DME Happenings

Jurisdiction A

September 2019

In This Issue...

FYI

ABN Form: Gain a Better Understanding to Avoid Denials 5

Automatic Mailing/Delivery of DMEPOS Reminder 5

Beneficiaries Call 1-800-MEDICARE 5

CMS Quarterly Provider Updates 6

Implementation to Exchange the List of eMDRs for Registered Providers via the esMD System - Revised 6

Jurisdiction A DME MAC Supplier Contacts and Resources 7

Medicare Learning Network Matters Disclaimer Statement 9

MSN Changes to Assist Beneficiaries Enrolled in the QMB Program - Revised.................... 10

Physician Documentation Responsibilities 10

Refunds to Medicare 10

Sources for “DME Happenings” Articles 11

Surgical Dressing Lookup Tools 11

Update to 46.2, 46.3, 46.4, and 46.5 in Publication (Pub.) 100-08 11

APPEALS

A DME MAC Program Manager Update: Redetermination Submission Tips 12

Appeals Decision Tree Helps Determine the Next Step 12

Redetermination Requests: Appellant Signatures No Longer Required Effective July 8, 2019 12

Supplier Information on the Upcoming DME QIC Transition 12

Telephone Reopenings: Resources for Success.. 12

CLAIM REVIEWS

CERT Documentation.. 15

Ankle Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Targeted Probe and Educate Review Updates: January-March 2019 15

Enteral Nutrition Targeted Probe and Educate Review Updates: January-March 2019....... 16

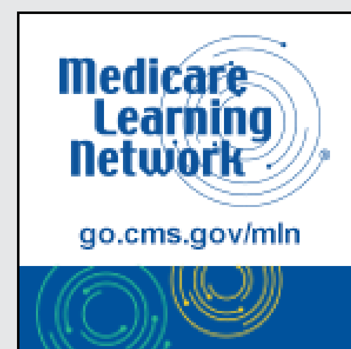
Glucose Monitors Targeted Probe and Educate Review Updates: January-March 2019...... 16

Hospital Beds Targeted Probe and Educate Review Updates: January-March 2019 16

CPT codes, descriptors, and other data only are copyright 2019 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS apply.

This Bulletin should be shared with all health care practitioners and managerial members of the provider/supplier staff. Bulletins are available at no-cost from our website at: http://med.noridianmedicare.com

Don’t be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select “Subscribe” on the bottom right-hand corner of any page.



https://go.cms.gov/mln//

noridian

Healthcare Solutions

Noridian Healthcare Solutions, LLC

Immunosuppressive Drugs Targeted Probe and Educate Review Updates: January-March 2019 16
Knee Orthoses Targeted Probe and Educate Review Updates: January-March 2019 17
Manual Wheelchair Bases Targeted Probe and Educate Review Updates: January-March 2019 17
Oral Anticancer Drugs Targeted Probe and Educate Review Updates: October - December 2018 17
Ostomy Supplies Targeted Probe and Educate Review Updates: January-March 2019 18
Oxygen Targeted Probe and Educate Review Updates: January-March 2019 18
Parenteral Nutrition Targeted Probe and Educate Review Updates: January-March 2019 18
Positive Airway Pressure (PAP) Devices Targeted Probe and Educate Review Updates: January-March 2019 18
Same or Similar: How to Avoid Denials 19
Spinal Orthoses Targeted Probe and Educate Review Updates: January-March 2019 19
Surgical Dressings Targeted Probe and Educate Review Updates: January-March 2019 19
Therapeutic Shoes Targeted Probe and Educate Review Updates: January-March 2019 19
Urological Supplies Targeted Probe and Educate Review Updates: January-March 2019 20

CODING

Condition of Payment Prior Authorization Expanding to Include Remaining Power Mobility Devices HCPCS Codes - Effective for Dates of Service on/after July 22, 2019 21
Correct Coding - Definitions Used for Off-the-Shelf versus Custom Fitted Prefabricated Orthotics (Braces) - Revised - Now Available 21
HCPCS Drug/Biological Code Changes - October 2019 Update 21
Quarterly HCPCS Drug/Biological Code Changes - July 2019 Update - Revised 21

COVERAGE

Condition of Payment Prior Authorization Program Expanding to Include Pressure Reducing Support Surfaces - Effective for Dates of Service on/after July 22, 2019 23
KF Modifier Use Correct Coding - Now Available 23
LCD and Policy Article Revisions Summary for July 18, 2019 - Now Available 23
Medicare Prior Authorization Condition of Payment for Group 2 - Pressure Reducing Support Surfaces Dear Clinician Letter - Now Available 23
New HCPCS Code - Revefenacin (Yupelri) - J7677 - Now Available 24
Partial Hand Prostheses Correct Coding - Now Available 24
Policy Article Revisions Summary for July 25, 2019 - Now Available 24
Policy Article Revisions Summary for August 8, 2019 24
Sleep Test Scoring and Medicare Dear Clinician Letter - Now Available 25
Tumor Treatment Field Therapy (TTFT) Final LCD (L34823) and Response to Comments (RTC) Article Published - Now Available 25
Tumor Treatment Field Therapy (TTFT) Open Meeting Agenda - Now Available 25

EDUCATIONAL

ABN DME on Demand Tutorial Available 26

External Infusion Pump DME on Demand Tutorials Available 26
Immunosuppressive Drugs DME on Demand Tutorial Available....26
Medicare Beneficiary Identifier (MBI) Retrieval and Resources Tutorial Now Available....26
Prior Authorization DME on Demands Available....26
Surgical Dressings and Supply Elements Required on DWO 26
Urological Supplies Documentation Checklist Available 27

EMERGENCIES AND DISASTERS

Tropical Storm Barry and Medicare Disaster Related Louisiana Claims....28

FEE SCHEDULE

DMEPOS Fee Schedule - July 2019 Update - Revised 29

ICD-10

ICD-10 and Other Coding Revisions to NCDs - January 2020 Update....30

MBI

MBI on Remittance Advice 31
New Medicare Beneficiary Identifier (MBI) Get It, Use It - Reissued 31

MEDICAL POLICIES

Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home 32
Ostomy Supplies: Usual Maximum Quantity....32

MLN CONNECTS

MLN Connects - June 6, 2019 33
MLN Connects - June 13, 2019 33
MLN Connects - June 20, 2019 34
MLN Connects - June 27, 2019 34
MLN Connects - July 11, 2019 35
MLN Connects - July 18, 2019 35
MLN Connects - July 25, 2019 36
MLN Connects - August 1, 2019 37
MLN Connects - August 8, 2019 38
MLN Connects - August 15, 2019 39
MLN Connects - August 22, 2019 40
MLN Connects - August 29, 2019 41
MLN Connects Special Edition - June 6, 2019....42
MLN Connects Special Edition - June 10, 2019....42
MLN Connects Special Edition - July 11, 2019 43

MLN Connects Special Edition - July 29, 2019 44
MLN Connects Special Edition - August 2, 2019 46
MLN Connects Special Edition - August 13, 2019 47

NORIDIAN MEDICARE PORTAL

HMO and MCO Details Available within NMP 48
NMP: Upload Appeals Documentation to a Submitted Request 48
Prior Authorization Request Submission Now Available in NMP 48
Transfer of Appeal Rights Form May be Submitted via NMP 48

OXYGEN

Oxygen Policy Update 49

REIMBURSEMENTS

Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - October 2019 50

REMITTANCE ADVICE

Claim Status Category and Claim Status Codes Update 51
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE 51

UPDATES

Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code Set Update 52
Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC, and CAGC Rule - Update from CAQH CORE 52
Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019 52

ABN Form: Gain a Better Understanding to Avoid Denials

Have you received a denial for an invalid Advance Beneficiary Notice of Noncoverage (ABN) form? Visit the ABN webpage to expand your knowledge on the Limitation of Liability, Refund Requirements, see examples, and access educational resources about the process.

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

Beneficiaries Call 1-800-MEDICARE

Suppliers are reminded that when beneficiaries need assistance with Medicare questions or claims that they should be referred to call 1-800-MEDICARE (1-800-633-4227) for assistance. The supplier contact center only handles inquiries from suppliers.

The table below provides an overview of the types of questions that are handled by 1-800-MEDICARE, along with other entities that assist beneficiaries with certain types of inquiries.

Organization	Phone Number	Types of Inquiries
1-800-MEDICARE	1-800-633-4227	General Medicare questions, ordering Medicare publications or taking a fraud and abuse complaint from a beneficiary
Social Security Administration	1-800-772-1213	Changing address, replacement Medicare card and Social Security Benefits
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
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, http://www.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 and access MyMedicare.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

CMS Quarterly Provider Updates

The Quarterly Provider Update is a listing of non-regulatory changes to Medicare including Program Memoranda, manual changes, and any other instructions that could affect providers or suppliers. This comprehensive resource is published by CMS on the first business day of each quarter. Regulations and instructions published in the previous quarter are also included in the Update. The purpose of the Quarterly Provider Update is to:

- Inform providers about new developments in the Medicare program;
- Assist providers in understanding CMS programs ad complying with Medicare regulations and instructions;
- Ensure that providers have time to react and prepare for new requirements;
- Announce new or changing Medicare requirements on a predictable schedule; and
- Communicate the specific days that CMS business will be published in the Federal Register.

The Quarterly Provider Update can be accessed at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

Implementation to Exchange the List of eMDRs for Registered Providers via the esMD System - Revised

MLN Matters Number: MM11003 Revised
Related CR Release Date: April 16, 2019
Related CR Transmittal Number: R2281OTN
Related Change Request (CR) Number: 11003
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Note: CMS revised this article on August 26, 2019, to reflect changes made to the eMDR registration screens within NPPES. The article includes illustrations of the new screens that providers will have to complete in order to register to receive the eMDRs. In particular, the steps and screens relating to "Create new Endpoint Information in NPPES" and "Delete an existing Endpoint Information in NPPES" have been revised or added. A section discussing "Who should Register the endpoint information in NPPES" was also added. The NPPES updates result in no changes to the CR. All other information is unchanged.

CR 11003 introduced the enrollment process for the providers who intend to get their Additional Documentation Request (ADR) letters electronically (as eMDR) through their registered Health Information Handler (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/Which_HIHs_Plan_to_Offer_Gateway_Services_to_Providers.html). Make sure your billing staffs are aware of these changes.

In response to a number of requests from Medicare providers, the Centers for Medicare & Medicaid Services (CMS) is adding the functionality to send ADR letters electronically. CMS conducted a pilot supporting the electronic version of the ADR letter known as Electronic Medical Documentation Request (eMDR) via the Electronic Submission of Medical Documentation (esMD) system.

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

Jurisdiction A DME MAC Supplier Contacts and Resources

PHONE NUMBERS

Department/System	Phone Number	Availability
Interactive Voice Response System (IVR)	866-419-9458	24/7 for Eligibility 8 a.m. - 5 p.m. for all other inquiries
Supplier Contact Center	866-419-9458	Monday - Friday 8 a.m. - 5 p.m. ET
Telephone Reopenings	866-419-9458	Monday - Friday 8 a.m. - 5 p.m. ET
Beneficiary Customer Service	800-633-4227	24/7

FAX NUMBERS

Department	Fax Number
Reopenings/Redeterminations Recovery Auditor Redeterminations	701-277-2425
Recoupment • Refunds to Medicare • Immediate Offsets	701-277-2427
MSP Refunds	701-277-7892
Recovery Auditor Offsets	701-277-7896
MR Medical Documentation	701-277-2426

EMAIL ADDRESSES

Correspondence	When to Use This Address	Email Address
Customer Service	Suppliers can submit emails to Noridian for answers regarding basic supplier information regarding Medicare regulations and coverage	See webpage https://med.noridianmedicare.com/web/jadme/contact/email-customer-service
Comprehensive Error Rate Testing (CERT)	Use this address for CERT related inquiries, such as outcomes and status checks. *Include the CID within the message*	jadmecert@noridian.com
Congressional Inquiries or FOIA Requests	Use this address when submitting Freedom of Information Act (FOIA) requests or if the request is coming from a Congressional office. *Emails sent to this address require specific information. Review the Freedom of Information Act or Congressional Inquiries webpages for a full listing of required items to include*	DMEACongressional.FOIA@noridian.com

Correspondence	When to Use This Address	Email Address
LCD: New LCD Request	Use this address to request the creation of a new LCD. *Emails sent to this address require specific information. Review the New LCD Request Process webpage for a full listing of required items to include*	DMERecon@noridian.com
LCD Reconsideration Request	Use this address to request a revision to an existing LCD. *Emails sent to this address require specific information. Review the LCD Reconsideration Process webpage for a full listing of required items to include*	DMERecon@noridian.com
Recoupment	Use this address to submit requests for immediate offsets of open debt(s)	dmemsprecoupment@noridian.com
Reopenings and Redeterminations	Use this address with questions regarding: Timely Filing Inquiries, Appeal Rights and Regulations, Coverage Questions, Redetermination Documentation Requirements, Social Security Laws, Interpretation of Redetermination Decisions and Policies	dmeredeterminations@noridian.com
Website Questions	Use this form to report website ease of use or difficulties	See webpage https://med.noridianmedicare.com/web/jadme/help/website-feedback
CMS Comments on Noridian	Use this contact information to send comments to CMS concerning Noridian's performance	See webpage https://med.noridianmedicare.com/web/jadme/contact/cotr

MAILING ADDRESSES

Department	Address
• Advance Determination of Medicare Coverage Requests • Claim Submission • Congressional Inquiries • Correspondence • Education • Freedom of Information Act (FOIA) • Medical Review Documentation • Recovery Auditor Overpayments • Redetermination Requests • Refunds • Written Reopening Requests	Noridian JA DME Attn: ___________ PO Box 6780 Fargo, ND 58108-6780

Department	Address
• Electronic Funds Transfer (EFT) • Overpayment Redetermination and Rebuttal Requests • Recovery Auditor Redeterminations	Noridian JA DME Attn: __________ PO Box 6728 Fargo, ND 58108-6728
• Administrative Simplification Compliance Act Exception Requests (ASCA) • Benefit Protection	Noridian JA DME Attn: _________ PO Box 6736 Fargo, ND 58108-6736
• LCD: New LCD Request • Medical Review - Prior Authorization Requests (PAR)	Noridian JA DME Attn: __________ PO Box 6742 Fargo, ND 58108-6742
• Extended Repayment Schedule (ERS) • Refund Checks	Noridian JA DME Attn: __________ PO Box 511470 Los Angeles, CA 90051-8025
Qualified Independent Contractor (QIC)	MAXIMUS Federal DME - QIC Project 3750 Monroe Avenue, Suite 777 Pittsford, NY 14534

DME MACS AND OTHER RESOURCES

MAC/Resource	Phone Number	Website
Noridian: Jurisdiction A	866-419-9458	https://med.noridianmedicare.com/web/jadme
Noridian: Jurisdiction D	877-320-0390	https://med.noridianmedicare.com/web/jddme
CGS: Jurisdiction B	877-299-7900	https://www.cgsmedicare.com/
CGS: Jurisdiction C	866-238-9650	https://www.cgsmedicare.com/
Pricing, Data Analysis and Coding (PDAC)	877-735-1326	https://www.dmepdac.com/
National Supplier Clearinghouse	866-238-9652	https://www.palmettogba.com/nsc
Common Electronic Data Interchange (CEDI) Help Desk	866-311-9184	https://www.ngscedi.com
Centers for Medicare and Medicaid Services (CMS)		https://www.cms.gov/

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."

MSN Changes to Assist Beneficiaries Enrolled in the QMB Program - Revised

MLN Matters Number: MM11230 Revised
Related CR Release Date: July 3, 2019
Related CR Transmittal Number: R4332CP
Related Change Request (CR) Number: 11230
Effective Date: October 1, 2019

Implementation Date: October 7, 2019 for claims processed on or after this date

Note: CMS revised this article on July 9, 2019, to reflect the revised CR 11230 issued on July 3. In the article, CMS deleted a reference to FISS rejections that was on page 3. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11230 alerts providers of further modifications to Medicare's claims processing systems to ensure that the Medicare Summary Notice (MSN) appropriately differentiates between Qualified Medicare Beneficiary (QMB) claims that are paid and denied and to show accurate patient payment liability amounts for beneficiaries enrolled in QMB. Please make sure your billing staffs are aware of these modifications.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11230.

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 5.3.2

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 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

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 at CMS's website, http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html. 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.

Surgical Dressing Lookup Tools

Have you seen the newest tools to determine what surgical dressings are covered? Check out the Surgical Dressings page to review the various search options available. A simple search by the HCPCS will provide the dressing type, wound depth, exudate and usual dressing change information. For a more complicated search, enter the exudate and wound depth information to determine what types of dressings would be applicable.

Update to 46.2, 46.3, 46.4, and 46.5 in Publication (Pub.) 100-08

MLN Matters Number: MM11242
Related CR Release Date: May 31, 2019
Related CR Transmittal Number: R884PI
Related Change Request (CR) Number: 11242
Effective Date: August 30, 2019
Implementation Date: August 30, 2019

The Centers for Medicare & Medicaid Services (CMS) initiated CR11242 after consultations with the following contractor types:

- DME MACs
- Recovery Audit Contractors
- Comprehensive Error Rate Testing (CERT) contractor
- Supplemental Medical Review Contractor (SMRC)

These contractors provided input regarding the content and format of Additional Documentation Request (ADR) Letters to produce uniformity among the letters. CMS collected this information to create and deliver more recognizable and understandable ADR letters to providers. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11242.

A DME MAC Program Manager Update: Redetermination Submission Tips

The Program Managers want to share the most common reasons why a redetermination cannot be processed. View the tips provided and keep them in mind before submitting a redetermination request. Following these will allow Medicare to process requests in an efficient and comprehensive manner. See the Redetermination Submission Tips webpage for details.

Appeals Decision Tree Helps Determine the Next Step

Are you a supplier who is not sure if an appeal request is the appropriate next step? By answering a series of Yes/No questions, the Appeals Decision Tree will help you make that determination

Redetermination Requests: Appellant Signatures No Longer Required Effective July 8, 2019

Effective for the date of receipt as of July 8, 2019, appellant signatures will no longer be required (optional only) on a Redetermination Request and requests will no longer be dismissed for a missing signature; however, any requests to vacate a dismissal issued prior to this date, solely for lack of a valid signature, will be denied.

Note: Signatures will still be required for medical records, documentation, orders, appointment of representative forms, etc.

Supplier Information on the Upcoming DME QIC Transition

Effective September 1, 2019, MAXIMUS Federal will serve as the DME Qualified Independent Contractor (QIC) for the entire United States and the U.S. territories. This means that any requests for reconsiderations received on or after September 1, 2019 will be processed by MAXIMUS and will need to be submitted to MAXIMUS. Any requests received before September 1, 2019 will be processed by C2C.

If a reconsideration is filed with MAXIMUS prior to September 1, 2019, MAXIMUS will send the appeal request to C2C for processing. If a reconsideration request is filed with C2C on or after September 1, 2019, C2C will forward the appeal request to MAXIMUS. This process should be seamless to suppliers. Suppliers will receive an acknowledgment letter from the entity that will be processing the reconsideration request.

Redeterminations will continue to be handled by the DME MACs - CGS and Noridian. Instructions on how to file a reconsideration request, including the mailing address, will be included on the Medicare Redetermination Notice.

Additional information about the DME QIC transition, including frequently asked questions, can be found by visiting the MAXIMUS DME QIC website at http://www.medicaredmeappeals.com/.

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.

Question	Answer
How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-866-419-9458
What are the hours for Telephone Reopenings?	Monday - Friday 8 a.m. - 5 p.m. ET Holiday and Training Closures can be found at https://med.noridianmedicare.com/web/jadme/contact/holiday-schedule
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.

Question	Answer
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?	a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 13 • Reopening webpage • CMS IOM, Publication 100-04, Chapter 34
Additional assistance available	Suppliers can email questions and concerns regarding reopenings and redeterminations to dmeredeterminations@noridian.com. Emails containing Protected Health Information (PHI) will be returned as unprocessable.

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 at the number/address specified below.

The secure fax number for submitting documentation to the CERT Documentation Contractor is 804-261-8100.

Mail all requested documentation to:
AdvanceMed
CERT Documentation Center
1510 East Parham Road
Henrico, VA 23228

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

Suppliers may call the CERT Documentation Contractor at 888-779-7477 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.

Also, 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.

Ankle Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L4360, L4361, L4386 and L4387. The quarterly edit effectiveness results from January - March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **36%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Claim is the same or similar to another claim on file.

For complete detail see, Ankle Foot/Knee-Ankle-Foot Orthosis (AFO/KAFO) Quarterly Results of Targeted Probe and Educate Review.

Enteral Nutrition Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) B4150, B4152 and B4154. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **40%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Refill request documentation is incomplete or missing elements.

For complete detail see, Enteral Quarterly Results of Targeted Probe and Educate Review

Glucose Monitors Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4253. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **65%**.

Top Denial Reasons

- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.
- Documentation does not support high utilization.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Glucose Monitors Quarterly Results of Targeted Probe and Educate Review

Hospital Beds Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) E0250 and E0260. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **38%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria for a semi-electric hospital bed.
- Documentation does not support coverage criteria for a fixed height hospital bed.

For complete detail see, Hospital Beds Quarterly Results of Targeted Probe and Educate Review

Immunosuppressive Drugs Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) J7507, J7517, J7518 and J7520. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **18%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.

- Documentation does not support the dispensing fee code.
- Claim is billed for greater quantity than the Detailed Written Order (DWO) indicates.

For complete detail see, Immunosuppressive Drugs Quarterly Results of Targeted Probe and Educate Review

Knee Orthoses Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L1832, L1833, L1843 and L1851. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **48%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Advance Beneficiary Notice of Noncoverage (ABN) was not properly executed

For complete detail see, Knee Orthoses Quarterly Results of Targeted Probe and Educate Review

Manual Wheelchair Bases Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) K0001 and K0003. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **21%**.

Top Denial Reasons

- Documentation does not support medical necessity.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Documentation does not support coverage criteria.
- Documentation does not support coverage criteria for a lightweight wheelchair.

For complete detail see, Manual Wheelchair Bases Quarterly Results of Targeted Probe and Educate Review

Oral Anticancer Drugs Targeted Probe and Educate Review Updates: October - December 2018

The Jurisdiction D, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) WW005, WW006, WW090 and WW093. The quarterly edit effectiveness results from October - December 2018 are as follows:

Based on dollars, the overall claim potential improper payment rate is **34%**.

Top Denial Reasons

- Refill request documentation is incomplete or missing elements.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Medical record documentation was not authenticated (handwritten or electronic) by the author.
- Detailed Written Order (DWO) was not received.

For complete detail see, Oral Anticancer Drugs Quarterly Results of Targeted Probe and Educate Review.

Ostomy Supplies Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4407 and A4409. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **36%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- Detailed Written Order (DWO) is incomplete or missing elements.
- Documentation does not support the dispensing fee code.
- Refill request documentation is incomplete or missing elements.

For complete detail see, Ostomy Supplies Quarterly Results of Targeted Probe and Educate Review

Oxygen Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) E0431 and E1390. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **40%**.

Top Denial Reason

- Documentation does not support coverage criteria.

For complete detail see, Oxygen Quarterly Results of Targeted Probe and Educate Review

Parenteral Nutrition Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) B4185, B4197 and B4199. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **17%**.

Top Denial Reasons

- Documentation does not support coverage criteria.

For complete detail see, Parenteral Quarterly Results of Targeted Probe and Educate Review

Positive Airway Pressure (PAP) Devices Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) E0601. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **10%**.

Top Denial Reasons

- Related Item Denied: Unbundling
- Detailed Written Order (DWO) was not received.
- Written Order Prior to Delivery (WOPD) is incomplete or missing elements.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Positive Airway Pressure (PAP) Devices Quarterly Results of Targeted Probe and Educate Review

Same or Similar: How to Avoid Denials

Numerous DMEPOS claims deny because the equipment/item billed is the “same as” or “similar to” the equipment/item already in a beneficiary’s possession and is within its Reasonable Useful Lifetime (RUL). To avoid such denials suppliers should verify same or similar details prior to providing an item, and to gain the necessary information required to determine whether an Advance Beneficiary Notice of Noncoverage (ABN) should be obtained or not.

Check out the Same and Similar Chart webpage for details.

Spinal Orthoses Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) L0648 and L0650. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **68%**.

Top Denial Reasons

- Documentation was not received in response to the Additional Documentation Request (ADR) letter.
- No medical record documentation was received. Refer to Medicare Program Integrity Manual 3.2.3.8.
- Claim is the same or similar to another claim on file.
- Documentation does not include verification that the equipment was lost, stolen or irreparably damaged in a specific incident.

For complete detail see, Spinal Orthoses Quarterly Results of Targeted Probe and Educate Review

Surgical Dressings Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A6021 and A6212. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **42%**.

Top Denial Reasons

- Documentation does not support coverage criteria.

For complete detail see, Surgical Dressings Quarterly Results of Targeted Probe and Educate Review

Therapeutic Shoes Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A5500. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **54%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Therapeutic Shoes Quarterly Results of Targeted Probe and Educate Review

Urological Supplies Targeted Probe and Educate Review Updates: January-March 2019

The Jurisdiction A, DME MAC, Medical Review Department is conducting a Targeted Probe and Educate (TPE) review of HCPCS code(s) A4351, A4352 and A4353. The quarterly edit effectiveness results from January 2019 through March 2019 are as follows:

Based on dollars, the overall claim potential improper payment rate is **34%**.

Top Denial Reasons

- Documentation does not support coverage criteria.
- Documentation was not received in response to the Additional Documentation Request (ADR) letter.

For complete detail see, Urological Supplies Quarterly Results of Targeted Probe and Educate Review

Condition of Payment Prior Authorization Expanding to Include Remaining Power Mobility Devices HCPCS Codes - Effective for Dates of Service on/after July 22, 2019

Seven additional Power Mobility Device (PMD) HCPCS codes, K0857-K0860 and K0862-K0864, will be added to the nationwide Condition of Payment Prior Authorization program as stated in the Federal Registry Notice posted April 22, 2019.

DME MACs will:

- begin accepting PA review requests for these codes under the COPPA program July 8, 2019 for planned dates of service on/after July 22, 2019
- honor Advance Determination of Medicare Coverage (ADMC) decisions on ADMC requests submitted for review prior to July 8, 2019

View the Prior Authorization for Power Mobility Devices webpage for information related to the PA request process, links to educational resources, and common reasons for non-affirmation of requests.

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

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

View the locally hosted 2019 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

HCPCS Drug/Biological Code Changes - October 2019 Update

MLN Matters Number: MM11422
Related CR Release Date: August 16, 2019
Related CR Transmittal Number: R4367CP
Related Change Request (CR) Number: 11422
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

CR 11422 updates the Healthcare Common Procedure Coding System (HCPCS) code set for codes related to drugs and biologicals. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11422.

Quarterly HCPCS Drug/Biological Code Changes - July 2019 Update - Revised

MLN Matters Number: MM11296 Revised
Related CR Release Date: June 12, 2019
Related CR Transmittal Number: R4320CP
Related Change Request (CR) Number: 11296
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Note: We revised this article on June 19, 2019 to reflect the revised CR 11296 issued on June 12. CMS revised the CR to update the short and long descriptors of Q5115 and we revised the article accordingly. In the article, we also revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11296 updates the Healthcare Common Procedure Coding System (HCPCS) code set for codes related to drugs and biologicals. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11296.

Condition of Payment Prior Authorization Program Expanding to Include Pressure Reducing Support Surfaces - Effective for Dates of Service on/after July 22, 2019

The addition of Pressure Reducing Support Surfaces (PRSS) Group Two HCPCS codes E0193, E0277, E0371, E0372, and E0373 to the Condition of Payment Prior Authorization program will be implemented in two phases as stated in the Federal Registry Notice posted April 22, 2019.

DME MACs will begin accepting PA review requests for the above PRSS items July 8, 2019 for planned dates of service on/after July 22, 2019 for California, Indiana, New Jersey, and North Carolina.

In October, the DME MACs will begin accepting PA review requests for the above PRSS items for the remaining states/territories October 7, 2019 for planned dates of service on/after October 21, 2019.

View the new Prior Authorization for Pressure Reducing Support Surfaces webpage for information related to the PA request process, links to educational resources, fillable forms, and PA tools.

KF Modifier Use Correct Coding - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, KF Modifier Use Correct Coding, has been created and published to our website.

View the locally hosted 2019 DMD articles.

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

LCD and Policy Article Revisions Summary for July 18, 2019 - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LCD and Policy Article Revisions Summary for July 18, 2019, has been created and published to our website.

View the locally hosted 2019 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

Medicare Prior Authorization Condition of Payment for Group 2 - Pressure Reducing Support Surfaces Dear Clinician Letter - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Medicare Prior Authorization Condition of Payment for Group 2 - Pressure Reducing Support Surfaces Dear Clinician Letter, has been created and published to our website.

View the locally hosted 2019 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

New HCPCS Code - Revefenacin (Yupelri) - J7677 - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, New HCPCS Code - Revefenacin (Yupelri®) - J7677, has been created and published to our website.

View the locally hosted 2019 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

Partial Hand Prostheses Correct Coding - Now Available

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

View the locally hosted 2019 DMD articles.

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

Policy Article Revisions Summary for July 25, 2019 - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for July 25, 2019, has been created and published to our website.

View the locally hosted 2019 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 8, 2019

Outlined below are the principal changes to the DME MAC Policy Article (PA) that has been revised and posted. The policy included is Standard Documentation Requirements for All Claims Submitted to DME MACs. Please review the entire PA for complete information.

STANDARD DOCUMENTATION REQUIREMENTS FOR ALL CLAIMS SUBMITTED TO DME MACS

PA

Revision Effective Date: 01/01/2019

DOCUMENTATION REQUIREMENTS:

- Added: Narrative section to clarify longstanding claims processing instructions
- Added: Date Span section to clarify longstanding claims processing instructions

08/08/2019: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

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

Sleep Test Scoring and Medicare Dear Clinician Letter - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Sleep Test Scoring and Medicare Dear Clinician Letter, has been created and published to our website.

View the locally hosted 2019 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

Tumor Treatment Field Therapy (TTFT) Final LCD (L34823) and Response to Comments (RTC) Article Published - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Tumor Treatment Field Therapy (TTFT) Final LCD (L34823) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2019 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

Tumor Treatment Field Therapy (TTFT) Open Meeting Agenda - Now Available

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Tumor Treatment Field Therapy (TTFT) Open Meeting Agenda, has been created and published to our website.

View the locally hosted 2019 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

ABN DME on Demand Tutorial Available

Noridian's Advance Beneficiary Notice of Noncoverage (ABN) tutorial provides information on the definition, purpose, standards, form completion, modifiers and more.

To view this tutorial, see the DME on Demand Tutorials webpage.

External Infusion Pump DME on Demand Tutorials Available

Noridian offers several self-paced tutorials on External Infusion Pumps (EIPs), including Inotropic Drugs Coverage Criteria, Completing the DME Information Form (DIF) and Insulin Pump.

To view these tutorials, see the DME on Demand Tutorials webpage.

Immunosuppressive Drugs DME on Demand Tutorial Available

Suppliers are encouraged to view the Immunosuppressive Drugs tutorial that reviews the five criteria for coverage.

To view this tutorial, see the DME on Demand Tutorials webpage.

Medicare Beneficiary Identifier (MBI) Retrieval and Resources Tutorial Now Available

The new Noridian MBI tutorial provides a background overview, reviews methods of obtaining the MBI, including the Noridian Medicare Portal (NMP) and remittance advices, and provides resources.

To view the new tutorial, see the DME on Demand Tutorials webpage.

Prior Authorization DME on Demands Available

Suppliers are encouraged to view the many tutorials Noridian offers on prior authorization.

- Advance Medicare of Coverage Determination (ADMC)
- Condition of Payment Prior Authorization
  - Overview
  - Package
  - Denial
  - Power Mobility Device (PMD)
  - Pressure Reducing Support Surface (PRSS)
  - Billing Modifiers and Secondary Insurance
- Prior Authorization of PMDs
  - Beneficiary Address Change
  - Demonstration and Expansion
  - Scenarios
  - Submitting a PAR

To view these tutorials, see the DME on Demand Tutorials webpage.

Surgical Dressings and Supply Elements Required on DWO

In addition to CMS "Standard Documentation Requirements for All Claims Submitted to DME MACs" (A55426), some Local Coverage Determinations (LCDs) have policy specific documentation requirements that must be adhered to as well. The Surgical Dressing Policy Related Article A54563 (Surgical Dressing LCD L33831) outlines specific surgical dressings and supply elements that are required on the Detailed Written Order (DWO), which must be obtained by the supplier prior to billing Medicare.

Check out the Surgical Dressings webpage to access coverage, documentation, and related tips.

Urological Supplies Documentation Checklist Available

Have you received a Redetermination denial or a denial based off the Targeted Probe and Educate (TPE) audits for urological supplies? If so, the CMS “Standard Documentation Requirements for All Claims Submitted to DME MACs” (A55426) is a great resource to ensure the necessary documentation is available when dispensing such supplies. Access the “Urological Supply Clinician Checklist” from the Urological Supplies webpage. This checklist will assist suppliers in identifying what information should be included within the medical records received.

Tropical Storm Barry and Medicare Disaster Related Louisiana Claims

MLN Matters Number: SE19014
Article Release Date: July 15, 2019

The Secretary of the Department of Health & Human Services declared a Public Health Emergency (PHE) in the state of Louisiana on July 12, 2019, and authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to July 10, 2019, and are in effect for 90 days.

The Centers for Medicare & Medicaid Services (CMS) is issuing blanket waivers consistent with those issued for past PHE declarations. These waivers prevent gaps in access to care for beneficiaries impacted by the disaster/emergency. You do not need to apply for an individual waiver if a blanket waiver is issued.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)19014

DMEPOS Fee Schedule - July 2019 Update - Revised

MLN Matters Number: MM11334 Revised
Related CR Release Date: June 28, 2019
Related CR Transmittal Number: R4328CP
Related Change Request (CR) Number: 11334
Effective Date: July 1, 2019
Implementation Date: July 1, 2019

Note: CMS revised this article on July 2, 2019, to reflect the revised CR11334 issued on June 28. CMS revised the CR to include a correction to the fee schedule amounts for HCPCS codes E1353 and E1355. The article includes this correction information on page 4. Also, CMS revised the CR release date, transmittal number, and the web address of CR11334. All other information remains the same.

CR11334 informs Durable Medical Equipment Medicare Administrative Contractors (DME MACs) about the changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule which Medicare updates on a quarterly basis, when necessary, to implement fee schedule amounts for new codes and correct any fee schedule amounts for existing codes. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11334.

ICD-10 and Other Coding Revisions to NCDs - January 2020 Update

MLN Matters Number: MM11392
Related CR Release Date: August 9, 2019
Related CR Transmittal Number: R2348OTN
Related Change Request (CR) Number: 11392
Effective Date: January 1, 2020
Implementation Date: January 6, 2020 -MAC local edits 45 days from date of this CR

CR 11392 constitutes a maintenance update of International Classification of Diseases, 10th Revision (ICD-10) conversions and other coding updates specific to national coverage determinations (NCDs). These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11392.

MBI on Remittance Advice

For Remittance Advices generated after October 1, 2019 and through December 31, 2019 (end of the transition period), CMS will return both the new Medicare Beneficiary Identifier (MBI) and Health Insurance Claim Number (HICN) when claims are submitted with a valid and active HICN. The MBI will be reported in the same place providers/suppliers get the "changed HICN" today. Providers can also get the MBI by asking their patients for his/her new Medicare card or by using the MBI look up tool within the Noridian Medicare Portal (NMP). Register Now to gain access.

To ensure Medicare patients continue to get care, use the HICN or MBI for all Medicare transactions through December 31, 2019.

Resource

- CMS Medicare Remittance Advice Examples

New Medicare Beneficiary Identifier (MBI) Get It, Use It - Reissued

MLN Matters Number: SE18006 Reissued
Article Release Date: August 19, 2019

Note: CMS reissued this article on August 19, 2019, to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.

Use MBIs now for all Medicare transactions. The Centers for Medicare & Medicaid Services (CMS) finished mailing new Medicare cards. The new cards without Social Security Numbers (SSNs) offer better identity protection. Help protect your patients' personal identities by getting their MBIs and using them for Medicare business, including claims submission and eligibility transactions.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)18006.

Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

MLN Matters Number: MM11295
Related CR Release Date: July 12, 2019
Related CR Transmittal Number: R259BP
Related Change Request (CR) Number: 11295
Effective Date: August 13, 2019
Implementation Date: August 13, 2019

CR11295 informs MACs about changes which update the list of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes for the coverage of IVIG for treatment of Primary Immune Deficiency Diseases (PIDD) in the home. Make sure that your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11295.

Ostomy Supplies: Usual Maximum Quantity

Have you received claim denials for ostomy supplies? Most ostomy supply claims are denied for overutilization. The Ostomy Supplies Local Coverage Determination (LCD) contains a chart that indicates the usual maximum quantity for each supply. In the event the beneficiary needs to use more than the usual amounts, the specific medical reason(s) must be clearly documented in the beneficiary's medical record. Use this documentation when requesting a redetermination for the initial claim denials and any subsequent appeals. If adequate documentation is not provided, the excess quantities will be denied as not reasonable and necessary. Access this LCD from the Active LCDs webpage.

MLN Connects - June 6, 2019

MLN Connects® for Thursday, June 6, 2019
View this edition as a PDF

News

- Medicare Shared Savings Program: Submit Notice of Intent to Apply Beginning June 11
- Promoting Interoperability Program: Submit Comments on Proposed Changes by June 24
- Promoting Interoperability Program: Submit a Measure Proposal by June 28
- Hospice Provider Preview Reports: Review Your Data by July 1
- PEPPERs for Short-term Acute Care Hospitals

Compliance

- Bill Correctly for Device Replacement Procedures

Claims, Pricers & Codes

- ICD-10-PCS Procedure Codes: FY 2020
- Average Sales Price Files: July 2019

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Developing a Hospice Assessment Tool Special Open Door Forum - June 12
- Ligature Risk in Hospitals Listening Session - June 20
- Hospital Co-location Listening Session - June 27

MLN Matters® Articles

- Chimeric Antigen Receptor (CAR) T-Cell Therapy Revenue Code and HCPCS Setup Revisions
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2
- July 2019 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Update to 46.2, 46.3, 46.4, and 46.5 in Publication (Pub.) 100-08

Publications

- Quality Payment Program: 2019 Measure Development Plan Annual Report

Multimedia

- CMS: Beyond the Policy Podcast: Innovation Center

MLN Connects - June 13, 2019

MLN Connects® for Thursday, June 13, 2019
View this edition as a PDF

News

- DMEPOS Competitive Bidding - Round 2021: Register Now
- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- LTCH Provider Preview Reports: Review Your Data by July 10
- IRF Provider Preview Reports: Review Your Data by July 10
- When It Comes To Our Health - Every Second Counts: Comment on RFI by August 12
- LTCH Compare Refresh
- IRF Compare Refresh
- Men's Health Week Ends on Father's Day

Compliance

- Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Ligature Risk in Hospitals Listening Session - June 20
- Hospital Co-location Listening Session - June 27

Publications

- Quality Payment Program: 2019 Resources
- Provider Compliance Tips for Urological Supplies - Revised

Multimedia

- Medicare Billing: Form CMS-1450 and the 837 Institutional Web-Based Training Course - Reminder

MLN Connects - June 20, 2019

MLN Connects® for Thursday, June 20, 2019
View this edition as a PDF

News

- New Medicare Card: 75% of Claims Submitted with MBI
- IRF: Voluntary Appeals Settlement Options
- CMS Proposes to Update e-Prescribing Standards
- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- Dermatology: Comparative Billing Report on Modifier 25 in June
- Hospice Provider Preview Reports: Review Your Data by July 1

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Hospital Co-location Listening Session - June 27
- Dermatology: Comparative Billing Report on Modifier 25 Webinar - July 10

MLN Matters® Articles

- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC), and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

MLN Connects - June 27, 2019

MLN Connects® for Thursday, June 27, 2019
View this edition as a PDF

News

- Medicare Shared Savings Program: Submit Notice of Intent to Apply by June 28
- MIPS Data Validation and Audit for Performance Years 2017 and 2018

Claims, Pricers & Codes

- FY 2020 ICD-10-CM Diagnosis Code Updates

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series

MLN Matters® Articles

- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2019 Update - Revised
- Clarification of Billing and Payment Policies for Negative Pressure Wound Therapy (NPWT) Using a Disposable Device -

Revised

MLN Connects - July 11, 2019

MLN Connects - New Medicare Card: Transition Period Ends in Less Than 6 Months

MLN Connects® for Thursday, July 11, 2019
View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 6 Months
- HHS To Transform Care Delivery for Patients with Chronic Kidney Disease
- CMS Expands Coverage of Ambulatory Blood Pressure Monitoring
- Open Payments: Program Year 2018 Data
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi-Factor Authentication for I&A System Webcast - July 30

MLN Matters® Articles

- Medicare Plans to Modernize Payment Grouping and Code Editor Software
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program - Revised
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2 - Revised
- July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule - Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised

Publications

- Get Your New Medicare Card
- Medicare Documentation Job Aid for Doctors of Chiropractic
- Medicare Preventive Services - Revised

Multimedia

- CMS: Beyond the Policy Podcast: Throwback to HIMSS Conference

MLN Connects - July 18, 2019

DMEPOS Competitive Bidding: Round 2021 Bid Window is Open

MLN Connects® for Thursday, July 18, 2019
View this edition as a PDF

News

- Is Your Vendor/Clearinghouse Submitting Your Claims with the MBI?
- DMEPOS Competitive Bidding: Round 2021 Bid Window is Open
- Nursing Homes: Updating Requirements for Arbitration Agreements and New Regulations
- CMS Proposes to Cover Acupuncture for Chronic Low Back Pain for Medicare Beneficiaries Enrolled in Approved Studies
- Quality Payment Program: 2018 MIPS Performance Feedback and Final Score
- Quality Payment Program Participation: Preliminary Data on 2018

- Physician Compare: 2017 Quality Payment Program Performance Information
- PEPPERs for HHAs, PHPs
- 2017 Physician and Other Supplier PUF
- 2017 Referring Provider DMEPOS PUF
- Qualified Medicare Beneficiary Billing Requirements
- Mass Casualty Triage White Paper and June Express
- Looking for Educational Materials?

Compliance

- Cardiac Device Credits: Medicare Billing

Events

- DMEPOS Competitive Bidding: Round 2021 Webcast Series
- Enrollment: Multi-Factor Authentication for I&A System Webcast - July 30
- IRF Appeals Settlement Initiative Call - August 13

MLN Matters® Articles

- Tropical Storm Barry and Medicare Disaster Related Louisiana Claims
- Reduce Risk of Opioid Overdose Deaths by Avoiding and Reducing Co-Prescribing Benzodiazepines
- Pre-Diabetes Services: Referring Patients to the Medicare Diabetes Prevention Program
- Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infant Protection Act
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2019
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019
- Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home
- July 2019 Update of the Ambulatory Surgical Center (ASC) Payment System
- Activation of Systematic Validation Edits for OPPS Providers with Multiple Service Locations - Revised

Publications

- Provider Compliance Tips for Respiratory Assistive Devices - Revised
- Provider Compliance Tips for Enteral Nutrition - Revised

Multimedia

- Post-Acute Care Call: Audio Recording and Transcript

MLN Connects - July 25, 2019

MLN Connects - Questions about Using the MBI?

MLN Connects® for Thursday, July 25, 2019
View this edition as a PDF

News

- New Medicare Card: Questions about Using the MBI?
- 2020 QRDA III Implementation Guide, Schematron, and Sample Files
- Antipsychotic Drug Use in Nursing Homes: Trend Update
- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- World Hepatitis Day: Medicare Coverage for Viral Hepatitis

Compliance

- Importance of Proper Documentation: Provider Minute Video

Claims, Pricers & Codes

- Medicare Diabetes Prevention Program: Valid Claims

Events

- Enrollment: Multi-Factor Authentication for I&A System Webcast - July 30
- Diagnosing and Treating Dementia: Current Best Practices Webinar - July 30
- Quality Payment Program Performance Information on Physician Compare Webinar - July 30/Aug 1
- Disability-Competent Care Conversation on Access Webinar - July 31
- IRF Appeals Settlement Initiative Call - August 13
- Home Health Patient-Driven Groupings Model: Operational Issues Call - August 21

MLN Matters® Articles

- Medicare Plans to Modernize Payment Grouping and Code Editor Software

Publications

- Medicare DMEPOS Improper Inpatient Payments
- Medicare Part D Vaccines - Revised
- Provider Compliance Tips for Enteral Nutrition Pumps - Revised

Multimedia

- Hospital Listening Session: Audio Recording and Transcript
- Hospice Quality Reporting Program Web-Based Courses

MLN Connects - August 1, 2019

MLN Connects - Protect Your Patients' Identities: Use the MBI Now

MLN Connects® for Thursday, August 1, 2019
View this edition as a PDF

News

- SNF: FY 2020 Payment and Policy Changes
- IPF: FY 2020 Payment and Quality Reporting Updates
- Protect Your Patients' Identities: Use the MBI Now
- CMS Advances MyHealthEData with New Pilot to Support Clinicians
- Reducing Administrative Burden: Comment by August 12
- Medicare Coverage for Treatment Services Furnished by Opioid Treatment Programs
- Open Payments Program Expansion
- Improve Accessibility of Care for People with Disabilities: New Resources
- Part A Providers: Formal Telephone Discussion Demonstration
- July - September Quarterly Provider Update
- Disaster Preparedness Resources
- Vaccines Are Not Just for Kids

Compliance

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

Events

- Emergency Triage, Treat, and Transport Model Application Tutorial Webinar - August 8
- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session - August 12
- IRF Appeals Settlement Initiative Call - August 13
- OPPS and ASC Proposed Rule Listening Session - August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call - August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call - August 21
- Understanding Your SNF VBP Program Performance Score Report Call - August 27

MLN Matters® Articles

- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging - Educational and Operations Testing Period - Claims Processing Requirements
- New Waived Tests
- Documentation of Medical Necessity of the Home Visit; and Physician Management Associated with Superficial Radiation Treatment - Revised

Publications

- Skilled Nursing Facility 3-Day Rule Billing
- Provider Compliance Tips for Glucose Monitors and Diabetic Accessories/Supplies - Revised

Multimedia

- Quality Payment Program Merit-based Incentive Payment System (MIPS): Cost Performance Category in 2019 Web-Based Training Course - Revised
- Quality Payment Program 2019 Overview Web-Based Training Course - Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Quality Performance Category in 2019 Web-Based Training Course - Revised
- Quality Payment Program Merit-based Incentive Payment System (MIPS): Improvement Activities in 2019 Web-Based Training Course - Revised

MLN Connects - August 8, 2019

MLN Connects - New Medicare Card: Will Your Claims Reject?

MLN Connects® for Thursday, August 8, 2019
View this edition as a PDF

News

- New Medicare Card: Will Your Claims Reject?
- Securing Access to Life-Saving Antimicrobial Drugs for American Seniors
- IRF/LTCH/SNF Quality Reporting Programs: Submission Deadline August 15
- Hospice Patient Assessment Instrument Focus Groups: Respond by August 26
- Emergency Triage, Treat, and Transport Model: Apply by September 19
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- 2019 QRDA III Implementation Guide: Updated Addendum
- Quality Payment Program: Reporting Patient Relationship Categories

Compliance

- Skilled Nursing Facility 3-Day Rule Billing

Events

- Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session - August 12
- IRF Appeals Settlement Initiative Call - August 13
- OPPS and ASC Proposed Rule Listening Session - August 14
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call - August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call - August 21
- Radiation Oncology Model Listening Session - August 22
- Understanding Your SNF VBP Program Performance Score Report Call - August 27

MLN Matters® Articles

- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020
- Instructions for Use of Informational Remittance Advice Remark Code Alert on Laboratory Service Remittance Advices
- Medicare Shared Savings Program (Shared Savings Program) Skilled Nursing Facility (SNF) Affiliates' Requirement to Include Demonstration Code 77 on SNF 3-Day Rule Waiver Claims
- Modification to the National Coordination of Benefits Agreement (COBA) Crossover Process

- October Quarterly Update to 2019 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
- Oxygen Policy Update
- Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment

Multimedia

- CMS: Beyond the Policy Podcast: Nursing Home Strategy Part 1 - Strengthening Oversight
- CLFS Public Meetings: Videos

MLN Connects - August 15, 2019

MLN Connects - New Medicare Card: Transition Period Ends in Less Than 5 Months

MLN Connects® for Thursday, August 15, 2019
View this edition as a PDF

News

- New Medicare Card: Transition Period Ends in Less Than 5 Months
- CAR T-Cell Cancer Therapy Available to Medicare Beneficiaries Nationwide
- DMEPOS Competitive Bidding: Round 2021 Deadlines
- MACRA Patient Relationship Categories and Codes: Learn More

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Events

- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call - August 20
- IPPS/LTCH PPS FY 2020 Final Rule Special Open Door Forum - August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call - August 21
- Self-Direction for Dually Eligible Individuals Utilizing LTSS Webinar - August 21
- Radiation Oncology Model Listening Session - August 22
- Understanding Your SNF VBP Program Performance Score Report Call - August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call - September 10

MLN Matters® Articles

- Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services
- Display PARHM Claim Payment Amounts
- Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2020 Update

Publications

- Chronic Care Management Services - Revised
- ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets - Revised

Multimedia

- I&A Enrollment Webcast: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos

MLN Connects - August 22, 2019

MLN Connects - New Medicare Card: Read the Updated MLN Matters Article

MLN Connects® for Thursday, August 22, 2019
View this edition as a PDF

News

- Overall Hospital Quality Star Ratings: Upcoming Enhancement
- Pneumococcal Vaccine Eligibility Data Issue
- Venipuncture: Comparative Billing Report in August
- SNF Provider Preview Reports: Review Your Data by September 16
- SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1
- Promoting Interoperability: 2019 Program Requirements for Hospitals
- Quality Payment Program Exception Applications
- Hospice Compare Refresh
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier
- CBRs: We Want Your Feedback

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- MACRA Patient Relationship Categories and Codes: Reporting HCPCS Level II Modifiers

Events

- Understanding Your SNF VBP Program Performance Score Report Call - August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call - September 10

MLN Matters® Articles

- New Medicare Beneficiary Identifier (MBI) Get It, Use It - Reissued
- Medicare Coverable Services for Integrative and Non-pharmacological Chronic Pain Management
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2019 Update
- Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update
- Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020 - Revised

Publications

- MLN Catalog September 2019 Edition
- Ambulance Fee Schedule and Medicare Transports
- QPP: New Resources
- Getting Started with Hospice CASPER Review and Correct Reports
- Behavioral Health Integration - Revised
- Critical Access Hospital - Revised
- Swing Bed Services - Revised
- Screening Pap Tests and Pelvic Examinations Booklet - Revised
- Hospices: CASPER QM Fact Sheet - Updated

MLN Connects - August 29, 2019

MLN Connects - New Medicare Card: Open Door Forum - September 11

MLN Connects® for Thursday, August 29, 2019
View this edition as a PDF

News

- Promoting Interoperability: 2019 PDMP Bonus Measure
- Beneficiary Notices Initiative Mailbox Portal
- Promoting Interoperability: 2020 Eligible Hospital eCQM Flows
- DMEPOS: Nationwide Expansion of Required PA of Pressure Reducing Support Surfaces

Compliance

- IRF Services: Follow Medicare Billing Requirements

Events

- MIPS Value Pathways RFI Webinar - September 4
- Venipuncture: Comparative Billing Report Webinar - September 5
- Dementia Care: Supporting Comfort and Resident Preferences Call - September 10
- New Medicare Card: Open Door Forum- September 11
- Hospice Outcomes & Patient Evaluation Tool ODF - September 12
- Opioids: What's an "Outlier Prescriber"? Listening Session - September 17
- Overall Hospital Star Ratings Listening Session - September 19

MLN Matters® Articles

- New Documentation Requirements for Filing Medicare Cost Reports
- Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020
- Claim Status Category and Claim Status Codes Update
- Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE
- Home Health (HH) Patient-Driven Groupings Model (PDGM) - Revised and Additional Manual Instructions
- 2020 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments
- Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code set Update
- Implementation to Exchange the List of Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System - Revised

Publications

- Inpatient Rehabilitation Facility Prospective Payment System Booklet - Revised

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript
- IRF Appeals Settlement Call: Audio Recording and Transcript
- OPPS and ASC Listening Session: Audio Recording and Transcript
- ESRD QIP Call: Audio Recording and Transcript
- SNF PPS: Patient Driven Payment Model Videos
- Inpatient Rehabilitation Facilities (IRFs): Improving Documentation Positively Impacts CERT Web-Based Training Course - Revised

MLN Connects Special Edition - June 6, 2019

CMS SEEKS PUBLIC INPUT ON PATIENTS OVER PAPERWORK INITIATIVE TO FURTHER REDUCE ADMINISTRATIVE, REGULATORY BURDEN TO LOWER HEALTHCARE COSTS

On June 6, CMS issued a Request for Information (RFI) seeking new ideas from the public on how to continue the progress of the Patients over Paperwork initiative. Since launching in fall 2017, Patients over Paperwork has streamlined regulations to significantly cut the "red tape" that weighs down our healthcare system and takes clinicians away from their primary mission-caring for patients. As of January 2019, we estimate that through regulatory reform alone, the healthcare system will save an estimated 40 million hours and $5.7 billion through 2021. These estimated savings come from both final and proposed rules.

This RFI provides an opportunity to share new ideas not conveyed during the first Patients over Paperwork RFI in 2017 and continue the national conversation on improving healthcare delivery. We are especially seeking innovative ideas that broaden perspectives on potential solutions to relieve burden and ways to improve:

- Reporting and documentation requirements
- Coding and documentation requirements for Medicare or Medicaid payment
- Prior authorization procedures
- Policies and requirements for rural providers, clinicians, and beneficiaries
- Policies and requirements for dually enrolled (i.e., Medicare and Medicaid) beneficiaries
- Beneficiary enrollment and eligibility determination
- CMS processes for issuing regulations and policies

Key Burden Reduction Milestones to Date:

We gathered feedback on burdensome requirements from medical and patient communities through other RFIs, listening sessions, and on-site meetings with frontline clinicians, healthcare staff, and patients and are working every day to reduce regulatory burden while safeguarding patient safety, quality, and program integrity. Achievements so far:

- Simplified Documentation and Coding
- Improved Quality and Operational Efficiency
- Meaningful Measures
- Changing CMS Culture

For More Information:

- RFI on Reducing Administrative Burden to Put Patients over Paperwork
- Patients over Paperwork webpage

See the full text of this excerpted CMS Press Release (issued June 6). Submit comments by August 12.

MLN Connects Special Edition - June 10, 2019

DMEPOS COMPETITIVE BIDDING - ROUND 2021: REGISTER NOW

Registration is open to all suppliers interested in participating in Round 2021 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program. In order to bid in Round 2021, you must have a user account in the CMS Enterprise Portal and have access added to the online DMEPOS Bidding System, DBidS, and Connexion, the program's secure portal. Instructions, including the Registration Reference Guide, are available on the Competitive Bidding Implementation Contractor (CBIC) website.

Register for webcasts from 3- 4 pm ET:

- June 11 - Registering and Submitting a Bid - Part 1
- July 3 - Registering and Submitting a Bid - Part 2

Once a live webcast is presented, on-demand sessions are available through the registration link. Resources such as slides and other handouts will be available during both the live and on-demand sessions.

The CBIC is the official information source for bidders and bidder education. CMS cautions bidders about potential inaccurate information concerning the Competitive Bidding Program posted on websites other than the CBIC website. Bidders that rely on this information in the preparation or submission of their bids could be at risk of submitting a non-compliant bid. Visit the CBIC website for resources, tools, and to subscribe to email updates.

If you have any questions or need assistance, call the CBIC customer service center at 877-577-5331 between 9 am and 5:30 pm ET, Monday through Friday.

MLN Connects Special Edition - July 11, 2019

HHAS: CY 2020 AND 2021 NEW HOME INFUSION THERAPY BENEFIT AND PAYMENT AND POLICY CHANGES

On July 11, CMS issued a proposed rule [CMS-1711-P] that proposes routine updates to the home health payment rates for CY 2020, in accordance with existing statutory and regulatory requirements. This rule will also include:

- Proposal to modify the payment regulations pertaining to the content of the home health plan of care
- Proposal to allow therapist assistants to furnish maintenance therapy
- Proposal related to the split percentage payment approach under the Home Health Prospective Payment System (PPS)
- Proposals related to the implementation of the permanent home infusion therapy benefit in 2021

This proposed rule sets forth implementation of the Patient-Driven Groupings Model (PDGM), an alternate case-mix adjustment methodology, and a 30-day unit of payment as mandated by the Bipartisan Budget Act of 2018 (BBA of 2018). CMS projects that Medicare payments to Home Health Agencies (HHAs) in CY 2020 will increase in aggregate by 1.3 percent, or $250 million, based on proposed policies. The increase reflects the effects of the 1.5 percent home health payment update percentage ($290 million increase) mandated by BBA of 2018. It also reflects a 0.2 percent decrease in aggregate payments due to reductions made by the new rural add-on policy mandated by the BBA of 2018 for CY 2020 (i.e., an estimated $40 million decrease in rural add-on payments). The rate updates also include adjustments for anticipated changes with implementation of the PDGM and a change to a 30-day unit of payment, the use of updated wage index data for the home health wage index, and updates to the fixed-dollar loss ratio to determine outlier payments.

In addition, the proposed rule includes:

- Proposed payment rate changes for home infusion therapy temporary transitional payments for CY 2020
- Payment proposals for new home infusion therapy benefit for CY 2021
- Regulatory burden reduction - Patients over paperwork and enhance and modernize program integrity
- Paraprofessional roles - Improving access to care
- Home Health Quality Reporting Program - Support MyHealthEData Initiative
- Home Health Value-Based Purchasing model

For More Information:

- Proposed Rule
- Press Release
- Home Health PPS website
- Home Health Quality Reporting Requirements webpage
- Home Health Value-Based Purchasing Model webpage

See the full text of this excerpted CMS Fact Sheet (issued July 11).

MLN Connects Special Edition - July 29, 2019

PFS: PROPOSED POLICY, PAYMENT, AND QUALITY PROVISIONS CHANGES FOR CY 2020

On July 29, CMS issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020. This proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation. It also includes proposals to streamline the Quality Payment Program with the goal of reducing clinician burden. This includes a new, simple way for clinicians to participate in our pay-for-performance program, the Merit-based Incentive Payment System (MIPS), called the MIPS Value Pathways.

The proposed rule also includes:

- CY 2020 PFS rate setting and conversion factor
- Medicare telehealth services
- Payment for evaluation and management services
- Physician supervision requirements for physician assistants
- Review and verification of medical record documentation
- Care management services
- Comment solicitation on opportunities for bundled payments
- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Bundled payments for substance use disorders
- Therapy services
- Ambulance services
- Ground ambulance data collection system
- Open Payments Program
- Medicare Shared Savings Program
- Stark advisory opinion process

For More information:

- Proposed Rule: Public comments due by September 27
- Press Release
- PFS Proposed Rule Fact Sheet
- Quality Payment Program Proposed Rule Fact Sheet

See the full text of this excerpted Fact Sheet (Issued July 29).

MEDICARE OPPS AND ASC PAYMENT SYSTEM CY 2020 PROPOSED RULE

On July 29, CMS proposed policies that follow directives in President Trump's Executive Order, entitled "Improving Price and Quality Transparency in American Health Care to Put Patients First," that lay the foundation for a patient-driven health care system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The proposed changes also encourage site-neutral payment between certain Medicare sites of services. Finally, the proposed rule proposes updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. The proposed polices in the CY 2020 OPPS/ASC Payment System proposed rule would further advance the agency's commitment to increasing price transparency, (including proposals for requirements that would apply to each hospital operating in the United States), strengthening Medicare, rethinking rural health, unleashing innovation, reducing provider burden, and strengthening program integrity so that hospitals and ambulatory surgical centers can operate with better flexibility and patients have what they need to become active health care consumers.

In accordance with Medicare law, CMS is proposing to update OPPS payment rates by 2.7 percent. This update is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for Multi-Factor Productivity (MFP).

In the CY 2019 OPPS/ASC final rule with comment period, we finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of 5 years (CY 2019 through CY 2023). CMS is not proposing any changes to its policy to use the hospital market basket update for ASC payment rates for CY 2020-2023. Using the hospital market basket, CMS proposes to update ASC rates for CY 2020 by 2.7 percent for ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 3.2 percent minus a 0.5 percentage point adjustment for MFP. This change will also help to promote site neutrality between hospitals and ASCs and encourage the migration of services from the hospital setting to the lower cost ASC setting.

The proposed rule also includes:

- Proposed definition of 'hospital,' 'standard charges,' and 'items and services'
- Proposed requirements for making public all standard charges for all items and services
- Proposed requirements for making public consumer-friendly standard charges for a limited set of 'shoppable services'
- Proposals for monitoring and enforcement
- Method to control for unnecessary increases in utilization of outpatient services
- Changes to the Inpatient Only list
- ASC covered procedures list
- High-cost/low-cost threshold for packaged skin substitutes
- Device pass-through applications
- Addressing wage index disparities
- Changes in the level of supervision of outpatient therapeutic services in hospitals and critical access hospitals
- Hospital Outpatient Quality Reporting Program
- Ambulatory Surgical Center Quality Reporting Program
- CY 2020 OPPS payment methodology for 340B purchased drugs
- Partial Hospitalization Program rate setting and update to per diem rates
- Revision to the organ procurement organization conditions for certification
- Potential changes to the organ procurement organization and transplant center regulations: Request for Information

For More Information:

- Proposed Rule: Public comments due by September 27
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 29).

ESRD AND DMEPOS CY 2020 PROPOSED RULE

On July 29, CMS issued a proposed rule that proposes to update payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries on or after January 1, 2020. This rule also:

- Proposes updates to the Acute Kidney Injury (AKI) dialysis payment rate for renal dialysis services furnished by ESRD facilities to individuals with AKI
- Proposes changes to the ESRD Quality Incentive Program
- Includes requests for information on data collection resulting from the ESRD PPS technical expert panel, on possible updates and improvements to the ESRD PPS wage index, and on new rules for the competitive bidding of diabetic testing strips.

In addition, this rule proposes a methodology for calculating fee schedule payment amounts for new Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) items and services and making adjustments to the fee schedule amounts established using supplier or commercial prices if such prices decrease within five years of establishing the initial fee schedule amounts. This rule would also:

- Make amendments to revise existing policies related to the competitive bidding program for DMEPOS
- Streamline the requirements for ordering DMEPOS items, and create one Master List of DMEPOS items that could potentially be subject to face-to-face encounter and written order prior to delivery and/or prior authorization requirements

The proposed CY 2020 ESRD PPS base rate is $240.27, an increase of $5.00 to the current base rate of $235.27. This proposed amount reflects a reduced market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.7 percent) and application of the wage index budget-neutrality adjustment factor (1.004180).

The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Eligibility criteria for the Transitional Drug Add-on Payment Adjustment (TDAPA)
- Basis of Payment for the TDAPA for calcimimetics
- Average sales price conditional policy for the application of the TDAPA:
- New and innovative renal dialysis equipment and supplies
- Discontinuing the application of the erythropoiesis-stimulating agent monitoring policy
- Impact analysis:

For More Information:

- Proposed Rule: Public comments due by September 27
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 29).

MLN Connects Special Edition - August 2, 2019

IPPS/LTCH: FY 2020 PPS FINAL RULE

On August 2, CMS finalized policy changes to spur competition and innovation that will help deliver improved care and outcomes at a better value to patients. The final rule updates Medicare payment policies for hospitals under the Inpatient Prospective Payment System (IPPS) and the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) for FY 2020 and advances two key CMS priorities—"Rethinking Rural Health" and "Unleashing Innovation" by making historic changes to how Medicare pays hospitals. This final rule:

- Increases the wage index for certain low-wage index hospitals, including many rural hospitals
- Increases Medicare add-on payments for high cost eligible new technologies from 50-65%
- Clarifies policies on "substantial clinical improvement" to qualify for new technology add on payments
- Provides an alternative pathway where Breakthrough Devices are no longer required to demonstrate evidence of "substantial clinical improvement" to qualify for new technology add-on payments
- Provides an alternative pathway where Qualified Infectious Disease Products are no longer required to meet the "substantial clinical improvement" criteria for technology add-on payments, which are increased from 50 to 75%

For More Information:

- Final Rule
- Fact Sheet

Press release See the full text of this excerpted CMS Press Release (Issued August 2).

IRF: FY 2020 PAYMENT AND POLICY CHANGES

On July 31, CMS issued a final rule that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program for FY 2020. We are continuing our efforts towards the eventual transition to a unified post-acute care system through updates to the data used for IRF payments, including revising the Case-Mix Groups (CMGs), updating the CMG relative weights and average length of stay values, and using concurrent inpatient prospective payment system wage index data for the IRF PPS to align wage index data across settings of care.

For FY 2020, CMS is finalizing updates to the IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket increase factor of 2.9 percent, reduced by a 0.4 percentage point multifactor productivity adjustment). CMS projects that IRF payments will increase by 2.5 percent (or $210 million) for FY 2020, relative to payments in FY 2019.

This Rule Finalizes:

- Rebase and revise the IRF market basket

- Clarification of "rehabilitation physician"
- Two new quality measures

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

HOSPICE: FY 2020 HOSPICE PAYMENT RATE FINAL RULE

On July 31, CMS issued a final rule that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices. For FY 2020, hospice payment rates are updated by 2.6 percent ($520 million increase in their payments). The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The aggregate cap limits the overall payments per patient made to a hospice annually.

This Rule Finalizes:

- Rebasing to more accurately align Medicare payments with the costs of providing care
- Modifications to the election statement beginning in FY 2021, increasing coverage transparency for beneficiaries under a hospice election
- Hospice Quality Reporting Program updates, including developing a hospice assessment tool for real-time patient assessments

For More Information:

- Final Rule
- Hospice Center webpage
- Hospice Quality Reporting webpage

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

MLN Connects Special Edition - August 13, 2019

DMEPOS COMPETITIVE BIDDING - ROUND 2021 DEADLINES

DBidS Registration Closes August 16

> Registration to request access to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Bidding System, DBidS, closes this Friday, August 16 at 8:59 pm ET. No authorized officials, backup authorized officials, or end users can register to request access after registration closes; you will not be able to bid.

Covered Document Review Date (CDRD) is August 19

> If you are bidding in Round 2021, you must upload required financial documents in Connexion, the program's secure portal, on or before Monday, August 19 to be notified of any missing financial documents.

For more details, including how to get assistance, see the DME Center webpage.

HMO and MCO Details Available within NMP

Are you receiving claim denials with Reason Code 109-Remark Code N418 for beneficiaries with Managed Care Organization (MCO) or Health Maintenance Organization (HMO) insurance plans? Prior to billing, suppliers can catch discrepancies by accessing related details via the Noridian Medicare Portal (NMP) "Eligibility" inquiry.

Not yet registered for NMP? View the New User Registration Guide to learn more.

NMP: Upload Appeals Documentation to a Submitted Request

Once an appeal request has been completed and submitted to Noridian, NMP users are still able to upload additional documentation to it within the portal. For information on how to add related documentation, see the Begin New Appeal section of the NMP End User Manual.

Prior Authorization Request Submission Now Available in NMP

The Noridian Medicare Portal (NMP) now allows DME users to submit Prior Authorization Requests (PAR) and view the decision letter following review. PAR submissions can be submitted for any user that already has access to the PAR Status Inquiry.

When a new PAR is submitted, users will complete a series of questions and information related to the PAR along with being able to submit supporting documentation.

To begin submitting PARs, view the Prior Authorization Request Status and Submit New Prior Authorization section of the NMP User Manual or access the Self Service Tools "Prior Authorizations" DME on Demand tutorial.

Transfer of Appeal Rights Form May be Submitted via NMP

Effective June 13, 2019, the CMS Transfer of Appeal Rights form may be submitted as documentation through the Noridian Medicare Portal (NMP). For submission details, see the Begin New Appeal section of the NMP User Manual.

RESOURCE

- CMS Change Request (CR)11042 - Pub. 100-04, Chapter 29 - Appeals of Claims Decisions - Revisions

Oxygen Policy Update

MLN Matters Number: MM10837
Related CR Release Date: July 31, 2019
Related CR Transmittal Number: R2326OTN
Related Change Request (CR) Number: 10837
Effective Date: January 1, 2019
Implementation Date: January 7, 2019

CR 10837 implements a new policy and coding for oxygen content. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)10837.

Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - October 2019

MLN Matters Number: MM11343
Related CR Release Date: July 5, 2019
Related CR Transmittal Number: R4331CP
Related Change Request (CR) Number: 11343
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

CR11343 informs MACs about new and revised Average Sales Price (ASP) and ASP Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs. The Centers for Medicare & Medicaid Services (CMS) will make files available for download on or after September 13, 2019. CMS gives MACs the ASP and NOC drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions available in Chapter 4, Section 50 of the Medicare Claims Processing Manual found at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf. Make sure that your billing staffs are aware of these changes

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11343.

Claim Status Category and Claim Status Codes Update

MLN Matters Number: MM11393
Related CR Release Date: August 23, 2019
Related CR Transmittal Number: R4377CP
Related Change Request (CR) Number: 11393
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

CR 11393 updates, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and ASC X12 277 Health Care Claim Acknowledgement transactions. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11393.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC and CAGC Rule - Update from CAQH CORE

MLN Matters Number: MM11394
Related CR Release Date: August 23, 2019
Related CR Transmittal Number: R4376CP
Related Change Request (CR) Number: 11394
Effective Date: January 1, 2020
Implementation Date: January 6, 2020

CR 11394 instructs MACs and Medicare's Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the CORE Code Combination List to be published on or about October 1, 2019. Make sure that your billing staffs are aware of these changes.

The Secretary of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) CORE, Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014 under the Affordable Care Act.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11394.

Healthcare Provider Taxonomy Codes (HPTCs) October 2019 Code Set Update

MLN Matters Number: MM11418
Related CR Release Date: August 23, 2019
Related CR Transmittal Number: R4371CP
Related Change Request (CR) Number: 11418
Effective Date: January 1, 2020
Implementation Date: January 6, 2020 - MACs with capability to do so should implement effective October 1, 2019

CR 11418 advises the MACs to obtain the most recent Healthcare Provider Taxonomy Codes (HPTCs) code set and use it to update their internal HPTC tables and, or reference files. Please make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11418.

Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of CARC, RARC, and CAGC Rule - Update from CAQH CORE

MLN Matters Number: MM11321
Related CR Release Date: June 7, 2019
Related CR Transmittal Number: R4317CP
Related Change Request (CR) Number: 11321
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

CR11321 instructs MACs and Shared System Maintainers (SSMs) to update systems based on the Committee on Operating Rules for Information Exchange (CORE) 360 Uniform use of Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Claim Adjustment Group Code (CAGC) rule publication. These system updates are based on the CORE Code Combination List, which will be published on or about June 4, 2019. Make sure that your billing staffs are aware of these updates.

The Department of Health and Human Services (HHS) adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE), Electronic Funds Transfer (EFT), and Electronic Remittance Advice (ERA) Operating Rule Set that was implemented on January 1, 2014, under the Affordable Care Act.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11321.

Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2019

MLN Matters Number: MM11336
Related CR Release Date: July 5, 2019
Related CR Transmittal Number: R4329CP
Related Change Request (CR) Number: 11336
Effective Date: October 1, 2019
Implementation Date: October 7, 2019

Medicare updates the DMEPOS Competitive Bidding Program (CBP) files on a quarterly basis to implement necessary changes to the Healthcare Common Procedure Coding System (HCPCS), ZIP code, and supplier files. CR11336 provides specific instruction for implementing the DMEPOS CBP files.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11336.