DME Happenings

Jurisdiction A

June 2021

In This Issue…

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

noridian
Healthcare Solutions

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Noridian Healthcare Solutions, LLC

NEWS

Jurisdiction A DME MAC Supplier Contacts and Resources

PHONE NUMBERS

Department/System	Phone Number	Availability
Interactive Voice Response System (IVR)	866-419-9458	General IVR inquiries: 24/7 Claim-specific inquiries: Monday - Friday 7 a.m. - 9 p.m. ET Saturday 7 a.m. - 4 p.m. ET
Supplier Contact Center	866-419-9458	Monday - Friday 8 a.m. - 5 p.m. ET
Telephone Reopenings	866-419-9458	Monday - Friday 8 a.m. - 5 p.m. ET
Beneficiary Customer Service	800-633-4227	24/7

FAX NUMBERS

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

EMAIL ADDRESSES

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

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

MAILING ADDRESSES

Department	Address

• Advance Determination of Medicare Coverage Requests
• Claim Submission
• Correspondence
• Medical Review Documentation
  ○ Complex Medical Review Response
  ○ Non-Complex Medical Review Response
• Redetermination Requests
  ○ Overpayment Redetermination and Rebuttal Requests
  ○ Recovery Auditor Redeterminations
• Refunds
• Written Reopening Requests
• Electronic Funds Transfer (EFT)
	Noridian JA DME
	Attn: _____
	PO Box 6780
	Fargo, ND 58108-6780

• Extended Repayment Schedule (ERS) • Refund Checks	Noridian JA DME Attn: Refunds PO Box 511470 Los Angeles, CA 90051-8025

Department	Address
Administrative Simplification Compliance Act (ASCA)	Noridian JA DME Attn: ASCA PO Box 6736 Fargo, ND 58108-6736
Benefit Integrity	Noridian JA DME Attn: Benefit Integrity PO Box 6736 Fargo, ND 58108-6736
Congressional Inquiries	Noridian JA DME Attn: Congressional PO Box 6780 Fargo, ND 58108-6780
Education	Noridian JA DME Attn: DME Education PO Box 6780 Fargo, ND 58108-6780
Freedom of Information Act (FOIA)	Noridian JA DME Attn: FOIA PO Box 6780 Fargo, ND 58108-6780
LCD: New LCD Request	Noridian JA DME Attn: New LCD Request PO Box 6742 Fargo, ND 58108-6742
Medical Review - Prior Authorization Requests (PAR)	Noridian JA DME Attn: DME MR-PAR PO Box 6742 Fargo, ND 58108-6742
Recovery Auditor Overpayments	Noridian JA DME Attn: Recovery Auditor Overpayments PO Box 6780 Fargo, ND 58108-6780

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

MAC/Resource	Phone Number	Website
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. 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. 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

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

Question	Answer
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.

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.

Appeal Status and Submission Functionality in NMP Saves Suppliers Time and Resources

Suppliers can save time and resources by using utilizing available appeal functionalities within the Noridian Medicare Portal (NMP). The portal can assist in reducing telephone calls made to the call center association with appeal status inquiries. By utilizing this self-service tool, suppliers can avoid postal mail delays and fax transmission errors by directly submitted their redetermination (appeal) and related documentation securely through the portal. Suppliers can learn more about what the portal offers by viewing the DME On Demand tutorials that are available on our website.

Noridian Medicare Portal: Appeal Submission and Status

Check out NMP today.

Appeal Status and Submission Functionality in Noridian Medicare Portal (NMP) Saves Suppliers Time and Resources

Suppliers can save time and resources by utilizing appeal functionalities within the NMP. The portal can assist in reducing telephone calls to the Provider Call Center (PCC) with appeal status inquiries. By utilizing this self-service tool, suppliers can avoid postal mail delays and fax transmission errors by directly submitting their redetermination (appeal) and related documentation securely through the portal. Suppliers can learn more about what the portal offers by viewing the DME On Demand tutorials available on our website including the Noridian Medicare Portal: Appeal Submission and Status.

Visit the NMP today.

Are You Providing Accessories or Supplies for Beneficiary Owned Equipment?

Suppliers must ensure that the beneficiary information is on file with Medicare Fee for Service (FFS) to avoid denials. Suppliers are reminded that additional documentation is required in situations where supplies and accessories are provided for a piece of equipment not paid for by Fee-For- Service (FFS) Medicare. In addition, drugs used with a nebulizer or external infusion pump would be considered supplies to a covered piece of DME.

Claims for supplies and accessories used with beneficiary owned equipment must include all three pieces of information listed below. Claims lacking any one of the above elements will be denied for missing information with reason code 16, remark code M124. Refer to the Denial Code Resolution page on resolving and avoiding this denial in the future.

ELEMENTS REQUIRED

- HCPCS code of base equipment; and,
- A notation equipment is beneficiary-owned; and,
- Date beneficiary obtained equipment (approximate)
- i.e. Beneficiary owned E0601 purchased June 2015

SOME COMMON REASONS FOR DENIALS FOR BENEFICIARY OWNED EQUIPMENT NOT ON FILE.

- Beneficiary purchased equipment prior to becoming Medicare eligible
- Beneficiary purchased equipment with another supplier
- Beneficiary purchased Glucose Monitor (E0607) and then purchased a Continuous Glucose Monitor (K0554) (The supplies for E0607 are not the same codes used with the K0554)
- Narrative does not match base equipment
- Base item coverage criteria not met

Change of Address Requirement - "Do Not Forward" (DNF)

This is a reminder that Supplier Standard 2 requires suppliers to notify the National Supplier Clearinghouse (NSC) of any change to the information provided on the CMS 855S form. Therefore, if you have moved to a new location, you must notify the NSC. Please refer to the NSC website for instructions.

If you do not update your address with the NSC, your payments for claims from the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) will be held under the "Do Not Forward" (DNF) Initiative.

CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 1, Section 80.5 instructs the MACs to use "Return Service Requested" envelopes for all hardcopy checks and hardcopy remittance advices (RAs) mailed to suppliers. This results in the U.S. Postal Service returning the undeliverable mail to the MAC. When the post office returns a check or a remittance advice, the DME MAC must notify the NSC and cease generating claim payments with a "DNF flag" until you furnish a new address and that address is verified by the NSC. The NSC will also notify the other DME MACs of the DNF issue and these contractors will also stop payments until the issue has been resolved with the NSC.

Once the NSC verifies the address change, communication between the NSC and the DME MAC takes place to remove the DNF flag. The DME MAC will then release the held payments.

Electronic Funds Transfer (EFT) banking information - Any changes to EFT banking information should be submitted to the DME MAC on the CMS-588 EFT form to the address listed on the Jurisdiction A Mailing Addresses webpage.

A DNF flag will be placed on your account if the DME MAC is notified by your bank of a change in your EFT banking information. The flag will be removed once the DME MAC receives updated EFT banking information on a valid CMS-588 form. You can avoid this situation by immediately notifying the DME MAC of any changes to your bank account.

Common Electronic Data Interchange (CEDI) - DME on Demand Tutorials Available

Noridian offers many self-paced training tutorials for CEDI, front end claim rejections and understanding front end errors for Certificates of Medical Necessity (CMNs). These can be accessed on our YouTube channel.

- Common Electronic Data Interchange (CEDI) - 3 minutes
- Front End Edits: Claim Rejections - 4 minutes
- Understanding Front End Errors for Certificates of Medical Necessity (CMNs) - 12 minutes

For a complete list of tutorials, visit the DME On Demand Tutorials page.

Competitive Bidding - Non-Contract Exceptions - Physicians and Other Treating Practitioners, Physical Therapists, and Occupational Therapists

For Physicians/Practitioners and Physical and Occupational Therapists the additional modifiers below should also be appended in the following situations:

- When providing brace as part of professional service in beneficiary's CBA **(must be same date of service)**
- Beneficiary travels to non-CBA for procedure (surgery) and then goes home (KT not applicable)
- Beneficiary temporarily living in another CBA or non-CBA (KT not applicable)

Physicians/Practitioners - **KV**
Physical Therapists and Occupational Therapists - **J5**

Correct Billing for Custom Fitted Orthotics When No Custom Fitting Is Completed With No off the Shelf Equivalent

When a prefabricated custom fit orthosis is being provided directly to a beneficiary and no custom fitting is completed at the time of delivery, the corresponding prefabricated off-the-shelf HCPCS code must be billed on the claim. When there is not a corresponding prefabricated off-the-shelf HCPCS code for the HCPCS categorized as Custom Fitted Orthotics, miscellaneous codes must be used for billing. Additional information can be found on our Orthotics webpage.

Corrections to the 2021 DMEPOS Fee Schedule Amounts

On December 11, 2020, CMS released the 2021 Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule amounts. The DMEPOS and Parenteral and Enteral Nutrition (PEN) public use files contain fee schedules for certain items that were adjusted based on information from the Medicare DMEPOS Competitive Bidding Program in accordance with Sections 1834(a)(1)(F) and 1842(s)(3)(B) of the Act. CMS identified errors in the fee schedule amounts for some items and has released revised public use fee schedule files. **A list of 919 Healthcare Common Procedure Coding System (HCPCS) code and modifier combinations affected by the revisions is included as a separate public use file under the link below.** The revised January 2021 public use files are available online: Revised January 2021 DMEPOS Fee Schedule

Claims submitted before January 26, 2021 with dates of service on or after January 1, 2021 may have been processed and paid using the incorrect fee schedule amounts. Most of the corrections to the fee schedule amounts were minor, resulting in the application of a missing update factor and an increase in the 2021 fee schedule amount of less than 1%.

However, in approximately 8% of the cases, the corrections were significant. CMS identified multiple calculation errors, and correction of those errors has resulted in changes that range from a 2021 fee schedule amount decrease of 30% to a 2021 fee schedule amount increase of 57%. Most of these significant fee schedule corrections are for claims that included a KE modifier, with the greatest fee schedule amount increases in the non-contiguous areas of the country.

Suppliers may request that the DME MAC reprocess and adjust incorrectly paid claims for these HCPCS code/modifier combinations by providing their Provider Transaction Access Number (PTAN) to the DME MAC. If the supplier makes this request, then **all the supplier's claims affected by the erroneous fee schedule amounts (both overpayments and underpayments) will be reprocessed and adjusted**.

How to request a reopening for all HCPCS code/modifier combinations:

- Call the DME Contact Center PCC or Reopenings and advise need the claims for the single or multiple PTANs with the comments of "Corrections to the 2021 DMEPOS Fee Schedule Amounts"
- Submit a Special Project with the comments of "Corrections to the 2021 DMEPOS Fee Schedule Amounts"

COVID-19 Accelerated and Advance Payments (CAAP) Recoupment and Netting Hierarchy

On October 1, 2020, Congress enacted the Continuing Appropriations Act, 2021 and Other Extensions Act, which set forth favorable terms for repayment of accelerated and advance payments issued to providers and suppliers, as defined by Social Security Act §1861 (u) and (d) respectively, during the COVID-19 PHE. Under the terms set forth in the Act, providers and suppliers will begin repaying their CAAP disbursements beginning one year from the date on which the payment was issued. After the one year delay, the Centers for Medicare & Medicaid Services (CMS) will collect these repayments through recoupment, by offsetting Medicare claims payments otherwise owed to providers and suppliers at a rate of 25% for 11 months and at a rate of 50% during the subsequent 6 month period. The netting will process at a TIN level for associated/related providers and suppliers in the same MAC jurisdiction.

Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Custom Fitted Orthotic HCPCS Codes Without a Corresponding Off-the-Shelf Code - Correct Coding, has been created and published to our website.

View the locally hosted 2021 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

Custom Fabricated Wheelchair Seat and Back Cushions - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Custom Fabricated Wheelchair Seat and Back Cushions - Correct Coding - Revised**, has been created and published to our website.

View the locally hosted 2021 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

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

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

View the locally hosted 2021 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

DME MAC Program Manager Update

The Program Mangers want to share the activities of the A/B and DME MAC Collaboration Workgroup, which evaluates DMEPOS high Comprehensive Error Rate Testing (CERT) error categories and develops educational opportunities for physicians and non-physician practitioners.

To view the findings in the full article, please see DME and A/B MAC Collaboration Workgroup.

Enteral Nutrition and Parenteral Nutrition Proposed Local Coverage Determinations (LCDs) Open Meeting Agenda

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Enteral Nutrition and Parenteral Nutrition Proposed Local Coverage Determinations (LCDs) Open Meeting Agenda, has been created and published to our website.

View the locally hosted 2021 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

Formal Telephone Discussion Demonstration FAQs

MAXIMUS Federal, the Qualified Independent Contractor (QIC), continues to promote the Formal Telephone Discussion Demonstration on their website at http://www.medicaredmeappeals.com/. The site contains information regarding the Formal Telephone Discussion and Reopening's Demonstration and contains a list of Frequently Asked Questions (FAQs). An informational webinar on the demonstration is also available for review and download.

A few of the most common QIC questions include

- Can reconsideration requests be faxed?
    - Yes, reconsideration requests can be sent by mail or by fax to 720-462-7580. Registered QIC portal users can upload reconsideration requests directly to the QIC portal.
- Who should participate in the telephone discussion?
    - Ultimately, the supplier decides who participates in the telephone discussion. Before the discussion, the participant should be familiar with the appealed case and the documentation provided in the case file Suppliers can utilize a third-party group/billing agency to participate in the telephone discussion, provided the individual is authorized to conduct the discussion on behalf of the supplier. Agency authorization should be kept up to date in the (Provider Enrollment, Chain, and Ownership System (PECOS).
- How can I check the status of reconsideration once it has been submitted?
    - By using the appeal ID in the QIC acknowledgement notice, suppliers can obtain a status by accessing the Appeals Status Lookup tool at http://www.q2a.com/, or by calling 585-348-3200.

Suppliers can email inquiries about the reconsideration process to Erin Carey at erinmcarey@maximus.com.

Full Remittances for DME Users Now Available on the Noridian Medicare Portal

DME suppliers are now able to view, save and print full remittance advices on the Noridian Medicare Portal (NMP). Remittance advices going forward from March 10, 2021 are available for users that have access to the Remittance Advice function. Previously full remittance advices were only available for those NPIs that received the standard paper remit (SPR). Using the Full Remittance Advice inquiry on NMP can be used instead of calling Customer Service to order a duplicate copy.

View the Remittance Advice section of the NMP Inquiry Guide to begin using this function today.

Looking for Information on an Offset from your Payment

The overpayments function in the Noridian Medicare Portal (NMP) allows suppliers to view a summary of claims that may have caused an overpayment. The Overpayment Results inquiry in the NMP will provide users the overpayment information such as what claim(s) caused the overpayment and the steps being taken to satisfy the overpayment. Through this function suppliers can identify any offsets and the beneficiary's name tied to the offset. To perform an inquiry:

- Select Financials tab
- Select Overpayment Results tab
    - Enter Provider/Supplier details for overpayment
    - Enter Overpayment Letter Number and/or Claim Number (CCN)
    - View most recent 100 or download a csv. file
- Results provides summary
    - Click on plus symbol (+) next to CCN to obtain Beneficiary Name, Claim Number, Date of Service and Overpayment Amount

Mobility Assistive Equipment (MAE) DME on Demand Tutorials

Noridian offers many self-paced training tutorials for MAE covering documentation requirements, home assessments, coverage criteria, coding, billing reminders and more. Below is just a sample of these quick, thorough aids.

Sample of available tutorials:

- Canes and Crutches - 4 minutes
- PMD: Captain's Chair vs. Sling/Solid Back Chair - 4 minutes
- PMD: Documentation - 6 minutes
- Walkers: Billing Reminders - 7 minutes
- L200 Manual Wheelchair K0001-K0003 Denials - 5 minutes

For a complete list of tutorials, visit the DME On Demand Tutorials page.

Noridian Medicare Portal Eligibility Enhancements Available April 3, 2021

Effective April 3, 2021 the Noridian Medicare Portal (NMP) has been updated to provide additional information to the Eligibility Inquiry responses.

BENEFICIARY ENTITLEMENT REASON CODE

The Beneficiary Entitlement Reason Code has been added to the Part A and Part B Beneficiary Details. The Entitlement Reason Code will display and provide a description of the beneficiary's entitlement.

ACUPUNCTURE SERVICES

Acupuncture Service Benefits will provide how many Technical and Professional Sessions are remaining. NMP will also display either the next eligible date or the date of the first acupuncture session, depending on whether the beneficiary has started using the service. This information will be displayed on the Preventive tab of the Eligibility response.

COVID-19 IMMUNIZATION DATA

A COVID-19 Vaccine Eligibility status will be provided on the Preventive tab of the Eligibility response that will indicate if the patient is eligible for the vaccine. The COVID-19 Immunization Data will also be returned on the Preventive tab. The data returned will be the HCPCS Code and Description of the vaccine that was provided, the previous date of service along with the Rendering NPI.

Oral Appliances for OSA, Positive Airway Pressure (PAP) Devices for the Treatment of OSA, and Respiratory Assist Devices Proposed Local Coverage Determinations (LCDs) Open Meeting Agenda

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Oral Appliances for OSA, Positive Airway Pressure (PAP) Devices for the Treatment of OSA, and Respiratory Assist Devices Proposed Local Coverage Determinations (LCDs) Open Meeting Agenda, has been created and published to our website.

View the locally hosted 2021 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

Patient Status Codes Page Now Available

We have added a Patient Status Codes page to our Consolidated Billing page to assist suppliers in identifying the status of a patient when checking eligibility on the Noridian Medicare Portal. Please refer to this page for the definition of the statuses listed on the portal when checking eligibility for Hospital/SNF.

Service Specific Post-Payment Review: December 2020 - February 2021

The Jurisdiction A, DME MAC, Medical Review Department is conducting a post-payment service specific review of the below specialties. The following quarterly edit effectiveness results from December 2020 - February 2021 can be located on our Medical Record Review Results webpage:

- Ankle-Foot Orthosis
- Knee Orthosis
- Surgical Dressings
- Urological Supplies

Service Specific Post-Payment Review: January 2021 - March 2021

The Jurisdiction A, DME MAC, Medical Review Department is conducting a post-payment service specific review of the below specialties. The following quarterly edit effectiveness results from December 2020 - February 2021 can be located on our Medical Record Review Results webpage:

- Ostomy Supplies

Service Specific Post-Payment Review: February 2021 - April 2021

The Jurisdiction A, DME MAC, Medical Review Department is conducting a post-payment service specific review of the below specialties. The following quarterly edit effectiveness results from February 2021 - April 2021 can be located on our Medical Record Review Results webpage:

- Glucose Monitors

Single Payment Amounts for the 2021 Competitive Bidding Program

Looking for information on Single Payment Amounts (SPA)?

Check out the “Browse by Topic” Competitive Bidding webpage as it provides access to the Competitive Bid website and the SPAs

Spinal Orthosis (HCPCS L0648 & L0650) Notification of Service Specific Post-Payment Review

Noridian Jurisdiction A, DME MAC, Medical Review is initiating service specific post-payment medical record review of claims for the following HCPCS codes:

- **L0648**: LUMBAR-SACRAL ORTHOSIS, SAGITTAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR PANELS, POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON THE INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF
- **L0650**: LUMBAR-SACRAL ORTHOSIS, SAGITTAL-CORONAL CONTROL, WITH RIGID ANTERIOR AND POSTERIOR FRAME/PANEL(S), POSTERIOR EXTENDS FROM SACROCOCCYGEAL JUNCTION TO T-9 VERTEBRA, LATERAL STRENGTH PROVIDED BY RIGID LATERAL FRAME/PANEL(S), PRODUCES INTRACAVITARY PRESSURE TO REDUCE LOAD ON INTERVERTEBRAL DISCS, INCLUDES STRAPS, CLOSURES, MAY INCLUDE PADDING, SHOULDER STRAPS, PENDULOUS ABDOMEN DESIGN, PREFABRICATED, OFF-THE-SHELF

Service specific reviews are initiated to prevent improper payments for services which present possible sustained or high-level payment errors. This review is being initiated based on data analysis identifying probable vulnerabilities. Please see the Medical Record Review Results page for further information.

Standard Documentation Requirements

The CMS Standard Documentation Requirements Article A55426 is your source for all general Medicare documentation requirements. This includes the change in order requirements implemented January 1, 2020 for the Standard Written Order (SWO). Please take time to review and understand all the standard documentation requirements for all claims submitted to the DME MACs. Many errors reported in all Medicare audits are due to claims submitted with incomplete or missing required documentation. By obtaining and submitting, when requested, all required documentation for claims, there will be less rework and quicker reimbursement for the services suppliers provide to beneficiaries.

Therapeutic Shoes for Persons with Diabetes Documentation Checklist

Did you know that Noridian offers a Documentation Checklist for Therapeutic Shoes for Persons with Diabetes? This checklist provides guidance for all documentation that may be requested for review. It specifies what is required on the signed and dated statement from the certifying physician and a detailed description of what should be contained in the medical records.

Using Denial Code Resolution Tool for Missing CMN DIF Denials

Did you know Noridian has a Denial Code Resolution tool to help suppliers identify corrective action to resolve and avoid denials? If you have received a denial for a missing initial, recertification or revised Certificate of Medical Necessity (CMN) or DME Information Form (DIF), you can enter the reason or remark code in the tool then click on the code to find next steps and how to avoid future denials.

Verify HMO/MCO Status on the Noridian Medicare Portal (NMP) to Ensure Billing to Correct Payor

A dedicated tab can be found in the NMP for Health Maintenance Organization (HMO) and Managed Care Organization (MCO) information.

Obtain the following information regarding beneficiaries by selecting the Eligibility tab on the NMP.

- Insurer name
- Policy number
- Effective and termination dates
- Plan type

- Bill option code
- Plan address
- Plan phone number

Utilizing the information found here, avoid denials by billing the correct payor the first time. Suppliers may learn more in the Inquiry Guide on the NMP webpage.

MEDICAL POLICIES AND COVERAGE .....

LCD and Policy Article Revisions Summary for March 18, 2021

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Knee Orthoses, Lower Limb Prostheses, Mechanical In-exsufflation Devices, Negative Pressure Wound Therapy Pumps, Pressure Reducing Support Surfaces - Group 1, Pressure Reducing Support Surfaces - Group 2, Pressure Reducing Support Surfaces - Group 3, Surgical Dressings and Therapeutic Shoes for Persons with Diabetes. Please review the entire LCDs and related Policy Articles for complete information.

KNEE ORTHOSES

PA

Revision Effective Date: 02/01/2021
CODING GUIDELINES:
Added: "(CVR)" after reference to coding verification review
Added: "(PCL)" after reference to "Product Classification List"
Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/18/2021: 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.

LOWER LIMB PROSTHESES

PA

Revision Effective Date: 08/01/2020
CODING GUIDELINES:
Removed: Trademark symbols
Removed: "etc." from the not all-inclusive list of other components of a prosthesis
Revised: Infinite Socket TT-S information, to include addition HCPCS code L5637
Revised: Coding guidelines for HCPCS codes L5968 and L5986
CODING VERIFICATION REVIEW:
Added: "(PCL)" after reference to "Product Classification List"
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/18/2021: 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: 10/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Reimbursement statement for replacement of A7020
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Added: A7020 to Group 1 Paragraph

03/18/2021: 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.

NEGATIVE PRESSURE WOUND THERAPY PUMPS

LCD

Revision Effective Date: 05/01/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: Roman to Arabic numerals in staging scheme
Revised: “an” to “a” before NPWT
APPENDICES:
Revised: Updated National Pressure Ulcer Advisory Panel to National Pressure Injury Advisory Panel and 2019 guidelines (unchanged from 2016 guidelines)

03/18/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive changes.

PA

Revision Effective Date: 01/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: “an” to “a” before NPWT
MODIFIERS:
Revised: "an” to “a” before NPWT

03/18/2021: 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.

PRESSURE REDUCING SUPPORT SURFACES - GROUP 1

LCD

Revision Effective Date: 05/01/2021
APPENDICES:
Revised: National Pressure Ulcer Advisory Panel to National Pressure Injury Advisory Panel and 2019 guidelines (unchanged from 2016 guidelines)

03/18/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive changes.

PA

Revision Effective Date: 05/01/2021
RELATED CLINICAL INFORMATION:
Revised: Roman to Arabic numerals in staging scheme

03/18/2021: 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.

PRESSURE REDUCING SUPPORT SURFACES - GROUP 2

LCD

Revision Effective Date: 05/01/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Spelling error from ‘appropriatge’ to ‘appropriate’
Revised: Roman to Arabic numerals in staging scheme
APPENDICES:
Revised: National Pressure Ulcer Advisory Panel to National Pressure Injury Advisory Panel and 2019 guidelines (unchanged from 2016 guidelines)

03/18/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive changes.

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Added: “(CVR)” after reference to coding verification review
Added: “(PCL)” after reference to “Product Classification List”

Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/18/2021: 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.

PRESSURE REDUCING SUPPORT SURFACES - GROUP 3

LCD

Revision Effective Date: 05/01/2021
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Revised: Roman to Arabic numerals in staging scheme
APPENDICES:
Revised: National Pressure Ulcer Advisory Panel to National Pressure Injury Advisory Panel 2019 guidelines (unchanged from 2016 guidelines)

03/18/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive changes.

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Added: E0194 includes heavy duty and bariatric devices

03/18/2021: 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: 05/01/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Revised: Roman to Arabic numerals in staging scheme
DOCUMENTATION REQUIREMENTS:
Revised: Statement to add in “treating practitioner’s”
APPENDICES:
Revised: National Pressure Ulcer Advisory Panel to National Pressure Injury Advisory Panel and 2019 guidelines (unchanged from 2016 guidelines)

03/18/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are due grammatical or non-substantive changes.

PA

Revision Effective Date: 05/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Roman to Arabic numerals in staging scheme
CODING GUIDELINES:
Revised: Roman to Arabic numerals in staging scheme
Added: “(CVR)” after reference to coding verification review
Added: “(PCL)” after reference to “Product Classification List”
Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/18/2021: 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.

THERAPEUTIC SHOES FOR PERSONS WITH DIABETES

PA

Revision Effective Date: 11/05/2020
CODING GUIDELINES:
Added: "(PCL)" after reference to "Product Classification List"
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/18/2021: 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(s) 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 April 29, 2021

Outlined below are the principal changes to the DME MAC Local Coverage Determinations (LCDs) and Policy Articles (PAs) that have been revised and posted. The policies included are Intravenous Immune Globulin and Urological Supplies. Please review the entire LCDs and related PAs for complete information.

INTRAVENOUS IMMUNE GLOBULIN

LCD

Revision Effective Date: 04/01/2021
HCPCS CODES:
Added: J1554

04/29/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

UROLOGICAL SUPPLIES

LCD

Revision Effective Date: 04/01/2021
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: Trademark symbol from first use of inflow
HCPCS CODES:
Removed: K1010, K1011 and K1012 (effective for DOS on or after 04/01/2021)

04/29/2021: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

PA

Revision Effective Date: 04/01/2021
GENERAL:
Removed: Trademark symbol from first use of inflow
CODING GUIDELINES:
Revised: inFlow HCPCS billing directions for K1010, K1011 and/or K1012 for DOS 10/01/2020 through 03/31/2021
Added: Billing direction for inFlow under HCPCS A4335 for DOS on or after 04/01/2021
Revised: inFlow replacement language, to include product information instead of K1010, K1011, and K1012

04/29/2021: 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(s) 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 March 11, 2021

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 Orthoses, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), Orthopedic Footwear, Osteogenesis Stimulators, Speech Generating Devices (SGD), Spinal Orthoses: TLSO and LSO, Standard Documentation Requirements for All Claims Submitted to DME MACs and Vacuum Erection Devices (VED). Please review the entire LCDs and related PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES

PA

Revision Effective Date: 02/01/2021
CODING GUIDELINES:
Removed: Coding verification review information for HCPCS codes L1906 and L2006
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review information
Added: Coding verification review information for HCPCS codes L1906 and L2006

03/11/2021: 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 ANTIEMETIC DRUGS (REPLACEMENT FOR INTRAVENOUS ANTIEMETICS)

PA

Revision Effective Date: 01/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: HCPCS Codes Q0981 and Q9978 which are no longer valid for billing

CODING GUIDELINES:
Removed: HCPCS Codes Q9978 and Q9981 which are no longer valid for billing

03/11/2021: 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.

ORTHOPEDIC FOOTWEAR

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: HCPCS code L3000 to noncovered statement, previously omitted in error

03/11/2021: 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.

OSTEOGENESIS STIMULATORS

PA

Revision Effective Date: 01/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Class III devices and KF modifier requirement for HCPCS codes E0747, E0748 and E0760
CODING GUIDELINES:
Removed: Class III devices and KF modifier requirements which were moved to the Policy Specific Documentation Requirements section

03/11/2021: 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.

SPEECH GENERATING DEVICES (SGD)

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Added: "(PCL)" after reference to "Product Classification List"
Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/11/2021: 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.

SPINAL ORTHOSES: TLSO AND LSO

PA

Revision Effective Date: 02/01/2021
CODING GUIDELINES:
Removed: Reference to L0640 from list of prefabricated orthoses
Removed: HCPCS codes L0622 and L0624 from list of custom fabricated orthoses for which all products must be listed on the PCL
Added: "(PCL)" after reference to "Product Classification List"
Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/11/2021: 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.

STANDARD DOCUMENTATION REQUIREMENTS FOR ALL CLAIMS SUBMITTED TO DME MACS

PA

STANDARD WRITTEN ORDER (SWO):
Revised: Reference to the Medicare Program Integrity Manual from 'Internet only manual' to 'CMS Pub.'
DOCUMENTATION REQUIREMENTS:
Revised: "DME MAC supplier" to "DMEPOS supplier" in second paragraph
CORRECT CODING:
Revised: Reference to the Medicare Program Integrity Manual from 'Internet only manual' to 'CMS Pub.'
Added: "45 CFR" in front of 162.1002 reference in first paragraph
Revised: 'Durable Medical Equipment Coding System' reference to 'DMECS' to match the PDAC website
REPAIRS/REPLACEMENT:
Revised: References to the Medicare Benefit Policy Manual from 'Internet only manual' to 'CMS Pub.'
SIGNATURE REQUIREMENTS:
Revised: Reference to the Medicare Program Integrity Manual from 'Internet only manual' to 'CMS Pub.'

03/11/2021: 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.

VACUUM ERECTION DEVICES (VED)

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: Social Security Act citation for non-coverage 1834(a)(1)(I)

03/11/2021: 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(s) 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 March 25, 2021

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Canes and Crutches, Eye Prostheses, Facial Prostheses, Manual Wheelchair Bases, Nebulizers, Power Mobility Devices, Wheelchair Options/Accessories, and Wheelchair Seating. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

CANES AND CRUTCHES

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: Non-coverage language for white canes and added NCD reference

03/25/2021: At this time the 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.

EYE PROSTHESES

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Removed: Trademark symbols from PROSE references, per AMA guidelines

03/25/2021: At this time the 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.

FACIAL PROSTHESES

PA

Revision Effective Date: 01/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: Modifiers section and related information for modifiers AV, KM, KN, RT and LT
CODING GUIDELINES:
Removed: KM and RT/LT modifier instructions. Relocated to Modifiers section within Policy Specific Documentation Requirements

03/25/2021: At this time the 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.

MANUAL WHEELCHAIR BASES

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Added: Coding verification review information for HCPCS code K0009 (effective for dates of service on or after 06.01.2013)
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review
Removed: Reference to HCPCS codes for billing of maintenance and service

03/25/2021: At this time the 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
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Trademark symbol from Foradil Aerolize, per AMA guidelines
Revised: Day references to include hyphen
CODING GUIDELINES:
Added: “(CVR)” after reference to coding verification review
Added: “(PCL)” after reference to “Product Classification List”
Revised: Coding verification review information, to include incorrect coding denial language for products billed using HCPCS that require written coding verification review
Added: HCPCS codes J7605, J7606, and J7686 to statement regarding KP KQ modifiers

03/25/2021: At this time the 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.

POWER MOBILITY DEVICES

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “physician’s” to “practitioner’s”
MISCELLANEOUS:
Revised: “coding verification determination” to “coding verification review”
Added: "CVR" after reference to "coding verification review"
Added: “PCL” after reference to “Product Classification List”
Revised: Coding verification review reference of “devices” to “products"
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/25/2021: At this time the 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.

WHEELCHAIR OPTIONS/ACCESSORIES

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Removed: Reference to HCPCS codes for replacement-only items

03/25/2021: At this time the 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.

WHEELCHAIR SEATING

PA

Revision Effective Date: 10/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Added: References to refer to group codes in the ICD-10 code list section
CODING GUIDELINES:
Revised: References of positioning back cushion HCPCS codes, from “E2314” and “E2315” to “E2614” and “E2615” respectively
Added: HCPCS code E2610 to list of HCPCS codes for which products require written coding verification review
Added: "CVR" after reference to "coding verification review"
Added: “(PCL)” after reference to “Product Classification List”
Revised: Coding verification review language for products that must be billed with HCPCS code K0669
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review

03/25/2021: At this time the 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(s) 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 April 1, 2021

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, Bowel Management Devices, Heating Pads and Heat Lamps, High Frequency Chest Wall Oscillation Devices, and Walkers. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

AUTOMATIC EXTERNAL DEFIBRILLATORS

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Revised: Instructions related to KF modifier for K0606 and E0617

04/01/2021: At this time the 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.

BOWEL MANAGEMENT DEVICES

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Trademark symbols, per AMA guidelines
CODING GUIDELINES:
Removed: Trademark symbols, per AMA guidelines

04/01/2021: At this time the 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.

HEATING PADS AND HEAT LAMPS

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Revised: References to Occupational Safety and Health Administration and Nationally Recognized Testing Laboratory references, to include acronyms

04/01/2021: At this time the 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.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: “etc.” from the not all-inclusive list of medical condition examples
CODING GUIDELINES:
Removed: “etc.” from the not all-inclusive list of differing technologies used by E0483 devices
Removed: “etc.” from the not all-inclusive list of components included in A7025

04/01/2021: At this time the 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.

WALKERS

PA

Revision Effective Date: 01/01/2020
CODING GUIDELINES:
Added: "(CVR)" after reference to coding verification review
Added: "(PCL)" after reference to "Product Classification List"
Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review
Revised: Reference to HCPCS code E0159 long description

04/01/2021: At this time the 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(s) 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 May 27, 2021

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

WHEELCHAIR SEATING

PA

Revision Effective Date: 06/01/2021
CODING GUIDELINES:
Revised: Flame resistance standards language to include "or equivalent" with reference to ASTM, EPA, or other national or international standards agencies

05/27/2021: At this time the 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(s) 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

Use of CR modifier and "COVID-19" narrative on Specified Claims Due to the COVID-19 PHE - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Use of CR modifier and "COVID-19" narrative on Specified Claims Due to the COVID-19 PHE - Revised, has been created and published to our website.

View the locally hosted 2021 DMD articles.

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

MLN CONNECTS

MLN Connects - March 4, 2021

COVID-19 Vaccine Codes: EUA for Janssen Biotech

MLN Connects® newsletter for Thursday, March 4, 2021

View this edition as a: Webpage | PDF

NEWS

- COVID-19 Vaccine Codes: EUA Effective Date for Janssen Biotech Inc.
- COVID-19 Vaccine Administration: Insurance Coverage, MBI, & MSP
- COVID-19 FAQs on Medicare FFS Billing to Administer Vaccines
- COVID Vaccine Resources for Hard to Reach Patients
- Cybersecurity Resources
- Nutrition-related Health Conditions: Medicare Covers Preventive Services

COMPLIANCE

- IRF Services: Follow Medicare Billing Requirements

CLAIMS, PRICERS, & CODES

- DMEPOS: Corrected 2021 Fee Schedule Amounts

EVENTS

- Medicare Part A Cost Report Appeals Listening Session - March 16
- Long-Term Care: Dementia-related Psychosis Call - March 23
- Open Payments & You Call - March 25

PUBLICATIONS

- Intravenous Immune Globulin Demonstration

MULTIMEDIA

- Section J: Health Conditions: Coding the SPADEs Related to Falls Web-Based Training

MLN Connects Special Edition - March 10, 2021 - CMS Updates Nursing Home Guidance with Revised Visitation Recommendations

On March 10, CMS, in collaboration with the CDC, issued updated guidance for nursing homes to safely expand visitation options during the COVID-19 pandemic public health emergency.

This latest guidance comes as more than 3 million doses of vaccines have been administered within nursing homes, thanks in part to the CDC's Pharmacy Partnership for Long-Term Care Program, following the FDA authorization for emergency use of COVID-19 vaccines.

According to the updated guidance, facilities should allow responsible indoor visitation at all times and for all residents, regardless of vaccination status of the resident, or visitor, unless certain scenarios arise that would limit visitation for:

- Unvaccinated residents, if the COVID-19 county positivity rate is greater than 10 percent and less than 70 percent of residents in the facility are fully vaccinated,
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated, until they have met the criteria to discontinue transmission-based precautions, or
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine

The updated guidance also emphasizes that "compassionate care" visits should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak. Compassionate care visits include visits for a resident whose health has sharply declined or is experiencing a significant change in circumstances.

CMS continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection control, including maintaining physical distancing and conducting visits outdoors whenever possible. This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated.

"CMS recognizes the psychological, emotional, and physical toll that prolonged isolation and separation from family have taken on nursing home residents and their families," said Dr. Lee Fleisher, MD, CMS Chief Medical Officer and Director of CMS' Center for Clinical Standards and Quality. "That is why, now that millions of vaccines have been administered to nursing home residents and staff, and the number of COVID cases in nursing homes has dropped significantly, CMS is updating its visitation guidance to bring more families together safely. This is an important step that we are taking, as we continue to emphasize the importance of maintaining infection prevention practices, given the continued risk of transmission of COVID-19."

High vaccination rates among nursing home residents, and the diligence of committed nursing home staff to adhere to infection control protocols, which are enforced by CMS, have helped significantly reduce COVID-19 positivity rates and the risk of transmission in nursing homes.

Although outbreaks increase the risk of COVID-19 transmission, as long as there is evidence that the outbreak is contained to a single unit or separate area of the facility, visitation can still occur.

More Information:

- Nursing Home Visitation - COVID-19 webpage
- Fact sheet

MLN Connects - March 11, 2021

Hospitals: Are You Using Your PEPPER Data?

MLN Connects newsletter for Thursday, March 11, 2021

View this edition as a: Webpage | PDF

NEWS

- PEPPERs for Short-term Acute Care Hospitals
- Colorectal Cancer: Medicare Covers Screening

COMPLIANCE

- Ambulance Services & SNF Consolidated Billing Requirements: Avoid Improper Payments

CLAIMS, PRICERS, & CODES

- Average Sales Price Files: April 2021

EVENTS

- Medicare Part A Cost Report Appeals Listening Session - March 16
- Long-Term Care: Dementia-related Psychosis Call - March 23
- Open Payments & You Call - March 25

MLN MATTERS® ARTICLES

- April 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.1
- April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes - Revised

MLN Connects Special Edition - March 15, 2021 - Biden-Harris Administration Increases Medicare Payment for Life-Saving COVID-19 Vaccine

On March 15, CMS increased the Medicare payment amount for administering the COVID-19 vaccine. This new and higher payment rate will support important actions taken by providers that are designed to increase the number of vaccines they can furnish each day, including establishing new or growing existing vaccination sites, conducting patient outreach and education, and hiring additional staff. At a time when vaccine supply is growing, CMS is supporting provider efforts to expand capacity and ensure that all Americans can be vaccinated against COVID-19 as soon as possible.

Effective for COVID-19 vaccines administered on or after March 15, 2021, the national average payment rate for physicians, hospitals, pharmacies, and many other immunizers will be $40 to administer each dose of a COVID-19 vaccine. This represents an increase from approximately $28 to $40 for the administration of single-dose vaccines and an increase from approximately $45 to $80 for the administration of COVID-19 vaccines requiring two doses. The exact payment rate for administration of each dose of a COVID-19 vaccine will depend on the type of entity that furnishes the service and will be geographically adjusted based on where the service is furnished.

These updates to the Medicare payment rate for COVID-19 vaccine administration reflect new information about the costs involved in administering the vaccine for different types of providers and suppliers, and the additional resources necessary to ensure the vaccine is administered safely and appropriately.

CMS is updating the set of toolkits for providers, states, and insurers to help the health care system swiftly administer the vaccine with these new Medicare payment rates. These resources are designed to increase the number of providers that can administer the vaccine, ensure adequate payment for administering the vaccine to Medicare beneficiaries, and make it clear that no beneficiary, whether covered by private insurance, Medicare, or Medicaid, should pay cost-sharing for the administration of the COVID-19 vaccine.

COVERAGE OF COVID-19 VACCINES:

As a condition of receiving free COVID-19 vaccines from the federal government, vaccine providers are prohibited from charging patients any amount for administration of the vaccine. To ensure broad and consistent coverage across programs and payers, the toolkits have specific information for several programs, including:

Medicare: Beneficiaries with Medicare pay nothing for COVID-19 vaccines and there is no applicable copayment, coinsurance, or deductible.

Medicare Advantage (MA): For calendar years 2020 and 2021, Medicare will pay providers directly for the COVID-19 vaccine (if they do not receive it for free) and its administration for beneficiaries enrolled in MA plans. MA plans are not responsible for paying providers to administer the vaccine to MA enrollees during this time. Like beneficiaries in Original Medicare, Medicare Advantage enrollees also pay no cost-sharing for COVID-19 vaccines.

Medicaid: State Medicaid and Children's Health Insurance Program agencies must provide vaccine administration with no cost sharing for nearly all beneficiaries during the Public Health Emergency (PHE) and at least one year after it ends. Through the American Rescue Plan Act signed by President Biden on March 11, 2021, the COVID vaccine administration will be fully federally funded. The law also provides an expansion of individuals eligible for vaccine administration coverage. There will be more information provided in upcoming updates to the Medicaid toolkit.

Private Plans: CMS, along with the Departments of Labor and Treasury, is requiring that most private health plans and issuers cover the COVID-19 vaccine and its administration, both in-network and out-of-network, with no cost sharing during the PHE. Current regulations provide that out-of-network rates must be reasonable, as compared to prevailing market rates, and reference the Medicare reimbursement rates as a potential guideline for insurance companies. In light of CMS's increased Medicare payment rates, CMS will expect commercial carriers to continue to ensure that their rates are reasonable in comparison to prevailing market rates.

Uninsured: For individuals who are uninsured, providers may submit claims for reimbursement for administering the COVID-19 vaccine to individuals without insurance through the Provider Relief Fund, administered by the Health Resources and Services Administration (HRSA).

More Information:

Medicare COVID-19 Vaccine Shot Payment webpage: Payment for COVID-19 vaccine administration, including a list of billing codes, payment allowances, and effective dates

CDC COVID-19 Vaccination Program Provider Requirements and Support webpage: How the COVID-19 vaccine is provided at 100% no cost to recipients

HRSA COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment, and Vaccine Administration for the Uninsured webpage

MLN Connects - March 18, 2021

Open Payments & You - Register for March 25 Call

MLN Connects newsletter for Thursday, March 18, 2021

View this edition as a: Webpage | PDF

NEWS

- Clinical Laboratory Data Reporting Delayed Until 2022: Reminder
- Comprehensive Eye Examinations: Comparative Billing Report in March

COMPLIANCE

- Polysomnography Services: Bill Correctly

EVENTS

- Long-Term Care: Dementia-related Psychosis Call - March 23
- Open Payments & You Call - March 25
- SNF Quality Reporting Program: Achieving a Full APU Webinar- March 30

MLN MATTERS® ARTICLES

- April 2021 Update to the Fiscal Year (FY) 2021 Inpatient Prospective Payment System (IPPS)
- April Quarterly Update for 2021 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Clinical Laboratory Fee Schedule - Medicare Travel Allowance Fees for Collection of Specimens
- 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) - April 2021 Update
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) & PC Print Update

PUBLICATIONS

- Medicare Quarterly Provider Compliance Newsletter

MLN Connects - March 25, 2021

Home Health Payment Corrections

MLN Connects newsletter for Thursday, March 25, 2021

View this edition as a: Webpage | PDF

NEWS

- Medicare Shared Savings Program: Application Deadlines for January 1, 2022, Start Date
- Repetitive, Scheduled Non-Emergent Ambulance Transport: Documentation Requirements
- PT During COVID-19 & Response to Texas Storm

COMPLIANCE

- Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

CLAIMS, PRICERS, & CODES

- Home Health Payment Corrections

MLN MATTERS® ARTICLES

- Common Working File (CWF) Edits for Medicare Telehealth Services and Manual Update
- Correction to Period Sequence Edits on Home Health Claims
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021
- Updated Billing Requirements for Home Infusion Therapy (HIT) Services on or After January 1, 2021
- Update to Rural Health Clinic (RHC) Payment Limits

MLN Connects Special Edition - March 30, 2021 - Temporary Claims Hold Pending Congressional Action to Extend 2% Sequester Reduction Suspension

In anticipation of possible Congressional action to extend the 2% sequester reduction suspension, we instructed the Medicare Administrative Contractors (MACs) to hold all claims with dates of service on or after April 1, 2021, for a short period without affecting providers' cash flow. This will minimize the volume of claims the MACs must reprocess if Congress extends the suspension; the MACs will automatically reprocess any claims paid with the reduction applied if necessary.

MLN Connects - April 1, 2021

Repayment of COVID-19 Accelerated and Advance Payments

MLN Connects newsletter for Thursday, April 1, 2021

View this edition as a: Webpage | PDF

NEWS

- Repayment of COVID-19 Accelerated and Advance Payments Began on March 30, 2021
- COVID-19 Vaccine Administration - No Out-of-Pocket Cost to Patients
- Alcohol Misuse: Medicare Covers Screening & Counseling

COMPLIANCE

- DMEPOS: Bill Correctly for Items Provided During Inpatient Stays

CLAIMS, PRICERS, & CODES

- COVID-19: RHC & FQHC Lump Sum Payments

EVENTS

- Medicare Part A Cost Report: Easier File Uploads for e-Filing in MCReF Webcast — April 29

MLN MATTERS® ARTICLES

- New Provider Enrollment Administrative Action Authorities
- April 2021 Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2021
- Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)
- Update to the Manual for Telephone Services, Physician Assistant (PA) Supervision, and Medical Record Documentation for Part B Services

MULTIMEDIA

- Medicare Part A Cost Report Appeals Listening Session: Audio Recording & Transcript

MLN Connects - April 8, 2021

More FY20 PEPPERs Available

MLN Connects newsletter for Thursday, April 8, 2021

View this edition as a: Webpage | PDF

NEWS

- PEPPERs for LTCHs, CAHs, IRFs, IPFs, Hospices, & SNFs
- Preparedness Resources: Cybersecurity & Post-Acute Sequelae of SARS-CoV-2
- Minority Health: Medicare Covers Preventive Services

COMPLIANCE

- Hospice Aide Services: Enhancing RN Supervision

CLAIMS, PRICERS, & CODES

- OPPS Pricer File: April 2021

EVENTS

- Changes in the Hospice Item Set Manual V3.00 Webinar - April 15
- Medicare Part A Cost Report: Easier File Uploads for e-Filing in MCReF Webcast - April 29

MLN MATTERS® ARTICLES

- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - July 2021
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.2, Effective July 1, 2021
- Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2021
- April 2021 Update of the Ambulatory Surgical Center (ASC) Payment System
- Penalty for Delayed Request for Anticipated Payment (RAP) Submission - Implementation - Revised

PUBLICATIONS

- How to Use the Medicaid NCCI Tools
- Hospital Value-Based Purchasing - Revised

MULTIMEDIA

- Dementia Care Call: Audio Recording & Transcript
- Open Payments Call: Audio Recording & Transcript
- SNF Resident Mood Interview Video
- 2021 Medicare Part C & Part D Reporting Requirements & Data Validation Web-Based Training - Revised

MLN Connects Special Edition - April 8, 2021 - 4 Proposed FY 2020 Payment Rules

SNF Prospective Payment System: FY 2022 Proposed Rule

On April 8, CMS issued a proposed rule that would update Medicare payment policies and rates for Skilled Nursing Facilities (SNFs) under the SNF Prospective Payment System (PPS) for Fiscal Year (FY) 2022. In addition, the proposed rule includes proposals for the SNF Quality Reporting Program and the SNF Value-Based Program (VBP) for FY 2022.

CMS estimates that the aggregate impact of the payment policies in this proposed rule would result in an increase of approximately $444 million in Medicare Part A payments to SNFs in FY 2022. This estimate reflects a $445 million increase from the update to the payment rates of 1.3 percent, which is based on a 2.3 percent SNF market basket update, less a 0.8 percentage point forecast error adjustment and a 0.2 percentage point multifactor productivity adjustment, and a $1.2 million decrease due to the proposed reduction to the SNF PPS rates to account for the recent blood-clotting factors exclusion. These impact figures do not incorporate the SNF VBP reductions that are estimated to be $184.25 million in FY 2022.

Proposed updates to the Patient Driven Payment Model:

- Methodology for recalibrating the parity adjustment
- Proposed changes in ICD-10 code mappings

More Information:

- Full fact sheet
- Proposed rule: CMS will accept comments until June 7

HOSPICE PAYMENT RATE UPDATE FOR FY 2022

On April 8, CMS issued a proposed rule that would provide routine updates to hospice base payments and the aggregate cap amount for Fiscal Year (FY) 2022. This proposed rule also includes a comment solicitation regarding hospice utilization. In addition, this rule proposes to rebase the hospice labor shares and clarify certain aspects of the hospice election statement addendum requirements.

This rule proposes changes to the hospice conditions of participation and Hospice Quality Reporting Program (HQRP). The proposed rule also includes a Home Health Quality Reporting Program proposal to display publicly 3 quarters of certain outcome and assessment information set data due to the COVID-19 public health emergency exemptions of the 2020 first and second quarter data.

As proposed, hospices would see a 2.3 percent ($530 million) increase in their payments for FY 2022. The proposed 2.3 percent hospice payment update for FY 2022 is based on the estimated 2.5 percent inpatient hospital market basket reduced by the multifactor productivity adjustment (0.2 percentage point). Hospices that fail to meet quality reporting requirements receive a 2 percentage point reduction to the annual market basket update for FY 2022.

Proposed updates:

- Hospice labor shares
- Fast health care interoperability resources in support of the HQRP - Request for Information (RFI)
- Closing the health equity gap in the HQRP - RFI

More Information:

- Full fact sheet
- Proposed rule: CMS will accept comments until June 7

IRF PROSPECTIVE PAYMENT SYSTEM: FY 2022 PROPOSED RULE

On April 7, CMS issued a proposed rule that would update Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program for Fiscal Year (FY) 2022.

CMS is proposing to update the IRF PPS payment rates by 2.2% based on the proposed IRF market basket update of 2.4%, less a 0.2 percentage point Multi-Factor Productivity (MFP) adjustment. CMS is proposing that if more recent data becomes available, we would use these data, if appropriate, to determine the FY 2022 market basket update and MFP adjustment in the final rule. In addition, the proposed rule contains an adjustment to the outlier threshold to maintain outlier payments at 3.0% of total payments. This adjustment would result in a 0.3 percentage point decrease in outlier payments. We estimate that the overall increase to IRF payments for FY 2022 would be 1.8% (or $160 million), relative to payments in FY 2021.

Proposed updates to quality reporting:

- Closing the health equity gap - Request for Information (RFI)
- COVID-19 Vaccination Coverage among Health Care Personnel measure

- Transfer of Health Information to the Patient Post-Acute Care quality measure
- Public reporting of quality measures with fewer than standard numbers of quarters due to COVID-19 public health emergency exemptions
- Fast health care interoperability resources in support of digital quality measurement in post-acute care quality reporting programs - RFI

More Information:

- Full fact sheet
- Proposed rule: CMS will accept comments until June 7
- IRF PPS webpage

IPF: PROPOSED MEDICARE PAYMENT & QUALITY REPORTING UPDATES

On April 7, CMS issued a proposed rule that would update Medicare payment policies and rates for the Inpatient Psychiatric Facility (IPF) Prospective Payment System (PPS) for Fiscal Year (FY) 2022 and propose changes to the IPF Quality Reporting (IPFQR) Program. We're soliciting comments on addressing health equity in the IPFQR Program.

Total estimated payments to IPFs are estimated to increase by 2.3% or $90 million in FY 2022 relative to IPF payments in FY 2021. For FY 2022, CMS is proposing to update the IPF PPS payment rates by 2.1% based on the proposed IPF market basket update of 2.3%, less a 0.2 percentage point productivity adjustment. CMS is proposing that if more recent data becomes available, we would use these data, if appropriate, to determine the FY 2022 market basket update and multi-factor productivity adjustment in the final rule. Accounting for an additional update to the outlier threshold so that estimated outlier payments remain at 2.0% of total payments, results in a 0.2% overall increase to aggregate payments due to updating the outlier threshold results.

More Information:

- Full fact sheet
- Proposed rule: CMS will accept comments until June 7

MLN Connects Special Edition - April 14, 2021 - J&J COVID-19 Vaccine: Health Alert

The CDC issued a Health Alert, about the CDC and FDA's recommended pause in the use of the J&J COVID-19 vaccine, in part, to ensure that the health care provider community is aware of the potential for adverse events and can provide proper management due to the unique treatment required with this type of blood clot. This alert includes specific recommendations for clinicians.

MLN Connects - April 16, 2021

2% Payment Adjustment (Sequestration) Suspended Through December

MLN Connects newsletter for Friday, April 16, 2021

View this edition as a: Webpage | PDF

NEWS

- Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through December
- COVID-19 Vaccine: Check Medicare Eligibility Starting April 16
- Johnson & Johnson COVID-19 Vaccine: Information for Long Term Care Facilities
- Medicare Telehealth Services: Updated List
- Medicare Pays to Help Patients Plan
- Sexual Health: Medicare Covers Preventive Services

COMPLIANCE

- Telehealth Services: Bill Correctly

EVENTS

- Medicare Part A Cost Report: Easier File Uploads for e-Filing in MCReF Webcast - April 29

MULTIMEDIA

- IRF Providers: Assessment of Cognitive Function Web-Based Training
- Diagnosis Coding: Using the ICD-10-CM Web-Based Training - Revised
- Procedure Coding: Using the ICD-10-PCS Web-Based Training - Revised

MLN Connects Special Edition - April 20, 2021 - COVID-19 Update: FDA Revoked the EUA for Bamlanivimab When Administered Alone

On April 16, the FDA revoked the Emergency Use Authorization (EUA) for bamlanivimab, when administered alone, due to a sustained increase in COVID-19 viral variants in the U.S. that are resistant to this antibody therapy. The FDA determined that the known and potential benefits of bamlanivimab, when administered alone, no longer outweigh the known and potential risks.

Medicare will cover and pay for bamlanivimab, when administered alone, for dates of service from November 10, 2020 - April 16, 2021.

The FDA indicates that alternative monoclonal antibody therapies remain appropriate to treat COVID-19 patients, and health care providers may continue using these authorized therapies when administered together:

- Casirivimab & imdevimab
- Bamlanivimab & etesevimab

More Information:

- Fact Sheet for Health Care Providers EUA of Casirivimab and Imdevimab Section 15, Antiviral Resistance
- Fact Sheet for Health Care Providers EUA of Bamlanivimab and Etesevimab Section 15, Antiviral Resistance
- Monoclonal Antibody COVID-19 Infusion webpage

MLN Connects - April 22, 2021

COVID-19: Partnership to Vaccinate Dialysis Patients & Health Care Personnel

MLN Connects newsletter for Thursday, April 22, 2021

View this edition as a: Webpage | PDF

NEWS

- Dialysis Facilities: Partnership to Vaccinate Dialysis Patients and Health Care Personnel
- Chronic Care Management: Comparative Billing Report in April
- Preparedness Resources: Acute Care Delivery at Home
- National Minority Health Month

COMPLIANCE

- Specimen Validity Testing Billed in Combination with Urine Drug Testing: Proper Coding

EVENTS

- Road to Equity: Examining Structural Racism in Health Care Virtual Forum - April 27-28
- Medicare Part A Cost Report: Easier File Uploads for e-Filing in MCReF Webcast - April 29

PUBLICATIONS

- Medicare Billing: Form CMS-1450 and the 837 Institutional - Revised
- Medicare Wellness Visits - Revised

MULTIMEDIA

- Achieving Health Equity Web-Based Training - Revised

MLN Connects Special Edition - April 27, 2021 - CMS Proposes to Enhance the Medical Workforce in Rural and Underserved Communities to Support COVID-19 Recovery and Beyond

Proposed rule would require hospitals to report vaccination rates among health care staff

On April 27, CMS issued a proposed rule (CMS-1752-P) for inpatient and long-term care hospitals that builds on the Biden Administration's key priorities to close health care equity gaps and provide greater accessibility to care. Major provisions in the proposed rule would fund medical residency positions in hospitals in rural and underserved communities to address workforce shortages and require hospitals to report COVID-19 vaccination rates among their workers to contain the spread of the virus.

CMS recognizes the importance of encouraging more health professionals to work in rural hospitals and underserved areas and the need to retain and train high-quality physicians to help address access to health care in these communities. In accordance with the Consolidated Appropriations Act, 2021, CMS is proposing to distribute 1,000 additional physician residency slots to qualifying hospitals, phasing in 200 slots per year over five years. CMS estimates that the additional funding for these additional residency slots, once fully phased in, will total approximately $0.3 billion each year to fund medical residency positions in hospitals to address the workforce shortages.

"Hospitals are often the backbone of rural communities - but the COVID-19 pandemic has hit rural hospitals hard, and too many are struggling to stay afloat," said HHS Secretary Xavier Becerra. "This rule will give hospitals more relief and additional tools to care for COVID-19 patients, and it will also bolster the health care workforce in rural and underserved communities. The Biden Administration is committed to expanding health equity in communities across the country, especially in rural America."

Consistent with President Biden's Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, CMS is also committed to addressing significant and persistent inequities in health outcomes in the U.S. through improving data collection to better measure and analyze disparities across programs and policies. In this proposed rule, CMS is soliciting feedback on opportunities to leverage diverse sets of data (race, Medicare/Medicaid dual eligible status, disability status, LGTBQ+, socioeconomic status, etc.) and new methodological approaches to advance equity through the quality measurement and value-based purchasing programs.

The rule also proposes to implement section 9831 of the American Rescue Plan Act of 2021 to permanently reinstate the imputed floor-wage-index for all-urban States for FY 2022.

Additionally, the rule proposes to update Medicare Fee-for-Service payment rates and policies for acute care inpatient hospitals and long-term care hospitals for fiscal year 2022. CMS estimates total Medicare spending on acute care inpatient hospital services will increase by about $2.5 billion in fiscal year 2022.

Strengthening COVID-19 Ongoing Response

In November 2020, CMS established the New COVID-19 Treatments Add-on Payment (NCTAP) to mitigate any potential financial disincentives for hospitals to provide new COVID-19 treatments during the Public Health Emergency (PHE). The proposed rule would extend the NCTAP for certain eligible technologies through the end of the fiscal year in which the PHE ends.

In addition, the proposed rule seeks to strengthen the ongoing response to the PHE and future health threats by leveraging meaningful measures for quality programs. CMS is proposing the adoption of the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) Measure to require hospitals to report COVID-19 vaccinations of workers in their facilities. This proposed measure is designed to assess whether hospitals are taking steps to limit the spread of COVID-19 among their workforce, reduce the risk of transmission within their facilities, help sustain the ability of hospitals to continue serving their communities through the PHE, and assess the nation's long-term recovery and readiness efforts.

Additionally, CMS is proposing to modify the Promoting Interoperability program requirements for eligible hospitals and critical access hospitals to expand reporting within the Public Health and Clinical Data Exchange Objective. The proposal would

require hospitals to report on all four of the following measures: Syndromic Surveillance Reporting, Immunization Registry Reporting, Electronic Case Reporting, and Electronic Reportable Laboratory Result Reporting.

Requiring hospitals to report these four measures would help to prepare public health agencies to respond to future health threats and a long-term COVID-19 recovery by strengthening public health functions, including early warning surveillance, case surveillance, and vaccine uptake, which will increase the information available to help hospitals better serve their patients. Requiring these measures would enable nationwide syndromic surveillance for early warning of emerging outbreaks and threats; automated case and laboratory reporting for rapid public health response; and local and national visibility on immunization uptake so public health can tailor vaccine distribution strategies.

More Information:

- Proposed rule: CMS will accept comments until June 28
- Fact sheet

MLN Connects - April 29, 2021

NPI: What You Need to Know

MLN Connects newsletter for Thursday, April 29, 2021

View this edition as a: Webpage | PDF

NEWS

- Clinical Diagnostic Laboratories: Resources about the Private Payor Rate-Based CLFS

COMPLIANCE

- Cardiac Device Credits: Medicare Billing

CLAIMS, PRICERS, & CODES

- Coordination of Benefits: Parts A & B Crossover Claims Issue

MLN MATTERS® ARTICLES

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Code 87636

PUBLICATIONS

- SBIRT Services
- NPI: What You Need to Know - Revised

MLN Connects - May 6, 2021

COVID-19: Ambulance Treatment in Place Waiver

MLN Connects newsletter for Thursday, May 6, 2021

View this edition as a: Webpage | PDF

NEWS

- New Program: HRSA COVID-19 Coverage Assistance Fund
- Ground Ambulance Services: Waiver for Treatment in Place
- Hospice Notices of Election: Option to Submit through Electronic Data Interchange
- COVID-19: Work of Hospital Allied & Supportive Care Providers
- IRF, LTCH, & SNF: Report Quality Data by May 17
- Asian American and Pacific Islander Heritage Month & National Mental Health Month
- Osteoporosis: Medicare Covers Bone Mass Measurements

COMPLIANCE

- Chiropractic Services: Comply with Medicare Billing Requirements

EVENTS

- Building COVID-19 Vaccine Confidence Webinar - May 13

MLN MATTERS® ARTICLES

- July 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- New Waived Tests

MLN Connects Special Edition - May 6, 2021 - CMS Increases Medicare Payment for COVID-19 Monoclonal Antibody Infusions

CMS Increases Medicare Payment for COVID-19 Monoclonal Antibody Infusions

New payment policy for at-home administration

As part of the ongoing response to address the COVID-19 pandemic, CMS has increased the Medicare payment rate for administering monoclonal antibodies to treat beneficiaries with COVID-19, continuing coverage under the Medicare Part B COVID-19 vaccine benefit. Beneficiaries pay nothing out of pocket, regardless of where the service is furnished - including in a physician's office, health care facility, or at home.

Effective May 6, the national average payment rate will increase from $310 to $450 for most health care settings. In support of providers' efforts to prevent the spread of COVID-19, CMS will also establish a higher national payment rate of $750 when monoclonal antibodies are administered in the beneficiary's home, including the beneficiary's permanent residence or temporary lodging (e.g., hotel/motel, cruise ship, hostel, or homeless shelter).

The new national payment rate for at-home administration of monoclonal antibodies accounts for increased costs associated with the one-on-one nature of this care model. These higher national average payment rates reflect additional information provided to CMS about the costs of providing these services in a safe and timely manner, such as clinical staff and personal protective equipment. This action also means Medicare payments to providers and suppliers will be more aligned to their costs to administer these products.

CMS's goal during the COVID-19 public health emergency has been to ensure that the agency is supporting beneficiary access to care. This new policy is based on timely, valuable input from stakeholders including the home health and ambulatory infusion industries on the costs associated with administering monoclonal antibodies.

CMS is updating the set of toolkits for providers, states, and insurers to help the health care system swiftly administer monoclonal antibody treatment with these new Medicare payment rates on the Monoclonal Antibody COVID-19 Infusion webpage.

In addition, CMS is updating coding resources for providers on the COVID-19 Vaccines and Monoclonal Antibodies webpage.

For additional clinical information about COVID-19 monoclonal antibodies, please visit:

- NIH Anti-SARS-CoV-2 Monoclonal Antibodies webpage
- NIH Therapeutic Management of Adults With COVID-19 webpage
- HHS COVID-19 Resources for Health Care Professionals webpage

MLN Connects Special Edition - May 11, 2021 - CMS Expanding Efforts to Grow COVID-19 Vaccine Confidence and Uptake Amongst Nation's Most Vulnerable

CMS Builds on Whole-of-Government COVID-19 Response with Vaccination Education, Offering, and Reporting

As part of the ongoing response to address the COVID-19 pandemic and to improve health care access and reduce the risk of severe illness and death from COVID-19, CMS issued a rule that will ensure long-term care facilities, and residential facilities serving clients with intellectual disabilities, educate and offer the COVID-19 vaccine to residents, clients, and staff. These

requirements apply to Long-Term Care (LTC) facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs-IID) and align with existing requirements for influenza and pneumococcal vaccines in LTC facilities.

The rule also requires LTC facilities to report weekly COVID-19 vaccination status data for both residents and staff. The new vaccination reporting requirement will not only assist in monitoring uptake amongst residents and staff but will also aid in identifying facilities that may be in need of additional resources and/or assistance to respond to the COVID-19 pandemic.

"These new requirements reinforce CMS' commitment of ensuring equitable vaccine access for Medicare and Medicaid beneficiaries," said Dr. Lee Fleisher, MD, CMS Chief Medical Officer and Director of CMS' Center for Clinical Standards and Quality (CCSQ). "Today's announcement directly aids nursing home residents and people with intellectual or developmental disabilities who have been disproportionately affected by COVID-19. Our goal is to increase COVID-19 vaccine confidence and acceptance among these individuals and the staff who serve them."

To ensure LTC facilities receive support for COVID-19 vaccination efforts, they are now required to report weekly vaccination data of residents and staff to the CDC National Healthcare Safety Network (NHSN), the nation's most widely used health care-associated infection tracking system. LTC facilities are already required to report COVID-19 testing, case, and mortality data to the NHSN for residents and staff but have not been required to report vaccination data. As data becomes available, CMS will post facility-specific vaccination status information reported to the NHSN for viewing by facilities, stakeholders, and the public on CMS' COVID-19 Nursing Home Data website.

While this announcement is specific to LTC facilities and ICFs-IID, CMS is also seeking comment on opportunities to expand these policies to help encourage vaccine uptake and access in other congregate care settings, such as psychiatric residential treatment facilities, group homes, and assisted living facilities. By requiring vaccine education and offering within LTC facilities and ICFs-IIDs, CMS is improving health care access and reducing the risk of severe illness and death from COVID-19.

More Information:

- Interim final rule
- COVID-19 Vaccine Immunization Requirements for Residents and Staff

MLN Connects - May 13, 2021

Cognitive Impairment: Medicare Provides Opportunities to Detect & Diagnose

MLN Connects newsletter for Thursday, May 13, 2021

View this edition as a: Webpage | PDF

NEWS

- Cognitive Impairment: Medicare Provides Opportunities to Detect & Diagnose
- Open Payments: Review & Dispute Data by May 15
- Medicare Shared Savings Program Application: NOIA Opens June 1
- Women's Health: Medicare Covers Preventive Services

COMPLIANCE

- Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

CLAIMS, PRICERS, & CODES

- FY 2021 SNF PC Pricer

EVENTS

- IRF Quality Reporting Program: Achieving a Full AIF Webinar - May 19
- Medicare Shared Savings Program: Establishing a Repayment Mechanism Webcast - May 27

MLN MATTERS® ARTICLES

- Update to Rural Health Clinic (RHC) Payment Limits - Revised

MULTIMEDIA

- Community Champions Video Launch

- SNF: Cognitive & Mood Assessment Web-Based Training Series
- Part A Cost Reports Webcast: Audio Recording & Transcript

MLN Connects - May 20, 2021

Mental Health: Medicare Covers Preventive Services

MLN Connects newsletter for Thursday, May 20, 2021

View this edition as a: Webpage | PDF

NEWS

- Hospice Outcomes & Patient Evaluation: Submit Beta Test Application by June 14
- Mental Health: Medicare Covers Preventive Services

COMPLIANCE

- Physician Orders: Provider Minute Video

EVENTS

- Medicare Shared Savings Program: Establishing a Repayment Mechanism Webcast - May 27
- LTCH Quality Reporting Program: Achieving a Full APU Webinar - May 27

MLN MATTERS® ARTICLES

- Requirement to Report DMEPOS Licensure, Product, & Service Changes
- 2021 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List
- Medicare Fee-for-Service (FFS) Coverage of Costs for Kidney Acquisitions in Maryland Waiver (MW) Hospitals for Medicare Advantage (MA) Beneficiaries
- October Quarterly Update to 2021 Annual Update of HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement
- Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) -- Manual Instructions
- Waiver of Coinsurance and Deductible for Hepatitis B Preventive Service Vaccine Code, Section 4104 of the Patient Protection and Affordable Health Care Act (the Affordable Care Act), Removal of Barriers to Preventive Services in Medicare

PUBLICATIONS

- Medical Record Maintenance & Access Requirements

MLN Connects - May 27, 2021

Critical Care E/M Services: Comparative Billing Report

MLN Connects newsletter for Thursday, May 27, 2021

View this edition as a: Webpage | PDF

NEWS

- Critical Care Evaluation & Management Services: Comparative Billing Report in May
- Medicare Shared Savings Program: Submit Notice of Intent to Apply Beginning June 1
- Submit Medicare GME Affiliation Agreements during COVID-19 PHE by January 1

COMPLIANCE

- Home Health LUPA Threshold: Bill Correctly

EVENTS

- Hospice Quality Reporting Program: Composite Quality Measure Webinar - June 2

MLN MATTERS® ARTICLES

- Addition of the Shared System CWF to the Business Requirements for the Healthcare Common Procedure Coding System (HCPCS) codes U0002QW and 87635QW Mentioned in Change Request 11765
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--July 2021
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2021 Update
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update

PUBLICATIONS

- Collaborative Patient Care is a Provider Partnership - Revised
- Complying with Medicare Signature Requirements - Revised
- Medicare Diabetes Prevention & Diabetes Self-Management Training - Revised
- Medicare Mental Health - Revised

MLN MATTERS

2021 DMEPOS HCPCS Code Jurisdiction List

MLN Matters Number: MM12134
Related CR Release Date: May 7, 2021
Related CR Transmittal Number: R10737CP
Related Change Request (CR) Number: 12134
Effective Date: January 1, 2021
Implementation Date: June 7, 2021

CR 12134 informs you about changes to the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) jurisdiction spreadsheet. CMS updates annually the spreadsheet containing a list of the HCPCS codes for DME MACs and MAC Part B jurisdictions. The spreadsheet shows which MAC has jurisdiction for which Healthcare Common Procedure Coding System (HCPCS) codes. The update shows added codes and discontinued (deleted) codes each year. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12134.

Additional Payment Edits for DMEPOS Suppliers of Custom Fabricated and Prefabricated (Custom Fitted) Orthotics. Update to Change Request (CR) 3959, CR 8390, and CR 8730

Release Date: May 20, 2021
CR Transmittal Number: R10801OTN
Change Request (CR) Number: 12282
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12282 communicates the addition of HCPCS codes which require the use of a licensed/certified orthotist or prosthetist for furnishing of orthotics or prosthetics under the following product and service codes:

1. OR01 Orthoses: Custom Fabricated
2. OR02 Orthoses: Prefabricated (Custom Fitted)

View the complete CMS Change Request (CR)12282.

April Quarterly Update for 2021 DMEPOS Fee Schedule

MLN Matters Number: MM12193
Related CR Release Date: March 12, 2021
Related CR Transmittal Number: R10681CP
Related Change Request (CR) Number: 12193
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

CR 12193 tells you about the changes to the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedules that Medicare updates on a quarterly basis, when necessary, 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)12193.

July 2021 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

MLN Matters Number: MM12244
Related CR Release Date: April 27, 2021
Related CR Transmittal Number: R10708CP
Related Change Request (CR) Number: 12244
Effective Date: July 1.2021
Implementation Date: July 6,2021

CR 12244 informs you about the Average Sales Price (ASP) methodology, which is based on quarterly data manufacturers submit to CMS. CMS gives the MACs ASP and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the Outpatient Prospective Payment System (OPPS) are incorporated into the Outpatient Code Editor (OCE) through separate instructions in Chapter 4, Section 50 of the Medicare Claims Processing Manual. Please make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12244.

New Provider Enrollment Administrative Action Authorities

MLN Matters Number: SE21003
Article Release Date: March 24, 2021

SE 21003 gives you important information about recently issued regulatory authorities. These authorities affect currently enrolled Medicare providers and suppliers, or prospective providers and suppliers. You and your staff should be aware of these new authorities.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)21003.

Quarterly Update for the DMEPOS CBP - July 2021

MLN Matters Number: MM12225
Related CR Release Date: March 31, 2021
Related CR Transmittal Number: R10688CP
Related Change Request (CR) Number: 12225
Effective Date: July 1, 2021
Implementation Date: July 6, 2021

CR 12225 updates the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) files on a quarterly basis to implement necessary changes to HCPCS codes, ZIP codes, and single payment amounts. CR12225 provides specific instruction for implementing the DMEPOS CBP files.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12225.

RARC, CARC, MREP & PC Print Update

MLN Matters Number: MM12102
Related CR Release Date: March 11, 2021
Related CR Transmittal Number: R10650CP
Related Change Request (CR) Number: 12102
Effective Date: July 1, 2021
Implementation Date: July 6, 2021

CR 12102 tells you of updates to the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs Medicare's Shared System Maintainers (SSMs) to update Medicare Remit Easy Print (MREP) and PC Print. Make sure billing staffs are aware of these updates. If you use the MREP or PC Print software, be sure to get the updated software.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12102.

RARC, CARC, MREP & PC Print Update

MLN Matters Number: MM12220
Related CR Release Date: May 21, 2021
Related CR Transmittal Number: R10814CP
Related Change Request (CR) Number: 12220
Effective Date: October 1, 2021
Implementation Date: October 4, 2021

CR 12220 tells you about updates to the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) lists and instructs the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print software. Make sure your billing staffs are aware of these updates. If you use MREP or PC Print, be sure to get the latest version when available.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12220.

Requirement to Report DMEPOS Licensure, Product, & Service Changes

MLN Matters Number: SE21005
Article Release Date: May 10, 2021

SE 21005 informs you about the requirement to update your Medicare enrollment record with changes to the products or services for which you bill Medicare. Also, you must report changes to applicable DMEPOS licensure information.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)21005.

Updated Billing Requirements for HIT Services on or After January 1, 2021

MLN Matters Number: MM12108
Related CR Release Date: March 15, 2021
Related CR Transmittal Number: R10621CP
Related Change Request (CR) Number: 12108
Effective Date: January 1, 2021
Implementation Date: July 6, 2021

CR 12108 informs you of new changes to Medicare claims processing for Home Infusion Therapy (HIT) services on or after January 1, 2021. Make sure your billing staffs are aware of this change.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12108.