DME Happenings

Jurisdiction D
December 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

In this Issue

In this Issue

In this Issue

Billing for Hospital Bed Upgrades

Following proper coding and billing guidelines is crucial when billing for Durable Medical Equipment (DME) hospital bed upgrades. A hospital bed upgrade occurs when a supplier provides a bed that exceeds Medicare's standard coverage-such as offering an E0265 (fully electric hospital bed) instead of an E0260 (semi-electric hospital bed) or an E0250 (fixed-height hospital bed). Medicare will only cover the cost of the equipment deemed a medical necessity, but upgrades may be provided in certain circumstances. There are three typical scenarios for which an upgrade is provided.

1. The physician ordered the upgrade
2. The beneficiary requested the upgrade
3. The supplier provides the upgrade for convenience

Because Medicare will only pay for the medically necessary items, it is pertinent to determine what the beneficiary qualifies for based on the Local Coverage Determination (LCD). Items that are not deemed medically necessary may be provided as an upgrade. For example, the physician wrote the order for, and the beneficiary meets coverage requirements for a semi-electric hospital bed (E0260); however, the supplier only has a total electric bed (E0265) in stock. The supplier may choose to provide the beneficiary with the E0265 for their convenience and bill the E0265 as an upgrade.

When billing upgrades, suppliers must ensure the proper modifiers are appended to the claim lines. If the supplier wants to collect the difference in cost for the E0265, the supplier must obtain a properly executed Advance Beneficiary Notice of Noncoverage (ABN).

- **GA:** Waiver of liability statement issued as required by payer policy (used when an ABN is on file).
- **GK:** Reasonable and necessary item/service associated with a GA or GZ modifier.
- **GL:** Medically unnecessary upgrade provided instead of non-upgraded item, no charge, no ABN.

Billing Example 1: Upgrade with Beneficiary Payment

Scenario: The beneficiary wants a fully electric bed (E0265), but Medicare only covers a semi-electric bed (E0260).

Steps:

1. Obtain a signed ABN from the beneficiary.
2. Submit two claim lines:
    - **Line 1:** Bill the E0265 with a **GA modifier** (denied as not medically necessary. The difference between what Medicare covers, and the upgrade is beneficiary liability).

- **Line 2:** Bill the E0260 with a **GK modifier** (physician ordered, medically necessary equipment processed and reimbursed by Medicare).

Example 1 Outcome:

- Medicare pays for the medically necessary E0260.
- The beneficiary pays the difference between E0265 and E0260, plus any deductible or coinsurance.

Billing Example 2: Upgrade at No Extra Charge

Scenario: The supplier provides a fully electric bed (E0265) but does not charge the beneficiary for the difference.

Steps:

1. Submit one claim line:
- **Line 1:** E0260 with **GL modifier**.
    1. No ABN is required
- Include a narrative description of the upgraded item (E0265).

Example 2 Outcome:

- Medicare pays for E0260.
- The supplier absorbs the cost difference.

Billing Medicare FFS for a hospital bed upgrade like E0265 requires careful attention to documentation, modifier usage, and billing. By following CMS guidelines, suppliers can ensure compliance and proper reimbursement.

CERT Review Contractor Phone Number Misidentified as Spam

It has come to our attention that some providers and suppliers have mistakenly flagged the CERT Review Contractor (CERT RC), Empower, AI, Inc., phone number - 888-779-7477 - as spam or have inadvertently blocked it. This has led to communication challenges that may hinder the effectiveness of the CERT program.

The CERT RC uses this number to contact providers and suppliers regarding documentation requests and other important matters related to CERT reviews. Blocking or ignoring calls from this number can result in:

- Delayed responses to documentation requests
- Missed deadlines that may affect claim reviews
- Payment recoupment due to unaddressed CERT requests
- Increased error rates due to incomplete or missing information

Noridian requests your assistance:

- Recognize 888-779-7477 as a legitimate and official phone number used by the CERT RC.
- Coordinate with your IT department to flag this number as safe.
- Ensure that staff responsible for responding to CERT inquiries are aware of this phone number and its importance.

For questions:

CERT Documentation Center

Toll Free: 888-779-7477

Email: certprovider@empower.ai

Next Steps for MSP Denials

If you've received a denial on a Medicare claim due to Medicare being billed as the primary payer when it should have been secondary, you might be wondering what to do next. The instinct may be to file an appeal-but that's not always the right step.

When Medicare is incorrectly billed as primary, the denial is typically due to a coordination of benefits (COB) issue. In these cases, you should submit an MSP Inquiry Form, not an appeal.

This form allows the Medicare Administrative Contractor (MAC) to investigate and correct the COB information. Once the COB is updated, you can resubmit the claim correctly.

When submitting the MSP Inquiry Form, be sure to include documentation from the primary insurance that confirms Medicare should be secondary. This helps the MAC verify the correct payer order and process the correction more efficiently.

Key Steps for Suppliers

- Submit an MSP Inquiry Form if Medicare was billed as primary but should have been secondary.
- Include COB documentation from the primary insurer with the form.
- Contact the MAC to correct COB records before initiating any appeals.
- Only appeal if the claim was correctly submitted and still denied for other reasons.

CMS and Noridian have published guidance confirming this process. For example:

- CMS MLN Matters SE21002 advises providers to review billing orders and contact the MAC before appealing.
- Noridian's MSP resources clarify that MSP denials are too complex for reopening and often require COB updates instead.

By following the correct process, suppliers can avoid unnecessary delays and ensure claims are handled efficiently. If you need help locating the MSP Inquiry Form or understanding the COB correction process, reach out to your MAC's supplier contact center.

Noridian Medicare Pneumatic Compression Devices Webpage

The Noridian Medicare Pneumatic Compression Devices (PCD) webpage provides detailed guidance on the coverage, coding, and documentation requirements for PCDs under Medicare. These devices are used primarily for treating conditions like lymphedema and chronic venous insufficiency.

Key highlights include:

- **Coverage Criteria:** As of November 14, 2024, the Local Coverage Determination (LCD) and related policy articles have been retired. Coverage is now governed by National Coverage Determination (NCD) 280.6. This outlines general and specific criteria for devices coded E0650, E0651, and E0652.
- **Documentation Requirements:** Providers must document the patient's diagnosis, symptoms, prior treatments, and response to initial PCD use. A four-week trial with compression therapy is required before prescribing devices.
- **Device-Specific Guidance:**
    - **E0652:** Requires documentation of unique patient characteristics that justify the need for a more advanced device.
    - **E0675:** Lacks specific policy guidance; claims are reviewed individually and may require appeals if denied.
- **Checklists and Tools:** The site includes clinician checklists and documentation templates to assist with compliance and reduce claim denials.

This resource is essential for suppliers and clinicians to ensure proper Medicare billing and reimbursement for PCDs.

News

Required Prior Authorization (PA) Program Pre-Claim Reviews

The Jurisdiction D, DME MAC, Medical Review Department conducts Prior Authorization (PA) reviews for select durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items per the CMS. The following quarterly non-affirmation results from July 2025 - September 2025 can be located on the Required Prior Authorization Programs webpage:

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

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction D, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from July 2025 - September 2025 can be located on the Medical Record Review Results webpage:

- Glucose Monitors & Supplies
- Enteral Nutrition
- Knee Orthosis
- Manual Wheelchairs
- Ostomy Supplies
- Oxygen
- Parenteral Nutrition
- Pneumatic Compression Devices (PCD)
- Positive Airway Pressure (PAP) Devices
- Surgical Dressing Supplies
- Therapeutic Shoes for Persons with Diabetes
- Urological Supplies

News

Using the KX Modifier When Billing Manual Wheelchair Claims

The KX modifier signals that all Medicare coverage criteria for a manual wheelchair have been met. It should only be used when the patient meets the following:

- Has a mobility limitation affecting daily activities (e.g., toileting, dressing)
- Cannot use a cane or walker
- Will benefit from a manual wheelchair used regularly at home
- Can self-propel or have a caregiver to assist

Required Documentation

To support the KX modifier, suppliers must have:

- A signed Standard Written Order (SWO)
- Medical records meet the requirements of the Local Coverage Determination (LCD) and Policy Article for Manual Wheelchairs
- A home assessment
- Delivery documentation with item details

Do not use the KX modifier if any criteria are unmet-use GA or GZ instead. For more information review the HCPCS Modifier section within the LCD.

Medical Policies and Coverage

2025 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2025 HCPCS Code Update -October Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2025 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

Additive Manufacturing Prosthetic Devices - Correct Coding

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

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Correct Billing for Upper Limb Prosthesis with L6895 instead of L7499 - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Billing for Upper Limb Prosthesis with L6895 instead of L7499 - Revised**, has been created and published to our website.

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Medical Policies and Coverage

Correct Coding - Partial Hand Prostheses - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Correct Coding - Partial Hand Prostheses - Revised**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for September 18, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for September 18, 2025**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for October 2, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for October 2, 2025**, has been created and published to our website.

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Medical Policies and Coverage

LCD and Policy Article Revisions Summary for October 9, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for October 9, 2025**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for October 23, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for October 23, 2025**, has been created and published to our website.

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LCD and Policy Article Revisions Summary for October 30, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for October 30, 2025**, has been created and published to our website.

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Medical Policies and Coverage

LCD and Policy Article Revisions Summary for November 13, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD and Policy Article Revisions Summary for November 13, 20**25, has been created and published to our website.

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Lithium Batteries - Correct Coding - Revised

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

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Open Meeting Agenda - Nebulizers Proposed Local Coverage Determination (LCD)

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

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Medical Policies and Coverage

Open Meeting Agenda - Urological Supplies Proposed Local Coverage Determination (LCD)

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

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Pneumatic Compression Devices - Correct Coding and Billing - Revised

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Policy Article Revisions Summary for September 4, 2025

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for September 4, 2025**, has been created and published to our website.

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Medical Policies and Coverage

Power Wheelchair Hardware and Accessories

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Power Wheelchair Hardware and Accessories**, has been created and published to our website.

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Power Wheelchair Hardware and Accessories - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Power Wheelchair Hardware and Accessories - Revised**, has been created and published to our website.

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Recordings and Transcripts Published - August 27, 2025 Virtual Open Meetings

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Recordings and Transcripts Published - August 27, 2025 Virtual Open Meetings** has been created and published to our website.

View the locally hosted 2025 DMD articles.

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Medical Policies and Coverage

Recordings and Transcripts Published - October 2, 2025 Virtual Open Meetings

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Recordings and Transcripts Published - October 2, 2025 Virtual Open Meetings**, has been created and published to our website.

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Scoliosis Brace - Correct Coding - Revised

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

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Urological Supplies - Final LCD and Response to Comments (RTC) Article Published

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

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MLN Connects

MLN Connects - September 4, 2025

MLN Connects® Newsletter for Thursday, September 4, 2025

Fraud, Waste & Abuse

- Ambulatory Surgical Centers: Prior Authorization Pilot Demonstration

Compliance

- DME: Complying with Proof of Delivery Requirements

Claims, Pricers & Codes

- National Correct Coding Initiative: October Update

MLN Matters® Articles

- Implementing the Transforming Episode Accountability Model: Skilled Nursing Facility 3-Day Rule Waiver

Publications & Multimedia

- Complying with Medicare Signature Requirements - Revised

MLN Connects - September 11, 2025

MLN Connects® Newsletter for Thursday, September 11, 2025

News

- Clinical Laboratory Fee Schedule: Submit Comments & Reconsideration Requests by October 9

Fraud, Waste & Abuse

- CMS IDea Challenge: Submit Interest Form by September 26

Compliance

- Orthopedic Footwear: Prevent Claim Denials

MLN Connects

Claims, Pricers & Codes

- COVID-19 Vaccine Pricing for 2025-2026 Season
- Ambulatory Surgical Center: Medicare Approved New High-Cost Gene Therapy Drug
- Medicare Part B Drug Pricing Files & Revisions: October Update
- Medicare Physician Fee Schedule Database: October Update
- Clinical Laboratory Fee Schedule: Revised Third Quarter File

MLN Matters® Articles

- National Fee Schedule for Vaccine Administration: October 2025 Update

MLN Connects - September 18, 2025

MLN Connects® Newsletter for Thursday, September 18, 2025

News

- Information for Critical Access Hospitals
- Prostate Cancer: Talk to Your Patients about Screening

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Laboratory Services Subject to Reasonable Charge Payment: October 2025 Update
- DMEPOS Fee Schedule: October 2025 Quarterly Update

Publications & Multimedia

- Evaluation and Management Services - Revised
- Ground Ambulance Data Collection System Codebook - Updated

MLN Connects - September 25, 2025

MLN Connects® Newsletter for Thursday, September 25, 2025

News

- Outpatient Therapy Services: Clarifying Qualifications for Speech-Language Pathologists
- Cognitive Assessment: Recommend Medicare-Covered Services for Your Patients

MLN Connects

Fraud, Waste & Abuse

- Duplicate Enrollment in Medicaid & Marketplace: New Fast Facts

Compliance

- Manual Wheelchairs: Prevent Claim Denials

Claims, Pricers & Codes

- Clinical Laboratory Fee Schedule: COVID-19 & Influenza Virus Types A and B Test Code
- Drug Claims: Billing for Zero Charges

MLN Matters® Articles

- Hospice Payments: FY 2026 Update
- Inpatient & Long-Term Care Hospital Prospective Payment Systems: FY 2026 Changes
- Medicare Claims Processing Manual, Chapter 18 Update: Hepatitis C Virus Preventive & Screening Services
- Medical Severity Diagnosis-Related Groups Subject to Inpatient Prospective Payment System Replaced Devices Policy: FY 2026 Update

From Our Federal Partners

- Ebola Outbreak in the Democratic Republic of the Congo

MLN Connects - October 1, 2025

Update on Medicare Operations: Telehealth, Claims Processing, and Medicare Administrative Contractors Status During the Shutdown

When certain legislative payment provisions ("extenders") are scheduled to expire, CMS directs all Medicare Administrative Contractors (MACs) to implement a temporary claims hold. This standard practice is typically up to 10 business days and ensures that Medicare payments are accurate and consistent with statutory requirements. The hold prevents the need for reprocessing large volumes of claims should Congress act after the statutory expiration date and should have a minimal impact on providers due to the 14-day payment floor. Providers may continue to submit claims during this period, but payment will not be released until the hold is lifted.

MLN Connects

Absent Congressional action, beginning October 1, 2025, many of the statutory limitations that were in place for Medicare telehealth services prior to the COVID-19 Public Health Emergency will take effect again for services that are not behavioral and mental health services. These include prohibition of many services provided to beneficiaries in their homes and outside of rural areas and hospice recertifications that require a face-to-face encounter. In some cases, these restrictions can impact requirements for meeting continued eligibility for other Medicare benefits. In the absence of Congressional action, practitioners who choose to perform telehealth services that are not payable by Medicare on or after October 1, 2025, may want to evaluate providing beneficiaries with an Advance Beneficiary Notice of Noncoverage. Practitioners should monitor Congressional action and may choose to hold claims associated with telehealth services that are not payable by Medicare in the absence of Congressional action. Additionally, Medicare would not be able to pay some kinds of practitioners for telehealth services. For further information: https://www.cms.gov/medicare/coverage/telehealth.

CMS notes that the Bipartisan Budget Act of 2018 allows clinicians in applicable Medicare Shared Savings Program Accountable Care Organizations (ACOs) to provide and receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restriction and in the beneficiary's home. There is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers. Clinicians in applicable ACOs can provide these covered telehealth services and bill Medicare for the telehealth services that are permissible under Medicare rules during CY 2025, irrespective of further Congressional action. For more information:

https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf.

MACs will continue to perform all functions related to Medicare Fee-for-Service claims processing and payment.

MLN Connects Special Edition: Claims Hold Update - October 15, 2025

MLN Connects® Newsletter for Wednesday, October 15, 2025

News

- Claims Hold Update

Claims, Pricers & Codes

- NCCI Alert: COVID-19 Vaccine Administration Edit Revision

MLN Connects

MLN Connects Special Edition: Claims Hold Update - October 21, 2025

Claims Hold Update

CMS instructed all Medicare Administrative Contractors (MACs) to lift the claims hold and process claims with dates of service of October 1, 2025, and later for certain services impacted by select expired Medicare legislative payment provisions passed under the Full-Year Continuing Appropriations and Extensions Act, 2025 (Pub. L. 119-4, Mar. 15, 2025). This includes claims paid under the Medicare Physician Fee Schedule, ground ambulance transport claims, and Federally Qualified Health Center (FQHC) claims. This includes telehealth claims that CMS can confirm are definitively for behavioral and mental health services. CMS has directed all MACs to continue to temporarily hold claims for other telehealth services (i.e. those that CMS cannot confirm are definitively for behavioral and mental health services) and for acute Hospital Care at Home claims.

Beginning October 1, 2025, for services that are not behavioral health services, many of the statutory limitations on payment for Medicare telehealth services that were, in response to the COVID-19 Public Health Emergency, lifted, and subsequently extended, through legislation again took effect. These include prohibition of many services provided to beneficiaries in their homes and outside of rural areas, and hospice recertifications that require a face-to-face encounter. In the absence of Congressional action, practitioners who choose to perform telehealth services that are not payable by Medicare on or after October 1, 2025, may want to evaluate providing beneficiaries with an Advance Beneficiary Notice of Noncoverage (ABN). Further information on use of the ABN, including ABN forms and form instructions: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-abn. Practitioners should monitor Congressional action and may choose to hold claims associated with telehealth services that are currently not payable by Medicare in the absence of Congressional action. For further information: https://www.cms.gov/medicare/coverage/telehealth.

CMS notes that the Bipartisan Budget Act of 2018 (Pub. L. 115-123, Feb. 9, 2018), which added section 1899(l) to the Social Security Act, allows clinicians in applicable Medicare Shared Savings Program Accountable Care Organizations (ACOs) to provide and receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restrictions and in the beneficiary's home. Separate from requirements to participate in the Medicare Shared Savings Program, there is no special application or approval process for applicable ACOs or their ACO participants or ACO providers/suppliers to offer these covered telehealth services. Clinicians in applicable ACOs can furnish and receive payment for covered telehealth services under these special telehealth flexibilities. For clinicians in applicable ACOs, telehealth claims that CMS can confirm are definitively for behavioral and mental health services will be paid. At this time, claims for some telehealth services will continue to be held. For more

information, including information on to which ACOs these flexibilities apply: https://www.cms.gov/files/document/shared-savings-program-telehealth-fact-sheet.pdf.

MLN Connects - November 3, 2025

Final Payment Rule

CMS Modernizes Payment Accuracy and Significantly Cuts Spending Waste

MLN Connects Special Edition: Update on Processing of Telehealth and Acute Hospital Care at Home Claims - November 7, 2025

In the absence of Congressional action, beginning October 1, 2025, many of the statutory limitations on payment for Medicare telehealth services that were, in response to the COVID-19 Public Health Emergency, lifted and subsequently extended through legislation again took effect. These statutory limitations include restrictions on payment for many telehealth services provided to beneficiaries in their homes and outside of rural areas, and the provision of hospice recertifications that require a face-to-face encounter via telehealth. These limitations are not applicable to all Medicare telehealth services, such as those for behavioral and mental health services, those for monthly ESRD-related clinical assessments, and those provided by applicable Medicare Shared Savings Program Accountable Care Organizations (ACO) participants.

CMS has been continuously evaluating our operations since October 1, 2025, and taking action when operationally feasible. To date, to ensure that CMS pays only the telehealth claims consistent with current law, CMS has instructed the Medicare Administrative Contractors (MACs) to pay telehealth claims with dates of service on and after October 1, 2025, when CMS can definitively confirm that the claims are for behavioral and mental health services or otherwise meet the requirements described at Section 1834(m) of the Social Security Act. CMS has identified these claims using the list of HCPCS codes identified in Table 1. Additionally, we have instructed the MACs to process Medicare telehealth claims with a place of service code 10 (patient's home) that contains a diagnosis code in the F01.A0-F99 range if the services were not performed by physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), or audiologists. We have further released a small batch of other telehealth claims that we can identify should be permissible to pay under current law.

However, due to systems limitations and recognizing that not all telehealth claims for behavioral and mental health services necessarily include a diagnosis code in the above range - often to further protect the privacy of the patient - we have not been able to

identify all claims that are payable under current law. These limitations have also impacted our ability to identify telehealth services performed by clinicians in applicable Medicare Shared Savings Program ACOs, who may receive payment for covered telehealth services to certain Medicare beneficiaries without geographic restrictions, including in the beneficiary's home, per section 1899(l) of the Social Security Act as added by the Bipartisan Budget Act of 2018 (Pub. L. 115-123). To date, this subset of telehealth claims, including those submitted by clinicians in applicable ACOs and those that we're not able to identify as for behavioral and mental health services, has been held.

To resolve this subset of claims and improve cash flow for practitioners, CMS is taking further action. For the subset of telehealth claims that are currently being held, and that were submitted on or before November 10, 2025, with dates of service on or after October 1, 2025, CMS will be returning those claims to providers. For professional claims, claims will be returned with the following messages: CARC 16 and RARC M77. Practitioners may resubmit returned claims that meet the statutory requirements.

See the spotlight on the All Fee-for-Service Providers webpage for information on statutory requirements and revised instructions for the submission of telehealth claims.

MLN Connects - November 20, 2025

MLN Connects® Newsletter for Thursday, November 20, 2025

News

- 2026 Medicare Parts A & B Premiums and Deductibles
- All 50 States Seek to Transform Rural Health with CMS
- CMS Releases Final Guidance for Initial Price Applicability Year 2028
- Information for Critical Access Hospitals
- Laboratories: Switch to Electronic Fee Coupons & CLIA Certificates
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- Medicare Improperly Paid Suppliers for Intermittent Urinary Catheters
- Parenteral Nutrition: Prevent Claim Denials

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: October 2025 Update
- Hospital Outpatient Prospective Payment System: October 2025 Update
- New Waived Tests

- DMEPOS Fee Schedule: October 2025 Quarterly Update - Revised

Publications & Multimedia

- Health Care Code Sets - Revised

Information for Patients

- 2026 Medicare & You Handbook

MLN Connects Special Edition: OPPS/ASC Final Payment Rule - November 24, 2025

CMS Empowers Patients and Boosts Transparency by Modernizing Hospital Payments

CMS is improving the quality of care for Medicare beneficiaries while significantly reducing unnecessary spending and improving choices and hospital price transparency for Medicare beneficiaries. The CY 2026 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System final rule (CMS-1834-FC) advances a series of patient-focused reforms that will modernize payments, expand access to care, enhance hospital accountability, and safeguard the Medicare Trust Funds from fraud, waste, and abuse.

More information:

- Full press release
- Final rule
- Fact sheet
- Hospital Price Transparency Policy Changes fact sheet

MLN Connects Special Edition: Medicare Participation Announcement for CY 2026: Decide by December 31

As you plan for next year, CMS reminds you of the advantages of participating in Medicare:

- You're paid the full Medicare Physician Fee Schedule allowed amount. If you're a non-participating provider, Medicare pays 5% less than the Medicare Physician Fee Schedule allowed amount.
- Medicare pays you directly (on an assignment-related basis).
- Medicare forwards claim information to Medigap (Medicare supplement coverage) insurance (if any).

MLN Connects

By December 31, 2025, all physicians, practitioners, and suppliers - regardless of their Medicare participation status - must decide whether to participate for CY 2026.

You don't need to do anything if you're:

- Already participating in Medicare, and you want to continue your participation
- Not currently participating, and you don't want to participate

See the Annual Medicare Participation Announcement webpage for more information on how to change your Medicare participation.

National Plan and Provider Enumeration System (NPPES) Taxonomy

Please check your data in NPPES and confirm that it still correctly reflects you as a health care provider with the appropriate taxonomy and correctly reflects your current practice address. Incorrect data in NPPES may lead to unnecessary inquiries about your credentials and delay enrollment with Medicare and health plans.

MLN Matters

DMEPOS Fee Schedule: October 2025 Quarterly Update - Revised

Related CR Release Date: September 29, 2025

MLN Matters Number: MM14214 Revised

Effective Date: October 1, 2025

Related Change Request (CR) Number: CR 14214

Implementation Date: October 6, 2025

Related CR Transmittal Numbers: R13388CP & R13436CP

Note: CMS revised this article to remove a reference to HCPCS Level II code E0716 (page 3). CMS also updated the CR release date, transmittal numbers, and transmittal links.

CR 14214 tells you about:

- Added and deleted HCPCS codes
- Corrected 2024 deflation factors originally found in the January 2025 DMEPOS fee schedule quarterly update

Make sure your billing staff knows about these updates effective October 1, 2025.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14214.

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) Review Contractor (RC) for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates a common 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 RC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT RC will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT RC via fax, the preferred method, or mail. Please see the CERT RC website for contact information at C3HUB.

Note: The CID number is the CERT reference number contained in the documentation request letter.

Suppliers may call the CERT RC with questions regarding specific documentation to submit.

Suppliers must submit medical records within 60 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 RC.

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.

Contacts, Resources, and Reminders

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.