DME Happenings

Jurisdiction A

March 2021

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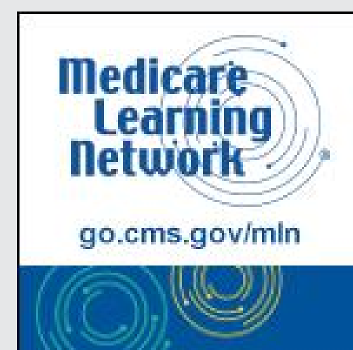
Don't be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select "Subscribe" on the bottom right-hand corner of any page.



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

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Healthcare Solutions

Noridian Healthcare Solutions, LLC

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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/index. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

CMS has implemented a series of educational articles within the Medicare Leaning Network (MLN), titled "MLN Matters", which will continue to be published in Noridian bulletins. The Medicare Learning Network is a brand name for official CMS national provider education products designed to promote national consistency of Medicare provider information developed for CMS initiatives.

CMS Quarterly Provider Updates

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

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

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

Physician Documentation Responsibilities

Suppliers are encouraged to remind physicians of their responsibility in completing and signing the Certificate of Medical Necessity (CMN). It is the physician's and supplier's responsibility to determine the medical need for, and the utilization of, all health care services. The physician and supplier should ensure that information relating to the beneficiary's condition is correct. Suppliers are also encouraged to include language in their cover letters to physicians reminding them of their responsibilities.

Source: CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 5, Section 5.3.2

Automatic Mailing/Delivery of DMEPOS Reminder

Suppliers may not automatically deliver DMEPOS to beneficiaries unless the beneficiary, physician, or designated representative has requested additional supplies/equipment. The reason is to assure that the beneficiary actually needs the DMEPOS.

A beneficiary or their caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. The supplier must not automatically dispense a quantity of supplies on a predetermined regular basis.

A request for refill is different than a request for a renewal of a prescription. Generally, the beneficiary or caregiver will rarely keep track of the end date of a prescription. Furthermore, the physician is not likely to keep track of this. The supplier is the one who will need to have the order on file and will know when the prescription will run out and a new order is needed. It is reasonable to expect the supplier to contact the physician and ask for a renewal of the order. Again, the supplier must not automatically mail or deliver the DMEPOS to the beneficiary until specifically requested.

Source: Internet Only Manual (IOM), Publication 100-4, Medicare Claims Processing Manual, Chapter 20, Section 200

Refunds to Medicare

When submitting a voluntary refund to Medicare, please include the Overpayment Refund Form found on the Forms page of the Noridian DME website. This form provides Medicare with the necessary information to process the refund properly. This is an interactive form which Noridian has created to make it easy for you to type and print out. We've included a highlight button to ensure you don't miss required fields. When filling out the form, be sure to refer to the Overpayment Refund Form instructions.

Processing of the refund will be delayed if adequate information is not included. Medicare may contact the supplier directly to find out this information before processing the refund. If the specific patient name, Medicare number or claim number information is not provided, no appeal rights can be afforded.

Suppliers are also reminded that "The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims."

Source: Transmittal 50, Change Request 3274, dated July 30, 2004

Telephone Reopenings: Resources for Success

This article provides the following information on Telephone Reopenings: contact information, hours of availability, required elements, items allowed through Telephone Reopenings, those that must be submitted as a redetermination, and more.

Per the CMS Internet-Only Manual (IOM) Publication 100-04, Chapter 34, Section 10, reopenings are separate and distinct from the appeals process. Contractors should note that while clerical errors must be processed as reopenings, all decisions on granting reopenings are at the discretion of the contractor.

Section 10.6.2 of the same Publication and Chapter states a reopening must be conducted within one year from the date of the initial determination.

Question	Answer
How do I request a Telephone Reopening?	To request a reopening via telephone, call 1-866-419-9458
What are the hours for Telephone Reopenings?	Monday - Friday 8 a.m. - 5 p.m. ET Holiday and Training Closures can be found at https://med.noridianmedicare.com/web/jadme/contact/holiday-schedule and https://med.noridianmedicare.com/web/jadme/contact/training-closures
What information do I need before I can initiate a Telephone Reopening?	Before a reopening can be completed, the caller must have ***all*** of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed. Verified by Customer Service Representative (CSR) or IVR • National Provider Identifier (NPI) • Provider Transaction Access Number (PTAN) • Last five digits of Tax Identification Number (TIN) Verified by CSR • Caller's name • Provider/Facility name • Beneficiary Medicare number • Beneficiary first and last name • Date of Service (DOS) • Last five digits of Claim Control Number (CCN) • HCPCS code(s) in question • Corrective action to be taken Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

Question	Answer
What may I request as a Telephone Reopening?	The following is a list of clerical errors and omissions that **may** be completed as a Telephone Reopening. Note: This list is not all-inclusive. • Diagnosis code changes or additions • Date of Service (DOS) changes • HCPCS code changes • Certain modifier changes or additions (not an all-inclusive list) If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.
What is not accepted as a Telephone Reopening?	The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation. • Overutilization denials that require supporting medical records • Certificate of Medical Necessity (CMN) issues (applies to Telephone Reopenings only) • Durable Medical Equipment Information Form (DIF) issues (applies to both Written and Telephone Reopenings) • Oxygen break in service (BIS) issues • Overpayments or reductions in payment. Submit request on Overpayment Refund Form • Medicare Secondary Payer (MSP) issues • Claims denied for timely filing (older than one year from initial determination) • Complex Medical Reviews or Additional Documentation Requests (ADRs) • Change in liability • Recovery Auditor-related items • Certain modifier changes or additions: EY, GA, GY, GZ, K0 - K4, KX, RA (cannot be added), RB, RP • Certain HCPCS codes: E0194, E1028, K0108, K0462, L4210, All HCPCS in Transcutaneous Electrical Nerve Stimulator (TENS) LCD, All National Drug Codes (NDCs), miscellaneous codes and codes that require manual pricing The above is not an all-inclusive list.
What do I do when I have a large amount of corrections?	If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.
Where can I find more information on Telephone Reopenings?	• Supplier Manual Chapter 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.

2020 1099 Tax Forms Available on NMP

The 2020 1099-INT and 1099-MISC are now available on the Noridian Medicare Portal (NMP). The 1099 inquiry is available through the Financials function.

1099s on the portal are a courtesy copy of the official 1099 form that was mailed to your facility. View the 1099 Inquiry section of the Portal Guide to download your copy today.

2020 Expansion Prior Authorization for Lower Limb Prosthetics Nationwide

Effective for dates of service on/after December 1, 2020, the Condition of Payment Prior Authorization (COPPA) program will be required nationwide for the six codes below for Lower Limb Prostheses.

- PA requests may be submitted November 17, 2020 for dates of service December 1, 2020 and after.
- PA will be required for these six LLP HCPCS codes: **L5856, L5857, L5858, L5973, L5980, and L5987**

Please refer to the Prior Authorization for Lower Limb Prosthetics for more information.

Ankle-Foot Orthosis (AFO) (HCPCS L4360 & L4361) 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:

- **L4360**: WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE

MATERIAL, PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE
- **L4361**: WALKING BOOT, PNEUMATIC AND/OR VACUUM, WITH OR WITHOUT JOINTS, WITH OR WITHOUT INTERFACE MATERIAL, 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.

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

Suppliers can save time and resources by using available appeal status and appeal submission functionalities within the Noridian Medicare Portal (NMP). NMP allows suppliers to reduce telephone calls associated with appeal status inquiries, decrease efforts associated with the submission of duplicate appeals, and avoid postal mail delays by directly submitting their redetermination and related documentation securely through NMP. To help suppliers learn more about what NMP offers, DME-on-Demand tutorials are available.

Noridian Medicare Portal: Appeal Submission and Status

Check out NMP today.

Extension of Medicare IVIG Demonstration through December 31, 2023

The Medicare Intravenous Immune Globulin (IVIG) Demonstration, was scheduled to end on December 31, 2020, but has been extended through December 31, 2023.

Beneficiaries enrolled as of November 15, 2020, do not need to re-enroll. New beneficiaries can continue to enroll, in accordance with the demonstration procedures.

For more information about the demonstration, see https://med.noridianmedicare.com/web/ivig

Glucose (HCPCS A4253) 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:

- **A4253**: BLOOD GLUCOSE TEST OR REAGENT STRIPS FOR HOME BLOOD GLUCOSE MONITOR, PER 50 STRIPS

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.

Learn More About the Serial Claims Initiative

CMS considers serial claims to be claims that are so closely related that the same payment decision should be applied to each claim for the same HCPC and beneficiary. Once the reason for denial for one claim that appears on the serial claim master list is resolved at any appeal level, the DME MACs will identify other claims in the same series that were denied for the same or similar reasons, and take that determination into consideration when adjudicating such claims. For more information and a list of qualifying HCPCs review Serial Claims Review Initiative article on our website.

Lower Limb Orthoses Clinician Letter

Did you know that Noridian offers Clinician directed letters for Lower Limb Orthoses? These letters will remind Clinicians of the importance of detailed medical records when providing a lower limb orthosis to their patients. If you are having trouble

getting the needed documentation from a Clinician, you can direct that Clinician to the Noridian Medicare website, or you can send a copy of the letter directly to the Clinician.

Now Available-Parenteral Nutrition Modifier Tool

Noridian now has a Parenteral Nutrition Pricing Calculator which will allow suppliers to determine the correct number of units to submit for Parenteral Nutrition claims. Many pricing and Parenteral HCPCS codes can be found by utilizing this tool. Visit the Parenteral Calculator webpage to access the resources, related articles, and the Manual Pen Pricing Tool we have available.

Oxygen Clinician Letter

Did you know that Noridian offers Clinician directed letters for oxygen? These letters will remind Clinicians of the importance of detailed medical records for Continued Medical Necessity, Home Oxygen Initial Qualification Testing, and Oxygen and Oxygen Equipment. If you are having trouble getting the needed documentation from a Clinician, you can direct that Clinician to the Noridian Medicare website, or you can send a copy of the letter directly to the Clinician.

Service Specific Post-Payment Review: September 2020 - November 2020

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 September 2020 - November 2020 can be located on our Medical Record Review Results webpage:

- Knee Orthosis
- Urological Supplies

Service Specific Post-Payment Review: October 2020 - December 2020

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 October 2020 - December 2020 can be located on our Medical Record Review Results webpage:

- Ostomy Supplies

Surgical Dressings (HCPCS A6010, A6196, and A6197) 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:

- **A6010**: COLLAGEN BASED WOUND FILLER, DRY FORM, STERILE, PER GRAM OF COLLAGEN
- **A6196**: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE 16 SQ. IN. OR LESS, EACH DRESSING
- **A6197**: ALGINATE OR OTHER FIBER GELLING DRESSING, WOUND COVER, STERILE, PAD SIZE MORE THAN 16 SQ. IN. BUT LESS THAN OR EQUAL TO 48 SQ. IN., EACH DRESSING

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.

MEDICAL POLICIES AND COVERAGE ....

Completion of Certificates of Medical Necessity (CMN) - Annual Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Completion of Certificates of Medical Necessity (CMN) - Annual Reminder, 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

Glucose Monitors and External Infusion Pumps Open Meeting Agenda

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Glucose Monitors and External Infusion Pumps Open Meeting Agenda, has been created and published to our website.

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- Locate/select article title

Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder, has been created and published to our website.

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- Locate/select article title

LCD Revisions Summary for December 31, 2020

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

EXTERNAL INFUSION PUMPS

LCD

Revision Effective Date: 01/01/2021

HCPCS CODES:

Removed: HCPCS codes G0068, G0069, G0070 from Group 3 Codes. These HCPCS codes are invalid for submission to the DME MACs, effective 01/01/21.

12/31/2020: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to CMS HCPCS coding determinations.

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

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

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

MyoPro® (Myomo, Inc.) Assist Device - Correct Coding - Revised

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

View the locally hosted 2021 DMD articles.

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- Locate/select article title

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

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

View the locally hosted 2021 DMD articles.

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- Locate/select article title

Open Meeting Announcement - Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, and Respiratory Assist Devices Proposed Local Coverage Determinations (LCDs)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Open Meeting Announcement - Oral Appliances for Obstructive Sleep Apnea, Positive Airway Pressure (PAP) Devices for the Treatment of

Obstructive Sleep Apnea, and Respiratory Assist Devices Proposed Local Coverage Determinations (LCDs), has been created and published to our website.

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- Locate/select article title

Proposed Local Coverage Determinations (LCDs) Released for Comment - Enteral Nutrition, Oral Appliances for Obstructive Sleep Apnea, Parenteral Nutrition, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, and Respiratory Assist Devices

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Proposed Local Coverage Determinations (LCDs) Released for Comment - Enteral Nutrition, Oral Appliances for Obstructive Sleep Apnea, Parenteral Nutrition, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, and Respiratory Assist Devices, has been created and published to our website.

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- Locate/select article title

MLN CONNECTS

MLN Connects Special Edition - December 1, 2020 - Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients

On December 1, CMS released the annual Physician Fee Schedule (PFS) final rule, prioritizing CMS' investment in primary care and chronic disease management by increasing payments to physicians and other practitioners for the additional time they spend with patients, especially those with chronic conditions. The rule allows non-physician practitioners to provide the care they were trained and licensed to give, cutting red tape so health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. This final rule takes steps to further implement President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors including prioritizing the expansion of proven alternatives like telehealth.

"During the COVID-19 pandemic, actions by the Trump Administration have unleashed an explosion in telehealth innovation, and we're now moving to make many of these changes permanent," said HHS Secretary Alex Azar. "Medicare beneficiaries will now be able to receive dozens of new services via telehealth, and we'll keep exploring ways to deliver Americans access to health care in the setting that they and their doctor decide makes sense for them."

"Telehealth has long been a priority for the Trump Administration, which is why we started paying for short virtual visits in rural areas long before the pandemic struck," said CMS Administrator Seema Verma. "But the pandemic accentuated just how transformative it could be, and several months in, it's clear that the health care system has adapted seamlessly to a historic telehealth expansion that inaugurates a new era in health care delivery."

Finalizing Telehealth Expansion and Improving Rural Health

Before the COVID-19 Public Health Emergency (PHE), only 15,000 Fee-for-Service beneficiaries each week received a Medicare telemedicine service. Since the beginning of the PHE, CMS has added 144 telehealth services, such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services, that are covered by Medicare through the end of the PHE. These services were added to allow for safe access to important health care services during the PHE. As a result, preliminary data show that between mid-March and mid-October 2020, over 24.5 million out of 63 million beneficiaries and enrollees have received a Medicare telemedicine service during the PHE.

This final rule delivers on the President's recent Executive Order on Improving Rural Health and Telehealth Access by adding more than 60 services to the Medicare telehealth list that will continue to be covered beyond the end of the PHE, and we will continue to gather more data and evaluate whether more services should be added in the future. These additions allow beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services. Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home. However, this is an important step, and as a result, Medicare beneficiaries in rural areas will have more convenient access to health care.

Additionally, CMS is announcing a commissioned study of its telehealth flexibilities provided during the COVID-19 PHE. The study will explore new opportunities for services where telehealth and virtual care supervision, and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity, whether they are being treated in the hospital or at home.

Payment for Office/Outpatient Evaluation and Management (E/M) and Comparable Visits

Last year, CMS finalized a historic increase in payment rates for office/outpatient face-to-face E/M visits that goes into effect in 2021. The Medicare population is increasing, with over 10,000 beneficiaries joining the program every day. Along with this growth in enrollment is increasing complexity of beneficiary health care needs, with more than two-thirds of Medicare beneficiaries having two or more chronic conditions. Increasing the payment rate of E/M office visits recognizes this demand and ensures clinicians are paid appropriately for the time they spend on coordinating care for patients, especially those with chronic conditions. These payment increases, informed by recommendations from the American Medical Association (AMA),

support clinicians who provide crucial care for patients with dementia or manage transitions between the hospital, nursing facilities, and home.

Under this final rule, CMS continues to prioritize this investment in primary care and chronic disease management by similarly increasing the value of many services that are similar to E/M office visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, and physical and occupational therapy evaluation services. These adjustments ensure CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients.

"This finalized policy marks the most significant updates to E/M codes in 30 years, reducing burden on doctors imposed by the coding system and rewarding time spent evaluating and managing their patients' care," Administrator Verma added. "In the past, the system has rewarded interventions and procedures over time spent with patients - time taken preventing disease and managing chronic illnesses."

In addition to the increase in payment for E/M office visits, simplified coding and documentation changes for Medicare billing for these visits will go into effect beginning January 1, 2021. The changes modernize documentation and coding guidelines developed in the 1990s, and come after extensive stakeholder collaboration with the AMA and others. These changes will significantly reduce the burden of documentation for all clinicians, giving them greater discretion to choose the visit level based on either guidelines for medical decision-making (the process by which a clinician formulates a course of treatment based on a patient's information, i.e., through performing a physical exam, reviewing history, conducting tests, etc.) or time dedicated with patients. These changes are expected to save clinicians 2.3 million hours per year in administrative burden so that clinicians can spend more time with their patients.

Professional Scope of Practice and Supervision

As part of the Patients Over Paperwork Initiative, the Trump Administration is cutting red tape so that health care professionals can practice at the top of their license and spend more time with patients instead of on unnecessary paperwork. The PFS final rule makes permanent several workforce flexibilities provided during the COVID-19 PHE that allow non-physician practitioners to provide the care they were trained and licensed to give, without imposing additional restrictions by the Medicare program.

Specifically, CMS is finalizing the following changes:

- Certain non-physician practitioners, such as nurse practitioners and physician assistants, can supervise the performance of diagnostic tests within their scope of practice and state law, as they maintain required statutory relationships with supervising or collaborating physicians.
- Physical and occupational therapists will be able to delegate "maintenance therapy" - the ongoing care after a therapy program is established - to a therapy assistant.
- Physical and occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare can review and verify, rather than re-document, information already entered by other members of the clinical team into a patient's medical record. As a result, practitioners have the flexibility to delegate certain types of care, reduce duplicative documentation, and supervise certain services they could not before, increasing access to care for Medicare beneficiaries.

For More Information:

- Final Rule
- Physician Fee Schedule Final Rule fact sheet
- Quality Payment Program Final Rule fact sheet and FAQs
- Medicare Diabetes Prevention Program fact sheet

MLN Connects Special Edition - December 2, 2020 - Trump Administration Finalizes Policies to Give Medicare Beneficiaries More Choices around Surgery

Outpatient Prospective Payment System and Ambulatory Surgical Center final rule empowers beneficiary choices and unleashes competition to lower costs and improve innovation

On December 2, CMS finalized policy changes that will give Medicare patients and their doctors greater choices to get care at a lower cost in an outpatient setting. The Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) final rules will increase value for Medicare beneficiaries and reflect the agency's efforts to transform the health care delivery system through competition and innovation. These changes implement the Trump Administration's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, and will take effect on January 1, 2021.

"President Trump's term in office has been marked by an unrelenting drive to level the playing field and boost competition at every turn," said CMS Administrator Seema Verma. "Today's rule is no different. It allows doctors and patients to make decisions about the most appropriate site of care, based on what makes the most sense for the course of treatment and the patient without micromanagement from Washington."

In this final rule, CMS will begin eliminating the Inpatient Only (IPO) list of 1,700 procedures for which Medicare will only pay when performed in the hospital inpatient setting over a three-year transitional period, beginning with some 300 primarily musculoskeletal-related services. The IPO list will be completely phased out by CY 2024. This will make these procedures eligible to be paid by Medicare when furnished in the hospital outpatient setting when outpatient care is appropriate, as well as continuing to be payable when furnished in the hospital inpatient setting when inpatient care is appropriate, as determined by the physician. In the short term, as hospitals face surges in patients with complications from COVID-19, being able to provide treatment in outpatient settings will allow non-COVID-19 patients to get the care they need.

In addition to putting decisions on the best site of care in the hands of physicians, allowing more procedures to be done in an outpatient setting also provides for lower-cost options that benefit the patient.

For example, thromboendarterectomy (HCPCS code 35372) is a surgical procedure that removes chronic blood clots from the arteries in the lung. If this procedure is performed in an inpatient setting, a patient who has not had other health care expenses that year would have a deductible of about $1500. In contrast, the copayment for this procedure for the same patient in the outpatient setting would be about $1150. Patient safety and quality of care will be safeguarded by the doctor's assessment of the risk of a procedure or service to the individual beneficiary and their selection of the most appropriate setting of care based on this risk. This is in addition to state and local licensure requirements, accreditation requirements, hospital conditions of participation, medical malpractice laws, and CMS quality and monitoring initiatives and programs.

Beginning January 1, 2021, we are adding eleven procedures to the ASC Covered Procedures List (CPL), including total hip arthroplasty (CPT 27130), under our standard review process. Additionally, we are revising the criteria we use to add surgical procedures to the ASC CPL, providing that certain criteria we used to add surgical procedures to the ASC CPL in the past will now be factors for physicians to consider in deciding whether a specific beneficiary should receive a covered surgical procedure in an ASC. Using our revised criteria, we are adding an additional 267 surgical procedures to the ASC CPL beginning January 1, 2021. Finally, we are adopting a notification process for surgical procedures the public believes can be added to the ASC CPL under the criteria we are retaining.

CMS is announcing that it will continue its policy of paying for 340B-acquired drugs at average sales price minus 22.5% after the July 31, 2020, decision of the Court of Appeals for the D.C. Circuit upholding the current policy. This policy lowers out-of-pocket drug costs for Medicare beneficiaries by letting them share in the discount that hospitals receive under the 340B program. Since this policy went into effect in 2018, Medicare beneficiaries have saved nearly $1 billion on drug costs, with expected Medicare beneficiary drug cost savings of over $300 million in CY 2021.

As part of the agency's Patients Over Paperwork Initiative, which is aimed at reducing burden for health care providers, CMS is establishing a simple updated methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating). The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Care Compare tool (the successor to Hospital Compare) for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Care Compare, the Overall Star Rating helps patients make better-informed health care decisions. Veterans Health Administration hospitals will be added to CMS' Care Compare, which will help veterans understand hospital quality

within the VA system. Overall, these changes will reduce provider burden, improve the predictability of the star ratings, and make it easier for patients to compare ratings between similar hospitals.

In response to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is not finalizing its proposal to stratify readmission measures under the new methodology based on dually eligible patients, but will continue to study the issue to find the best way to convey quality of care for this vulnerable population.

Finally, in order to address the ongoing public health emergency, CMS is finalizing a new requirement for the nation's 6,200 hospitals and critical access hospitals to report information about their inventory of therapeutics to treat COVID-19. This reporting will provide the information needed to track and accurately allocate therapeutics to the hospitals that need additional inventory to care for patients and meet surge needs.

For More Information:

- Final Rule
- Fact Sheet

MLN Connects - December 3, 2020

Register for Physician Fee Schedule Call on 12/10

MLN Connects® for Thursday, December 3, 2020

View this edition as a: Webpage | PDF

NEWS

- Comprehensive Strategy to Enhance Hospital Capacity Amid COVID-19 Surge
- CMS Updates Coverage Policies for Artificial Hearts and Ventricular Assist Devices
- PEPPERs for Short-term Acute Care Hospitals: Download December 4 through 14
- Provider Enrollment Application Fee Amount for CY 2021

COMPLIANCE

- Hospices: Create an Effective Plan of Care

EVENTS

- Hospital Price Transparency Webcast - December 8
- Interoperability and Patient Access Final Rule Call - December 9
- Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call - December 10

MLN MATTERS® ARTICLES

- 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 - Revised

PUBLICATIONS

- Major Joint Replacement (Hip or Knee) - Revised
- Provider Compliance Tips for Tracheostomy Supplies - Revised

MULTIMEDIA

- Diagnosis Coding: Using the ICD-10-CM Web-Based Training Course - Revised
- Procedure Coding: Using the ICD-10-PCS Web-Based Training Course - Revised

MLN Connects Special Edition - December 3, 2020 - COVID-19 Antibody Treatment and Enforcement Discretion Reminder

CMS TAKES FURTHER STEPS TO ENSURE MEDICARE BENEFICIARIES HAVE WIDE ACCESS TO COVID-19 ANTIBODY TREATMENT

The U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the investigational monoclonal antibody therapy, casirivimab and imdevimab, administered together, for the treatment of mild-to-moderate COVID-19 in adults and pediatric patients with positive COVID-19 test results who are at high risk for progressing to severe COVID-19 and/or hospitalization. Casirivimab and imdevimab, administered together, may only be administered in settings in which health care providers have immediate access to medications to treat a severe infusion reaction, such as anaphylaxis, and the ability to activate the Emergency Medical System (EMS), as necessary. Review the Fact Sheet for Health Care Providers EUA of Casirivimab and Imdevimab regarding the limitations of authorized use when administered together.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for these infusions the same way it covers and pays for COVID-19 vaccines (when furnished consistent with the EUA).

CMS identified specific code(s) for the monoclonal antibody product and specific administration code(s) for Medicare payment: Regeneron's Antibody Casirivimab and Imdevimab (REGN-COV2), EUA effective November 21, 2020.

Q0243:

Long descriptor: Injection, casirivimab and imdevimab, 2400 mg

Short descriptor: casirivimab and imdevimab

M0243:

Long Descriptor: intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring

Short Descriptor: casirivi and imdevi infusion

Additional Resources:

- List COVID-19 monoclonal antibody infusion billing codes, payment allowances and effective dates
- Monoclonal Antibody COVID-19 Infusion Program Instruction
- CMS COVID-19 Vaccine Provider Toolkit

COVID-19 VACCINES AND MONOCLONAL ANTIBODY INFUSION: ENFORCEMENT DISCRETION RELATING TO SNF CONSOLIDATED BILLING

To facilitate the efficient administration of COVID-19 vaccines to Skilled Nursing Facility (SNF) residents, CMS is exercising enforcement discretion with respect to statutory provisions requiring consolidated billing by SNFs as well as any associated statutory references and implementing regulations, including as interpreted in pertinent guidance. Through the exercise of this discretion, we will allow Medicare-enrolled immunizers working within their scope of practice and subject to applicable state law, including, but not limited to, pharmacies working with the United States, as well as infusion centers, and home health agencies, to bill directly and receive direct reimbursement from the Medicare program for vaccinating Medicare Part A SNF residents. This enforcement discretion, and accordingly the ability for entities other than the SNF to submit claims for these monoclonal antibody products and their administration furnished to Medicare Part A SNF residents, is limited to the period described in the above-cited enforcement discretion notice.

MLN Connects Special Edition - December 9, 2020

In Case You Missed It: CMS Announces Guidance for Medicare Coverage of COVID-19 Antibody Treatment

On December 9, CMS posted updates to FAQs and an infographic about coverage and payment for monoclonal antibodies to treat COVID-19. The FAQs include general payment and billing guidance for these products, including questions on different setting types. The infographic has key facts about expected Medicare payment to providers and information about how Medicare beneficiaries can receive these innovative COVID-19 treatments with no cost-sharing during the public health emergency (PHE). CMS' November 10, 2020 announcement about coverage of monoclonal antibody therapies allows a broad

range of providers and suppliers, including freestanding and hospital-based infusion centers, home health agencies, nursing homes, and entities with whom nursing homes contract, to administer this treatment in accordance with the Food & Drug Administration's Emergency Use Authorization (EUA), and bill Medicare to administer these infusions. Currently, two monoclonal antibody therapies have received EUA's for treatment of COVID-19.

For More Information:

- Therapeutics Coverage Infographic
- Section BB of the FAQs: billing and payment for COVID-19 monoclonal antibody treatments
- Monoclonal toolkit and program guidance

MLN Connects - December 10, 2020

Flu & Pneumonia Vaccines: Protect Your Patients

MLN Connects® for Thursday, December 10, 2020

View this edition as a: Webpage | PDF

NEWS

- Flu & Pneumonia Vaccines: Protect Your Patients
- VBID Model: Hospice Benefit Component
- Open Payments: Review and Dispute Data by December 31
- Hospital Price Transparency: Requirements Effective January 1
- Annual Participation Enrollment Period Extended to January 31
- 2020 MIPS Extreme and Uncontrollable Circumstances Exception Application: Deadline February 1
- COVID-19: Hospital Operations Toolkit

COMPLIANCE

- Telehealth Services: Bill Correctly

CLAIMS, PRICERS & CODES

- ICD-10 MS-DRG Grouper V38.1 & 2021 ICD-10-PCS Code Files
- Average Sales Price Files: January 2021

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - December 10 & January 7

MLN MATTERS® ARTICLES

- Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2021
- Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2021 - Recurring File Update
- New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE - Revised
- Changes to the Laboratory National Coverage Determination (NCD) Edit Software for October 2020 - Revised
- 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 - Revised

PUBLICATIONS

- Medicare Provider Enrollment - Revised
- Provider Compliance Tips – Revised

MLN Connects Special Edition - December 10, 2020 - CMS Proposes New Rules to Address Prior Authorization and Reduce Burden on Patients and Providers

On December 10, under President Trump's leadership, CMS issued a proposed rule that would improve the electronic exchange of health care data among payers, providers, and patients and streamline processes related to prior authorization to reduce burden on providers and patients. By both increasing data flow and reducing burden, this proposed rule would give providers more time to focus on their patients and provide better quality care.

For More Information:

- Proposed Rule: Comment period closes January 4
- Full press release
- Fact sheet
- Blog
- CMS Interoperability and Patient Access Final Rule webpage
- Register for December 16 listening session

MLN Connects Special Edition - December 14, 2020 - COVID-19 Vaccine Codes: Updated Effective Date for Pfizer-BioNTech

On December 11, 2020, the U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the Pfizer-BioNTech COVID 19 Vaccine for the prevention of COVID-19 for individuals 16 years of age and older. Review Pfizer's Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) regarding the limitations of authorized use.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA). Review our updated payment and HCPCS Level I CPT code structure for specific COVID-19 vaccine information. Only bill for the vaccine administration codes when you submit claims to Medicare; don't include the vaccine product codes when vaccines are free.

Related links:

- CMS COVID-19 Provider Toolkit
- CMS COVID-19 FAQs
- CDC COVID-19 Vaccination Communication Toolkit for medical centers, clinics, and clinicians
- FDA COVID-19 Vaccines webpage

MLN Connects - December 17, 2020

Physician Fee Schedule Final Rule Summary: Telehealth, Preventive Services & More

MLN Connects® for Thursday, December 17, 2020

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NEWS

- MLN Web-Based Training: Complete Training & Save Certificates by January 31
- IRF Quality Reporting Program: December Refresh
- LTCH Quality Reporting Program: December Refresh
- COVID-19: Stress & Resilience, Crisis Standards of Care
- COVID-19: Designated Hospitals Lessons Learned and Patient Surge Management Strategies

COMPLIANCE

- Ambulance Fee Schedule and Medicare Transports

MLN MATTERS® ARTICLES

- 2021 Annual Update of Per-Beneficiary Threshold Amounts
- CY 2021 Update for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Summary of Policies in the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)--April 2021 - Revised

PUBLICATIONS

- Opioid Treatment Programs (OTPs) Medicare Enrollment - Revised
- Opioid Treatment Programs (OTPs) Medicare Billing and Payment - Revised

MLN Connects Special Edition - December 18, 2020 - COVID-19: Add-on Payment for New Treatments

CMS issued an Interim Final Rule with Comment Period, which established the New COVID-19 Treatments Add-on Payment (NCTAP) under the Medicare Inpatient Prospective Payment System (IPPS), effective from November 2, 2020, until the end of the Public Health Emergency (PHE) for COVID-19. To mitigate potential financial disincentives for hospitals to provide new COVID-19 treatments during the COVID-19 PHE, the Medicare program will provide an enhanced payment for eligible inpatient cases that involve use of certain new products with current Food and Drug Administration approval or emergency use authorization to treat COVID-19. Visit the NCTAP webpage for more information.

MLN Connects Special Edition - December 18, 2020 - Monitoring for Hospital Price Transparency

Hospital Price Transparency requirements go into effect January 1, 2021. CMS plans to audit a sample of hospitals for compliance starting in January, in addition to investigating complaints that are submitted to CMS and reviewing analyses of non-compliance, and hospitals may face civil monetary penalties for noncompliance.

Is your institution prepared to comply with the requirements of the Hospital Price Transparency Final Rule? Effective January 1, 2021, each hospital operating in the United States is required to provide publicly accessible standard charge information online about the items and services they provide in 2 ways:

- Comprehensive machine-readable file with all items and services
- Display of 300 shoppable services in a consumer-friendly format

In the final rule, CMS outlined a monitoring and enforcement plan to ensure compliance with the requirements. We finalized a policy that CMS monitoring activities may include, but would not be limited to, the following, as appropriate:

- Evaluation of complaints made by individuals or entities to CMS
- Review of individuals' or entities' analysis of noncompliance
- Audit of hospital websites

If we conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, we may take any of the following actions, which generally, but not necessarily, will occur in the following order:

- Provide a written warning notice to the hospital of the specific violation(s)
- Request a Corrective Action Plan (CAP) if noncompliance constitutes a material violation of one or more requirements
- Impose a civil monetary penalty not in excess of $300 per day and publicize the penalty on a CMS website if the hospital fails to respond to our request to submit a CAP or comply with the requirements of a CAP

See 45 CFR part 180 Subpart C- Monitoring and Penalties for Noncompliance.

Visit the Hospital Price Transparency website for additional information and resources to help hospitals prepare for compliance, including:

- FAQs (PDF)
- 8 Steps to a Machine-Readable File (PDF)
- 10 Steps to a Consumer-Friendly Display (PDF)
- Quick Reference Checklists (PDF)

MLN Connects Special Edition - December 22, 2020 - COVID-19 Vaccine Codes: Updated Effective Date for Moderna

On December 18, 2020, the U.S. Food and Drug Administration issued an Emergency Use Authorization (EUA) for the Moderna COVID 19 Vaccine for the prevention of COVID-19 for individuals 18 years of age and older. Review Moderna's Fact Sheet for Healthcare Providers Administering Vaccine (Vaccination Providers) regarding the limitations of authorized use.

During the COVID-19 Public Health Emergency (PHE), Medicare will cover and pay for the administration of the vaccine (when furnished consistent with the EUA). Review our updated payment and HCPCS Level I CPT code structure for specific COVID-19 vaccine information. Only bill for the vaccine administration codes when you submit claims to Medicare; don't include the vaccine product codes when the vaccines are free.

Related links:

- CMS COVID-19 Provider Toolkit
- CMS COVID-19 FAQs
- CDC COVID-19 Vaccination Communication Toolkit for medical centers, clinics, and clinicians
- FDA COVID-19 Vaccines webpage

MLN Connects - December 23, 2020

ICD-10 Code Files for FY 2021

MLN Connects® for Wednesday, December 23, 2020

View this edition as a: Webpage | PDF

Editor's Note: Happy holidays from the MLN Connects team! We'll release the next regular edition on Thursday, January 7, 2021.

NEWS

- Redesign of Medicare Supplier Directory Improves Beneficiary Decision-making
- Proposed Updates to Coverage Policy for Autologous Blood-Derived Products for Chronic Non-Healing Wounds
- Open Payments: Review & Dispute Data by December 31
- Hospital Price Transparency: Requirements Effective January 1
- DMEPOS Competitive Bidding Program: Round 2021 Begins January 1
- Clinics/Group Practices & Certain Other Suppliers: Revised CMS-855B Required January 4
- Acute Hospital Care at Home: Increasing Capacity through Hospital without Walls Program
- Orthoses Referring Providers: Comparative Billing Report in December
- National Correct Coding Initiative Medicare Policy Manual: Annual Update

COMPLIANCE

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

CLAIMS, PRICERS & CODES

- ICD-10 Code Files for FY 2021
- COVID-19: PC-ACE Software Vaccine Roster Billing Issue

MLN MATTERS® ARTICLES

- FAQs on the 3-Day Payment Window for Services Provided to Outpatients Who Later Are Admitted as Inpatients
- Calendar Year (CY) 2021 Annual Update for Clinical Laboratory Fee Schedule and Services Subject to Reasonable Charge

PUBLICATIONS

- Medicare Preventive Services - Revised

MULTIMEDIA

- Promoting Interoperability Call: Audio Recording & Transcript
- Physician Fee Schedule Call: Audio Recording & Transcript

MLN Connects Special Edition - December 28, 2020 - Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Suspended Through March

The Coronavirus Aid, Relief, and Economic Security (CARES) Act suspended the payment adjustment percentage of 2% applied to all Medicare Fee-For-Service (FFS) claims from May 1 through December 31. The Consolidated Appropriations Act, 2021, signed into law on December 27, extends the suspension period to March 31, 2021.

MLN Connects - January 7, 2020

COVID-19 Vaccines: CDC Long-Term Care Facility Toolkit

MLN Connects® for Thursday, January 7, 2020

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NEWS

- COVID-19 Vaccines: CDC Long-Term Care Facility Toolkit
- MLN Web-Based Training: Complete Training & Save Certificates by January 31
- 2020 MIPS Extreme and Uncontrollable Circumstances Exception Application: Deadline February 1
- Extension of Medicare IVIG Demonstration through December 31, 2023
- Teaching Hospitals Receiving FTE Resident Caps Under Section 5506 of the Affordable Care Act
- Cervical Health: Medicare Covers Screening Services

COMPLIANCE

- Importance of Proper Documentation: Provider Minute Video

EVENTS

- CMS-CDC Fundamentals of COVID-19 Prevention for Nursing Home Management Call - January 7

MLN MATTERS® ARTICLES

- Addition of the QW Modifier to Healthcare Common Procedure Coding System (HCPCS) Codes 87811 and 87428
- 2021 Annual Update to the Therapy Code List
- Instructions to Medicare Administrative Contractors (MACs) on COVID-19 Emergency Declaration Blanket Waivers for Medicare-Dependent, Small Rural Hospitals and Sole Community Hospitals
- Quarterly Update to Home Health (HH) Grouper
- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 27.1, Effective April 1, 2021
- Updating Calendar Year (CY) 2021 Medicare Diabetes Prevention Program (MDPP) Payment Rates
- Billing for Home Infusion Therapy Services on or After January 1, 2021 - Revised
- Telehealth Expansion Benefit Enhancement under the Pennsylvania Rural Health Model (PARHM) - Implementation - Revised

PUBLICATIONS

Complying with Laboratory Services Documentation Requirements - Revised

MULTIMEDIA

- Enroll in Medicare to Administer COVID-19 Vaccine Shots: Information for Health Care Providers Video
- Hospital Price Transparency Webcast: Audio Recording & Transcript
- Promoting Interoperability Listening Session: Audio Recording & Transcript

INFORMATION FOR MEDICARE PATIENTS

- From Coverage to Care Resources Help Navigate Health Coverage

MLN Connects Special Edition - January 7, 2020 - Physician Fee Schedule Update

Physician Fee Schedule Update

On December 27, the Consolidated Appropriations Act, 2021 modified the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS):

- Provided a 3.75% increase in MPFS payments for CY 2021
- Suspended the 2% payment adjustment (sequestration) through March 31, 2021
- Reinstated the 1.0 floor on the work Geographic Practice Cost Index through CY 2023
- Delayed implementation of the inherent complexity add-on code for evaluation and management services (G2211) until CY 2024

CMS has recalculated the MPFS payment rates and conversion factor to reflect these changes. The revised MPFS conversion factor for CY 2021 is 34.8931. The revised payment rates are available in the Downloads section of the CY 2021 Physician Fee Schedule final rule (CMS-1734-F) webpage.

MLN Connects - January 14, 2020

Ensuring our Nation's Seniors Have Access to Latest Advancements

MLN Connects® for Thursday, January 14, 2021

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NEWS

- Ensuring our Nation's Seniors Have Access to Latest Advancements
- Opioid Treatment Programs: New for 2021
- Electronic Funds Transfer: Revised CMS-588 Required on February 28
- Recommend Glaucoma Screening for High-Risk Patients

COMPLIANCE

- Inhalant Drugs: Bill Correctly

CLAIMS, PRICERS & CODES

- Payment for Outpatient Clinic Visit Services at Excepted Off-Campus Provider-Based Departments
- ASC Payment System Update Effective January 1, 2021

MLN MATTERS® ARTICLES

- January 2021 Integrated Outpatient Code Editor (I/OCE) Specifications Version 22.0
- January 2021 Update of the Ambulatory Surgical Center (ASC) Payment System
- January 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

PUBLICATIONS

- Clinical Laboratory Fee Schedule - Revised

MULTIMEDIA

- Achieving Health Equity Web-Based Training Course

MLN Connects - January 21, 2021

Give Flu Shots through January & Beyond

MLN Connects® for Thursday, January 21, 2021

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NEWS

- Hospital IPPS: FAQs on Market-Based MS-DRG Relative Weights
- MLN Web-Based Training: Complete Training & Save Certificates by January 31
- Intensity-Modulated Radiation Therapy: Comparative Billing Report in January
- 2020 MIPS Extreme & Uncontrollable Circumstances Exception Application: Deadline February 1
- Give Flu Shots through January & Beyond

COMPLIANCE

- SNF 3-Day Rule: Bill Correctly

EVENTS

- COVID-19 Listening Sessions with CMS Office of Minority Health - January 22, 26, & 28
- Physicians, Nurses & Allied Health Professionals Open Door Forum - January 27

CLAIMS, PRICERS, & CODES

- ESRD Facilities: Machine Reported Dialysis Treatment Time on the 072X Bill Type
- Therapy Claims: Reprocessing Dates of Service from January 1 through February 15
- Home Health RAP Workaround

MLN MATTERS® ARTICLES

- 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 - Revised

MULTIMEDIA

- Quality Reporting Programs: From Data Elements to Quality Measures Web-Based Training
- Section M: Assessment and Coding of Pressure Ulcers & Injuries Web-Based Training

MLN Connects - January 28, 2021

Medicare Wellness Visits: Get Your Patients Off to a Heathy Start

MLN Connects® for Thursday, January 28, 2021

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NEWS

- Care Compare: 2019 Preview Period Open through March 25
- Open Payments Data
- Medicare Wellness Visits: Get Your Patients Off to a Heathy Start

COMPLIANCE

- Hospice Care: Safeguards for Medicare Patients

CLAIMS, PRICERS, & CODES

- Drug Claims Rejected in Error

MLN MATTERS® ARTICLES

- Calendar Year (CY) 2021 Annual Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment - Revised

MLN Connects - February 4, 2021

Improving Accuracy of Medicare Payments

MLN Connects® for Thursday, February 4, 2021

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NEWS

- Improving Accuracy of Medicare Payments
- Cardiovascular Health: Medicare Covers Screening & Therapy

CLAIMS, PRICERS, & CODES

- OPPS Pricer File: January 2021
- FQHC Claims: Retroactive Adjustment for Geographic Adjustment Factor
- HCPCS Code G2211 is a Bundled Service & Not Separately Paid

EVENTS

- ICD-10 Coordination & Maintenance Committee Meeting - March 9-10

MLN Connects - February 11, 2021

PFS Payment for Office & Outpatient E/M Visits

MLN Connects® for Thursday, February 11, 2021

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NEWS

- Flu & Pneumococcal Shots: Protect Your Patients

COMPLIANCE

- Hospices: Create an Effective Plan of Care

CLAIMS, PRICERS, & CODES

- COVID-19: Revised Clinician Codes Accepted with CS Modifier
- PFS Payment for Office & Outpatient E/M Visits
- ESRD: Claims Processing Issues for Type of Bill 072X

MLN Connects - February 18, 2021

COVID-19: EUA for Antibody Treatment

MLN Connects® for Thursday, February 18, 2021

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NEWS

- CMS Takes Further Steps to Ensure Medicare Beneficiaries Have Wide Access to COVID-19 Antibody Treatment
- IPPEs & AWVs: Comparative Billing Report in February

- American Heart Month & Black History Month

COMPLIANCE

- Hospice Aide Services: Enhancing RN Supervision

CLAIMS, PRICERS, & CODES

- FQHC & RHC Claims: Retroactive Rate Adjustment for Code G2025

MULTIMEDIA

- Section N: Medications - Drug Regimen Review Web-Based Training

MLN Connects - February 25, 2021

Medicare Secondary Payer: Billing for Services

MLN Connects® newsletter for Thursday, February 25, 2021

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NEWS

- CMS Offers Comprehensive Support to the State of Texas to Combat Winter Storm

COMPLIANCE

- Post-Acute Care Transfers: Bill Correctly

MLN MATTERS® ARTICLES

- Billing for Services when Medicare is a Secondary Payer
- April 2021 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits
- Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2021

MLN MATTERS

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

MLN Matters Number: MM12133
Related CR Release Date: January 20, 2021
Related CR Transmittal Number: R10562CP
Related Change Request (CR) Number: 12133
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

CR 12133 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)12133.

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

MLN Matters Number: MM11880 Revised
Related CR Release Date: December 31, 2020
Related CR Transmittal Number: R10547BP, R10547CP
Related Change Request (CR) Number: 11880
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

Note: CMS revised this article to reflect a revised CR 11880 issued on December 31. In the article, CMS added two codes (J1559 JB and J7799 JB) as shown in red print in Table 3.2 on page 7. Also, CMS revised the CR release date, transmittal numbers, and the web addresses of the transmittals. All other information remains the same.

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

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

Billing for Services when Medicare is a Secondary Payer

MLN Matters Number: SE21002
Article Release Date: February 23, 2021

Don’t deny treatment, entry to a SNF or hospital, or services based on an open or closed Liability (L), No-Fault (NF) or Workers’ Compensation (WC) Medicare Secondary Payer (MSP) record on the beneficiary’s Medicare file or if a claim was inappropriately denied. You must continue to see or provide services to the beneficiary.

If services relate to an open MSP accident or injury incident, first bill the other insurer as primary.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)21002.

Clarifying the Use of As-Needed/PRN Orders for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) - Rescinded

Release Date: December 30, 2020
CR Transmittal Number: R10538PI
Change Request (CR) Number: 11997
Effective Date: January 1, 2020
Implementation Date: December 29, 2020

Note: Transmittal 10492, dated November 25, 2020, is being rescinded and replaced by Transmittal 10538, dated December 30, 2020, to revise business requirement 11997.3.1. All other information remains the same.

Effective for dates of service on or after January 1, 2020, CMS amended its order requirements for items of DMEPOS via recent regulation CMS-1713-F. The rule provides a standard written order with set elements required to be included for payment purposes. Since frequency is no longer a required element, CMS is updating section 5.11 in Chapter 5 of Pub. 100-08 to remove the language stating that "PRN" or "as-needed" are not acceptable frequencies to be included on a Standard Written Order.

View the complete CMS Change Request (CR) 11997.

CY 2021 Update for DMEPOS Fee Schedule

MLN Matters Number: MM12063
Related CR Release Date: December 4, 2020
Related CR Transmittal Number: R10504CP
Related Change Request (CR) Number: 12063
Effective Date: January 1, 2021
Implementation Date: January 4, 2021

CR 12063 provides the Calendar Year (CY) 2021 annual update for the Medicare DMEPOS fee schedule. The article includes information on the data files, update factors, and other information related to the update of the fee schedule. Make sure your billing staffs are aware of these updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12063.

New & Expanded Flexibilities for RHCs & FQHCs during the COVID-19 PHE - Revised

MLN Matters Number: SE20016 Revised
Article Release Date: December 3, 2020

Note: CMS revised this article to provide additional guidance on telehealth services that have cost-sharing and cost-sharing waived. You'll find substantive content updates in dark red font (see page 5).

To provide as much support as possible to you and your patients during the COVID-19 PHE, both Congress and CMS have made several changes to the RHC and FQHC requirements and payments. These changes are for the duration of the COVID-19 PHE, and CMS will make other discretionary changes as necessary to make sure that your patients have access to the services they need during the pandemic. For more information, please see the RHC/FQHC COVID-19 FAQs at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

View the complete CMS Medicare Learning Network (MLN) Matters (SE)20016.

Quarterly Update for DMEPOS CBP - April 2021

MLN Matters Number: MM12128
Related CR Release Date: January 20, 2021
Related CR Transmittal Number: R10565CP
Related Change Request (CR) Number: 12128
Effective Date: April 1, 2021
Implementation Date: April 5, 2021

CR 12128 tells you that Medicare updates the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) files on a quarterly basis to implement necessary changes to Healthcare Common Procedure Coding System (HCPCS) codes, ZIP codes, single payment amounts, and supplier files. CR12128 provides specific instruction for implementing the DMEPOS CBP files.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12128.