DME Happenings

Jurisdiction D
June 2024

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Healthcare Solutions
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Answer Consolidated Billing Questions

Suppliers are urged to confirm beneficiary eligibility status on either the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR). This verification helps identify when the beneficiary is in a Part A Skilled Nursing Facility (SNF) inpatient stay, in a SNF after the Part A stay has ended, undergoing a home health episode plan of care, or covered under hospice care. By assessing eligibility, suppliers can make well-informed decisions on whether to proceed with providing items or services, considering some items that may fall under consolidated billing requirements.

To streamline this process, suppliers are advised to utilize the Consolidated Billing Tool available on the Noridian Medicare website. This tool assists in determining whether a Healthcare Common Procedure Coding System (HCPCS) code is subject to consolidated billing requirements. For further details and additional references, please consult the Consolidated Billing page on our website, where the new Consolidated Billing Chart can be found.

April 2024 HCPCS Updates - Revised

CMS has released the April 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 April 1, 2024. Please watch the Noridian website for additional policy updates regarding HCPCS codes.

Added HCPCS Codes

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

HCPCS	DESCRIPTION
A4271	Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per month
A4593	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime
A4594	Neuromodulation stimulator system, adjunct to rehabilitation therapy regime, mouthpiece each
E0152	Walker, battery powered, wheeled, folding, adjustable or fixed height
E0468	Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions

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HCPCS	DESCRIPTION
E0736	Transcutaneous tibial nerve stimulator
E0738	Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories
E0739	Rehab system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors
E2104	Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge
E2298	Complex rehabilitative power wheelchair accessory, power seat elevation system, any type
J0177	Injection, aflibercept hd, 1 mg
J0209	Injection, sodium thiosulfate (hope), 100 mg
J0589	Injection, daxibotulinumtoxina-lanm, 1 unit
J0650	Injection, levothyroxine sodium, not otherwise specified, 10 mcg
J0651	Injection, levothyroxine sodium (fresenius kabi) not therapeutically equivalent to j0650, 10 mcg
J0652	Injection, levothyroxine sodium (hikma) not therapeutically equivalent to j0650, 10 mcg
J1203	Injection, cipaglucosidase alfa-atga, 5 mg
J1323	Injection, elranatamab-bcmm, 1 mg
J1434	Injection, fosaprepitant (focinvez), 1 mg
J2277	Injection, motixafortide, 0.25 mg
J2782	Injection, avacincaptad pegol, 0.1 mg
J2801	Injection, risperidone (rykindo), 0.5 mg
J3055	Injection, talquetamab-tgvs, 0.25 mg
J3424	Injection, hydroxocobalamin, intravenous, 25 mg
J7165	Injection, prothrombin complex concentrate, human-lans, per i.u. of factor ix activity
J9376	Injection, pozelimab-bbfg, 1 mg

HCPCS	DESCRIPTION
K1037	Docking station for use with oral device/appliance used to reduce upper airway collapsibility
L1320	Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated
L5783	Addition to lower extremity, user adjustable, mechanical, residual limb volume management system
L5841	Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control
Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg
Q5134	Injection, natalizumab-sztn (tyruko), biosimilar, 1 mg

Deleted HCPCS Code

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

HCPCS	DESCRIPTION
E2300	WHEELCHAIR ACCESSORY, POWER SEAT ELEVATION SYSTEM, ANY TYPE
J0576	INJECTION, BUPRENORPHINE EXTENDED-RELEASE (BRIXADI), 1 MG
J1020	INJECTION, METHYLPREDNISOLONE ACETATE, 20 MG
J1030	INJECTION, METHYLPREDNISOLONE ACETATE, 40 MG
J1040	INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG
J1246	INJECTION, DINUTUXIMAB, 0.1 MG
J1840	INJECTION, KANAMYCIN SULFATE, UP TO 500 MG
J1850	INJECTION, KANAMYCIN SULFATE, UP TO 75 MG
J2920	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 40 MG
J2930	INJECTION, METHYLPREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG
J9070	CYCLOPHOSPHAMIDE, 100 MG
J9250	METHOTREXATE SODIUM, 5 MG

News

Description Update

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

HCPCS	DESCRIPTION
E2001	Suction pump, home model, portable or stationary, electric, any type, for use with external urine and/or fecal management system
J0208	Injection, sodium thiosulfate (pedmark), 100 mg
J0612	Injection, calcium gluconate, not otherwise specified, 10 mg
J0613	Injection, calcium gluconate (wg critical care), not therapeutically equivalent to j0612, 10 mg
J3380	Injection, vedolizumab, intravenous, 1 mg
J3425	Injection, hydroxocobalamin, intramuscular, 10 mcg
J7516	Injection, cyclosporine, 250 mg
J9029	Intravesical instillation, nadofaragene firadenovec-vncg, per therapeutic dose
J9260	Injection, methotrexate sodium, 50 mg
J9071	Injection, cyclophosphamide (auromedics), 5 mg
J9072	Injection, cyclophosphamide (dr. reddy's), 5 mg

Billing Ankle-Foot/Knee-Ankle-Foot Orthoses for Travelers or Snowbirds

When a claim is filed with Medicare for a DMEPOS item, including Ankle-Foot/Knee-Ankle-Foot orthoses, the beneficiary's permanent address on file with the Social Security Administration (SSA) determines which Medicare jurisdiction should be billed. This is regardless of the jurisdiction where the brace is actually provided. More information is available on the Traveling/Snowbird Beneficiary webpage.

News

Change Healthcare Security Incident - Resolved 04/24/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable.

Claim Coding Impact: Not applicable.

Description of Issue: Noridian is aware of the recent cyber security incident at Change Healthcare. Our priority is to ensure the security of our data. There is no indication of any impact on our data. In the meantime, we appreciate your patience and understanding.

Noridian Action Required: We are closely monitoring the situation and assessing any potential impact.

Provider/Supplier Action Required: If your Electronic Data Interchange (EDI) clearinghouse is impacted by the Change Healthcare cyber security incident, we recommend you check with them for further instructions.

Proposed Resolution/Solution:

Update 04/24/24: Optum, the parent company for Change Healthcare, has worked with Noridian to transition providers enrolled in Change Healthcare connections to the Optum iEDI Clearinghouse. The transition has been completed for claim submission as well as electronic remittance advices. Noridian will maintain dual enrollment for claim submission to ensure an easy transition as the Change Healthcare platforms come online. Partners and providers do not need to take any action. For additional information, visit: Optum Solution Status

Update 04/05/24: If providers are unable to submit medical records timely for requested Medical Review Additional Documentation Requests (ADRs) related to the recent Change Healthcare Security Incident, please reach out to the clinical reviewer contact listed in your notification letter to discuss and possibly extend your documentation submission timeline. Please have a listing of the ordered ADRs identifier number ready. The Case Manager will require verbal or written attestation that your request is related to the Change Healthcare cyber security incident.

For assistance with updating electronic transactions, please visit the CEDI website to make changes to your CEDI enrollment or contact the CEDI Help Desk at 1-866-311-9184 or via e-mail at ngs.cedihelpdesk@anthem.com. CEDI offers a list of approved software vendors, billing services and clearinghouses alternatives for claims submission and Electronic Remittance Advice (ERA) retrieval. The CEDI Claims Portal is available for manual entry of claims and ERA retrieval.

If you do determine there are no other options for you to submit electronic claims, you may submit a waiver request on company letterhead that includes your billing PTAN

and that you are requesting a waiver related to the Change Healthcare security incident. Providers may submit their request via fax at 701-277-7882 or email dmeasca@noridian.com. Please be aware the payment floor for paper claims is 29 days (versus 14 days for electronic claims).

Request for Change Healthcare/Optum Payment Disruption Accelerated and Advance Payment

Providers should use the request for Change Healthcare/Optum payment disruption (CHOPD) Accelerated Payment to Part A Providers and Advance Payments to part B Suppliers [DOCX] template to submit a request. The template must be initialed for all certification of facts and signed by the provider's authorized official that is legally able to make financial commitments and assume financial obligations on behalf of the provider/supplier.

Please submit the completed CHOPD Accelerated/Advance Payment request to: dmemsprecoupment@noridian.com or Fax: 701-277-7892

For additional information such as eligibility requirements, required acknowledgement of terms, and payment amount, please refer to CMS Fact Sheet Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated Payments to Part A Providers and Advance Payments to Part B Suppliers [PDF]

Change Healthcare/Optum Payment Disruption (CHOPD) Accelerated and Advance Payments for Part A Providers and Part B Suppliers Frequently Asked Questions

Date Reported: 02/28/24

Date Resolved: 04/24/24

Clarification on Ostomy Supply HCPCS A4436 and A4437

For the benefit of the supplier community, Noridian wishes to clarify that supply allowance codes A4436 (irrigation supply; sleeve, reusable, per month) and A4437 (irrigation supply; sleeve, disposable, per month) are for a **month's irrigation sleeve supply allowance**. One unit of service would be billed regardless of how many sleeves are required. If the beneficiary requires more than the monthly limit of four sleeves, the supplier must deliver the additional sleeves to the beneficiary. Below is an excerpt from the CMS Medicare Learning Network (MLN) MM12521 - Calendar Year 2022 Update for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule that discusses a one-month supply, not one sleeve a month.

"The irrigation supply sleeve code A4397 is divided into separate reusable and disposable irrigation sleeve codes. The fee schedule amount for one month of the

sleeves is equivalent to the A4397 fee schedule amount multiplied by the monthly use limit of four. Therefore, the current monthly fee schedule amounts will continue to apply to codes A4436 and A4437 effective January 1, 2022. Medicare pays in advance for the month's supply of irrigation sleeves and suppliers must ensure that the patient has enough sleeves to last for the entire month. If the patient needs more replacement sleeves before the end of the month, the supplier must deliver the additional sleeves to the patient."

Common Denial for Hospital Beds and Accessories

A common denial suppliers receive for hospital beds and accessories is for billing hospital beds at the same time as a mattress-type pressure-reducing support surface (PRSS). The DME MACs remind suppliers that billing a hospital bed with mattress in conjunction with a mattress-type support surface (i.e., **not** a support surface mattress overlay) is considered to be a claim for duplicate items (same or similar). Suppliers must not bill HCPCS codes for two types of mattresses concurrently.

Please refer to the joint DME-MAC DMD articles titled Billing Instructions: Hospital Beds and Pressure-Reducing Support Surfaces. This article contains special billing instructions for beneficiary-owned hospital beds, capped rental beds, and new initial rental hospital beds, including scenarios and HCPCS codes with descriptors detailing the Group 1 and Group 2 mattress-type PRSS and the hospital beds that include mattresses.

Competitive Bid Gap Period

Effective for date of service (DOS) on or after January 1, 2024, a temporary gap period is in place for the Competitive Bidding Program (CBP). The competitive bid modifiers KV, J4, and J5 are no longer valid. Treating practitioners and previously non-contract suppliers under competitive bid requirements, now have the flexibility for HCPCS codes L0648, L0650, L1833, and L1851. They can choose to follow the standard prior authorization process with its typical review timeframe, request an expedited review, or use the ST modifier to indicate an acute/emergent need.

It is crucial to note that this procedural change specifically impacts non-contract competitive bid suppliers who are practitioners/physicians, physical therapists, and occupational therapists. For more detailed information, please refer to the Timeline and Updates section of the Prior Authorization and Pre-Claim Review Initiatives webpage on the CMS website.

News

Comprehensive Error Rate Testing: Reporting Year 2024 Progress Report Letters

The Noridian Comprehensive Error Rate Testing (CERT) team will not be issuing our annual Reporting Year (RY) 2024 Progress Report Letters. A Progress Report Letter is a summary of the claims selected by CERT for review, claims in error, and weighted error dollars, if any. We will resume sending Progress Report Letters for RY 2025. If you have any questions or concerns, please email jddmecert@noridian.com.

J1575 (HyQvia) Added for Treatment of Chronic Inflammatory Demyelinating Polyneuritis

Effective January 12, 2024, J1575 (HyQvia) is now included in the Group 6 codes in the External Infusion Pumps (EIP) policy for the treatment of Chronic Inflammatory Demyelinating Polyneuritis (CIDP) (ICD-10 code G61.81). Previously, coverage for J1575 was only included for treatment of Primary Immune Deficiency Disorder (PIDD) under the Group 3 diagnosis codes found in the policy. Criterion can be found in the EIP Policy Article (A52507).

Paper Claim Submission Errors

Considering the recent cyber security incident at Change Healthcare and an increasing number of suppliers reverting to paper claims submission, Noridian has experienced an increase in paper claims. We have observed that certain crucial fields on paper claims, particularly Box 11 and Box 33, are either missing or inaccurately completed.

Instructions for Box 11:

- Insured's Policy Group or FECA Number: If there is no primary insurance preceding Medicare, input "**NONE**" in Box 11 and proceed to item 12.
- If primary insurance exists before Medicare for the service date(s), provide the insured's policy or group number in Box 11 and proceed to items 11a-11c. Additionally, complete Items 4, 6, and 7.
- If Box 11 is left blank, the claim will be denied, unprocessable, requiring correction and claim resubmission with accurate primary insurer information.
- This field is mandatory and must be completed. By filling this field, the physician/supplier acknowledges having exerted due diligence in determining whether Medicare serves as the primary or secondary payer.

Instructions for Box 33:

- Provider/Supplier Telephone Number, Billing Name, Address, and ZIP Code: input the provider of service/supplier's billing name, address, ZIP Code, and telephone number. This is a required field and it's imperative that these details are accurate to aid in contact, if required.

We kindly request your cooperation in adhering to these guidelines to ensure seamless claims processing.

Paper Claim Submission Tip

With an observed increase in paper claim submissions, Noridian would like to provide a tip for attaching documents to claims for processing. An update has been made to Item 19, the narrative field on the 1500 claim form, which states:

> **Note paper claim submission:** Enter "see attached" if attaching documents and on attachments make a note to "refer to Item 19." This will help ensure all documentation matches up at the time of claim processing.

Paper Remittance Advices and Additional Documentation Requests (ADR)

Due to temporary print and mail service disruptions, suppliers are encouraged to utilize the Noridian Medicare Portal to access remittance advices and additional documentation request (ADR) letters.

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

Positive Airway Pressure (PAP) and Respiratory Assist Device (RAD) Orders

The DME MACs recently published a clinician letter regarding masks for PAP and RAD devices. This letter gives direction regarding the Standard Written Order (SWO) requirements for PAP and RAD masks. Effective February 1, 2024, the SWO may now include a general description of the mask, such as:

- CPAP Mask
- Mask of choice
- Mask - Fit to comfort
- Mask - One per three months

This flexibility also extends to related cushions, pillows, and headgear. While the SWO must list all separately payable accessories provided, the description may be general such as those examples listed above. With this flexibility, checklists with each type of accessory (i.e. pillows, cushions, headgear) may be used. For more information, refer to the joint DME MAC publication Masks: Positive Airway Pressue Devices and Respiratory Assist Devices.

Preventive Services Codes on Eligibility Inquiry

Due to the recent CMS HIPAA Eligibility Transaction System (HETS) Quarter 1 release, Noridian implemented a section on the Eligibility inquiry screen that allows users to choose up to three Preventive Services HCPCS codes that can be checked to see when the patient is next eligible for that service. When this was implemented on the evening of April 5th, this section was required in order to perform an Eligibility inquiry, which was incorrect. The requirement of the HCPCS code selection was removed on the evening of April 8th, but the Preventive Services codes section is still available for users that wish to use this feature. Noridian will be looking into other user-friendly options to accommodate the use of the Preventive Services codes look up while still maintaining CMS regulations.

Noridian apologizes for any inconvenience and confusion this may have caused our users.

Prior Authorization for Replacement of Power Mobility Devices - Effective June 2, 2024

A Prior Authorization Request (PAR) is required for all replacement power mobility devices (PMDs) on the Required Prior Authorization List. PMDs replaced within the five-year reasonable useful lifetime (RUL) due to lost, stolen, or irreparably damaged items should be submitted as an expedited review. Expedited reviews must be indicated either on the coversheet, or on the Noridian Medicare Portal (NMP) and are completed by the DME MAC within two business days. When an expedited review is requested, documentation must support the reason for the expedited review. **Reminder:** Append

the RA modifier to replacement PMD claims. Claims will be denied if the RA modifier is billed but a PAR for replacement was not received and affirmed.

Provider Level Adjustment Codes on Remittance Advice

Suppliers informed the DME MACs they needed a way to identify which of their locations, sharing the same Tax ID (TIN), caused their payments to be withheld. As a result, an update to the Healthcare Integrated General Ledger Accounting System (HIGLAS) is complete. Beginning April 1, 2024, you will see a change in your remittance advice. This update adds the PTAN of the location that caused the withholding to occur. HIGLAS recovers overpayments from any of the associated PTANs sharing the same TIN. Your funds may have been withheld by HIGLAS because you share the same TIN with other location(s) that were offset. The PTAN that caused the withholding will now appear on the remittance advice.

Surgical Dressings Example Scenarios

The Policy Article (A54563) was recently updated with example scenarios to assist the supplier community in determining when to use the A1-A9 modifiers.

Modifiers A1-A9 have been established to indicate that a particular HCPCS code is being used as a primary or secondary dressing on a qualifying surgical or debrided wound. Modifiers A1-A9 are used to indicate the number of qualifying wounds on which a specific dressing HCPCS code is being used.

The modifier number must correspond to the number of qualifying wounds on which the dressing HCPCS code is being used, not the total number of wounds treated.

Modifiers A1-A9 are not used with codes A6531 and A6532.

Example Scenarios:

- September 1 Dressing Shipment: Beneficiary has two wounds that require two different categories of dressings, A61XX (max allowance of 30 per month) and A62XX (max allowance of 12 per month)
    - Supplier should bill:
        - A61XX A1 UOS = 30
        - A62XX A1 UOS = 12
- September 15 Dressing Shipment: Beneficiary has a new wound that requires one of the same categories of dressings as another wound (A61XX - max allowance of 30 per month)

    - Supplier should supply and bill 15 units (to last for the next 2 weeks) and should append the A2 modifier because this dressing category is now used on 2 wounds. NOTE: The modifier number corresponds to the number of wounds on which the dressing is being used, not the total number of wounds treated.
        - A61XX A2 UOS = 15
- October 1 Dressing Shipment: Beneficiary still has three wounds: two require A61XX (max allowance of 60 per month) and one requires A62XX (max allowance of 12 per month)
    - Supplier should bill:
        - A61XX A2 UOS = 60
        - A62XX A1 UOS = 12

The Noridian Surgical Supplies webpage has additional information about surgical supplies, including Local Coverage Determination (LCD) L33803 and Policy Article (A54563).

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from January 2024 - March 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
- Spinal Orthosis

- Surgical Dressings
- Therapeutic Shoes
- Urological Supplies

Tips for Billing Positive Airway Pressure (PAP)/Respiratory Assist Device (RAD) Accessories

The Standard Written Order (SWO) for the device and/or accessories may be completed by someone other than the treating practitioner. The SWO may then be sent to the treating practitioner to review and sign prior to claim submission.

Accessories for use with medically necessary beneficiary-owned equipment may be billed with the KX modifier if the criteria outlined in the Local Coverage Determination (LCD) have been met.

A narrative must be included for supplies used with beneficiary-owned equipment. The narrative must include:

- HCPCS of base equipment
- Indication that equipment is beneficiary-owned
- Approximate month and year of purchase

Narrative example for accessories with beneficiary-owned equipment:

- Bene-owned E0601 pur Jan 2023 (approximate)

Multiple accessories that provide the same function will not be payable on the same date of service (DOS) or within the usual maximum timeframe specified in the LCD. Examples include but are not limited to:

- HCPCS A7037 (tubing) and A4604 (heated tubing)
- Multiple masks (A7027, A7030, and A7034)

Same or similar equipment on file may be verified through the Noridian Medicare Portal.

- For more information on Noridian Medicare Portal registration: Registration Guide
- Existing users may use the Portal Guide for more information: Inquiry Guide

News

Top Medical Necessity Denial Reasons for Pneumatic Compression Devices

Through the Targeted Probe and Educate (TPE) program, Noridian has identified the top medical necessity denial reasons for pneumatic compression devices (PCD):

- Medical record documentation does not include a four-week trial of conservative therapy demonstrating a failed response to treatment.
- The medical record does not include documentation by the treating practitioner of the medical necessity of a pneumatic compression device, including the patient's diagnosis and prognosis; symptoms and objective findings, including measurements that establish the severity of the condition; the reason the device is required, including the treatments that have been tried and failed; and the clinical response to an initial treatment with the device.
- The medical record does not include the clinical response to an initial treatment with the device.

Suppliers billing Medicare should be familiar with the documentation requirements and utilization parameters. Visit the Pneumatic Compression Devices (PCD) webpage to access coverage documents such as Local Coverage Determination (LCD), Policy Article, National Coverage Determination (NCD), documentation letters, forms, checklists, reviews, tips, tools, resources, related articles; and educational events and tutorials, if applicable.

Urological Supplies and Continuing Medical Need

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered. Beneficiary medical records demonstrating that the item is reasonable and necessary are prepared just before, or simultaneously with, the initial prescription.

Once the initial medical need has been established, unless continued coverage requirements are specified in the Local Coverage Determination (LCD), an ongoing need for urological supplies to drain or collect urine is assumed for an individual with permanent urinary incontinence or retention. There is no requirement for further documentation of continued medical need if the beneficiary continues to meet the prosthetic device benefit.

The Noridian Urological Supplies webpage has additional information about urological supplies, including the LCD L33803 and Policy Article A52521.

Medical Policies and Coverage

2024 HCPCS Code Update - April Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2024 HCPCS Code Update - April 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 (L1843, L1951) and Osteogenesis Stimulator (E0747, E0748, E0760)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Code Verification Review Requirement for Lower Limb Orthoses (L1843, L1951) and Osteogenesis Stimulator (E0747, E0748, E0760)**, has been created and published to our website.

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Code Verification Review Requirement for Multi-Functional Ventilators

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Code Verification Review Requirement for Multi-Functional Ventilators**, has been created and published to our website.

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Medical Policies and Coverage

Correct Billing and Coding of Ventilators

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

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Correct Coding of ActaStim-S Spine Fusion Stimulator

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding of ActaStim-S Spine Fusion Stimulator**, has been created and published to our website.

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LCD Revisions Summary for April 4, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD Revisions Summary for April 4, 2024**, has been created and published to our website.

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Medical Policies and Coverage

LCD Revisions Summary for May 2, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD Revisions Summary for May 2, 2024**, has been created and published to our website.

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Policy Article Revisions Summary for March 7, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for March 7, 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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Policy Article Revisions Summary for March 14, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for March 14, 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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Medical Policies and Coverage

Policy Article Revisions Summary for March 21, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for March 21, 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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Policy Article Revisions Summary for May 9, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for May 9, 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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Policy Article Revisions Summary for May 16, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for May 16, 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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Medical Policies and Coverage

PureWick Urine Collection System - Coding and Billing Instructions - Revised

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

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MLN Connects

MLN Connects - March 7, 2024

MLN Connects Newsletter: Mar 7, 2024

News

- HHS Statement Regarding the Cyberattack on Change Healthcare
- Final Guidance to Help People with Medicare Prescription Drug Coverage Manage Prescription Drug Costs
- Current Status of Blood Tests for Organ Transplant Rejection
- Opioid Use Disorder: Medicare Pays for Certain Treatment Services
- Skilled Nursing Facility Value-Based Purchasing Program: March Confidential Feedback Reports
- Marriage and Family Therapists & Mental Health Counselors: Manual Updates
- Nutrition-Related Health Conditions: Recommend Medicare Preventive Services

Compliance

- Comprehensive Outpatient Rehabilitation Facility Services: Prevent Claim Denials

Claims, Pricers, & Codes

- National Correct Coding Initiative: April Update
- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: April Update

Publications

- Proper Use of Modifiers 59, XE, XP, XS, & XU - Revised

MLN Connects - March 14, 2024

MLN Connects Newsletter: Mar 14, 2024

News

- CMS Roundup (Mar 8, 2024)
- Marriage and Family Therapists & Mental Health Counselors: Updated Enrollment FAQs
- Skilled Nursing Facilities: Billing Medicare for Respiratory Vaccines
- Colorectal Cancer: Screening Saves Lives

MLN Connects

Claims, Pricers, & Codes

- Web Pricer: Send Us Your Feedback by April 15
- ICD-10 Medicare Severity Diagnosis-Related Group Version 41.1 - Updated

MLN Matters® Articles

- New Waived Tests
- Stay of Enrollment

Publications

- Federally Qualified Health Center - Revised
- Information for Rural Health Clinics - Revised
- Medicare & Mental Health Coverage - Revised

MLN Connects - March 21, 2024

MLN Connects Newsletter: Mar 21, 2024

News

- New Initiative to Increase Investments in Person-Centered Primary Care
- Marriage and Family Therapists & Mental Health Counselors: Get Information about Billing Medicare
- Electronic Funds Transfer: Revised CMS-588 Required on May 1
- Health-Related Social Needs FAQs
- Promote Kidney Health During National Kidney Month

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination Edit Software: July 2024 Update
- Medicare Claims Processing Manual Updates - HCPCS Billing Codes & Advance Beneficiary Notice of Non-coverage Requirements

MLN Connects

MLN Connects - March 28, 2024

MLN Connects Newsletter: Mar 28, 2024

Proposed Payment Rule

- FY 2025 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule

News

- CMS Roundup (Mar 22, 2024)
- Hospital Price Transparency: Tools to Help Hospitals Comply by July 1

Claims, Pricers, & Codes

- Integrated Outpatient Code Editor Version 25.1

MLN Matters® Articles

- DMEPOS Fee Schedule: April 2024 Quarterly Update
- Electronic Medical Documentation Requests via the Electronic Submission of Medical Documentation System - Revised

MLN Connects - April 4, 2024

MLN Connects Newsletter: Apr 4, 2024

Proposed Payment Rules

- FY 2025 Skilled Nursing Facility Prospective Payment System Proposed Rule
- FY 2025 Inpatient Psychiatric Facilities Prospective Payment System & Quality Reporting Updates Proposed Rule
- FY 2025 Hospice Payment Rate Update Proposed Rule

News

- ESRD Claims: Manual Update to Revise Section Title & Correct Condition Codes

Compliance

- Surgical Dressings: Prevent Claim Denials

MLN Connects

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: April Update
- DMEPOS: Provider Level Adjustment Codes on Remittance Advice

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: April 2024 Update

From Our Federal Partners

- Providers Accepting CHAMPVA: Enroll in Direct Deposit Now
- Increase in Invasive Serogroup Y Meningococcal Disease in the U.S.
- Health Care Preparedness Resources

MLN Connects - April 11, 2024

MLN Connects Newsletter: Apr 11, 2024

Proposed Payment Rule

- CMS Proposes New Policies to Support Underserved Communities, Ease Drug Shortages, and Promote Patient Safety

News

- CMS Roundup (Apr. 5, 2024)
- Medicare Shared Savings Program: Application Toolkit Materials
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Help Improve the Health of Minority Populations

Compliance

- Advance Care Planning: Bill Correctly for Services

Claims, Pricers, & Codes

- COVID-19 Monoclonal Antibody: New Codes for PEMGARDA
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

MLN Connects

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - April 2024

Publications

- Medical Record Maintenance & Access Requirements - Revised

From Our Federal Partners

- Extended & Large-Scale Emergency Resources
- Highly Pathogenic Avian Influenza Virus: Identification of Human Infection and Recommendations for Investigations and Response

MLN Connects - April 18, 2024

MLN Connects Newsletter: Apr 18, 2024

News

- PrEP for HIV: Prepare for Potential Medicare Part B Coverage

Events

- Clinical Laboratory Fee Schedule Upcoming Meetings: Register to Present, Speak, or Attend in Person by June 1

Publications

- Medicare Preventive Services - Revised
- Original Medicare vs. Medicare Advantage - Revised

MLN Connects - April 25, 2024

MLN Connects Newsletter: Apr 25, 2024

Editor's Note:

CMS updated a message because we delayed the effective date that physicians who certify hospice services must enroll in or opt-out of Medicare until June 3, 2024. You may have to refresh the webpage to see the updated content.

MLN Connects

News

- Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule
- CMS Roundup (Apr 19, 2024)
- Hospice Requirement for Certifying Physicians to Enroll in or Opt-Out of Medicare: Delayed until June 3
- Comprehensive Error Rate Testing Program: Reduced Sample Size Starting with Reporting Year 2025
- Skilled Nursing Facility Value-Based Purchasing Program: FY 2026 Early Look Performance Score Report

Compliance

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

Claims, Pricers, & Codes

- Hospital Outpatient Prospective Payment System: Correcting Errors to Codes 0621T, J7353, & C9167

MLN Matters® Articles

- Medicare Claims Processing Manual Update: Inpatient Rehabilitation Facility
- National Coverage Determination 20.7: Percutaneous Transluminal Angioplasty
- DMEPOS Fee Schedule: April 2024 Quarterly Update - Revised

From Our Federal Partners

- Adverse Effects Linked to Counterfeit or Mishandled Botulinum Toxin Injections

MLN Connects - May 2, 2024

MLN Connects Newsletter: May 2, 2024

News

- CMS Statement on Proposed Local Coverage Determination for Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers
- Quality in Motion: Acting on the CMS National Quality Strategy

- ESRD: Oral-Only Renal Dialysis Service Drugs & Biological Products

Claims, Pricers, & Codes

- Clinical Laboratory Improvement Amendments: Adjusting Claims

Events

- CMS National Provider Enrollment Conference in San Diego - August 28 & 29

Publications

- Skilled Nursing Facility Place of Service Codes: Updated Resources

MLN Connects - May 9, 2024

MLN Connects Newsletter: May 9, 2024

News

- HHS Releases New Data Showing Over 10 million People with Medicare Received a Free Vaccine Because of the President's Inflation Reduction Act; Releases Draft Guidance for the Second Cycle of Medicare Drug Price Negotiation Program
- CMS Roundup (May 3, 2024)
- Medicare Shared Savings Program: Prepare to Apply & Register for June 5 Webinar
- Clinical Laboratory Fee Schedule Preliminary Gapfill Rates: Submit Comments by July 1
- Home Health Quality Reporting Program: Draft OASIS-E1 Instruments & Manual
- Mental Health: It's Important at Every Stage of Life

Claims, Pricers, & Codes

- Skilled Nursing Facility Prospective Payment System: Patient Driven Payment Model FY 2024 ICD-10 Code Mappings

Events

- HCPCS Public Meeting - May 28-30

Publications

- Part B Drug Payment Limits Overview

- Resource of Health Equity-related Data Definitions, Standards, and Stratification Practices

From Our Federal Partners

- Providers Accepting CHAMPVA: Enroll in Direct Deposit Now

MLN Connects - May 16, 2024

MLN Connects Newsletter: May 16, 2024

News

- Administration Acts to Improve Access to Kidney Transplants
- DMEPOS: Updated List of Items Potentially Subject to Conditions of Payment
- Lymphedema Compression Treatment Items: New DMEPOS Benefit Category
- Hospice: New Requirement for Physicians Who Certify Patient Eligibility Effective June 3
- Medicare Physician Fee Schedule Database: July Update
- Women's Health: Talk with Your Patients About Prevention, Care, & Wellbeing

Compliance

- Diabetic Shoes: Prevent Claim Denials

Claims, Pricers, & Codes

- Home Health Claims: Additional Enforcement of Required County Codes

Events

- Overcoming COVID-19 Vaccine Payment Challenges Webinar - May 30

MLN Matters® Articles

- Annual Wellness Visit: Social Determinants of Health Risk Assessment
- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update
- Diabetes Screening & Definitions Update: CY 2024 Physician Fee Schedule Final Rule
- ESRD Prospective Payment System: Quarterly Update

- Updates for Split or Shared Evaluation and Management Visits

Multimedia

- Skilled Nursing Facility Quality Reporting Program: Social Determinants of Health Video
- Skilled Nursing Facility Quality Reporting Program: Annual Payment Update Webinar Materials

Information for Patients

- Mental Health & Substance Use Disorders: Updated Medicare.gov Content

MLN Connects - May 23, 2024

MLN Connects Newsletter: May 23, 2024

News

- Medicare Shared Savings Program: Apply by June 17 for January 1 Start Date
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Institutional Providers: Medicare Enrollment & Certification Roadmap
- Improve Your Search Results for CMS Content

Compliance

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

Claims, Pricers, & Codes

- Pass-Through Device: Correct Returned Claims

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2024 Update
- National Coverage Determination 110.23: Allogeneic Hematopoietic Stem Cell Transplantation
- Hospice Claims Edits for Certifying Physicians – Revised

MLN Connects

From Our Federal Partners

- Meningococcal Disease Cases Linked to Travel to the Kingdom of Saudi Arabia: Ensure Travelers are Current on Meningococcal Vaccination

MLN Connects - May 30, 2024

MLN Connects Newsletter: May 30, 2024

News

- Hospice Interdisciplinary Team: Addition of Marriage and Family Therapists & Mental Health Counselors
- Revised Part B Inflation Rebate Guidance: Using the 340B Modifier - Reminder

MLN Matters® Articles

- HCPCS Codes & Clinical Laboratory Improvement Amendments Edits: October 2024
- Medicare Claims Processing Manual Update: Gap-Filling DMEPOS Fees

Publications

- SBIRT Services - Revised

MLN Matters

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

Related CR Release Date: December 21, 2023

Effective Date: April 1, 2024

Implementation Date: April 1, 2024

Related Change Request (CR) Number: CR 13492

Related CR Transmittal Number: R12422CP

CR 13492 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)13492.

DMEPOS Fee Schedule: April 2024 Quarterly Update - Revised

Related CR Release Date: April 15, 2024

Effective Date: January 1, 2024 or April 1, 2024, as noted in Article

Implementation Date: April 1, 2024

MLN Matters Number: MM13574 Revised

Related Change Request (CR) Number: CR 13574

Related CR Transmittal Number: R12584CP

Note: CMS revised the Article to show the addition of 4 HCPCS Level II codes to CWF category 58 (page 4). CMS also revised the effective date and the web address of CR 13574.

CR 13574 tells you about:

- Updates to CY 2024 fee schedule amounts for new and existing DMEPOS codes
- Changes in payment policy

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13574.

MLN Matters

eMDR via the Electronic Submission of Medical Documentation System - Revised

Related CR Release Date: April 16, 2019

Effective Date: February 3, 2020, per CR 11141

Implementation Date: July 1, 2019

MLN Matters Number: MM11003 Revised

Related Change Request (CR) Number: CR 11003

Related CR Transmittal Number: R2281OTN

Note: CMS added information about the implementation of a new feature to accept review outcome letters during October 2023 release. Substantive content changes are in dark red on pages 2, 3, and 9.

CR 11003 tells you about:

- The enrollment process to get Additional Documentation Request (ADR) letters as electronic Medical Documentation Requests (eMDR) through your registered Health Information Handler (HIH)
- Who's exempt from participating in eMDR

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11003.

Medicare Claims Processing Manual Update: Gap-Filling DMEPOS Fees

Related CR Release Date: May 16, 2024

Effective Date: June 17, 2024

Implementation Date: June 17, 2024

MLN Matters Number: MM13617

Related Change Request (CR) Number: CR 13617

Related CR Transmittal Number: R12645CP

CR 13617 tells you about:

- Revised Section 60.3, Medicare Claims Processing Manual, Chapter 23
- Updated factors for gap-filling purposes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13617.

MLN Matters

RARC, CARC, MREP and PC Print Update

Related CR Release Date: November 22, 2023

Effective Date: April 1, 2024

Implementation Date: April 1, 2024

Related Change Request (CR) Number: CR 13433

Related CR Transmittal Number: R12377CP

CR 13433 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the Viable Information Processing Systems (ViPS) Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy (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)13433.

Update to Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 DMEPOS Benefit Category Determinations and Add Section 145 Lymphedema Compression Treatment Items

Related CR Release Date: March 7, 2024

Effective Date: October 1, 2023

Implementation Date: May 6, 2024

Related Change Request (CR) Number: CR 13526

Related CR Transmittal Number: R12532BP

CR 13526 updates Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Benefit Category Determinations and add Section 145 Lymphedema Compression Treatment Items.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13526.

Updates to Pub. 100-04 Claims Processing Manual, Chapter 20, Section 181.1 Payment for Lymphedema Compression Treatment Items

Related CR Release Date: March 28, 2024

Effective Date: January 1, 2024

Implementation Date: April 29, 2024

Related Change Request (CR) Number: CR 13528

Related CR Transmittal Number: R12557CP

CR 13528 adds Pub. 100-04 Claims Processing Manual, Chapter 20, Section 181.1 Payment for Lymphedema Compression Treatment Items.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13528.

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.