DME Happenings

Jurisdiction A
September 2025

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

Alert: Medicare Fraud Scheme Involving Phishing Fax Requests

CMS has identified a fraud scheme targeting Medicare providers and suppliers. Scammers are impersonating CMS and sending phishing fax requests for medical records and documentation, falsely claiming to be part of a Medicare audit.

Important: CMS does not initiate audits by requesting medical records via fax. Protect your information. If you receive a suspicious request, don't respond.

Legitimate requests for medical records are typically sent via mail or courier services, not fax.

Valid requests for records will provide the name of the beneficiary, as well as relevant details such as date of service, claim number, or services or items billed, so the receiver can provide the appropriate records.

Valid requests will include the name of the requester, such as the Medicare Administrative Contractor (MAC), Durable Medical Equipment MAC (DME MAC), Unified Program Integrity Contractor (UPIC), Recovery Audit Contractor (RAC), Comprehensive Error Rate Testing (CERT) program or Supplemental Medical Review Contractor (SMRC). These entities may use the CMS logo on their cover sheets or letterhead, in addition to the requesting companies name and/or logo.

If you receive phone calls in follow-up to this fax, these are not valid. CMS will never call requesting records. Please inform the caller that you will not be complying as the request is not valid or ignore the calls.

If you think you received a fraudulent or questionable request, work with your Medical Review Contractor to confirm it's real.

CERT Awareness Month: 2025 CERT Documentation Deadline

The Part A, Part B, Durable Medical Equipment (DME), Home Health and Hospice, and Railroad Board Medicare Administrative Contractors (MACs) are working together to promote the importance of complying with CERT documentation requests. This is the first of four articles in our CERT Awareness Month.

Providers and suppliers must send all requested documentation to the CERT Review Contractor (RC) by **Thursday, August 7, 2025**, for claims submitted July 1, 2023 - June 30, 2024. Favorable CERT decisions ensure proper payment and lowers the national improper payment rate. Send questions to CERTQuestion@noridian.com.

Resources

- CERT RC C3HUB

- Collaborative Patient Care is a Provider Partnership

CERT Awareness Month: Steps to Take if You Get a CERT Documentation Request

The Part A, Part B, Durable Medical Equipment (DME), Home Health and Hospice, and Railroad Board Medicare Administrative Contractors (MACs) are working together to promote the importance of complying with CERT documentation requests. This is the second of four articles in our CERT Awareness Month.

To be compliant and ensure a timely response to CERT review contractor (RC) documentation requests:

1. Review the CERT RC letter request for these important sections
   - Action: Medical Records Required
     - This is the list of records to support claim payment
   - When: "Date"
     - This is the deadline to provide medical records to the CERT RC
2. Prepare the records for submission
   - Locate and assemble all records listed on the CERT RC's letter
   - Identify if anything is missing and if so, take action to obtain the needed record(s)
   - Make copies and keep the originals
3. Submit the information by the deadline
   - Follow instructions on the CERT RC's letter
   - Place the CERT RC's bar-coded cover sheet in front of your records

Follow up by accessing the CERT RC C3HUB. The Claim Status Search feature will confirm if the CERT RC got your records. Failure to submit the requested documentation to the CERT RC may result in a recoupment of payment.

Resources

- CERT Background
- Complying With Medical Records Documentation Requirements Fact Sheet
- Provider Minute: The Importance of Proper Documentation

News

CERT Awareness Month: Verify Your Medical Records Correspondence Address

The Part A, Part B, Durable Medical Equipment (DME), Home Health and Hospice, and Railroad Board (RRB) Medicare Administrative Contractors (MACs) are working together to promote the importance of complying with CERT documentation requests. This is the third of four articles in our CERT Awareness Month.

If you have a payment recoupment for a CERT error, but didn't get a CERT Review Contractor (RC) documentation request, verify your Provider Enrollment, Chain, and Ownership System (PECOS) Medical Records Correspondence Address. Please refer to the CERT RC's C3HUB "Letters and Contact Information" and "How to Submit Address Updates."

**For Part B RRB claims, refer to Palmetto RRB's Update an Enrollment Record to ensure your provider information is up-to-date with the RRB Specialty MAC.*

Updating address information with the CERT RC will only update for the current claim under review. Any additional CERT RC claim reviews will revert to your current MAC contact information for CERT RC requests.

Resource

- CERT Background

CERT Awareness Month: We Appreciate Your Efforts

The Part A, Part B, Durable Medical Equipment (DME), Home Health and Hospice, and Railroad Board Medicare Administrative Contractors (MACs) are working together to promote the importance of complying with CERT documentation requests. This is the last of four articles in our CERT Awareness Month.

Thank you for your attention to this national MAC effort to promote CERT documentation awareness and compliance. We created this article series to help you understand CERT processes. For additional information, contact JADMECERT@noridian.com.

Resources

- CERT Background
- CERT RC C3HUB
- CERT Reports
- CERT Task Force

News

Claims for Oral Anti-Cancer Drug Capecitabine - Revised

Oral anti-cancer drugs (OACD) must be billed to the Durable Medical Equipment Medicare Administrative Contactors (DME MACs) with the National Drug code (NDC) that matches the product/HCPCS code dispensed. The following instructions pertain to the billing of oral Capecitabine covered under the Oral Anticancer Drugs Local Coverage Determination (LCD L33826).

- **Effective October 1, 2024 - December 31, 2024**
  - Suppliers must bill Capecitabine with HCPCS code J8999 (prescription drug, oral, chemotherapeutic, NOS) for processing dates between October 1, 2024, and December 31, 2024. The following should have been included in those claims processed between that time frame:
    - Claim narrative: drug name (Capecitabine or Xeloda), dosage, and National Drug Code (NDC).
    - Electronic claims: NTE 2300 or NTE 2400 narrative segment field.
    - Paper claims (CMS-1500 Claim Form): Line Item 19.

    Note: Do not bill Capecitabine with the National Drug Code (NDC) for claims processed between October 1, 2024, and December 31, 2024.
  - HCPCS codes J8520 and J8521 for Capecitabine were end-dated as of September 30, 2024, as indicated by the PDAC.
    - New HCPCS code for Capecitabine, J8522, was effective October 1, 2024, but was not implemented until January 1, 2025, therefore no crosswalk was available for processing dates between October 1, 2024, and December 31, 2024.
- **Effective January 1, 2025**
  - HCPCS code J8522 for Capecitabine was implemented on January 1, 2025, and was effective for DOS on or after October 1, 2025, with a crosswalk to the appropriate NDC.
    - For claims submitted on or after January 1, 2025, for dates of service between October 1, 2024, and December 31, 2024, supplier must bill the NDC for J8522.

    Note: Do not bill Capecitabine using J8522 or J8999 for claims submitted on or after January 1, 2025. Suppliers must use the appropriate NCD that cross walked to J8522.

News

Continuous Glucose Monitor Supply Allowance

The billing codes A4238 and A4239 for continuous glucose monitor (CGM) supplies have a maximum limit of three units of service (UOS) per ninety days. The next billable date for a 30-day supply is 31 days from the last billing date, while for a 90-day supply, it is 91 days from the last billing date. Non-adjunctive CGM supplies under code A4239, including sensors, transmitters, and home blood glucose monitor supplies, must be billed as 1 UOS per 30 days, allowing up to 3 UOS for a 90-day supply. Adjunctive CGM devices (A4238) do not replace standard home blood glucose monitors, and the supply allowance covers all necessary items except home BGM supplies. The CGM supply allowance codes do not follow standard documentation requirements for refills, and if additional items are needed during the billing period, the DME supplier must provide them at no charge. Billing before the expected end of the current supply is not allowed, claims must not be submitted to Medicare until the appropriate time has passed. The date of service for A4238 and A4239 should not have a span date and claims with span dates will be returned as un-processable, requiring correction and resubmission.

Additional information is available in the Glucose Monitors LCD (L33822) and LCD-related Policy Article (A52464).

Determining the Maximum Quantity of Ostomy Supplies

Suppliers frequently seek guidance in determining the standard maximum quantity of ostomy supplies a beneficiary may receive in a month. Local Coverage Determination (LCD) L33828 provides a comprehensive list of commonly used codes and the typical quantities considered reasonable and necessary for monthly use. If a beneficiary requires a quantity exceeding these guidelines, the justification must be clearly documented in their medical record. Failure to provide sufficient documentation upon request may result in denial of excess quantities as not reasonable and necessary.

Documentation Checklist for Pneumatic Compression Devices

To ensure compliance when supplying Pneumatic Compression Devices (PCD), refer to the Documentation Checklist available on the Noridian Medicare website. This checklist, applicable to dates of service on or after November 14, 2024, helps suppliers obtain all required documentation for Medicare claims processing and payment. Additionally, it outlines the essential records necessary to secure reimbursement and uphold compliance in the event of future Medicare reviews.

News

How to Bill for Hospital Beds and Pressure Reducing Support Surfaces

Suppliers have asked how they can bill appropriately for hospital beds and pressure reducing support surfaces (PRSS). Noridian maintains a Hospital Beds webpage which provides suppliers with the most up-to-date information. On this page, you will find a link to the Billing Instruction - Hospital Beds and Pressure Reducing Support Surfaces article published by the DME Medical Directors. It contains special billing instructions on beneficiary owned hospital beds, capped rental beds, and new initial rental hospital beds.

The Noridian Educational Experience is Live

We are pleased to announce that the Noridian Educational Experience is now live. This platform is designed to support your ongoing learning and professional development through a wide range of self-paced training modules. Whether you're looking to expand your knowledge or earn Continuing Education Unit (CEU) credits, the Noridian Educational Experience offers comprehensive curriculums tailored to meet your needs.

Registration is open exclusively to providers and suppliers within Noridian's jurisdictions. Please note that a valid National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN) are required to complete the registration process.

October 2025 HCPCS Updates

CMS has released the October 2025 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 October 1, 2025. Visit the CMS HCPCS Quarterly Update site to review the listing.

Watch the Noridian website for additional policy updates regarding these HCPCS codes.

Refill Requirements for Immunosuppressive Drugs

Immunosuppressive drugs are essential for beneficiaries who have undergone organ transplants. Ensuring the beneficiary is receiving and utilizing medically necessary medications is crucial.

Key refill requirements:

- **Prospective Billing:** For Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) provided on a recurring basis, billing must be based on prospective, not retrospective use.
- **Beneficiary Contact:** Suppliers must contact the beneficiary or their designee prior to dispensing a refill. This contact must occur no sooner than 30 calendar days before the delivery or shipping date. This contact must include a documented affirmative response from the beneficiary confirming the need for a refill.
- **Documentation:** For items delivered to the beneficiary, documentation of a request for refill must be either a written document received from the beneficiary or a contemporaneous written record of a phone conversation/contact between the supplier and beneficiary.
- **Quantity Limits:** Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. Suppliers are expected to stay attuned to changed or atypical utilization patterns and verify with the ordering practitioners that any changes are warranted.
- **Delivery:** The supplier must deliver the DMEPOS product no sooner than 10 calendar days before the end of usage for the current product.

Refer to Local Coverage Determination (LCD) L33824 and Policy Article A52474 for details.

Required Prior Authorization (PA) Program Pre-Claim Reviews

The Jurisdiction A, DME MAC, Medical Review Department is conducting pre-claim required prior authorization reviews for the below specialties. The following quarterly edit effectiveness results from April 2025 - June 2025 can be located on the Required Prior Authorization Programs webpage:

- Lower Limb Prosthetics
- Orthoses
- Power Mobility Devices
- Pressure Reducing Support Surfaces

News

Rounding Test Results

Several questions have arisen about how to handle reporting test results and determining coverage when the values are not whole numbers. This most often occurs for oxygen saturation results (either arterial blood gas or pulse oximetry) and sleep tests, where the apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) results are expressed with a decimal.

In both instances, standard numerical rounding rules apply. For example, consider a sleep test where the AHI is reported as below:

- If the value is 12.01 to 12.49, round down to 12
- If the value is 12.50 to 12.99, round up to 13

This is also on the Positive Airway Pressure (PAP) webpage.

Supplier Reminder: No Coverage of Hydration Therapy Under DME Benefit

Suppliers have inquired whether hydration therapy is covered under the Durable Medical Equipment (DME) benefit provided for enteral nutrition, parenteral nutrition, and infusion therapy. Although the equipment used for nutrition and/or infusions may be covered, neither the hydration therapy itself nor the equipment and supplies for its administration are covered.

According to the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 20, Section 10.1, DME is covered under Part B as a medical or other health service and is equipment that:

a. Can withstand repeated use
b. Is primarily and customarily used to serve a medical purpose
c. Generally is not useful to a person in the absence of an illness or injury; and
d. Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered as durable medical equipment. For any item to be covered by Medicare, it must:

1. Be eligible for a defined Medicare benefit category,
2. Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
3. Meet all other applicable Medicare statutory and regulatory requirements.

Hydration therapy and supplies do not meet the definition of DME therefore, there is no payment for hydration therapy, or related supplies and equipment under the DME Benefit. Refer to the policy-specific LCD and Policy Article for coverage details.

News

Understanding Medicare Coverage for Positive Airway Pressure Devices

Noridian's dedicated resource page for Positive Airway Pressure (PAP) Devices provides essential guidance for suppliers navigating Medicare coverage for the treatment of Obstructive Sleep Apnea (OSA).

Coverage Overview

Medicare covers PAP therapy-including CPAP and BiPAP devices-when specific clinical criteria are met. These include a documented diagnosis of OSA through a qualifying sleep study and evidence of medical necessity. The National Coverage Determination (NCD 240.4) outlines these requirements in detail.

Documentation Requirements

To ensure compliance, Noridian offers:

- Clinician Checklists for initial and continued coverage
- Clinician Letters to assist in documenting medical necessity and continued use
- Guidance on Sleep Study Standards and acceptable testing methods

Adherence and Compliance

Medicare requires patients to demonstrate adherence within the first 90 days of therapy. Devices must track usage accurately, and suppliers are encouraged to educate patients on the importance of consistent use to avoid loss of coverage.

Supplier and Clinician Support

The site includes:

- Medical Review Tips
- Audit Findings
- Tips and articles to help streamline the claims process

Urological Supplies Frequently Asked Questions (FAQs)

To help our suppliers, Noridian and CGS Provider Outreach and Education worked together to answer the most frequently asked questions on Urological Supplies. These FAQs are found on the Urological Supplies page.

Q1: A patient requests 230 intermittent catheters per month, but the usual maximum quantity in the Urological Supplies Policy Article is 200. How should I handle the 30 additional catheters?
A1: You should bill upgrade modifiers on the claim if you expect the beneficiary to pay

for any quantity above the maximum as outlined in the LCD. If there is medical justification for the additional quantity, you can file an appeal for denied claims.

Q2: Is the A4353 (sterile catheterization kits) covered for a high-level spinal cord injury patient immunocompromised beneficiary?
A2: Yes, a spinal cord injury could meet LCD coverage criteria if the beneficiary is immunosuppressed and the condition is supported by the beneficiary's medical record.

Q3: If a beneficiary new to Medicare was using the A4353, do they have to go back to intermittent urinary catheters (A4351 or A4352) and have two urinary tract infections (UTIs) in a year to continue coverage of the A4353?
A3: No, they don't need to switch. However, the beneficiary's medical record must show they had UTIs in the past or that one of the other LCD coverage criteria is met.

Q4: Is the diagnosis of neurogenic bladder enough or does the practitioner need to specify permanent urinary retention or incontinence?
A4: The beneficiary's medical record must show permanent urinary retention or permanent urinary incontinence and meet the LCD requirements for urological supplies.

Q5: For intermittent catheters, does the frequency of use need to be documented in the medical records even if indicated on the standard written order (SWO)?
A5: Additional elements included on the SWO, such as frequency of use, must be corroborated by the information in the medical record but not necessarily redocumented in the medical records.

Q6: Do I need a refill request if the patient picks up the catheter at the local store?
A6: Per the Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426), for items that the beneficiary obtains in-person at a retail store, the signed delivery slip or a copy of the itemized sales receipt is sufficient documentation of a request for refill.

Q7: Are urological supplies separately payable for beneficiaries enrolled in a home health episode?
A7: No, urological supplies fall within the consolidated billing requirements and should be provided by the home health agency. View the Home Health Consolidated Billing Master Code List for HCPCS that shouldn't be billed to the DME MACs during a 60-day home health episode.

Q8: If a beneficiary can't use an indwelling catheter due to issues and they switched to intermittent straight tip catheters, is that justification for providing over 200 each month?
A8: Medical documentation must show both the need to switch to intermittent catheters and the necessity for more than the usual maximum quantity. If you expect the beneficiary to pay for quantities above the maximum, bill upgrade modifiers on the claim. If the beneficiary doesn't qualify, obtain a valid Advance Beneficiary Notice (ABN)

to transfer financial responsibility to the beneficiary for the extra catheters. If there is medical justification for the additional quantity, you can file an appeal for denied claims.

Q9: Is there a medical justification for providing both sterile catheterization kits (A4353) and straight tip intermittent catheters (A4351) at the same time?
A9: No, Medicare guidelines and clinical standards don't support providing both sterile catheterization kits (A4353) and straight tip catheters (A4351) at the same time. Patients who qualify for sterile catheterization kits should use them exclusively rather than in combination with regular catheters. Sterile catheterization kits provide a higher level of protection against infection for high-risk patients.

Q10: Can a beneficiary use a Coude tip intermittent catheter (A4352) to stretch a stricture and then void on their own for the rest of week? Can I bill both a Coude and a straight tip (A4351) to Medicare in these situations?
A10: No, urinary catheters and external urinary collection devices are covered to drain or collect urine for a beneficiary with permanent urinary incontinence or retention. The beneficiary must have a permanent impairment of urination.

Q11: Does Medicare provide coverage for the PureWick female catheter system?
A11: The DME MACs manually process claims for the PureWick and associated supplies or accessories. Coverage is considered on a claim-by-claim basis. If a claim is denied, appeal rights are available. Review the PureWick Urine Collection System - Coding and Billing Instructions - Revised article.

Q12: When should I bill with the AU modifier?
A12: The AU modifier should be used with sterile water or saline, and tape codes when used with urological supplies. If these codes are billed without an AU modifier or the appropriate modifier under another LCD (e.g., AW or AV), the claim will be rejected as missing information.

Q13: For shipping, what information do I need as proof of delivery? What date of service do I use?
A13: For items shipped to the beneficiary, the proof of delivery should include the delivery service's package identification number, supplier invoice number, or alternative method that links the supplier's delivery documents with the delivery service's records. The date of service can be either the date the label was created, the date the item(s) were shipped, or the date the beneficiary received the item. For more information, see the Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426) Policy Article.

Q14: For a Coude tip catheter (A4352) justification, is "due to benign prostatic hyperplasia (BPH), a non-cancerous enlargement of the prostate gland," sufficient?
A14: A diagnosis alone is not enough. When a Coude tip catheter is used, there must be

documentation in the medical record of the medical necessity for that catheter. For example, the beneficiary can't be catheterized with a straight-tip catheter.

Q15: Does the urine culture need to state, "greater than 10,000 pathogenic bacteria," or can it just state the specific bacteria?
A15: The urine culture should state the specific bacterial count. Per Local Coverage Determination (LCD) L33803, "A beneficiary would be considered to have a urinary tract infection if they have a urine culture with greater than 10,000 colony forming units of a urinary pathogen AND concurrent presence of one or more of the following signs, symptoms, or laboratory findings:

- Fever (oral temperature greater than 38° C [100.4° F])
- Systemic leukocytosis
- Change in urinary urgency, frequency, or incontinence
- Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation)
- Physical signs of prostatitis, epididymitis, orchitis
- Increased muscle spasms
- Pyuria (greater than 5 white blood cells [WBCs] per high-powered field."

Medical Policies and Coverage

2025 HCPCS Code Update - July Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **2025 HCPCS Code Update - July Edition - Correct Coding**, has been created and published to our website.

View the locally hosted 2025 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

Lung Expansion Airway Clearance, Continuous High Frequency Oscillation, and Nebulization Device (HCPCS Code E0469) - Correct Coding and Billing of HCPCS

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Lung Expansion Airway Clearance, Continuous High Frequency Oscillation, and Nebulization Device (HCPCS Code E0469) - Correct Coding and Billing of HCPCS, has been created and published to our website.

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Open Meeting Agenda - External Infusion Pumps Proposed Local Coverage Determination (LCD)

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Medical Policies and Coverage

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Medical Policies and Coverage

Open Meeting Announcement - Nebulizers Proposed Local Coverage Determination (LCD)

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Open Meeting Announcement - Urological Supplies Proposed Local Coverage Determination (LCD)

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Policy Article Revisions Summary for June 19, 2025

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Medical Policies and Coverage

Policy Article Revisions Summary for August 21, 2025

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- Locate/select article title

Proposed Local Coverage Determinations (LCDs) Released for Comment - Nebulizers and Urological Supplies

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Proposed Local Coverage Determinations (LCDs) Released for Comment - Nebulizers and Urological Supplies**, has been created and published to our website.

View the locally hosted 2025 DMD articles.

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

Medical Policies and Coverage

Upper Extremity Prosthetic Myoelectronic Control - Correct Coding and Code Verification Review Requirement

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, **Upper Extremity Prosthetic Myoelectronic Control - Correct Coding and Code Verification Review Requirement**, has been created and published to our website.

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- Locate/select article title

Urological Supplies and Continued Medical Need

For all DMEPOS items, the initial justification for medical necessity is determined when the item is first prescribed. Beneficiary medical records confirming the item's reasonableness and necessity are created immediately before or at the time of the initial prescription.

Once medical necessity is established, ongoing need for urological supplies is presumed for beneficiaries with permanent urinary incontinence or retention, unless continued coverage requirements are outlined in the LCD. If the beneficiary continues to qualify under the Prosthetic Devices benefit, no further documentation of continued medical need is required.

For additional details on surgical dressings, refer to Local Coverage Determination (LCD) L33803 and Policy Article A52521 available on the Noridian Urological Supplies webpage.

VYALEV® (foscarbidopa and foslevodopa), the VYAFUSER Pump, and Related Infusion Supplies - Correct Coding and Billing - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, VYALEV® (foscarbidopa and foslevodopa), the **VYAFUSER Pump, and Related Infusion Supplies - Correct Coding and Billing - Revised**, has been created and published to our website.

View the locally hosted 2025 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 - June 5, 2025

MLN Connects Newsletter: June 5, 2025

News

- 2023 Doctors & Clinicians Preview Period Open Until June 25
- Hospital Price Transparency: Respond to Accuracy & Completeness RFI by July 21
- Medicare & Veteran Affairs: Adjustments for Duplicate Claims Start Next Month
- Join an Accountable Care Organization

Claims, Pricers & Codes

- RHC & FQHC Care Coordination Services: HCPCS Code G0511 Deadline Extended to September 30
- Medical Education: Submit No-Pay Bills for Programs of All-Inclusive Care for the Elderly

MLN Matters® Articles

- ESRD & Acute Kidney Injury Dialysis: CY 2025 Updates - Revised

Publications & Multimedia

- Quality in Focus Interactive Video Series: 4 New Videos to Enhance Quality of Care

MLN Connects - June 12, 2025

MLN Connects Newsletter: June 12, 2025

News

- Final National Coverage Determination: Noninvasive Positive Pressure Ventilation in Home for Treatment of Chronic Respiratory Failure Consequent to COPD
- Skilled Nursing Facility Value-Based Purchasing Program: June 2025 Confidential Feedback Reports

Compliance

- Mechanical Ventilation: Bill Correctly for Inpatient Claims
- SNF Services: Prevent Claim Denials

MLN Connects

Claims, Pricers & Codes

- ICD-10 Codes: FY 2026
- National Correct Coding Initiative: July Update

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2025 Update
- ESRD Prospective Payment System: July 2025 Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2025 Update

MLN Connects - June 18, 2025

MLN Connects Newsletter: June 18, 2025

News

- 2023 Doctors & Clinicians Preview Period Open Until June 25
- Hospital Price Transparency: Respond to Accuracy & Completeness RFI by July 21
- Medicare Part B Discarded Drug Program: Get the Latest Updates
- Medicare Part B Blood Clotting Factor Furnishing Fee Guidance
- Medicare Part B Average Sales Price Guidance

MLN Matters® Articles

- Updates to Colorectal Cancer Screening & Hepatitis B Vaccine Policies

From Our Federal Partners

- VA Recovering Overpaid Claims from Some CHAMPVA Providers

MLN Connects - June 26, 2025

MLN Connects Newsletter: June 26, 2025

News

- Alert: Medicare Fraud Scheme Involving Phishing Fax Requests
- Medicare Diabetes Prevention Program: CY 2025 Payment Rates

Compliance

- Commodes, Bed Pans & Urinals: Prevent Claim Denials

MLN Connects

Claims, Pricers & Codes

- Integrated Outpatient Code Editor Version 26.2
- Medical Education: Don't Submit Claims for Programs of All-Inclusive Care for the Elderly

MLN Matters® Articles

- DMEPOS Fee Schedule: July 2025 Quarterly Update

Publications & Multimedia

- Medicare & Mental Health Coverage - Revised
- Substance Use Screenings & Treatment - Revised

MLN Connects - July 3, 2025

MLN Connects Newsletter: July 3, 2025

Proposed Payment Rules

- ESRD: CY 2026 Proposed Rule - Submit Comments by August 29
- Home Health: CY 2026 Proposed Rule - Submit Comments by August 29

News

- CMS Launches New Model to Target Wasteful, Inappropriate Services in Original Medicare
- National Health Care Fraud Takedown Results in 324 Defendants Charged in Connection with Over $14.6 Billion in Alleged Fraud
- Skilled Nursing Facilities: Revalidation Deadline August 1
- Hospice Quality Reporting Program: Vendor Update Slide Deck & Errata for Data Specifications Effective October 1

MLN Matters® Articles

- Inpatient Rehabilitation Facility Prospective Payment System: FY 2026 Pricer Update
- Hospital Outpatient Prospective Payment System: July 2025 Update

Publications & Multimedia

- Screening, Brief Intervention & Referral to Treatment (SBIRT) Services - Revised

MLN Connects

Information for Patients

- CMS Notifies Individuals Potentially Impacted by Data Incident

MLN Connects - July 10, 2025

MLN Connects Newsletter: July 10, 2025

News

- Hospital Price Transparency: Respond to Accuracy & Completeness RFI by July 21
- Alert: Medicare Fraud Scheme Involving Phishing Requests Via Fax and Other Means
- Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation: Final National Coverage Determination

Compliance

- Medicare Improperly Paid Suppliers for Intermittent Urinary Catheters
- Acute Care Hospital Outpatient Services for Hospice Enrollees: Reduce Improper Payments

Claims, Pricers & Codes

- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals

From Our Federal Partners

- Providers Accepting CHAMPVA: You Must Get Paid by EFT

MLN Connects - July 15, 2025

CMS Proposes Physician Payment Rule to Significantly Cut Spending Waste, Enhance Quality Measures, and Improve Chronic Disease Management for People with Medicare

MLN Connects

MLN Connects - July 16, 2025

CY 2026 Proposed Payment Rule

CMS Proposes Bold Reforms to Modernize Hospital Payments, Strengthen Transparency, and Put Patients Back in Control

News

CMS Expands Access to Lifesaving Gene Therapies Through Innovative State Agreements

MLN Connects - July 17, 2025

MLN Connects Newsletter: July 17, 2025

News

- CMS Announces Resources, Flexibilities to Assist with Public Health Emergency in State of Texas
- Skilled Nursing Facilities: Revalidation Deadline Extended to January 1
- Join an Accountable Care Organization

Compliance

- Ostomy Supplies: Prevent Claim Denials

Claims, Pricers & Codes

- Core-Based Statistical Area: Revised ZIP Code Files

Publications & Multimedia

- Chronic Care Management Services - Revised
- Patients in Custody Under a Penal Authority – Revised

MLN Connects

MLN Connects - July 24, 2025

MLN Connects Newsletter: July 24, 2025

News

- 2025 Quality Conference Highlights
- July 2025 Provider Specific Data for Public Use Files

Compliance

- Remote Patient Monitoring: Use & Bill Correctly

Publications & Multimedia

- Hospice Fast Facts

MLN Connects - July 31, 2025

MLN Connects Newsletter: July 31, 2025

News

- White House, Tech Leaders Commit to Create Patient-Centric Healthcare Ecosystem
- Medicare & Medicaid at 60: Strengthening Health Care for the Future
- Skilled Nursing Facilities: Revalidation Deadline Extended to January 1

Compliance

- Opioid Use Disorder: Learn about Services to Help Your Patients Continue Treatment

MLN Matters® Articles

- Acute Kidney Injury Renal Dialysis Billing: Additional Revenue Codes
- Laboratory National Coverage Determination Edit Software Updates: October 2025

MLN Connects

MLN Connects - August 4, 2025

MLN Connects Newsletter: 5 FY 2026 Final Payment Rules - Monday, August 4, 2025

FY 2026 Final Payment Rules

- Hospital Inpatient Prospective Payment System & Long-Term Care Hospital Prospective Payment System
- Inpatient Rehabilitation Facility Prospective Payment System
- Inpatient Psychiatric Facility Prospective Payment System & Quality Reporting Updates
- Skilled Nursing Facility Prospective Payment System
- Hospice Wage Index, Payment Rate Update & Quality Reporting Program Requirements

MLN Connects - August 7, 2025

MLN Connects® Newsletter for Thursday, August 7, 2025

News

- Laboratories: Switch to Electronic Fee Coupons & CLIA Certificates
- Improve Your Search Results for CMS Content

Fraud, Waste & Abuse

- Crushing Fraud

Compliance

- Evaluation & Management Services: Prevent Claim Denials

Claims, Pricers & Codes

- Ambulance Claims: Revised July ZIP Code Files
- Skilled Nursing Facility Prospective Payment System: FY 2025 Pricer Update

Events

- CMS Listening Session: Opportunities to Enhance Real-Time Claims Processing & EDI Cybersecurity Controls - August 13

MLN Connects

MLN Matters® Articles

- Billing the Laboratory Specimen Collection Travel Allowance to the 10th of a Mile
- National Coverage Determination 20.37: Transcatheter Tricuspid Valve Replacement
- Ambulatory Surgical Center Payment System: July 2025 Update - Revised

MLN Connects - August 14, 2025

MLN Connects® for Thursday, August 14, 2025

News

- FY 2026 SNF VBP Program: Download Your August 2025 Performance Score Reports

Compliance

- Skilled Nursing Facilities: Identify & Prevent Improper Part D Payments for Drugs

Claims, Pricers & Codes

- Method II Critical Access Hospitals
- Incarcerated Beneficiaries: Update to National Uniform Billing Committee Condition Code 63

MLN Matters® Articles

- Bypassing Common Working File Edits on Inpatient Medicare Part B Ancillary 12X Claims: Effective Date Change

Publications & Multimedia

- Medicare Preventive Services - Revised
- Combating Medicare Parts C & D Fraud, Waste & Abuse – Revised

MLN Connects

MLN Connects - August 21, 2025

MLN Connects® Newsletter for Thursday, August 21, 2025

News

- Information for Critical Access Hospitals
- 2023 Doctors & Clinicians Preview Period Closing August 21
- Nursing Home Care Compare Updates: Temporary Pause
- Ambulance Fee Schedule Ground Ambulance Services: Updated List of Advanced Life Support, Level 2 Procedures

Fraud, Waste & Abuse

- Crushing Fraud Chili Cook-Off Competition

Claims, Pricers & Codes

- Seasonal Flu Vaccine Pricing for 2025-2026 Season
- Integrated Outpatient Code Editor: Correcting Errors for Reason Code W7113
- Home Health Prospective Payment System Grouper: October Update

Publications & Multimedia

- Evaluation and Management Services - Revised
- Part C Organization Determinations, Appeals & Grievances - Revised
- Part D Coverage Determinations, Appeals & Grievances - Revised

MLN Connects - August 28, 2025

MLN Connects® Newsletter for Thursday, August 28, 2025

News

- HHS Drives Reform to Restore Patient-Centered Care, Announces Request for Nominations of Members to Serve on Federal Healthcare Advisory Committee

Claims, Pricers & Codes

- Rural Health Clinic & Federal Qualified Health Center: Adjusting Claims for Care Coordination Services
- HCPCS Application Summaries & Coding Determinations: Non-Drug & Non-Biological Items and Services

MLN Connects

MLN Matters® Articles

- Home-Based Noninvasive Positive Pressure Ventilation to Treat Chronic Respiratory Failure Due to Chronic Obstructive Pulmonary Disease
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2026 Update
- National Coverage Determination 20.38: Transcatheter Edge-to-Edge Repair for Tricuspid Valve Regurgitation

Publications & Multimedia

- A Prescriber's Guide to Medicare Prescription Drug (Part D) Opioid Policies - Revised

MLN Matters

DMEPOS Fee Schedule: July 2025 Quarterly Update

Related CR Release Date: June 20, 2025

MLN Matters Number: MM14088

Effective Date: July 1, 2025

Related Change Request (CR) Number: CR 14088

Implementation Date: July 7, 2025

Related CR Transmittal Numbers: R13257CP & R13277CP

Related CR Title: July Quarterly Update for 2025 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

CR 14088 tells you about these updates effective July 1, 2025:

- No added or deleted codes
- Corrections to the 2025 fee schedule amounts for certain items provided in non-contiguous areas
- DMEPOS rural ZIP codes

Make sure your billing staff are aware of these changes.

View the complete CMS Change Request (CR) 14088.

Home-Based Noninvasive Positive Pressure Ventilation to Treat Chronic Respiratory Failure Due to Chronic Obstructive Pulmonary Disease

Related CR Release Date: August 21, 2025

MLN Matters Number: MM14177

Effective Date: June 9, 2025

Related Change Request (CR) Number: CR 14177

Implementation Date: October 22, 2025

Related CR Transmittal Numbers: R13374CP & R13374NCD

CR 14177 tells you about:

- Respiratory assistance devices (RADs)
- Home mechanical ventilators (HMVs)

Make sure your billing staff knows about these updates effective June 9, 2025.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14177.

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

Contacts, Resources, and Reminders

Organization	Phone Number	Types of Inquiries
RRB - Railroad Retirement Board	1-800-808-0772	For Railroad Retirement beneficiaries only - RRB benefits, lost RRB card, address change, enrolling in Medicare
Coordination of Benefits - Benefits Coordination & Recovery Center (BCRC)	1-855-798-2627	Reporting changes in primary insurance information

Another great resource for beneficiaries is the website, Medicare.gov, where they can:

- Compare hospitals, nursing homes, home health agencies, and dialysis facilities
- Compare Medicare prescription drug plans
- Compare health plans and Medigap policies
- Complete an online request for a replacement Medicare card
- Find general information about Medicare policies and coverage
- Find doctors or suppliers in their area
- Find Medicare publications
- Register for Medicare.gov

As a registered user of MyMedicare.gov, beneficiaries can:

- View claim status (excluding Part D claims)
- Order a duplicate Medicare Summary Notice (MSN) or replacement Medicare card
- View eligibility, entitlement and preventive services information
- View enrollment information including prescription drug plans
- View or modify their drug list and pharmacy information
- View address of record with Medicare and Part B deductible status
- Access online forms, publications and messages sent to them by CMS

Medicare Learning Network Matters Disclaimer Statement

Below is the Centers for Medicare & Medicaid (CMS) Medicare Learning Network (MLN) Matters Disclaimer statement that applies to all MLN Matters articles in this bulletin.

"This article was prepared as a service to the public and is not intended to grant rights or impose obligations. MLN Matters articles may contain references or links to statutes, regulations or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents."

Contacts, Resources, and Reminders

Sources for "DME Happenings" Articles

The purpose of "DME Happenings" is to educate Noridian's Durable Medical Equipment supplier community. The educational articles can be advice written by Noridian staff or directives from CMS. Whenever Noridian publishes material from CMS, we will do our best to retain the wording given to us; however, due to limited space in our bulletins, we will occasionally edit this material. Noridian includes "Source" following CMS derived articles to allow for those interested in the original material to research it on the CMS Manuals webpage. CMS Change Requests and the date issued will be referenced within the "Source" portion of applicable articles.

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

Automatic Mailing/Delivery of DMEPOS Reminder

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

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

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

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

Contacts, Resources, and Reminders

CERT Documentation

This article is to remind suppliers they must comply with requests from the Comprehensive Error Rate Testing (CERT) Review Contractor (RC) for medical records needed for the CERT program. An analysis of the CERT related appeals workload indicates a common 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 RC sends written requests for medical records to suppliers that include a checklist of the types of documentation required. The CERT RC will mail these letters to suppliers individually. Suppliers must submit documentation to the CERT RC via fax, the preferred method, or mail. Please see the CERT RC website for contact information at C3HUB.

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

Suppliers may call the CERT RC with questions regarding specific documentation to submit.

Suppliers must submit medical records within 60 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 RC.

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.

Contacts, Resources, and Reminders

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.

Contacts, Resources, and Reminders

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 12
- 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.