DME Happenings

Jurisdiction A

September 2020

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COVERAGE

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://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

EDUCATIONAL

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UPDATES

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
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

Correspondence	When to Use This Address	Email Address
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 • Electronic Funds Transfer (EFT) • Freedom of Information Act (FOIA) • Medical Review Documentation • Overpayment Redetermination and Rebuttal Requests • Recovery Auditor Overpayments • Recovery Auditor Redeterminations • Redetermination Requests • Refunds • Written Reopening Requests	Noridian JA DME Attn: _____ PO Box 6780 Fargo, ND 58108-6780
• Administrative Simplification Compliance Act Exception Requests (ASCA) • Benefit Integrity	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/

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, https://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

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."

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, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index. 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.

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 https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index. Suppliers may also sign up to receive notification when regulations and program instructions are added throughout the quarter on this page.

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

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

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

CERT Contractor Email Addresses

Providers and suppliers are now able to submit medical records directly to the CERT contractor at CERTmail@nciinc.com. As a best practice, providers and suppliers are encouraged to password protect their documentation. Passwords should be submitted in a separate email to the CERT contractor.

Have questions? Reach out to the CERT Contractor at CERTprovider@nciinc.com. They can assist with questions related to medical records requests, review status, and more.

Your MAC's CERT team is also able to assist with questions you may have regarding the CERT process. Locate their contact information on your MAC's website.

The IVIG Demonstration: Demonstration is ending on December 31, 2020

MLN Matters Number: MM11877
Related CR Release Date: August 21, 2020
Related CR Transmittal Number: R10307DEMO
Related Change Request (CR) Number: 11877
Effective Date: January 1, 2021 -

Demonstration ends December 31, 2020
Implementation Date: January 4, 2021

CR 11877 notifies you that the Intravenous Immune Globulin (IVIG) Demonstration is ending on December 31, 2020. Please be sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11877.

Required Prior Authorization for Certain DMEPOS Items to Resume

Due to the importance of medical review activities to the Centers for Medicare & Medicaid Services (CMS) program integrity efforts, effective August 3, 2020, CMS will discontinue exercising enforcement discretion and resume the requirement to prior authorize certain Power Mobility Devices (PMDs) and Pressure Reducing Support Surfaces (PRSS).

For Prior Authorization (PA) requests and claims **prior to August 3**, DME MACs will continue to accept and review voluntary PA requests for HCPCS codes on the Required Prior Authorization List. Suppliers are reminded they must continue to use the CR modifier for all HCPCS codes billed and enter "COVID-19" in the NTE 2400 (line note) or NTE 2300 (claim note) segments of the American National Standard Institute (ANSI X12) format or field 498-PP of the National Council for Prescription Drug Program (NCPDP) format for claims associated with a non-affirmation decision or claims submitted without requesting PA that would normally cause a payment denial. These abbreviations may also be used in Item 19 of the CMS-1500 claim form. These instructions must be applied to all subsequent rental months to ensure payment.

Additionally, the implementation of PA for Lower Limb Prostheses HCPS codes: L5856, L5857, L5858, L5973, L5980 and L5987 will begin for dates of service on or after September 1, 2020 in the states of California, Michigan, Pennsylvania, and Texas.

Reopenings

For claims denied due to the COVID-19 Public Health Emergency (PHE) associated with PA submissions on or after March 01, 2020 until August 2, 2020, suppliers may request a reopening of their claim by contacting their MAC.

Revising Chapters 3 and 5 of Pub. 100-08, to Reflect the Recent Final Rule CMS-1713-F

MLN Matters Number: MM11599
Related CR Release Date: June 19, 2020
Related CR Transmittal Number: R10190pi
Related Change Request (CR) Number: CR 11599
Effective Date: January 1, 2020
Implementation Date: July 1, 2020

CR 11599 revises the Medicare Program Integrity Manual, Chapters 3 (Verifying Potential Errors and Taking Corrective Actions) and 5 (Items and Services Having Special DMEPOS Review Considerations) to include finalized regulatory updates, including those related to face-to-face encounter and written order requirements.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11599.

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 and https://med.noridianmedicare.com/web/jadme/contact/training-closures
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have ***all*** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. Verified by Customer Service Representative (CSR) or IVR • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digits of Tax Identification Number (TIN) Verified by CSR • Caller's name • Provider/Facility name • Beneficiary Medicare number • Beneficiary first and last name • Date of Service (DOS) • Last five digits of Claim Control Number (CCN) • HCPCS code(s) in question • Corrective action to be taken Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.
What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive. • Diagnosis code changes or additions • Date of Service (DOS) changes • HCPCS code changes • Certain modifier changes or additions (not an all-inclusive list) If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.

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?	If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 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.

Clarification of Right to Escalate Reconsideration Request to OMHA for Suppliers Participating in QIC Telephone Discussions

The Qualified Independent Contractor (QIC) revised the Notice of the Telephone Discussion letter to clarify language regarding the opportunity to escalate an appeal to the Office of Medicare Hearings and Appeals (OMHA). Please note that “escalation” is the regulatory term used when an appellant chooses to proceed to the next level of appeal when the QIC cannot make a timely appeal decision. Escalation is a different action than filing a separate appeal with OMHA.

In comparison to a standard reconsideration which has 60 days to render a decision, participation in a telephone discussion extends the QICs time frame to render a decision by an additional 60 days for a total time frame of 120 days from the appeal receipt. By participating in a telephone discussion, you will not have the opportunity to “escalate” your reconsideration request to OMHA if the QIC has not rendered a reconsideration decision within the 60-day processing standard. However, participation in a telephone discussion as part of the Demonstration does not impact future appeal rights following the reconsideration decision.

Include Multiple Dates of Service on Reconsideration Appeal Request

Suppliers may include multiple dates of service for the same beneficiary on one reconsideration request form instead of submitting separate reconsideration requests for each date of service. Additionally, two or more redeterminations can be submitted in one appeal request to the QIC as long as the items are for the same beneficiary.

Billing for Home Infusion Therapy Services on or After January 1, 2021

MLN Matters Number: MM11880
Related CR Release Date: August 7, 2020
Related CR Transmittal Number: R10269BP, R10269CP
Related Change Request (CR) Number: 11880
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 11880 provides guidance to providers and suppliers about claims processing systems changes necessary to implement Section 5012(d) of the 21st Century Cures Act. These changes are effective on and after January 1, 2021. Make sure that your billing staff is aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11880

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.

CMS Issues Interim Final Rules with Comment (CMS-1744- IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, CMS Issues Interim Final Rules with Comment (CMS-1744- IFC & CMS-5531-IFC) - COVID-19 Public Health Emergency - Revised, has been created and published to our website.

View the locally hosted 2020 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

Correct Coding and Coverage of Ventilators - Revised July 2020

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Correct Coding and Coverage of Ventilators - Revised July 2020, has been created and published to our website.

View the locally hosted 2020 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

External Infusion Pumps Final LCD (L33794) and Response to Comments (RTC) Article Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, External Infusion Pumps Final LCD (L33794) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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- Locate/select article title

Incorrect Use of HCPCS Code A9279 - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Incorrect Use of HCPCS Code A9279 - Correct Coding, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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

Insulin Infusion Pumps with Integrated Continuous Glucose Sensing Capabilities and Related Accessories/Supplies - Codes E0787 and A4226 - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Insulin Infusion Pumps with Integrated Continuous Glucose Sensing Capabilities and Related Accessories/Supplies - Codes E0787 and A4226 - Correct Coding, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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

Oxygen and Oxygen Equipment Final LCD (L33797) and Response to Comments (RTC) Article Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Oxygen and Oxygen Equipment Final LCD (L33797) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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

Prosthetic Feet and Additions to Lower Limb Extremity Prostheses - Correct Coding and Coding Verification Review Requirement

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Prosthetic Feet and Additions to Lower Limb Extremity Prostheses - Correct Coding and Coding Verification Review Requirement, has been created and published to our website.

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Same or Similar Denials for Orthoses and the Appeals Process

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Same or Similar Denials for Orthoses and the Appeals Process, has been created and published to our website.

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- Locate/select article title

Scoliosis Brace - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, SCOLIOSIS BRACE - CORRECT CODING, has been created and published to our website.

View the locally hosted 2020 DMD articles.

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

Value-Based Insurance Design (VBID) Model - Implementation of the Hospice Benefit Component - Revised

MLN Matters Number: MM11754 Revised
Related CR Release Date: June 9, 2020
Related CR Transmittal Number: R10170DEMO
Related Change Request (CR) Number: 11754
Effective Date: January 1, 2021 - When the Hospice Election Start Date is on or after January 1, 2021 and prior to January 1, 2025
Implementation Date: October 5, 2020

Note: CMS revised this article on June 10, 2020, to reflect a revised CR 11754 issued on June 9. CMS revised the article to add a note to the effective date. Also, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11754 informs you of the implementation of the hospice benefit component associated with the VBID Model, being tested by the Centers for Medicare & Medicaid Services (CMS) Innovation Center and starting in Calendar Year (CY) 2021. The hospice benefit component of the Model will be tested through CY 2024. Thus, the Model test will apply when the Hospice Election Start Date is on or after January 1, 2021 and prior to January 1, 2025.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11754.

Xembify® - Correct Coding

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

View the locally hosted 2020 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

Monday Live Chats Extended

Noridian Provider Outreach and Education staff is proud to announce that Monday Live Chat has officially been extended to one hour. Live Chats will now take place Mondays from 3-4 p.m. EDT. Please join us for responses to your own questions as well as questions posed by other suppliers. Registration will take place through our schedule of events.

National DME MAC Education Webpage - Now Live

In previous articles, we shared how the Noridian and CGS Program Managers oversee a variety of operational and collaborative workgroups that meet monthly to discuss opportunities for DME MAC process improvements across all four DME MAC jurisdictions. In this article, the Program Managers are excited to announce the launch of the CGS and Noridian National DME MAC Education Webpage, and to highlight a new Self Service Tools & Resources reference.

Supplier Education on Use of Upgrades for Multi-Function Ventilators - Revised

MLN Matters Number: SE20012 Revised
Article Release Date: May 29, 2020

Note: CMS revised this article to show that the policy on use of multi-function ventilators, as discussed in the "What You Need to Know" section, is a permanent change.

Medicare's multi-function ventilator policy applies to beneficiaries who are prescribed and meet the medical necessity coverage criteria for a ventilator and at least one of the four additional functions (namely, oxygen concentrator, cough stimulator, suction pump, and nebulizer). HCPCS code E0467 is used to describe multi-function ventilators. **Starting in April 2020, the Centers for Medicare & Medicaid Services (CMS) permanently suspended claims editing for multi-function ventilators when there are claims for separate devices in history that have not met their reasonable useful lifetime.**

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)20012.

Using the KU Modifier for Wheelchair Accessories and Seat Back Cushions starting July 6, 2020

The KU modifier is used to receive the unadjusted fee schedule amount and is being implemented for a variety of wheelchair accessories and seat back cushions used with complex rehabilitative manual wheelchairs and certain manual chairs. The use of the KU modifier will start with claims submitted on July 6, 2020 and be effective for dates of service from January 1, 2020 through June 30, 2021. Previously paid claims with dates of service on or after January 1, 2020 can be reopened to add the KU modifier. The accessories impacted are listed in the manual wheelchair section of our website and apply to wheelchair codes K0005, E1161, E1231-E1238 and K0008.

Comprehensive Error Rate Testing (CERT) Reviews and COVID-19

The CERT team at Noridian is here to help suppliers through their CERT review. Contact us with your provider transaction access number (PTAN) and CERT claim identifier (CID), or general education request. Services offered include:

- CERT Review Status
- Provider Number Lookup for All Current CERT Reviews
- Review of Medical Records
- Custom PowerPoint Presentation
- Supplier Improper Payment Rate Analysis
- Electronic Visit
- Teleconference
- And more

Email your inquiry to jadmecert@noridian.com.

Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) - Revised

MLN Matters Number: SE20011 Revised
Article Release Date: August 26, 2020

Note: CMS revised the article to add information about the HCPCS codes for OPPS, RHC, FQHC, and CAH billers in the Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services section. All other information remains the same.

The Secretary of the Department of Health & Human Services declared a public health emergency (PHE) in the entire United States on January 31, 2020. On March 13, 2020 Secretary Azar authorized waivers and modifications under Section 1135 of the Social Security Act (the Act), retroactive to March 1, 2020.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)20011.

New COVID-19 Policies for IPPS Hospitals, LTCHs, and IRFs due to Provisions of the CARES Act - Revised

MLN Matters Number: SE20015 Revised
Article Release Date: August 17, 2020

Note: CMS revised this article on August 17, 2020, to add an update regarding the implementation of Section 3710 of the CARES Act for IPPS hospitals to address potential Medicare program integrity risks. All other information is unchanged.

SE 20015 describes certain provisions of the Coronavirus Aid, Relief, and Economic Security (CARES) Act that relate to Inpatient Prospective Payment System (IPPS) hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs). These provisions are Sections 3710 and 3711 of the CARES Act.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)20015.

Comment Period Closes June 15, 2020 for the External Infusion Pumps (DL33794) Proposed LCD

The Comment period will close on Monday, June 15, 2020 at 5:00 PM EDT/4:00 PM CDT for the External Infusion Pumps (DL33794) Proposed LCD. Additional information is available in the article Open meeting Announcement - External Infusion Pumps (DL33794).

LCD and Policy Article Revisions Summary for June 11, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is Urological Supplies. Please review the entire LCD and related PA for complete information.

UROLOGICAL SUPPLIES

LCD

Revision Effective Date: 07/26/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed
Added: Billing and coverage information for the inFlow device (HCPCS Code A4335)
Removed: Denial statement for inFlow device (A4335)

GENERAL:
Added: References to Standard Written Order (SWO)

REFILL REQUIREMENTS:
Revised: "ordering physicians" to "treating practitioners"

SUMMARY OF EVIDENCE:
Added: Information related to inFlow device

ANALYSIS OF EVIDENCE:
Added: Information related to inFlow device

CODING INFORMATION:
Removed: Field titled "Bill Type" Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

DOCUMENTATION REQUIREMENTS:
Revised: "physician's" to "practitioner's"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: "Prescriptions (orders)" to "SWO"

BIBLIOGRAPHY:
Added: Section related to inFlow device

RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58231)

PA

Revision Effective Date: 07/26/2020

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

GENERAL:
Revised: Billing direction for inFlow and urological supplies when inserted or used in a practitioner's office
Revised: "physician" updated to "treating practitioner"

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Directional statement regarding practitioner as supplier
Added: Continued medical need language

MODIFIER:
Added: inFlow device to KX modifier directions

MISCELLANEOUS:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed
Revised: inFlow device statement to replace battery and/or wand with "activator"

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

06/11/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for June 18, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is Oxygen and Oxygen Equipment. Please review the entire LCD and related PA for complete information.

OXYGEN AND OXYGEN EQUIPMENT

LCD

Revision Effective Date: 08/02/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: "physicians" to "treating practitioners

Removed: Statement to refer to ICD-10 Codes that are Covered section in the LCD-related PA
Added: Statement to refer to ICD-10 codes in the LCD-related Policy Article

GENERAL:
Revised: Order information as a result of Final Rule 1713

SUMMARY OF EVIDENCE:
Added: Information related to topical oxygen

ANALYSIS OF EVIDENCE:
Added: Information related to topical oxygen

CODING INFORMATION:
Removed: Field titled "Bill Type"
Removed: Field titled "Revenue Codes"
Removed: Field titled "ICD-10 Codes that Support Medical Necessity"
Removed: Field titled "ICD-10 Codes that DO NOT Support Medical Necessity"
Removed: Field titled "Additional ICD-10 Information"

GENERAL DOCUMENTATION REQUIREMENTS:
Revised: Prescriptions (orders) to SWO

BIBLIOGRAPHY:
Added: Section related to topical oxygen

RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A58247)

PA

Revision Effective Date: 08/02/2020

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: "physician" to "treating practitioner"

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PERSUANT TO 42 CFR 410.38(g):
Removed: Section removed

REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 Fed. Reg Vol 217):
Added: Section and related information based on Final Rule 1713

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: "physician" to "treating practitioner"

CERTIFICATE OF MEDICAL NECESSITY (CMN):
Revised: "physician" to "treating practitioner"
Revised: "detailed written order" to "standard written order"
Removed: Outdated CMN Form number

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Covered" updated to "ICD-10 Codes that Support Medical Necessity"

ICD-10 CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:
Revised: Section header "ICD-10 Codes that are Not Covered" updated to "ICD-10 Codes that DO NOT Support Medical Necessity"

06/18/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website
        i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for June 25, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Articles (PAs) that have been revised and posted. The policies included are Lower Limb Prostheses and Surgical Dressings. Please review the entire LCDs and related PAs for complete information.

LOWER LIMB PROSTHESES

PA

Revision Effective Date: 08/01/2020

CODING GUIDELINES:
Added: Coding guidelines for HCPCS codes L5856, L5857, L5858, L5980, L5981, and L5987

CODING VERIFICATION REVIEW:
Added: Section header for information related to PDAC coding verification review
Revised: PDAC coding verification review information for HCPCS code L5969, to include effective for DOS on or after 01/01/2014
Added: PDAC coding verification review information for HCPCS codes L5856, L5857, L5858, L5973, L5980, and L5987, effective for DOS on or after 01/01/2021

06/25/2020: 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.

SURGICAL DRESSINGS

LCD

Revision Effective Date: 01/01/2020

CPT/HCPCS CODES:
Corrected: Descriptor for the A9 modifier to include "or more" in Group 1 Paragraph

06/25/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-substantive corrections.

PA

Revision Effective Date: 01/01/2020

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: Included descriptor of the A9 modifier

06/25/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

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        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

LCD and Policy Article Revisions Summary for July 23, 2020

Outlined below are the principal changes to the DME MAC Local Coverage Determination (LCD) and Policy Article (PA) that have been revised and posted. The policy included is External Infusion Pumps. Please review the entire LCD and related PA for complete information.

EXTERNAL INFUSION PUMPS

LCD

Revision Effective Date: 09/06/2020

COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: J7799 (Xembify) to J1558 for Dates of Service on or after 07/01/2020
Clarification: Coverage for Xembify effective for Dates of Service on or after 07/3/2019 (FDA Approval Date)
Added: Cutaquig to coverage criteria V(H) effective for Dates of Service on or after 12/12/2018 (FDA Approval Date)
Added: Statement regarding covered pumps for Cutaquig

SUMMARY OF EVIDENCE:
Added: Information related to Cutaquig

ANALYSIS OF EVIDENCE:
Added: Information related to Cutaquig

CODING INFORMATION:
Added: HCPCS code J1558 to Group 3 table

BIBLIOGRAPHY:
Added: Section related to Cutaquig

RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments document A58288

PA

Revision Effective Date: 09/06/2020

MODIFIERS:
Added: J1558 and J7799 (Cutaquig) to the JB modifier requirements

CODING GUIDELINES:
Added: Billing instructions for Xembify based on DOS
Added: UOS billing instruction for J7799 (Cutaquig)

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: J1558 and J7799 (Cutaquig) to the Group 3 paragraph

07/23/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

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        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for June 4, 2020

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthosis, Ostomy Supplies and Surgical Dressings. Please review the entire LCDs and PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS

PA

Revision Effective Date: 07/01/2020

ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: ICD-10 diagnosis codes E08.610, E09.610, E10.610, and E11.610 to Group 2 Codes for L4631

06/04/2020: 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.

OSTOMY SUPPLIES

PA

Revision Effective Date: 01/01/2020

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Continued medical need language

06/04/2020: 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

SURGICAL DRESSINGS

PA

Revision Effective Date: 01/01/2020

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Directional statement regarding practitioner as supplier

Added: Financial interest prohibition exception for practitioners who are also the supplier
Revised: Format of HCPCS code references, from code 'spans' to individually-listed

CODING GUIDELINES:
Revised: Format of HCPCS code references, from code 'spans' to individually-listed

06/04/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

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        ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for July 16, 2020

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are High Frequency Chest Wall Oscillation Devices, Mechanical In-exsufflation Devices, Nebulizers, Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Respiratory Assist Devices, and Suction Pumps. Please review the entire LCDs and PAs for complete information.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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.

MECHANICAL IN-EXSUFFLATION DEVICES

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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.

NEBULIZERS

PA

Revision Effective Date: 05/17/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS (Effective April 3, 2020)

07/16/2020: 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.

ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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.

POSITIVE AIRWAY PRESSURE (PAP) DEVICES FOR THE TREATMENT OF OBSTRUCTIVE SLEEP APNEA

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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.

RESPIRATORY ASSIST DEVICES

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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.

SUCTION PUMPS

PA

Revision Effective Date: 04/03/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 based on DOS

07/16/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

With the update listed above, Noridian would like to remind users how to find the policy that was previously effective. When billing, the supplier should follow guidance that was effective on the date of service. The below steps can be followed to find all previous policies:

1. Open the currently effective policy on the Medical Coverage Database (MCD)
    a. Links to the MCD can be found on the Active LCDs page on the Noridian website

   i. There is a link at the top of the Active LCD page that goes to a full list of the LCDs or PAs, depending on which link is selected OR
   ii. There are direct links to all LCDs under the 'LCD ID number and Effective Date' column
2. Scroll down to the bottom of the policy
3. Find the section labeled Public Version(s)
4. Look for the link to the policy that was effective on the dates of service in question
5. Click on hyperlink to go to the policy

Policy Article Revisions Summary for August 13, 2020

Outlined below is the principal change to the DME MAC Policy Article (PA) which has been revised and posted. The policy included is Oxygen and Oxygen Equipment. Please review the entire LCD and PA for complete information.

OXYGEN AND OXYGEN EQUIPMENT

PA

Revision Effective Date: 08/02/2020

CODING GUIDELINES:
Revised: Guidance for billing HCPCS code E0467 (Effective April 3, 2020)

08/13/2020: 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 LCDs and PAs. For complete information on any topic, you must review the LCDs and/or PAs.

Urological Supplies Final LCD (L33803) and Response to Comments (RTC) Article Published

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Urological Supplies Final LCD (L33803) and Response to Comments (RTC) Article Published, has been created and published to our website.

View the locally hosted 2020 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

MACs Resume Medical Review on a Postpayment Basis

To protect the Medicare Trust Fund against inappropriate payments, Medicare Administrative Contractors (MACs) are resuming fee-for-service medical review activities. Beginning August 17, the MACs are resuming with postpayment reviews of items/services provided before March 1, 2020. The Targeted Probe and Educate program (intensive education to assess provider compliance through up to three rounds of review) will restart later. The MACs will continue to offer detailed review decisions and education as appropriate.

MLN Connects Special Edition - June 1, 2020 - COVID-19: Using the CR Modifier and DR Condition Code

CMS revised MLN Matters Special Edition Article SE20011 on Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) to clarify when you must use modifier CR (catastrophe/disaster related) and/or condition code DR (disaster related) when submitting claims to Medicare. The update includes a chart of blanket waivers and flexibilities that require the modifier or condition code.

MLN Connects - June 4, 2020

ICD-10-PCS Procedure Codes: FY 2021

MLN Connects® for Thursday, June 4, 2020
View this edition as a PDF

News

- Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results
- Hospice Provider Preview Reports: Review Your Data by June 29

Claims, Pricers & Codes

- ICD-10-PCS Procedure Codes: FY 2021

Events

- COVID-19: Lessons from the Front Lines Call - June 5

MLN Matters® Articles

- Claim Status Category Codes 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
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Public Health Emergency (PHE) Interim Final Rules
- Value-Based Insurance Design (VBID) Model - Implementation of the Hospice Benefit Component
- Supplier Education on Use of Upgrades for Multi-Function Ventilators - Revised
- Therapy Codes Update - Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--October 2020 Update - Rescinded

Publications

- Medicare Secondary Payer - Revised

MLN Connects - June 11, 2020

COVID-19: Reopening Health Care Facilities

MLN Connects® for Thursday, June 11, 2020
View this edition as a PDF

News

- Nursing Home COVID-19 Data and Inspections Results Available on Nursing Home Compare
- Trump Administration Encourages Reopening of Health Care Facilities
- HHS Announces New Laboratory Data Reporting Guidance for COVID-19 Testing
- Prior Authorization Process and Requirements for Certain Hospital OPD Services: Payment for Related Services

Events

- Medicare Documentation Requirement Lookup Service Special Open Door Forum - June 25

MLN Matters® Articles

- July 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.2
- July Quarterly Update for 2020 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS)
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2020

MLN Connects - June 18, 2020

COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

MLN Connects® for Thursday, June 18, 2020
View this edition as a PDF

News

- Hospitals: Submit Medicare GME Affiliation Agreements by October 1 During the COVID-19 PHE

Claims, Pricers & Codes

- COVID-19 Diagnostic Laboratory Tests: Billing for Clinician Services

Events

- COVID-19: Lessons from the Front Lines Call - June 19
- Medicare Part A Cost Report: New Online Status Tracking Feature Call - July 9

MLN Matters® Articles

- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to Home Health (HH) Grouper
- NCD (20.32) Transcatheter Aortic Valve Replacement (TAVR) - Revised
- Value-Based Insurance Design (VBID) Model - Implementation of the Hospice Benefit Component - Revised

Publications

- CLIA Program and Medicare Laboratory Services - Revised
- Medicare Preventive Services - Revised

MLN Connects Special Edition - June 19, 2020 - Medicare Coverage of COVID-19 Testing for Nursing Home Residents and Patients

Today, the Centers for Medicare & Medicaid Services (CMS) has instructed Medicare Administrative Contactors and notified Medicare Advantage plans to cover coronavirus disease 2019 (COVID-19) laboratory tests for nursing home residents and patients. This instruction follows the Centers for Disease Control and Prevention's (CDC) recent update of COVID-19 testing guidelines for nursing homes that provides recommendations for testing of nursing home residents and patients with symptoms consistent with COVID-19 as well as for asymptomatic residents and patients who have been exposed to COVID like in an outbreak. Original Medicare and Medicare Advantage plans will cover COVID-19 lab tests consistent with CDC guidance.

Medicare Advantage plans must continue not to charge cost sharing (including deductibles, copayments, and coinsurance) or apply prior authorization or other utilization management requirements for COVID-19 tests and testing-related services.

Read the Medicare Learning Network article: https://www.cms.gov/files/document/se20011.pdf.

Read the memo to Medicare Advantage plans: https://www.cms.gov/files/document/hpms-memo-diagnostic-testing-nursing-home-residents-and-patients-coronavirus-disease-2019.pdf.

More information about Medicare coverage of COVID-19 tests is available at: https://www.medicare.gov/coverage/coronavirus-disease-2019-covid-19-tests.

MLN Connects - June 25, 2020

COVID-19: New Data Details Impacts on Medicare Beneficiaries

MLN Connects® for Thursday, June 25, 2020
View this edition as a PDF

News

- Trump Administration Issues Call to Action Based on New Data Detailing COVID-19 Impacts on Medicare Beneficiaries
- Hospital Outpatient Departments: Prior Authorization Begins July 1
- IRF Provider Preview Reports: Review Your Data by July 18
- LTCH Provider Preview Reports: Review Your Data by July 18
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Personal Protective Equipment Strategies for COVID Care Webcast - June 25
- Medicare Part A Cost Report: New Online Status Tracking Feature Call - July 9

Publications

- Clinical Laboratory Fee Schedule Annual Payment Determination Process

MLN Connects Special Edition - June 26, 2020 - COVID-19: SNF Benefit Period Waiver, HHAs Proposed Rule, Ending Nursing Home Blanket Waiver

COVID-19: SNF Benefit Period Waiver

Disruptions during a Public Health Emergency can affect the Skilled Nursing Facility (SNF) benefit:

- Prevent a beneficiary from having the Qualifying Hospital Stay (QHS)
- Disrupt the process of ending the beneficiary's current benefit period and renewing their benefits

Emergency waivers of QHS and benefit period requirements under §1812(f) of the Social Security Act help restore SNF coverage that beneficiaries affected by the emergency would be entitled to under normal circumstances.

Learn more about the waiver and how to bill in MLN Matters Article SE20011.

HHAs: Proposed Payment and Policy Changes and Home Infusion Therapy Benefit for CY 2021

On June 25, CMS issued a proposed rule [CMS-1730-P] for FY 2021 that updates the Medicare payment rates for Home Health Agencies (HHAs). This proposed rule also includes a proposal to make permanent the regulatory changes related to telecommunications technologies in providing care under the Medicare home health benefit beyond the expiration of the Public Health Emergency for the COVID-19 pandemic.

For More Information:

- Fact Sheet
- Proposed Rule

CMS Announces Plans to End the Blanket Waiver Requiring Nursing Homes to Submit Staffing Data

On June 25, CMS announced plans to end the emergency blanket waiver requiring all nursing homes to resume submitting staffing data through the Payroll-Based Journal (PBJ) system by August 14, 2020. The PBJ system allows CMS to collect nursing home staffing information which impacts the quality of care residents receive. The blanket waiver was intended to temporarily allow the agency to concentrate efforts on combating COVID-19 and reduce administrative burden on nursing homes so they could focus on patient health and safety during this Public Health Emergency.

The memorandum also provides updates related to staffing and quality measures used on the Nursing Home Compare website and the Five Star Rating System.

To view the memorandum to states and nursing home stakeholders, visit: https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/changes-staffing-information-and-quality-measures-posted-nursing-home-compare-website-and-five-star.

MLN Connects - July 2, 2020

Attend Nursing Home Training Series Webcasts

MLN Connects® for Thursday, July 2, 2020
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News

- CMS Proposes to Expand Coverage Policy for Transcatheter Edge-to-Edge Repair for Patients with Mitral Valve Regurgitation
- Physician Compare Preview Period Open through August 20
- ABN Form Renewal
- Medicare Enrollment Application Fee Refunds through EFT

Claims, Pricers & Codes

- SNF Benefit Waiver Period: Billing Update

Events

- Nursing Home Training Series Webcasts - July 2, 9, and 16
- Medicare Part A Cost Report: New Online Status Tracking Feature Call - July 9

MLN Matters® Articles

- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 26.3, Effective October 1, 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage

Determination (NCDs) - July 2020 Update - Revised
- National Coverage Determination (NCD) 160.18 Vagus Nerve Stimulation (VNS) - Revised
- Quarterly Update to the Long Term Care Hospital (LTCH) Prospective Payment System (PPS) Fiscal Year (FY) 2020 Pricer - Revised

MLN Connects Special Edition - July 6, 2020 - ESRD PPS CY 2021 Proposed Rule; COVID-19: New and Expanded Flexibilities for RHCs & FQHCs

ESRD PPS CY 2021 Proposed Rule

On July 6, 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, 2021. 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 and proposes changes to the ESRD Quality Incentive Program (QIP).

In addition to the annual technical updates for the ESRD PPS, the proposed rule proposes the following:

- An addition to the ESRD PPS base rate to include calcimimetics in the ESRD PPS bundled payment
- Changes to the eligibility criteria and determination process for the Transitional add-on Payment adjustment for New and Innovative Equipment and Supplies (TPNIES)
- Expansion of the TPNIES to include new and innovative capital-related assets that are home dialysis machines
- A change to the low-volume adjustment eligibility criteria and attestation requirement to account for the COVID-19 public health emergency
- An update to the ESRD PPS wage index to adopt the new Office of Management and Budget delineations with a transition period
- Information received from two manufacturers whose products, a dialyzer and a cartridge for a home dialysis machine, are being considered for TPNIES in CY 2021

Additionally, the proposed rule proposes the following updates to the ESRD QIP:

- Scoring methodology changes to the ultrafiltration rate reporting measure
- Updates to the National Healthcare Safety Network validation study

The proposed CY 2021 ESRD PPS base rate is $255.59, an increase of $16.26 to the current base rate of $239.33. This proposed amount reflects the application of the proposed wage index budget-neutrality adjustment factor (.998652), the proposed addition to the base rate of $12.06 to include calcimimetics, and a proposed productivity-adjusted market basket increase as required by section 1881(b)(14)(F)(i)(I) of the Act (1.8 percent), equaling $255.59 (($239.33 x .998652) + $12.06) x 1.018 = $255.59).

The proposed rule also includes:

- Annual update to the wage index
- Update to the outlier policy
- Low-volume eligibility criteria and attestation requirement
- Impact analysis

For More Information:

- Proposed Rule
- Press Release

See the full text of this excerpted CMS Fact Sheet (issued July 6).

COVID-19: New and Expanded Flexibilities for RHCs & FQHCs during the Public Health Emergency

On July 6, CMS updated MLN Matters Article SE20016 to clarify how Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) can apply the Cost Sharing (CS) modifier to preventive services furnished via telehealth. This update includes:

- Additional claim examples

- New section on the RHC Productivity Standard

MLN Connects - July 9, 2020

ICD-10-CM Diagnosis Codes: FY 2021

MLN Connects® for Thursday, July 9, 2020
View this edition as a PDF

News

- Open Payments: Program Year 2019 Data
- LTCH Provider Preview Reports: Review Your Data by July 18
- IRF Provider Preview Reports: Review Your Data by July 21
- Reduce Provider Burden: Participate in Medical Documentation Interoperability Pilot
- COVID-19: Alternate Care Site Toolkit, Third Edition

Claims, Pricers & Codes

- ICD-10-CM Diagnosis Codes: FY 2021
- Teaching Physicians and Residents: Expansion of CPT Codes that May Be Billed with the GE Modifier

Events

- Nursing Home Training Series Webcasts - July 9 and 16

MLN Matters® Articles

- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Revising Chapters 3 and 5 of Publication (Pub.) 100-08, to Reflect the Recent Final Rule CMS-1713-F
- New Point of Origin Code for Transfer from a Designated Disaster Alternate Care Site - Revised

Publications

- Hospice Quality Reporting Program: COVID-19 PHE

MLN Connects - July 16, 2020

Nursing Homes & COVID: Five Things to Know, Additional Resources, Training

MLN Connects® for Thursday, July 16, 2020
View this edition as a PDF

News

- CMS Directs Additional Resources to Nursing Homes in COVID-19 Hotspot Areas
- Five Things About Nursing Homes During COVID-19
- PEPPER for Short-term Acute Care Hospitals
- Lower Extremity Joint Replacement: Comparative Billing Report

Events

- Nursing Home Training Series Webcasts: New Topic for July 16
- COVID-19: Lessons from the Front Lines Call - July 17

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020
- Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021

- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - July 2020 Update
- July 2020 Update of the Ambulatory Surgical Center (ASC) Payment System - Revised
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised
- Claim Status Category Codes and Claim Status Codes Update - Rescinded

MLN Connects Special Edition - July 17, 2020 - COVID-19: Nursing Home Testing, SNF Benefit Period Waiver

COVID-19: Nursing Home Testing, SNF Benefit Period Waiver

MLN Matters Special Edition Article SE20011 Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) is updated. Learn about:

- Updated Centers for Disease Control and Prevention guidelines for testing nursing home residents and patients
- Update on applying the Skilled Nursing Facility (SNF) benefit period waiver

MLN Connects - July 23, 2020

Telemedicine Hack: 10-Week Learning Community for Ambulatory Providers

MLN Connects® for Thursday, July 23, 2020
View this edition as a PDF

News

- Peripheral Vascular Intervention for Claudication: Comparative Billing Report
- Physician Compare Preview Period Open through August 20

Claims, Pricers & Codes

- SNF Patient Driven Payment Model Interrupted Stay Issue

Events

- Telemedicine Hack: A 10-Week Learning Community to Accelerate Telemedicine Implementation for Ambulatory Providers: July 22-September 23
- National CMS/CDC Nursing Home COVID-19 Training Series Webcast - July 23

MLN Matters® Articles

- Change to the Payment of Allogeneic Stem Cell Acquisition Services
- July 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS) - Revised

Multimedia

- Part A Cost Report Call: Audio Recording and Transcript

MLN Connects - July 30, 2020

COVID-19 Impacts on Medicare Beneficiaries - Updated Data

MLN Connects® for Thursday, July 30, 2020
View this edition as a PDF

News

- CMS Updates Data on COVID-19 Impacts on Medicare Beneficiaries
- Short-Term Acute Care Hospitals: Submit Occupational Mix Surveys by September 3
- PEPPERs for SNFs, Hospices, IRFs, IPFs, CAHs, and LTCHs
- Hospice Quality Reporting Program: HART v1.6.0
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- COVID-19: Laboratory Claims Requiring the NPI of the Ordering/Referring Professional - Update
- Medicare Diabetes Prevention Program: Valid Claims

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast - July 30

MLN Matters® Articles

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87426
- Overview of the Repetitive, Scheduled Non-Emergent Ambulance Prior Authorization Model - Revised
- Modify Edits in the Fee for Service (FFS) System when a Beneficiary has a Medicare Advantage (MA) Plan - Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 4
- Home Health, IRF, LTCH, and SNF Quality Reporting Programs: COVID-19 PHE

MLN Connects Special Edition - July 30, 2020 - Payment for COVID-19 Counseling, Reporting Hospital Therapeutics, Out-of-Pocket Drug Costs

PAYMENT FOR COVID-19 COUNSELING, REPORTING HOSPITAL THERAPEUTICS, OUT-OF-POCKET DRUG COSTS

CMS and CDC Announce Provider Reimbursement Available for Counseling Patients to Self-Isolate at Time of COVID-19 Testing

On July 30, CMS and the Centers for Disease Control and Prevention (CDC) are announcing that payment is available to physicians and health care providers to counsel patients, at the time of Coronavirus Disease 2019 (COVID-19) testing, about the importance of self-isolation after they are tested and prior to the onset of symptoms.

The transmission of COVID-19 occurs from both symptomatic, pre-symptomatic, and asymptomatic individuals emphasizing the importance of education on self-isolation as the spread of the virus can be reduced significantly by having patients isolated earlier, while waiting for test results or symptom onset. The CDC models show that when individuals who are tested for the virus are separated from others and placed in quarantine, there can be up to an 86 percent reduction in the transmission of the virus compared to a 40 percent decrease in viral transmission if the person isolates after symptoms arise.

Provider counseling to patients, at the time of their COVID-19 testing, will include the discussion of immediate need for isolation, even before results are available, the importance to inform their immediate household that they too should be tested for COVID-19, and the review of signs and symptoms and services available to them to aid in isolating at home. In addition, they will be counseled that if they test positive, to wear a mask at all times, and they will be contacted by public health authorities and asked to provide information for contact tracing and to tell their immediate household and recent contacts in case it is appropriate for these individuals to be tested for the virus and to self-isolate as well.

CMS will use existing evaluation and management payment codes to reimburse providers who are eligible to bill CMS for counseling services no matter where a test is administered, including doctor's offices, urgent care clinics, hospitals, and community drive-thru or pharmacy testing sites.

For More Information:

- Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) MLN Matters Special Edition Article SE20011
- Counseling Check List, including resource links

CMS Announces New Hospital Procedure Codes for Therapeutics in Response to the COVID-19 Public Health Emergency

With the emergence of Coronavirus Disease 2019 (COVID-19) and the new treatments that have followed, it is critical to be able to track the use of these treatments and their effectiveness in real-time. CMS responded to this need, and in record time is implementing new procedure codes to allow Medicare and other insurers to identify the use of the therapeutics remdesivir and convalescent plasma for treating hospital in-patients with COVID-19. These new codes, which go into effect August 1, will enable CMS to conduct real-time surveillance and obtain real-world evidence in how these drugs are working and provide critical information on their effectiveness and how they can protect patients. These codes can be reported to Medicare and other insurers may also use the codes to identify the use of COVID-19 therapies and help facilitate monitoring and data collection on their use.

These new codes are being implemented into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS). ICD-10-PCS is the Health Insurance Portability and Accountability Act (HIPAA) designated code set for reporting hospital inpatient procedures, which is developed and maintained by CMS and can be used by other health insurers.

The implementation of these new procedure codes is part of the Trump Administration's ongoing efforts to protect the health and safety of COVID-19 patients across the country during the public health emergency.

For more information, see ICD-10 MS-DRGs Version 37.2 Effective August 1.

Trump Administration Continues to Keep Out-of-Pocket Drug Costs Low for Seniors

On July 29, CMS announced the average basic premium for Medicare Part D prescription drug plans, which cover prescription drugs that beneficiaries pick up at a pharmacy. Under the leadership of President Trump, for the first time seniors that use insulin will be able to choose a prescription drug plan in their area that offers a broad set of insulins for no more than $35 per month per prescription.

The average basic Part D premium will be $30.50 in 2021. The 2021 and 2020 average basic premiums are the second lowest and lowest, respectively, average basic premiums in Part D since 2013. This trend of lower Part D premiums, which have decreased by 12 percent since 2017, means that beneficiaries have saved nearly $1.9 billion in premium costs over that time. Further, Part D continues to be an extremely popular program, with enrollment increasing by 16.7 percent since 2017.

"At every turn, the Trump Administration has prioritized policies that introduce choice and competition in Part D," said CMS Administrator Seema Verma. "The result is lower prices for life-saving drugs like insulin, which will be available to Medicare beneficiaries at this fall's Open Enrollment for no more than $35 a month. In short, Part D premiums continue to stay at their lowest levels in years even as beneficiaries enjoy a more robust set of options from which to choose a plan that meets their needs."

In addition to the $1.9 billion in premium savings for beneficiaries since 2017, the Trump Administration has produced substantial Part D program savings for taxpayers. With about 200 additional standalone prescription drug plans and 1,500 additional Medicare Advantage plans with prescription drug coverage joining the program between 2017 and 2020, and that trend expected to continue in 2021, increased market competition has led to lower costs and lower Medicare premium subsidies, which has saved taxpayers approximately $8.5 billion over the past four years.

Earlier this year, CMS launched the Part D Senior Savings Model, which will allow Medicare beneficiaries to choose a plan that provides access to a broad set of insulins at a maximum $35 copay for a month's supply. Starting January 1, 2021, beneficiaries who select these plans will save, on average, $446 per year, or 66 percent, on their out-of-pocket costs for insulin. Beneficiaries will be able to choose from more than 1,600 participating standalone Medicare Part D prescription drug plans and Medicare Advantage plans with prescription drug coverage, all across the country this open enrollment period, which runs from October 15 through December 7. And because the majority of participating Medicare Advantage plans with prescription

drug coverage do not charge a Part D premium, beneficiaries who enroll in those plans will save on insulin and not pay any extra premiums.

In January 2020, CMS, through the Part D Payment Modernization Model, offered an innovative new opportunity for Part D plan sponsors to lower costs for beneficiaries, while improving care quality. Under this model, Part D sponsors can better manage prescription drug costs through all phases of the Part D benefit, including the catastrophic phase. Through the use of better tools and program flexibilities, sponsors are better able to negotiate on high cost drugs and design plans that increase access and lower out-of-pocket costs for beneficiaries. For CY 2021, there will be nine plan options in Utah, New Mexico, Idaho and Pennsylvania that participate in this model.

In Medicare Part D, beneficiaries choose the prescription drug plan that best meets their needs, and plans have to improve quality and lower costs to attract beneficiaries. This competitive dynamic sets up clear incentives that drive towards value. CMS has taken steps to modernize the Part D program by providing beneficiaries the opportunity to choose among plans with greater negotiating tools that have been developed in the private market and by providing patients with more transparency on drug prices. Improvements to the Medicare Part D program that CMS has made to date include:

- Beginning in 2021, providing more information on out-of-pocket costs for prescription drugs to beneficiaries by requiring Part D plans to provide a real time benefit tool to clinicians with information that they can discuss with patients on out-of-pocket drug costs at the time a prescription is written
- Implementing Part D legislation signed by President Trump to prohibit “gag clauses,” which keep pharmacists from telling patients about lower-cost ways to obtain prescription drugs
- Beginning in 2021, requiring the Explanation of Benefits document that Part D beneficiaries receive each month to include information on drug price increases and lower-cost therapeutic alternatives
- Providing beneficiaries with more drug choices and empowering beneficiaries to select a plan that meets their needs by allowing plans to cover different prescription drugs for different indications, an approach used in the private sector
- Reducing the maximum amount that low-income beneficiaries pay for certain innovative medicines known as “biosimilars,” which will lower the out-of-pocket cost of these innovative medicines for these beneficiaries
- Empowering Medicare Advantage to negotiate lower costs for physician-administered prescription drugs for seniors for the first time, as well allowing Part D plans to substitute certain generic drugs on plan formularies more quickly during the year, so beneficiaries immediately have access to the generic, which typically has lower cost sharing than the brand
- Increasing competition among plans by removing the requirement that certain Part D plans have to “meaningfully differ” from each other, making more plan options available for beneficiaries

For More Information:

- Part D Senior Savings Model webpage
- Ratebooks & Supporting Data webpage: View the 2021 Part D base beneficiary premium, the Part D national average monthly bid amount, the Part D regional low-income premium subsidy amounts, the de minimis amount, the Medicare Advantage employer group waiver plan regional payment rates, and the Medicare Advantage regional PPO benchmarks

MLN Connects Special Edition - July 31, 2020 - FY 2021 Medicare Payment Policies for IPFs, SNFs, and Hospices

FY 2021 MEDICARE PAYMENT POLICIES FOR IPFS, SNFS, AND HOSPICES

CMS Updates Medicare Payment Policies for IPFs, SNFs, and Hospices

On July 31, CMS finalized three Medicare payment rules that further advance our efforts to strengthen the Medicare program by better aligning payments for Inpatient Psychiatric Facilities (IPFs), Skilled Nursing Facilities (SNFs), and hospices.

Inpatient Psychiatric Facilities:

The final rule updates Medicare payment policies and rates for the IPF Prospective Payment System (PPS) for FY 2021. In this final rule, CMS is finalizing a 2.2 percent payment rate update and finalizing its proposal to adopt revised Office of

Management and Budget (OMB) statistical area delineations resulting in wage index values being more representative of the actual costs of labor in a given area. CMS is finalizing updates to allow advanced practice providers, including physician assistants, nurse practitioners, psychologists, and clinical nurse specialists to operate within the scope of practice allowed by state law by documenting progress notes in the medical record of patients for whom they are responsible, receiving services in psychiatric hospitals.

Skilled Nursing Facilities:

The final rule updates the Medicare payment rates and the quality programs for SNFs. These updates include routine technical rate-setting updates to the SNF PPS payment rates, as well as finalizes adoption of the most recent OMB statistical area delineations and applies a 5 percent cap on wage index decreases from FY 2020 to FY 2021. CMS is also finalizing changes to the ICD-10 code mappings that would be effective beginning in FY 2021 in response to stakeholder feedback. CMS projects aggregate payments to SNFs will increase by $750 million, or 2.2 percent, for FY 2021, compared to FY 2020.

Hospices:

For FY 2021, hospice payment rates are updated by the market basket percentage increase of 2.4 percent ($540 million). Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket percentage increase for the year. The hospice payment system includes a statutory aggregate cap. The aggregate cap limits the overall payments made to a hospice annually. The final hospice cap amount for the FY 2021 cap year is $30,683.93, which is equal to the FY 2020 cap amount ($29,964.78) updated by the final FY 2021 hospice payment update percentage of 2.4 percent.

For More Information:

- IPF Final Rule and Fact Sheet
- SNF Final Rule and Fact Sheet
- Hospice Final Rule and Fact Sheet

COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents

The current COVID-19 Public Health Emergency (PHE) does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing (CB); however, CMS added CPT codes 99441, 99442, and 99443, to the list of telehealth codes coverable under the waiver during the COVID-19 PHE. These codes designate three different time increments of telephone evaluation and management service provided by a physician. You can bill for these physician services separately under Part B when furnished to a SNF's Part A resident.

Medicare Administrative Contractors (MACs) will reprocess claims for CPT codes 99441, 99442, and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits. You do not have to do anything. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim.

MLN Connects Special Edition - August 04, 2020 - PFS, OPPS, and IRF: FY 2021 Payment Rules

Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

CMS is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

Expanding Beneficiary Access to Care through Telehealth:

Over the last three years, as part of the Fostering Innovation and Rethinking Rural Health strategic initiatives, CMS has been working to modernize Medicare by unleashing private sector innovations and improve beneficiary access to services furnished via telecommunications technology. Starting in 2019, Medicare began paying for virtual check-ins, meaning patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to the COVID-19 pandemic, CMS moved swiftly to significantly expand payment for telehealth services and implement other flexibilities so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus. Before the Public Health Emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week, while over 10.1 million beneficiaries have received a Medicare telehealth service during the PHE from mid-March through early-July. For more information on Medicare's unprecedented increases in telemedicine and its impact on the health care delivery system, visit the CMS Health Affairs blog.

As directed by President Trump's Executive Order on Improving Rural and Telehealth Access, through this rule, CMS is taking steps to extend the availability of certain telemedicine services after the PHE ends, giving Medicare beneficiaries more convenient ways to access health care particularly in rural areas where access to health care providers may otherwise be limited.

"Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for Americas seniors," said CMS Administrator Seema Verma. "The Trump Administration's unprecedented expansion of telemedicine during the pandemic represents a revolution in health care delivery, one to which the health care system has adapted quickly and effectively. Never one merely to tinker around the edges when it comes to patient-centered care, President Trump will not let this opportunity slip through our fingers."

During the PHE, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services that could be paid when delivered by telehealth. CMS is proposing to permanently allow some of those services to be done by telehealth, including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient's home) and certain types of visits for patients with cognitive impairments. CMS is seeking public input on other services to permanently add to the telehealth list beyond the PHE in order to give clinicians and patients time as they get ready to provide in-person care again. CMS is also proposing to temporarily extend payment for other telehealth services, such as emergency department visits for a specific time period, through the calendar year in which the PHE ends. This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE.

Prioritizing Investment in Preventive Care and Chronic Disease Management:

Under our Patients Over Paperwork initiative, the Trump Administration has taken steps to eliminate burdensome billing and coding requirements for Evaluation and Management (E/M) (for office/outpatient visits) that make up 20 percent of the spending under the Physician Fee Schedule. These billing and documentation requirements for E/M codes were established 20 years ago and have been subject to longstanding criticism from clinicians that they do not reflect current care practices and needs. After extensive stakeholder collaboration with the American Medical Association and others, simplified coding and billing requirements for E/M visits will go into effect January 1, 2021, saving clinicians 2.3 million hours per year in burden reduction. As a result of this change, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less time on documenting visits and more time on treating their patients.

Additionally, last year, the Trump Administration finalized historic changes to increase payment rates for office/outpatient E/M visits beginning in 2021. The higher payment for E/M visits takes into account the changes in the practice of medicine, recognizing that additional resources are required of clinicians to take care of their Medicare patients, of which two-thirds have multiple chronic conditions. The prevalence of certain chronic conditions in the Medicare population is growing. For example, as of 2018, 68.9% of beneficiaries have 2 or more chronic conditions. In addition, between 2014 and 2018, the percent of beneficiaries with 6 or more chronic conditions has grown from 14.3% to 17.7%.

In this rule, CMS is proposing to similarly increase the value of many services that are comparable to or include office/outpatient E/M visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, physical and occupational therapy evaluation services, and others. The proposed adjustments, which implement recommendations from the American Medical Association, help to ensure that CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients, like primary care and complex or chronic disease management.

Bolstering the Health Care Workforce/Patients Over Paperwork:

CMS is also taking steps to ensure that health care professionals can practice at the top of their professional training. During the COVID-19 public health emergency, CMS announced several temporary changes to expand workforce capacity and reduce clinician burden so that staffing levels remain high in response to the pandemic. As part of its Patients over Paperwork initiative to reduce regulatory burden for providers, CMS is proposing to make some of these temporary changes permanent following the PHE. Such proposed changes include:

- Nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives (instead of only physicians) to supervise others performing diagnostic tests consistent with state law and licensure, providing that they maintain the required relationships with supervising/collaborating physicians as required by state law
- Clarifying that pharmacists can provide services as part of the professional services of a practitioner who bills Medicare
- Allowing physical and occupational therapy assistants (instead of only physical and occupational therapists) to provide maintenance therapy in outpatient settings
- Allowing physical or occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare to review and verify (sign and date), rather than re-document, information already entered by other members of the clinical team into a patient's medical record

For More Information:

- CY 2021 Physician Fee Schedule and Quality Payment Program Proposed Rule: Public comments are due by October 5, 2020.
- CY 2021 Physician Fee Schedule Proposed Rule Fact Sheet
- CY 2021 Quality Payment Program Proposed Rule Fact Sheet
- Medicare Diabetes Prevention Program Fact Sheet

Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS' commitment to increasing competition

As directed by President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, CMS is proposing several policies that would give Medicare beneficiaries more choices in where they seek care and lower their out-of-pocket costs for surgeries. The proposed rule takes steps that would allow hospitals and ambulatory surgical centers to operate with better flexibility and patients to have what they need to make informed decisions on where they receive care.

"President Trump's mandate is to put patients and doctors back in charge of health care," said CMS Administrator Seema Verma. "Following through on that mandate entails loosening the stranglehold of government control that has accumulated over decades. Surgeries can be expensive. Patients should have as many options as possible for lowering their costs while getting quality care. These proposed changes, if finalized, would do exactly that, help put patients and doctors back in the driver's seat and in a position to make decisions about their own care."

For patients having surgery, hospital outpatient departments are subject to the same quality and safety standards as inpatient settings under Medicare rules. With this in mind, for 2021, CMS proposes to expand the number of procedures that Medicare would pay for in the hospital outpatient setting by eliminating the "Inpatient Only list," which includes procedures for which Medicare will only make payment when performed in the hospital inpatient setting. This proposed change would remove regulatory barriers to give beneficiaries the choice to receive these services in a lower cost setting and convenience to go home as early as the same day after a procedure, when their clinician decides such a setting is appropriate. CMS would phase-in this proposal over three years and would gradually allow over 1,700 additional services to be paid when furnished in the hospital outpatient setting. In 2021, approximately 300 musculoskeletal services (such as certain joint replacement procedures) would be newly payable in the hospital outpatient setting. The proposed change would be the largest one-time reduction to the Inpatient Only list by far; from 2017 through 2020, approximately 30 services total were removed from the Inpatient Only list.

Medicare pays for most services furnished in ASCs at a lower rate than hospital outpatient departments. As a result, when receiving care in an ASC rather than a hospital outpatient department, patients can potentially lower their out-of-pocket costs for certain services. For example, for one of the most common cataract surgeries, currently, on average, a Medicare beneficiary pays $101 if the procedure is done in a hospital outpatient department compared to $51 if done in a surgery center.

CMS proposes to expand the number of procedures that Medicare would pay for when performed in an ASC, which would give patients more choices in where they receive care and ensure CMS does not favor one type of care setting over another. For CY 2021, we propose to add eleven procedures that Medicare would pay for when provided in an ASC, including total hip arthroplasty. Since 2018, CMS has added 28 procedures to the list of surgical services that can be paid under Medicare when performed in ASCs.

Additionally, we propose two alternatives that would further expand our goals of increasing access to care at a lower cost. Under the first alternative, CMS would establish a process where the public could nominate additional services that could be performed in ASCs based on certain quality and safety parameters. Under the other proposed alternative, we would revise the criteria used to determine the procedures that Medicare would pay for in an ASC, potentially adding approximately 270 procedures that are already payable when performed in the hospital outpatient setting to the ASC list. Under this alternative, we solicit comment on whether the ASC conditions for coverage (the baseline health and safety requirements for Medicare-participating ASCs) should be revised given the potential for a significant expansion in the nature of services that would be added under this alternative proposal.

As part of the Trump Administration's commitment to lowering drug prices, CMS is proposing a change that would lower beneficiaries' out-of-pocket drug costs for certain hospital outpatient drugs. In 2018 and 2019, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments and acquired through the 340B program, which allows certain hospitals to buy outpatient drugs at lower costs. Due to CMS' policy change, which was recently upheld by the United States Court of Appeals for the D.C Circuit, Medicare beneficiaries now benefit from the steep discounts that 340B-enrolled hospitals receive when they purchase drugs through the 340B program.

For 2021, CMS would provide even larger discounts for beneficiaries by proposing to further reduce the payment rate for drugs purchased through the 340B Program based on hospital survey data on drug acquisition costs. CMS is proposing to pay for 340B acquired drugs at average sales price minus 28.7 percent. With this proposed change, CMS estimates that, in 2021, Medicare beneficiaries would save an additional $85 million on out-of-pocket payments for these drugs and that OPPS payments for 340B drugs would be reduced by approximately $427 million. The savings from this change would be reallocated on an equal percentage basis to all hospitals paid under the OPPS. We propose that children's hospitals, certain cancer hospitals, and rural sole community hospitals would continue be excepted from these drug payment reductions. In the alternative, and in light of the court's recent decision, we propose to continue our current policy of paying ASP minus 22.5% for 340B drugs.

In continuing the agency's Patients Over Paperwork Initiative to reduce burden for health care providers, CMS is proposing to establish, update, and simplify the methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) beginning with CY 2021. The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Hospital Compare tool for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Hospital Compare, the Overall Star Rating helps patients make better informed health care decisions.

Responding to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is proposing revisions on how to calculate the ratings and grouping hospitals in the Readmission measure group by the hospital's percentage of patients who are dually enrolled in Medicare and Medicaid, which would help provide better insight on health disparities. These and other proposed changes are intended to reduce provider burden, improve the predictability of the star ratings, and make it easier to compare ratings between similar hospitals.

As part of the agency's Rethinking Rural Health Initiative, in the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS increased the wage index for certain low wage index hospitals for at least four years, beginning in FY 2020. In the CY 2020 OPPS/ASC Payment System final rule, CMS adopted changes to the wage index for outpatient hospitals as were finalized in the FY 2020 IPPS final rule, including the increase in wage index for certain low wage index hospitals. The OPPS wage index adjusts hospital outpatient payment rates to account for local differences in wages that hospitals face in their respective labor markets. For 2021, under the OPPS, CMS proposes to continue to adopt the IPPS post-reclassified wage index, including the wage index increase for certain low wage index hospitals. The increase would address a common concern that the current wage index system contributes to disparities between high and low wage index hospitals. Overall, CMS estimates that payment for outpatient services in rural hospitals across the country would increase by 3 percent, which is 0.5 percent higher than the national average increase of 2.5 percent.

For More Information:

- Proposed Rule

- Fact Sheet

CMS Updates Medicare Payment Policies for IRFs

On August 4, CMS finalized a Medicare payment rule that further advances our efforts to strengthen the Medicare program by better aligning payments for Inpatient Rehabilitation Facilities (IRFs). The final rule updates Medicare payment policies and rates for facilities under the IRF Prospective Payment System (PPS) for FY 2021. This final rule also includes making permanent the regulatory change to eliminate the requirement for physicians to conduct a post admission visit since much of the information is included in the pre-admission visit. This flexibility was offered during the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), and the rule would make this flexibility permanent beyond the expiration of the PHE. In recognition of the interdisciplinary role that non-physician practitioners are currently performing with patients in the IRF, CMS is also finalizing that a non-physician practitioner may perform one of the three required visits in lieu of the physician in the second and later weeks of a patient's care when consistent with the non-physician practitioner's state scope of practice. Additionally, for FY 2021, CMS is updating the IRF PPS payment rates by 2.4 percent.

For More Information:

- Final Rule
- Fact Sheet

MLN Connects - August 06, 2020

Physician Fee Schedule Proposed Rule Listening Session: Register Now

MLN Connects® for Thursday, August 6, 2020
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News

- Electronic Prescribing of Controlled Substances in Medicare Part D: Request for Information
- Release of the IRF Web Pricer
- Subsequent Nursing Facility E/M Services: Comparative Billing Report
- Nursing Home Compare Refresh
- Medicare Ground Ambulance Data Collection System: Updated Documents
- MACs Resume Medical Review on a Post-Payment Basis
- Renewed ABN: Deadline Extended to January 1
- COVID-19: Telemedicine, Clinical Experiences, Resources for Hospitals and Urgent Care Centers
- Protect Your Patients Against Vaccine-Preventable Diseases

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast - August 6
- COVID-19: Lessons from the Front Lines Call - August 7
- Physician Fee Schedule Proposed Rule: Understanding 4 Key Topics Listening Session - August 13
- Dr. Todd Graham Pain Management Study Listening Session - August 27

MLN Matters® Articles

- New Waived Tests
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission - Implementation

MLN Connects - August 13, 2020

COVID-19: CMS/CDC Nursing Home Training Series Webcast - August 13

MLN Connects® for Thursday, August 13, 2020
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News

- Trump Administration Announces Initiative to Transform Rural Health
- Physician Compare Preview Period Open through August 20
- Management of Acute and Chronic Pain - Stakeholder Engagement Opportunity: Reply by August 21
- SNF Provider Preview Reports: Review Your Data by August 30
- PEPPERs for HHAs and PHPs
- Hospitals: Three Year Geographic Reclassification Data for FY 2022 MGCRB Applications
- Opioids: Co-Prescribing Naloxone

Events

- National CMS/CDC Nursing Home COVID-19 Training Series Webcast - August 13
- Dr. Todd Graham Pain Management Study Listening Session - August 27

MLN Matters® Articles

- Billing for Home Infusion Therapy Services On or After January 1, 2021
- Correction to Editing Update for Vaccine Services
- International Classification of Diseases, 10th Revision (ICD10) and Other Coding Revisions to National Coverage Determination (NCDs) - January 2021 Update
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2020 Update
- Update to Osteoporosis Drug Codes Billable on Home Health Claims
- Influenza Vaccine Payment Allowances - Annual Update for 2020-2021 Season - Revised

Multimedia

- HQRP Training Resources Web-Based Training Course

MLN Connects - August 20, 2020

Routine Provider Inspections Resume

MLN Connects® for Thursday, August 20, 2020
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News

- CMS Announces Resumption of Routine Inspections of All Provider and Suppliers, Issues Updated Enforcement Guidance to States, and Posts Toolkit to Assist Nursing Homes
- Reduce Provider Burden: Electronic Medical Documentation Interoperability Pilot Program

Events

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Homes: New Format

MLN Matters® Articles

- New COVID-19 Policies for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act - Revised

Publications

- Enhancing RN Supervision of Hospice Aide Services

Multimedia

- Medicare Secondary Payer (MSP) Provision (June 2020)

MLN Connects - August 27, 2020

COVID-19: Training to Strengthen Nursing Home Infection Control Practices

MLN Connects® for Thursday, August 27, 2020
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News

- Trump Administration Launches National Training Program to Strengthen Nursing Home Infection Control Practices
- SNF Provider Preview Reports: Review Your Data by August 30
- COVID: Nursing Home Toolkit
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Claims, Pricers & Codes

- COVID-19: Waive Cost Sharing for These HCPCS Codes

MLN Matters® Articles

- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2021 - Revised
- October 2020 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - Revised

Publications

- Creating an Effective Hospice Plan of Care

Multimedia

- Physician Fee Schedule Listening Session: Audio Recording and Transcript

MLN Connects Special Edition - August 28, 2020 - CMS Offers Comprehensive Support for Louisiana and Texas with Hurricane Laura

On August 27, CMS announced efforts underway to support Louisiana and Texas in response to Hurricane Laura. On August 26, 2020, Department of Health and Human Services (HHS) Secretary Alex Azar declared public health emergencies (PHEs) in these states, retroactive to August 22, 2020 for the state of Louisiana and to August 23, 2020 for the state of Texas. CMS is working to ensure hospitals and other facilities can continue operations and provide access to care despite the effects of Hurricane Laura.

CMS provided numerous waivers to health care providers during the current coronavirus disease 2019 (COVID-19) pandemic to meet the needs of beneficiaries and providers. The waivers already in place will be available to health care providers to use during the duration of the COVID-19 PHE determination timeframe and for the Hurricane Laura PHE. CMS may waive certain additional Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements, create special enrollment opportunities for individuals to access healthcare quickly, and take steps to ensure dialysis patients obtain critical life-saving services.

"Our thoughts are with everyone who is in the path of this powerful and dangerous hurricane and CMS is doing everything within its authority to provide assistance and relief to all who are affected," said CMS Administrator Seema Verma. "We will partner and coordinate with state, federal, and local officials to make sure that in the midst of all of the uncertainty a natural

disaster can bring, our beneficiaries will not have to worry about access to healthcare and other crucial life-saving and sustaining services they may need."

Below are key administrative actions CMS will be taking in response to the PHEs declared in Louisiana and Texas:

Waivers and Flexibilities for Hospitals and Other Healthcare Facilities: CMS has already waived many Medicare, Medicaid, and CHIP requirements for facilities. The CMS Dallas Survey & Enforcement Division, under the Survey Operations Group, will grant other provider-specific requests for specific types of hospitals and other facilities in Louisiana and Texas. These waivers, once issued, will help provide continued access to care for beneficiaries. For more information on the waivers CMS has granted, visit http://www.cms.gov/emergency.

Special Enrollment Opportunities for Hurricane Victims: CMS will make available special enrollment periods for certain Medicare beneficiaries and certain individuals seeking health plans offered through the Federal Health Insurance Exchange. This gives people impacted by the hurricane the opportunity to change their Medicare health and prescription drug plans and gain access to health coverage on the Exchange if eligible for the special enrollment period. For more information, please visit:

- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/8-9-natural-disaster-SEP.pdf
- https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Past-Emergencies/Hurricanes-and-tropical-storms.html

Disaster Preparedness Toolkit for State Medicaid Agencies: CMS developed an inventory of Medicaid and CHIP flexibilities and authorities available to states in the event of a disaster. For more information and to access the toolkit, visit: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/index.html.

Dialysis Care: CMS is helping patients obtain access to critical life-saving services. The Kidney Community Emergency Response (KCER) program has been activated and is working with the End Stage Renal Disease (ESRD) Network, Network 13 - Louisiana, and Network 14 - Texas, to assess the status of dialysis facilities in the potentially impacted areas related to generators, alternate water supplies, education and materials for patients and more.

The KCER is also assisting patients who evacuated ahead of the storm to receive dialysis services in the location to which they evacuated. Patients have been educated to have an emergency supply kit on hand including important personal, medical, and insurance information; contact information for their facility, the ESRD Network hotline number, and contact information of those with whom they may stay or for out-of-state contacts in a waterproof bag. They have also been instructed to have supplies on hand to follow a three-day emergency diet. The ESRD Network 8 - Mississippi hotline is 1-800-638-8299, Network 13 - Louisiana hotline is 800-472-7139, the ESRD Network 14 - Texas hotline is 877-886-4435, and the KCER hotline is 866-901-3773. Additional information is available on the KCER website https://www.kcercoalition.com/.

During the 2017 and 2018 hurricane seasons, CMS approved special purpose renal dialysis facilities in several states to furnish dialysis on a short-term basis at designated locations to serve ESRD patients under emergency circumstances in which there were limited dialysis resources or access-to-care problems due to the emergency circumstances.

Medical equipment and supplies replacements: Under the COVD-19 waivers, CMS suspended certain requirements necessary for Medicare beneficiaries who have lost or realized damage to their durable medical equipment, prosthetics, orthotics, and supplies as a result of the PHE. This will help to make sure that beneficiaries can continue to access the needed medical equipment and supplies they rely on each day. Medicare beneficiaries can contact 1-800-MEDICARE (1-800-633-4227) for assistance.

Ensuring Access to Care in Medicare Advantage and Part D: During a public health emergency, Medicare Advantage Organizations and Part D Plan sponsors must take steps to maintain access to covered benefits for beneficiaries in affected areas. These steps include allowing Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities and waiving, in full, requirements for gatekeeper referrals where applicable.

Emergency Preparedness Requirements: Providers and suppliers are expected to have emergency preparedness programs based on an all-hazards approach. To assist in the understanding of the emergency preparedness requirements, CMS Central Office and the Regional Offices hosted two webinars in 2018 regarding Emergency Preparedness requirements and provider expectations. One was an all provider training on June 19, 2018 with more than 3,000 provider participants and the other an all-surveyor training on August 8, 2018. Both presentations covered the emergency preparedness final rule which included emergency power supply; 1135 waiver process; best practices and lessons learned from past disasters; and helpful resources and more. Both webinars are available at https://qsep.cms.gov/welcome.aspx.

CMS also compiled a list of Frequently Asked Questions (FAQs) and useful national emergency preparedness resources to assist state Survey Agencies (SAs), their state, tribal, regional, local emergency management partners and health care providers to develop effective and robust emergency plans and tool kits to assure compliance with the emergency preparedness rules. The tools can be located at:

- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Templates-Checklists.html

CMS Regional Offices have provided specific emergency preparedness information to Medicare providers and suppliers through meetings, dialogue, and presentations. The regional offices also provide regular technical assistance in emergency preparedness to state agencies and staff, who, since November 2017, have been regularly surveying providers and suppliers for compliance with emergency preparedness regulations.

Additional information on the emergency preparedness requirements can be found here: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf

CMS will continue to work with all geographic areas impacted by Hurricane Laura. We encourage beneficiaries and providers of healthcare services that have been impacted to seek help by visiting CMS' emergency webpage (http://www.cms.gov/emergency).

For more information about the HHS PHE, please visit: https://www.hhs.gov/about/news/2020/08/26/hhs-secretary-azar-declares-public-health-emergencies-in-louisiana-and-texas-due-to-hurricane-laura.html.

Noridian Medicare Portal Eligibility and MBI Lookup Tool Enhancements

Effective June 15, 2020 the Noridian Medicare Portal (NMP) has been updated to provide additional information to the Eligibility and Medicare Beneficiary Identifier (MBI) Lookup tool responses.

MBI Lookup Tool

The MBI Lookup tool will now provide the MBI if a deceased beneficiary has a date of death on file within the last four years of the current date. Prior to June 15, 2020, the MBI Lookup Tool only provided the MBI if the date of death occurred within 13 months prior to the date of the search.

Eligibility

The Home Health Episode History (HHEH) tab within an Eligibility inquiry will now display the Patient Status Code along with the description of that code. This will help determine if the patient is continuing to receive home health benefits.

Preventive Services section will now include the human papillomavirus (HPV) HCPCS code G0476 on Eligibility responses for female beneficiaries. NMP will provide the next eligible date for this service.

Claim Status Category Codes and Claim Status Codes Update - Rescinded

MLN Matters Number: MM11699
Related CR Release Date: May 22, 2020
Related CR Transmittal Number: R10148CP
Related Change Request (CR) Number: 11699

This article was rescinded on July 9, 2020, as the related Change Request (CR) 11699, Transmittal R10148CP, dated May 22, 2020, was rescinded and will not be replaced.

DMEPOS Fee Schedule - July 2020 Quarterly Update

MLN Matters Number: MM11810
Related CR Release Date: June 5, 2020
Related CR Transmittal Number: R10168CP
Related Change Request (CR) Number: 11810
Effective Date: July 1, 2020
Implementation Date: July 5, 2020

CR 11810 informs DME MACs about the changes to the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedules that are updated on a quarterly basis, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. Make sure your billing staffs are aware of these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11810.

Quarterly HCPCS Drug/Biological Code Changes - July 2020 Update

MLN Matters Number: MM11769
Related CR Release Date: June 23, 2020
Related CR Transmittal Number: R10196CP
Related Change Request (CR) Number: 11769
Effective Date: July 1, 2020
Implementation Date: July 6, 2020

CR 11769 updates the Healthcare Common Procedure Coding System (HCPCS) code set for codes related to drugs and biologicals. Please alert your billing staffs of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11769.

Quarterly Update for the Temporary Gap Period of the DMEPOS CBP - October 2020

MLN Matters Number: MM11819
Related CR Release Date: June 5, 2020
Related CR Transmittal Number: R10167CP
Related Change Request (CR) Number: CR 11819
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Medicare updates the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (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. CR11819 provides specific instruction for implementing the DMEPOS CBP files.

The Round 1 2017, Round 2 Recompete, and National Mail Order (NMO) Recompete CBP contracts expired on December 31, 2018. Due to a delay in the announcement of the next round of the CBP, contracts are not in effect in Round 1, Round 2, or the NMO Competitive Bidding Areas (CBAs) as of January 1, 2019, resulting in a temporary gap period in the CBP.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11819.

October 2020 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files - Revised

MLN Matters Number: MM11854 Revised
Related CR Release Date: August 14, 2020
Related CR Transmittal Number: R10306CP
Related Change Request (CR) Number: 11854
Effective Date: October 1, 2020
Implementation Date: October 5, 2020

Note: CMS revised this article to reflect a revised CR 11854 issued on August 14, 2020. The revised CR did not change the substance of the article. In the article, CMS revised the CR release date, transmittal number, and the web address of the CR. All other information remains the same.

CR 11854 updates the Quarterly Average Sales Price (ASP) Medicare Part B Pricing Files and informs providers of revisions to prior quarterly pricing files. Please make sure your billing staffs are aware of these updates and revisions.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11854.