DME Happenings

Jurisdiction A

June 2022

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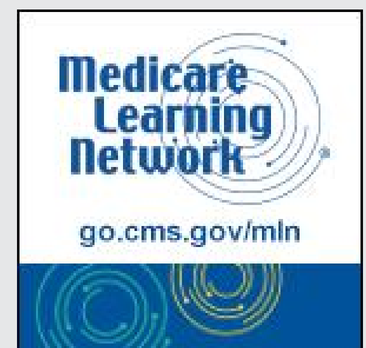
Don’t be left in the dark, sign up for the Noridian e-mail listing to receive updates that contain the latest Medicare news. Visit the Noridian website and select “Subscribe” on the bottom right-hand corner of any page.



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

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NEWS

Jurisdiction D 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
• 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
Administrative Simplification Compliance Act (ASCA)	Noridian JA DME Attn: ASCA PO Box 6736 Fargo, ND 58108-6736

Department	Address
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
LCD Reconsideration Request	Noridian JA DME Attn: DME MR-PAR 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
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.

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:

CERT Documentation Center
8701 Park Central Drive, Suite 400-A
Richmond, VA 23227

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.

2022 Expansion for Face-to-Face (F2F) and Written Order Prior to Delivery (WOPD)

Effective for dates of service on or after April 13, 2022, new codes will require a F2F within six months of a WOPD. One osteogenesis stimulator code (E0748), two lumbar-sacral orthosis codes (L0648, L0650), one SEWH orthosis code (L3960) and three knee orthosis codes (L1832, L1833, L1851) have been added to the CMS Required Face-to-Face Encounter and Written Order Prior to Delivery List.

Additional information can be found in MLN Matters SE20007.

Are You Utilizing the Noridian Medicare Portal for All Your Self-Service Needs?

The Noridian Medicare Portal (NMP) is a free and secure internet-based portal. It allows users access to beneficiary and claim information without spending valuable time on phone calls. The portal is available for all Durable Medical Equipment (DME) users in Jurisdictions A and D. The Centers for Medicare & Medicaid Services (CMS) governs the security regulations and other policies of the NMP. Functions include:

- Eligibility
- Claim status (including claim denial details)
- Full and claim specific remittance advices
- Self-service re-openings
- Appeals/redeterminations
- Same or similar information
- CERT inquiry
- Prior authorization
- Overpayment information
- 1099s

If you have not taken advantage of this great self-service tool to save time and money, do it today.

Billing Drugs or Supplies When the External Infusion Pump (EIP) is Beneficiary-Owned

Suppliers must ensure that beneficiary-owned equipment information is on file with Medicare Fee-for-Service (FFS) to avoid denials. Additional documentation to support medical necessity is required for supplies and accessories when the base equipment, such as a pump, has been provided and was not initially paid for by Medicare FFS.

Claims submitted for drugs and supplies used with beneficiary-owned equipment require three elements as listed below.

1. Healthcare Common Procedure Coding System (HCPCS) code of base equipment (pump); and
2. A notation that the pump is beneficiary-owned; and
3. Approximate date the beneficiary obtained the pump

Example narrative for EIP supplies for a beneficiary owned pump:

BENEFICIARY OWNED K0455 PURCHASED MARCH 2016

Refer to the Drugs Used With External Infusion Pumps - Coverage and Billing Reminders for additional information on billing for drugs used with external infusion pumps.

Billing for Orthotics Requiring Prior Authorization in Acute Situations and Under Competitive Bidding

CMS has given special consideration for acute situations for orthotics. Prior authorization requirements will be suspended for HCPCS codes L0648, L0650, L1832, L1833, and L1851 for the following criteria:

- When there is an acute situation where a two-day expedited review would delay care and risk the health or life of the beneficiary, a supplier may opt to bypass the prior authorization program. These claims should be billed using modifier ST and will be subject to 100% prepayment review.
- For a Physician/Practitioner or Occupational Therapist (OT)/Physical Therapist (PT) furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)), claims billed with modifiers KV, J5 or J4 would convey that the DMEPOS item is needed immediately. When submitted with one of these modifiers, 10% of claims will be subject to prepayment review.

ST Modifier- This modifier is **only to be used for DME suppliers** providing the codes above requiring prior authorization in an acute/emergent situation where a two-business day expedited review would delay care and risk the health or life of the beneficiary. Claims will be subject to 100% prepay review.

J4, J5, and KV Modifier - The ST modifier is **not** to be used by a physician/practitioner or occupational therapist (OT)/physical therapist (PT) or hospital who is a non-contract supplier with the competitive bidding program, who have the option to furnish off-the-shelf (OTS) back and knee braces to their own patients. Claims that are billed to the DME MACs by these suppliers must have the same date of service as the professional office visit or physical/occupational therapy service that is billed to the

Part B MAC. The billable office visit is an absolute requirement. Claims will be subject to 10% prepayment review. The following modifiers should be used for these suppliers.

- **J5 - Physical therapists and occupational therapists** furnishing DMEPOS item subject to DMEPOS Competitive Bidding Program as a non-contract supplier. Professional service and DME must be billed on the same date of service.
- **KV - Physicians and other treating practitioners** furnishing DMEPOS item subject to DMEPOS Competitive Bidding Program as a non-contract supplier. Professional service and DME must be billed on the same date of service.
- **J4 - Hospital** furnishing DMEPOS item subject to DMEPOS Competitive Bidding Program as a non-contract supplier. DME must be billed on same day as discharge from hospital.

ORTHOTIC HCPCS CODES REQUIRING PRIOR AUTHORIZATION

Spinal Orthoses

- 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.
    - **Brace is included in Competitive Bid program**
- 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
    - **Brace is included in Competitive Bid program**

Knee Orthoses

- L1832 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise
    - **Brace is not considered in the Competitive Bid program, as it is a custom fit item**
- L1833 - Knee orthosis, adjustable knee joints (unicentric or polycentric), positional orthosis, rigid support, prefabricated, off-the shelf
    - **Brace is included in Competitive Bid program**
- L1851 - Knee orthosis, single upright, thigh and calf, with adjustable flexion and extension joint (unicentric or polycentric), medial-lateral and rotation control, with or without varus/valgus adjustment, prefabricated, off-the-shelf
    - **Brace is included in Competitive Bid program**

Please keep in mind a prior authorization request for a brace that is needed post-operatively will be denied as not reasonable and necessary. The need for the item cannot be clearly established until the time at which the beneficiary undergoes the procedure. A supplier has two options:

1. Submit an expedited request if the beneficiary's health/life is in jeopardy without the use of the orthotic device in the regular prior authorization review timeframe. A response will be available on the Noridian Medicare Portal or postmarked within two business days following the request.
2. If there is an emergent need, where waiting two days for an expedited decision would jeopardize the life or health of the beneficiary, the supplier may provide the brace and bill with an ST modifier. This will bypass prior authorization and will then be subject to a prepayment review.

Reference: Operational Guide and FAQs

Billing Reminder for Mounting Hardware - HCPCS E1028

Claims billed with HCPCS code E1028 (wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory) must include a narrative description that indicates what the E1028 is to be used for (see examples below). This information must be included in the 2400 loop (line note), NTE02 segment (NTE01=ADD) of the ANSI X12N, version 5010A1 professional electronic claim format or in Item 19 on the paper claim form, the narrative field.

Any E1028 billed without a narrative will result in unprocessable claims that do not have appeal or reopening rights and cannot be adjusted. These claims cannot be adjusted and must be resubmitted as a new claim with a narrative.

An example (not all-inclusive) of a covered indication for swing-away, retractable, or removable hardware (E1028) would be to move the component out of the way so that a beneficiary can perform a slide transfer to a chair or bed from a power or manual wheelchair.

Narrative examples:
"Retractable joystick mounting"
"Removable headrest mount"

Since this code encompasses various types of hardware, suppliers must add a description for **each** E1028 that is billed.

Medicare coverage and payment reminder: swing-away, retractable, or removable hardware (E1028) is non-covered if the primary indication for its use is to allow the beneficiary to move close to desks or other surfaces while seated in a wheelchair. If it is ordered for this indication, a GY modifier must be added to the code

Example with modifiers: E1028NUGY.

Additionally, the description provided should coincide with a corresponding HCPCS that requires or can accommodate specialty hardware.

Example: When billing an E1028 for swing away lateral support hardware, the corresponding code for lateral supports should be on the same claim. If your billing system does not allow this, then the corresponding code requiring the hardware must be in the beneficiary's billing history or a claim processing at the same time for this item, for the E1028 to be paid.

Suppliers are reminded that fixed mounting hardware is not separately payable.

Suppliers are encouraged to read the entire Local Coverage Determination (LCD) and policy article for Wheelchair Options and Accessories and Wheelchair Seating for additional coverage, coding and documentation requirements.

CMS Expands its Prior Authorization Program for Orthotics and Power Mobility

According to CMS, the prior authorization program:

- Helps to protect the Medicare Trust Fund from improper payments
- Ensures that beneficiaries receive DMEPOS items they need in a timely manner.

CMS moved six power operated vehicle (POV) codes and five orthotics codes from the Master List to the CMS Required Prior Authorization List. The effective dates of service are:

- POVs - April 13, 2022
- Orthotics - on or after April 13, 2022, depending on the state

You will find the PA Process for Certain DMEPOS Items Operational Guide and Frequently Asked Questions pages CMS has published very helpful.

Continuous Glucose Monitor (CGM) Alert: What You Need to Know Following April 1 Code Changes

Noridian has observed trending claim submission errors that result in claim denials since the allowance for billing both adjunctive and non-adjunctive CGM.

These trends include:

- Missing KX and CG modifier
- Incorrect infusion pump on file
- Therapeutic CGM (K0554) already on file

Noridian would like to remind suppliers of the joint DME MAC publication [Continuous Glucose Monitors - Correct Coding and Billing - Revised] that thoroughly outlines the requirements for both adjunctive CGM and non-adjunctive CGM.

Non-adjunctive CGM provision, coverage requirements and billing have not changed. Existing HCPCS K0554 (Receiver (monitor), dedicated, for use with therapeutic glucose continuous monitor system) and K0553 (Supply allowance for therapeutic continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit or service) remain in place.

Adjunctive CGM devices were assigned code E2102 (Adjunctive continuous glucose monitor or receiver) effective April 1, 2022. When providing and billing for E2102, there must be accompanying billing for E0784 (External ambulatory infusion pump, insulin) as well. Additionally, code A4238 (Supply allowance for adjunctive continuous glucose monitor (CGM), includes all supplies and accessories, 1 month supply = 1 unit of service) should be used when billing accessories for the adjunctive CGM.

Finally, modifiers CG (all coverage criteria met), KF (Class III devices), and KX (insulin treated) are required as appropriate when billing CGM devices.

Durable Medical Equipment (DME) Information Form (DIF) for Parenteral Nutrition

The Parenteral Nutrition policy requires a DIF), form 10126. This form must be completed, signed, dated by the supplier, kept on file and made available upon request to the Medicare contractor (MAC). The initial claim must include an electronic copy of the DIF. All items being billed to Medicare must be on this form. In the case of upgrades, we ask that the DIF only include the item(s) the beneficiary qualifies for, not the upgraded item(s).

A new Initial DIF is required when:

- Parenteral nutrition services are resumed when they are not required for two consecutive months.

A revised DIF is required when:

- There is a change in HCPCS code for the current nutrient provided
- There is a change (increase or decrease) in the calories prescribed for any HCPCS codes other than B4189, B4193, B4197, B4199, B5000, B5100, B5200
- There is a change in the number of days per week of administration
- There is a change in route of administration
- The length of need (LON) previously entered on the DIF has expired and the treating practitioner is extending the LON for the item(s)

Note: When billing for more items than space allows on the DIF, suppliers may add these codes to question 3. The supply kits do not require a DIF but may also be listed in question 3 with overflow codes.

Reminder: The information on the DIF must be corroborated within the medical record and the Standard Written Order (SWO). If the medical record does not support parenteral nutrition requirements, question 7 must be answered “no”. By answering no on question 7, the claim will deny as non-covered.

Glucose Monitors and Testing Supplies Tutorials Available 24/7

There are nine oxygen [DME on Demand] tutorials available. Take a minute to scan the titles on our webpage for information you might need. Here’s just a sample.

- Collaborative Glucose Monitors - 13 minutes
- Glucose Monitors and Supplies: Coverage - 5 minutes
- Glucose Monitors and Supplies: Documentation - 9 minutes
- Glucose Monitors and Supplies: Overutilization - 7 minutes
- Glucose Monitors and Supplies L200 - High Utilization - 6 minutes

All our tutorials are housed on YouTube.

How Pricing Is Identified for Certain Products

CMS is responsible for the accurate and appropriate calculation and implementation of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) pricing.

Note: The beneficiary's permanent address on file with the Social Security Administration (SSA), rather than the location of the DMEPOS supplier, will determine the amount allowed by Medicare for a particular service.

Pricing methodologies include:

- **Fee Schedules** - applies to the allowed amount for inexpensive or other routinely purchased (IRP) items, those items that require frequent and substantial servicing, other prosthetic and orthotic devices, capped rental items, oxygen and oxygen supplies, and parenteral and enteral nutrition (PEN). Fee schedule amounts are updated in January and July of each year.
- **Gap Filling** - the fee schedule for items that have no historical pricing data on file is calculated based on fee schedule amounts for comparable equipment, fee schedule amounts of other DME MACs, supplier price lists, and manufacturers wholesale price.
- **Reasonable Charge** - applies to the allowed amount for certain dialysis equipment and supplies. Reasonable charge amounts are updated annually.
- **Drug Pricing** - applies to the allowed amount for drugs billable to the DME MAC. Most fees determined under drug pricing are subject to quarterly updates.

Please refer to the Pricing page on the Noridian Medicare website for more information.

Identifying if the Referring Practitioner is Enrolled with PECOS

The link to the CMS ordering/referring provider downloadable report containing the NPI, first name, and last name of providers enrolled in PECOS, published quarterly has been added to the tools page on the Noridian Medicare website. The file can be viewed online or be downloaded. Check out this page today.

Many Oxygen and Oxygen Equipment Tutorials Available 24/7

Did you know there are 12 oxygen DME on Demand tutorials available? Take a minute to scan the titles on our webpage for information you might need. Here’s just a sample.

- Collaborative Oxygen: A/B and DME Collaborative Presentation - 18 minutes
- Dear Physician Prescribing Home Oxygen - 4 minutes
- Oxygen: Certificate of Medical Necessity (CMN) Requirements - 7 minutes
- Oxygen: Coding and Billing Guidelines - 12 minutes
- Oxygen: Testing Requirements - 5 minutes

All our tutorials are housed on YouTube.

Missing CMN or DIF Denials

Are you receiving denials for Service/Equipment not prescribed by a physician, prescription is not current or an initial Certificate of Medical Necessity (CMN) or DME Information Form (DIF) was not submitted with the claim or is not on file with Noridian? Visit our Denial Code Resolution page on our website for common reasons for the denial, what to do next, and how to avoid these denials in the future.

- Reason Code 173, Remark Code N668
- Reason Code 176, Remark Code N592
- Reason Code 16, Remark Code M60

Negative Pressure Wound Therapy (NPWT) Continued Coverage

For NPWT to continue, a licensed medical professional must do the following: on a regular basis, directly assess the wound(s) being treated with the NPWT pump and supervise or directly perform the NPWT dressing changes. And on at least a monthly basis, document changes in the ulcer's dimensions and characteristics. This information can be found in the NPWT Local Coverage Determination (LCD) L33821 on the Active LCDs page.

New Competitive Bid HCPCS Lookup Tool Now Available

A new look up tool has been created to help suppliers and billers determine if a specific Healthcare Common Procedure Coding System (HCPCS) code is included in the Round 2021 Competitive Bidding Program. After entering the HCPCS code, in the Competitive Bid HCPCS Lookup Tool, the tool will provide information when the item is included in competitive bid. This tool will also provide guidance on how to identify if a beneficiary's permanent address is in a competitive bid area.

The following information will be displayed when entering a competitive bid HCPCS.

- Utilize the Round 2021 CBA Zip Code Lookup Tool to identify if the beneficiary's permanent address is included in a competitive bid area for the item you are providing.
- Follow the Competitive Bid guidelines provided by the Competitive Bid Implementation Contractor (CBIC)
- Some HCPCS codes require Prior Authorization, Face-to-Face and Written Order Prior to Delivery with dates of service April 13, 2022 and after.

This new tool can be found on the Noridian website Tools webpage.

New F2F, WOPD, and Prior Authorization Requirements Effective April 13, 2022

Additional codes for face-to-face and written order prior to delivery and the expansion of HCPCS codes were added to Prior Authorization Program for orthotics and power mobility.

The required face-to-face encounter and written order prior to delivery list is effective nationwide April 13, 2022. A F2F encounter must be held with a beneficiary within six (6) months prior to prescribing the item(s). A WOPD must be communicated to the DMEPOS supplier before delivery of the item(s). The Required Prior Authorization List has been expanded to include six power operated vehicle (POV) codes and five orthotics codes. The effective dates of service are: POVs - April 13, 2022; orthotics - on or after April 13, 2022, depending on the state. Helpful resources can be found on the CMS website.

- Face-to-Face Encounter and Written Order Prior to Delivery
- Required Face-to-Face Encounter and Written Order Prior to Delivery List (PDF)
- Prior Authorization
- **Required Prior Authorization List (PDF)**

New WOPD and Face-to-Face Required List HCPCS Code Look Up Tool - Now Available

A new look up tool has been created to help suppliers and billers determine which HCPCS codes require a written order prior to delivery (WOPD) and face-to-face (F2F) encounter. Effective April 13, 2022, HCPCS codes listed in the Federal Register will require a WOPD and F2F within six months preceding the date of the WOPD. The tool can be found on the Noridian website. WOPD and Face-to-Face Required List HCPCS Code Lookup Tool.

Noridian and Facebook

Noridian posts information on Facebook regarding all policies and Medicare processes. It's just another way we hope you use to get the information you need. You can Like us or enter a comment. If you know someone who could use the information, you can share it with them.

Osteogenesis Stimulator KF Modifier Use

In general terms, an ultrasonic osteogenesis stimulator is a noninvasive device. It's applied to the surface of the skin at a fracture site. The device emits low intensity, pulsed ultrasound waves via a conductive coupling gel to stimulate fracture healing.

There are three different stimulators E0747, E0748 and E0760. Each of these codes has different coverage criteria per the Local Coverage Determination (L33796). These criteria will need to be established for the Osteogenesis Stimulator to be found medically necessary.

These devices codes are classified by the Food and Drug Administration as Class III devices. Therefore, the KF modifier must be appended to all claims for codes E0747, E0748 and E0760. If the claim line is billed without a KF modifier, that claim will be rejected as missing information. The Modifier Lookup Tool can help determine which modifiers are appropriate to use when billing these codes.

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.

Resolving denial: Supplier must provide that information to Medicare to place on file. This can be accomplished in the following ways:

- Telephone reopening through the Supplier Contact Center
- Written reopening using the NMP appeals process
- Mail
- Fax

The information that must be put on file includes the claim narrative required elements listed below.

Once the beneficiary-owned item is placed on file, subsequent supply claims do not require a narrative.

CLAIM NARRATIVE REQUIRED ELEMENTS

- HCPCS code of base equipment; and,
- A notation equipment is beneficiary-owned; and,
- Date beneficiary obtained equipment (approximate)

Good example: Bene-owned E0601 pur Jan 2021

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

Receiving Inpatient Denials with Reason Code 109, Remark Code N538

Are you receiving inpatient denials? Check out the exception to delivery rules when the beneficiary is in a Part A inpatient stay. Checking beneficiary eligibility, acceptable time of delivery, and billing the discharge date are key. For more information review the Standard Documentation Requirements for All claims Submitted to DME MACS and to assist in resolving denials, you can go to our Denial Code Resolution page on the Noridian Medicare website.

Standard Documentation Requirements for All Claims Submitted to DME MACs

Registering for the Noridian Medicare Portal Just Got Easier

New tutorials have been added to every step of the Noridian Medicare Portal (NMP) Registration Guide. Once you have navigated to the Registration Guide, you'll find seven steps. Click on the plus sign next to each step to expand the view. You will find written instructions but if you would rather see and hear the instructions, select the DME tutorial. Each step has its own tutorial.

- Find out how to:
- Enter your personal information
- Log in to your account
- Set up security questions
- Account confirmation
- How to set up organization information
- How to add providers/suppliers
    - Possible registration errors
- What to do once your registration request is submitted

Required Face-to-Face Encounter and Written Order Prior to Delivery versus Standard Written Order and Face-to-Face Encounter

For items on the Required Face-to-Face (F2F) Encounter and Written Order Prior to Delivery (WOPD) List, a complete order is required prior to the item's delivery. The WOPD must be on file with the supplier within six months of the F2F encounter unless the policy specifies a different timeline. The WOPD follows the same documented requirements as the Standard Written Order (SWO); the only difference is the timeliness requirements of the order, prior to dispensing versus prior to claim submission.

For all other DMEPOS items not listed on the Required Face-to-Face Encounter and Written Order Prior to Delivery (WOPD) List, the SWO is required prior to claim submission. As a reminder, all policies require a F2F encounter to support the medical necessity of the items ordered. For more information on orders review the Standard Documentation Requirements Policy Article - A55426.

See How Nurse Practitioners (NP) and Physician Assistants (PA) Qualify as Certifying Physicians for Therapeutic Shoes and Inserts

NPs and PAs who are practicing under the supervision of an MD or DO (i.e., "incident to") as the certifying physician can provide therapeutic shoes to beneficiaries with diabetes if certain criteria are met:

- The supervising physician has documented in the medical record that the patient is diabetic and has been, and continues to provide, the patient follow-up under a comprehensive management program of that condition; and,
- The NP or PA certifies that the therapeutic shoes are part of the comprehensive treatment plan being provided to the patient; and,
- The supervising physician must review and verify (sign and date) all the NP or PA notes in the medical record

concerning the provision of the therapeutic shoes and inserts, and must acknowledge their agreement with the actions of the NP or PA.

In states where the NP may practice independently, they must still comply with these rules to serve as the certifying physician for Medicare. You can refer to Policy Article A52501 and the applicable A/B MAC for more information.

Sequestration Rate Taken in Error - Resolved 03/01/22

Provider/Supplier Type(s) Impacted: Not applicable.

Reason Codes: Not applicable.

Claim Coding Impact: Not applicable.

Description of Issue: The sequestration rate was applied to claims with dates of service from 01/01/22-01/20/22 when it should not have, since the suspension of the payment adjustment has been extended.

Noridian Action Required: Mass adjustments will be initiated to pay claims without the sequestration rate applied.

Provider/Supplier Action Required: Not applicable

Proposed Resolution/Solution: Mass adjustments will be initiated to pay claims without the sequestration rate applied.

03/01/22 - Noridian initiated the mass adjustments.

Date Reported: 01/24/22

Date Resolved: 03/01/22

Surgical Dressings and Pneumatic Compressions Devices (PCD)

These two policies have a total of 15 DME on Demand tutorials available for viewing anytime, anywhere. This includes a surgical dressings A1-A9 modifiers refresher, real claim denial examples, and questions about stockings and wraps.

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction A, DME MAC, Medical Review Department is conducting a pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from January 2022 - March 2022 can be located on our Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Glucose Monitors
- Knee Orthosis
- Manual Wheelchairs
- Ostomy Supplies
- Therapeutic Shoes
- Spinal Orthotics
- Surgical Dressings
- Urological Supplies

There are Many Benefits to Signing Up for Electronic Funds Transfer (EFT)

With Electronic Funds Transfer (EFT), Medicare can send payments directly to a provider's financial institution whether claims are filed electronically or on paper. All Medicare providers may apply for EFT.

ADVANTAGES OF EFT

EFT is similar to other direct deposit operations, such as paycheck deposits, and it offers a safe, modern alternative to paper checks. Providers who use EFT may notice the following benefits:

- Reduction of paper in the office
- Staff saves valuable time and avoids hassle of going to the bank to deposit a Medicare check
- The risk of Medicare paper checks being lost or stolen in the mail is eliminated
- Faster access to funds; (many banks credit direct deposits faster than paper checks)
- Easier reconciliation of payments with bank statements.

HOW TO ENROLL IN EFT

The National Supplier Clearinghouse (NSC) processes all Medicare applications for DMEPOS suppliers. Per 42 CFR 424.510(e)(1), providers and suppliers are required to receive electronic funds transfer (EFT) at the time of enrollment, revalidation, change of Medicare contractors or submission of an enrollment change request; and (2) submit the EFT Authorization Agreement CMS-588 form to receive Medicare payment via electronic funds transfer.

If you have not yet signed up for EFT, take advantage of all the benefits.

- Download the CMS 588 (PDF) form from the CMS website
- Follow the instructions for completing the EFT authorization agreement
- Mail the form to the Medicare contractor that services your geographical area
  - An EFT authorization form must be submitted for each Medicare contractor to whom you submit claims for Medicare payment
  - Jurisdiction A Mailing Addresses

Three External Infusion Pump (EIP) Tutorials Available 24/7

Watch a self-paced DME on Demand tutorial anytime, at your own pace.

- EIP: Completing the DME Information Form (DIF) - 5 minutes
- EIP: Inotropic Drugs Revised: Coverage Criteria - 3 minutes
- EIP: Insulin Pump - 7 minutes

All our tutorials are housed on YouTube.

Top Claim Denial and Ways to Avoid the Denial in the Future

Are you receiving Reason Code 151 and Remark Code M3 denials on your Remittance Notice? Those indicate the equipment is the same or similar to equipment already being used. Do you know how to resolve these denials and prevent them from occurring in the future? Noridian has many tools to help providers in billing correctly such as the Denial Code Resolution Tool and Same or Similar Chart. Noridian also has self-service tools to help suppliers identify same or similar equipment prior to billing. These include the Noridian Medicare Portal and the Interactive Voice Response (IVR) - Self-Service Technology. By knowing if the beneficiary has similar equipment on file with Medicare, suppliers can issue an Advanced Beneficiary Notice of Non-Coverage (ABN) and bill utilizing the GA, GY or GZ modifier. As a reminder, same or similar denials can be appealed including all documentation requirements to support the need for a new/different piece of equipment.

Updated Browse by Topic Webpage

Are you looking for information on repairs, maintenance, and replacement? Questions answered on:

- Who can complete a repair
- What documentation is required
- Loaner equipment - what can be billed
- Claim narrative requirements
- How to bill labor and minor parts
- Modifiers
- Not otherwise classified (NOC) codes
- Warranties
- Replacement guidelines, and much more

Check out our updated Repairs, Maintenance and Replacement pages on our website.

Updated Information on Prior Authorization

Phase one of prior authorization for HCPCS codes L0648, L0650, L1832, L1833, and L1851 begins April 13, 2022 for New York, Illinois, Florida, and California.

CMS has revised the Prior Authorization Process for Certain DMEPOS Items FAQs and the Prior Authorization Process for DMEPOS - Operational Guide.

Find more information on our Required Prior Authorization Programs webpage.

Urological Supplies and Continued Medical Need

For all DMEPOS items, the initial justification for medical need is established at the time the item(s) is first ordered. Beneficiary medical records demonstrating that the item is reasonable and necessary are created just prior to, or at the time of, the creation of the initial prescription.

Once initial medical need is established, unless continued coverage requirements are specified in the LCD, ongoing need for urological supplies is assumed to drain or collect urine for a beneficiary who has permanent urinary incontinence or permanent urinary retention. There is no requirement for further documentation of continued medical need if the beneficiary continues to meet the Prosthetic Devices benefit.

Additional information on Surgical dressing can be found in the Local Coverage Determination (LCD) L33803 and Policy Article A52521 on the Noridian Urological Supplies webpage.

Verify HMO/MCO Status on the Noridian Medicare Portal (NMP) Eligibility Tab 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, avoids denials by billing the correct payor the first time. To resolve denials please utilize the Denial Code Resolution webpage on the Noridian Medicare Website.

Watch Urological Tutorials Anytime

Do you need a little urological refresher? Watch a self-paced DME on Demand tutorial in five minutes or less. Ok, we snuck one in that's 11 minutes, but you want to get coding and billing right - right?

- Indwelling Catheters: Coverage Criteria - 4 minutes
- Intermittent Catheterization: Coverage Criteria - 5 minutes
- Intermittent Catheter Kits (A4353): Coding - 4 minutes
- Urological Supplies: Coding and Billing - 11 minutes
- Urological Supplies: Drainage Systems - 4 minutes

What is the Noridian Medicare Portal?

The Noridian Medicare Portal (NMP) is a free and secure, internet-based portal that allows users access to beneficiary and claim information. The NMP is available to all Durable Medical Equipment (DME) users in Jurisdictions A and D. The Centers for Medicare & Medicaid Services (CMS) governs the security regulations and other policies of the NMP. Functions include eligibility, claim status (including claim denial details), claim-specific remittance advices, self-service reopenings, CERT inquiry, appeals/redeterminations, same or similar, prior authorization, overpayment information, and 1099s. If you haven't taken advantage of this great self-service tool to save time and money, do it today.

MEDICAL POLICIES AND COVERAGE ....

2022 HCPCS Code Update - April Edition - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, 2022 HCPCS Code Update - April Edition - Correct Coding - Revised, has been created and published to our website.

View the locally hosted 2022 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

Code Verification Review Requirement for Lower Limb Orthoses (L1832, L1833, and L1851) and Lumbar Sacral Orthoses (L0648 and L0650)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Code Verification Review Requirement for Lower Limb Orthoses (L1832, L1833, and L1851) and Lumbar Sacral Orthoses (L0648 and L0650), has been created and published to our website.

View the locally hosted 2022 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

Continuous Glucose Monitors - Correct Coding and Billing - Revised

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

View the locally hosted 2022 DMD articles.

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- Locate/select article title

Correct Coding and Billing of Halo Procedure

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Correct Coding and Billing of Halo Procedure, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

LCD and Policy Article Revisions Summary for March 24, 2022

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 External Infusion Pumps and Glucose Monitors. Please review the entire LCDs and related PAs for complete information.

EXTERNAL INFUSION PUMPS

LCD

Revision Effective Date: 02/28/2022
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Language regarding CGMs and how the term refers to therapeutic/non-adjunctive and non-therapeutic/adjunctive devices
Added: Direction for claims on or after date of service April 1, 2022 with the HCPCS code combination of E0784 plus E2102
SUMMARY OF EVIDENCE:
Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes
ANALYSIS OF EVIDENCE:
Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes
BIBLIOGRAPHY:
Removed: Bibliography information, due to not being applicable to the non-discretionary changes

03/24/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are non-discretionary.

PA

Revision Effective Date: 02/28/2022
CODING GUIDELINES:
Added: Billing directions for insulin infusion pumps with integrated adjunctive or non-therapeutic continuous glucose monitor receiver functionality, and supply codes A4224, A4225, and A4999 for dates of service on or before March 31, 2022
Added: Billing directions for HCPCS codes E0784 and E2102 for insulin infusion pumps with integrated adjunctive or non-therapeutic continuous glucose monitor receiver functionality, and supply codes A4224, A4225, and A4238 for dates of service on or after April 1, 2022
CODING INFORMATION:
Removed: ICD-10-CM codes O24.415, O24.425, O24.435 from Group 1 codes

03/24/2022: 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.

GLUCOSE MONITORS

LCD

Revision Effective Date: 02/28/2022
CMS NATIONAL COVERAGE POLICY:
Removed: “CMS Ruling 1682R”
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Removed: Reference to CMS Ruling 1682R
Added: CGM refers to both therapeutic/nonadjunctive and non-therapeutic/adjunctive CGMs
Added: Language describing “therapeutic,” “non-adjunctive,” “non-therapeutic,” and “adjunctive” terms and term usage
Added: Information regarding classification of CGMs as DME
Revised: Coverage information to include reference to adjunctive CGM (E2102) and related supply allowance (A4238)
Added: Statement referring to External Infusion Pumps LCD for information regarding billing of CGM receiver functionality integrated into external insulin infusion pump
Added: “Adjunctive CGM devices do not replace a standard home BGM”
Added: HCPCS code A4238 does not include a home BGM and related BGM testing supplies
Added: Reference to coding verification review requirement for HCPCS code E2102 (effective July 1, 2022)
Clarified: No more than a 90-day supply of CGM supplies may be dispensed at a time

Revised: “Refill requirements do not apply to code K0553” to “Refill requirements do not apply to code K0553 or A4238”
SUMMARY OF EVIDENCE:
Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes
ANALYSIS OF EVIDENCE:
Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes
HCPCS CODES:
Added: HCPCS code E2102 to Group 1 Codes (information located in Group 1 Paragraph text) - code effective 04/01/2022
Added: HCPCS code E1399 to Group 1 Codes
Added: HCPCS code A4238 to Group 2 Codes (information located in Group 2 Paragraph text) - code effective 04/01/2022
Added: HCPCS codes A9279 and A9999 to Group 2 Codes
Removed: HCPCS codes A9276, A9277, and A9278 from Group 2 Codes
BIBLIOGRAPHY:
Removed: Bibliography information, due to not being applicable to the non-discretionary changes

03/24/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are non-discretionary.

PA

Revision Effective Date: 02/28/2022
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Removed: Reference to CMS Ruling 1682R
Removed: “therapeutic” from the DME benefit statement
Added: Information regarding classification of CGMs as DME
Added: “CGM devices that solely display results on a smartphone and do not have a stand-alone receiver or integration into an insulin infusion pump do not meet the definition of DME and will be denied as non-covered (no benefit).”
Added: Supply allowance HCPCS code A4238 to billing information
Added: HCPCS codes A4238 and E2102 to supply allowance statements
Revised: Statement regarding supply allowance that is not covered by Medicare, to include when a beneficiary never uses a DME “insulin infusion pump to display CGM glucose data"
Revised: “requirements for a therapeutic” to “DME benefit category requirements”
Revised: Product coding information to include coding of product as A9279 when product does not meet the DME benefit category requirements at PDAC review
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: “therapeutic” from references to CGM
MODIFIERS:
Revised: “KS, KX and CG MODIFIERS:” to “CG, KF, KS and KX MODIFIERS:"
Added: HCPCS codes E2102 and A4238 to KX, KS modifier instructions
Added: “CG” modifier billing information for therapeutic CGM and “adjunctive CGM (E2102) incorporated into an insulin infusion pump and the supply allowance (code A4238)”
Added: HCPCS codes E2102 and A4238 to KF modifier billing instruction
CODING GUIDELINES:
Removed: Billing instruction for therapeutic CGMs billed for DOS from January 12, 2017 through June 30, 2017
Added: Billing instruction for adjunctive CGMs and adjunctive CGM disposable supplies for DOS on or before March 31, 2022
Added: Billing instruction for adjunctive CGMs and adjunctive CGM disposable supplies for DOS on or after April 1, 2022
Added: “There are currently no stand-alone adjunctive CGMs on the United States Market which meet the definition of DME.”
Added: “adjunctive CGMs incorporated into an insulin infusion pump may meet the definition of DME” and reference to the “External Infusion Pumps LCD (L33794)” for billing information
Revised: References to items included in CGM system supply allowance
Revised: Statement regarding supplies used with a non-covered CGM
Added: HCPCS code A4238 to supply quantity information
Clarified: A 90-day supply of CGM supplies may be dispensed
Removed: Reference to “CMS Ruling 1682R” and requirements of DME benefit statement
Removed: Coding guideline information for HCPCS codes A9276 and A9278
Added: Coding guideline information for HCPCS code A9279

03/24/2022: 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/or 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 21, 2022

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

NEBULIZERS

LCD

Revision Effective Date: 06/05/2022
COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:
Added: Group 3 Codes reference for small volume nebulizer (A7003, A7004, A7005) and related compressor (E0570)
Revised: Language regarding coverage of E0574, to include administration of Treprostinil inhalation solution to beneficiaries with pulmonary hypertension only and reference to Group 11 Codes in the LCD-related PA
Revised: Coverage criteria for treprostinil and iloprost
Added: Separate criteria language for iloprost
Removed: Thromboembolic disease of the pulmonary arteries from criteria for treprostinil and iloprost
Added: Criterion 4 to treprostinil coverage criteria and reference to Group 11 Codes in the LCD-related PA
Added: Reference to Group 14 Codes in the LCD-related PA for iloprost
SUMMARY OF EVIDENCE:
Added: Information related to treprostinil inhalation solution for PH-ILD and related to iloprost and treprostinil inhalation solution for CTEPH
ANALYSIS OF EVIDENCE:
Added: Information related to treprostinil inhalation solution for PH-ILD and related to iloprost and treprostinil inhalation solution for CTEPH
BIBLIOGRAPHY:
Added: Section related to treprostinil inhalation solution for PH-ILD and related to iloprost and treprostinil inhalation solution for CTEPH
RELATED LOCAL COVERAGE DOCUMENTS:
Added: Response to Comments (A59085)

PA

Revision Effective Date: 06/05/2022
ICD-10 CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: HCPCS codes K0730 and Q4074 from Group 11 Paragraph

Added: ICD-10-CM code I27.23 to Group 11 Codes
Removed: ICD-10-CM code I27.24 from Group 11 Codes
Added: Group 14 Paragraph for HCPCS codes K0730 and Q4074
Added: Group 14 Codes section for ICD-10-CM codes

04/21/2022: 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 LCD and/or PA. For complete information on any topic, you must review the LCD and/or PA.

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 Revisions Summary for March 10, 2022

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

ENTERAL NUTRITION

LCD

Revision Effective Date: 01/01/2022
CMS NATIONAL COVERAGE POLICY:
Removed: Reference to Medicare National Coverage Determinations Manual (CMS Pub. 100-03), Chapter 1, Part 3, Section 180.2. NCD was retired for claims with dates of service on and after January 1, 2022

03/10/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS’ retiring of the National Coverage Determination.

PARENTERAL NUTRITION

LCD

Revision Effective Date: 01/01/2022
CMS NATIONAL COVERAGE POLICY:
Removed: Reference to Medicare National Coverage Determinations Manual (CMS Pub. 100-03), Chapter 1, Part 3, Section 180.2. NCD was retired for claims with dates of service on and after January 1, 2022
COVERAGE INDICATIONS, LIMITATIONS AND/OR MEDICAL NECESSITY:
Removed: Reference to Medicare National Coverage Determinations Manual (CMS Pub. 100-03), Chapter 1, Part 3, Section 180.2. NCD was retired for claims with dates of service on and after January 1, 2022

03/10/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS’ retiring of the National Coverage Determination.

Note: The information contained in this article is only a summary of revisions to the LCDs and/or 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 Revisions Summary for April 28, 2022

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

GLUCOSE MONITORS

LCD

Revision Effective Date: 02/28/2022
HCPCS CODES:
Revised: Location of E2102 information, moving the information from Group 1 Paragraph text to Group 1 Codes HCPCS list (code remains effective for dates of service on or after 04/01/2022)
Revised: Location of A4238 information, moving the information from Group 2 Paragraph text to Group 2 Codes HCPCS list (code remains effective for dates of service on or after 04/01/2022)

04/28/2022: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they 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/or 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

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

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

View the locally hosted 2022 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

PDAC Code Verification Reviews for CGM Devices - Coding and Billing

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, PDAC Code Verification Reviews for CGM Devices - Coding and Billing, has been created and published to our website.

View the locally hosted 2022 DMD articles.

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

Policy Article Revisions Summary for March 31, 2022

Outlined below are the principal changes to the DME MAC Policy Article (PA) that has been revised and posted. The policy included is Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics). Please review the entire LCD and related PA for complete information.

ORAL ANTIEMETIC DRUGS (REPLACEMENT FOR INTRAVENOUS ANTIEMETICS)

PA

Revision Effective Date: 04/01/2022
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO Final Rule 1713 (84 Fed. Reg Vol 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list
ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:
Removed: ICD-10-CM D49.4, D49.511, D49.512, D49.6, D49.89 from Group 1 due to NCD 110.18 update

03/31/2022: 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/or 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:

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 14, 2022

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthosis, Automatic External Defibrillators, Bowel Management Devices, Canes and Crutches, Cervical Traction Devices, Cold Therapy, Commodes, Enteral Nutrition, External Breast Prostheses, External Infusion Pumps, Eye Prostheses, Facial Prostheses, Glucose Monitors, Heating Pads and Heat Lamps, High Frequency Chest Wall Oscillation Devices, Hospital Beds and Accessories, Immunosuppressive Drugs, Infrared Heating Pad Systems, Intrapulmonary Percussive Ventilation System, Intravenous Immune Globulin, Knee Orthoses, Lower Limb Prostheses, Manual Wheelchair Bases, Mechanical In-exsufflation Devices, Nebulizers, Negative Pressure Wound Therapy Pumps, Oral Anticancer Drugs, Oral Appliances for Obstructive Sleep Apnea, Orthopedic Footwear, Osteogenesis Stimulators, Ostomy Supplies, Oxygen and Oxygen Equipment, Parenteral Nutrition, Patient Lifts, Pneumatic Compression Devices, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Power Mobility Devices, Pressure Reducing Support Surfaces - Group 1, Pressure Reducing Support Surfaces - Group 2, Pressure Reducing Support Surfaces - Group 3, Refractive Lenses, Respiratory Assist Devices, Seat Lift Mechanisms, Speech Generating Devices (SGD), Spinal Orthoses: TLSO and LSO, Standard Documentation Requirements for All Claims Submitted to DME MACs, Suction Pumps, Surgical Dressings, Therapeutic Shoes for Persons with Diabetes, Tracheostomy Care Supplies, Transcutaneous Electrical Joint Stimulation Devices (TEJSD), Transcutaneous Electrical Nerve Stimulators (TENS), Tumor Treatment Field Therapy (TTFT), Urological Supplies, Vacuum Erection Device (VED), Walkers, Wheelchair Options/Accessories, and Wheelchair Seating. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSIS

PA

Revision Effective Date: 02/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: 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.

AUTOMATIC EXTERNAL DEFIBRILLATORS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: "provides" to "provide"
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list
MODIFIERS:
Added: Instructions related to KF modifier for K0606 and E0617
Revised: "KX, GA, AND GZ MODIFIERS:" to "KX, GA, GZ and KF MODIFIERS:"
CODING GUIDELINES:
Removed: Instructions related to KF modifier for K0606 and E0617

04/14/2022: 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: 10/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

CANES AND CRUTCHES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

CERVICAL TRACTION DEVICES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

COLD THERAPY

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

COMMODES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):

Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

ENTERAL NUTRITION

PA

Revision Effective Date: 09/05/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

EXTERNAL BREAST PROSTHESES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

EXTERNAL INFUSION PUMPS

PA

Revision Effective Date: 02/28/2022
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

GLUCOSE MONITORS

PA

Revision Effective Date: 02/28/2022
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

HIGH FREQUENCY CHEST WALL OSCILLATION DEVICES

PA

Revision Effective Date: 10/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

HOSPITAL BEDS AND ACCESSORIES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

IMMUNOSUPPRESSIVE DRUGS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

INFRARED HEATING PAD SYSTEMS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

INTRAPULMONARY PERCUSSIVE VENTILATION SYSTEM

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

INTRAVENOUS IMMUNE GLOBULIN

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

KNEE ORTHOSES

PA

Revision Effective Date: 02/01/2021
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “equipment” to “orthosis”
Revised: “Knee Orthosis” to “Knee orthosis (KO)”
Revised: “Braces Benefit” to “braces benefit”

Revised: “knee orthoses” to “KO”
Revised: “coding guideline” to “CODING GUIDELINES section”
Revised: “(See definitions below.)” to “(See definitions in the CODING GUIDELINES section below.)”
Revised: “(See Policy Specific Documentation Requirements section below)” to “(See the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS” section below)”
Revised: “CAD-CAM” to “computer-aided design/computer-added manufacturing (CAD/CAM)”
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Revised: “these items” to “orthoses”
Revised: “off-the-shelf” to “OTS”
Revised: “Coding Guidelines” to “CODING GUIDELINES section below”
Added: “(as defined in the CODING GUIDELINES section below)”
MODIFIERS:
Revised: “KX, GA, and GZ MODIFIERS” to “KX, GA, GZ, LT and RT MODIFIERS:”
Revised: “knee orthoses” to “the KO”
Added: Statement regarding use of RT and LT, with reference to CODING GUIDELINES section for additional information
MISCELLANEOUS:
Added: “MISCELLANEOUS” section regarding billing of custom fabricated items without a specific HCPCS code
Added: Billing information for all orthoses with the same date of service on the same claim
CODING GUIDELINES:
Revised: “Braces Benefit “ to “braces benefit”
Added: “See “more than minimal self-adjustment” definition below for additional information.” to paragraph referencing the term “minimal self-adjustment”
Revised: “custom-fit” to “custom fitted”
Revised: “off-the-shelf (OTS)” to “OTS”
Revised: Language describing parallel code set availability for identical types of products
Added: “(e.g., L1832, L1833, L1845, L1846, L1847 and L1848)” to language describing parallel code set availability for identical types of products
Added: Language describing kits
Added: Long HCPCS descriptions to coding guidelines for L1810, L1812, L1820, L1830, L1831, L1847, L1848, L1832, L1833, L1834, L1836, L1840, L1843, L1844, L1851, L1845, L1846, L1852, L1850, L1860, L2755, L2820, L2830, L2320, L2330, L4002
Revised: “Durable Medical Equipment” to “durable medical equipment”
Revised: codes” to “code”
Revised: “Braces” to “braces”
Removed: Coding verification review information in reference to HCPCS codes L1845 and L1852
CODING VERIFICATION REVIEW:
Added: Section header and PDAC coding verification review information
Revised: PDAC coding verification review information for HCPCS code L1845, to include effective for DOS on or after 07/01/2008
Revised: PDAC coding verification review information for HCPCS code L1852, to include effective for DOS on or after 01/01/2017
Added: PDAC coding verification review information for HCPCS codes L1832, L1833, and L1851, effective for DOS on or after 10/10/2022

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

MANUAL WHEELCHAIR BASES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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: 10/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

NEGATIVE PRESSURE WOUND THERAPY PUMPS

PA

Revision Effective Date: 08/15/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

ORAL ANTICANCER DRUGS

PA

Revision Effective Date: 10/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

ORAL APPLIANCES FOR OBSTRUCTIVE SLEEP APNEA

PA

Revision Effective Date: 08/08/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

ORTHOPEDIC FOOTWEAR

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

OSTEOGENESIS STIMULATORS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

OSTOMY SUPPLIES

PA

Revision Effective Date: 01/01/2022
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

CODING GUIDELINES:
Added: Code description for HCPCS codes A4436 and A4437

04/14/2022: 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.

OXYGEN AND OXYGEN EQUIPMENT

PA

Revision Effective Date: 08/02/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

PARENTERAL NUTRITION

PA

Revision Effective Date: 09/05/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

PATIENT LIFTS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

PNEUMATIC COMPRESSION DEVICES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

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

PA

Revision Effective Date: 08/08/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):

Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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

PA

Revision Effective Date: 05/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

PRESSURE REDUCING SUPPORT SURFACES - GROUP 2

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

PRESSURE REDUCING SUPPORT SURFACES - GROUP 3

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

REFRACTIVE LENSES

PA

Revision Effective Date: 10/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

RESPIRATORY ASSIST DEVICES

PA

Revision Effective Date: 08/08/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: 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.

SEAT LIFT MECHANISMS

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: 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.

SPEECH GENERATING DEVICES (SGD)

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: "provides" to "provide"
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: 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.

SPINAL ORTHOSES: TLSO AND LSO

PA

Revision Effective Date: 02/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: "The link will be located here once it is available."
Added: "The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here." with a hyperlink to the list

04/14/2022: 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

Revision Effective Date: 04/06/2020
WRITTEN ORDERS PRIOR TO DELIVERY (WOPD):
Added: “The current required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

SUCTION PUMPS

PA

Revision Effective Date: 08/15/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

SURGICAL DRESSINGS

PA

Revised Effective Date: 05/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

THERAPEUTIC SHOES FOR PERSONS WITH DIABETES

PA

Revision Effective Date: 11/05/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

TRACHEOSTOMY CARE SUPPLIES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

TRANSCUTANEOUS ELECTRICAL JOINT STIMULATION DEVICES (TEJSD)

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

PA

Revision History Effective Date: 11/20/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

TUMOR TREATMENT FIELD THERAPY (TTFT)

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

UROLOGICAL SUPPLIES

PA

Revised Effective Date: 04/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

VACUUM ERECTION DEVICE (VED)

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Revised: “provides” to “provide”
Removed: “The link will be located here once it is available.”

Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

WHEELCHAIR OPTIONS/ACCESSORIES

PA

Revision Effective Date: 01/01/2020
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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.

WHEELCHAIR SEATING

PA

Revision Effective Date: 10/01/2021
REQUIREMENTS FOR SPECIFIC DMEPOS ITEMS PURSUANT TO FINAL RULE 1713 (84 FED. REG VOL 217):
Removed: “The link will be located here once it is available.”
Added: “The required Face-to-Face Encounter and Written Order Prior to Delivery List is available here.” with a hyperlink to the list

04/14/2022: 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/or 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 26, 2022

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, Lower Limb Prostheses, Manual Wheelchair Bases, Orthopedic Footwear, Refractive Lenses, and Transcutaneous Electrical Nerve Stimulators (TENS). Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

ANKLE-FOOT/KNEE-ANKLE-FOOT ORTHOSES

PA

Revision Effective Date: 02/01/2021NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “Braces Benefit” to “braces benefit”
Revised: “Coding Guidelines” to “CODING GUIDELINES”
Revised: “Ankle-Foot Orthosis” to “ankle-foot orthosis”
Revised: “CAD-CAM” to “computer-aided design/computer-aided manufacturing (CAD/CAM)”
GENERAL REQUIREMENTS:
Revised: “Coding Guidelines” to “CODING GUIDELINES”
Revised: “off-the-self” to “OTS”
MODIFIERS:
Revised: “KX, GA, and GZ MODIFIERS:” to “GA, GZ, KX, LT and RT MODIFIERS:”
Added: Statement regarding use of RT and LT, with reference to CODING GUIDELINES section for additional information
CODING GUIDELINES:
Revised: Language describing parallel code set availability for identical types of products
Revised: Coding guideline language for HCPCS codes L1900, L1902, L1904, L1906, L1907, L1910, L1920, L1930, L1932, L1940, L1945, L1950, L1951, L1960, L1970, L1971, L1980, L1990, and L2006
Revised: Coding guideline information for HCPCS codes L1910, L1932, and L1951, to include that there are no additional HCPCS codes for these types of orthoses
Added: Long HCPCS descriptions to coding guidelines for HCPCS codes L2006, L2340, and L2755
Revised: Language describing the coding of foot orthotics as L-codes or A-codes
Revised: “Durable Medical Equipment” to “durable medical equipment”
Revised: “Braces” to “braces”
Revised: Format of long HCPCS descriptions for HCPCS codes A9270 and L4205

05/26/2022: 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
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: “beneficiary to be eligible” to “beneficiary’s lower limb prosthesis to be eligible” in regard to eligibility for reimbursement
CONTINUED MEDICAL NEED:
Added: Section header and continued medical need language
MODIFIERS:
Added: Section Header and “RT and LT MODIFIERS:”
Added: Statement regarding use of RT and LT, with reference to CODING GUIDELINES section for additional information
CODING GUIDELINES:
Added: L5781, L5782, L5985, L5988, L5000, L5010, and L5020 coding guidelines
Revised: “ANKLES” to “ANKLE AND LOWER EXTREMITY MOTION UNITS”
Revised: Statement pertaining to products that provide single motion or combination of motions, to include HCPCS codes L5985 and L5988 and to note “functional movement of lower limb during ambulation”
Added: “manufactured by R.G. Rincoe & Associates, Inc.” to L5968 coding guideline predicate product information
Added: “PARTIAL FOOT AND TOE FILLER INSERTS”
Removed: “MODIFIERS”

CODING VERIFICATION REVIEW:
Revised: Location of coding verification review information

05/26/2022: 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.

MANUAL WHEELCHAIR BASES

PA

Revision Effective Date: 01/01/2020
POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:
Removed: Reference to ADMC program-specific information

05/26/2022: 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.

ORTHOPEDIC FOOTWEAR

PA

Revision Effective Date: 01/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Added: L5220 to the list of partial foot or lower extremity prosthesis HCPCS codes that will result in orthopedic shoes denial when the shoes are put on over the prosthesis
MODIFIERS:
Added: LT and RT modifiers
Removed: “code (specific to the 5th digit)”
Added: “code(s) to the highest level of specificity”
Added: Statement regarding use of RT and LT, with reference to CODING GUIDELINES section for additional information
CODING GUIDELINES:
Added: L5220 to the list of other types of leg prostheses that must not be used with HCPCS code L3250

05/26/2022: 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.

REFRACTIVE LENSES

PA

Revision Effective Date: 10/01/2020
NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:
Revised: "Prosthetics and Artificial Limbs" to "prosthetic devices"
CONTINUED MEDICAL NEED:
Added: Section header and continued medical need language

05/26/2022: 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.

TRANSCUTANEOUS ELECTRICAL NERVE STIMULATORS (TENS)

PA

Revision History Effective Date: 11/20/2021
MODIFIERS:
Removed: Q0 (zero) modifier from sub-header, modifier details previously removed

05/26/2022: 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/or 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

Upper Limb Prostheses - Correct Coding

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

View the locally hosted 2022 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 3, 2022

2022 Payment, Quality, & Policy Changes

MLN Connects newsletter for Thursday, March 3, 2022

NEWS

- Ambulance Prior Authorization Model Expands April 1
- Nutrition-related Health Conditions: Recommend Medicare Preventive Services

CLAIMS, PRICERS, & CODES

- HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals

EVENTS

- ICD-10 Coordination & Maintenance Committee Meeting - March 8-9

MLN MATTERS® ARTICLES

- An Omnibus CR Covering: (1) Removal of Two National Coverage Determination (NCDs), (2) Updates to the Medical Nutrition Therapy (MNT) Policy, and (3) Updates to the Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR), and Intensive Cardiac Rehabilitation (ICR) Conditions of Coverage
- The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year (FY) 2020 for Inpatient Prospective Payment System (IPPS) Hospitals, Inpatient Rehabilitation Facilities (IRFs), and Long Term Care Hospitals (LTCHs)

PUBLICATIONS

- Medicare Payment Systems - Revised

MLN Connects - March 10, 2022

COVID-19 Monoclonal Antibodies: Revised Emergency Use Authorization for EVUSHELD

MLN Connects newsletter for Thursday, March 10, 2022

NEWS

- COVID-19 Monoclonal Antibodies: Revised Emergency Use Authorization for EVUSHELD
- Program for Evaluating Payment Patterns Electronic Reports for Short-term Acute Care Hospitals
- Quality Payment Program: 2020 Performance Information on Care Compare
- Skilled Nursing Facilities: Submit Technical Expert Panel Nominations by March 16
- Long-term Care Hospitals: Reissued March 2022 Preview Reports
- Inpatient Rehabilitation Facilities: Reissued March 2022 Preview Reports
- Teaching Hospitals: Direct Graduate Medical Education Resets
- Colorectal Cancer: Screening Saves Lives

COMPLIANCE

- Implanted Spinal Neurostimulators: Document Medical Records

CLAIMS, PRICERS, & CODES

- Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 28.1, Effective April 1, 2022

MLN MATTERS® ARTICLES

- Internet Only Manual Update, Pub. 100-04, Chapter 11, Sections 20.1.4 and 30.3 Regarding the Cancellation of an Election and Billing for Services
- Gap Billing Between Hospice Transfers - Revised

PUBLICATIONS

- Collaborative Patient Care is a Provider Partnership - Revised

MLN Connects - March 17, 2022

Kidney Health: Help Address Disparities

MLN Connects newsletter for Thursday, March 17, 2022

NEWS

- Medicare Shared Savings Program: Application Deadlines for January 1, 2023, Start Date
- Kidney Health: Help Address Disparities

CLAIMS, PRICERS, & CODES

- April 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Federally Qualified Health Centers: Retroactive Claims Adjustments
- Home Health Web Pricer

EVENTS

- Medicare Ground Ambulance Data Collection System: Q&A Session - March 29

MLN MATTERS® ARTICLES

- April 2022 Update to the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)

PUBLICATIONS

- Complying with Medicare Signature Requirements - Revised
- Medicare Preventive Services - Revised
- SBIRT Services - Revised

MLN Connects - March 24, 2022

ICD-10: Comment on Proposed Procedure and Diagnosis Codes

MLN Connects newsletter for Thursday, March 24, 2022

NEWS

- Additional Residency Positions: Apply by March 31
- Long-term Care Hospitals: March Preview Period Ends April 6
- Inpatient Rehabilitation Facilities: March Preview Period Ends April 6
- Home Health Quality Reporting Program: Review Your Preview Reports
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Register in the Open Payments System
- Long-term Care Facilities: Quality Measure Rating Threshold Changes
- Lipid Panel Testing: Comparative Billing Report in March

COMPLIANCE

- DMEPOS Standard Written Order Requirements

CLAIMS, PRICERS, & CODES

- ICD-10 Procedure Codes: Comment by April 8
- ICD-10 Diagnosis Codes: Comment by May 9

MLN MATTERS® ARTICLES

- April Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

MLN Connects Special Edition - March 30, 2022 - Fiscal Year 2023 Hospice Payment Rate Update Proposed Rule - Comment by May 31

On March 30, CMS issued a proposed rule (CMS-1773-P) that would provide routine updates to hospice-based payments and the aggregate cap amount for fiscal year (FY) 2023 in accordance with existing statutory and regulatory requirements. This rule proposes to establish a permanent mitigation policy to smooth the impact of year-to-year changes in hospice payments related to changes in the hospice wage index.

CMS is committed to addressing consistent and persistent inequities in health outcomes by improving data collection to measure and analyze disparities across programs and policies that apply to the Hospice Quality Reporting Program (HQRP). This rule discusses the HQRP including the Hospice Outcomes and Patient Evaluation (HOPE) tool; provides an update on quality measures (QMs) that will be in effect in FY 2023 as well as future QMs; and also provides updates on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey Mode Experiment. This rule also contains a request for information (RFI) on health equity and proposes updates to advancing a health information exchange.

Proposed Medicare Hospice Payment Policies:

This proposed rule proposes a permanent, budget neutral approach to smooth year-to-year changes in the hospice wage index. Specifically, we are proposing a permanent cap on negative wage index changes greater than a 5% decrease from the prior year (regardless of the underlying reason for the decrease) for hospices in the FY 2023 proposed rule.

Routine Annual Rate Setting Changes:

As proposed, hospices would see a 2.7% ($580 million) increase in their payments for FY 2023. The proposed 2.7% hospice payment update for FY 2023 is based on the estimated 3.1% inpatient hospital market basket update reduced by the productivity adjustment (0.4 percentage point). Hospices that fail to meet quality reporting requirements receive a 2-percentage point reduction to the annual market basket update for FY 2023.

The hospice payment update includes a statutory aggregate cap that limits the overall payments per patient that is made to a hospice annually. The proposed cap amount for FY 2023 is $32,142.65 (FY 2022 cap amount of $31,297.61 increased by 2.7%.

Hospice Quality Reporting Program:

This rule provides an update on the development of a patient assessment instrument, titled HOPE, which would contribute to a patient’s plan of care when adopted. This includes an update on the BETA testing and derivatives that will be achieved during this phase of testing, such as burden estimates and timepoints for collection, as well as additional outreach efforts that will be conducted during and after BETA testing and during our future plans for adoption. CMS also discusses potential future quality measures within the HQRP based on HOPE and administrative data, including HOPE-based process measures and hybrid quality measures, which could be based upon multiple sources that include HOPE, claims, and other data sources.

This rule announces a potential future update to the CAHPS Hospice Survey, which is used to collect data on experiences of hospice care from primary caregivers of hospice patients. In particular, CMS is providing an update on a mode experiment whose goal was to test the effect of adding a web-based mode to the CAHPS Hospice Survey.

In this proposed rule, we are seeking information on our Health Equity Initiative within the HQRP by describing our current assessment of health equity within hospice. We are also seeking input on a potential future structural measure as well as responses to specific questions that would further inform future efforts.

More Information:

- Proposed rule: We'll accept public comments until May 31, 2022
- Hospice Center webpage

MLN Connects - March 31, 2022

Continuous Glucose Monitor: Provide Supplies for a Calendar Month

MLN Connects newsletter for Thursday, March 31, 2022

NEWS

- Home Health Providers: Services Provided Data for April 2022 Refresh
- Continuous Glucose Monitor: Provide Supplies for a Calendar Month
- Cognitive Impairment: Medicare Provides Opportunities to Detect & Diagnose

CLAIMS, PRICERS, & CODES

- Hospice Web Pricer

EVENTS

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar - April 26

MLN MATTERS® ARTICLES

- April 2022 Update of the Ambulatory Surgical Center (ASC) Payment System
- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System - Revised

MLN Connects Special Edition - March 31, 2022 - IPF and IRF Proposed FY 2023 Payment Rules

IPF & IRF PROPOSED FY 2023 PAYMENT RULES

- Inpatient Psychiatric Facilities: Fiscal Year 2023 Proposed Rule - Submit Comments by May 31
- Inpatient Rehabilitation Facilities: Fiscal Year 2023 Proposed Rule - Submit Comments by May 31

INPATIENT PSYCHIATRIC FACILITIES: FISCAL YEAR 2023 PROPOSED RULE - SUBMIT COMMENTS BY MAY 31

On March 31, CMS issued the fiscal year 2023 inpatient psychiatric facility (IPF) prospective payment system proposed rule to update IPF payments, wage index, and policies. See a summary of key provisions.

Proposals include:

- Updating payment rates by 2.7% with estimated payments to increase by 1.5% after productivity adjustment
- Requesting comments on the IPF prospective payment system refinement analysis
- Applying a permanent 5% cap on wage index decreases

We encourage you to review the rule, and submit formal comments by May 31, 2022.

INPATIENT REHABILITATION FACILITIES: FISCAL YEAR 2023 PROPOSED RULE - SUBMIT COMMENTS BY MAY 31

On March 31, CMS issued the fiscal year 2023 inpatient rehabilitation facility (IRF) prospective payment system proposed rule to update Medicare payment policies and rates. See a summary of key provisions.

Proposals include:

- Updating payment rates by 2.8%, with estimated overall payments to increase by 2.0% after productivity and outlier adjustments
- Applying a permanent 5% cap on annual wage index decreases
- Expanding quality data reporting on all IRF patients, regardless of payer

We encourage you to review the rule, and submit formal comments by May 31, 2022.

MLN Connects Special Edition - April 4, 2022 - Biden-Harris Administration Announces a New Way for Medicare Beneficiaries to Get Free Over-the-Counter COVID-19 Tests

On April 4, The Biden-Harris Administration announced that more than 59 million Americans with Medicare Part B, including those enrolled in a Medicare Advantage plan, now have access to FDA approved, authorized, or cleared over-the-counter COVID-19 tests at no cost. People with Medicare can get up to 8 tests per calendar month from participating pharmacies and health care providers for the duration of the COVID-19 public health emergency.

“With today’s announcement, we are expanding access to free over-the-counter COVID-19 testing for people with Medicare Part B, including those enrolled in a Medicare Advantage plan. People with Medicare Part B will now have access to up to 8 FDA-approved, authorized or cleared over-the-counter COVID-19 tests per month at no cost. This is all part of our overall strategy to ramp -up access to easy-to-use, at-home tests free of charge,” said HHS Secretary Xavier Becerra. “Since we took office, we have more than tripled the number of sites where people can get COVID-19 tests for free, and we’re also delivering close to 250 million at-home, rapid tests to send for free to Americans who need them. Under the Biden-Harris Administration’s leadership, we required state Medicaid programs, insurers and group health plans to make tests free for millions of Americans. With today’s step, we are further expanding health insurance coverage of free over-the-counter tests to Medicare beneficiaries, including our nation’s elderly and people with disabilities.”

This is the first time that Medicare has covered an over-the-counter self-administered test at no cost to beneficiaries. This new initiative enables payment from Medicare directly to participating eligible pharmacies and other health care providers to allow Medicare beneficiaries to receive tests at no cost, in addition to the 2 sets of 4 free at-home COVID-19 tests Americans can continue to order from covidtests.gov. National pharmacy chains are participating in this initiative, including: Albertsons Companies, Inc., Costco Pharmacy, CVS, Food Lion, Giant Food, The Giant Company, Hannaford Pharmacies, H-E-B Pharmacy, Hy-Vee Pharmacy, Kroger Family of Pharmacies, Rite Aid Corp., Shop & Stop, Walgreens, and Walmart.

“Testing remains a critical tool in mitigating the spread of COVID-19, and we are committed to making sure people with Medicare have the tools they need to stay safe and healthy,” said CMS Administrator Chiquita Brooks-LaSure. “By launching this initiative, the Biden-Harris Administration continues to demonstrate that we are doing everything possible to make over-the-counter COVID-19 testing free and accessible for millions more Americans.”

Providers and suppliers eligible to participate include certain types of pharmacies and other health care providers who are enrolled in Medicare and able to furnish ambulatory health care services such as preventive vaccines, COVID-19 testing, and regular medical visits. To ensure that people with Medicare have access to these tests, Medicare is not requiring participating eligible pharmacies and health care providers go through any new Medicare enrollment processes. If a health care provider currently provides ambulatory health care services such as vaccines, lab tests, or other clinic type visits to people with Medicare, then they are eligible to participate in this initiative.

“For the first time in its history, Medicare is paying for an over-the-counter test,” said Deputy Administrator Dr. Meena Seshamani, Director of the Center for Medicare at CMS. “This is because COVID-19 testing is a critical part of our pandemic response. Combined with the free over-the-counter tests available through covidtests.gov, this initiative will significantly increase testing access for Americans most vulnerable to COVID-19 and will provide valuable information for future payment policy supporting accessible, comprehensive, person-centered health care.”

A list of eligible pharmacies and other health care providers that have committed publicly to participate in this initiative can be found here. Because additional eligible pharmacies and health care providers may also participate, people with Medicare should check with their pharmacy or health care provider to find out whether they are participating.

This initiative adds to existing options for people with Medicare to access COVID-19 testing, including:

- Requesting free over-the-counter tests for home delivery at covidtests.gov. Every home in the U.S. is eligible to order 2 sets of 4 at-home COVID-19 tests.
- Access to no-cost COVID-19 tests through health care providers at over 20,000 testing sites nationwide. A list of community-based testing sites can be found here.
- Access to lab-based PCR tests and antigen tests performed by a laboratory when the test is ordered by a physician, non-physician practitioner, pharmacist, or other authorized health care professional at no cost through Medicare.

- In addition to accessing a COVID-19 laboratory test ordered by a health care professional, people with Medicare can also access one lab-performed test without an order and cost-sharing during the public health emergency.

People with Medicare can get additional information by contacting 1-800-MEDICARE and going to: https://www.medicare.gov/medicare-coronavirus. Medicare also maintains several resources to help ensure beneficiaries receive the correct benefits while also avoiding the potential for fraud or scams. More details—particularly on identifying scams due to COVID-19—can be found at https://www.medicare.gov/basics/reporting-medicare-fraud-and-abuse.

Pharmacies and other health care providers interested in participating in this initiative can get more information here: https://www.cms.gov/COVIDOTCtestsProvider.

More Information:

- Fact Sheet
- COVID-19 Over-the-Counter Tests webpage

MLN Connects Special Edition - April 6, 2022 - Eligible Individuals Can Receive Second COVID-19 Booster Shot at No Cost

On April 6, CMS announced it will pay for a second COVID-19 booster shot of either the Pfizer-BioNTech or Moderna COVID-19 vaccines without cost sharing, as it continues to provide coverage for this critical protection from the virus. People with Medicare pay nothing to receive a COVID-19 vaccine, and there is no applicable copayment, coinsurance, or deductible. People with Medicaid coverage can also get COVID-19 vaccines, including boosters, at no cost.

The CDC recently updated its recommendations regarding COVID-19 vaccinations. Certain immunocompromised individuals and people ages 50 years and older who received an initial booster dose at least 4 months ago are eligible for another booster to increase their protection against severe disease from COVID-19. Additionally, the CDC recommends that adults who received a primary vaccine and booster dose of Johnson & Johnson's Janssen COVID-19 vaccine at least 4 months ago can receive a second booster dose of a Pfizer-BioNTech or Moderna COVID-19 vaccine.

The COVID-19 vaccine, including the booster doses, is the best defense against severe illness, hospitalization, and death from the virus. CMS continues to explore ways to ensure maximum access to COVID-19 vaccinations. More information regarding the CDC COVID-19 Vaccination Program Provider Requirements and how the COVID-19 vaccine is provided through that program at no cost to recipients is available at https://www.cdc.gov/vaccines/covid-19/vaccination-provider-support.html and through the CMS COVID-19 Provider Toolkit.

People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

MLN Connects - April 7, 2022

Improve the Health of Minority Populations with Covered Preventive Services

MLN Connects newsletter for Thursday, April, 7, 2022

NEWS

- Fiscal Year 2021 Program for Evaluating Payment Patterns Electronic Reports
- Preventive Services & Health Equity: Improve the Health of Minority Populations

COMPLIANCE

- What’s the Comprehensive Error Rate Testing Program?

CLAIMS, PRICERS, & CODES

- April 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.1
- Claim Status Category and Claim Status Codes Update

MLN MATTERS® ARTICLES

- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers
- Update to Chapter 7, “Home Health Services,” of the Medicare Benefit Policy Manual (Pub 100-02)

- April 2022 Update of the Hospital Outpatient Prospective Payment System (OPPS)
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Claims Processing Instructions for the New Pneumococcal 15-valent Conjugate Vaccine Code 90671 and Pneumococcal 20-valent Conjugate Vaccine Code 90677 - Revised

PUBLICATIONS

- Advanced Practice Registered Nurses, Anesthesiologist Assistants, & Physician Assistants - Revised

MLN Connects Special Edition - April 7, 2022 - Returning to Certain Pre-COVID-19 Policies & Coverage of Monoclonal Antibodies for Alzheimer's Disease Stakeholder Call

Returning to Certain Pre-COVID-19 Policies & Coverage of Monoclonal Antibodies for Alzheimer's Disease Stakeholder Call

CMS RETURNING TO CERTAIN PRE-COVID-19 POLICIES IN LONG-TERM CARE AND OTHER FACILITIES

CMS is taking steps to continue to protect nursing home residents' health and safety by announcing guidance that restores certain minimum standards for compliance with CMS requirements. Restoring these standards will be accomplished by phasing out some temporary emergency declaration waivers that have been in effect throughout the COVID-19 public health emergency (PHE). These temporary emergency waivers were designed to provide facilities with the flexibilities needed to respond to the COVID-19 pandemic.

During the PHE, CMS used a combination of emergency waivers, regulations, and sub-regulatory guidance to offer health care providers the flexibility needed to respond to the pandemic. In certain cases, these flexibilities suspended requirements in order to address acute and extraordinary circumstances. CMS has consistently monitored data within nursing homes and has used these data to inform decision making.

With steadily increasing vaccination rates for nursing home residents and staff, and with overall improvements seen in nursing homes' abilities to respond to COVID-19 outbreaks, CMS is taking steps to phase out certain flexibilities that are generally no longer needed to re-establish certain minimum standards while continuing to protect the health and safety of those residing in skilled nursing facilities/nursing facilities. Similarly, some of the same waivers are also being terminated for inpatient hospices, intermediate care facilities for individuals with intellectual disabilities, and ESRD facilities.

More Information:

- Full press release
- Quality, Safety, and Oversight memo

JOIN CMS FOR A STAKEHOLDER CALL ON THE MEDICARE COVERAGE POLICY FOR MONOCLONAL ANTIBODIES DIRECTED AGAINST AMYLOID FOR THE TREATMENT OF ALZHEIMER'S DISEASE

Today, the Centers for Medicare & Medicaid Services (CMS) released a national policy for coverage of aducanumab (brand name Aduhelm™) and any future monoclonal antibodies directed against amyloid approved by the FDA with an indication for use in treating Alzheimer's disease. From the onset, CMS ran a transparent, evidence-based process that incorporated more than 10,000 stakeholder comments and more than 250 peer-reviewed documents into the determination.

As finalized in this two-part National Coverage Determination (NCD), Medicare will cover monoclonal antibodies that target amyloid (or plaque) for the treatment of Alzheimer's disease that receive traditional approval from the Food and Drug Administration (FDA) under coverage with evidence development (CED). CMS, as a part of this decision, will provide enhanced access and coverage for people with Medicare participating in CMS-approved studies, such as a data collection through routine clinical practice or registries. Registry data may be used to assess whether outcomes seen in carefully controlled clinical trials (e.g., FDA trials) are reproduced in the real-world and in a broader range of patients. Any new drugs in this class that receive FDA traditional approval may be available in additional care settings that people with Medicare can use, such as an outpatient department or an infusion center. Secondly, for drugs that FDA has not determined to have shown a clinical benefit (or that receive an accelerated FDA approval), Medicare will cover in the case of FDA or National Institutes of Health (NIH) approved trials. Under this NCD, CMS will support the FDA by covering the drug and any related services (including, in some cases, PET scans if required by trial protocol) for people with Medicare who are participating in these trials.

More Information:

- Complete press release
- Fact sheet on Medicare coverage policy for monoclonal antibodies directed against amyloid for the treatment of Alzheimer's disease
- Final NCD CED decision memorandum

STAKEHOLDER CALL

What: CMS invites you to join a stakeholder call on the Medicare Coverage Policy for Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease

Decision Follows Robust Stakeholder Input and Creates Pathway for Enhanced Access and Coverage of Drugs that Receive Traditional FDA Approval

When: April 11, 2022 at 11:00 AM ET

How to register.

MLN Connects Special Edition - April 11, 2022 - HHS Takes Actions to Promote Safety & Quality in Nursing Homes

HHS Takes Actions to Promote Safety & Quality in Nursing Homes

On April 11, CMS issued its fiscal year (FY) 2023 Skilled Nursing Facilities Prospective Payment System (SNF PPS) proposed rule, which includes asking for public feedback on how staffing in nursing homes and health equity improvements could lead to better health outcomes.

The proposed rule builds upon the Biden-Harris Administration’s commitment to advance health equity, drive high-quality person-centered care, and promote sustainability of its programs. The rule is an important step in fulfilling its goal to protect Medicare skilled nursing facility (SNF) residents and staff by improving the safety and quality of care of the nation’s SNFs (commonly referred to as nursing homes). The SNF PPS provides Medicare payments to over 15,000 nursing homes, serving more than 1.5 million people. Medicare spending to nursing homes is projected to be approximately $35 billion in FY 2022. Through the SNF PPS proposed rule, CMS is continuing its work to transform the SNF payment system to a more patient-centered model by making payments based on the needs of the whole patient, rather than focusing on the volume of certain services the patient receives.

“Everyone deserves to receive safe, dignified, and high-quality care, no matter where they live,” said HHS Secretary Xavier Becerra. “Today we are starting the necessary work to ensure our loved ones living in nursing homes receive the best care at the staffing levels they need. We are working hard to deliver on President Biden’s commitment to protecting seniors and improving the quality of our nation’s nursing homes.”

The SNF PPS proposed rule aims to realize the President’s vision for the nation’s nursing homes as outlined in his State of the Union Address, with a focus on providing safe, dignified, and appropriate care for residents. As part of this vision, the Biden-Harris Administration recently set a goal to improve the quality of nursing homes so that seniors, people with disabilities, and others living in nursing homes get the reliable, high-quality care they deserve. A key part of reaching this goal is addressing staffing levels in nursing homes, which have a substantial impact on the quality of care and outcomes residents experience.

“The COVID-19 pandemic has highlighted serious problems at some of the nation’s nursing homes that have persisted for too long. And we have seen the tragic impact that inadequate staff resources can have on residents and staff,” said CMS Administrator Chiquita Brooks-LaSure. “The Biden-Harris Administration has promised that we will work with all stakeholders to do better for nursing home residents, and today’s proposed rule includes important steps toward our goal to promote safety and quality of care for all residents and staff.”

In the SNF PPS proposed rule, CMS is soliciting input to help the agency establish minimum staffing requirements that nursing homes will need to meet to ensure all residents are provided safe, high-quality care, and nursing home workers have the support they need. This input will be used in conjunction with a new research study being conducted by CMS to determine the optimal level and type of nursing home staffing needs. The agency intends to issue proposed rules on a minimum staffing level requirement for nursing homes within one year.

CMS is also requesting stakeholder input on a measure that would examine staff turnover levels in nursing homes for possible inclusion in CMS' SNF Value-Based Purchasing (VBP) Program, which rewards facilities with incentive payments based on the quality of care they provide to people with Medicare. Looking at the relationship between staff turnover and quality of care, preliminary analysis by CMS has shown that as the average staff turnover decreases, a facility's overall rating on CMS' Nursing Home Five Star Quality Rating System increases, which suggests that lower turnover is associated with higher overall quality. CMS will use the stakeholder feedback to inform a proposal of this measure to include in the SNF VBP Program in the future.

In January, CMS began posting nursing home staff turnover rates (as well as weekend staff levels) on the Medicare.gov Care Compare website, and CMS will be including this information in the star rating system starting in July 2022. This information helps consumers better understand each nursing home facility's staffing environment and also helps providers to improve the quality of care and services they deliver to residents.

The proposed rule also proposes the adoption of 3 new measures into the SNF VBP Program:

- The Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI) is an outcome measure that assesses SNF performance on infection prevention and management.
- The Total Nursing Hours per Resident Day is a structural measure that uses auditable electronic data to calculate total nursing hours per resident each day.
- The Adoption of the Discharge to Community - Post Acute Care Measure for SNFs (DTC) is an outcome measure that assesses the rate of successful discharges to community from a SNF setting.

To advance health equity and address the health disparities that underlie the U.S. health care system, CMS is requesting stakeholder feedback on the role health equity plays in improving health outcomes and the quality of care in nursing homes. Specifically, CMS is seeking comment on how to arrange or classify measures in nursing home quality reporting programs by indicators of social risk to better identify and reduce disparities.

CMS is proposing a 3.9%, or $1.4 billion, update to the payment rates for nursing homes, which is based on a 2.8% SNF market basket update plus a 1.5 percentage point market basket forecast error adjustment and less a 0.4 percentage point productivity adjustment. The proposed rule also contains a proposed adjustment to payment rates as the result of the transition to the SNF payment case-mix classification model - the Patient Driven Payment Model (PDPM) that went into effect on October 1, 2019. When finalizing the PDPM, CMS also stated that the transition to PDPM would not result in an increase or decrease in aggregate SNF spending. Since PDPM implementation, CMS' data analysis has shown an unintended increase in payments. Therefore, CMS is proposing to adjust SNF payment rates downward by 4.6%, or $1.7 billion, in FY 2023 to achieve budget neutrality with the previous payment system. As a result, the estimated aggregate impact of the payment policies in this proposed rule would be a decrease of approximately $320 million in Medicare Part A payments to SNFs in FY 2023 compared to FY 2022.

More Information:

- Proposed rule
- Fact sheet: President Biden's remarks during the State of the Union Address on improving nursing home safety and quality
- Fact sheet: FY 2023 SNF PPS proposed rule

MLN Connects - April 14, 2022

COVID-19: New Codes for Moderna Vaccine Booster Doses

MLN Connects newsletter for Thursday, April 14, 2022

NEWS

- Launch of the Cross-Cutting Initiatives
- Value-Based Insurance Design Model: Medicare Advantage Organizations Pay for Hospice Care

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

CLAIMS, PRICERS, & CODES

- COVID-19: New Codes for Moderna Vaccine Booster Doses

EVENTS

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar - April 26

MLN Connects Special Edition - April 18, 2022 - CMS Proposes Policies to Advance Health Equity & Maternal Health, Support Hospitals

On April 18, CMS issued a proposed rule for inpatient and long-term hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. In addition to annual policies that promote Medicare payment accuracy and hospital stability, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule includes measures that will encourage hospitals to build health equity into their core functions, thereby improving care for people and communities who are disadvantaged and/or underserved by the health care system. The rule includes 3 health equity-focused measures in hospital quality programs, seeks stakeholder input related to documenting social determinants of health in inpatient claims data, and proposes a "Birthing-Friendly" hospital designation.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users, the proposed increase in operating payment rates is projected to be 3.2%. This reflects a FY 2023 projected hospital market basket update of 3.1% reduced by a projected 0.4 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by statute. Under the LTCH PPS, CMS expects payments to increase by approximately 0.8% or $25 million.

Additional items in the proposed rule related to payment stability for hospitals include a policy that smooths out significant year-to-year changes in hospitals' wage indexes and a solicitation for comments on payment adjustments for purchasing domestically made surgical N95 respirators. Specifically, CMS is proposing to apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior FY; and is considering the appropriateness of payment adjustments accounting for additional costs of purchasing surgical N95 respirators made in the U.S.

More Information:

- Complete press release
- Proposed payment rule fact sheet
- Maternal health & health equity measures fact sheet
- White House statement on Reducing Maternal Mortality and Morbidity
- Proposed rule: Comment by June 17

MLN Connects - April 21, 2022

Medicare Provider Compliance News

MLN Connects newsletter for Thursday, April 21, 2022

NEWS

- Hospice Quality Reporting Program: Key Dates & Measure Change
- Ambulance Ground Transport: Comparative Billing Report in April
- Hospices: Aggregate & Inpatient Caps under the Value-Based Insurance Design Model

COMPLIANCE

- Medicare Provider Compliance Newsletter
- DMEPOS Items: Medical Record Documentation

EVENTS

- CMS Health Equity Symposium - April 28

MLN MATTERS® ARTICLES

- Update to Publication 100-04, Chapter 18 and Publication 100-02, Chapter 15, Section to Add Data Regarding Novel Coronavirus (COVID-19) and its Administration to Current Claims Processing Requirements and Other General Updates

PUBLICATIONS

- Medicare Modernization of Payment Software - Revised

MLN Connects - April 28, 2022

Get Patient Eligibility Information for Additional Services

MLN Connects newsletter for Thursday, April 28, 2022

NEWS

- Patient Eligibility Information for Additional Services - Now Available
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Are You on the Missing Digital Contact Information Report?

CLAIMS, PRICERS, & CODES

- HCPCS Application Summaries & Coding Decisions: Drugs and Biologicals
- Corrections to Home Health Billing for Denial Notices and Calculation of 60-Day Gaps in Services
- Updates for Medical Severity Diagnosis Related Groups (MS-DRG) Subject to Inpatient Prospective Payment System (IPPS) Replaced Devices Offered Without Cost or With a Credit Policy Fiscal Years (FYs) 2021-2022
- Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

EVENTS

- Inpatient Rehabilitation Facility & Long-Term Care Hospital Virtual Training Program - June 15-16

MLN Connects - May 5, 2022

COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers

MLN Connects newsletter for Thursday, May 5, 2022

NEWS

- COVID-19: Patients Can Get Free Over-the-Counter Tests from Participating Providers
- Immunosuppressive Drug Coverage for Kidney Transplant Patients: Proposed Rule
- Diabetic Testing Supplies Ordering Guide
- Inpatient Rehabilitation Facilities: Care Compare March Preview Reports Reissued & April Refresh
- Long-Term Care Hospitals: Care Compare March Preview Reports Reissued & April Refresh
- Skilled Nursing Facilities: Care Compare April Preview Reports & Refresh
- May is National Asian American, Native Hawaiian, & Pacific Islander Heritage Month

CLAIMS, PRICERS, & CODES

- Outpatient Claims with Reason Code W7120 Returned in Error
- Eliminating Certificates of Medical Necessity & Durable Medical Equipment Information Forms - January 1, 2023

EVENTS

- CMS National Provider Enrollment Conference in Boston - August 16 & 17

MLN MATTERS® ARTICLES

- Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance
- Update to the Payment for Grandfathered Tribal Federally Qualified Health Centers (FQHCs) for Calendar Year (CY) 2022
- Section 127 of the Consolidated Appropriations Act: Graduate Medical Education (GME) Payment for Rural Track Programs (RTPs)
- New Waived Tests - Revised
- Update to Chapter 7, "Home Health Services," of the Medicare Benefit Policy Manual (Pub 100-02) - Revised

PUBLICATIONS

- Medical Record Maintenance & Access Requirements - Revised
- Medicare Mental Health - Revised

MLN Connects - May 12, 2022

Biosimilars Curriculum: Resources for Teaching Your Students

MLN Connects newsletter for Thursday, May 12, 2022

NEWS

- Comprehensive Error Rate Testing Documentation Center Moved on April 13
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Ambulance Prior Authorization Model Expands June 1
- Clinical Laboratory Fee Schedule 2023 Preliminary Gapfill Rates: Submit Comments by July 11
- Medicare Cards Without Full Names
- CMS Releases Chronic Pain Experience Journey Map
- Biosimilars Curriculum: Resources for Teaching Your Students
- Women's Health: Talk to Your Patients About Preventive Services

COMPLIANCE

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

EVENTS

- HCPCS Public Meeting - June 7-10

MLN MATTERS® ARTICLES

- Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model - Implementation
- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests
- National Coverage Determination (NCD) 210.14 Reconsideration - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers - Revised

INFORMATION FOR MEDICARE PATIENTS

- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

MLN Connects - May 19, 2022

Biosimilars: Safe, Effective, & May Reduce Patient Costs

MLN Connects newsletter for Thursday, May 19, 2022

NEWS

- Biosimilars: Safe, Effective, & May Reduce Patient Costs
- PECOS Scroll Functionality
- Clinical Laboratory Improvement Amendments: Unpaid Certificate Fees
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB)
- Mental Health: Help Address Disparities

COMPLIANCE

- Collaborative Patient Care is a Provider Partnership

MLN MATTERS® ARTICLES

- Elimination of Certificates of Medical Necessity & Durable Medical Equipment Information Forms
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs)-October 2022 Update
- Revisions to Medicare Part B Coverage of Pneumococcal Vaccinations for the Medicare Benefit Policy Manual Chapter 15, Section 50.4.4.2

PUBLICATIONS

- Chronic Care Management Services - Revised
- Home Health Quality Reporting Program: Draft OASIS-E Guidance Manual

MLN Connects - May 26, 2022

Biosimilars: Interchangeable Products May Increase Patient Access

MLN Connects newsletter for Thursday, May 26, 2022

NEWS

- COVID-19: New Administration Code for Pfizer Pediatric Vaccine Booster Dose
- Biosimilars: Interchangeable Products May Increase Patient Access
- Critical Care Evaluation & Management Services: Comparative Billing Report in May

COMPLIANCE

- Surgical Dressings: Medicare Requirements

PUBLICATIONS

- Screening Pap Tests & Pelvic Exams - Revised

MLN MATTERS

April 2022 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: December 22, 2021
Related CR Transmittal Number: R11169CP
Related Change Request (CR) Number: CR12559
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12559 tells you that CMS will supply the contractors with the Average Sales Price (ASP) and Not Otherwise Classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12559.

April Quarterly Update for 2022 DMEPOS Fee Schedule

MLN Matters Number: MM12654
Related CR Release Date: May 10, 2022
Related CR Transmittal Number: R11292CP
Related Change Request (CR) Number: 12654
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12654 tells you about:

- The April 2022 quarterly update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule
- Fee schedule amounts for new and existing codes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12654.

Calendar Year 2023 Modifications/Improvements to VBID Model - Implementation

MLN Matters Number: MM12688
Related CR Release Date: April 29, 2022
Related CR Transmittal Number: R11383DEMO
Related Change Request (CR) Number: 12688
Effective Date: January 1, 2023
Implementation Date: January 3, 2023

CR 12688 tells you about:

- Modifications in the Value-Based Insurance Design (VBID) Model's Hospice Benefit Component for Calendar Year (CY) 2023; and
- The applicable requirements in CR 11754 and CR 12349 that still apply.

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)12688.

Claim Status Category and Claim Status Codes Update

Related CR Release Date: February 4, 2022
Related CR Transmittal Number: R11251CP
Related Change Request (CR) Number: 12505
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12505 is to update, as needed, the Claim Status and Claim Status Category Codes used for the Accredited Standards Committee (ASC) X12 276/277 Health Care Claim Status Request and Response and the ASC X12 277 Health Care Claim Acknowledgment transactions.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12505.

Elimination of Certificates of Medical Necessity & DME Information Forms

MLN Matters Number: SE22002
Article Release Date: May 12, 2022
Related CR Transmittal Number: R11414CP
Related Change Request (CR) Number: 12734
Effective Date: June 13, 2022
Implementation Date: June 13, 2022

CMS is discontinuing Certificates of Medical Necessity (CMNs) and Durable Medical Equipment (DME) Information Forms (DIFs) effective January 1, 2023.

Make sure your billing and IT staff knows about these changes for CMNs and DIFs:

- For services on or after January 1, 2023: Don't submit CMN or DIF forms or their electronic claim data elements with the claims or we'll reject your claims and return them to you
- For services before January 1, 2023: Submit CMN and DIF forms or their electronic claim data elements with the claims if required

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)22002.

Mental Health Visits via Telecommunications for RHCs & FQHCs - Revised

MLN Matters Number: SE22001 Revised
Article Release Date: May 5, 2022

Note: CMS revised this Article to show that RHCs must include modifier CG on claims for mental health visits via telecommunications. This change is in dark red font on page 2. All other information is the same.

SE 22001 tells you about:

- Regulatory changes for mental health visits in Rural Health Clinics (RHCs) & Federally Qualified Health Centers (FQHCs)
- Billing information for mental health visits done via telecommunications

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters Special Edition (SE)22001.

Quarterly Update for the DMEPOS CBP - April 2022

Related CR Release Date: January 14, 2022
Related CR Transmittal Number: R11182CP
Related Change Request (CR) Number: 12569
Effective Date: April 1, 2022
Implementation Date: April 4, 2022

CR 12569 explains that the DME CBP files are updated on a quarterly basis in order to implement necessary changes to the healthcare common procedure coding system, ZIP code, and single payment amount files. These requirements provide specific instruction for implementing the Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) files. This recurring update notification applies to chapter 23, section 100.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)12569.

RARC, CARC, MREP and PC Print Update

MLN Matters Number: MM12676
Related CR Release Date: March 25, 2022
Related CR Transmittal Number: R11301CP
Related Change Request (CR) Number: 12676
Effective Date: July 1, 2022
Implementation Date: July 5, 2022

CR 12676 tells you about:

- The latest update of the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason Code (CARC) code sets
- What you must do if you use Medicare Remit Easy Print (MREP) or PC Print
- Where to find the official code lists

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)12676.