# DME Happenings

## Jurisdiction A
## March 2024

noridian
Healthcare Solutions
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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# News

## Avoiding Denials for Beneficiary Enrolled in a Medicare Advantage Plan

Avoiding denials for reason code 109 and remark code N418 on remittance advice is crucial. These codes signify that the claim was billed to the incorrect contractor, requiring the submission of the claim or service to the accurate payer or contractor. Additionally, they indicate that, for the submitted date of service, the beneficiary was enrolled in a Medicare Advantage Plan. A Health Maintenance Organization (HMO) is a common type of Medicare Advantage Plan.

109 Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.

N418 Misrouted claim. See the payer's claim submission instructions.

To mitigate expenses associated with rework and denials, it is imperative to verify the beneficiary's eligibility on the Noridian Medicare Portal (NMP) before submitting claims. This becomes especially critical when billing for ongoing rental claims. Verification is paramount during specific times, particularly during open enrollment periods and after the first of the year, when beneficiaries may switch to Medicare Advantage Plans or revert to Medicare Fee-for-Service.

The NMP offers a dedicated tab for Health Maintenance Organization (HMO) or Medicare Advantage Plan (MA) verification, ensuring that the correct payer is billed. When verifying eligibility through the HMO/MA tab, suppliers can obtain crucial information such as the insurer's name, plan code number, effective and termination date, Managed Care Organization (MCO) plan type, MCO bill option code, address, phone number, and contract website of the payer. This comprehensive verification process streamlines billing procedures, reduces the risk of claim denials, and promotes an efficient and error-free healthcare reimbursement process.

## Change to Refill Policy

Effective January 1, 2024, the timeframe for contacting beneficiaries for confirmation of refills changes from 14 to 30 days.

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective use. For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary, and document an affirmative response, prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are expected to end, and to confirm any changes or modifications to the order. Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply. For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply. This is regardless of which delivery method is utilized.

For all DMEPOS items that are provided on a recurring basis, suppliers are required to have contact with the beneficiary or caregiver/designee and document an affirmative response, prior to dispensing a new supply of items. Suppliers must not deliver refills without a refill request and an affirmative response from a beneficiary. Items delivered without a valid, documented refill request will be denied as not reasonable and necessary.

## CMS' New Tool for Exchanging Healthcare Documentation - Healthcare Information Handler

Recently, CMS updated how providers submit documentation to the Medicare Administrative Contractor (MAC), or other contractors. It is called the Health Information Handler (HIH), and it is hosted on CMS' Amazon Web Services (AWS) environment.

There is no cost to providers submitting directly to CMS, regardless of the number of transactions sent monthly. HIH meets all security and privacy requirements, and there is no Information Technology (IT) expertise required.

Providers still have the option to contract with an HIH through their existing Gateway services, or they can build a gateway of their own (and sign up as an HIH).

Providers and suppliers can use for:

- Prior authorization requests and supporting documentation for Parts A/B and DME
- Paperwork (PWK) documentation for claims
- First and second level appeal requests
- Advanced Determination of Medicare Coverage Requests (ADMC)
- Durable Medical Equipment (DME) phone discussion requests

**Resources:**

CMS Health Information Handler

CMS esMD for Health Information Handlers (HIH) - Getting Started and Frequently Asked Questions (FAQ's)

## Competitive Bid Temporary Gap Period Modifier Use

Effective January 1, 2024, and thereafter, a temporary gap period will be in place for the Competitive Bidding Program (CBP). The competitive bid modifiers KV, J4, and J5 will no longer be used. For HCPCS codes L0648, L0650, L1833, and L1851, treating practitioners have the option to undergo the regular prior authorization process with the standard timeframe for review, requesting an expedited review, or utilize the ST modifier to indicate an acute/emergent need. It is important to note that this process

change specifically impacts non-contract competitive bid suppliers who are practitioners/physicians, physical therapists, and occupational therapists. For further details, please consult the Timeline and Updates section of the Prior Authorization and Pre-Claim Review Initiatives webpage on the CMS website.

## Contact Information for Noridian and Other Medicare Entities

Noridian has a webpage dedicated to contact information for Noridian and other Medicare entities. Mailing addresses, email addresses, fax numbers, Noridian Medicare Portal and telephone numbers can all be found on our DME Contact Information webpage.

- Supplier Contact Center
  - JA - 866-419-9458
  - JD - 877-320-0390
- Mailing Addresses
- Fax Numbers
- Noridian Medicare Portal (NMP)
- DME Medical Director (DMD)
- Congressional Inquiries
- Other Medicare Entities

## Continuous Glucose Monitor (CGM) Supply Allowance National DME MAC Education

The continuous glucose monitor (CGM) supply allowance codes A4238 and A4239 can be billed up to a maximum of three (3) units of service (UOS) per ninety (90) days at a time. Standard refill requirements do not apply to CGM supply fee codes A4238 or A4239. For example, if A4238 was billed on December 5, 2023, the next billable date for a 30-day supply would be January 4, 2024, and for a 90-day supply would be March 4, 2024. Noridian Healthcare Solutions and CGS Administrators, LLC have a continuous glucose monitor supply allowance calculator located on their websites to help suppliers with determining accurate billing dates.

Procedure code A4239 is the procedure code for all non-adjunctive CGM supplies and accessories. Non-adjunctive CGM supplies include, but are not limited to a CGM sensor, a CGM transmitter, a home blood glucose monitor, and related blood glucose monitor (BGM) supplies (such as test strips, lancets, lancing devices, and calibration solutions) and all batteries. Claims for supplies must be billed as 1 unit of service per 30 days. Effective January 1, 2024, up to 3 units of service are allowed when billing CGM supplies. If providing and billing for a 90-day supply, then 3 units of service would be submitted on the claim.

Adjunctive CGM devices do not replace standard home BGM. The supply allowance for an adjunctive CGM (A4238) encompasses all items necessary for the device's use and includes the CGM sensors and

transmitters. Code A4238 does not include a home BGM or related BGM testing supplies. The BGM supplies may be billed separately, in addition to code A4238 for the adjunctive CGMs. Refer to the Glucose Monitors LCD-related Policy Article (A52464) for this guidance.

The CGM supply allowance does not follow standard documentation requirements for refills. If a Medicare beneficiary requires additional items (e.g., sensors) during the billing period, the DME supplier must provide them at no charge to the beneficiary or to the Medicare program. A4238 and A4239 are supply allowances and the DME supplier must provide the items the beneficiary requires/requests to use their continuous glucose monitor in their home. Supply items must not be billed separately as any claims will be denied as unbundling.

If a DME supplier wants to provide CGM items prior to the expected end of the current supply, they are welcome to do so, but they must not bill the Medicare program until the 30 or 90 days has passed, depending on when the items were billed last. When a DME supplier provides either a 30-day or 90-day supply, a claim narrative indicating the number of supplies is not required. The presence of 1 unit of service will indicate a 30-day supply and 3 units of service will indicate a 90-day supply.

The date of service for procedure codes A4238 and A4239 should not be billed with a span date. The "From" and "To" date fields on the claim should be the same. Claims for procedure codes A4238 and A4239 billed with a span date will be returned as Un processable. Un processable claims must be corrected and resubmitted; they do not have appeal rights or the ability to be reopened or adjusted.

Refer to the Glucose Monitors LCD (L33822) and LCD-related Policy Article (A52464) for additional information concerning the CGM supply allowance.

## Effective January 1, 2024, Self-Service Reopenings Available on the Noridian Medicare Portal (NMP) Sent as a Written Reopening Will be Dismissed

Starting January 1, 2024, Noridian mandates that suppliers exclusively utilize the **Noridian Medicare Portal (NMP)** for all **Self-Service Reopenings**. Any written reopenings received on or after January 1, 2024, in written form and available for correction on the portal will be dismissed. A notification letter will be sent to the supplier, emphasizing the necessity of performing the reopening via the NMP self-service function.

The reopening process empowers suppliers to rectify clerical errors or omissions on denials without the need for a formal appeal, exhausting redetermination appeal rights.

Prior to initiating a reopening request, suppliers are advised to investigate the reason for claim denial, utilizing the Denial Code Resolution tool to determine the appropriate resolution and prevent future occurrences. Guidance on correcting errors in the NMP through a self-service reopening is available on the Noridian website.

# News

## Find the Most Current Fee Schedules

The Noridian Fee Schedules webpage has the following tools and resources, among others.

- DMEPOS Fee Schedules including:
  - Sequestration
  - Sequestration History
  - Rural Zip Code File
- Drug, Pharmacy Supply, and Dispensing Fees
- Fee Schedule Lookup Tool
- Jurisdiction List
  - List assists suppliers in determining which Medicare contractor to bill for certain HCPCS codes
- Labor Payment Rates
- Medically Unlikely Edit (MUE) Lookup Tool
- Oral Anti-Cancer Drug Fees
- Parenteral and Enteral Nutrition (PEN) Fees
- Pricing (i.e., gap filling, reasonable charges, not otherwise classified (NOC) codes)

This page will be updated with the new 2024 fee schedules when they are released.

## Identifying Beneficiary Information in Overpayment Recoupment/Offset Situations

There are a couple methods for obtaining information related to overpayment recoupment/offset. One method is utilizing the Remittance Advice (RA), accessible under the Provider Adjustment (ADJ) Details Section and PLB Reason Codes. The PLB REASON CODE field specifies the provider-level adjustment reason code, with PLB code WO signifying an offset due to a prior overpayment in accounts receivable. A reference number, comprising the original ICN and Medicare ID, is listed for tracking purposes.

Providers, affiliated with various NPIs but sharing the same Tax Identification Number (TIN), may experience withholdings from one provider (PTAN) to cover the overpayments of another provider (PTAN). In these instances where funds are reclaimed by TIN, and the supplier cannot ascertain the PTAN subject to recoupment, contact the Supplier Contact Center (SCC) for the respective jurisdiction. Suppliers may need to leave a message and await a callback.

Example: Supplier 123 PTAN in California has an offset for supplier 345 PTAN in Florida. Both share the same TIN, but supplier 123 cannot locate the details pertaining to the offset in their accounts receivable for reconciliation. Contacting the SCC is advised for obtaining this specific information.

An alternative method to gather such information is through the Noridian Medicare Portal (NMP), specifically the Overpayments function. This tool enables suppliers to access a summary of claims potentially causing overpayments. The Overpayment Results inquiry in the NMP offers details on the claims leading to overpayment, along with the actions taken to address the overpayment. Suppliers can identify offsets and link them to the beneficiary's name. To initiate an inquiry:

1. Navigate to the Financials tab.
2. Select the Overpayment Results tab.
    - Enter Provider/Supplier details for overpayment.
    - Input Overpayment Letter Number and/or Claim Number (CCN).
    - Choose to view the most recent 100 results or download a CSV file.
3. The results provide a summary.
    - Click on the plus symbol (+) next to CCN to access Beneficiary Name, Claim Number, Date of Service, and Overpayment Amount.

## Information on ADMC and How Suppliers Are Notified of Decisions in Writing and on the IVR

Advance Determination of Medicare Coverage (ADMC) is a voluntary program. Beneficiaries and suppliers **are not required** to submit ADMC requests in order to submit claims. Additionally, DME MACs may not require an ADMC request as a prerequisite for claim submission.

Several DME items are customized and are quite costly to purchase; therefore, beneficiaries and suppliers can request an ADMC. It is important to note that an ADMC decision is not an initial determination as defined in 42 CFR 405.920 and 405.924, because no request for payment is being made. As such, an ADMC decision cannot be appealed.

An ADMC is a request by the supplier or beneficiary to determine if an item may be covered before the item is delivered. HCPCS eligible for ADMC determination are:

### Manual Wheelchairs

- E1161, E1231, E1232, E1233, E1234, K0005, K0008, and K0009

### Power Wheelchairs

- K0890, K0891, and K0013

### ADMC Request

The ADMC request is sent with a coversheet and is faxed or mailed to Noridian Healthcare Solutions. The ADMC request must include the documentation listed on the coversheet. Once a request is

received, the DME MAC shall determine if there is sufficient medical documentation to support whether or not the item is reasonable and necessary. The DME MAC shall render a determination within **30 calendar days in writing with their decision, whether affirmative or negative**.

Requests received for appropriate items without documentation to support coverage will be denied as not meeting the Medicare established medical necessity requirements.

### ADMC MR Decisions

An approved ADMC decision provides the supplier and the beneficiary with assurance that the beneficiary will meet the medical necessity requirements Medicare has established for the item. This assurance is based on the information submitted with the request.

An affirmative ADMC decision is valid for a period of **six months** from the date the decision is rendered. The date the item is provided to the beneficiary cannot be more than six months after the date the ADMC decision was rendered.

A negative ADMC decision indicates to the supplier and the beneficiary that the beneficiary does not meet the medical necessity requirements Medicare has established for the item. Requests may be resubmitted **once** during a six-month period for a negative ADMC decision only if additional medical documentation is supplied.

The DME MACs provide their decision to the requestor in writing, whether affirmative or negative. Currently, there is no way to view an ADMC status on the Noridian Medicare Portal. ADMC decision information can be found on the Interactive Voice Response (IVR) system by selecting the Prior Authorization function and speaking a verbal response of **prior** or a touch tone response of 1. The information that can be obtained is:

- **Receipt date, status (pending, affirmed, denied), and tracking number**

The IVR guide can be found on our website under Contact > Interactive Voice Response (IVR) - Self-Service Technology.

### Questions

If suppliers have additional questions, call the Pre-Claim Hotline regarding the ADMC process or any negative or affirmative decisions.

Acceptable use of the hotline includes; questions a supplier may have during the preparation of an ADMC submission, questions on a decision that was received, or information on coverage criteria.

When calling the hotline number, the caller will be directed to a voicemail. He or she must provide the information below.

- Beneficiary name
- Supplier name
- Phone number

- Hours of availability and time zone
- Beneficiary Medicare number or Medicare Beneficiary Identifier (MBI), if applicable
- A brief description of the question or issue

A clinical reviewer will return each voicemail within two business days.

## Intravenous Immune Globulin Resource

A new webpage has been added to the Noridian website regarding Intravenous Immune Globulin (IVIG) under Browse by DMEPOS Category. This page contains information on eligibility, billing, and documentation. As new information is provided to Noridian, it will be added to this page.

## January 2024 HCPCS Updates

CMS has released the January 2024 Healthcare Common Procedure Coding System (HCPCS) File. Inclusion on this list does not indicate coverage. All HCPCS code changes are effective and should be used for claims with dates of service on or after January 1, 2024. Please watch the Noridian website for additional policy updates regarding HCPCS codes.

### Added HCPCS Codes

Effective for dates of service on and after January 1, 2024

| HCPC | DESCRIPTION |
|---|---|
| A4287 | Disposable collection and storage bag for breast milk, any size, any type, each |
| A4457 | Enema tube, with or without adapter, any type, replacement only, each |
| A4468 | Exsufflation belt, includes all supplies and accessories |
| A4540 | Distal transcutaneous electrical nerve stimulator, stimulates peripheral nerves of the upper arm |
| A4541 | Monthly supplies for use of device coded at e0733 |
| A4542 | Supplies and accessories for external upper limb tremor stimulator of the peripheral nerves of the wrist |
| A6520 | Gradient compression garment, glove, padded, for nighttime use, each |
| A6521 | Gradient compression garment, glove, padded, for nighttime use, custom, each |
| A6522 | Gradient compression garment, arm, padded, for nighttime use, each |
| A6523 | Gradient compression garment, arm, padded, for nighttime use, custom, each |
| A6524 | Gradient compression garment, lower leg and foot, padded, for nighttime use, each |
| A6525 | Gradient compression garment, lower leg and foot, padded, for nighttime use, custom, each |
| A6526 | Gradient compression garment, full leg and foot, padded, for nighttime use, each |
| A6527 | Gradient compression garment, full leg and foot, padded, for nighttime use, custom, each |

| HCPC | DESCRIPTION |
|---|---|
| A6528 | Gradient compression garment, bra, for nighttime use, each |
| A6529 | Gradient compression garment, bra, for nighttime use, custom, each |
| A6552 | Gradient compression stocking, below knee, 30-40 mmhg, each |
| A6553 | Gradient compression stocking, below knee, 30-40 mmhg, custom, each |
| A6554 | Gradient compression stocking, below knee, 40 mmhg or greater, each |
| A6555 | Gradient compression stocking, below knee, 40 mmhg or greater, custom, each |
| A6556 | Gradient compression stocking, thigh length, 18-30 mmhg, custom, each |
| A6557 | Gradient compression stocking, thigh length, 30-40 mmhg, custom, each |
| A6558 | Gradient compression stocking, thigh length, 40 mmhg or greater, custom, each |
| A6559 | Gradient compression stocking, full length/chap style, 18-30 mmhg, custom, each |
| A6560 | Gradient compression stocking, full length/chap style, 30-40 mmhg, custom, each |
| A6561 | Gradient compression stocking, full length/chap style, 40 mmhg or greater, custom, each |
| A6562 | Gradient compression stocking, waist length, 18-30 mmhg, custom, each |
| A6563 | Gradient compression stocking, waist length, 30-40 mmhg, custom, each |
| A6564 | Gradient compression stocking, waist length, 40 mmhg or greater, custom, each |
| A6565 | Gradient compression gauntlet, custom, each |
| A6566 | Gradient compression garment, neck/head, each |
| A6567 | Gradient compression garment, neck/head, custom, each |
| A6568 | Gradient compression garment, torso and shoulder, each |
| A6569 | Gradient compression garment, torso/shoulder, custom, each |
| A6570 | Gradient compression garment, genital region, each |
| A6571 | Gradient compression garment, genital region, custom, each |
| A6572 | Gradient compression garment, toe caps, each |
| A6573 | Gradient compression garment, toe caps, custom, each |
| A6574 | Gradient compression arm sleeve and glove combination, custom, each |
| A6575 | Gradient compression arm sleeve and glove combination, each |
| A6576 | Gradient compression arm sleeve, custom, medium weight, each |
| A6577 | Gradient compression arm sleeve, custom, heavy weight, each |
| A6578 | Gradient compression arm sleeve, each |
| A6579 | Gradient compression glove, custom, medium weight, each |
| A6580 | Gradient compression glove, custom, heavy weight, each |
| A6581 | Gradient compression glove, each |
| A6582 | Gradient compression gauntlet, each |
| A6583 | Gradient compression wrap with adjustable straps, below knee, 30-50 mmhg, each |
| A6584 | Gradient compression wrap with adjustable straps, not otherwise specified |
| A6585 | Gradient pressure wrap with adjustable straps, above knee, each |
| A6586 | Gradient pressure wrap with adjustable straps, full leg, each |

| HCPC | DESCRIPTION |
|---|---|
| A6587 | Gradient pressure wrap with adjustable straps, foot, each |
| A6588 | Gradient pressure wrap with adjustable straps, arm, each |
| A6589 | Gradient pressure wrap with adjustable straps, bra, each |
| A6593 | Accessory for gradient compression garment or wrap with adjustable straps, not-otherwise specified |
| A6594 | Gradient compression bandaging supply, bandage liner, lower extremity, any size or length, each |
| A6595 | Gradient compression bandaging supply, bandage liner, upper extremity, any size or length, each |
| A6596 | Gradient compression bandaging supply, conforming gauze, per linear yard, any width, each |
| A6597 | Gradient compression bandage roll, elastic long stretch, linear yard, any width, each |
| A6598 | Gradient compression bandage roll, elastic medium stretch, per linear yard, any width, each |
| A6599 | Gradient compression bandage roll, inelastic short stretch, per linear yard, any width, each |
| A6600 | Gradient compression bandaging supply, high density foam sheet, per 250 square centimeters, each |
| A6601 | Gradient compression bandaging supply, high density foam pad, any size or shape, each |
| A6602 | Gradient compression bandaging supply, high density foam roll for bandage, per linear yard, any width, each |
| A6603 | Gradient compression bandaging supply, low density channel foam sheet, per 250 square centimeters, each |
| A6604 | Gradient compression bandaging supply, low density flat foam sheet, per 250 square centimeters, each |
| A6605 | Gradient compression bandaging supply, padded foam, per linear yard, any width, each |
| A6606 | Gradient compression bandaging supply, padded textile, per linear yard, any width, each |
| A6607 | Gradient compression bandaging supply, tubular protective absorption layer, per linear yard, any width, each |
| A6608 | Gradient compression bandaging supply, tubular protective absorption padded layer, per linear yard, any width, each |
| A6609 | Gradient compression bandaging supply, not otherwise specified |
| A6610 | Gradient compression stocking, below knee, 18-30 mmhg, custom, each |
| A7023 | Mechanical allergen particle barrier/inhalation filter, cream, nasal, topical |
| E0492 | Power source and control electronics unit for oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, controlled by phone application |
| E0493 | Oral device/appliance for neuromuscular electrical stimulation of the tongue muscle, used in conjunction with the power source and control electronics unit, controlled by phone application, 90-day supply |
| E0530 | Electronic positional obstructive sleep apnea treatment, with sensor, includes all components and accessories, any type |
| E0678 | Non-pneumatic sequential compression garment, full leg |

| HCPC | DESCRIPTION |
|---|---|
| E0679 | Non-pneumatic sequential compression garment, half leg |
| E0680 | Non-pneumatic compression controller with sequential calibrated gradient pressure |
| E0681 | Non-pneumatic compression controller without calibrated gradient pressure |
| E0682 | Non-pneumatic sequential compression garment, full arm |
| E0732 | Cranial electrotherapy stimulation (ces) system, any type |
| E0733 | Transcutaneous electrical nerve stimulator for electrical stimulation of the trigeminal nerve |
| E0734 | External upper limb tremor stimulator of the peripheral nerves of the wrist |
| E0735 | Non-invasive vagus nerve stimulator |
| E1301 | Whirlpool tub, walk-in, portable |
| E2001 | Suction pump, home model, portable or stationary, electric, any type, for use with external urine management system |
| E3000 | Speech volume modulation system, any type, including all components and accessories |
| L3161 | Foot, adductus positioning device, adjustable |
| L5615 | Addition, endoskeletal knee-shin system, 4 bar linkage or multiaxial, fluid swing and stance phase control |
| L5926 | Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type |
| Q0516 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 30-days |
| Q0517 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 60-days |
| Q0518 | Pharmacy supplying fee for hiv pre-exposure prophylaxis fda approved prescription drug, per 90-days |

### Description Update

The long description of the HCPCS code has been updated as of January 1, 2024

| HCPC | DESCRIPTION |
|---|---|
| A6531 | Gradient compression stocking, below knee, 30-40 mmhg, used as a surgical dressing, each |
| A6532 | Gradient compression stocking, below knee, 40-50 mmhg, used as a surgical dressing, each |
| A6545 | Gradient compression wrap, non-elastic, below knee, 30-50 mmhg, used as a surgical dressing, each |
| Q2052 | Services, supplies, and accessories used in the home for the administration of intravenous immune globulin (ivig) |

# News

## Lymphedema Compression Treatment Resource

A new webpage has been added to the Noridian website regarding Lymphedema Compression Treatment under Browse by DMEPOS Category. This page contains information on the new benefit category, including coverage, quantities, modifiers, accessories, replacements, and HCPCS codes. As new information is provided to Noridian, it will be added to this page.

## Manual Wheelchairs and Advance Determination of Medicare Coverage

Certain manual wheelchairs are eligible for Advance Determination of Medicare Coverage (ADMC), a voluntary program for suppliers or beneficiaries, to request in advance of delivery of the item, to determine whether payment for the item may be made or not.

HCPCS codes K0005 (ultra-lightweight wheelchair), E1161, E1231, E1232, E1233, and E1234 (tilt in space wheelchairs), K0008 (custom wheelchair), and K0009 (other wheelchair) are eligible for ADMC.

The request is mailed or faxed, with a coversheet, to Noridian. The DME MAC determines if there is sufficient medical documentation that supports whether the item is reasonable and necessary. Noridian renders a determination within 30 calendar days.

For complete information, see the ADMC webpage.

## Medicare Beneficiary Identifier (MBI) Replacement for Lost or Stolen Cards

In the event of a lost or stolen Medicare card, beneficiaries will be issued a new Medicare Beneficiary Identifier (MBI) number. Suppliers must promptly transition to billing using the newly assigned MBI when a beneficiary receives a replacement. Utilizing the old MBI for billing purposes may lead to denials accompanied by Reason Code 16, along with Remark Codes MA27 and N382.

- Reason Code 16: Claim/service lacks information or has submission/billing error(s).
- Remark Code MA27: Missing/incomplete/invalid entitlement number or name shown on the claim.
- Remark Code N382: Missing/incomplete/invalid patient identifier.

Should you encounter a denial featuring the reason and remark codes above, please ensure the accuracy of the beneficiary's MBI by utilizing the MBI Lookup Tool. Refer to the Denial Code Resolution tool for specific instructions on addressing denials associated with this reason and remark code.

# News

## Missing Noridian Medicare Portal Administrators

In the course of reviewing users for the Noridian Medicare Portal (NMP), it has come to our attention that certain accounts lack a current Provider Administrator. The NMP serves as a crucial self-service tool, and it necessitates the presence of an active Provider Administrator in the system before Provider End Users can proceed with account registration. We urge you to verify that your account has an active administrator on file to facilitate user access and enable them to utilize the portal's functionalities. For any inquiries, kindly consult the NMP Registration Guide or refer to the Registration FAQs.

The Noridian Medicare Portal (NMP) is a free and secure, internet-based portal that allows users access to beneficiary and claim information. The portal is available for all Part A, Part B, and Durable Medical Equipment (DME) users in the Noridian MAC Jurisdictions JA, JD, JE, and JF. The Centers for Medicare & Medicaid Services (CMS) governs the security regulations and other policies of the NMP.

## Negative Pressure Wound Therapy Pumps Policy Specific Requirements

The beneficiary's medical records must contain information regarding the history, prior treatment plans (if applicable), and current wound care for which a Negative Pressure Wound Therapy (NPWT) pump is being billed. The records have to contain:

- Time NPWT pump was in use
- Dressing types and frequency of change, and
- Changes in wound conditions, including
    - Precise measurements,
    - Quantity of exudates,
    - Presence of granulation and necrotic tissue, and
    - Concurrent measures being addressed relevant to wound therapy
        - Debridement
        - Nutritional concerns
        - Support surfaces in use
        - Positioning
        - Incontinence control

Information describing the wound evaluation and treatment that is recorded in the beneficiary's medical record must be used to demonstrate the regular evaluation and treatment of the beneficiary's wounds. Comparing the size of wounds month to month requires comparing areas with similar measurements. The supplier of the equipment and supplies must obtain from the treating clinician an assessment of wound healing progress based upon the wound measurement as documented in the

beneficiary's medical record in order to determine whether the NPWT equipment and supplies still qualify for Medicare coverage.

Documentation of quantitative measurements of wound characteristics including:

- Wound length and width (surface area), and depth, and
- Amount of wound exudate (drainage),
- Indicating progress of healing must be entered at least monthly.

Additional information on Negative Pressure Would Therapy Pumps can be found in the Local Coverage Determination (LCD) L33821 and Policy Article A52511 on the CMS website.

## New Claim Narrative Page

Explore our latest addition - the Claim Narratives Page. This webpage is designed to assist suppliers by providing explicit guidance on crafting narratives when submitting claims. Take a moment to discover the valuable insights on our new Claim Narratives page.

A well-constructed narrative is crucial for expediting the claims processing timeline in diverse situations. When integrating a narrative into a claim, ensure it is entered in Item 19 of the 1500 hard copy claim form or the 2400/NTE segment of an electronic claim. To accommodate space constraints for narratives, consider utilizing common abbreviations when submitting both paper and electronic claims that include a narrative.

Visit our new page to delve into the various scenarios that call for a narrative in the claim process. Each scenario is conveniently linked, providing suppliers with guidance on the specific narratives required for claims.

## New Therapeutic Shoes for Persons with Diabetes Activity Timeline Tool

Noridian is excited to introduce the new Therapeutic Shoes for Persons with Diabetes (TSPD) Activity Timeline Tool, now accessible for use. The TSPD Timeline Activity Tool is designed to assist suppliers in whether important documentation dates are compliant with the Local Coverage Determination (LCD) and Policy Article. This tool determines whether the Certification Statement date, the date of the face-to-face visit with the certifying physician and other providers, and the date of service meet policy specific timeframes.

# News

## Nurse Practitioner (NP) or Physician Assistant (PA) Practicing "Incident to" Certifying Physician

The certifying physician for Therapeutic Shoes for Persons with Diabetes (TSPD) is defined as a Doctor of Medicine (MD) or a Doctor of Osteopathy (DO). A Nurse Practitioner (NP) or Physician Assistant (PA) can serve as the certifying physician if they are practicing "incident to" the MD or DO. "Incident to" requires that the NP or PA are practicing under the supervision of the certifying physician and all billing is under the certifying physician's national provider identifier (NPI). The Centers for Medicare & Medicaid Services (CMS) provided guidance of diabetes responsibilities to NPs and PAs prescribing therapeutic shoes and inserts for persons with diabetes that can be found as a joint DME MAC article posted on November 5, 2020. This clarification is specific to NPs and PAs who are practicing under the supervision of an MD or DO (i.e., "incident to") and does not extend to NPs who practice independently (i.e., bill under their own NPI).

Additional information on "incident to" can be found in the CMS Internet Only Manual (IOM), Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60 - Services and Supplies Furnished Incident to a Physician's/NPP's Professional Service.

## Open Enrollment - Beneficiaries Switching to a Medicare Advantage Plan

Many suppliers face claim denials citing a beneficiary's enrollment in a Medicare Advantage Plan. To minimize expenses associated with rework and denials, it is crucial to verify beneficiary's eligibility on the Noridian Medicare Portal (NMP) before submitting claims.

### Importance During Open Enrollment Periods

Verification becomes even more critical during specific times, especially during open enrollment periods. The **Medicare Fee-for-Service (FFS)** or original Medicare yearly open enrollment period, from **October 15 to December 7**, sees numerous beneficiaries opting to transition from FFS to a Medicare Advantage Plan (also known as Part C). Benefits for this switch commence on January 1 of next year.

Beneficiaries enrolled in a Medicare Advantage (MA) Plan have the flexibility to change their minds. They can either switch back to the original Medicare or opt for a different Medicare Advantage Plan during the **Medicare Advantage Open Enrollment Period** from January 1 to March 31.

These Medicare Advantage Plans, approved by Medicare and offered by private companies, provide an alternative to original Medicare, covering both Medicare Part A and Part B. Various types of Medicare Advantage Plans cater to diverse beneficiary needs.

### Verifying Eligibility on the NMP

Ensuring that the correct payer is billed is paramount. The Noridian Medicare Portal features a dedicated tab for Health Maintenance Organization (HMO) or Medicare Advantage Plan verification.

When verifying eligibility through the HMO/MA tab, suppliers may obtain the following information:

- Insurer Name
- Plan Code Number
- Effective and Termination Date
- MCO Plan Type
- MCO Bill Option Code
- Address
- Phone Number
- Contract Website

This comprehensive verification process contributes to streamlined billing procedures, minimizing the risk of claim denials, and promoting an efficient and error-free healthcare reimbursement process.

## Ostomy Supplies Refill Requirements

For DMEPOS items and supplies provided on a recurring basis, billing must be based on prospective, not retrospective, use. For DMEPOS products supplied as refills to the original order, suppliers must contact the beneficiary before dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, that existing supplies are expected to end, and to confirm any changes or modifications to the order. Contact the beneficiary or designee about refills must take place no sooner than 30 calendar days before the expected end of the current supply. For refill delivery, the supplier must deliver the DMEPOS product no sooner than 10 calendar days before the expected end of the current supply. This is regardless of which delivery method is utilized.

Additional information on ostomy supplies can be found in the Local Coverage Determination (LCD) L33828 and Policy Article A52487 on the CMS website.

## Primary Care First Model Demonstration Project

Effective January 1, 2021, through December 31, 2025, a nurse practitioner (NP) is allowed to certify an order for diabetic shoes under the Primary Care First (PCF) Model Demonstration Project. Only NPs practicing in the PCF demonstration are eligible to serve as the certifying physician. More information on the PCF model can be found on the Primary Care First Model Options | CMS Innovation Center.

# News

## Reminder - Competitive Bid Temporary Gap Period Modifier Use

Starting January 1, 2024, a temporary gap period is in effect for the Competitive Bidding Program (CBP) until CMS provides further notification. Claims with HCPCS codes L0648, L0650, L1833, and L1851 from non-contract physicians or practitioners that require prior authorization should not include the competitive bid modifiers KV, J4, or J5, as they will not be accepted. This is due to the absence of a CBP exception for non-contract physicians or practitioners. Treating practitioners can choose to undergo the standard prior authorization process within the regular timeframe, request an expedited review, or use the ST modifier to denote an acute or urgent need.

Claims with dates of service on or after January 1, 2024, with the ST modifier appended, to indicate acute/emergent need, will be subject to prepayment review. It is essential to highlight that this procedural change specifically affects non-contract competitive bid suppliers who are practitioners/physicians, physical therapists, and occupational therapists. For detailed information, please refer to the Timeline & Updates section of the Prior Authorization and Pre-Claim Review Initiatives webpage on the CMS website and the Noridian Medicare website for Competitive Bid information.

## Requesting Claim Examples

Noridian seeks the assistance of suppliers in providing examples of claim scenarios and billing documentation for which they have received payment or denials. We aim to enhance our educational resources by incorporating these real-world examples into our policy webinars and L200 series webinars. The information gathered will be used to assist all suppliers in addressing and resolving denials effectively. We encourage submissions from all policies. To ensure privacy, please redact any PHI or PII, while including enough details to verify the paid or unpaid determination. Kindly include a coversheet directed to the attention of DME POE and fax redacted claim information to 701-433-5957.

## 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 specialties below. The following quarterly edit effectiveness results from October 2023 - December 2023 can be located on the Medical Record Review Results webpage:

- Ankle-Foot Orthotics
- Enteral Nutrition
- Glucose Supplies
- Hospital Beds

- Knee Orthosis
- Manual Wheelchairs
- Ostomy Supplies
- Parenteral Nutrition
- Pneumatic Compression Devices
- Spinal Orthotics
- Surgical Dressings
- Therapeutic Shoes
- Urological Supplies

## Welcome to the New NoridianMedicare.com

In response to survey feedback, Noridian has recently updated the look and feel of NoridianMedicare.com. This new design provides a wider view of content to better utilize common screen resolutions, more white space to remove distractions, and updated font sizing and spacing to allow users to easily focus on reading.

Our site may look different but navigation remains the same. All webpages are still in the same place, so bookmarks will work as they always have, and users will continue to follow the same menu selections to get to the sections they need.

You spoke. We Listened. Many of these changes were driven by user comments, and Noridian thanks everyone for their feedback. Please continue to use our survey and feedback tab to leave messages and suggestions about future changes for us to review.

## What's in the Urological Supplies Tips Section

The Urological Supplies webpage has a Tips section covering the following important topics: Continued Medical Need, and Coverage Criteria for Intermittent Urinary Catheters A4353 - Immunosuppressed Beneficiaries Meeting Criterion 2. Take a moment to review these criteria to ensure you understand the requirements.

## 2024 HCPCS Code Update - January Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, 2024 HCPCS Code Update - January Edition - Correct Coding, has been created and published to our website.

View the locally hosted 2024 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

## 3-D Printed Orthotic Devices - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **3-D Printed Orthotic Devices - Correct Coding**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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

## April 2024 HCPCS Updates

CMS has released the April 2024 Healthcare Common Procedure Coding System (HCPCS) File. Inclusion on this list does not indicate coverage. All HCPCS code changes are effective and should be used for claims with dates of service on or after April 1, 2024. Please watch the Noridian website for additional policy updates regarding HCPCS codes.

### Added HCPCS Codes

Effective for dates of service on and after April 1, 2024

| HCPC | LONG DESCRIPTION |
|---|---|
| A4271 | Integrated lancing and blood sample testing cartridges for home blood glucose monitor, per month |
| E0468 | Home ventilator, dual-function respiratory device, also performs additional function of cough stimulation, includes all accessories, components and supplies for all functions |
| E0736 | Transcutaneous tibial nerve stimulator |

| HCPC | LONG DESCRIPTION |
|---|---|
| E0738 | Upper extremity rehabilitation system providing active assistance to facilitate muscle re-education, include microprocessor, all components and accessories |
| E0739 | Rehab system with interactive interface providing active assistance in rehabilitation therapy, includes all components and accessories, motors, microprocessors, sensors |
| E2104 | Home blood glucose monitor for use with integrated lancing/blood sample testing cartridge |
| E2298 | Complex rehabilitative power wheelchair accessory, power seat elevation system, any type |
| K1037 | Docking station for use with oral device/appliance used to reduce upper airway collapsibility |
| L1320 | Thoracic, pectus carinatum orthosis, sternal compression, rigid circumferential frame with anterior and posterior rigid pads, custom fabricated |
| L5783 | Addition to lower extremity, user adjustable, mechanical, residual limb volume management system |
| L5841 | Addition, endoskeletal knee-shin system, polycentric, pneumatic swing, and stance phase control |

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

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

View the locally hosted 2024 DMD articles.

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

## External Infusion Pumps and Related Drugs - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **External Infusion Pumps and Related Drugs - Revised**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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- Locate/select article title

# Medical Policies and Coverage

## External Upper Limb Tremor Stimulator Therapy - Final LCD and Response to Comments (RTC) Article Published

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

View the locally hosted 2024 DMD articles.

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

## HCPCS Codes K1018 and K1019 - Correct Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **HCPCS Codes K1018 and K1019 - Correct Coding - 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

## Home Assessment for Manual Wheelchairs - Reminder

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Home Assessment for Manual Wheelchairs - Reminder**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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

# Medical Policies and Coverage

## Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder - January 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Items Provided on a Recurring Basis and Request for Refill Requirements - Annual Reminder - January 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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- Locate/select article title

## LCD and Policy Article Revisions Summary for December 14, 2023

**Joint DME MAC Publication**

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, External Breast Prostheses, External Infusion Pumps, Glucose Monitors, Immunosuppressive Drugs, Intravenous Immune Globulin, Lower Limb Prostheses, Nebulizers, Negative Pressure Wound Therapy Pumps, Oral Anticancer Drugs, Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics), Osteogenesis Stimulators, Ostomy Supplies, Parenteral Nutrition, Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea, Respiratory Assist Devices, Standard Documentation Requirements for All Claims Submitted to DME MACs, Suction Pumps, Surgical Dressings, Tracheostomy Care Supplies, Transcutaneous Electrical Nerve Stimulators (TENS), and Urological Supplies. Please review the entire LCDs and related PAs for complete information.

**Enteral Nutrition**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply.”

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply.”

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**External Breast Prostheses**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**External Infusion Pumps**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee

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**Glucose Monitors**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Immunosuppressive Drugs**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F*

**Intravenous Immune Globulin**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Lower Limb Prostheses**

***LCD***

**Revision Effective Date: 10/01/2023**

HCPCS CODES:

Added: HCPCS code L5991

*12/14/2023: 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**

CODING GUIDELINES:

Added: “PROSTHETIC CONNECTORS”

Added: HCPCS code L5991 coding guideline information

Added: “L5614” to the HCPCS codes listed in reference to addition codes for exoskeletal knee-shin systems

Added: HCPCS code L5845 coding guideline information

Added: HCPCS code L5848 coding guideline information

Revised: HCPCS code L5982 coding guideline information, to include “Motion of this product is separate from any similar incidental prosthetic foot/ankle motions."

Revised: HCPCS code L5984 coding guideline information, to include “Motion of this product is separate from any similar incidental prosthetic foot/ankle motions."

*12/14/2023: 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.*

**Nebulizers**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Negative Pressure Wound Therapy Pumps**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

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**Oral Anticancer Drugs**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

Revised: "Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date." to "Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply."

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Osteogenesis Stimulators**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Ostomy Supplies**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

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*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Parenteral Nutrition**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

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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

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Positive Airway Pressure (PAP) Devices for the Treatment of Obstructive Sleep Apnea**

***LCD***

Revision Effective Date: 01/01/2024

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

Revised: "Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date." to "Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply."

Revised: "For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product." to "For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply."

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Respiratory Assist Devices**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply.”

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply.”

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

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Standard Documentation Requirements for All Claims Submitted to DME MACs**

***PA***

**Revision Effective Date: 01/01/2024**

MEDICAL RECORD DOCUMENTATION:

Revised: Supplier produced records by replacing “Supplier-produced records, even if signed by the treating practitioner, and attestation letters (e.g. letters of medical necessity) are deemed not to be part of a medical record for Medicare payment purposes.” with “Supplier prepared statements and physician attestations by themselves do not provide sufficient documentation of medical necessity, even if signed by the ordering physician.” as clarification

REFILL DOCUMENTATION REQUIREMENTS:

Removed: “either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary”

Added: “individualized to the beneficiary (i.e., the beneficiary or their caregiver/designee affirms the need for refill) and documented in the record. Medicare does not prescribe the mode of communication used to gather the information. For example, the refill request communication may be performed via automated text messaging or email as long as each required aspect of the refill request is captured.” as clarification

Added: “Documentation of affirmative response indicating a need for refill” based on CMS Final Rule CMS-1780-F

Removed: “For consumable supplies i.e., those that are used up (e.g., ostomy or urological supplies, surgical dressings, etc.) the supplier must assess the quantity of each item that the beneficiary still has remaining to document that the amount remaining will be nearly exhausted on or about the supply anniversary date.” based on CMS Final Rule CMS-1780-F

Removed: “For non-consumable supplies i.e., those more durable items that are not used up but may need periodic replacement (e.g., PAP and RAD supplies) the supplier must assess whether the supplies remain functional, providing replacement (a refill) only when the supply item(s) is no longer able to function. The supplier must document the functional condition of the item(s) being refilled in sufficient detail to demonstrate the cause of the dysfunction that necessitates replacement (refill).” based on CMS Final Rule CMS-1780-F

*12/14/2023: 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.*

**Suction Pumps**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply.”

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply.”

12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.

**Surgical Dressings**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply.”

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply.”

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Tracheostomy Care Supplies**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: “and document an affirmative response” to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: “approaching exhaustion” to “expected to end” in regard to existing supplies

Revised: “Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date.” to “Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply.”

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier

must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply."

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Transcutaneous Electrical Nerve Stimulators (TENS)**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

Revised: "Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date." to "Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply."

Revised: "For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product." to "For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply."

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**Urological Supplies**

***LCD***

**Revision Effective Date: 01/01/2024**

COVERAGE INDICATIONS, LIMITATIONS, AND/OR MEDICAL NECESSITY:

Added: "and document an affirmative response" to language that pertains to contact with the beneficiary or caregiver/designee for DMEPOS products supplied as refills

Revised: "approaching exhaustion" to "expected to end" in regard to existing supplies

Revised: "Contact with the beneficiary or designee regarding refills must take place no sooner than 14 calendar days prior to the delivery/shipping date." to "Contact with the beneficiary or designee regarding refills must take place no sooner than 30 calendar days prior to the expected end of the current supply."

Revised: “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.” to “For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the expected end of the current supply.”

*12/14/2023: Pursuant to the 21st Century Cures Act, these revisions do not require notice and comment because the revisions are non-discretionary updates to refill requirement information per CMS Final Rule CMS-1780-F.*

**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 December 28, 2023

**Joint DME MAC Publication**

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

**Lower Limb Prostheses**

***LCD***

**Revision Effective Date: 01/01/2024**

HCPCS CODES:

Added: HCPCS codes L5615 and L5926

*12/28/2023: 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: 01/01/2024**

CODING GUIDELINES:

Added: HCPCS code L5926 coding guideline information

*12/28/2023: 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.*

**Power Mobility Devices**

***PA***

**Revision Effective Date: 05/16/2023**

CODING GUIDELINES:

Revised: No Power Options definition, from “A category of PWCs that is incapable of accommodating a power tilt, recline, seat elevation, or standing system. If a PWC can only accept power elevating legrests, it is considered to be a No Power Option chair.” to “No Power Options - A category of PWCs that is incapable of accommodating a power tilt, recline, or standing system. If a PWC can only accept power elevating legrests and/or seat elevation, it is considered to be a No Power Option chair.”

Revised: Group 2 no power option PWC information, by removing “seat elevation” from the options the PWC is incapable of accommodating

Revised: Group 3 and 4 no power option PWC information, by removing “seat elevation” from the options the PWC is incapable of accommodating

# Medical Policies and Coverage

*12/28/2023: 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

## LCD Revisions Summary for January 25, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD Revisions Summary for January 25, 2024**, has been created and published to our website.

View the locally hosted 2024 DMD articles.

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

## LCD Revision Summary for February 15, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **LCD Revision Summary for February 15, 2024**, has been created and published to our website.

View the locally hosted 2024 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

## Lymphedema Compression Treatment Items - Correct Coding and Billing - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Lymphedema Compression Treatment Items - Correct Coding and Billing - Revised**, has been created and published to our website.

View the locally hosted 2024 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

## Lymphedema Compression Treatment Items Requirement for Registration with the Food and Drug Administration

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Lymphedema Compression Treatment Items Requirement for Registration with the Food and Drug Administration**, has been created and published to our website.

View the locally hosted 2024 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

## Open Meeting Agenda - Lower Limb Prostheses Proposed Local Coverage Determination (LCD)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Open Meeting Agenda - Lower Limb Prostheses Proposed Local Coverage Determination (LCD)**, has been created and published to our website.

View the locally hosted 2024 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

## Open Meeting Announcement - Lower Limb Prostheses Proposed Local Coverage Determination (LCD)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Open Meeting Announcement - Lower Limb Prostheses Proposed Local Coverage Determination (LCD)**, has been created and published to our website.

View the locally hosted 2024 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 December 7, 2023

Joint DME MAC Publication

Outlined below are the principal changes to the DME MAC Policy Articles (PAs) that have been revised and posted. The policies included are Ankle-Foot/Knee-Ankle-Foot Orthoses, Knee Orthoses, and Spinal Orthoses: TLSO and LSO. Please review the entire Local Coverage Determinations (LCDs) and related PAs for complete information.

**Ankle-Foot/Knee-Ankle-Foot Orthoses**

***PA***

**Revision Effective Date: 02/01/2021**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Language that describes prefabricated and custom fabricated orthoses

Revised: “This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training.” to “This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training (as defined in the CODING GUIDELINES section).”

Revised: HCPCS referenced as custom fabricated orthoses, to include “L1900”

Revised: “This information will be corroborated by the functional evaluation in the orthotist or prosthetist’s records.” to “This information will be corroborated by the functional evaluation in the orthotist’s records and the method of custom fabrication should adhere to the DMEPOS Quality Standards, Appendix C.”

MODIFIERS:

Removed: “refer to the CODING GUIDELINES section for additional information” pertaining to RT and LT modifiers

Added: RT and LT modifier information (relocated from the CODING GUIDELINES section)

MISCELLANEOUS:

Added: “(Refer to the REPAIR/REPLACEMENT section for more information regarding billing of L4205 and L4210 HCPCS codes.)”

CODING GUIDELINES:

Added: “CUSTOM FABRICATED”

Added: “Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and should not be billed with prefabricated base orthotics” (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: Language that describes custom fabricated orthoses, molded-to-patient-model custom fabrication, and positive model of the patient

Added: “Specialized Training” and the definition of specialized training

Added: “PREFABRICATED” and language that describes prefabricated orthoses

Removed: “However, for certain types of orthoses, the HCPCS code narrative that best describes the product does not make a distinction between prefabricated orthoses that are provided as custom-fit or OTS. These code narratives are correct and must be used for Medicare billing, without regard to how the product is provided to the beneficiary at the final delivery.” (Effective March 11, 2021)

Added: “Corresponding HCPCS Code Sets”

Revised: “parallel” to “corresponding” in regard to HCPCS codes

Removed: “(e.g., L4360, L4361, L4386, L4387, L4396 and L4397)” from the sentence that pertains to corresponding sets of HCPCS codes

Added: HCPCS codes L4360, L4361, L4386, L4387, L4396, and L4397 to a table that pertains to corresponding sets of HCPCS codes

Added: Information that pertains to the coding of a prefabricated orthosis when a corresponding HCPCS code set is not available and the unique HCPCS code describes a custom fitted item, including “Code the product using the unique HCPCS code, if the product was custom fitted at the time of delivery to the beneficiary” and “Code the product using a miscellaneous HCPCS code, if the product was not custom fitted at delivery to the beneficiary and, instead, was provided as OTS to the

beneficiary. The miscellaneous HCPCS code for billing of AFOs and KAFOs is HCPCS code L2999." (Effective March 11, 2021)

Revised: "Elastic and Similar Stretchable Materials" to "ELASTIC AND SIMILAR STRETCHABLE MATERIALS"

Added: "ANKLE-FOOT ORTHOSES," "KNEE-ANKLE-FOOT ORTHOSES," "POSITIONING DEVICES," "SHOE INSERTS," "CONCENTRIC TORSION JOINTS," "WALKING BOOTS," "OTHER DEVICES," and "REPAIR/REPLACEMENT"

Added: Coding guideline information for HCPCS codes L2034, L2036, L2200, L2210, L2220, L2280, L2330, and L2820

Added: "LOWER EXTREMITY ADDITIONS" and language that describes custom-fabricated additions

Removed: Language that referred to the HCPCS codes which describe custom fabricated and prefabricated orthoses

Removed: Language that referred to the HCPCS codes which describe orthoses worn when a beneficiary is ambulatory, non-ambulatory, or minimally ambulatory

Revised: Language that pertains to shoes, inserts, and shoe modifications that are integral components of a leg brace and the pertinent HCPCS codes

Removed: RT and LT modifier information

*12/07/2023: 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.*

**Knee Orthoses**

***PA***

**Revision Effective Date: 07/20/2023**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Language that describes prefabricated and custom fabricated orthoses

Removed: Reasonable and useful lifetime (RUL) language and chart of knee orthoses codes with RUL guidelines

Removed: Language pertaining to noncoverage of L-coded additions when the base orthosis is noncovered

Removed: "Brace sleeves (A9270) used in conjunction with orthoses are noncovered because they are not used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body (i.e., it does not meet the definition of a brace)."

Removed: Repair information

POLICY SPECIFIC DOCUMENTATION REQUIREMENTS:

Added: "General Requirements"

Added: “The supplier must include on the claim line the diagnosis code(s) for HCPCS codes L1830, L1831, L1832, L1833, L1834, L1836, L1840, L1843, L1844, L1845, L1846, L1850, L1851, L1852 and L1860.”

Added: “For a custom-fabricated orthosis, there must be documentation in the supplier's records to support the medical necessity of that type of device rather than a prefabricated orthosis. This information must be available upon request.”

Revised: "prescribing practitioner" to "treating practitioner"

Removed: “The beneficiary’s condition (diagnosis code) that necessitates the need for the knee orthosis must be included on the claim.”

Added: Prefabricated orthoses HCPCS codes to language that pertains to coding of prefabricated orthoses

Revised: "This information will be corroborated by the functional evaluation in the orthotist’s or prosthetist’s records.” to “This information will be corroborated by the functional evaluation in the orthotist’s records and the method of custom fabrication should adhere to the DMEPOS Quality Standards, Appendix C.”

MODIFIERS:

Removed: “(refer to the CODING GUIDELINES section for additional information)” pertaining to RT and LT modifiers

Added: RT and LT modifier information (relocated from the CODING GUIDELINES section)

MISCELLANEOUS:

Added: Language pertaining to information for inclusion in claims for codes L4205 and L4210

CODING GUIDELINES:

Removed: "Definitions," language pertaining to terms used to describe devices in the Policy Article, and brace definition language

Revised: “Custom Fabricated” to “CUSTOM FABRICATED”

Added: “Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and should not be billed with prefabricated base orthotics” (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: Updated language that describes custom fabricated orthoses, molded-to-patient-model custom fabrication, and positive model of the patient

Added: “PREFABRICATED” and language that describes prefabricated orthoses

Revised: “More than minimal self-adjustment is defined as changes made to achieve an individualized fit of the item that requires the expertise of a certified orthotist or an individual who has specialized training in the provision of orthotics in compliance with all applicable Federal and State licensure and regulatory requirements.” to “In contrast to “minimal self-adjustment,” “more than minimal self-adjustment” is defined as changes made to achieve an individualized fit during the final fitting at the

time of delivery of the item that requires the expertise of a certified orthotist or an individual who has specialized training in the provision of orthotics in compliance with all applicable Federal and State licensure and regulatory requirements."

Added: "Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient is considered as custom fitted if the final fitting at the time of delivery to the patient requires more than minimal self-adjustment requiring expertise as described in this section."

Removed: "However, for certain types of orthoses, the HCPCS code narrative that best describes the product does not make a distinction between prefabricated orthoses that are provided as custom-fit or OTS. These code narratives are correct and must be used for Medicare billing, without regard to how the product is provided to the beneficiary at the final delivery." (Effective March 11, 2021)

Added: "Corresponding HCPCS Code Sets"

Revised: "parallel" to "corresponding" in regard to HCPCS codes

Removed: "(e.g., L1832, L1833, L1845, L1846, L1847, and L1848)" from the sentence that pertains to corresponding sets of HCPCS codes

Added: HCPCS codes L1810, L1812, L1832, L1833, L1843, L1845, L1847, L1848, L1851, L1852 to a table that pertains to corresponding sets of HCPCS codes

Added: Information that pertains to the coding of a prefabricated orthosis when a corresponding HCPCS code set is not available and the unique HCPCS code describes a custom fitted item, including "Code the product using the unique HCPCS code, if the product was custom fitted at the time of delivery to the beneficiary" and "Code the product using a miscellaneous HCPCS code, if the product was not custom fitted at delivery to the beneficiary and, instead, was provided as OTS to the beneficiary. The miscellaneous HCPCS code for billing of knee orthoses is HCPCS code L2999." (Effective March 11, 2021)

Revised: "Elastic and Similar Stretchable Materials" to "ELASTIC AND SIMILAR STRETCHABLE MATERIALS"

Added: "KNEE ORTHOSES"

Removed: "(respectively)" from the description of codes L1843, L1844, L1845, L1846, L1851 and L1852

Added: "LOWER EXTREMITY ADDITIONS" and language that describes custom-fabricated additions

Revised: "Not medically necessary" to "Not reasonable and necessary" in regard to the four (4) categories into which addition codes are grouped

Added: Reasonable and useful lifetime (RUL) language and chart of knee orthoses codes with RUL guidelines (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: Language pertaining to noncoverage of L-coded additions when the base orthosis is noncovered (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: "CONCENTRIC TORSION JOINTS" and "REPAIR/REPLACEMENT"

Revised: “dynamic adjustable knee extension/flexion device” to “DYNAMIC ADJUSTABLE KNEE EXTENSION/FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL”

Removed: “Code L4002 (REPLACEMENT STRAP, ANY ORTHOSIS, INCLUDES ALL COMPONENTS, ANY LENGTH, ANY TYPE) is for billing of replacement component(s) and is not payable at initial issue of a base orthosis. When code L4002 is billed at the time of initial issue of a base orthosis, it will be denied as not separately payable.”

Removed: RT and LT modifier information

Added: Reasonable and useful lifetime (RUL) language and chart of knee orthoses codes with RUL guidelines (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: “Addition codes K0672, L2390, L2750, L2780, L4002 are for billing of replacement component(s) and are not payable at initial issue of a base orthosis. When code L4002 is billed at the time of initial issue of a base orthosis, it will be denied as not separately payable.”

Added: “Some replacement items have unique Healthcare Common Procedure Coding System (HCPCS) codes. Replacement components that do not have a unique HCPCS code must be billed with a "not otherwise specified" code - L2999. Items that have unique codes must not be billed using a NOC code.”

*12/07/2023: 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.*

**Spinal Orthoses: TLSO and LSO**

***PA***

**Revision Effective Date: 07/07/2022**

NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES:

Removed: Language that describes prefabricated and custom fabricated orthoses

Revised: “This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training.” to “This minimal self-adjustment does not require the services of a certified orthotist or an individual who has specialized training (as defined in the CODING GUIDELINES section).”

Revised: “This information will be corroborated by the functional evaluation in the orthotist’s or prosthetist’s records.” to “This information will be corroborated by the functional evaluation in the orthotist’s records and the method of custom fabrication should adhere to the DMEPOS Quality Standards, Appendix C.”

CODING GUIDELINES:

Added: “CUSTOM FABRICATED”

Added: “Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and should not be billed with prefabricated base orthotics” (relocated from the NON-MEDICAL NECESSITY COVERAGE AND PAYMENT RULES section)

Added: Updated language that describes custom fabricated orthoses, molded-to-patient-model custom fabrication, and positive model of the patient

Added: “Specialized Training” and the definition of specialized training

Added: “PREFABRICATED” and language that describes prefabricated orthoses

Removed: “However, for certain types of orthoses, the HCPCS code narrative that best describes the product does not make a distinction between prefabricated orthoses that are provided as custom-fit or OTS. These code narratives are correct and must be used for Medicare billing, without regard to how the product is provided to the beneficiary at the final delivery.” (Effective March 11, 2021)

Added: “Use of CAD/CAM or similar technology to create an orthosis without a positive model of the patient is considered as custom fitted if the final fitting at the time of delivery to the patient requires more than minimal self-adjustment requiring expertise as described in this section.”

Added: “Corresponding HCPCS Code Sets”

Revised: “parallel” to “corresponding” in regard to HCPCS codes

Added: HCPCS codes L0454, L0455, L0456, L0457, L0466, L0467, L0468, L0469, L0626, L0641, L0627, L0642, L0630, L0643, L0631, L0648, L0633, L0649, L0637, L0650, L0639, and L0651 to a table that pertains to corresponding sets of HCPCS codes

Added: Information that pertains to the coding of a prefabricated orthosis when a corresponding HCPCS code set is not available and the unique HCPCS code describes a custom fitted item, including “Code the product using the unique HCPCS code, if the product was custom fitted at the time of delivery to the beneficiary” and “Code the product using a miscellaneous HCPCS code, if the product was not custom fitted at delivery to the beneficiary and, instead, was provided as OTS to the beneficiary. The miscellaneous HCPCS code for billing of spinal orthoses is HCPCS code L1499.” (Effective March 11, 2021)

Added: “SPINAL ORTHOSES”

Revised: “Elastic and Similar Stretchable Materials” to “ELASTIC AND SIMILAR STRETCHABLE MATERIALS”

*12/07/2023: 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.*

**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 January 18, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for January 18, 2024**, has been created and published to our website.

View the locally hosted 2024 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 February 8, 2024

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Policy Article Revisions Summary for February 8, 2024**, has been created and published to our website.

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- Locate/select article title

# Medical Policies and Coverage

## Policy Article Revisions Summary for February 29, 2024

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## Powered Lower Extremity Exoskeleton - Correct Coding

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# Medical Policies and Coverage

## Proposed Local Coverage Determination (LCD) Released for Comment - Lower Limb Prostheses

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Proposed Local Coverage Determination (LCD) Released for Comment - Lower Limb Prostheses**, has been created and published to our website.

View the locally hosted 2024 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

## PureWick Urine Collection System - Coding and Billing Instructions - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **PureWick Urine Collection System - Coding and Billing Instructions - 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

# MLN Connects

## MLN Connects - December 7, 2023

MLN Connects Newsletter: Dec 7, 2023

**News**

- Citrix Bleed Vulnerability: Act Now
- Marriage and Family Therapists & Mental Health Counselors: Enroll in Medicare Now
- Health Professional Shortage Area: CY 2024 Bonus Payments
- Skilled Nursing Facility Value-Based Purchasing Program: December Confidential Feedback Reports
- Flu Shots: There's Still Time to Protect Your Patients

**Claims, Pricers, & Codes**

- Medicare Physician Fee Schedule: New CPT Codes for RSV Vaccine Administration
- Discarded Drugs & Biologicals: JZ Modifier Use for Pharmacies
- National Correct Coding Initiative: Annual Policy Manual Update
- ICD-10: New Procedure Codes Effective April 1

**MLN Matters® Articles**

- Edits to Prevent Payment of G2211 with Office/Outpatient Evaluation and Management Visit and Modifier 25
- New Waived Tests
- Update for Blood Clotting Factor Add-on Payments - Revised

## MLN Connects - December 14, 2023

MLN Connects Newsletter: December 14, 2023

**News**

- CMS Releases Revised Guidance for Medicare Prescription Drug Inflation Rebate Program
- Medicare Part B Inflation Rebate Guidance: Use of the 340B Modifier - Revised
- Billing for Flu, Pneumococcal, & COVID-19 Vaccines
- Expanded Home Health Value-Based Purchasing Model: October 2023 Interim Performance Reports

## MLN Connects

**Claims, Pricers, & Codes**

- New Place of Service Code 27 for Outreach Site/Street
- National Correct Coding Initiative: January Update

**MLN Matters® Articles**

- Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting & Reporting Data for the Private Payor Rate-Based Payment System - Revised
- Clinical Laboratory Fee Schedule: 2024 Annual Update
- Medicare Program Integrity Manual: CY 2024 Home Health Prospective Payment System Updates
- Activation of Validation Edits for Providers with Multiple Service Locations - Revised

**Publications**

- Medicare Diabetes Prevention Program Expanded Model - Revised
- Rural Emergency Hospitals - Revised

**Multimedia**

- Expanded Home Health Value-Based Purchasing Model: Agency Perspectives Video Series

**From Our Federal Partners**

- Severe & Fatal Confirmed Rocky Mountain Spotted Fever among People with Recent Travel to Tecate, Mexico

## MLN Connects - December 21, 2023

MLN Connects Newsletter: Dec 21, 2023

**Editor's Note:**

Happy holidays from the MLN Connects team. We'll release the next regular edition on Thursday, January 4, 2024.

**News**

- CMS Roundup (Dec 15, 2023)
- Opioid Use Disorder Screenings & Treatment: Medicare Pays for Services
- Opioid Treatment Programs: New Information for 2024

- Skilled Nursing Facility Consolidated Billing: Are You Following the Requirements?

**Compliance**

- Global Surgery: Bill Correctly

**Claims, Pricers, & Codes**

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

**MLN Matters® Articles**

- DMEPOS Fee Schedule: CY 2024 Update

**Multimedia**

- Medicare Diabetes Prevention Program Orientation Video

**From Our Federal Partners**

- Urgent Need to Increase Immunization Coverage for Influenza, COVID-19, and RSV & Use of Authorized/Approved Therapeutics in the Setting of Increased Respiratory Disease Activity During the 2023-2024 Winter Season

## MLN Connects - January 4, 2024

MLN Connects Newsletter: Jan 4, 2024

**News**

- CMS Roundup (Dec 29, 2023)
- In-Home Vaccine Administration: Additional Payment
- Organizational Providers: Do You Need to Revalidate Your Enrollment Record Soon?
- Value-Based Insurance Design Model: Learn about the Hospice Benefit Component
- CMS Health Information Handler Helps You Submit Medical Review Documentation Electronically
- Cervical Health: Encourage Screening

**Claims, Pricers, & Codes**

- Skilled Nursing Facility Consolidated Billing: CY 2024 HCPCS Codes
- Integrated Outpatient Code Editor: Version 25.0

## MLN Connects

### MLN Matters® Articles

- Ambulatory Surgical Center Payment System: January 2024 Update
- New Condition Code 92: Billing Requirements for Intensive Outpatient Program Services
- Activation of Validation Edits for Providers with Multiple Service Locations - Revised
- New Waived Tests - Revised

## MLN Connects - January 11, 2024

MLN Connects Newsletter: Jan 11, 2024

### News

- Marriage and Family Therapist & Mental Health Counselor Services: Overpayments to Critical Access Hospitals Billing under Method II
- Medicare Part A Cost Report Exhibits: New Electronic Templates
- Additional Residency Positions: Apply by March 31
- Therapy Services: Per-Beneficiary CY 2024 Threshold Amounts
- COVID-19 Vaccine CY 2024 Geographically-Adjusted Payment Rates
- Medicare Diabetes Prevention Program: CY 2024 Payment Rates
- Ambulance Fee Schedule: CY 2024 Inflation Factor
- Medicare Wellness Visits: Healthy Start to 2024

### Claims, Pricers, & Codes

- Therapy Code List: 2024 Annual Update

### Events

- Medicare Ground Ambulance Data Collection System Overview Webinar - January 18

### From Our Federal Partners

- Health Care Preparedness Resources

# MLN Connects

## MLN Connects - January 18, 2024

MLN Connects Newsletter: Jan 18, 2024

**News**

- CMS Finalizes Rule to Expand Access to Health Information and Improve the Prior Authorization Process
- Acute Hospital Care at Home Data Release
- CMS Roundup (Jan 12, 2024)
- Medicare Part B Vaccine Administration: CY 2024 Payment Amounts
- Glaucoma Awareness Month: Act to Prevent Vision Loss

**Events**

- Immunization Strategies for Long-Term Care: Stories from the Field Webinar - January 31
- Medicare Cost Report E-Filing System Webinar - February 14

**MLN Matters® Articles**

- Hospital Outpatient Prospective Payment System: January 2024 Update
- Specimen Collection Fees & Travel Allowance: 2024 Update

## MLN Connects - January 25, 2024

MLN Connects Newsletter: Jan 25, 2024

**News**

- CMS Announces New Actions to Help Hospitals Meet Obligations under EMTALA
- CMS Announces New Model to Advance Integration in Behavioral Health
- Doctor & Clinician Utilization (Procedure Volume) Data on Medicare.gov Compare Tool: Now Available
- Continuous Glucose Monitor Supplies: Option to Bill for 90 Days
- Grandfathered Tribal Federally Qualified Health Centers: CY 2024 Rate
- Skilled Nursing Facility: Updates to Services Excluded from Consolidated Billing
- Poverty: Help Improve Access to Health Care

## MLN Connects

### Compliance

- Opioid Treatment Program: Bill Correctly for Opioid Use Disorder Treatment Services

### MLN Matters® Articles

- Billing Requirements for Intensive Outpatient Program Services for Federally Qualified Health Centers & Rural Health Clinics
- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: April 2024 Quarterly Update
- How to Use the Office & Outpatient Evaluation and Management Visit Complexity Add-on Code G2211
- Refillable DMEPOS Documentation Requirements

## MLN Connects - February 1, 2024

MLN Connects Newsletter: Feb 1, 2024

### News

- Participation Continues to Grow in CMS' Accountable Care Organization Initiatives in 2024
- CMS Roundup (Jan 26, 2024)

### Claims, Pricers, & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- Medicare Physician Fee Schedule: New CPT Codes for RSV Vaccine Administration

### Events

- Medicare Cost Report E-Filing System Webinar - February 14

### Publications

- Medicare Provider Enrollment - Revised
- Practitioner & DMEPOS Supplier Information on Power Mobility Devices – Revised

# MLN Connects

## MLN Connects - February 8, 2024

MLN Connects Newsletter: Feb 8, 2024

**News**

- Medicare Shared Savings Program: Application Deadlines for a January 1, 2025, Start Date
- New Dental Specialty Codes for Medicare
- Hospices & Skilled Nursing Facilities: Report All Managing Employees
- Skilled Nursing Care & Skilled Therapy Services to Maintain Function or Prevent or Slow Decline: Reminder
- Help Address Heart Disease Disparities

**Claims, Pricers, & Codes**

- ICD-10 Medicare Severity Diagnosis-Related Group Version 41.1

**Events**

- Medicare Ground Ambulance Data Collection System: Office Hours Session - February 29

**Publications**

- Medicare Ground Ambulance Data Collection System: Updated GADCS User Guide

## MLN Connects - February 15, 2024

MLN Connects Newsletter: Feb 15, 2024

**News**

- CMS Roundup (Feb 9, 2024)
- Marriage and Family Therapists & Mental Health Counselors: New Specialty Codes for Medicare
- Medicare Physician Fee Schedule Database: April Update

**MLN Matters® Articles**

- ICD-10 & Other Coding Revisions to National Coverage Determinations: July 2024 Update
- Activation of Validation Edits for Providers with Multiple Service Locations - Revised

**Publications**

- Medicare Preventive Services - Revised

# MLN Connects

## MLN Connects - February 22, 2024

MLN Connects Newsletter: Feb 22, 2024

**News**

- CMS Issues Additional Guidance on Program to Allow People with Medicare to Pay Out-of-Pocket Prescription Drug Costs in Monthly Payments

**Compliance**

- Medical Services Authorized by the Veteran's Health Administration: Avoid Duplicate Payments

**MLN Matters® Articles**

- Limitation on Recoupment of Medicare Overpayments
- Pulmonary Rehabilitation, Cardiac Rehabilitation, & Intensive Cardiac Rehabilitation Expansion of Supervising Practitioners

**Publications**

- Health Equity Services in the 2024 Physician Fee Schedule Final Rule

## MLN Connects - February 29, 2024

MLN Connects Newsletter: Feb 29, 2024

**Events**

- ICD-10 Coordination & Maintenance Committee Meeting - March 19-20

**MLN Matters® Articles**

- Appropriate Use Criteria for Advanced Diagnostic Imaging: CY 2024 Update
- Clinical Laboratory Fee Schedule & Laboratory Services Reasonable Charge Payment: Quarterly Update

**Publications**

- Medicare Coverage of Diabetes Supplies
- Medicare Ground Ambulance Data Collection System: Tip Sheet for Rural & Super Rural Organizations

## 2024 Annual Update of HCPCS Codes for SNF CB Update

**Related CR Release Date: September 28, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13394**

**Related CR Transmittal Number: R12266CP**

CR 13394 identifies the changes to Healthcare Common Procedure Coding System (HCPCS) codes and explain how Medicare Physician Fee Schedule designations will be used to revise Common Working File (CWF) edits to allow A/B Medicare Administrative Contractors (MACs) to make appropriate payments in accordance with policy for Skilled Nursing Facility (SNF) Consolidated Billing (CB) in Chapter 6, Section 110.4.1 for A/B MACs (B) and Chapter 6, Section 20.6 for A/B MACs (A).

Make sure your billing staff are aware of these changes.

View the complete CMS Change Request (CR)13394.

## Adjustment to Fraud Prevention System (FPS) and Unified Program Integrity Contractor (UPIC) Edits to Increase Billing Increments From 30 Days to 90 Days for CGM Supplies

**Related CR Release Date: October 19, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13397**

**Related CR Transmittal Number: R12303OTN**

CR 13397 instructs Medicare Administrative Contractors (MACs) to make adjustments to their local edits to allow for Continuous Glucose Monitor (CGM) supplies to be billed in 90-day increments to align with the current practices in place for Blood Glucose Monitor (BGM) supplies.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13397.

# MLN Matters

## Changes to Value-Based Insurance Design Model: CY 2024

**Related CR Release Date: June 29, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**MLN Matters Number: MM13236**

**Related Change Request (CR) Number: CR13236**

**Related CR Transmittal Number: R12111DEMO**

CR 13236 tells you about:

- Changes in the VBID Model's hospice benefit component for CY 2024
- The business requirements in CR 11754, CR 12349, CR 12688 and CR 12964

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13236.

## DMEPOS Fee Schedule: CY 2024 Update

**Related CR Release Date: December 7, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**MLN Matters Number: MM13463**

**Related Change Request (CR) Number: CR 13463**

**Related CR Transmittal Number: R12398CP**

CR 13463 tells you about:

- CY 2024 fee schedule amounts for new and existing codes
- Payment policy changes

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13463.

# MLN Matters

## Implementation of the New Home IVIG Items and Services Payment

**Related CR Release Date: December 28, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13217**

**Related CR Transmittal Number: R12437CP**

CR 13217 implements the new Intravenous Immune Globulin (IVIG) payment effective January 1, 2024.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13217.

## January 2024 Quarterly ASP Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

**Related CR Release Date: September 21, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13380**

**Related CR Transmittal Number: R12258CP**

CR 13380 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)13380.

# MLN Matters

## Limitation on Recoupment of Medicare Overpayments

**Related CR Release Date: February 15, 2024**

**Effective Date: July 1, 2024**

**Implementation Date: July 1, 2024**

**MLN Matters Number: MM11808**

**Related Change Request (CR) Number: CR 11808**

**Related CR Transmittal Number: R12509FM**

CR 11808 tells you about:

- Limits on recouping of overpayments
- When to request an extended repayment plan (ERS) or choose an immediate recoupment
- How CMS pays interest on overpayments

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11808.

## Manual Updates for Coverage of IVIG For Treatment of Primary Immune Deficiency Diseases in the Home

**Related CR Release Date: November 8, 2023**

**Effective Date: January 1, 2024**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13414**

**Related CR Transmittal Number: R12352BP**

CR 13414 updates Pub. 100-02 Medicare Benefit Policy Manual to edit Chapter 15, Section 50.6 Coverage of Intravenous Immune Globulin (IVIG) for Treatment of Primary Immune Deficiency Diseases in the Home to reflect changes from the Consolidated Appropriations Act of 2023 (CAA, 2023).

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13414.

# MLN Matters

## New POS Code 27 - "Outreach Site/Street" - Rescinded

**Related CR Release Date: December 14, 2023**

**Effective Date: October 1, 2023**

**Implementation Date: January 2, 2024**

**Related Change Request (CR) Number: CR 13314**

**Related CR Transmittal Number: R12411CP**

**Note:** Transmittal 12254 issued September 20, 2023, is being rescinded and replaced by Transmittal 12411, dated December 14, 2023, to add a new business requirement (13314.3) providing direction on how to treat claims submitted with POS 27. All other information remains the same.

CR 13314 creates a new place of service (POS) code 27 for "Outreach Site/Street" - A non-permanent location on the street or found environment, not described by any other POS code, where health professionals provide preventive, screening, diagnostic, and/or treatment services to unsheltered homeless individuals.

Make sure your billing staff knows about these changes.

View the complete CMS Change Request (CR)13314.

## Refillable DMEPOS Documentation Requirements

**Related CR Release Date: January 18, 2024**

**Effective Date: January 1, 2024**

**Implementation Date: February 19, 2024**

**MLN Matters Number: MM13480**

**Related Change Request (CR) Number: CR 13480**

**Related CR Transmittal Number: R12468PI**

CR 13480 tells you about:

- Updated documentation requirements for refillable DMEPOS
- The requirement to contact the patient before refilling DMEPOS

Make sure your billing staff knows about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13480.

# 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

## 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

## 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.