DME Happenings

Jurisdiction A
December 2023

Healthcare Solutions

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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Advanced Beneficiary Notice of Non-coverage (ABN) and Appeals - Appeals Newsletter Part 5

Noridian's Appeals team has seen an increase in appeals that do not have the ABN form with the request, Without the ABN, the appeal decision will cause the liability to change to the providers. Frequently, we receive the ABN once the providers receive the shift in liability notice.

- Noridian can no longer treat this as a Redetermination, and it must be sent to the Reconsideration contractor.
- This increases the amount of time for your appeals to be finalized.
- Adds work unnecessarily for our Appeals team and the Reconsideration contractor.

Action

Make sure you have your documentation available when creating an appeal. When a service is appealed that has a previously signed ABN, include a copy in the appeal request.

Avoid Denials - Reminder When Billing Multiple Units of Service with the Same HCPCS Code and Same Date of Service

Suppliers should **always** bill multiple units of service with the same HCPCS code and the same date of service on one claim line, with these exceptions:

- Submitted amount exceeds $999,999
- Single line units exceed 999
- Modifier requirements i.e., RT, LT for bilateral items, or liability modifiers
- Nutrition and drugs, different strengths or types of formula with narrative included on claim to explain

If this requirement is not met, the claim will be denied as exact duplicate claim/service and the claim will need to be appealed.

Canceled Orders for Customized Items

When an order for a customized item is canceled, the beneficiary passes away before the scheduled delivery or the beneficiary's condition changed and the item is no longer reasonable and necessary or appropriate, suppliers are eligible for reimbursement for the labor and parts invested in the customization process.

The allowed amount is based on the services furnished and materials used, up to the date the supplier learned of the beneficiary's death or of the cancellation of the order or that the item was no longer reasonable and necessary or appropriate.

To facilitate this reimbursement process, the following guidelines must be adhered to:

1. **Claim Narrative:** When submitting a claim for reimbursement, it is imperative to include a clear and concise claim narrative that describes the reason for the cancellation. This narrative should provide specific details, such as the cause of cancellation (e.g., death, order cancellation), and should be placed in Item 19 of the CMS-1500 claim form or within the NTE segment of loop 2400 when submitting an electronic claim.
2. **Date of Service (DOS):** The DOS indicated on the claim must correspond to either the date when the order was officially canceled or the date of the beneficiary's death. Ensuring accurate DOS information is vital to expedite the reimbursement process.

For more comprehensive guidance and additional information regarding the reimbursement process for canceled orders of customized items, please consult the CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 20.3

Competitive Bid Non-Contract Exceptions

Exception: Medicare physicians or other treating practitioners IN a CBA, who are enrolled as Medicare DMEPOS suppliers (without being a competitive bid contract supplier) must append the KV or J5 modifier to the claim only when the following requirements are met:

- The OTS back or knee brace must be furnished by the physician or other treating practitioner to their own patient as part of their professional service
- If brace provided prior to surgery or no surgery planned, brace must be medically necessary to be worn at home prior to surgery

CMS Update: If a brace is provided post-surgery, the claim should adhere to the following guidelines:

- If brace provided after surgery, claim must have same date of service (DOS) as surgery
- If brace provided as part of an unbillable follow-up visit during post-operative period **and** related to recovery
    - Bill with surgery DOS, or
    - Bill with follow-up visit DOS and include narrative indicating brace applies to same date as surgery
        - **Narrative example:** brace associated with surgery DOS 05/01/2023
        - Enter narrative in Item 19 of 1500 claim form or 2400/NTE segment of electronic claim

If the claim denies, appeal with documentation to support need for the brace post-surgery.

News

CMS Appeal Update: Appeal rights have been offered for off-the-shelf orthotics furnished by physicians and other treating practitioners in a CBA on DOS January 1, 2021 - December 31, 2023. Braces must have been furnished under the physician exception (above) for these circumstances to allow an appeal:

- Brace provided at unbillable office visit with KV modifier on claim
- Brace provided (as necessary part of recovery) at unbillable office visit as part of global services following post-op procedure with KV modifier

Find additional information on the Noridian Competitive Bidding webpage.

Continuous Glucose Monitors - No Prior Authorization Required for Medicare Fee-for-Service

Noridian has received many calls to the Provider Call Center and questions to the Education team about continuous glucose monitors (CGMs) needing prior authorization for Medicare coverage. No prior authorization is required for coverage of CGMs for beneficiaries with Medicare Fee-for-Service.

Coverage Criteria for Intermittent Urinary Catheters A4353 - Immunosuppressed Beneficiaries Meeting Criteria 2

Immunosuppressed criteria for the A4353 (intermittent urinary catheter, with insertion supplies) are covered when a beneficiary requires catheterization and the beneficiary is immunosuppressed, for example below (**not an all-inclusive list**).

- On a regimen of immunosuppressive drugs post-transplant,
- On cancer chemotherapy,
- Has AIDS,
- Has a drug-induced state such as chronic oral corticosteroid use.
- High-level spinal cord injury patients (T3 and higher) will be considered for coverage when conducting medical reviews

Please note that the above list indicates that it is not an all-inclusive list. For all conditions, the practitioner is required to clearly document the condition causing the immunosuppression within the beneficiary's medical records to qualify for criteria 2. These practitioner records must meet the medical necessity based on the coverage criteria listed within the Local Coverage Determination (LCD) L33803.

News

Ensure Your Medical Records Correspondence Address is Correct

We encourage all providers and suppliers to ensure your enrollment record in PECOS has a Medical Records Correspondence Address (MRCA) on file that is kept up-to-date. This address is used by your Medicare Administrative Contractor (MAC) to request medical records.

Although the MRCA has been on the enrollment forms for some time, the use of addresses by MACs is relatively new, so we would encourage all providers to make sure that an address is present in this field. Note that if this field is blank, the payee address is used for medical records requests.

The MRCA may also be used by other Medicare contractors doing claim reviews to request medical documentation, but the following contractors are not doing so at this time, as explained below. When applicable, we have provided ways you can control which address is used for your medical records requests.

CERT (Comprehensive Error Rate Testing program): Call CERT Customer Service at 888-779-7477 to request that records requests be mailed to a specific address.

SMRC (Supplemental Medical Review Contractor): This contractor uses the mailing address for requesting records.

RAC (Recovery Audit Contractor): This contractor uses the payee address or physical address for requesting records. For the DME RAC, below is a link for specifying contact information.

Performant Financial - CMS RAC - Update Provider Contact Information

UPIC (Unified Program Integrity Contractor): For pre-payment reviews, the UPIC uses the MRCA for records request, with the default to the payee address if the MRCA is not present. For post-payment review requests, the payee address is used.

Enteral Nutrition - Documentation Requirements

In order to justify payment for enteral nutrition, suppliers have met the following documentation in their records (to be available upon request):

- Standard Written Order (SWO)
- Medical record documentation (including continued need/use when applicable)
- Correct coding
- Proof of delivery (POD)

No more than one month's supply of nutrients, equipment or supplies is allowed with prospective billing. Claims submitted retroactively may include multiple months.

Treating Practitioner Expectations

A SWO is required for each item billed to Medicare. The medical records must support the information provided on the SWO, as an order is not considered part of the medical record.

The medical record must contain sufficient information about the medical condition to substantiate that the applicable Medicare coverage criteria have been met. The documentation must support that the beneficiary has full or partial non-function or disease of the structures that normally permit food to reach the small bowel; or, disease that impairs digestion/absorption of an oral diet, directly or indirectly, by the small bowel, and that the condition is of long and indefinite duration.

This information must justify the type of enteral nutrient ordered, the number of calories ordered, how the nutrition is administered, justification when special formulas are used, and the frequency of feedings.

The medical records must include enough information to support that coverage criteria have been met, including, but not limited to:

- Beneficiary's diagnosis (this alone does not support medical necessity)
- Duration of beneficiary's condition
- Clinical course (worsening or improvement)
- Prognosis
- Nature and extent of functional limitations
- Other therapeutic interventions and results
- Previous experience with related items
- Any other pertinent information related to use of enteral nutrition

The Clinician Letter - Medical Records and Documentation Checklist are invaluable resources to ensure all necessary information is included. Refer to the Noridian Medicare Enteral Nutrition webpage for additional resources.

Entering the Correct Ordering Practitioner on Claims

Recently the Durable Medical Equipment Medicare Administrative Contractors (DME MAC) have noted an increase in Comprehensive Error Rate Testing (CERT) program denials when the name and National Provider Identifier (NPI) of the referring practitioner, listed in Item 17 and Item 17b of the CMS-1500 claim form and electronic equivalent do not match the name and NPI of the practitioner who **completed the order**. Title XVIII §1833(q) of the Social Security Act requires the referring/ordering physician information be submitted on a Medicare claim when the billing provider/supplier has received a referral or order for the referred/ordered service(s) or item.

This type of error can occur as the result of Medicare beneficiaries who are under the care of multiple physicians or the death, reassignment, or retirement of their primary care provider, resulting in a change in providers. Suppliers are strongly encouraged to check their documentation from referring practitioners and ensure that the information listed in Item 17 and Item 17b on the CMS-1500 form or electronic equivalent for the referring provider matches the information on the order for any item of durable medical equipment, orthotics, prosthetics or supplies (DMEPOS).

External Breast Prostheses: Supporting Medicare Beneficiaries

During Breast Cancer Awareness Month, we extend our support to suppliers offering essential services to those affected by this devastating disease. Medicare covers external breast prostheses for Medicare beneficiaries who meet the necessary criteria.

Robust medical documentation is critical in supporting the provision of external breast prostheses and related supplies.

Medicare coverage mandates that a patient's medical record must indicate a history of mastectomy and include a valid and complete order for coverage. This includes coverage for supplies both at the time of mastectomy and for ongoing needs.

Suppliers should refrain from submitting reimbursement claims until they receive a Standard Written Order (SWO). Additionally, the patient's medical record must contain information that justifies ongoing medical necessity. This information should be made available to the supplier or review contractor upon request.

The following types of documentation may substantiate the continued medical need for external breast prostheses and supplies:

- A recent order from the treating physician for refills
- The treating physician does not have to be the surgeon, and the order can address ongoing care not necessarily related to the mastectomy.
- A recent prescription change.
- Timely documentation in the beneficiary's medical record demonstrating the use of these items, as defined by a record entered within the preceding 12 months.
    - This documentation must indicate mastectomy or the absence of a breast.
    - In the absence of evidence of reconstruction, the original mastectomy surgery documentation is sufficient to verify the mastectomy.

Medicare guidelines typically determine the reasonable and useful lifetime of DME, orthotics, and certain prosthetics, with a minimum duration of five (5) years. However, external breast prostheses are an exception to this rule. The useful lifetime of silicone breast prostheses is 2 years, and fabric, foam, or fiber-filled breast prostheses, is 6 months. Nevertheless, a breast prosthesis may be replaced at any

time if it is lost, irreparably damaged (excluding ordinary wear and tear), or if there is a change in the beneficiary's medical condition necessitating a different type of item.

By following these guidelines, you can ensure that Medicare beneficiaries receive the necessary support and that claims for external breast prostheses are processed correctly.

Hospital Bed Resources

The Noridian website provides an all-in-one resource page for hospital beds. The page includes link to the Local Coverage Determination (LCD), Policy Article, Clinician Checklist, Clinician Letter, Documentation Checklist, and tips on billing miscellaneous code E1399, providing a pressure reducing support surface with a hospital bed, and billing instructions.

How to Bill for Hospital Beds and Pressure Reducing Support Surfaces

Suppliers have asked how they can bill appropriately for hospital beds and pressure reducing support surfaces (PRSS). Noridian maintains a Hospital Beds webpage, which provides suppliers with the most up-to-date information. On this page, you will find links to the Medical Director Articles page. Under the 2017 articles, you will find a publication titled, Billing Instructions - Hospital Beds and Pressure Reducing Support Surfaces. This article contains special billing instructions for beneficiary-owned hospital beds, capped rental beds, and new initial rental hospital beds.

Intravenous Immune Globulin (IVIG) Demonstration Ending on December 31, 2023

The Intravenous Immune Globulin (IVIG) Demonstration is ending on December 31, 2023. IVIG will become a permanent benefit of Medicare starting January 1, 2024. Suppliers should continue supplying IVIG as usual. The new fee schedule amount for IVIG in 2024 is $420.48. Suppliers will continue to bill with HCPCS code Q2052 (administration code). The Q2052 code and J codes (drug codes) can be billed on separate claims. Suppliers will need to bill the appropriate DME MAC based on the beneficiary’s permanent address with the Social Security Administration. For more information on these changes monitor our Website and Schedule of Events for webinars covering this information.

Introducing the Noridian Medicare Chat

The Noridian Medicare website has launched a new chatbot feature named the **Noridian Medicare Chat**. This chatbot is available as an icon in the lower right-hand corner on each of our webpages.

Currently, the **Noridian Medicare Chat** can assist you with:

- An **Application** to enroll as a provider
- To **Appeal** an application to enroll
- To **Reopen** a claim

Moving forward, we will add functionality to assist users with additional topics. If you want to suggest topics you'd like to see added to the **Noridian Medicare Chat**, please use the Feedback Tab found on the right side of our website to let us know.

New CMS Home Page - Provider Feedback Desired

On September 6, 2023, the Centers for Medicare and Medicaid Services (CMS) will be launching an updated homepage with new navigation functions and search features on CMS.gov. CMS would like to hear from you on how these changes will affect your work and any further enhancements that could be made.

Noridian encourages providers to visit CMS' homepage, https://www.cms.gov/, to review these new changes. On the top of CMS' current homepage there is a link to review the new page and share your feedback.

Noridian Medicare Portal vs. Noridian Medicare Website: Know the Difference

It's not uncommon for suppliers to be unaware that there are two distinct resources available: the Noridian Medicare website and the Noridian Medicare Portal (NMP). These two platforms serve different purposes, and understanding their functions can be highly beneficial.

The Noridian Medicare website offers a wealth of educational materials and resources. On the other hand, the Noridian Medicare Portal serves as a self-service tool for suppliers, providing various functionalities such as checking eligibility, accessing claim information (including remittance advices), managing claim reopenings and appeals, and much more.

Switching between these two websites is simple:

- When working within the NMP, clicking on the prominent Noridian icon in the top left-hand corner will take you directly to the main page of the Noridian Medicare website. From there, you can select the jurisdiction you need to access.
- Conversely, if you find yourself on the Noridian Medicare website and wish to swiftly navigate to the portal, there is a convenient quick link located at the top right of the website for speedy login access. Additionally, a prominent button in the center of the jurisdiction homepage provides the same access.

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The Noridian Medicare website serves as a repository for essential resources, including links to CMS, Local Coverage Determinations, Policy Articles, comprehensive documentation, clinician checklists, guidance on submitting claims, strategies for resolving denials, and much more. Noridian also offers webinars for suppliers with registration available on the website, 24/7 self-service tutorials, one-on-one electronic supplier visits, and a range of tools designed to facilitate the reimbursement process.

Whereas the NMP serves as a self-service tool for suppliers, providing various functionalities.

The following functions are offered within NMP:

- Eligibility
- MBI Lookup Inquiry
- Claim Status
- ADR Status and Submission
- CID Status Lookup (CERT Claims)
- Self Service Reopenings (DME)
- Recoupment Requests
- Appeals Status (Part B and DME)
- Begin New Appeal
- Remittance Advices
- Financials
- Overpayments
- 1099s
- Same or Similar (DME Only)
- Prior Authorizations (DME)
- Message Center

By distinguishing between these two resources and making efficient use of both, suppliers can enhance their ability to navigate the Medicare system effectively and provide better support to beneficiaries.

Notification of the 2024 Dollar Amount in Controversy Required to Sustain Appeal Rights for an ALJ Hearing or Federal District Court Review

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2024, for an Administrative Law Judge (ALJ) Hearing is **$180**.

The dollar amount in controversy required to sustain appeal rights, beginning January 1, 2024, for a Federal District Court Review is **$1,840**.

News

Optimizing Claim Denial Resolution with Noridian Medicare Portal (NMP)

Suppliers frequently reach out to our Supplier Contact Center seeking clarification on denied claims or updates on a claims' status. Fortunately, our self-service tool on the Noridian Medicare Portal (NMP) offers a convenient and cost-effective solution to address these common concerns. Accessible under the "Claim Status" section, this tool empowers suppliers to swiftly retrieve the information they need, saving valuable time and resources.

Furthermore, the NMP provides access to the claim specific remittance advice, where detailed reason and remark codes explaining claim denials are readily available. By leveraging this feature, suppliers can gain invaluable insights into why a particular claim was denied, offering methods of resolution. Equipped with this knowledge, suppliers can then turn to our Denial Code Resolution Tool to find actionable steps to rectify and prevent similar denials in the future.

We strongly encourage suppliers to take full advantage of this robust resource to enhance the efficiency of their business operations. Embrace the NMP today to:

1. Easily identify claim denials.
2. Access comprehensive reason and remark codes via claim-specific remittance advices.
3. Utilize the Denial Code Resolution Tool for guidance on resolving issues and preventing future denials.

Empower your business with the tools it needs to succeed - explore the NMP now and optimize your claims management process. Don't miss out on this valuable resource; unlock its potential today.

Pneumatic Compression Devices - Documentation Requirements

To justify payment for Pneumatic Compression Devices (PCD) items, suppliers must meet the following documentation requirements:

- Standard Written Order (SWO)
- Beneficiary Authorization
- Proof of Delivery (POD)
- Continued Need
- Continued Use
- Certificate of Medical Necessity (CMS 846 CMN) (Required for dates of service prior to January 1, 2023)

Financial Attestation Statement - signed and dated stating the licensed/certified medical professional (LCMP) has no financial relationship with the supplier

Medical records from treating practitioner must include enough information to support that coverage criteria have been met, including, but not limited to:

- The patient's diagnosis and prognosis.
- Symptoms and objective findings, including measurements (meaning more than one) which establish the severity of the condition.
- The reason the device is required, including the treatments which have been tried and failed; and
- The clinical response to an initial treatment with the device.
    - The clinical response includes the change in pre-treatment measurements, ability to tolerate the treatment session and parameters, and ability of the patient (or caregiver) to apply the device for continued use in the home.
- A four-week trial.
- The treating practitioner concurrence when the LCMP performs the assessment/evaluation.

Noridian has created a Documentation Checklist for Pneumatic Compression Devices as a resource tool for suppliers and a guide for acquiring and maintaining good patient files.

Resources:

- Local Coverage Determination (L33829)
- Policy Article (A52488)
- National Coverage Determination (280.6)
- Standard Documentation Requirements Policy Article (A55426)

Reasonable Useful Lifetime (RUL) Explained

The Reasonable Useful Lifetime (RUL) is the period of time, after which Medicare payment can be made for replacement of Durable Medical Equipment, Prosthetics, and Orthotics if the item or equipment has been in continuous use by the beneficiary on either a rental or purchase basis. If equipment has been lost, stolen, or rendered irreparably damaged the item or equipment can be replaced. The RUL for DMEPOS (excluding artificial limbs) is established by the Secretary of Health and Human Services and must extend for a minimum of five years, as stipulated by 42 CFR §414.210(f). It's important to note that the RUL is employed to determine the appropriate frequency of Medicare-funded DME replacement and isn't explicitly intended as a minimum standard for the equipment's lifespan.

Within the context of the RUL, two key concepts warrant consideration: "irreparable damage" and "irreparable wear."

- "Irreparable damage" pertains to unforeseen incidents like loss, theft, or unanticipated accidents. Such circumstances are encompassed by the RUL.
- "Irreparable wear" refers to the gradual deterioration resulting from day-to-day usage over time, without being attributable to a specific event. This type of wear is not covered by Medicare and fails to meet the RUL criteria.

The determination of the RUL for durable medical equipment, prosthetics, and orthotics is guided by program instructions. In the absence of program instructions, Medicare Administrative Contractors (MACs) may establish the RUL for equipment, ensuring it is a minimum of five years.

- The calculation of the RUL is dependent on the delivery date of the item to the beneficiary, rather than the item's age.
- Instances of replacement due to wear aren't covered during the RUL period.
- Throughout the RUL, Medicare does offer coverage for repairs up to the cost of replacement (though not the actual replacement), exclusively for beneficiary owned medically necessary items.

Reopening Claims: Understanding Your Options

Have you ever faced a claim denial and wondered about your next steps? Can you reopen the claim without an appeal, or is it necessary to correct and rebill it? Look no further, as the Noridian Medicare webpage provides comprehensive answers and guidance on this matter. Understanding the avenues for reopening claims is crucial, and we are here to help.

Here is a breakdown of the types of claims reopenings:

Self-Service Reopening Through Noridian Medicare Portal (NMP):

- Billed amount
- Billed in error
- Date of service
- Diagnosis
- Modifier
- Medicare Secondary Payer (MSP) type
- Place of service (exceptions 31 and 32)
- Procedure code and billed amount (some exceptions)
- Procedure code, modifier (some exceptions), and billed amount
- Referring provider - PECOS updated reprocessing only
- Rendering provider - PECOS updated reprocessing only

- Reprocessing a claim
- Units and billed amount
- Units, modifiers (some exceptions), and billed amounts

Telephone Reopening Required:

- 90-day supplies
- Place of service 31 and 32
- Duplicate denials (situational)
- Narrative for accessories/supplies for beneficiary-owned items (requires HCPCS and purchase month/year of base item)
- Referring or Ordering Physician PECOS changes (requires NPI and name per PECOS enrollment)
- Adding dispensing fee (requires paid drug and CCN of billed dispensing fee)
- Date of death now on file
- Medicare now primary
- Adding some CR (Catastrophe/disaster related) narratives

Written Reopening Required:

- Some wheelchair accessories
- Some narrative additions
- Most Intravenous Immune Globulin Demonstration (IVIG) claims
- KU (DMEPOS item subject to DMEPOS Competitive Bidding Program Number 3) modifier addition
- KY (DMEPOS Item Subject to DMEPOS Competitive Bidding Program Number 5) modifier addition

Too Complex for Reopening and Must Be Appealed (with supporting documentation):

- Overutilization denials (requires supporting medical records)
- Oxygen break in service (BIS) issues
- Medicare Secondary Payer (MSP) issues (except when Medicare is now primary)
- Medical reviews or additional documentation requests (ADRs)
- Change in liability - beneficiary responsibility denial request
- Timely filing (older than one year from initial determination)
- Recovery Auditor (RAC) related items
- Transcutaneous Electrical Nerve Stimulators (TENS) policy
- Duplicate denials (situational)

- Miscellaneous and - NOC codes and claims requiring specific narratives
- Manually priced items
- Adding or removing modifiers:
    - Liability modifiers - EY, GA, GY, GZ, GX, KX
    - Specialty modifiers - JW, K0, K1, K2, K3, K4, KE, KK, RB, RP
    - RA
    - KG, KT
    - CR
    - CG
- Certain HCPCS codes:
    - Common codes - E0194 (air fluidized bed), E1028 (wheelchair accessory), K0108 (wheelchair component or accessory, K0462 (loaner equipment during repair), L4210 (repair of orthotic device)
    - K1018 - K1019 (external upper limb tremor stimulator and supplies and accessories)
    - All National Drug Codes (NDCs)
- Noncovered items/services per LCD
- Claims with previous recoupment or refund requests
- Claims with equipment in a non-covered status

Remember that most reopenings can be managed efficiently through the self-service Noridian Medicare Portal, with exceptions outlined above. For clarity on which reopening method to use, the Noridian Medicare webpage offers detailed guidance. Understanding these procedures can streamline the claims reopening process and ensure effective resolution. And just a reminder, for any claim that has already been appealed, the reopening process is not available.

Required Date Spans on Claims Clarified

Noridian has received numerous inquiries regarding the necessity of including date spans on claims. The following Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) items mandate the inclusion of a date span on all claims submitted to the DME MACs (Medicare Administrative Contractors). This requirement is detailed in the Standard Documentation Requirements Article:

- Diabetic testing supplies (e.g., test strips, lancets)
- Continuous passive motion devices (CPM)
- Parenteral and enteral nutrition
- Parenteral and enteral administration kits
- External infusion pump supplies (recommended)

Suppliers are obligated to encompass the service dates using "From" and "To" dates on any electronic or paper claim for the aforementioned items. The "From" date signifies when the items were furnished to the Medicare beneficiary. Conversely, the "To" date corresponds to the anticipated final date of usage for the items. For instance, if a three-month provision (January - March 2023) of diabetic testing supplies is being supplied to a beneficiary, the "From" date on the claim should be "01/01/2023," and the "To" date should be "03/31/2023." This information is required to facilitate accurate processing of the claim by the DME MACs.

Surgical Dressings and RT/LT Modifiers

The RT and/or LT modifiers must be used with HCPCS codes A6531, A6532, and A6545 for gradient compression stockings and wraps.

Each item must be billed on two separate lines using the RT and LT modifiers with one unit of service on each line. Claim lines for HCPCS codes requiring the use of these modifiers billed without or on a single claim line will be rejected as incorrect coding.

Surgical Dressings Resources

The Noridian website offers many tools for suppliers on the Surgical Dressings webpage.

The tools include:

- Local Coverage Determination
- Policy Article
- Standard Documentation Requirements for All Claims Submitted to DME MACs
- Clinician checklist
- Clinician letter
- Documentation checklist
- Reference chart (which surgical dressings are covered for various wound depths and exudates, along with Medicare's recommended frequency of change coverage information)
- Tips on documentation, modifiers, HCPCS codes for multiple policies, and supplies

Under Educational Resources on the left side of the page, the following are available (not all-inclusive):

- Denial Code Resolution
- DME on Demand Tutorials (A1-A9 Modifiers; Gradient Compression Stockings and Wraps; Coverage Criteria; Medical Records; Orders; Refill Requirements; L200)
- Surgical Dressings Tools (Exudate and Wound Depth Lookup Tool; HCPCS Lookup Tool; Surgical Dressings Type Lookup Tool)

Targeted Probe and Education (TPE) Pre-Payment Reviews

The Jurisdiction A, DME MAC, Medical Review Department is conducting pre-payment supplier specific reviews for the below specialties. The following quarterly edit effectiveness results from July 2023 - September 2023 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Hospital Beds
- Enteral Nutrition
- Glucose Supplies
- Knee Orthosis
- Manual Wheelchairs
- Pneumatic Compression Devices
- Therapeutic Shoes
- Spinal Orthotics
- Surgical Dressings
- Urological Supplies

Treating Practitioner Must Conduct and Sign Any Follow Up Visits for Continuous Glucose Monitor (CGM) Coverage

It has come to the attention of the DME MACs that clarification is needed regarding follow-up care for beneficiaries using a continuous glucose monitor (CGM). As noted in the Glucose Monitors Local Coverage Determination (LCD L33822), for continued CGM coverage, every six (6) months following the initial prescription of the CGM, the treating practitioner must conduct an in-person or Medicare-approved telehealth visit with the beneficiary to document adherence to their CGM regimen and diabetes treatment plan (emphasis added). For Medicare purposes, a pharmacist is not considered a statutorily recognized treating practitioner; therefore, a pharmacist entry in a beneficiary's medical

record does not meet the continued coverage requirements in the Glucose Monitors LCD. Please see the Standard Documentation Requirements Article for a clear definition of who qualifies as a treating practitioner.

Urological Supplies Clinician Letter Available to Suppliers

The DME Medical Directors provide a clinician letter with reminders when ordering urological supplies for their beneficiaries. These reminders are regarding information to include on the prescription and in the medical records.

Refer to the Urological Supplies webpage for additional resources.

Use of the KF Modifier with Osteogenesis Stimulators

The KF modifier is required if the FDA has designated that item as a Class III device. Osteogenesis stimulator devices coded E0747, E0748, and E0760 are classified by the FDA as Class III devices; therefore, all claims for codes E0747, E0748, and E0760 must include the KF modifier. Claim lines billed without a KF modifier will be rejected as missing information. Additional information can be found on the Osteogenesis Stimulators webpage.

Verifying Eligibility - Providing Precise Details on Claim Forms Minimizes Delays in Reimbursement

Suppliers engaged in Medicare billing face a significant challenge in the form of denials arising from billing claims sent to incorrect jurisdictions, beneficiaries categorized as inpatient, beneficiaries enrolled in a Medicare Advantage plan or who have secondary Medicare coverage, or from submitting claims with missing, incomplete, invalid patient identifiers. These occurrences lead to disruptions in claim processing and subsequent delays in reimbursement.

To effectively reduce these denials and ensure precise billing procedures, Noridian offers a comprehensive toolkit and resources to address these critical aspects.

Noridian's solution is the Noridian Medicare Portal (NMP), an empowering self-service platform that readily addresses a spectrum of eligibility inquiries. For suppliers who lack NMP access, the Interactive Voice Response System (IVR) is on hand to furnish the same vital information.

During the intake process, it is paramount for suppliers to gather extensive beneficiary information. Maintaining a copy of each beneficiary's Medicare card in their records is recommended whenever feasible. This card presents pivotal details, encompassing the beneficiary's name, Medicare ID, and effective dates of enrollment into Medicare's hospital and/or medical plans. It's important to note that beneficiaries might not be enrolled in both Medicare Part A and B, with Part B being an elective option.

The lower section of the beneficiary's Medicare card identifies enrollment plans and effective dates, this information is crucial. For DMEPOS services to qualify for coverage, the beneficiary must be enrolled in Medicare Part B, which is indicated on their card.

To ensure the accurate processing of Medicare claims, it's imperative that the beneficiary's complete name (matching the legal name on file with the Social Security Administration), Medicare ID, and permanent address (as recorded with the Social Security Administration) are correctly entered onto all claim forms.

For comprehensive guidance on resolving or preempting denials, the NMP Inquiry Guide serves as a valuable resource, offering insights into various critical categories:

- **Eligibility**
  - Part A and B effective and termination dates
  - Beneficiary permanent address
    - If address changes are necessary, claims should be directed to the jurisdiction where the beneficiary's permanent residence is registered with the Social Security Administration
    - Any necessary changes require the beneficiary to contact the Social Security Administration (800-772-1213)
- **HMO/MA**
  - Insurer Name
  - Plan Code Number
  - Effective and Termination Date
  - Address
  - Phone Number
  - Contract Web Site
- **MSP**
  - Insurer Name
  - Policy Number
  - Effective and Termination Date
  - Patient Relationship
  - Address
- **Hospital/SNF**
  - Location
  - Billing NPI
  - Admit Date

- End Date
- Discharge Status Code and Description

Moreover, the proper billing of the service date is emphasized, especially for items provided within two days before an anticipated home discharge. The discharge date must be appropriately billed in such cases. Payment cannot be processed by the DME MAC for items received during a beneficiary's Part A stay unless the equipment was delivered no more than two days before the anticipated discharge to home. Furthermore, insights into Home Health Episodes and Hospice information are available for reference.

Written Reopenings Available on the Noridian Medicare Portal (NMP)

Effective January 1, 2024, Noridian will be requiring that suppliers use the Noridian Medicare Portal (NMP) for all written reopenings that are available through the Self-Service Reopening feature.

The reopening process allows suppliers to correct clerical errors or omissions on denials received without having to request a formal appeal.

Before submitting a reopening request, suppliers should research the claim denial reason to determine the proper way to resolve the denial and avoid it in the future. This can be accomplished in the Denial Code Resolution tool. A list of errors that must be corrected in the NMP using a self-service reopening can be found on the Noridian website.

Medical Policies and Coverage

2023 HCPCS Code Update - October Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2023 HCPCS Code Update - October Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2023 DMD articles.

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

Correct Coding and Coverage of Ventilators - Revised

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

View the locally hosted 2023 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

L1681 Prefabricated Bilateral Hip Abduction Orthosis - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **L1681 Prefabricated Bilateral Hip Abduction Orthosis - Correct Coding**, has been created and published to our website.

View the locally hosted 2023 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

Medical Policies and Coverage

LCD and Policy Article Revisions Summary for September 7, 2023

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 Pneumatic Compression Devices and Surgical Dressings. Please review the entire LCDs and related PAs for complete information.

Pneumatic Compression Devices

LCD

Revision Effective Date: 10/22/2023

SUMMARY OF EVIDENCE:

Added: Information related to arterial intermittent pneumatic compression

ANALYSIS OF EVIDENCE:

Added: Information related to arterial intermittent pneumatic compression

BIBLIOGRAPHY:

Added: Information related to arterial intermittent pneumatic compression

RELATED LOCAL COVERAGE DOCUMENTS:

Added: Response to Comments document (A59219)

PA

Revision Effective Date: 10/22/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Table containing only a description of HCPCS code E0676

Added: Full description of E0676 within last sentence

CODING GUIDELINES:

Removed: "etc"

Added: Incorrect coding denial language for products billed using HCPCS that require written coding verification review

09/07/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Surgical Dressings

PA

Revision Effective Date: 09/07/2023

CODING GUIDELINES:

Removed: “It has a non-adherent property over the wound site” regarding foam dressing HCPCS codes A6209, A6210, A6211, A6212, A6213, A6214, A6215

09/07/2023: 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:

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 October 12, 2023

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

Manual Wheelchair Bases

PA

Revision Effective Date: 10/12/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Information pertaining to the specialty evaluation

Added: “If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.”

10/12/2023: 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: 05/16/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Information pertaining to the specialty evaluation

10/12/2023: 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

LCD

Revision Effective Date: 10/01/2023

HCPCS CODES:

Revised: Description of HCPCS code A4344 to “INDWELLING CATHETER, FOLEY TYPE, TWO-WAY, ALL SILICONE OR POLYURETHANE, EACH”

10/12/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

Wheelchair Options/Accessories

PA

Revision Effective Date: 10/12/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Information pertaining to the specialty evaluation

Added: “If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation.”

10/12/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Wheelchair Seating

PA

Revision Effective Date: 10/12/2023

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: Information pertaining to the specialty evaluation

Added: "If the supplier is owned by a hospital, the PT, OT, or practitioner working in the inpatient or outpatient hospital setting may perform the specialty evaluation."

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: "E0955" to Group 2 Paragraph and Group 3 Paragraph

Added: Information pertaining to the diagnosis code requirements for E0955

ICD-10-CM CODES THAT DO NOT SUPPORT MEDICAL NECESSITY:

Added: "Exception: For HCPCS code E0955, the ICD-10-CM codes specified in the preceding section are not an exhaustive list. See Group 2 and Group 3 in the preceding section, for additional information." to Group 1 Paragraph

Removed: "E0955" from language that noted "There are no specified ICD-10 codes"

10/12/2023: 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:

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.

Medical Policies and Coverage

LCD and Policy Article Revisions Summary for November 9, 2023

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 Enteral Nutrition, Glucose Monitors, and Wheelchair Seating. Please review the entire LCDs and related PAs for complete information.

Enteral Nutrition

LCD

Revision Effective Date: 10/01/2023

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Revised: Language pertinent to the feeding supply allowance corresponding to the method of administration, to add "B4148" and "elastomeric control fed"

Revised: Language pertinent to supply allowances, to add "B4148"

SUMMARY OF EVIDENCE:

Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes

ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):

Removed: Analysis of evidence information, due to not being applicable to the non-discretionary changes

HCPCS CODES:

Added: HCPCS code B4148

11/09/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS HCPCS coding determinations.

PA

Revision Effective Date: 10/01/2023

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: "B4148" to supply allowance codes

CODING GUIDELINES:

Added: "B4148" to supply allowance codes

11/09/2023: 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.

Glucose Monitors

LCD

Revision Effective Date: 01/01/2024

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “or Medicare-approved telehealth” to High Utilization coverage criteria

Removed: One (1) unit of service (UOS) per thirty (30) days regarding billing for supply allowance code A4238 or A4239

Added: Three (3) UOS per ninety (90) days regarding billing for supply allowance code A4238 or A4239 and “Billing more than three (3) UOS per ninety (90) days of code A4238 or A4239 will be denied as not reasonable and necessary.”

SUMMARY OF EVIDENCE:

Removed: Summary of evidence information, due to not being applicable to the non-discretionary changes

ANALYSIS OF EVIDENCE (RATIONALE FOR DETERMINATION):

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

11/09/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because they are non-discretionary.

PA

Revision Effective Date: 01/01/2024

CODING GUIDELINES:

Removed: Language regarding billing only one (1) month, thirty (30) days of the supply allowance for code A4238 or A4239

Added: Language regarding billing up to a maximum of three (3) months, ninety (90) days of the supply allowance for code A4238 or A4239

11/09/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Wheelchair Seating

PA

Revision Effective Date: 12/20/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: Information, to Group 1 Paragraph and Group 4 Paragraph, which specifies Z87.2 ICD-10-CM code must be appended when the beneficiary has a history of a healed pressure ulcer on the area of contact with the seating surface, Z87.2 is not for use to describe a current pressure ulcer on the area of contact with the seating surface, and other ICD-10-CM codes in the Group 1 Codes and Group 4 Codes are not for use to represent a history of a healed pressure ulcer on the area of contact with the seating surface

Added: ICD-10-CM code Z87.2 to Group 1 Codes and Group 4 Codes

11/09/2023: 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:

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 November 30, 2023

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 Intravenous Immune Globulin. Please review the entire LCD and related PA for complete information.

Intravenous Immune Globulin

LCD

Revision Effective Date: 01/01/2024

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Removed: Denial statement regarding IVIG used with an infusion pump

HCPCS CODES:

Added: Q2052 (in Group 1 Paragraph text)

11/30/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates per CMS Final Rule CMS-1780-F.

PA

Revision Effective Date: 01/01/2024

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Added: Services, supplies and accessories to noncovered statement when statutory criteria not met

Removed: Statement to refer to the LCD when IVIG administered with an infusion pump and statutory criteria not met

Removed: Statement regarding IVIG benefit limited to IVIG itself

Added: Services, supplies and accessories are billed with HCPCS code Q2052 and only one unit of service shall be paid per infusion date of service

CODING GUIDELINES:

Removed: Use of HCPCS code A4223 instructions when IVIG not administered with an infusion pump

Removed: Reference to the External Infusion Pump LCD and Policy Article when IVIG is administered with an infusion pump

Added: Coding instructions for Q2052

11/30/2023: 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:

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    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.

Oxygen Modifiers - Billing Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Oxygen Modifiers - Billing Reminder**, has been created and published to our website.

View the locally hosted 2023 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

Pneumatic Compression Devices - Final LCD and Response to Comments (RTC) Article Published

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

View the locally hosted 2023 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 September 21, 2023

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Automatic External Defibrillators, External Infusion Pumps, Mechanical In-exsufflation Devices, Oral Anticancer Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics) and Wheelchair Seating. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

Automatic External Defibrillators

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM code I21.B to Groups 1 and 2 Codes due to ICD-10-CM code updates

09/21/2023: 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: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Removed: ICD-10-CM code G20 from Group 4 Codes due to ICD-10-CM code updates

Added: ICD-10-CM codes G20.A1, G20.A2, G20.B1, G20.B2 to Group 4 Codes due to ICD-10-CM code updates

09/21/2023: 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.

Mechanical In-exsufflation Devices

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM code E74.05 to Group 1 Codes due to ICD-10-CM code updates

09/21/2023: At this time 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Oral Anticancer Drugs

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Removed: ICD-10-CM code D48.1 from Group 7 Codes due to ICD-10-CM code updates

Added: ICD-10-CM codes D48.110, D48.111, D48.112, D48.113, D48.114, D48.115, D48.116, D48.117, D48.118, D48.119, D48.19 to Group 7 Codes due to ICD-10-CM code updates

09/21/2023: 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 Antiemetic Drugs (Replacement for Intravenous Antiemetics)

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Removed: ICD-10-CM code D48.1 from Group 1 Codes due to ICD-10-CM code updates

Added: ICD-10-CM codes D48.110, D48.111, D48.112, D48.113, D48.114, D48.115, D48.116, D48.117, D48.118, D48.119, D48.19 to Group 1 Codes due to ICD-10-CM code updates

09/21/2023: At this time the 21st Century Cures Act applies to new and revised LCDs which require comment and notice. This revision is to an article that is not a local coverage determination.

Wheelchair Seating

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Removed: ICD-10-CM codes G20 and G37.8 from Group 2 and Group 4 Codes, due to ICD-10-CM code updates

Added: ICD-10-CM codes E75.27, E75.28, G20.A1, G20.A2, G20.B1, G20.B2, G20.C, G31.80, G31.86, G37.81, and G37.89 to Group 2 and Group 4 Codes, due to ICD-10-CM code updates

Added: ICD-10-CM code G31.89 to Group 2 and Group 4 Codes

09/21/2023: 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:

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 September 28, 2023

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

Orthopedic Footwear

PA

Revision Effective Date: 11/01/2023

MODIFIERS:

Added: Statement, "When billing for a shoe replacement or shoe transfer that is an integral part of a leg brace, a KX modifier must be added to the code."

09/28/2023: 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.

Patient Lifts

PA

Revision Effective Date: 01/01/2020

CODING GUIDELINES:

Added: Description of code E0635

09/28/2023: 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 October 5, 2023

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

Nebulizers

PA

Revision Effective Date: 10/01/2023

ICD-10-CM CODES THAT SUPPORT MEDICAL NECESSITY:

Added: ICD-10-CM Codes J12.82, U07.1 and U09.9 to Groups 3, 8 and 12 Codes due to ICD-10-CM Code updates

Removed: ICD-10-CM Code J15.6 from Groups 2, 3, 7, 12 and 13 Codes due to ICD-10-CM Code updates

Added: ICD-10-CM Codes J15.61 and J15.69 to Groups 2, 3, 7, 12 and 13 Codes due to ICD-10-CM Code updates

Added: ICD-10-CM Codes J44.81 and J44.89 to Groups 2, 3, 6, 7, 8, 12 and 13 Codes due to ICD-10-CM Code updates

10/05/2023: 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:

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 October 26, 2023

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

Wheelchair Options/Accessories

PA

Revision Effective Date: 10/26/2023

CODING GUIDELINES:

Revised: Information pertaining to the RT and LT modifiers

Removed: "The right (RT) and left (LT) modifiers must be used when appropriate."

Added: "The right (RT) and left (LT) modifiers are optional on claim lines billed for wheelchair options and accessories."

Added: "If RT and LT modifiers are not appended, then the bilateral items (left and right) with a unit of service "each" may be billed on a single claim line with 2 UOS."

10/26/2023: 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:

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.

MLN Connects

MLN Connects - September 7, 2023

MLN Connects Newsletter: Sept 7, 2023

News

- New Version of CMS.gov
- HHS Proposes Minimum Staffing Standards to Enhance Safety and Quality in Nursing Homes
- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in the State of Florida
- Laboratory Tests for Blood Counts: Comparative Billing Report in September
- Expanded Home Health Value-Based Purchasing Model: Submit Technical Expert Panel Nominations by September 27
- Physicians & Non-Physician Practitioners: Revised Medicare Enrollment Application Required November 1
- DMEPOS: New Benefit Category Determinations
- Short-Term Acute Care Hospitals: Program for Evaluating Payment Patterns Electronic Reports
- Healthy Aging: Recommend Services for Your Patients

MLN Matters® Articles

- Changes to the Laboratory National Coverage Determination Edit Software: January 2024 Update
- Inpatient Psychiatric Facilities Prospective Payment System: FY 2024 Updates

Publications

- Evaluation and Management Services Guide - Revised

Multimedia

- Medicare Ground Ambulance Data Collection System Video

From Our Federal Partners

- Severe Vibrio vulnificus Infections in U.S. Associated with Warming Coastal Waters
- Increased Respiratory Syncytial Virus Activity in Parts of Southeastern U.S.: New Prevention Tools Available to Protect Patients

MLN Connects

Information for Patients

- CMS Hosts Patient-Focused Listening Sessions this Fall

MLN Connects - September 14, 2023

MLN Connects Newsletter: Sept 14, 2023

News

- Inflation Reduction Act Continues to Lower Out-of-Pocket Prescription Drug Costs for Drugs with Price Increases Above Inflation
- CMS Roundup (Sept 8, 2023)
- New Provider Types 2024: Marriage and Family Therapists & Mental Health Counselors
- PECOS 2.0 Is Coming Soon
- Medicare Secondary Payer: Are You Getting Diagnosis Codes?
- Social Determinants of Health: Collect Data with ICD-10-CM Z Codes
- ESRD: Submitting Dialysis Claims That Include Capital Related Assets Eligible for the TPNIES
- Medicare Physician Fee Schedule Database: October Update
- Prostate Cancer: Encourage Your Patients to Get Screened

Claims, Pricers, & Codes

- National Correct Coding Initiative: October Update
- Integrated Outpatient Code Editor: Version 24.3

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: October 2023 Update
- DMEPOS Fee Schedule: October 2023 Quarterly Update
- Hospital Outpatient Prospective Payment System: October 2023 Update

Publications & Multimedia

- Expanded Home Health Value-Based Purchasing Model: Updated Resource & Event Materials

MLN Connects

MLN Connects Newsletter: COVID-19: Updated mRNA Vaccines for Patients 6 Months & Older - Sept 14, 2023

MLN Connects Newsletter: COVID-19: Updated mRNA Vaccines for Patients 6 Months & Older - Sept 14, 2023

News

COVID-19: Updated mRNA Vaccines for Patients 6 Months & Older

MLN Connects - September 21, 2023

MLN Connects Newsletter: Sept 21, 2023

News

- CMS Announces Resources and Flexibilities to Assist with the Public Health Emergency in the State of Georgia
- Organ Transplantation Affinity Group: Strengthening Accountability, Equity, And Performance
- Psychotherapy for Crisis: Medicare Pays for Services
- Flu Shot: Encourage Preferred Vaccines for Patients 65+
- Help Reduce Health Gaps for Hispanic or Latino Patients

MLN Matters® Articles

- Limitation on Recoupment of Overpayments
- Inpatient & Long-Term Care Hospital Prospective Payment System: FY 2024 Changes

Information for Patients

- HHS Takes the Most Significant Action in a Decade to Make Care for Older Adults & People with Disabilities More Affordable and Accessible

MLN Connects - September 28, 2023

MLN Connects Newsletter: Sept 28, 2023

News

- CMS Statement on Current Status of Blood Tests for Organ Transplant Rejection
- CMS Roundup (Sept 22, 2023)

- Cardiovascular Disease: Talk with Your Patients about Screening

Claims, Pricers, & Codes

- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2023 Update

Publications

- Expanded Home Health Value-Based Purchasing Model: September Newsletter
- Checking Medicare Eligibility - Revised

MLN Connects - October 5, 2023

MLN Connects Newsletter: Oct 5, 2023

News

- Administration Moves Forward with Medicare Drug Price Negotiations to Lower Prescription Drug Costs for People with Medicare
- CMS Requests Public Input on Coverage of Over-the-Counter Preventive Services, Including Contraception, Tobacco Cessation, and Breastfeeding Supplies
- Action Plan for Sickle Cell Disease Month
- CMS Burden Reduction News & Insights Fall Newsletter
- New COVID-19 Treatments Add-On Payment Ended September 30
- Clinical Laboratory Fee Schedule: Submit Your Comments
- DMEPOS: New Provider Enrollment Appeals & Rebuttals Contractor Starts October 9
- Help Detect Breast Cancer Early

Claims, Pricers, & Codes

- RARCs, CARCs, Medicare Remit Easy Print, & PC Print: October Update

Publications

- Medicare Provider Compliance Newsletter

MLN Connects

Multimedia

- Post-Acute Care Quality Reporting Programs: Brief Interview for Mental Status Video

MLN Connects Newsletter: COVID-19: Updated Novavax COVID-19 Vaccine, Adjuvanted for Patients 12 & Older - Oct 6, 2023

News

COVID-19: Updated Novavax COVID-19 Vaccine, Adjuvanted for Patients 12 & Older

MLN Connects - October 12, 2023

MLN Connects Newsletter: Oct 12, 2023

News

- CMS Roundup (Oct 6, 2023)
- Protect Your Patients: Give Them a Flu Shot

Publications

- Direct Data Entry: 10-Digit Screen Expansion
- Medicare Preventive Services - Revised
- Medicare Provider Compliance Tips - Revised

MLN Connects - October 19, 2023

MLN Connects Newsletter: Oct 19, 2023

News

- 2024 Medicare Parts A & B Premiums and Deductibles
- Help CMS Improve Provider Resources - Respond by November 9
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Health Literacy: Help Your Patients Get Information & Services

MLN Connects

Claims, Pricers, & Codes

- Discarded Drugs & Biologicals: When to Use JW & JZ Modifiers

Events

- Provider Compliance Focus Group Meeting - November 2
- Expanded Home Health Value-Based Purchasing Model: Preparing for CYs 2024 & 2025 Webinar - November 9

MLN Matters® Articles

- Update for Blood Clotting Factor Add-on Payments

Publications

- Complying with Medical Record Documentation Requirements - Revised
- Expanded Home Health Value-Based Purchasing Model Resource Index - Updated

From Our Federal Partners

- Health Care Preparedness Resources

MLN Connects - October 26, 2023

MLN Connects Newsletter: Oct 26, 2023

News

- Help CMS Improve Provider Resources - Respond by November 9
- CMS Roundup (Oct 20, 2023)
- Nursing Facility Evaluation and Management Visits: Comparative Billing Report in October

Claims, Pricers, & Codes

- Conditional Payment Claims: Continue to Submit to Your Medicare Administrative Contractor
- Home Health Consolidated Billing Enforcement: CY 2024 HCPCS Code
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

Events

- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29

MLN Connects

MLN Matters® Articles

- Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update
- Processing Claims Affected by Retroactive Entitlement

Publications

- Medicare Secondary Payer: Don’t Deny Services & Bill Correctly - Revised

Information for Patients

- 2024 Medicare & You Handbook

MLN Connects Newsletter: Take Our Provider Survey Today - Nov 1, 2023

News

Take Our Provider Survey Today

MLN Connects - November 2, 2023

MLN Connects Newsletter: Nov 2, 2023

News

- CY 2024 Home Health Prospective Payment System Final Rule
- CY 2024 End-Stage Renal Disease Prospective Payment System Final Rule
- Behavioral Health: Medicare Pays for 3 Services
- Lymphedema Compression: Medicare Pays for Treatment Items
- Diabetes: Recommend Preventive Services
- Flu Shots Can Take Flu from Wild to Mild

Claims, Pricers, & Codes

- Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827

Publications

- Interns & Residents Duplicate FTEs Audit Reviews
- Expanded Home Health Value-Based Purchasing Model: October Newsletter
- Medicare Payment Systems - Revised

MLN Connects

MLN Connects Newsletter: PFS, OPPS/ASC, & OPPS 340B-Acquired Drug Final Rules - Nov 2, 2023

Final Rules

- CMS Finalizes Physician Payment Rule that Advances Health Equity
- CMS Makes Hospital Prices More Transparent and Expands Access to Behavioral Health Care
- Hospital Outpatient Prospective Payment System (OPPS): Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule (CMS 1793-F)

MLN Connects - November 9, 2023

MLN Connects Newsletter: Nov 9, 2023

News

- CMS Roundup (Nov 3, 2023)
- Marriage and Family Therapists & Mental Health Counselors: Enroll in Medicare Now
- American Indians or Alaska Natives: Help Your Patients Achieve Optimal Health

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update

Events

- CMS Hospice Forum - November 14
- Optimizing Healthcare Delivery to Improve Patient Lives Conference - November 15
- HCPCS Public Meeting - November 28-30
- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2024 Update
- Removal of a National Coverage Determination & Expansion of Coverage of Colorectal Cancer Screening – Revised

MLN Connects

Publications

- Home Health & Hospice Resources
- Independent Diagnostic Testing Facility - Revised

MLN Connects - November 16, 2023

MLN Connects Newsletter: Nov 16, 2023

News

- Unprecedented Efforts to Increase Transparency of Nursing Home Ownership
- Hospital Price Transparency: Use Required CMS Template Layout to Encode Hospital Standard Charge Information
- Quality Payment Program: Preview Your Performance Information by December 12
- Medicare Participation for CY 2024
- Hospice: New Requirement for Physicians Who Certify Patient Eligibility
- Medicare Ground Ambulance Data Collection System: CY 2024 Final Policies, Printable Instrument, & FAQs
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- National Rural Health Day: Address Unique Health Care Needs
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- Skilled Nursing Facility: Appropriate Use of Place-Of-Service Codes

Claims, Pricers, & Codes

- Vagus Nerve Stimulators: Transitional Pass-through Status for HCPCS Code C1827 - Updated

MLN Matters® Articles

- Home Health Prospective Payment System: CY 2024 Update
- Provider Enrollment Changes to the Medicare Program Integrity Manual
- Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Claims
- Allowing Audiologists to Provide Certain Diagnostic Tests Without a Physician Order - Revised

MLN Connects

Multimedia

- Home Health Agency Perspectives on Innovation: Panel Materials

MLN Connects - November 22, 2023

MLN Connects Newsletter: Nov 22, 2023

News

- CMS Roundup (Nov 17, 2023)
- Provider Enrollment Application Fee: CY 2024
- Clinical Laboratory Fee Schedule: CY 2024 Final Payment Determinations & Reporting Delay
- Medicare Ground Ambulance Data Collection System: 5 Top Tips
- Respiratory Virus Season: Protect Your Patients

Events

- Inpatient Rehabilitation Facility Prospective Payment System: Coverage Requirements Webinar - November 29
- Ambulance Open Door Forum - November 30

MLN Matters® Articles

- Lymphedema Compression Treatment Items: Implementation
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2024 Update - Revised

Publications

- New Ownership Reporting Requirements for Providers Using the Form CMS-855A
- Intravenous Immune Globulin Demonstration - Revised
- Repetitive, Scheduled Non-Emergent Ambulance Transport Prior Authorization Model – Revised

MLN Connects

MLN Connects - November 30, 2023

MLN Connects Newsletter: Nov 30, 2023

News

- Quality Payment Program: Preview Your Performance Information by December 12
- HIV: Screening is Knowledge

Claims, Pricers, & Codes

- Resubmit Telehealth Claims with Modifier CS
- Federally Qualified Health Center Prospective Payment System: CY 2024 Pricer
- Rural Health Clinic CY 2024 All-Inclusive Rate

MLN Matters® Articles

- Beta Amyloid Positron Emission Tomography in Dementia and Neurodegenerative Disease
- ESRD & Acute Kidney Injury Dialysis: CY 2024 Updates
- Medicare Physician Fee Schedule Final Rule Summary: CY 2024

Information for Patients

- Medicaid and CHIP Renewals: Patient-Centered Messaging for Clinical Offices and Health Care Settings

MLN Matters

DMEPOS Fee Schedule: October 2023 Quarterly Update

Related CR Release Date: August 31, 2023

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

MLN Matters Number: MM13343

Related Change Request (CR) Number: CR 13343

Related CR Transmittal Number: R12228CP

CR 13343 tells you about:

- Fee schedule adjustment relief for rural and non-contiguous areas
- New HCPCS codes added
- New fee schedule amounts

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13343.

Limitation on Recoupment of Overpayments

Related CR Release Date: September 7, 2023

Effective Date: December 11, 2023

Implementation Date: December 11, 2023

MLN Matters Number: MM11262

Related Change Request (CR) Number: CR 11262

Related CR Transmittal Number: R12236FM

CR 11262 tells you about:

- Medicare recoups overpayments
- Appeals and reconsiderations affect these recoupments

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11262.

MLN Matters

Lymphedema Compression Treatment Items: Implementation

Related CR Release Date: November 9, 2023

Effective Date: January 1, 2024

Implementation Date: January 2, 2024

MLN Matters Number: MM13286

Related Change Request (CR) Number: CR 13286

Related CR Transmittal Number: R12359CP

CR 13286 tells you about the new Medicare DMEPOS benefit category starting January 1, 2024:

- Codes
- Billing
- Payment

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13286.

Medicare Deductible, Coinsurance, & Premium Rates: CY 2024 Update

Related CR Release Date: October 19, 2023

Effective Date: January 1, 2024

Implementation Date: January 1, 2024

MLN Matters Number: MM13365

Related Change Request (CR) Number: CR 13365

Related CR Transmittal Number: R12307GI

CR 13365 tells you about:

- Medicare Part A and Medicare Part B deductible and coinsurance rates
- Part A and Part B premium amounts

Make sure your billing staff knows about CY 2024

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13365.

MLN Matters

October 2023 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Related CR Release Date: June 15, 2023

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

Related Change Request (CR) Number: CR 13260

Related CR Transmittal Number: R12088CP

CR 13260 supplies 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. The ASP payment limits are calculated quarterly based on quarterly data submitted to CMS by manufacturers.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13260.

RARC, CARC, MREP and PC Print Update

Related CR Release Date: May 18, 2023

Effective Date: October 1, 2023

Implementation Date: October 2, 2023

Related Change Request (CR) Number: CR 13207

Related CR Transmittal Number: R12043CP

CR 13207 updates the Remittance Advice Remark Code (RARC) and Claims Adjustment Reason (CARC) lists and to instruct the ViPS Medicare System (VMS) and the Fiscal Intermediary Shared System (FISS) to update the Medicare Remit Easy Print (MREP) and the PC Print. This Recurring Update Notification (RUN) applies to Chapter 22, Sections 40.5, 60.2, and 60.3 of Publication (Pub.) 100-04.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13207.

Update to Pub. 100-02 Medicare Benefit Policy, Chapter 15, Section 110.8 DMEPOS Benefit Category Determinations

Related CR Release Date: August 3, 2023

Effective Date: September 4, 2023

Implementation Date: September 4, 2023

Related Change Request (CR) Number: CR 13228

Related CR Transmittal Number: R12171BP

CR 13228 updates Pub. 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 110.8 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Benefit Category Determinations for new benefit category determinations made as part of the Second Biannual (B2) 2022 Healthcare Common Procedure Coding System (HCPCS) coding cycle in accordance with the procedures at 42 CFR §414.114 and §414.240.

Make sure your billing staffs are aware of these changes.

View the complete CMS Change Request (CR)13228.

Contacts, Resources, and Reminders

Jurisdiction A DME MAC Supplier Contacts and Resources

Supplier Contact Center (SCC) - View hours of availability, call flow, authentication details and customer service areas of assistance.

Email Addresses - Suppliers may submit emails to Noridian for answers regarding basic Medicare regulations and coverage information. View this page for details and request form.

Fax Numbers - View fax numbers and submission guidelines.

Holiday Schedule - View holiday dates that Noridian operations, including customer service phone lines, will be unavailable for customer service.

Interactive Voice Response (IVR) - Self-Service Technology - View conversion tool and information on how to use IVR and what information is available through system. General IVR inquiries available 24/7.

Mailing Addresses - View mail addresses for submitting written correspondence, such as claims, letters, questions, general inquiries, enrollment applications and changes, written Redetermination requests and checks to Noridian.

DME MACs and Other Resources

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

Contacts, Resources, and Reminders

Organization	Phone Number	Types of Inquiries
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, 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 Medicare.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."

Contacts, Resources, and Reminders

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 on the CMS Manuals webpage. 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.

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

Contacts, Resources, and Reminders

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.

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

Suppliers may call the CERT Documentation Contractor 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.

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.

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 5.5

Contacts, Resources, and Reminders

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's 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.

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

Closures:

- Holiday Schedule
- Training Closures

What information do I need before I can initiate a Telephone Reopening?

Before a reopening can be completed, the caller must have all of the following information readily available as it will be verified by the Telephone Reopenings representative. If at any time the information provided does not match the information in the claims processing system, the Telephone Reopening cannot be completed.

Verified by Customer Service Representative (CSR) or IVR:

- National Provider Identifier (NPI)
- Provider Transaction Access Number (PTAN)
- Last five digits of Tax Identification Number (TIN)

Verified by CSR:

- Caller's name
- Provider/Facility name
- Beneficiary Medicare number
- Beneficiary first and last name
- Date of Service (DOS)
- Last five digits of Claim Control Number (CCN)
- HCPCS code(s) in question
- Corrective action to be taken

Claims with remark code MA130 can **never** be submitted as a reopening (telephone or written). Claims with remark code MA130 are considered unprocessable and do not have reopening or appeal rights. The claim is missing information that is needed for processing or was invalid and must be resubmitted.

What may I request as a Telephone Reopening?

The following is a list of clerical errors and omissions that may be completed as a Telephone Reopening. **Note:** This list is not all-inclusive.

- Diagnosis code changes or additions
- Date of Service (DOS) changes
- HCPCS code changes
- Certain modifier changes or additions (not an all-inclusive list)

If, upon research, any of the above change are determined too complex, the caller will be notified the request needs to be sent in writing as a redetermination with the appropriate supporting documentation.

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.