records.

**Q: What happens if a referring physician is no longer with the clinic or hospital and an LMN is needed? Can another provider write the LMN?**
A: If the beneficiary has seen this physician, they can write an LMN; however, LMNs are not considered part of the medical record and cannot be used alone to support medical necessity on Medicare claims.

**Q: If a beneficiary qualified for oxygen originally under COVID due to no qualifying oxygen saturation testing and is due or coming up due for replacement following the RUL, does the beneficiary need to complete new testing or is the CR modifier good for lifetime and no new testing is required?**
A: Suppliers may continue to append the CR modifier if the oxygen remains medically necessary. New testing would not be required if therapy has been continuous. More information is available on our website under Policies > Medical Director Articles > 2023 > Claim Submission Instruction Post-PHE - Continued Use of Modifier CR and COVID Narrative - Revised.

**Q: Regarding oxygen saturation testing, if it previously was not signed by the doctor and now it's at the end of the RUL, do we have to have it mentioned in the current F2For order?**
A: Mention of the original testing is not required for replacement oxygen following the RUL. There must be a new standard written order (SWO) for the replacement oxygen to demonstrate continued medical need.

**Q: For PAP beneficiaries entering Medicare where the beneficiary started the process prior to becoming eligible for Medicare, F2F, sleep study, and order, (equipment not received yet), then becomes Medicare-eligible, does the beneficiary have to be seen again for another F2F and order after the Medicare effective date and before the equipment is delivered?**
A: As long as the initial coverage requirements in the PAP LCD have been met, a new sleep study, order, and F2F are not required.

**Q: Regarding oxygen for nocturnal use, if the doctor is ordering oxygen for congestive heart failure, chronic obstructive pulmonary disease, etc., and the F2F documents sleep-related symptoms, such as snoring, daytime sleepiness, and fatigue, etc., can the qualifying saturation test come from an overnight oximetry, or does it have to come from a titration study?**
A: A titration would only be required if there was documentation of sleep apnea. Otherwise, an overnight oximetry test would be acceptable.

**Follow-up Question: Wouldn't the titration be needed to rule out the sleep apnea because the beneficiary has symptoms of sleep apnea?**
A: That would be up to the treating practitioner. Medicare only requires a titration for oxygen if the documentation specifically mentions sleep apnea or suspected sleep apnea.

**Q: We previously attended a joint webinar from CGS and Noridian for surgical dressings. The educators advised that Medicare will only pay for 12 foam dressings per month but that an ABN would have to be on file if the beneficiary is paying for the additional 18 foam dressings ordered. This advice was upheld through four years of redeterminations, Targeted Probe and Educate (TPE) reviews, Comprehensive Error Rate Testing (CERT) reviews, and post payment claim reviews. We recently had a Unified Program Integrity Contractor (UPIC) review and received our first denials for foam dressings over alginate primary when the doctor recommends daily change, and it has been documented that the facility is providing the 18 extra foam dressings. Was there a change in coverage and frequency?**
A: An ABN would be valid for the additional 18 units if the documentation does not support it. For denied claims, a redetermination should be submitted with supporting documentation.

## Claim Line Maximums to Prevent Claim Line Splitting During Processing

When submitting claims, it's essential to follow specific guidelines regarding claim line maximums. Adhering to these guidelines helps prevent claim lines from being split into multiple claim submissions, ensuring that all claim lines are processed together under the same date of service (DOS).

### Key Guidelines

### Claim Line Totals

After entering the maximum claim lines based on the submission format, be sure to include a **total amount for those claim lines at the bottom of the claim form**. This

should be indicated in Item 28 on the CMS-1500 form or the equivalent field in the electronic format. Importantly, avoid using the word "continued" on the claim.

**Electronic Claims: Maximum Claim Lines = 13 Lines per Claim Submission**

For electronic submissions, there is a strict limit of 13 claim lines per claim submission. Exceeding this limit may result in the automatic splitting of claim lines during processing when the claim is not totaled at the bottom of the claim form.

**Hard Copy 1500 Claim Form: Maximum Claim Lines = 6 Lines per Claim Submission**

When submitting claims using the hard copy 1500 form, the maximum number of claim lines is limited to 6. If the number of claim lines exceeds this maximum and totals are not provided, the claim lines may split during processing. This could lead to necessary items being separated across multiple claims, resulting in delays or denials.

**What to Do If Claims Are Split**

Even with strict adherence to these guidelines, there may be instances where claims are split into multiple claim submissions during processing. If this occurs, you may need to appeal the claim to resolve the issue and ensure proper processing.

## CMS Suspends Prior Authorization for Osteogenesis Stimulators

Effective August 28, 2024, CMS is suspending prior authorization requirements for HCPCS codes E0747, E0748, and E0760 due to continued confusion over some noninvasive osteogenesis stimulators and whether they comply with the DME three-year expected life requirement at 42 CFR 414.202. CMS plans to provide additional direction regarding the three-year expected life requirement at 42 CFR 414.202 in future notice and comment rulemaking.

## Continuous Glucose Monitor (CGM) Supply Allowance

The billing codes A4238 and A4239 for continuous glucose monitor (CGM) supplies have a maximum limit of three units of service (UOS) per ninety days. Refill requirements do not apply to these codes. The next billable date for a 30-day supply is 31 days from the last billing date, while for a 90-day supply, it is 91 days from the last billing date. Non-adjunctive CGM supplies under code A4239, including sensors, transmitters, and home blood glucose monitor supplies, must be billed as 1 UOS per 30 days, allowing up to 3 UOS starting January 1, 2024, for a 90-day supply. Adjunctive CGM devices (A4238) do not replace standard home blood glucose monitors, and the supply allowance covers all

necessary items except home BGM supplies. The CGM supply allowance codes do not follow standard documentation requirements for refills, and if additional items are needed during the billing period, the DME supplier must provide them at no charge. Billing before the expected end of the current supply is not allowed, claims must not be submitted to Medicare until the appropriate time has passed. The date of service for A4238 and A4239 should not have a span date and claims with span dates will be returned as un-processable, requiring correction and resubmission. Additional information is available in the Glucose Monitors Local Coverage Determination (LCD) (L33822) and LCD-related Policy Article (A52464).

## Coverage of Ostomy Supplies

Ostomy supplies are covered under the Prosthetic Device benefit and are covered for a beneficiary with a surgically created opening (stoma) to divert urine or fecal contents outside the body. Ostomy supplies are appropriately used for colostomies, ileostomies, or urinary ostomies. Use for other conditions will be denied as noncovered. These guidelines are outlined in the Ostomy Supplies Policy Article (A52487).

## External Breast Prostheses Coverage and Upgrades

Medicare will cover a breast prosthesis and garments for a beneficiary who has had a mastectomy with a diagnosis code listed in Policy Article A52478. The quantity of covered bras and camisoles are not specified within the policy; that is determined by the physician. The medical records must support what is ordered and dispensed.

There are some items that are denied in this policy because they are deemed not reasonable and necessary:

L8031 - Silicone prosthesis with integral adhesive

L8033 - Nipple prosthesis, custom fabricated, reusable

L8035 - Custom mastectomy form

However, the items deemed not medically necessary (L8031, L8033, and L8035) may be billed as upgrades with the RT or LT modifier appended. View the Upgrades page on the Noridian Medicare website for billing information.

## Face-to-Face Encounters

All items billed to Medicare require a standard written order (SWO), and the beneficiary's medical record needs to substantiate that order. Beneficiaries need to see

their practitioner so that medical need can be established and so the practitioner can order the specific DMEPOS item needed.

The Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List is a list of DMEPOS items which require the beneficiary to see their practitioner within six months preceding the order, and have a WOPD on file with the supplier within six months of the face-to-face encounter.

The absence of a DMEPOS item from the Required List does not mean that the beneficiary has no need of a practitioner encounter; it just means that the beneficiary does not have to follow the face-to-face and WOPD timeline requirements. All policies require a practitioner encounter confirming medical necessity for item(s) ordered, and suppliers should be sure to follow individual policy guidelines. The only difference between items that require a face-to-face and WOPD and those that do not is the completion timeline for the physician encounter and order.

## How to Prevent and Address Same and Similar Denials

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

### Key Considerations Before Replacement

Before proceeding with any equipment or item replacement, suppliers should assess the following:

- **Change in Medical Condition**: Has there been a significant change in the beneficiary's medical condition that warrants a new item? Ensure the medical record substantiates the change in medical condition for the replacement item.
- **Loss, Theft, or Irreparable Damage**: Has the original item been lost, stolen, or irreparably damaged? The **Standard Documentation Requirements Article A55426** states:
    - The definition of replacement is found in the Medicare Benefit Policy Manual (CMS Pub. 100-02), Chapter 15, Section 110.2.C. That section generally defines replacement as the provision of an entirely identical or nearly identical item when it is lost, stolen or irreparably damaged.
        - Beneficiary-owned items or a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage may be due

to a specific accident or to a natural disaster (e.g., fire, flood). Contractors may request documentation confirming details of the incident (e.g., police report, insurance claim report).

- **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).

It is important to note that the NMP will confirm that a beneficiary either has or has not had a same or similar item with Jurisdictions A and D. It is the supplier's responsibility to check other jurisdictions for same or similar if there is reason to believe that the beneficiary may have obtained a same or similar item within a different jurisdiction. The claims in the NMP are specific to each jurisdiction so each Jurisdiction, JA and JD, may need to be verified along with other jurisdiction's portals for same or similar.

**Note:** Some HCPCS codes may be updated when a temporary code is deleted. If the deleted code is not searched for during a same or similar inquiry, it could result in a denial. For instance, the deletion of code K0554 and the introduction of code E2103 exemplify this need for thorough searches. Ensure that all relevant HCPCS codes are entered when conducting searches in the NMP to avoid potential denials.

Answering the above questions will help determine whether an Advance Beneficiary Notice of Noncoverage (ABN) is necessary.

- **No Previous History of Similar Item**: If there is no previous history of a "same as" or "similar" item, suppliers can bill the claim without obtaining an ABN.
- **History Exists, but RUL Reached**: If a history of a "same as" or "similar" item exists, determine if the item has reached the RUL. If it has, the claim can be billed without obtaining an ABN.
- **RUL not Reached**: If the item has not reached the RUL, suppliers should obtain an ABN and proceed with billing the claim while applying the appropriate modifier.

### Addressing Denials

When a DMEPOS claim is denied due to equipment/item similarity, suppliers may want to consider initiating an appeal/redetermination request. This appeal must include thorough documentation to support the replacement item, which may involve:

- **Evidence of Loss, Theft or Irreparable Damage**: If applicable, provide documentation supporting that the original item was lost, stolen, or sustained irreparable damage.
- **Medical Records**: Include records from the prescribing physician or practitioner that indicate a change in the beneficiary's medical condition, underscoring the necessity for a different item.

- **Advance Beneficiary Notice of Noncoverage (ABN)**: Include a valid ABN when one was obtained prior to providing the item.

This documentation is crucial when appealing the claim to justify the need for an item that is the "same as" or "similar to" what the beneficiary already has been provided.

### Resources

Suppliers can access additional guidance and instructions on managing ABN requirements and using the Same or Similar functionality through the following resources:

- NMP Same or Similar Inquiry Guide
- ABN Instructions
- Same or Similar Chart

## Importance of Claim Narratives in DMEPOS Billing

Including a narrative on the claim line when billing for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items, is often essential for timely processing. Narratives provide crucial context and information that facilitates accurate claim review and processing. Understanding when and how to include a narrative can significantly improve claim outcomes.

### Where to Enter Narratives

For electronic claims, narratives should be added in the **NTE 2400 (line note)** or **NTE 2300 (claim note)** segments. For paper claims, you can enter this information in **Item 19** of the CMS-1500 form.

Given that the NTE 2400 field is limited to **80 characters**, using common abbreviations can help in conveying necessary information concisely.

### Situations Requiring a Narrative

Here are some key scenarios where a claim narrative is mandatory or highly recommended:

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1. **Recurring DMEPOS Supplies**
   When billing for DMEPOS accessories or supplies provided on a recurring basis, such as a three-month supply, include a narrative that indicates the duration. For example, for three months of PAP accessories, specify "90-day supply" in the NTE segment.
2. **Repair Labor**
   When billing for repair labor, a narrative should detail the nature of the repair performed.
3. **Minor Parts without Specific HCPCS Codes**
   For minor parts that do not have a designated HCPCS code, include a narrative explaining what the parts are.
4. **Loaner Equipment**
   When billing for loaner equipment (HCPCS K0462), include a narrative to clarify the situation.
5. **Not Otherwise Classified (NOC) Codes**
   Items billed with NOC codes must have a narrative explaining the service or item. This helps ensure the claim is not denied due to lack of clarity.
6. **Replacing Items with Modifiers**
   If you are replacing an item and appending an RA modifier due to loss, theft, or irreparable damage, provide a narrative detailing the circumstances.
7. **Appending RB Modifiers**
   When using the RB modifier, a narrative is necessary to explain the billing context.
8. **Breaks in Need or Break in Billing**
   If there's a break in need or billing, a narrative should be included to clarify the situation.
9. **Upgrades and CPM Devices**
   When billing for upgrades or Continuous Passive Motion (CPM) devices, a narrative detailing the upgrade and its necessity is required.
10. **Beneficiary-Owned Equipment**
    When billing for accessories and supplies related to beneficiary-owned equipment, include a narrative that specifies the relationship to the beneficiary-owned item.
11. **Custom Fabricated Orthotics**
    For custom orthotics, provide a narrative that includes details about the fabrication process and unique features.

12. **Extended Anticipated Discharge Dates**
    If the anticipated discharge date is extended, include a narrative to explain the circumstances.
13. **Modifier Overflow**
    If more than four modifiers are required, use modifier 99 (overflow) as the fourth modifier and include the additional modifiers in the claim narrative.
14. **Surgical Dressings**
    When using modifier A9 (for dressing covering nine or more wounds), specify the number of wounds in the narrative.

## Incarcerated Claim Denials - Resolved 11/04/24

**Provider/Supplier Type(s) Impacted:** All

**Reason Codes:** Not applicable

**Claim Coding Impact:** Not applicable

**Description of Issue:** Noridian is aware of an issue with claims potentially denying for incarcerated status when the beneficiary does not have incarcerated record(s). Claims denying with CARC 258 "Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service."

**Noridian Action:** DME claims are not able to be suspended due to system limitations. Claims may continue to deny in error until the issue is resolved.

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

**Proposed Resolution/Solution:** The shared systems maintainer is working to resolve the issue.

11/04/24 - Noridian initiated mass adjustments on or before 10/30/24.

10/15/24 - The incarcerated file was updated on 09/23/24. Noridian will initiate adjustments by 10/25/24. Noridian will provide another update when all mass adjustments are initiated.

09/20/24 - No updates. Noridian is monitoring the issue and will provide updates as they are available.

09/05/24 - No updates. Noridian is monitoring the issue and will provide updates as they are available.

**Date Reported:** 08/15/24

**Date Resolved:** 11/04/24

# News

## January 2025 HCPCS Updates

CMS has released the January 2025 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 January 1, 2025. Watch the Noridian website for additional policy updates regarding these HCPCS codes.

### Added HCPCS Codes

Effective for dates of service on and after January 1, 2025

| HCPCS | DESCRIPTION |
|---|---|
| E1803 | Dynamic adjustable elbow extension only device, includes soft interface material |
| E1804 | Dynamic adjustable elbow flexion only device, includes soft interface material |
| E1807 | Dynamic adjustable wrist extension only device, includes soft interface material |
| E1808 | Dynamic adjustable wrist flexion only device, includes soft interface material |
| E1813 | Dynamic adjustable knee extension only device, includes soft interface material |
| E1814 | Dynamic adjustable knee flexion only device, includes soft interface material |
| E1822 | Dynamic adjustable ankle extension only device, includes soft interface material |
| E1823 | Dynamic adjustable ankle flexion only device, includes soft interface material |
| E1826 | Dynamic adjustable finger extension only device, includes soft interface material |
| E1827 | Dynamic adjustable finger flexion only device, includes soft interface material |
| E1828 | Dynamic adjustable toe extension only device, includes soft interface material |
| E1829 | Dynamic adjustable toe flexion only device, includes soft interface material |
| J1552 | Injection, immune globulin (alyglo), 500 mg |
| J7601 | Ensifentrine, inhalation suspension, FDA approved final product, non-compounded, administered through DME, unit dose form, 3 mg |

| HCPCS | DESCRIPTION |
|---|---|
| Q0155 | Dronabinol (syndros), 0.1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen |
| Q0521 | Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription |

**Description Update**

The long description of the HCPCS code has been updated as of January 1, 2025

| HCPCS | DESCRIPTION |
|---|---|
| E1800 | Dynamic adjustable elbow extension and flexion device, includes soft interface material |
| E1805 | Dynamic adjustable wrist extension and flexion device, includes soft interface material |
| E1810 | Dynamic adjustable knee extension and flexion device, includes soft interface material |
| E1815 | Dynamic adjustable ankle extension and flexion device, includes soft interface material |
| E1825 | Dynamic adjustable finger extension and flexion device, includes soft interface material |
| E1830 | Dynamic adjustable toe extension and flexion device, includes soft interface material |

## Medical Documentation: A Reminder for Enteral and Parenteral Nutrition

Medical records for enteral and parenteral nutrition should not resemble Local Coverage Determination criteria but should provide a detailed account of the beneficiary's condition. The records should include (but is not limited to) information on diagnosis, prognosis, treatment, functional limitations, and therapeutic interventions. Records should also detail past experiences with related equipment. Prescriptions are not considered part of the medical record, and supporting documentation must be maintained for seven years.

# News

## Negative Pressure Wound Therapy Pumps (NPWT) Exclusions from Coverage

A NPWT pump and supplies will be denied at any time as not reasonable and necessary if one or more of the following are present: The presence in the wound of necrotic tissue with eschar, if debridement is not attempted; Osteomyelitis within the vicinity of the wound that is not concurrently being treated with intent to cure; Cancer present in the wound; The presence of an open fistula to an organ or body cavity within the vicinity of the wound. This information can be found on the Noridian NPWT webpage in Local Coverage Determination (LCD) L33821.

## Non-Covered Urological Supplies

Supplies used in the management of incontinence include but are not limited to the following items. These items will be denied as non-covered because they are not prosthetic devices, nor are they required for the effective use of a prosthetic device:

- Creams, salves, lotions, barriers (liquid, spray, wipes, powder, paste) or other skin care products (A6250)
- Catheter care kits (A9270)
- Adhesive remover (A4455, A4456) (Coverage remains for use with ostomy supplies.)
- Catheter clamp or plug (A9270)
- Non-disposable underpads (A4553)
- Disposable underpads, e.g., Chux (A4554)
- Diapers, or incontinent garments, disposable or reusable (A4520)
- Drainage bag holder or stand (A9270)
- Urinary suspensory without leg bag (A9270)
- Measuring container (A9270)
- Urinary drainage tray (A9270)
- Gauze pads (A6216, A6217, A6218) and other dressings (coverage remains under other benefits, e.g., surgical dressings)
- Other incontinence products not directly related to the use of a covered urinary catheter or external urinary collection device (A9270)
- Disposable external urethral clamp or compression device, with pad and/or pouch (A4360)

# News

## Notification of the 2025 Dollar Amount in Controversy Required to Sustain Appeal Rights for an ALJ Hearing or Federal District Court Review

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2025, for an Administrative Law Judge (ALJ) Hearing is **$190**.

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2025, for a Federal District Court Review is **$1,900**.

## October 2024 HCPCS Updates

CMS has released the October 2024 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, 2024. Watch the Noridian website for additional policy updates regarding these HCPCS codes.

### Added HCPCS Codes

Effective for dates of service on and after October 1, 2024

| HCPCS | DESCRIPTION |
|---|---|
| A4543 | Supplies for transcutaneous electrical nerve stimulator, for nerves in the auricular region, per month |
| A4544 | Electrode for external lower extremity nerve stimulator for restless legs syndrome |
| A4545 | Supplies and accessories for external tibial nerve stimulator (e.g., socks, gel pads, electrodes, etc.), needed for one month |
| A7021 | Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter) |
| A9610 | Xenon xe-129 hyperpolarized gas, diagnostic, per study dose |
| E0469 | Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device |
| E0683 | Non-pneumatic, non-sequential, peristaltic wave compression pump |

| HCPCS | DESCRIPTION |
|---|---|
| E0715 | Intravaginal device intended to strengthen pelvic floor muscles during kegel exercises |
| E0716 | Supplies and accessories for intravaginal device intended to strengthen pelvic floor muscles during kegel exercises |
| E0721 | Transcutaneous electrical nerve stimulatory, stimulates nerves in the auricular region |
| E0737 | Transcutaneous tibial nerve stimulator, controlled by phone application |
| E0743 | External lower extremity nerve stimulator for restless legs syndrome, each |
| E0767 | Intrabuccal, systemic delivery of amplitude-modulated, radiofrequency electromagnetic field device, for cancer treatment, includes all accessories |
| E2513 | Accessory for speech generating device, electromyographic sensor |
| E3200 | Gait modulation system, rhythmic auditory stimulation, including restricted therapy software, all components and accessories, prescription only |
| J0138 | Injection, acetaminophen 10 mg and ibuprofen 3 mg |
| J1171 | Injection, hydromorphone, 0.1 mg |
| J1749 | Injection, iloprost, 0.1 mcg |
| J2002 | Injection, lidocaine hcl in 5% dextrose, 1 mg |
| J2003 | Injection, lidocaine hydrochloride, 1 mg |
| J2004 | Injection, lidocaine hcl with epinephrine, 1 mg |
| J2252 | Injection, midazolam in 0.8% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg |
| J2253 | Injection, midazolam (seizalam), 1 mg |
| J2601 | Injection, vasopressin (baxter), 1 unit |
| J8522 | Capecitabine, oral, 50 mg |
| J8541 | Dexamethasone (hemady), oral, 0.25 mg |

| HCPCS | DESCRIPTION |
|---|---|
| J9329 | Injection, tislelizumab-jsgr, 1mg |
| L1006 | Scoliosis orthosis, sagittal-coronal control provided by a rigid lateral frame, extends from axilla to trochanter, includes all accessory pads, straps and interface, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise |
| L1653 | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, off the shelf |
| L1821 | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated, off the shelf |
| L8720 | External lower extremity sensory prosthesis, cutaneous stimulation of mechanoreceptors proximal to the ankle, per leg |
| L8721 | Receptor sole for use with L8720, replacement, each |

**Description Update**

The long description of the HCPCS code has been updated as of October 1, 2024

| HCPCS | DESCRIPTION |
|---|---|
| A4271 | Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per 50 tests |
| E0739 | Rehabilitation system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors |
| J2251 | Injection, midazolam in 0.9% sodium chloride, intravenous, not therapeutically equivalent to J2250, 1 mg |
| J9172 | Injection, docetaxel (docivyx), 1 mg |
| L1652 | Hip orthosis, bilateral thigh cuffs with adjustable abductor spreader bar, adult size, prefabricated, includes fitting and adjustment, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise |

| HCPCS | DESCRIPTION |
|---|---|
| L1820 | Knee orthosis, elastic with condylar pads and joints, with or without patellar control, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise |
| Q0516 | Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription oral drug, per 30-days |
| Q0517 | Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription oral drug, per 60-days |
| Q0518 | Pharmacy supplying fee for HIV pre-exposure prophylaxis FDA approved prescription oral drug, per 90-days |

**Deleted HCPCS Code**

Invalid for billing for dates of service October 1, 2024 and after

| HCPCS | DESCRIPTION |
|---|---|
| J1170 | INJECTION, HYDROMORPHONE, UP TO 4 MG |
| J2001 | INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG |
| J8520 | CAPECITABINE, ORAL, 150 MG |
| J8521 | CAPECITABINE, ORAL, 500 MG |
| J9258 | INJECTION, PACLITAXEL PROTEIN-BOUND PARTICLES (TEVA), NOT THERAPEUTICALLY EQUIVALENT TO J9264, 1 MG |

## Oxygen Modifier Decision Tree Tool

Suppliers have asked about modifiers on oxygen and oxygen equipment claims. Noridian offers the Oxygen Modifier Decision Tree to assist in determining the most accurate modifiers to use.

## Providing a Pressure Reducing Support Surface for a Hospital Bed

When a hospital bed with a mattress is in a capped rental period, providing a mattress-type pressure reducing support surface (PRSS) to replace an existing mattress is allowed

if there is a change in the beneficiary's medical condition that justifies coverage of the PRSS. In this scenario, the regular mattress must be returned to the supplier and the supplier must stop billing the HCPCS code for the combination bed with mattress. For example.

- E0260 (semi-electric hospital bed, with side rails, with mattress) in an active rental period
- E0277 (powered pressure reducing air mattress) becomes medically necessary within active hospital bed rental
    - E0277 will be denied unless the hospital bed with mattress is removed and billing resumes with a HCPCS for a bed without a mattress.
        - Example: E0261 (semi-electric hospital bed, with side rails, without mattress)

See the PRSS webpage for more information.

## Required Prior Authorization (PA) Program Pre-Claim Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-claim required prior authorization reviews for the below specialties. The following quarterly edit effectiveness results from July 2024 - September 2024 can be located on the Required Prior Authorization Programs webpage:

- Lower Limb Prosthetics
- Orthoses
- Power Mobility Devices
- Pressure Reducing Support Surfaces

## Spinal Orthoses Added to Required Face-to-Face Encounter and Written Order Prior to Delivery List

Suppliers are reminded, effective for dates of service on or after August 12, 2024, six lumbar-sacral orthoses (LSO) HCPCS codes (L0635, L0636, L0638, L0639, L0640, and L0651) were added to the Required Face-to-Face Encounter and Written Order Prior to Delivery List.

For DMEPOS items appearing on the Required Face-to-Face and Written Order Prior to Delivery List, the treating practitioner must document and communicate to the DMEPOS supplier that they had a face-to-face encounter with the patient within six months before the date on the written order/prescription.

Suppliers must maintain the written order/prescription and the supporting documentation provided by the treating practitioner to support payment for the DMEPOS items and make the documentation available to CMS or its contractors upon request.

## Suppliers Seeing More Beneficiaries with New Medicare Cards Including New MBI Numbers

Recently some DME suppliers have noticed an increase in beneficiaries who previously were assigned an MBI, being sent a new Medicare card with a different MBI. There could be various reasons for this; some of which are explained below.

- Data breach: Data breaches may occur at the Medicare Administrative Contractor, including when using third-party software, even though these contractors are to follow strict security guidelines. Depending on the circumstances of the breach, new Medicare numbers may be assigned to replace compromised numbers due to the data breach. In early September, 2024 CMS notified beneficiaries of such a breach at a MAC and that new Medicare cards would be issued in two weeks.
- Fraudulent Claims: In early 2023, there was a fraud scheme where 15 suppliers were billing catheters for patients where CMS determined that people with Medicare did not receive catheters from these suppliers, physicians did not order these supplies, and the supplies were not needed. CMS replaced hundreds of thousands of Medicare Beneficiary Identifiers (MBIs) that were used to file the suspicious claims. CMS changed the MBIs of the most at-risk people with Medicare and completed changing all impacted MBIs in March 2024.
- Medicare Card Was Stolen or Lost and MBI was Compromised: If a beneficiary feels that someone is using or has obtained their MBI number or card, they may request that a new MBI be issued.

### Importance of Verification for DME Suppliers

In light of the above, it is essential for DME suppliers to verify beneficiaries' Medicare cards and MBI numbers. Accurate and up-to-date information is critical to prevent interruptions in the reimbursement process for claims. Here are key actions suppliers should take:

1. Verify Beneficiary Information: Regularly check and update beneficiary MBI numbers in your systems. Ask to see the beneficiary’s card or for them to verify the MBI or ask them if their Medicare insurance has changed on a regular basis to prompt them to report changes to their MBI. These steps are vital to ensure that your records reflect the latest information.

- Utilize the NMP MBI Lookup Tool: If a claim denial occurs with Reason Code 16 and Remark Codes MA27 and N382, use the NMP MBI Lookup Tool to confirm the beneficiary's MBI.
- Reason Code 16: Claim/service lacks information or contains submission/billing errors.
- Remark Code MA27: Missing, incomplete, or invalid entitlement number or name
- Remark Code N382: Missing, incomplete, or invalid patient identifier.

2. Follow Denial Code Resolution Guidelines: In the event of receiving a denial, consult the Denial Code Resolution tool for instructions on how to resolve these.

## System Availability Notices

The Noridian Medicare Portal (NMP) Team is proud to announce an enhancement to the Availability section of NMP. We are now able to offer a "Partial Availability" option, which will be displayed when some inquiries may not be available. This status will be indicated by a yellow banner to inform users of potential limited access and will include which inquiries may be unavailable. The following section outlines the different notifications users can expect to see regarding the status of NMP, helping ensure transparency and clarity in service availability.

| Status | Banner Color | Explanation |
|---|---|---|
| System Normal | Green | All Functions Available |
| Partial Availability | Yellow | Some inquiries may not be available or delayed |
| Functions Unavailable | Red | All inquiries are unavailable |

This enhancement ensures users are kept informed about the system's status, allowing them to manage expectations and plan accordingly. With these updates, the NMP Team aims to provide a more efficient and reliable experience, helping users navigate any potential disruptions smoothly.

## Therapeutic Shoes for Persons with Diabetes DME on Demands

Suppliers of Therapeutic Shoes for Persons with Diabetes (TSPD) are encouraged to view the self-paced tutorials available under the Education and Outreach tab:

- Certifying, Prescribing, and Supplier Roles

- Coverage Criteria
- Documentation Requirements

## Transitioning to Medicare Coverage for Durable Medical Equipment: What Beneficiaries Need to Know

As beneficiaries transition into Medicare Fee-for-Service (FFS) coverage, they may encounter various scenarios affecting their Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) that were previously covered by another payer. It's essential to understand that Medicare does not automatically extend coverage for items obtained prior to eligibility. This article outlines key scenarios beneficiaries should consider regarding their DMEPOS needs.

### Renting an Item Previously Paid by Another Payer

When a beneficiary is renting a DMEPOS item under their previous insurance, it may be eligible for payment as a new initial rental under Medicare FFS, provided specific conditions are met.

A. **Requirements for Current Rental Item to Be Eligible as a New Initial Rental**
To qualify for Medicare coverage, the following must be satisfied:
   - **Coverage and Documentation**: The beneficiary must meet all Medicare's coverage, coding, and documentation requirements effective on the date of service (DOS) for the initial Medicare claim. It's important to refer to the applicable Local Coverage Determination (LCD) and Policy Article for the item.
   - **Proof of Delivery (POD)**: A POD is mandatory for all items, even those in the beneficiary's possession that were provided by another insurer prior to Medicare eligibility. The POD must include:
     - A statement signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item (date of DME item examination = date of service), meets the POD requirements; and
     - A supplier attestation confirming the item meets Medicare's standards, including reasonable useful lifetime (RUL) requirements.
   - **Start Date for RUL and Continuous Use**: The first day of the initial rental month for which Medicare FFS payments are made serves as the start date for the RUL and the period of continuous use.

B. **Choosing to Obtain a New Rental Item**
If a beneficiary opts to get a new rental item under Medicare FFS, they must fulfill the following:
    - **Documentation Requirements**: The beneficiary must meet all relevant Medicare coverage, coding, and documentation requirements on the DOS for the initial Medicare claim. This includes referencing the appropriate LCD and Policy Article.
    - **Supplier Responsibilities**: The supplier must submit the initial rental claim, ensuring that all billing and documentation requirements are satisfied.

**Previous Payer Purchased Items Requiring Supplies or Accessories**

For items previously purchased by another payer, suppliers must ensure that the beneficiary-owned equipment information is properly documented with Medicare FFS to avoid claim denials. The required information includes:

- **Beneficiary-Owned Item HCPCS Code**: This should include the approximate month and year of purchase. For example: "Bene-owned E0601 pur Jan 2023 (approximate)."

**Previous Payer Purchased Items Requiring Repairs**

Repairs to items owned by beneficiaries are covered under Medicare when they are necessary to make the items serviceable. Suppliers should consult the Standard Documentation Requirements Policy Article A55426 to ensure compliance.

## Understanding Assignment and Non-Assignment of Benefits in Medicare

An assignment agreement is a formal arrangement between a Medicare beneficiary and a supplier of services. Under this agreement, the beneficiary allows the supplier to request direct payment from Medicare for covered services. The supplier, in turn, agrees to accept the Medicare-approved payment amount as full compensation for the services rendered.

**Types of Suppliers: Participating vs. Non-Participating**

1. **Participating Suppliers:**
    - These suppliers agree to accept assignment for all services provided to Medicare beneficiaries. This means they accept Medicare-allowed amounts as full payment, collecting only the Medicare deductible and coinsurance from the beneficiary.

- Participating suppliers are bound by a contract signed with the National Provider Enrollment (NPE) West and must submit claims for all services rendered to Medicare beneficiaries.
- Required to use the Medicare Participating Physician or Supplier Agreement (Form CMS-460) to enroll or change their participation status, typically during the annual open enrollment period.

2. **Non-Participating Suppliers:**
   - Suppliers who choose not to sign the participation agreement are categorized as non-participating. They have the flexibility to accept assignment on a claim-by-claim basis, except in situations where assignment is mandatory.
   - When billing non-assigned, the Medicare payment goes directly to the beneficiary, who is then responsible for paying the supplier in full.

### Participation Status and its Implications

Participation status is linked to an entity's tax identification number and cannot vary by location. All locations under a single tax ID must adhere to the same participation status.

- **Open Enrollment**: Each November, open enrollment forms, including the CMS-460, are sent to active suppliers. Non-participating suppliers wishing to transition to participating status must submit their forms before December 31. Conversely, if a participating supplier wants to become non-participating, they can request to become non-participating by sending the request to the NPE on their company letterhead. The request must be postmarked before December 31 of that year to become non-participating effective January 1 of the next year.

### Claim Assignment and Payment Process

When a participating supplier accepts assignment, they are legally obligated to accept the Medicare-approved amount as full payment for the service. For instance, if a service is billed at $25 but the approved charge is $20, the supplier cannot collect the difference of $5. Instead, they must absorb this reduction.

- **Example:**
  - Submitted Fee: $25.00
  - Approved Charge: $20.00
  - Medicare Payment (80%): $16.00
  - Coinsurance (20%): $4.00

Suppliers violating assignment agreements may face serious penalties, including fines or imprisonment.

### Mandatory Assignment for Certain Services

Certain services, especially those involving covered drugs under Medicare, are subject to mandatory assignment. In these cases, suppliers cannot charge beneficiaries any amount beyond the Medicare deductible and coinsurance.

### Non-Assignment of Benefits

Non-assignment means a supplier chooses not to accept assignment for Medicare payment. Consequently, the beneficiary becomes responsible for the full payment.

### Important Distinctions

It is crucial to understand that the assignment of benefits does not authorize a supplier to submit claims. Beneficiary Authorization requirements for claim submission are separate from assignment agreements. In mandatory assignment cases, beneficiaries are not required to sign an assignment agreement.

## Understanding Billing Not Otherwise Classified (NOC) HCPCS Codes

Healthcare Common Procedure Coding System (HCPCS) correct coding is crucial for suppliers providing Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items to beneficiaries. One area that often leads to confusion is the use of Not Otherwise Classified (NOC) codes. Properly coding NOC items not only ensures compliance with Centers for Medicare & Medicaid Services (CMS) guidelines but also helps prevent claim denials.

### Importance of Correct Coding

Suppliers must adhere to specific coding guidelines established by CMS, including Local Coverage Determinations (LCDs), Policy Articles (PAs), and DME Medicare Administrative Contractor (MAC) articles. Claims submitted using NOC codes will be denied if a valid HCPCS code exists for the billed item. Therefore, accurate coding is not just a best practice; it's a requirement.

### NOC Code Requirements

When billing with NOC codes, it is essential to provide detailed narratives in the appropriate claim segments:

1. **NTE 2400 (line note)** or **NTE 2300 (claim note)** for electronic claims.
2. **Item 19** of the CMS-1500 claim form for paper claims.

Narratives must clearly articulate:

- **Description of the item or service**
- **Manufacturer name**
- **Product name, model name, and model number**
- **Supplier Price List (PL) amount**
- **HCPCS code of related item** (if applicable)
- If applicable, the **HCPCS code for the item being repaired**.

### Example Narrative

A properly formatted narrative might read:

**"Titanium Hooks, 3010865, Manufacturer name, for (HCPCS Code XXX), Supplier Price List (PL) amount $XXX.XX**

Given that the NTE 2400 field is limited to 80 characters, suppliers are encouraged to use Common Abbreviations to Use as Narratives to convey all necessary information concisely.

### Handling Denials

Claims lacking the required narrative information will be denied for being incomplete or invalid. These claims must be corrected and resubmitted, as the denial notice will indicate that there are no appeal rights available because the claim is unprocessable.

If a claim is denied for other reasons, suppliers can request a redetermination by providing supporting documentation, which includes:

- Medical records demonstrating medical necessity
- Detailed descriptions of custom-fabricated items, highlighting unique features and including a breakdown of costs (materials and labor).

### Additional Resources

For specific NOC coding information, refer to Individual Local Coverage Determinations (LCDs) or Policy Articles (PAs). Suppliers seeking guidance on correct coding practices can contact the Pricing, Data Analysis, and Coding (PDAC) contractor for further assistance.

# News

## Understanding CGM Supply Allowances: A Guide for Suppliers

Billing supply allowances can often be confusing, particularly when it comes to billing codes for continuous glucose monitors (CGMs). Unlike standard refill requirements, these codes allow for specific items to be provided within designated time frames and understanding the distinction is crucial for accurate billing and compliance.

### What Are CGM Supply Allowances?

CGM supply allowances are designed to cover a set of essential items associated with the use of CGMs, billed once every 30 days. Once a supply code is billed, suppliers are obligated to deliver all included items at no additional cost for the following 30 days. It's important to note that any items **not covered under the supply code** can be billed separately, allowing for additional support as needed.

### Supply Codes: A4238 and A4239

The two primary supply codes for CGMs—A4238 and A4239—each have distinct billing criteria:

1. **A4239 - Non-Adjunctive CGM Supply Allowance**
    - This code covers all supplies and accessories for **non-adjunctive, non-implanted CGMs**.
    - **Included Items:**
        - CGM sensors
        - CGM transmitters
        - Home blood glucose monitor (BGM) and related supplies, including:
            - Test strips
            - Lancets
            - Lancing devices
            - Calibration solutions and batteries
    - **Billing**: One unit of service (UOS) can be billed every 30 days. If any of the included supplies are billed separately, those claims will be denied.
2. **4238 - Adjunctive CGM Supply Allowance**
    - This code applies to **adjunctive, non-implanted CGMs** and includes essential supplies for the device's operation.
    - **Included Items:**
        - CGM sensors

        - CGM transmitters
    - Billing: Similar to the A4239, one unit of service can be billed every 30 days. However, this code does not cover home BGM or related supplies, which can be billed separately.

**Billing Guidelines**

Both A4238 and A4239 can be billed for a maximum of three units of service per 90 days. To help suppliers manage their billing schedules and ensure compliance with regulations, the Continuous Glucose Monitor Supply Allowance Calculator is available. This tool assists in determining accurate billing dates and prevents errors that could lead to denied claims. Please refer to the Glucose Monitors Local Coverage Determination (LCD) for more information.

## Update for Billing Custom Fitted Orthotics When no Custom Fitting is Completed With no Off the Shelf Equivalent Available

Due to recent inquiries from suppliers, it has come to our attention that some miscellaneous codes used for billing off-the-shelf orthotics, when a custom fit orthotic is provided but no custom fitting is performed, may require specific policy and laterality modifiers. These claims must also include a narrative with the information outlined below.

If you have received denials for these claims, please correct and resubmit them or pursue redeterminations through the appeals process. We encourage you to use the Noridian Medicare Portal for Redeterminations/Appeals submissions.

For detailed billing instructions, refer to the Noridian Medicare Website under "**Correct Billing for Custom Fitted Orthotics when no Custom Fitting is Completed with no Off the Shelf Equivalent**." The guidelines are as follows:

- **Miscellaneous Codes:** When no corresponding prefabricated off-the-shelf HCPCS code is available, use one of the following codes:
    - **L1499** - Spinal orthosis, not otherwise specified
        - Apply any policy-specific modifiers as required
    - **L2999** - Lower extremity orthosis, not otherwise specified
        - Apply any policy-specific modifiers as required
        - Use RT or LT modifiers as appropriate

        - For bilateral items on the same date of service, list each item on a separate claim line with the RT and LT modifiers and 1 unit of service (UOS) on each line (e.g., L2999 RTKX)
    - **L3999** - Upper limb orthosis, not otherwise specified
        - Apply RT or LT modifiers as appropriate
        - For bilateral items on the same date of service, list each item on a separate claim line with the RT and LT modifiers and 1 unit of service (UOS) on each line (e.g., L3999 RT)
- **Narrative Requirement**: Include a narrative on the claim with the following information:
    - HCPCS code of the item being provided
    - Indication of "OTS" (off-the-shelf)
    - Supplier's Retail Price (SRP)

  Example: **L1820 OTS $150 SRP**

# Medical Policies and Coverage

## 2024 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2024 HCPCS Code Update - October Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2024 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

## Code Verification Review Requirement for Lower Limb Orthoses (L1832, L1833, and L1851) and Lumbar Sacral Orthoses (L0648 and L0650) - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Code Verification Review Requirement for Lower Limb Orthoses (L1832, L1833, and L1851) and Lumbar Sacral Orthoses (L0648 and L0650) - Revised**, has been created and published to our website.

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- Locate/select article title

## Contractor Advisory Committee (CAC) Meeting Information - Oxygen and Oxygen Equipment (L33797)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Contractor Advisory Committee (CAC) Meeting Information - Oxygen and Oxygen Equipment (L33797)**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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# Medical Policies and Coverage

## Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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- Locate/select article title

## Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2024 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 October 17, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for October 17, 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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

## Pneumatic Compression Devices - Correct Coding and Billing

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

View the locally hosted 2024 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 Revision Summary for September 12, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revision Summary for September 12, 2024**, has been created and published to our website.

View the locally hosted 2024 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 Revision Summary for September 26, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revision Summary for September 26, 2024**, has been created and published to our website.

View the locally hosted 2024 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

# Medical Policies and Coverage

## Policy Article Revision Summary for November 7, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revision Summary for November 7, 2024**, has been created and published to our website.

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- Locate/select article title

## Prior Authorization and Code Verification Review Requirement for Lower Limb Orthoses (L1843, L1845, L1951) and Spinal Orthoses (L0631, L0637, L0639)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Prior Authorization and Code Verification Review Requirement for Lower Limb Orthoses (L1843, L1845, L1951) and Spinal Orthoses (L0631, L0637, L0639)**, has been created and published to our website.

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- Locate/select article title

## Retirement of Pneumatic Compression Devices Local Coverage Determination (LCD) and Related Policy Article - Effective November 14, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revision Summary for September 26, 2024**, has been created and published to our website.

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- Locate/select article title

## Supplier Exit from Oxygen Equipment Business - Revised

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- Locate/select article title

## Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from July 2024 - September 2024 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthosis
- Enteral Nutrition
- Glucose Monitors
- Hospital Beds
- Knee Orthosis
- Manual Wheelchairs
- Ostomy Supplies
- Oxygen
- Pneumatic Compression Devices (PCD)
- Positive Airway Pressure (PAP) Devices
- Parenteral Nutrition
- Therapeutic Shoes

- Surgical Dressings
- Urological Supplies

## Topical Oxygen Therapy Contractor Advisory Committee (CAC) Agenda - December 11, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Topical Oxygen Therapy Contractor Advisory Committee (CAC) Agenda - December 11, 2024**, has been created and published to our website.

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- Locate/select article title

# MLN Connects

## MLN Connects - September 5, 2024

MLN Connects Newsletter: Sept 5, 2024

### News

- Osteogenesis Stimulators: Prior Authorization Requirements Suspended
- Hospice Benefit: Expanding Prepayment Review in 4 States
- Skilled Nursing Facility Advance Beneficiary Notice: Revised Form & Instructions
- Hospital Price Transparency: Use a CMS Template Layout
- Healthy Aging: Recommend Medicare-Covered Services
- National Recovery Month: Take the First Step

### Compliance

- Global Surgery: Bill Correctly

### Claims, Pricers, & Codes

- Alzheimer's Monoclonal Antibody Treatment: New Code for Kisunla Drug
- Claim Status Category & Claim Status Codes
- DMEPOS: Provider Level Adjustment Codes on Remittance Advice

### MLN Matters® Articles

- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2025 Changes
- New Waived Tests

### Publications

- Items & Services Not Covered Under Medicare – Revised

# MLN Connects

## MLN Connects - September 12, 2024

MLN Connects Newsletter: Sept 12, 2024

### News

- COVID-19: Updated Vaccines for 2024-2025 Season
- Rural Emergency Hospital Provisions, Conversion Process, & Conditions of Participation: Revised Guidance
- CMS Roundup (September 6, 2024)
- Organizational Providers: Do You Need to Revalidate Your Enrollment Record Soon?
- Prostate Cancer: Talk to Your Patients about Screening
- Advance Health Equity During National Sickle Cell Awareness Month

### Claims, Pricers, & Codes

- National Correct Coding Initiative: October Update
- Integrated Outpatient Code Editor Version 25.3

### MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - October 2024
- Changes to the Laboratory National Coverage Determination Edit Software: January 2025 Update
- Hospital Outpatient Prospective Payment System: October 2024 Update

## MLN Connects - September 19, 2024

MLN Connects Newsletter: Sept 19, 2024

### News

- Resources & Flexibilities to Assist with the Public Health Emergency in Louisiana
- Skilled Nursing Facilities: Report Your Expanded Ownership, Management, & Related Party Data
- Hospice Outcomes and Patient Evaluation Assessment Tool: Version 1.00 Resources
- Hospital Price Transparency: Get Tools to Comply

- Risk Less. Do More. Get This Season's Vaccines
- Help Reduce Health Disparities for Hispanic or Latino Patients

**Compliance**

- Tracheostomy Supplies: Prevent Claim Denials

**Claims, Pricers, & Codes**

- ACO REACH Model: Adjusting Claims
- Influenza Vaccine: Holding Claims for CPT Code 90658
- ICD-10 Medicare Severity Diagnosis-Related Group Version 42

## MLN Connects - September 26, 2024

MLN Connects Newsletter: Sept 26, 2024

**News**

- CMS Roundup (September 20, 2024)
- Cardiovascular Disease: Talk with Your Patients about Screening

**Claims, Pricers, & Codes**

- Cardiology CPT Code 75580: Issue with Claims Returned to Provider

**Events**

- Optimizing Healthcare Delivery to Improve Patient Lives Conference - December 12

**MLN Matters® Articles**

- DMEPOS Fee Schedule: October 2024 Quarterly Update
- Hospice Claims Edits for Certifying Physicians - Revised
- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2025 Changes - Revised

**Publications**

- Expanded Prepayment Review of Existing Hospices in Arizona, California, Nevada, & Texas

## MLN Connects

### Multimedia

- Medicare Ground Ambulance Data Collection System: Reporting Labor Information Video

### From Our Federal Partners

- Prevention Strategies for U.S. Travelers Visiting Countries with Clade I Mpox Outbreaks
- Health Care Preparedness Resources

## MLN Connects - October 3, 2024

MLN Connects Newsletter: Oct 3, 2024

### News

- HHS Releases Final Guidance for Second Cycle of Historic Medicare Drug Price Negotiation Program
- Resources & Flexibilities to Assist with the Public Health Emergency in Florida, Georgia, North Carolina, Tennessee, & South Carolina
- CMS to Provide Hurricane Helene Public Health Emergency Accelerated Payments to Medicare Fee-for-Service Providers and Suppliers
- Changes to the Fiscal Year 2025 Hospital Inpatient Prospective Payment System (IPPS) Rates Due to Court Decision (CMS-1808-IFC)
- CMS Covers PrEP to Prevent HIV
- Clinical Laboratory Fee Schedule: Submit Comments & Reconsideration Requests by October 25
- DMEPOS: Adding New Product Categories to CMS-855S Enrollment Form on October 26
- Improve Your Search Results for CMS Content
- Help Detect Breast Cancer Early

### Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: October Update
- PrEP for HIV Billing: CMS Requires Diagnosis Codes
- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: October Update

## MLN Connects

### Events

- Hospital Price Transparency: Encoding January 2025 Requirements in the Machine-Readable File Webinar - October 21

### Publications

- Substance Use Screenings & Treatment

## MLN Connects - October 10, 2024

MLN Connects Newsletter: Oct 10, 2024

### News

- Resources & Flexibilities to Assist with the Public Health Emergency in Florida
- CMS Roundup (October 4, 2024)
- Clinical Laboratory Fee Schedule: Reporting Delayed Until 2026
- Respiratory Viruses: Vaccinate against Flu, COVID-19, & RSV

### Compliance

- Allergy & Immunology Services: Prevent Claim Denials

### Claims, Pricers, & Codes

- Outpatient Skin Substitute Claims: New Codes & Updates Effective October 1
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

### Multimedia

- Hospice Quality Reporting Program: HOPE Tool Web-Based Training

### From Our Federal Partners

- First Marburg Virus Disease Outbreak in the Republic of Rwanda
- Enroll in EFT to Get Paid for CHAMPVA Claims

### Information for Patients

- 2025 Medicare & You Handbook

# MLN Connects

## MLN Connects - October 17, 2024

MLN Connects Newsletter: Oct 17, 2024

### News

- Inpatient Psychiatric Facilities: Guidance on All-Inclusive Cost Reporting
- No-Pay Medicare Summary Notice Mailing Frequency Changed to Every 120 Days
- Health Literacy: Help Your Patients Get Information & Services

### Compliance

- Opioid Treatment Program: Bill Correctly for Opioid Use Disorder Treatment Services

### Claims, Pricers, & Codes

- National Uniform Billing Committee: New Codes Effective July 1
- PrEP for HIV Billing: CMS Requires Diagnosis Codes

### Events

- HCPCS Public Meeting - November 6-8

### MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - October 2024 - Revised

### Publications

- Medicare Preventive Services - Revised

## MLN Connects - October 24, 2024

MLN Connects Newsletter: Oct 24, 2024

### News

- CMS Roundup (October 18, 2024)
- Rural Health Clinic & Federally Qualified Health Center: Final CY 2024 Payment Policies

### Claims, Pricers, & Codes

- Home Health Consolidated Billing: New Physician Specialty Code F6 Excluded

# MLN Connects

### MLN Matters® Articles

- Allowing Home Health Telehealth Services During an Inpatient Stay
- Correction for Inpatient Medicare Part B Ancillary 12X Claims & Manual Updates
- Separate Payment for Essential Medicines - New Biweekly Interim Payments for the Inpatient Prospective Payment System
- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2025 Changes - Revised

### From Our Federal Partners

- Biosimilars: Updated Curriculum Toolkit
- Disruptions in Availability of Peritoneal Dialysis & Intravenous Solutions from Baxter International Facility in North Carolina

## MLN Connects - October 31, 2024

MLN Connects Newsletter: Oct 31, 2024

### News

- Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality Health Care

### Compliance

- Major Hip & Knee Replacement or Reattachment of Lower Extremity: Prevent Claim Denials
- Comprehensive Error Rate Testing Medical Record Requests: Respond Timely

### Claims, Pricers, & Codes

- PrEP for HIV Billing: CMS Requires Diagnosis Codes

### Publications

- Prohibition on Billing Qualified Medicare Beneficiaries - Revised
- Provider Information on Medicare Diabetes Self-Management Training - Revised

## MLN Connects - November 7, 2024

# MLN Connects

MLN Connects Newsletter: Nov 7, 2024

**Final Rules**

- Physician Fee Schedule CY 2025 Final Rule
- Hospital Outpatient Prospective Payment System & Ambulatory Surgical Center Payment System CY 2025 Final Rule
- ESRD Prospective Payment System CY 2025 Final Rule
- Home Health Prospective Payment System CY 2025 Final Rule

**News**

- CMS Roundup (November 1, 2024)
- Respiratory Viruses: Get Up to Date on Flu, COVID-19, & RSV Vaccines
- Diabetes: Recommend Preventive Services

**Compliance**

- Medical Services Authorized by the Veterans Health Administration: Avoid Duplicate Payments

**Claims, Pricers, & Codes**

- Expanded Diabetes Screening: Claims for HCPCS Code 82947 Returned in Error
- Home Intravenous Immune Globulin Items & Services: CY 2025 Rate Update
- Discarded Drugs & Biologicals: Updated HCPCS Codes

**Events**

- Greenhouse Gas Reduction Fund Opportunities for the Health Sector Webinar - November 20

**Publications**

- Medicare Provider Compliance Tips - Revised

**Information for Patients**

- Medicare Prescription Payment Plan

# MLN Connects

## MLN Connects - November 14, 2024

MLN Connects Newsletter: Nov 14, 2024

### News

- 2025 Medicare Parts A & B Premiums and Deductibles
- Medicare Participation for CY 2025
- Ambulance Fee Schedule: CY 2025 Final Policies
- Prior Authorization Review Timeframe Change
- Skilled Nursing Facilities: Revalidation Due Date Extension
- Home Health & Hospice Resources
- Help Your American Indian & Alaska Native Patients Achieve Optimal Health

### Claims, Pricers, & Codes

- PrEP for HIV Pharmacy Claims: New HCPCS Code & FAQ Update

### MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2025 Update
- New Waived Tests

### Publications

- Checking Medicare Claim Status - Revised
- Checking Medicare Eligibility - Revised

## MLN Connects - November 21, 2024

MLN Connects Newsletter: Nov 21, 2024

### News

- Medicare-Funded Physician Residency Positions
- CMS Roundup (November 15, 2024)
- Hepatitis B Vaccine: Billing Requirement Update Effective January 1
- Hospitals: Use Renewed Beneficiary Notices Starting January 1
- National Rural Health Day: Address Unique Health Care Needs

## MLN Connects

- Lung Cancer: Help Your Patients Reduce Their Risk

**Compliance**

- Mechanical Ventilation: Bill Correctly for Inpatient Claims
- Enteral Nutrition: Prevent Claim Denials

**Events**

- Environmental Justice Thriving Communities Grantmakers Program - December 4
- Optimizing Healthcare Delivery to Improve Patient Lives Conference - December 12

**MLN Matters® Articles**

- Home Health Prospective Payment System: CY 2025 Rate Update

**Publications**

- Medicare Preventive Services - Revised

**From Our Federal Partners**

- First Case of Clade I Mpox Diagnosed in the U.S.

## MLN Connects - November 27, 2024

MLN Connects Newsletter: Nov 27, 2024

**News**

- Opioid Treatment Programs: CY 2025 Updates
- HIV Screening & Prevention

**Claims, Pricers, & Codes**

- Home Health Prospective Payment System Grouper: January Update
- Clotting Factor: CY 2025 Furnishing Fee

**Events**

- Hospice Quality Reporting Program Webinar - December 12

# MLN Connects

## MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update

## Changing the Frequency of No-Pay MSN Mailings from Every 90 Days to Every 120 Days - Revised

**Note:** CMS added the VMS maintainer as a responsible party to business requirement 13627.7 and provider education to this CR. All other information remains the same

CR 13627 changes the frequency of Medicare Summary Notice (MSN) mailings from every 90 days to every 120 days, in order to conserve funding. This instruction also deletes chapter 21, section 10.1 General Requirements for the MSN in publication 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13627.

## CSC and CSCC Update

CR 13206 updates, as needed, the Claim Status (CSC) and Claim Status Category Codes (CSCC) 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)13206.

# MLN Matters

## Disable Beneficiary Eligibility Information from MAC IVR Systems

CR 13754 directs Medicare Administrative Contractors (MACs) to disable beneficiary eligibility information from their Interactive Voice Response (IVR) systems by March 31, 2025.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13754.

## DMEPOS Fee Schedule: October 2024 Quarterly Update

CR 13774 tells you about:

- New and deleted HCPCS codes
- New fee schedule amounts
- Fee schedule amount revisions for A4271

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13774.

# MLN Matters

## Enhancements to Home Health Consolidated Billing Edits

CR 13550 ensures Original Medicare systems edits enforcing home health consolidated billing are accurate and consistent with existing payment policies.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13550.

## Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update - Revised

**Note:** CMS revised this Article to update the transmittal number, CR link, and CR release date. There are no substantive changes to the Article.

CR 13796 tells you about:

- Medicare Part A and Part B deductibles
- Part A and Part B coinsurance rates
- Part A and Part B premiums

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13796.

## October 2024 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

CR 13679 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)13679.

## RARC, CARC, MREP and PC Print Update

CR 13633 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs 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)13633.

# 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 |

## Contacts, Resources, and Reminders

| Organization | Phone Number | Types of Inquiries |
|---|---|---|
| RRB - Railroad Retirement Board | 1-800-808-0772 | For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare |
| Coordination of Benefits - Benefits Coordination & Recovery Center (BCRC) | 1-855-798-2627 | Reporting changes in primary insurance information |

Another great resource for beneficiaries is the website, Medicare.gov, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for Medicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

## Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

# 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

# Contacts, Resources, and Reminders

## 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.

# Contacts, Resources, and Reminders

## 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 12
- 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.