DME Happenings

Jurisdiction D
September 2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Addendum Reference

For inquiries regarding addendums, Noridian has received numerous requests and has included a reference on the documentation page of the Noridian Medicare website. Please consult this resource for any questions you may have.

An addendum provides additional information that was not available at the time the services were rendered or at the time of the original entry. It is crucial that an addendum does not alter or delete any existing information in the medical record. In cases where entries related to provided services are insufficiently documented, the documentation may necessitate an amendment, correction, or delayed entry after the service has been provided. Any such amendment, correction, or delayed entry should clearly indicate the date and author, and these changes/addenda should be clearly and permanently marked.

For further details, please refer to the CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.5

Advance Determination of Medicare Coverage Resources

Advance Determination of Medicare Coverage (ADMC) is a voluntary program that allows suppliers to request prior approval of "eligible" items before item delivery. The Noridian Advance Determination of Medicare Coverage (ADMC) webpage defines ADMC, reviews eligible HCPCS, outlines the ADMC request process, and answers general questions.

Avoiding a Top Denial - Patient in Skilled Nursing Facility

One of the top denial reasons suppliers are receiving is when a patient is in a skilled nursing facility (SNF). To help avoid this denial, suppliers are encouraged to check a beneficiary's eligibility either through the Noridian Medicare Portal (NMP) or the Interactive Voice Response (IVR) to verify the **discharge status** code.

On the NMP, under the eligibility tab is Hospital/SNF. The discharge status code will determine if the beneficiary is eligible to receive DMEPOS items as some items may be covered under the Consolidated Billing requirements. Suppliers will need to "click here for discharge status" under the discharge status column for the code to display. It is critical for suppliers to ensure that the **discharge status** code indicates that the beneficiary has been discharged to home in order to be eligible for coverage.

Suppliers are encouraged to utilize the Consolidated Billing Tool on the Noridian Medicare website to assist them in determining whether a Healthcare Common Procedure Coding System (HCPCS) code is considered under consolidated billing.

Is the beneficiary in a Part A covered stay or in a SNF after the Part A stay has ended, or have they been discharged to home?

Inpatient SNF Hospital Summary

Each table will display a summary of the "Earliest and Latest Billing Dates" with the following information:

- Location
- Billing NPI
- Admit Date
- End Date
- **Discharge Status Code and Description**

Note: If the patient discharge status code does not reference that the beneficiary has been discharged to home, suppliers may need to work directly with the facility to ensure the discharge did occur and that the medical record is updated accordingly.

Claims for Oral Anti-Cancer Drug Capecitabine

Effective October 1, 2024, Capecitabine with dates of service October 1, 2024, through January 6, 2025, shall be billed with HCPCS code J8999 (prescription drug, oral, chemotherapeutic, NOS). Suppliers shall utilize HCPCS J8999 and include drug name "Capecitabine" in the claim narrative until the January 2025 release and implementation of the new cross-walked HCPCS code J8522. Suppliers are currently billing for Capecitabine oral anti-cancer drugs to the Durable Medical Equipment Medicare Administrative Contactors (DME MACs) using the associated NDC. HCPCS Codes J8520 and J8521 will be removed from the policy. There are no changes to the policy requirements for Capecitabine.

Claims for Oral Anti-Cancer Drug Methotrexate (revised)

Effective July 1, 2024, claims for Methotrexate (Jylamvo and Xatmep) with dates of service July 1, 2024, through September 30, 2024, shall be billed with HCPCS code J8999 (prescription drug, oral, chemotherapeutic, NOS) including adding a claim narrative to the line. Suppliers shall utilize J8999 until the October 2024 release and implementation

of National Drug Code (NDC) cross walked HCPCS codes. Suppliers are currently billing for Methotrexate oral anti-cancer drugs to the Durable Medical Equipment Medicare Administrative Contactors (DME MACs) using the associated NDC. There are no changes to the policy requirements for these drugs.

Continuous Glucose Monitors (CGMs) Supply Allowance

When a CGM (code E2102 or E2103) is covered, the related supply allowance (code A4238 or A4239) is also covered. CGM Supply Allowance HCPCS codes A4238 and A4239 Include:

A4238 (supply allowance for adjunctive, non-implanted CGM) includes all items necessary for the use of the device.

- Do not bill these items separately: CGM sensors and transmitters.
- Code A4238 does not include a home blood glucose monitor and related BGM testing supplies and these items may be billed separately.

A4239 (supply allowance for non-adjunctive, non-implanted CGM) includes all items necessary for the use of the device.

- Do not be bill these items separately: CGM sensors, CGM transmitters, home blood glucose monitors (BGMs), related BGM supplies (test strips, lancets, lancing devices, and calibration solutions), batteries, or any other items needed to use the device.

Additional information on the CGM supply fee codes can be found in the Glucose Local Coverage Determination (LCD) L33822 and Glucose Monitor policy article A52464.

Continuous Glucose Monitors for Insulin Treated Beneficiaries

Noridian wants clarification on the requirements for insulin-treated beneficiaries to be eligible for Continuous Glucose Monitors (CGM). According to coverage criterion 4A found in the Glucose Monitors LCD L33822, a beneficiary must receive insulin treatment to be eligible for CGM. It is a common misperception among providers and suppliers that medications such as Mounjaro, Ozempic, and Metformin (not all-inclusive list) are insulin and can be used to qualify patients for (CGM). These medications are not a form of insulin, and the beneficiary receiving them would not be considered insulin treated based on these medications.

Note: Non-insulin beneficiaries could still qualify for a CGM under coverage criteria 4B.

Additional information on CGM coverage criteria can be found in the Glucose Monitors Local Coverage Determination (LCD) L33822 and related Policy Article

Determining Factors for Ostomy Supplies

The quantity of ostomy supplies needed by a beneficiary is determined primarily by the type of ostomy, its location, its construction, and the condition of the skin surface surrounding the stoma. There will be variation according to individual beneficiary need and their needs may vary over time. There is a table within the Local Coverage Determination (LCD) L33828 that lists the maximum number of items/units of service that are usually reasonable and necessary. The actual quantity needed for a particular beneficiary may be more or less than the amount listed depending on the factors that affect the frequency of barrier and pouch change.

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

For more information, view the Ostomy Supplies LCD.

Electronic Funds Transfer (EFT) Form Requests from the NPE

If you are currently **not** receiving Medicare payments via electronic funds transfer (EFT) and you received a letter from one of the National Provider Enrollment (NPE) contractors requesting submission of a CMS-588 EFT form, please make certain you follow all instructions within the letter and submit to the NPE within the timeframe provided to avoid deactivation of billing privileges. If you have any questions about the letter, please reach out to the proper NPE contractor. The DME MACs are not able to answer questions about this matter.

Send CMS-588 Electronic Funds Transfer (EFT) Authorization Agreements to the applicable National Provider Enrollment (NPE) contractor for the supplier's physical location.

NPE Contact Information:

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

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

NPE West Contractor (NPWEST): Palmetto GBA

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

Enteral and Parenteral Modifiers - Proper Use

Suppliers are reminded that enteral nutrition and parenteral nutrition claims (nutrition, pump, and supplies) submitted without a KX, GA, GY, or GZ modifier will be rejected as missing information for dates of service on or after July 2, 2023.

The proper use of modifiers indicates whether the beneficiary meets reasonable and necessary requirements in a Local Coverage Determination (LCD). The KX modifier indicates the applicable payment criteria are met, and provides additional information related to the coverage and/or liability. The GA, GY, and GZ modifiers indicate policy criteria are not met. The use of one of these modifiers is mandatory. Claim lines billed without a KX, GA, GY, or GZ modifier will be rejected as missing information. The KX modifier must not be appended on the same line as the GA, GY, or GZ modifier.

KX - The requirements specified in the medical policy have been met

The KX modifier must be appended to enteral and parenteral nutrition, pump, and supply claims when all reasonable and necessary and statutory requirements are met. Suppliers are not required to secure all the required documentation prior to claim submission, however, appending the KX modifier to each of the nutrition codes billed serves as an attestation by the supplier that the requirements for its use have been met.

GA - Waiver of liability (item/service expected to be denied as not reasonable and necessary, Advance Beneficiary Notice of Noncoverage (ABN) on file)

The GA modifier indicates that the supplier has a waiver of liability statement on file. When claim denials are expected because the reasonable and necessary criteria are not met, an ABN must be issued to the beneficiary before an item is dispensed. When the beneficiary signs a valid ABN, they accept financial responsibility. The supplier may then submit a claim to Medicare with the GA modifier appended to each corresponding HCPCS code. If the issued ABN is not valid, the GA modifier must not be appended. Claims submitted with the GA modifier will receive a beneficiary liable medical necessity denial.

GZ - Item or service not reasonable and necessary (expected to be denied as not reasonable and necessary, no ABN on file)

When an item does not meet the reasonable and necessary criteria and a denial is expected, the supplier must issue an ABN to the beneficiary to transfer liability. The GZ

modifier indicates that the supplier does not have a waiver of liability statement (ABN) on file. Claims submitted with the GZ modifier will receive a supplier liable medical necessity denial. The GZ modifier must be appended to each corresponding HCPCS code if an ABN is deemed invalid or the supplier chooses to accept liability for the expected denial.

GY - Item or service statutorily excluded or does not meet the definition of any Medicare benefit

The GY modifier indicates that an item or service is statutorily excluded or does not meet the definition of any Medicare benefit. Claims submitted with the GY modifier will be denied as statutorily noncovered holding the beneficiary liable for the excluded services.

Suppliers are expected to know and understand policy requirements and append the correct modifiers. When reasonable and necessary criteria are not met, either the GA or GZ modifier is appropriate based on the ABN status. Some criteria are based upon statutory requirements. Failure to meet a statutory requirement justifies the use of the GY modifier.

Additional information on the coverage, coding, and documentation requirements can be found in the Local Coverage Determination and related Policy Article. Refer to the Advance Beneficiary Notice of Noncoverage (ABN) webpage on the Noridian Medicare website for liability limitations.

Face-to-Face Encounter and Written Order Prior To Delivery (WOPD) Update Effective August 12, 2024

On May 13, 2024, CMS announced updates to the Master List and the Required Face-to-Face Encounter and Required Written Order Prior to Delivery (WOPD) List.

Effective August 12, 2024, Medicare selected additional HCPCS codes that require a face-to-face encounter and Written Order Prior to Delivery (WOPD):

- Eight orthoses: L0635, L0636, L0638, L0639, L0640, L0651, L1845, and L1852
- Three hospital beds: E0290, E0301, E0304
- Two osteogenesis stimulators: E0747, E0760

Effective August 12, 2024, Medicare will not require prior authorization and face-to-face encounter and Written Order Prior to Delivery (WOPD) for HCPCS code L1833 a knee orthosis.

For more information review CMS website for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Order and Face-to-Face Encounter Requirements.

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Hospital Beds & Accessories: Prevent Claim Denials

General coverage requirements must exist in the medical records and practitioners' reports that prove the hospital bed's medical necessity due to one of these reasons:

- The patient's condition requires positioning of the body (for example, to alleviate pain, promote good body alignment, prevent contractures, and avoid respiratory infections) in ways that aren't workable in an ordinary bed
- The patient's condition requires special attachments not fixable or used on an ordinary bed

Variable height features are considered medically necessary when the beneficiary meets one of the Local Coverage Determination (LCD) defined criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position. While the policy requirements are not diagnosis dependent, medical documentation may include the following conditions to support variable height criteria:

- Severe arthritis and other injuries to lower extremities (for example, fractured hip). The condition requires the variable height feature to help the patient place their feet on the floor while sitting on the edge of the bed
- Severe cardiac conditions. For those cardiac patients who can leave bed, but who must avoid the strain of "jumping" up or down
- Spinal cord injuries, including quadriplegic and paraplegic patients, multiple limb amputees, and stroke patients. For those patients who can transfer from a bed to a wheelchair, with or without help
- Other severely debilitating diseases and conditions if the patient requires the variable height feature to ambulate

Semi-electric powered hospital beds may be covered to lower and raise the patient's head and foot when the beneficiary meets the LCD defined criteria for a fixed height hospital bed and:

- The patient's condition requires frequent change in body position
- The patient may need an immediate change in body position (no delay is tolerable), and they can work the controls and cause the adjustments (exceptions to this last requirement in cases of spinal cord injury and brain-injured patients)

Hospital beds with additional or different features from those described above must meet the criteria defined in the LCD. Total electric hospital beds with electric height adjustment and with electric head and leg elevation adjustments are not covered. Accessories may be covered for the hospital bed when the medical necessity exists in the beneficiary's medical record.

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Reference: MLN4824456 - Medicare Provider Compliance Tips (cms.gov)

Knee Orthosis HCPCS Code L1833 Changes - Prior Authorization, Face-to-Face Encounter, and Written Order Prior to Delivery No Longer Required for Dates of Service on or After August 12, 2024

Effective for dates of service on or after August 12, 2024, knee orthosis HCPCS code L1833 (Adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf) no longer requires prior authorization or a face-to-face encounter or a written order prior to delivery. Prior Authorization requests submitted on or after August 12, 2024 will be rejected.

For a list of HCPCS codes that **do** require prior authorization, please refer to the Required Prior Authorization List.

For a list of HCPCS codes that **do** require a face-to-face encounter and a written order prior to delivery, please refer to the Required Face-to-Face Encounter and Written Order Prior to Delivery List.

Lower Limb Prostheses Policy Updates Effective September 1, 2024

The Lower Limb Prostheses (LLP) Local Coverage Determination (LCD) and Policy Article (PA) have been updated to reflect the following changes:

Effective September 1, 2024, all LLP HCPCS codes must be submitted with the KX, GA, GZ, or GY modifier. The LT or RT modifiers are still a requirement. If a claim is submitted for an LLP HCPCS code and is missing these modifier requirements, the claim will be rejected and will need to be corrected and resubmitted.

In addition, effective September 1, 2024, HCPCS codes L5615 and L5841 will now require either a K0, K1, K2, K3, or K4 modifier.

Lastly, HCPCS codes L5973, L5976, L5979, L5980, L5981, L5987, L5610, L5613, L5614, L5615, L5722, L5724, L5726, L5728, L5780, L5814, L5822, L5824, L5826, L5828, L5830, L5840, L5841, L5848, L5856, L5857, and L5858 can now be allowed with the K2, K3, or K4 modifier. Previously, these HCPCS codes were only allowed with a K3 or K4 modifier.

For more information, refer to the Lower Limb Prostheses LCD L33787

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Lymphedema Compression Treatment Items Frequently Asked Questions (FAQs)

To help our suppliers, Noridian and CGS Provider Outreach and Education worked together to answer the most frequently asked questions on lymphedema compression treatment items. These FAQs are found on the Lymphedema Compression Treatment Items page.

Navigating Claim Denials for Incorrect Jurisdiction: Common Reasons and Solutions

Navigating Medicare claim denials at times can be frustrating. However, understanding common reasons for denial and how to address them can reduce denials and ensure timely reimbursement. A common reason for claim denials, along with steps to rectify the situation is below.

Incorrect Jurisdiction: Claims must be billed to the jurisdiction listed as the beneficiary's permanent address on file with the Social Security Administration (SSA).

Next Step: Submit the claim to the correct jurisdiction indicated by the beneficiary's permanent address on file with the SSA. Verification of this address can be done through the Noridian Medicare Portal.

How to Avoid Future Denials:

- **Verify Permanent Address:** Regularly check the beneficiary's permanent address on file with the SSA using the Noridian Medicare Portal to ensure accuracy.
- **Select Correct Medicare Contractor:** Identify the correct DME Medicare contractor based on the beneficiary's permanent address.
- **Submit Claims to Correct Jurisdiction:** Ensure that claims are submitted to the appropriate MAC, whether the DME MAC for **DMEPOS** items or the Part B MAC for physicians or other outpatient services. **The beneficiary's permanent address on file with the SSA should be listed as the address in line item 5 of the 1500 form or the appropriate electronic loop for an electronic claim, to ensure it is submitted and processed by the correct jurisdiction.**
- **Update Address if Necessary:** If there are any changes to the beneficiary's permanent residence, prompt action must be taken by the beneficiary by contacting the SSA to update the address.

By following these steps, suppliers can minimize the risk of claim denials, streamline the reimbursement process, and ensure that beneficiaries receive the care they need without unnecessary delays.

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Negative Pressure Wound Therapy Billing Modifiers

KX, GA, and GZ Modifiers:

Suppliers must add a KX modifier to a code only if all of the criteria in the "Coverage Indications, Limitations and/or Medical Necessity" section of the related LCD have been met.

The KX modifier must not be used with a NPWT pump and supplies for wounds if:

1. The pump has been used to treat a single wound and the claim is for the fifth or subsequent month's rental, or
2. The pump has been used to treat more than one wound and the claim is for the fifth or subsequent month's rental after therapy has begun on the most recently treated wound. In this situation, the KX modifier may be billed for more than four total months of rental.

In all of the situations above describing use of the KX modifier, if all of the coverage criteria have not been met, the GA or GZ modifier must be added to a claim line for the Negative Pressure Wound Therapy (NPWT) pump and supplies. When there is an expectation of a reasonable and necessary denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier if they have not obtained a valid ABN.

Claim lines billed without a KX, GA, or GZ modifier will be rejected as missing information.

Noridian Healthcare Solutions (Noridian) & CGS Administrators, LLC (CGS) Signature Requirements

This is collaborative education presented by the four DME MAC jurisdictions.

This publication is a collaboration between CGS and Noridian Provider Outreach and Education. It assists suppliers in identifying typical signature requirements needed on documentation submitted to the DME MACs. These are common situations and do not reflect all possible signature requirements. The CMS Medicare Program Integrity Manual Publication 100-08, Chapter 3, Section 3.3.2.4 is the reference for these requirements.

Medicare requires that the person(s) responsible for the care of the beneficiary, including providing/ordering/certifying items/services for the beneficiary, be identifiable as such in accordance with Medicare billing and coverage policies, such as the Social Security Act §1815(a) and §1833(e). Medicare contractors shall consider the totality of the medical record when reviewing for compliance with the above. The method used should be a handwritten or electronic signature. Stamped signatures are typically not

acceptable (see note for exceptions). When signatures are missing from medical records and orders, Medicare reviewers shall accept signature attestations from the authors and prescribers of the documents.

When a scribe is used by a provider in documenting medical record entries (e.g., progress notes), CMS does not require the scribe to sign/date the documentation. The treating physician/non-physician practitioner's (NPP's) signature on a note indicates that the physician/NPP affirms the note adequately documents the care provided.

Handwritten, Electronic & Rubber Stamp Signatures

A **handwritten signature** (i.e., pen and ink signature) is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation. Signature logs and signature attestation statements may be used to identify authors of records when signatures are illegible.

An **electronic signature** is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation that has been generated through computerization. This type of signature should contain the date, time stamp, an indication the document is being signed electronically, the practitioner's name, and preferably a professional designation.

Rubber Signature Stamps are not typically acceptable. CMS permits use of a rubber stamp for signature in accordance with the Rehabilitation Act of 1973 in the case of an author with a physical disability that can provide proof to a CMS contractor of his/her inability to sign their signature due to their disability. By affixing the rubber stamp, the provider is certifying that they have reviewed the document.

Signature on Orders

Standard Written Order (SWO): A Standard Written Order (SWO) must be communicated to the supplier before a claim is submitted. The signature of the prescribing practitioner, personally entered by that individual, is a required SWO element.

Written Order Prior to Delivery (WOPD): A WOPD is a completed SWO that is communicated to the supplier before delivery of item(s). The prescribing practitioner signature, personally entered by that individual, is a required element of the WOPD prior to delivery.

Pursuant to Final Rule 1713 (84 Fed. Reg Vol 217), CMS may select DMEPOS items appearing on the Master List of DMEPOS Items potentially subject to a face-to-face encounter and WOPD requirement and include them on a Required List. Items appearing on the Required List are subject to the face-to-face encounter and WOPD requirements.

References

- Standard Documentation Requirements for All Claims Submitted to DME MACs Policy Article (A55426)
- Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master list of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements-SE20007

Proof of Delivery

When items are delivered directly to Medicare beneficiaries by a supplier, beneficiaries or their designees are required to review proof of delivery documents and provide a signature. The signature on the proof of delivery represents knowledge, approval, and acceptance of the delivery. Proof of delivery documentation must include the date of delivery. This date may be entered by the beneficiary, their designee, or the DME supplier.

Reference

Program Integrity Manual 100-08 Chapter 4, section 4.7.3.1

Advance Beneficiary Notice (ABN)

The ABN issued by the supplier must be signed and dated by the beneficiary or representative prior to delivery.

References

- Medicare Claims Processing Manual 100-04 Chapter 20, section 120
- Medicare Claims Processing Manual 100-04 Chapter 30, Section 5

Oxygen and Oxygen Equipment: Continued Coverage

For beneficiaries to be considered for continued coverage in Groups II and III, there is additional criteria that needs to be met between days 61-90 after initiation of oxygen therapy.

Group II:

1. Evaluation and documentation of a repeat qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy.
2. A new Standard Written Order (SWO) by the treating practitioner.

Group III:

1. Evaluation and documentation of a repeat, normoxemic, qualifying blood gas test by the treating practitioner between the 61st and 90th days after initiation of therapy,
2. A new Standard Written Order (SWO) by the treating practitioner.

For more information, visit the Oxygen and Oxygen Equipment webpage for links to the Local Coverage Determination (LCD), Policy Article, Oxygen Modifier Decision Tree and so much more.

Payment for Second Ventilator

Suppliers may bill for two ventilators if it is required to serve a different medical purpose that is determined by the beneficiary's medical needs. Examples include:

- When a beneficiary requires one type of ventilator for part of the day and needs a different type of ventilator during the rest of the day.
- When a beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day and needs another ventilator of the same type for use while in bed.

The second ventilator may deny as same or similar as there is one ventilator already on file. Same or similar denials may be appealed with all documentation to support the medical necessity for the second ventilator. When submitting the claim, we would encourage a narrative that states "mounted". We recommend this to help avoid initial denials.

Primary Care First Model Demonstration Project

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

Quarterly Targeted Probe and Educate (TPE) Results for Ostomy Supplies

The Jurisdiction D, DME MAC, Medical Review Department is conducting TPE Reviews of HCPCS codes A4362 and A4430. The quarterly edit effectiveness results are from October 2023 to December 2023. Based on dollars, the overall claim potential improper payment rate for JD is 23%.

The Top Technical denial reasons are that the claim is billed for greater quantity than the order indicates, and the Standard Written Order (SWO) is missing the quantity to be dispensed.

Additional information on the top medical necessity denial reasons, the top technical denials, and any educational resources can be found at the TPE Reviews page.

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

Recovery Audit Contractor Steps to Appeal

The Medicare Administrative Contractor (MAC) would like to offer the supplier community a reminder regarding Recovery Audit Contractor (RAC) appeals. If requests are sent to the MAC without first receiving the demand letter from the recoupment department, the appeal to the MAC will be dismissed. A dismissal letter will be sent, and the supplier must wait for the overpayment demand letter before sending a valid appeal request to the MAC. The overpayment demand letter indicates that an overpayment has been completed and grants the claim appeal rights.

Requests for SSI Realignment for Cost Reporting Periods Starting Before October 1, 2013

The purpose of the Change Request 13413 is to provide information and implementation instructions for CMS-1739-F | CMS issued June 9, 2023, which concerned the treatment of Medicare Part C days for the purposes of calculating Medicare DSH.

The MAC will verify the written notification it received from the provider and determine DSH payments for verified realignment requests in accordance with CR 13413. Below is the excerpt from the CR that CMS has posted on the CMS website at 2024 Transmittals.

All Correspondence or questions should be sent to ssirealignment@noridian.com

On June 9, 2023, in response to the Supreme Court's ruling in Azar v. Allina Health Services, 139 S. Ct. 1804 (2019), the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1739-F) that established a policy on the treatment of Part C days for purposes of calculating a hospital's disproportionate patient percentage (DPP) for cost reporting periods starting before October 1, 2013 (that is, for cost reporting periods starting before Federal fiscal year (FY) 2014) (88 FR 37772). In this rule, CMS expressed

its view that, in light of Becerra v. Empire Health Foundation, for Valley Hospital Medical Center, 597 U.S. 424, 435 (June 24, 2022), it is clear that the DSH statute requires CMS to count Part C days in the Medicare fraction because Medicare beneficiaries remain "entitled to [Medicare Part A]" regardless of whether they enroll in Part C, and thus there was no statutory gap to fill that would require rulemaking under Allina. Nonetheless, because Empire did not squarely address whether Part C enrollees remain "entitled to Part A," CMS adopted, through retroactive rulemaking for cost reporting periods starting before October 1, 2013, the same policy of including Part C days in the Medicare fraction (also known as the "SSI fraction" or "SSI ratio") that was prospectively adopted in the FY 2014 IPPS final rule. Under the policy articulated in this rule, CMS will calculate a hospital's DPP by including Part C days in the Medicare fraction and excluding them from the numerator of the Medicaid fraction.

42 CFR 412.106(b)(3) allows a hospital the opportunity to request to have its SSI ratio realigned based on its cost reporting period (as opposed to the Federal fiscal year). Under this regulation, a realignment will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official SSI ratio for that period. After the Supreme Court's Allina decision, CMS held processing of requests for SSI ratio realignment for cost reporting periods starting before FY 2014 due to a lack of policy established through notice-and-comment rulemaking regarding the treatment of Part C days for that period of time. With the issuance of the final rule (CMS-1739-F), the processing of realignment requests for cost reporting periods starting before FY 2014 will resume.

This letter explains the process for hospitals to confirm or make new realignment requests for cost reporting periods starting before October 1, 2013.

Posting of Cost Reporting Period-Based SSI Ratios for Cost Reporting Periods Starting Before October 1, 2013

Cost reporting period-based SSI ratios for cost reporting periods starting before October 1, 2013, are available on the CMS website at Disproportionate Share Hospital (DSH).

Realignment Requests for Cost Reporting Periods Starting Before October 1, 2013

Existing Realignment Requests: For any realignment requests for cost reporting periods starting before October 1, 2013, that the provider submitted to its MAC prior to August 1, 2024, providers MUST confirm these existing requests with their MAC before they can be processed.

New Realignment Requests: In addition to confirming existing requests, providers may also request realignments for other cost reporting periods starting before October 1, 2013, in accordance with CMS regulations.

Information to Send to MACs for Existing or New Realignment Requests: To confirm an existing request or make a new request for cost reporting periods starting before

October 1, 2013, the provider must send a written notification to the MAC which contains the following information:

- Cost report begin date
- Cost report end date

The MAC will verify the written notification it received from the provider and determine DSH payments for verified realignment requests in accordance with CR 13413 (posted on the CMS website at 2024 Transmittals).

Finally, we note that, in accordance with the existing rules regarding realignment requests (42 CFR 412.106(b)(3)), once a hospital has confirmed its request for realignment of cost reporting periods starting before October 1, 2013 (in the case of requests made prior to August 1, 2024, or made a new request for such a reporting period, that request may not be withdrawn. The realigned ratio for the cost reporting period posted at Disproportionate Share Hospital (DSH) will be the hospital's ratio, regardless of whether the ratio is higher or lower than the Federal fiscal year ratio.

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 April 2024 - June 2024 can be located on the Required Prior Authorization Programs webpage:

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

Resolving a Top Denial for Billing Accessories or Supplies for Beneficiary Owned Equipment

Suppliers must have beneficiary-owned equipment information on file with Medicare Fee-for-Service (FFS) when billing for accessories and supplies for that equipment to prevent denials. Additional documentation is required when supplies and accessories are provided for purchased equipment that is not on file with Medicare FFS. Drugs used with nebulizers or external infusion pumps are considered supplies for covered Durable Medical Equipment (DME).

Denial Process

- Denials occur if base equipment is not on file, preventing payment for accessories or supplies.
- Examples of beneficiary-owned items include Positive Airway Pressure (PAP) Devices, Respiratory Assist Devices (BiPAPs), nebulizers, glucose monitors, hospital bed, and humidifiers.
- To bill supplies for beneficiary-owned equipment, the base equipment information must be on file with Medicare FFS.

Information Required When Billing Accessories or Supplies for Beneficiary Owned Equipment

- HCPCS code of beneficiary-owned item and approximate purchase date.
- Example: Bene-owned E0601 pur Jan 2023 (approximate).

Methods for Claims Processing

- For denials with Reason Code 16, Remark Code M124 on the Remittance Advice (RA):
    - Request a telephone reopening through the Supplier Contact Center (SCC) to add beneficiary-owned equipment information.
    - SCC provides guidance if telephone reopening is unavailable.
    - Submit appeals/redeterminations via NMP appeals process if necessary.
- Ensure beneficiary-owned equipment information is included in claim narrative.
- Add required information to claim narratives **ONLY until equipment is on file with Medicare**.
- Claims missing necessary elements will be denied.

After Equipment is On File

- Once beneficiary-owned equipment is on file, subsequent supply claims **do not require narrative details**.

Avoiding Denials

- Verify equipment ownership through the same or similar function on the Noridian Medicare Portal (NMP) or Interactive Voice Response (IVR) to prevent denials due to missing ownership indication.
- Ask questions regarding potential beneficiary-owned equipment at intake.

News

Resolving and Avoiding Denials for Same or Similar Items

Consider the questions below prior to providing Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items, and to gain the necessary information to determine whether an item may be considered same or like equipment already obtained.

Has the beneficiary had a same or similar item paid for by Medicare Fee for Service (FFS)? Verify prior to providing item.

- The Noridian Medicare Portal can be accessed under Same or Similar, option 2 to verify same or similar **or**
- Call the Noridian Interactive Voice Response (IVR) System for same or similar
    - If they have not had a same or similar item, bill claim without obtaining an ABN (no ABN necessary)
    - If they have had a same or similar item, determine if item has reached its Reasonable Useful Lifetime (RUL)
        - If RUL reached, bill claim without ABN (no ABN necessary)
- Has there been a **change in the beneficiary's medical condition** that supports the need for a same or similar type of item?
    - If item has not reached RUL, obtain an ABN and all medical records to support the change in medical condition requiring replacement
- Has the original item been lost, stolen, or irreparably damaged?
    - Include the **RA modifier and a narrative description** on the claim explaining why the equipment is being replaced. Suppliers should maintain documentation indicating that the item was lost, destroyed, irreparably damaged and the details of the incident (e.g., police report, insurance claim report or beneficiary statement) in the medical record.

Answering these questions will help determine whether an Advance Beneficiary Notice of Noncoverage (ABN) should be obtained

Common Reasons for Denial:

- Item billed matches one already received by beneficiary.

Resolving Denial

Appeal claim with all relevant supporting documentation. Noridian encourages Redeterminations/Appeals submission through the Noridian Medicare Portal.

News

Resolving Denials for PECOS Errors

One of the top denials suppliers receive each month is for **PECOS Edits**. These edits ensure that the ordering or referring provider is enrolled in the Provider Enrollment, Chain, and Ownership System (PECOS) and the ordering or referring provider is eligible to order the DMEPOS

The ordering/referring provider name, entered in line item 17 and the NPI number that is entered in line item 17b, on the claim must match the information in PECOS.

- During the claims process, Medicare will verify that the NPI is in PECOS and provider is eligible to order and refer
- If the ordering/referring provider is not in PECOS, or is in PECOS but is not a valid specialty to order or refer, the claim will be denied
- If the name submitted on the claim does not match the provider's name in PECOS, the claim will be denied

The remittance advice will display the following remark codes when claims are denied due to an error in the ordering physician's NPI:

N265-Missing/incomplete/invalid ordering provider primary identifier

N276-Missing/incomplete/invalid other payer referring provider identifier

Next Step in Resolving Denials

- Verify that the ordering physician NPI is on the list of physicians and other non-physician practitioners enrolled in PECOS. Even if a provider has an individual NPI, it does not mean that their enrollment record is in PECOS and/or is active. Verification of enrollment in PECOS can be done by:
    - Checking the CMS ordering/referring provider downloadable report containing the NPI, first name, and last name of providers enrolled in PECOS.
        - Be sure the name and NPI entered for the ordering provider belong to a physician or non-physician practitioner. **A group NPI cannot be used as an ordering NPI on a Medicare claim. In addition, be sure the qualifier in the electronic claim (2310A NM102 loop) is 1 (person). Organizations (qualifier 2) cannot order and refer.**
- Resubmit the claim with a valid ordering physician NPI registered in PECOS.

Please refer to the PECOS Edits page for more information on the CMS ordering/referring provider downloadable report and what information is included in the report.

Top Ordering/Referring Submission Errors

- Supplier is interchanging the first and last name of the referring physician
- Supplier submitting the organizational NPI of the referring physician
- Nurse practitioners and interns not enrolled in Medicare are listed as the referring physician
- The supplier submitted a last name that did not match PECOS

Surgical Dressings Recommended Frequency of Change

The frequency of recommended dressing changes depends on the type and use of the surgical dressing. When combinations of primary dressings, secondary dressings, and wound filler are used, the change frequencies of the individual products should be similar. For purposes of this policy, the product in contact with the wound determines the change frequency. It is not reasonable and necessary to use a combination of products with differing change intervals. For example, it is not reasonable and necessary to use a secondary dressing with a weekly change frequency over a primary dressing with a daily change interval. Such claims will be denied as not reasonable and necessary.

See the Surgical Dressings Local Coverage Determination for more information.

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from April 2024 - June 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
- Spinal Orthosis
- Surgical Dressings
- Urological Supplies

Temporary Disruption to External Print and Mail Services - Resolved 08/06/24

Provider/Supplier Type(s) Impacted: All

Reason Codes: Not applicable.

Claim Coding Impact: Not applicable.

Description of Issue: Noridian is currently experiencing a temporary disruption to our external print and mail services, affecting the printing of standard paper remittance advices (SPRs) and additional documentation requests (ADRs).

Noridian Action Required: We are actively working to resolve the issue, and once restored, SPRs and ADRs be promptly mailed where applicable.

07/22/24 - As of 07/19/24, all delayed SPRs have been mailed.

07/12/24 - The print and mail services are restored for SPRs. Noridian is in the process of mailing all SPRs delayed by the print disruption. Newly issued SPRs will be printed and mailed as they are generated. All delayed SPRs are expected to be mailed by July 19.

06/14/24 - There continues to be a print service disruption affecting the printing and mailing of SPRs. Noridian anticipates the disruption to be resolved by mid-July. Once resolved, all delayed SPRs will be mailed.

05/28/24 - There continues to be a print service disruption affecting the printing and mailing of SPRs.

05/03/24 - There continues to be a print service disruption affecting the printing and mailing of SPRs.

04/09/24 - There continues to be a print service disruption affecting the printing and mailing of SPRs.

Provider/Supplier Action Required: During this time, please access SPRs and any available ADRs online through the Noridian Medicare Portal.

07/22/24 - If providers/suppliers are missing any SPRs after 08/01/24, please follow your normal procedures to receive a duplicate. Some suppliers were impacted by an issue

that caused additional copies of SPRs generated in April to be mailed. These additional copies can be discarded.

07/12/24 - Due to the disruption in our external print and mail services, Noridian will accept appeals for denied claims included in the SPRs up to 120 days from the postmark date. This extension will allow time to gather documentation and submit appeals for any disputed claims. Our intention is to ensure all parties are afforded appropriate filing timelines for valid appeals and receive consideration for good cause in accordance with Internet Only Manual (IOM) 100-04 Chapter 29. Please include a comment with the late file rationale for the appeal to be reviewed for good cause.

Previously submitted appeals dismissed for a late file but were delayed as a result of the disruption to print and mail services, should be brought to the MACs attention. Appeals will be reviewed on a case-by-case basis to determine if good cause is established for a reopening.

06/14/24 - During this time, please access available SPRs online through the Noridian Medicare Portal. For more information on both full remittance advices and claim specific remittance advices please visit Remittance Advices - Portal Guide - Noridian (noridianmedicare.com). SPRs generated throughout the disruption period will be mailed once all disruptions are resolved.

05/28/24 - During this time, please access available SPRs online through the Noridian Medicare Portal. For more information on both full remittance advices and claim specific remittance advices please visit Remittance Advices - Portal Guide - Noridian (noridianmedicare.com). SPRs generated throughout the disruption period will be mailed once all disruptions are resolved.

05/03/24 - During this time, please access available SPRs online through the Noridian Medicare Portal. For more information on both full remittance advices and claim specific remittance advices please visit Remittance Advices - Portal Guide - Noridian (noridianmedicare.com). SPRs generated throughout the disruption period will be mailed once all disruptions are resolved.

04/09/24 - During this time, please access SPRs online through the Noridian Medicare Portal. For more information on both full remittance advices and claim specific remittance advices please visit Remittance Advices - Portal Guide - Noridian (noridianmedicare.com).

Proposed Resolution/Solution: N/A

Date Reported: 03/06/24

Date Resolved: 08/06/24

News

Treating Practitioner Evaluation of the Blood Gas Study for Oxygen

National DME MAC Education

The Oxygen and Oxygen Equipment Local Coverage Determination (LCD) (L33797) requires that "The treating practitioner has … evaluated the results of a qualifying blood gas study performed at the time of need." The DME MACs have received many inquiries regarding how this information may be documented to satisfy the requirement.

As a reminder, it is required that the medical record documentation include the results of the qualifying blood gas study performed by a treating practitioner, qualified provider, or supplier of laboratory services.

In situations where the blood gas study was not conducted directly by the treating practitioner, documentation to support that the treating practitioner evaluated the qualifying blood gas study results may include (not all inclusive):

- The incorporation of a copy of the blood gas study or the results from the blood gas study into the treating practitioner's chart notes; or,
- Treating practitioner documentation in which he/she references the evaluation of the blood gas study performed on a specific date; or,
- The treating practitioner's signature on a copy of the blood gas study results. The treating practitioner's signature indicates he/she evaluated the results; or,
- Inclusion of either of the following on the treating practitioner's standard written order (SWO) for home oxygen therapy: blood gas study results or reference to the evaluation of the blood gas study performed on a specific date.
    - **Note:** While inclusion, of either of the above, on the treating practitioner's SWO may support that the treating practitioner evaluated the blood gas study results, as previously noted the results of the blood gas study must also be documented in the medical record documentation rendered by a practitioner, qualified provider, or supplier of laboratory services who performed the study.

When the treating practitioner directly conducts the qualifying blood gas study, the treating practitioner's documentation of the blood gas study results satisfies, both, the requirement that the medical record documentation include the results of the study and that the treating practitioner evaluate the results.

The DME MACs strongly encourage suppliers to obtain medical records upfront to confirm sufficient documentation exists to support the coverage criteria are met prior to dispensing the equipment or billing the claim to Medicare.

News

Update: How to Determine Whether to Obtain Prior Authorization for an Off-the-shelf vs Custom Fit Brace or Both Codes

Obtaining a prior authorization for an orthotic brace can be confusing if suppliers are unsure of what type of brace will be provided and billed since the off-the-shelf and custom fit codes are only differentiated by the nature of the final fitting performed at the time of delivery. To solve this confusion, suppliers should obtain a prior authorization for both the off-the-shelf and custom fit braces. Then, after the final fitting, bill for the brace provided based on the type of adjustment that was needed at the final fitting. Medicare will only cover one medically necessary brace. Suppliers may choose to submit multiple codes on one prior authorization request; however, when multiple codes are submitted, each HCPCS will be treated as its own review, and the supplier will obtain a prior authorization decision for each code. To avoid a missed code, suppliers must make sure documentation clearly shows both codes that are intended to be reviewed.

Updates to the Master List and Required Prior Authorization List Effective August 12, 2024

On May 13, 2024, CMS announced updates to the Master List and the Required Prior Authorization List. The following changes will be effective August 12, 2024:

Orthoses:

Medicare will no longer require prior authorization and face-to-face encounter and Written Order Prior to Delivery (WOPD) for HCPCS code L1833.

CMS included six additional orthosis HCPCS codes (L0631, L0637, L0639, L1843, L1845, L1951) for required prior authorization to begin nationwide.

Osteogenesis Stimulators:

CMS included three additional osteogenesis stimulator HCPCS codes (E0747, E0748, E0760) subject to required prior authorization.

There will be two phases of implementation for the newly added codes:

Phase one begins August 12, 2024, in **California**, Florida, Ohio, and **Pennsylvania**.

Phase two begins November 12, 2024, in all remaining states and territories not included in phase one. For more information review CMS website for Master List of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Items Potentially Subject to Conditions of Payment.

News

Utilize Correct Modifier(s) Per HCPCS Code

Modifiers can be alphabetic, numeric, or a combination of both, but will always be two digits for Medicare purposes. Some modifiers initiate automated pricing changes, while others are used only to convey information. Modifiers are not required on all HCPCS codes; however, if required and not submitted, the claim will deny as unprocessable and the claim will need to be corrected and rebilled.

Modifiers that are applicable to a policy are listed in the Local Coverage Determination (LCD) with requirements for those modifiers listed in the specific policy article, except for items that can be rented or purchased.

Rental or purchase item modifiers

- **NU** New durable medical equipment purchase
- **UE** Used durable medical equipment purchase
- **RR** Rental

These modifiers are identified on the Pricing Data Analysis Coding (PDAC) website under each applicable HCPCS code fee schedule lookup

Capped rental modifiers

- **RR** Rental
- **KH** First rental month
- **KI** Second and third rental months
- **KJ** Fourth to the thirteenth rental months

Capped rental items allowable - First three months calculated 10% allowed purchase. Months 4-13 limited to 7.5% allowed purchase

Note: Capped Rental items **cannot be sold to the beneficiary and billed to Medicare as a purchase**, as they are statutorily non-covered as the item would not meet the definition of any benefit category for DME.

Liability modifiers

- **GA** Waiver of Liability statement on file. Valid Advance Beneficiary Notice of Noncoverage (ABN) obtained
- **GZ** Item or service expected to be denied as not reasonable or necessary or ABN not obtained or was invalid. (Items submitted with GZ are automatically denied and not subject to complex medical review).

- **GY** Item or service statutorily excluded or does not meet the definition of any Medicare benefit

Note: The modifiers **GA, GZ, GY, and KX must never be used on the same claim** line together as the claim will deny as unprocessable and the claim will need to be corrected and rebilled.

Informational modifiers most frequently used (not all-inclusive list)

KX Requirements specified in the medical policy have been met

- **LT** Left side
- **RT** Right side
- **K0-K4** Lower extremity prosthesis functional level modifiers
- **N1, N2, N3, QA, QB, QE, QF, QG, QH**, or **QR** Oxygen modifiers as indicated in the LCD

Note: The **LT and RT modifiers are often billed incorrectly**.

- **Bill bilateral items on two separate claim lines using the RT and LT modifiers and 1 unit of service (UOS) on each claim line**
    - Claims billed with the RTLT modifier on the same claim line with 2 UOS will deny as unprocessable and the claim will need to be corrected and rebilled.

Please refer to the Modifier Lookup Tool to assist in determining potential modifiers that may be used in billing DMEPOS HCPCS codes.

When to Contact the National Provider Enrollment Contractors vs. the DME MAC

Noridian receives several calls each day that should be addressed by the National Provider Enrollment Contractors (NPEs), either NPEAST (Novitas) or NPWEST (Palmetto GBA). Call NPEAST or NPWEST, based on the physical location of your supplier's office as outlined at the end of this article, for the following topics:

- Payment Hold or Do Not Forward Questions: Contact your DME MAC to inquire on the type of payment hold in place. The call representative will advise how to have the payment hold removed, which may involve contacting the NPE contractors.
- Setting up Electronic Fund Transfer (EFT) or making EFT changes
- Providing documentation to establish enrollment compliance such as proof of insurance, surety bond, licenses, or other documents
- Reactivation status for a PTAN (Provider Transaction Access Number)

- To check why a PTAN was deactivated or revoked
- Reporting changes in ownership
- Updating supplier enrollment records

The only involvement Noridian has in the enrollment process is generating overpayments as directed by the NPEs or CMS when a PTAN is deactivated or revoked. Noridian will send an overpayment letter. This letter will explain how to appeal if you disagree with the overpayment decision.

All other enrollment related direction comes from the NPEs or the Appeals and Rebuttals Contractor, Chags Health Information Technology (C-HIT), as they handle enrollment related appeals and implementing appeal decisions. Please ensure that you are responding to these letters and not to Noridian to resolve your PTAN reactivation or appeals process. Noridian will not forward documentation to other contractors on your behalf.

To check on the status of an enrollment appeal or corrective action plan for revocation/termination of a PTAN, call or email C-HIT at 800-245-9206 or PEARC@c-hit.com

Novitas Solutions NPE East (JA): Alabama, **Connecticut, Delaware**, Florida, Georgia, Illinois, Indiana, Kentucky, **Maine, Maryland, Massachusetts**, Michigan, Mississippi, **New Hampshire, New Jersey, New York**, North Carolina, Ohio, **Pennsylvania, Rhode Island**, South Carolina, Tennessee, **Vermont**, Virginia, West Virginia, Wisconsin, **District of Columbia**, Puerto Rico, US Virgin Islands

Phone: 866-520-5193 9 a.m. - 5 p.m. ET

Palmetto GBA NPE West (JD): Alaska, Arizona, Arkansas, **California**, Colorado, **Hawaii, Idaho, Iowa, Kansas**, Louisiana, Minnesota, **Missouri, Montana, Nebraska, Nevada**, New Mexico, **North Dakota**, Oklahoma, **Oregon, South Dakota**, Texas, **Utah, Washington, Wyoming, American Samoa, Guam, Northern Mariana Islands**

Phone: 866-238-9652 10 a.m. - 6 p.m. ET

Medical Policies and Coverage

ALYGLO® (immune globulin intravenous, human-stwk), 10% Liquid - Correct Coding and Coverage

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **ALYGLO® (immune globulin intravenous, human-stwk), 10% Liquid - Correct Coding and Coverage**, 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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Correct Coding of Elbow, Shoulder, Shoulder-Elbow-Wrist-Hand and Shoulder-Elbow-Wrist-Hand-Finger Braces (Orthoses) - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding of Elbow, Shoulder, Shoulder-Elbow-Wrist-Hand and Shoulder-Elbow-Wrist-Hand-Finger Braces (Orthoses) - Revised**, has been created and published to our website.

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July 2024 HCPCS Updates

CMS has released the July 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 July 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 July 1, 2024

HCPCS	DESCRIPTION
J0211	Injection, sodium nitrite 3 mg and sodium thiosulfate 125 mg (nithiodote)
J0687	Injection, cefazolin sodium (wg critical care), not therapeutically equivalent to j0690, 500 mg
J0872	Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg
J1597	Injection, glycopyrrolate (glyrx-pf), 0.1 mg
J1598	Injection, glycopyrrolate (fresenius kabi), not therapeutically equivalent to j1596, 0.1 mg
J1748	Injection, infliximab-dyyb (zymfentra), 10 mg
J2183	Injection, meropenem (wg critical care), not therapeutically equivalent to j2185, 100 mg
J2246	Injection, micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1 mg
J2267	Injection, mirikizumab-mrkz, 1 mg
J2373	Injection, phenylephrine hydrochloride (immphentiv), 20 micrograms
J2468	Injection, palonosetron hydrochloride (avyxa), not therapeutically equivalent to j2469, 25 micrograms
J2470	Injection, pantoprazole sodium, 40 mg
J2471	Injection, pantoprazole (hikma), not therapeutically equivalent to j2470, 40 mg
J3247	Injection, secukinumab, intravenous, 1 mg
J3263	Injection, toripalimab-tpzi, 1 mg
J3393	Injection, betibeglogene autotemcel, per treatment
J3394	Injection, lovotibeglogene autotemcel, per treatment
J8611	Methotrexate (jylamvo), oral, 2.5 mg
J8612	Methotrexate (xatmep), oral, 2.5 mg
J9361	Injection, efbemalenograstim alfa-vuxw, 0.5 mg
Q5137	Injection, ustekinumab-auub (wezlana), biosimilar, subcutaneous, 1 mg
Q5138	Injection, ustekinumab-auub (wezlana), biosimilar, intravenous, 1 mg

Description Update

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

HCPCS	DESCRIPTION
J0134	Injection, acetaminophen (fresenius kabi), not therapeutically equivalent to j0131, 10 mg
J0136	Injection, acetaminophen (b braun), not therapeutically equivalent to j0131, 10 mg
J0137	Injection, acetaminophen (hikma), not therapeutically equivalent to j0131, 10 mg
J0173	Injection, epinephrine (belcher), not therapeutically equivalent to j0171, 0.1 mg
J0401	Injection, aripiprazole (abilify maintena), 1 mg
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
J0873	Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg
J0893	Injection, decitabine (sun pharma), not therapeutically equivalent to j0894, 1 mg
J1574	Injection, ganciclovir sodium (exela), not therapeutically equivalent to j1570, 500 mg
J1806	Injection, esmolol hydrochloride (wg critical care), not therapeutically equivalent to j1805, 10 mg
J1921	Injection, labetalol hydrochloride (hikma), not therapeutically equivalent to j1920, 5 mg
J2021	Injection, linezolid (hospira), not therapeutically equivalent to j2020, 200 mg
J2184	Injection, meropenem (b braun), not therapeutically equivalent to j2185, 100 mg
J2251	Injection, midazolam hydrochloride (wg critical care), not therapeutically equivalent to j2250, per 1 mg
J2272	Injection, morphine sulfate (fresenius kabi), not therapeutically equivalent to j2270, up to 10 mg
J2281	Injection, moxifloxacin (fresenius kabi), not therapeutically equivalent to j2280, 100 mg
J2599	Injection, vasopressin (american regent), not therapeutically equivalent to j2598, 1 unit

HCPCS	DESCRIPTION
J2806	Injection, sincalide (maia), not therapeutically equivalent to j2805, 5 micrograms
J3244	Injection, tigecycline (accord), not therapeutically equivalent to j3243, 1 mg
J3371	Injection, vancomycin hcl (mylan), not therapeutically equivalent to j3370, 500 mg
J3372	Injection, vancomycin hcl (xellia), not therapeutically equivalent to j3370, 500 mg
J9046	Injection, bortezomib (dr. reddy's), not therapeutically equivalent to j9041, 0.1 mg
J9172	Injection, docetaxel (ingenus), not therapeutically equivalent to j9171, 1 mg
J9258	Injection, paclitaxel protein-bound particles (teva), not therapeutically equivalent to j9264, 1 mg
J9259	Injection, paclitaxel protein-bound particles (american regent), not therapeutically equivalent to j9264, 1 mg
J9294	Injection, pemetrexed (hospira), not therapeutically equivalent to j9305, 10 mg
J9296	Injection, pemetrexed (accord), not therapeutically equivalent to j9305, 10 mg
J9314	Injection, pemetrexed (teva), not therapeutically equivalent to j9305, 10 mg
J9322	Injection, pemetrexed (blue point), not therapeutically equivalent to j9305, 10 mg
J9393	Injection, fulvestrant (teva), not therapeutically equivalent to j9395, 25 mg
Q2055	Idecabtagene vicleucel, up to 510 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose

Deleted HCPCS Code

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

HCPCS	DESCRIPTION
J2780	Injection, Ranitidine Hydrochloride, 25 MG
J9371	Injection, Vincristine Sulfate Liposome, 1 MG

Medical Policies and Coverage

LCD and Policy Article Revisions Summary for July 18, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for July 18, 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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LCD Revisions Summary for August 1, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD Revisions Summary for August 1, 2024**, has been created and published to our website.

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Lower Limb Prostheses - Final LCD and Response to Comments (RTC) Article Published

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

View the locally hosted 2024 DMD articles.

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Medical Policies and Coverage

Policy Article Revisions Summary for June 6, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for June 6, 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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Policy Article Revisions Summary for June 13, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for June 13, 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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Policy Article Revisions Summary for June 20, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for June 20, 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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Medical Policies and Coverage

Policy Article Revisions Summary for June 27, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for June 27, 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

Policy Article Revisions Summary for August 8, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for August 8, 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 Revisions Summary for August 29, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for August 29, 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

MLN Connects

MLN Connects - June 6, 2024

MLN Connects Newsletter: June 6, 2024

News

- CMS Roundup (May 31, 2024)
- Quality Payment Program: 2022 Performance Information on Medicare.gov Compare Tool
- Skilled Nursing Facility Value-Based Purchasing Program: June Confidential Feedback Reports
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Advancing Health Equity During Pride Month

Claims, Pricers, & Codes

- DMEPOS: Clarification of Claim Liability for Overlapping Inpatient Hospital Stays
- Integrated Outpatient Code Editor Version 25.2
- National Correct Coding Initiative: July Update

MLN Matters® Articles

- National Coverage Determination 200.3: Monoclonal Antibodies for the Treatment of Alzheimer's Disease

Publications

- Medicare Preventive Services - Revised

MLN Connects - June 13, 2024

MLN Connects Newsletter: June 13, 2024

News

- Medicare Shared Savings Program: Apply for January 1 Start Date by June 17
- Men's Health: Encourage Your Patients to Prioritize Their Health

Compliance

- Hospital Beds & Accessories: Prevent Claim Denials

MLN Connects

Claims, Pricers, & Codes

- ICD-10-PCS Procedure Codes: FY 2025

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting: Now Virtual-Only on June 25

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: July 2024 Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: October 2024 Quarterly Update

Multimedia

- Medicare Ground Ambulance Data Collection System: Labor Costs Webinar Recording

Information for Patients

- Medicare Information in Other Languages

MLN Connects - June 20, 2024

MLN Connects Newsletter: June 20, 2024

News

- CMS Preparing to Close Program that Addressed Medicare Funding Issues Resulting from Change Healthcare Cyber-Attack
- Federal Study Examines Care Following Nonfatal Overdose Among Medicare Beneficiaries; Identifies Effective Interventions & Gaps in Care
- CMS Roundup (June 14, 2024)
- Medical Records Request Scam: Watch out for Phishing
- Provider & Supplier Enrollment Site Visits: CMS has Authority to Conduct
- Cognitive Health: Medicare Covers Services

Compliance

- Global Surgery: Bill Correctly

MLN Connects

Claims, Pricers, & Codes

- Outpatient Institutional Providers: Find Out When to Split Claims for Updated Rates

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting: Now Virtual-Only on June 25

MLN Matters® Articles

- Ambulatory Surgical Center Payment Update - July 2024
- Medicare Benefit Policy Manual Update: DMEPOS Benefit Category Determinations

From Our Federal Partners

- Disrupted Access to Prescription Stimulant Medications Could Increase Risk of Injury & Overdose
- Severe Illness Potentially Associated with Consuming Diamond Shruumz Brand Chocolate Bars, Cones, & Gummies
- CHAMPVA Claims: Enroll in Direct Deposit - Reminder

MLN Connects - June 27, 2024

MLN Connects Newsletter: June 27, 2024

News

- CY 2025 Home Health Prospective Payment System Proposed Rule
- PrEP Using Antiretroviral Therapy to Prevent HIV Infection: Technical FAQs for Pharmacies

Claims, Pricers, & Codes

- Medicare Part B Drug Pricing Files & Revisions: July Update
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2024 Update

Events

- 2024 Virtual National Provider Compliance Conference - August 7 & 8

MLN Connects

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2024 Quarterly Update

Multimedia

- Medicare Ground Ambulance Data Collection System: Webinar Recordings

From Our Federal Partners

- Increased Risk of Dengue Virus Infections in the U.S.
- Health Care Preparedness Resources

MLN Connects - July 3, 2024

MLN Connects Newsletter: July 3, 2024

News

- ESRD Prospective Payment System CY 2025 Proposed Rule - Submit Comments by August 26
- CMS Roundup (June 28, 2024)
- Improve Your Search Results for CMS Content

Claims, Pricers, & Codes

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

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination Edit Software: October 2024 Update
- Ambulatory Surgical Center Payment Update - July 2024 - Revised
- Diabetes Screening & Definitions Update: CY 2024 Physician Fee Schedule Final Rule - Revised

Publications

- Medicare Part D Vaccines - Revised
- Period of Enhanced Oversight for New Hospices in Arizona, California, Nevada, & Texas - Revised

MLN Connects

MLN Connects - July 11, 2024

MLN Connects Newsletter: July 11, 2024

Proposed Rules

- Physician Fee Schedule CY 2025 Proposed Rule
- Hospital Outpatient Prospective Payment System & Ambulatory Surgical Center Payment System CY 2025 Proposed Rule
- Mitigating the Impact of Significant, Anomalous, & Highly Suspect Billing Activity on Medicare Shared Savings Program Financial Calculations in CY 2023 Proposed Rule - Submit Comments by July 29

News

- Guiding an Improved Dementia Experience by Clearing the Path for Comprehensive, High-Quality Dementia Care
- New Alzheimer's Drugs: Updates to CMS National Patient Registry
- Epileptologists: New Physician Specialty Code
- Medicare Diabetes Prevention Program Supplier Enrollment: Updated CDC Organization Codes
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Help People Living with Disabilities Get the Care They Need

Compliance

- Negative Pressure Wound Therapy: Prevent Claim Denials

Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests: Now Virtual-Only on July 25-26

Publications

- Post-Acute Care Quality Reporting Programs: Technical Expert Panel Measurement Sets Report

MLN Connects

MLN Connects - July 18, 2024

MLN Connects Newsletter: July 18, 2024

News

- Final Part Two Guidance to Help People with Medicare Prescription Drug Coverage Manage Prescription Drug Costs
- Medicare Ground Ambulance Data Collection System: Submit Comments by September 9
- Medicare Providers: Deadlines for Joining an Accountable Care Organization
- Skilled Nursing Facility Value-Based Purchasing Program: May 2 Webinar Materials Available
- CMS Roundup (July 12, 2024)

Claims, Pricers, & Codes

- ICD-10-CM Diagnosis Codes: FY 2025

Events

- Medicare Advisory Panel on Clinical Diagnostic Laboratory Tests: Now Virtual-Only on July 25-26

Publications

- Guiding an Improved Dementia Experience Model

MLN Connects - July 25, 2024

MLN Connects Newsletter: July 25, 2024

News

- CMS Announces Resources & Flexibilities to Assist with Public Health Emergency in Texas
- CMS Oral Health Cross-Cutting Initiative Fact Sheet
- Doctors & Clinicians: Utilization Data on Medicare.gov Compare Tool
- Help Improve the Program for Evaluating Payment Patterns Electronic Reports & Comparative Billing Reports
- Viral Hepatitis: Talk with Your Patients About Shots & Screenings

MLN Connects

Compliance

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

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: October Update
- Lymphedema Compression Treatment Items: Implementation - Revised

Publications

- Ground Ambulance Industry Trends 2017-2022

Multimedia

- Post-Acute Care Quality Reporting Programs: FY & CY 2025 Program Updates Web-Based Training

From Our Federal Partners

- Disruptions in Availability of Becton Dickinson BACTEC Blood Culture Bottles

MLN Connects - August 1, 2024

MLN Connects Newsletter: Aug 1, 2024

Final Payment Rules

- Skilled Nursing Facility FY 2025 Final Rule
- Inpatient Rehabilitation Facility FY 2025 Final Rule
- Inpatient Psychiatric Facility FY 2025 Final Rule
- Hospice FY 2025 Final Rule

News

- CMS Roundup (July 26, 2024)
- Opioid Treatment Program: Learn How to Bill Medicare

Claims, Pricers, & Codes

- DMEPOS: Provider Level Adjustment Codes on Remittance Advice

MLN Connects

Publications

- Beneficiaries Dually Eligible for Medicare & Medicaid - Revised

Multimedia

- Post-Acute Care Quality Reporting Programs: Patient Mood Interview Video Tutorial

MLN Connects - August 8, 2024

MLN Connects Newsletter: Aug 8, 2024

Final Payment Rule

- Hospital Inpatient Prospective Payment System & Long-Term Care Hospital Prospective Payment System FY 2025 Final Rule

News

- Transitional Coverage for Emerging Technologies - Final Notice
- Help Improve the Program for Evaluating Payment Patterns Electronic Reports & Comparative Billing Reports - Updated Request for Information
- Immunization: Protect Your Patients

Compliance

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

Claims, Pricers, & Codes

- Clinical Laboratory Improvement Amendments: Reprocessing Denied Claims
- Skilled Nursing Facility Prospective Payment System: FY 2025 Pricer Update

Multimedia

- Clinical Diagnostic Laboratory Tests: Medicare Advisory Panel Meeting Materials

From Our Federal Partners

- Mpox Caused by Human-to-Human Transmission of Monkeypox Virus in the Democratic Republic of the Congo with Spread to Neighboring Countries
- Ready to Get Paid via EFT for CHAMPVA Claims?

MLN Connects

MLN Connects - August 15, 2024

MLN Connects Newsletter: Aug 15, 2024

News

- Negotiating for Lower Drug Prices Works, Saves Billions
- Resources & Flexibilities to Assist with the Public Health Emergency in Florida, Georgia, and South Carolina
- Hospitals: New EMTALA Poster for Use in Emergency Departments
- PrEP for HIV Transition of Coverage: Get Ready Now
- CMS Roundup (August 9, 2024)
- ESRD: Oral-Only Renal Dialysis Service Drugs & Biological Products - Revised Guidance

Compliance

- Patient Lifts: Prevent Claim Denials

Claims, Pricers, & Codes

- Telehealth Services: Billing & Payment for Place of Service Code 10
- Medicare Physician Fee Schedule Database: October Update

MLN Matters® Articles

- Hospice Payments: FY 2025 Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2025 Update
- Hospital Outpatient Prospective Payment System: July 2024 Update - Revised

Publications

- Skilled Nursing Facility Place of Service Codes: Updated Resources

From Our Federal Partners

- Increase in Human Parvovirus B19 Activity in the U.S.

MLN Connects

MLN Connects - August 22, 2024

MLN Connects Newsletter: Aug 22, 2024

News

- Commemorating the 2nd Anniversary of the Lower Cost Prescription Drug Law
- MolDx Local Coverage Determination Statement
- Hospital Price Transparency: Get Resources to Help You Comply
- New Residency Programs Request for Information: Submit Comments by October 15
- Open Payments: Program Year 2023 Data

Claims, Pricers, & Codes

- Seasonal Flu Vaccine Pricing for 2024-2025 Season
- Inpatient Rehabilitation Facility Prospective Payment System: FY 2025 Pricer Update
- Home Health Prospective Payment System Grouper: October Update

Publications

- A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies - Revised
- Chronic Care Management Services - Revised

From Our Federal Partners

- Increased Oropouche Virus Activity & Associated Risk to Travelers

MLN Matters

Clarification of Liability for DMEPOS Claims Overlapping Inpatient Hospital Stays

Related CR Release Date: May 31, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

Related Change Request (CR) Number: CR 13631

Related CR Transmittal Number: R12667OTN

CR 13631 updates the denial liability from a patient responsibility liability to a contractual obligation liability.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13631.

DMEPOS Fee Schedule: July 2024 Quarterly Update

Related CR Release Date: June 13, 2024

Effective Date: July 1, 2024 - except for fee schedules for HCPCS codes E2298 and K1007 effective April 1, 2024

Implementation Date: July 1, 2024

MLN Matters Number: MM13658

Related Change Request (CR) Number: CR 13658

Related CR Transmittal Number: R12685CP

Related CR Title: July Quarterly Update for 2024 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

CR 13658 tells you about:

- Updates to CY 2024 fee schedule amounts for certain DMEPOS codes
- Changes in payment policy
- New fee schedule information for HCPCS codes K1007 and E2298

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13658.

MLN Matters

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

Related CR Release Date: June 4, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

Related Change Request (CR) Number: CR 13560

Related CR Transmittal Number: R12670CP

CR 13560 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)13560.

Lymphedema Compression Treatment Items: Implementation - Revised

Related CR Release Date: January 24, 2024 & July 18, 2024

Effective Date: January 1, 2024 & January 1, 2025

Implementation Date: January 2, 2024 & January 6, 2025

MLN Matters Number: MM13286 Revised

Related Change Request (CR) Number: CR 13286 & CR 13670

Related CR Transmittal Number: R12471CP & R12725OTN

Note: CMS added information on how to prevent claims denial due to duplicate payments for compression bandaging systems (pages 1 & 4). Substantive content changes are in dark red.

CR 13670 tells you about the new Medicare DMEPOS benefit category starting January 1, 2024, including:

- Codes
- Billing
- Payment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13670.

MLN Matters

Medicare Benefit Policy Manual Update: DMEPOS BCD

Related CR Release Date: June 13, 2024

Effective Date: January 1, 2024 - for 3 orthotic brace determinations; April 1, 2024 - for all other items, equipment, and devices

Implementation Date: July 15, 2024

MLN Matters Number: MM13651

Related Change Request (CR) Number: CR 13651

Related CR Transmittal Number: R12684BP

CR 13651 tells you about:

- Updates to Section 110.8, Medicare Benefit Policy Manual, Chapter 15
- Added DMEPOS items and their national benefit category determinations (BCDs)

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13651.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: February 8, 2024

Effective Date: July 1, 2024

Implementation Date: July 1, 2024

Related Change Request (CR) Number: CR 13517

Related CR Transmittal Number: R12498CP

CR 13517 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and to instruct the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13517.

Replacement Wheelchair Equipment When the Manufacturer Exits Wheelchair Business - Revised

Related CR Release Date: July 8, 2024

Effective Date: July 8, 2024

Implementation Date: August 5, 2024

Related Change Request (CR) Number: CR 13610

Related CR Transmittal Number: R12768OTN

Note: CMS revised the background section clarifying the replacement scenario discussed in this change request does not apply to situations when the wheelchair equipment does not yet need repairs that require replacement parts or when repair / replacement parts (e.g. aftermarket) are available from other sources other than the discontinued manufacturer that can be used to make the wheelchair equipment operable for the reasonable useful lifetime of the equipment.

CR 13610 provide instructions for processing claims for replacement power or manual wheelchairs when 1) the manufacturer exits the wheelchair business resulting in the wheelchair ceasing to exist on the market, and 2) there is no availability of aftermarket repair or replacement parts to make the manufacturer's equipment operable.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13610.

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.