DME Happenings

Jurisdiction A
September 2026

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

Ask the Contractor Meeting (ACM) Minutes from May 12, 2026, Now Available

Did you miss the latest ACM, or do you want to revisit key discussions? The ACM is designed to provide clear, timely guidance in an open Q&A format, and all questions and answers are compiled for your convenience. The May 12, 2026, ACM Questions and Answers are now available on our website under Education and Outreach > Ask the Contractor Meeting (ACM).

Avoiding PAP Claim Denials: How Strong Documentation Supports Medicare Compliance

Positive Airway Pressure (PAP) devices are a key treatment for obstructive sleep apnea, and Medicare outlines specific requirements that must be met before coverage is approved. Strong documentation is essential for achieving favorable outcomes and helping suppliers avoid common errors. Required records include standard written order (SWO), sleep study results, practitioner notes, adherence downloads, refill requirements, and proof of delivery for equipment and supplies. These foundational elements ensure that beneficiaries receive appropriate therapy while suppliers remain compliant with Medicare policy.

Because PAP therapy is one of the most frequently audited DME categories, resources play an important role in helping suppliers stay compliant. Noridian webinars, FAQs, and policy updates offer practical support for navigating coverage criteria, documentation expectations, and billing requirements. By using these tools, suppliers can reduce denials, improve claim accuracy, and ensure beneficiaries receive the therapy they need. For more information, visit the Browse by DMEPOS Category - Positive Airway Pressure (PAP) Devices web page.

Billing DME Insulin (J1811, J1813, J1817) - Modifier Reminders

Suppliers billing Medicare for insulin administered through Durable Medical Equipment (DME), must ensure claims include the appropriate Healthcare Common Procedure Coding System (HCPCS) modifier. Claims submitted without the required modifier will be denied.

Medicare policy requires that claims for external infusion pumps and associated drugs and supplies, including insulin, include either a KX, GA, or GZ modifier for billing. Claims that do not include one of these modifiers will be denied. Recent data analysis

has identified insulin claims (e.g., HCPCS codes J1811, J1813, J1817) being submitted without the required modifiers, resulting in avoidable denials.

Scenario	Modifier	What It Means
Coverage criteria **met**	**KX**	The supplier attests that all Medicare coverage requirements are met and documentation is on file.
Coverage criteria **not met**, valid ABN obtained	**GA**	A valid Advance Beneficiary Notice (ABN) is on file and a denial is anticipated.
Coverage criteria **not met**, no valid ABN	**GZ**	A denial is expected and no valid ABN is on file.

Key Reminders

- Either a KX, GA, or GZ modifier is required on every claim line.
  - These modifiers may not be billed on the same claim line.
- Claims submitted without these modifiers will be denied.
- KX modifier indicates coverage criteria in the policy have been met; GA and GZ indicate criteria is not met.

Suppliers are encouraged to review Local Coverage Determination (LCD) L33794 and Policy Article A52507 for detailed billing requirements, including documentation expectations for insulin administered through DME.

Hydrophilic Coated Catheters Coding

Prior to January 1, 2026, hydrophilic coated catheters were billed under standard HCPCS codes (A4351-A4353) without being clearly distinguished from non hydrophilic catheters, often leading to documentation and reimbursement confusion. Effective January 1, 2026, Medicare implemented new HCPCS codes to specifically identify hydrophilic coated catheters, both with and without insertion supplies, improving billing accuracy and coverage clarity. Providers should reference Noridian DME guidance for detailed coding, billing, and documentation requirements related to these catheter changes.

News

Knee Orthosis: Documentation and Coverage Overview

Knee orthoses are covered under the Medicare braces benefit when coverage, documentation, and billing requirements are met. These items are intended to support a weak or deformed body member or restrict or eliminate motion in an injured or diseased knee and must be rigid or semi rigid to qualify for coverage.

Coverage criteria for knee orthoses vary by the type of brace and the beneficiary's clinical condition. In general, documentation must support that the beneficiary:

- Is ambulatory, and
- Has a condition such as knee instability, weakness, deformity, recent injury or surgery, or qualifying osteoarthritis, depending on the specific orthosis provided

Suppliers should refer to the Knee Orthoses Local Coverage Determination (LCD L33318) and related Policy Article A52465 for code specific coverage criteria and limitations.

Medical record documentation must support medical necessity and include relevant clinical findings from the treating practitioner. Depending on the HCPCS code billed, certain knee orthoses are subject to:

- Required Prior Authorization, and/or
- Face to Face Encounter and Written Order Prior to Delivery (WOPD) requirements

Suppliers are responsible for ensuring all required documentation is obtained and maintained in the supplier file prior to claim submission.

Correct coding is critical. Suppliers must ensure:

- The HCPCS code billed accurately reflects the type of knee orthosis provided
- Required modifiers (such as RT/LT and policy specific modifiers) are appended appropriately
- Claims meet all Medicare coverage, documentation, and billing rules to avoid denials

Knee orthoses remain a high-review item in medical review and Comprehensive Error Rate Testing (CERT) findings. Suppliers are encouraged to review the applicable LCD, policy articles, and Orthotics webpage to ensure compliance and support accurate claim submission.

October 2026 HCPCS Updates

CMS has released the October 2026 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, 2026. Visit the CMS HCPCS Quarterly Update site to review the listing.

News

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

Public Health Emergency (PHE) Declared for Wildfires in the State of Washington

Pursuant to section 319 of the Public Health Service Act, a federal disaster declaration was approved on August 4, 2026, for areas affected by the Washington wildfires. On August 7, 2026, the Secretary of Health and Human Services (HHS) declared a Public Health Emergency (PHE) for Washington State due to major wildfires beginning August 1, 2026. CMS has made applicable waivers and flexibilities available retroactive to August 1, 2026, to ensure continued access to care for affected beneficiaries and providers.

During the Washington PHE, the Administrator of the Centers for Medicare & Medicaid Services (CMS) authorized waivers under §1812(f) of the Social Security Act for beneficiaries who were evacuated, transferred, displaced, or otherwise impacted by the wildfires. In addition, Section 1135 waiver authority allows CMS to waive or modify certain Medicare, Medicaid, and CHIP requirements to ensure adequate access to healthcare services during the emergency.

Sections listed in the federal disaster declaration, along with authorized waivers and modifications under §1135 of the Social Security Act, are currently in effect for affected areas of Washington State. CMS blanket waivers and other flexibilities are available retroactive to August 1, 2026, for providers and suppliers impacted by the wildfires. Healthcare providers requiring additional flexibility may submit an individual 1135 waiver request to CMS.

When Medicare covered DMEPOS is lost, destroyed, irreparably damaged, or rendered unusable due to the Washington wildfires, CMS permits replacement of equipment without obtaining a new face-to-face examination, new physician order, or new medical necessity documentation. Suppliers must maintain documentation demonstrating that the item was impacted by the disaster. Claims associated with applicable disaster-related waivers should include the CR modifier. For more information, refer to CMS Current Emergencies.

News

Reminder: Claims for Oral Anti-Cancer Drug Capecitabine

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

HCPCS code J8522 (Capecitabine) was implemented on January 1, 2025, effective for dates of service (DOS) on or after October 1, 2025, and was subsequently cross walked to the appropriate NDC. Claims for Capecitabine submitted to the DME MAC must be billed using the appropriate NDC.

Suppliers are reminded not to bill Capecitabine using HCPCS J8522 or J8999. Suppliers bill with the appropriate NDC. Refer to LCD L33826 and Policy Article A52479 for more information.

Reminder to Suppliers: Updated Advance Beneficiary Notice of Noncoverage (ABN)

Noridian Healthcare Solutions reminds all suppliers to use the current version of the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131 when appropriate. Proper use ensures compliance and helps transfer financial liability to the beneficiary when Medicare is expected to deny coverage. If an ABN was issued during the allowed transition period, it remains valid for the duration specified, provided there have been no changes to the treatment, condition, or coverage situation.

To be clear, the implementation of a new ABN form does not require the beneficiary to sign a new ABN. An ABN remains effective after valid delivery so long as there has been no change in:

- Care from what is described on the original ABN; and/or
- The beneficiary's health status which would require a change in the subsequent treatment for the non-covered condition; and/or
- The Medicare coverage guidelines for the items or services in question (i.e., updates or changes to the policy of an item or service).

Note: If any of the above changes during the course of treatment, a new ABN must be issued

For more information, visit the Noridian Medicare website for a variety of resources, including the Noridian Educational Experience (NEE), Webinars on Demand Recordings, and the Schedule of Events.

News

Tracheostomy Supplies - Prevent Claim Denials

In a recent MLN Connects Newsletter, CMS reports continued improper payments for tracheostomy supplies, with insufficient documentation remaining the leading cause of errors. Recent DME MAC analysis identified more than 13,000 denied claims for tracheostomy-related supplies during the second quarter of 2026, including tracheostomy tubes, care kits, cleaning supplies, dressings, and accessories.

Common reasons for denial include insufficient documentation of:

- Supply quantities billed
- Medical necessity for quantities above policy limits
- Refill requirements for recurring supplies
- Continued need for supplies
- Coverage criteria for tracheostomy care and starter kits

To help prevent denials:

- Ensure medical records support the quantity of supplies billed and clearly document any clinical need for amounts that exceed Medicare's usual allowances.
    - When excess quantities are provided, the medical record should include detailed justification for additional utilization.
- Refill documentation is critical.
    - For recurring supplies, records must show that the beneficiary requested or confirmed the refill before additional supplies were dispensed.
    - Missing refill documentation can result in claim denial, even when the order, proof of delivery, and practitioner records are available.
- Medicare generally considers HCPCS code A4625 (tracheostomy care or cleaning starter kit) medically necessary only during the immediate post-surgical period.
    - Claims submitted beyond that timeframe may be denied as not reasonable and necessary.

For additional guidance, review the Tracheostomy Care Supplies Local Coverage Determination (LCD) L33832, associated Policy Article A52492, and Standard Documentation Requirements for All Claims Submitted to the DME MACs Article A55426 before submitting claims.

News

Urinary Catheters - Documentation Matters

The Centers for Medicare & Medicaid Services (CMS) recently highlighted findings from an Office of Inspector General (OIG) report that identified improper Medicare payments for intermittent urinary catheters and sterile catheter kits. The report found that claims were frequently paid when documentation did not support eligibility for curved-tip catheters or sterile catheter kits, or when refill, proof of delivery, or Standard Written Order (SWO) requirements were not met.

This remains an important reminder for suppliers: documentation should clearly support the item billed before the claim is submitted. In Jurisdictions A and D, a second quarter 2026 review of 20,000 denied claims found that 99.7% of the observed denials were due to missing beneficiary medical records, with an estimated billed amount of $32,863,603. Complete and accurate documentation helps protect the Medicare Trust Fund by supporting payment only for covered, reasonable, and necessary items. It also protects beneficiaries by reducing avoidable denials, delays in access to medically necessary supplies, and potential financial responsibility when coverage requirements are not met.

To help reduce claim denials and improper payments, suppliers should review documentation requirements carefully and ensure medical records support for the billed items. Documentation must support medical necessity and eligibility criteria for catheters and catheter kits. Refill requests, proof of delivery, and supplier records must be maintained and made available upon request.

For example, when billing a Coude-tip catheter, in addition to showing permanent urinary incontinence or retention, the medical record should clearly document why a straight-tip catheter cannot be used. Documentation supporting the beneficiary's inability to catheterize with a straight-tip catheter is essential.

Strong documentation is one of the most effective ways to prevent claim denials and support Medicare coverage requirements. Documentation requirements can be found in the Standard Documentation Requirements for All Claims Submitted to DME MACs Article A55426. Review the CMS Urological Supplies compliance resources and current Local Coverage Determination (LCD) L33803 and Policy Article A52521 to ensure claims are billed correctly.

Medical Policies and Coverage

2026 HCPCS Code Update - July Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, 2026 HCPCS Code Update - July Edition - Correct Coding, has been created and published to our website.

View the locally hosted 2026 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

Buzzy® - Correct Coding - Revised

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

View the locally hosted 2026 DMD articles.

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LCD and Policy Article Revisions Summary for June 25, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LCD and Policy Article Revisions Summary for June 25, 2026, has been created and published to our website.

View the locally hosted 2026 DMD articles.

- Go to Noridian Medical Director Articles webpage
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Medical Policies and Coverage

Open Meeting Agenda - External Breast Prostheses Proposed Local Coverage Determination (LCD)

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

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Open Meeting Agenda - Oxygen and Oxygen Equipment Proposed Local Coverage Determination (LCD)

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

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Open Meeting Announcement - External Breast Prostheses Proposed Local Coverage Determination (LCD)

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

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Medical Policies and Coverage

Open Meeting Announcement - Oxygen and Oxygen Equipment Proposed Local Coverage Determination (LCD)

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Policy Article Revisions Summary for June 18, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for June 18, 2026, has been created and published to our website.

View the locally hosted 2026 DMD articles.

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Policy Article Revisions Summary for July 2, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for July 2, 2026, has been created and published to our website.

View the locally hosted 2026 DMD articles.

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

Medical Policies and Coverage

Policy Article Revisions Summary for July 9, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for July 9, 2026, has been created and published to our website.

View the locally hosted 2026 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

Proposed Local Coverage Determination (LCD) Released for Comment - External Breast Prostheses

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

View the locally hosted 2026 DMD articles.

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Proposed Local Coverage Determination (LCD) Released for Comment - Oxygen and Oxygen Equipment

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

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Medical Policies and Coverage

Use of the KF Modifier with Osteogenesis Stimulators

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Use of the KF Modifier with Osteogenesis Stimulators, has been created and published to our website.

View the locally hosted 2026 DMD articles.

- Go to Noridian Medical Director Articles webpage
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MLN Connects

MLN Connects - June 4, 2026

MLN Connects® Newsletter for Thursday, June 4, 2026

News

- Federal Rule Takes Aim at Health Care Bureaucracy, Reducing Dispute Fees & Boosting Transparency
- CMS Releases Educational Materials for the Medicare GLP-1 Bridge
- Hospices: Download Your FY 2025 PEPPER
- Skilled Nursing Facility Value-Based Purchasing Program: Download Your June 2026 Confidential Feedback Report
- Clinical Diagnostic Laboratory Reporting: Are You an Applicable Lab?
- Hospitals: Accurately Report Allogeneic Hematopoietic Stem Cell Acquisition Costs

Fraud, Waste & Abuse

- June 1-5 is Medicare Fraud Prevention Week

Compliance

- DME: Complying with Proof of Delivery Requirements

Claims, Pricers & Codes

- Medicare Physician Fee Schedule Database: July Update
- National Correct Coding Initiative: July Update

MLN Matters® Articles

- ESRD Prospective Payment System: July 2026 Quarterly Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2026 Update
- Method II Critical Access Hospital: Line-Level Rendering Provider Billing
- Rural Health Clinics & Federally Qualified Health Centers: Billing Distant Site Telehealth Services

Publications & Multimedia

- Substance Use Screenings & Treatment – Revised

MLN Connects

MLN Connects - June 11, 2026

MLN Connects® Newsletter for Thursday, June 11, 2026

News

- Medicare Shared Savings Program: Apply by June 23
- Clinical Diagnostic Laboratories: Report Your Data Through July 31
- Clinics, Group Practices & Other Suppliers: Use Revised Medicare Enrollment Application Starting August 3
- DMEPOS Competitive Bidding Phase I Bidder Education: Get Ready for Round 2028
- ACCESS Model: Learn How to Support Your Patients with Chronic Conditions
- Opioid Treatment Programs: CY 2026 Updates

Compliance

- DMEPOS: Bill Correctly for Continuous Positive Airway Pressure Devices

Claims, Pricers & Codes

- ICD-10 Codes: FY 2027
- ICD-10 & Other Coding Revisions to National Coverage Determinations: Manual Updates

MLN Connects - June 18, 2026

MLN Connects® Newsletter for Thursday, June 18, 2026

News

- CMS Proposed Rule Locks in Lower Prices & Fosters Innovation for the Medicare Drug Price Negotiation Program
- CMS Ensures Accrediting Organizations Uphold Trust in Standards & Oversight
- Short-Term Acute Care Hospitals: Download Your Q1 FY 2026 PEPPER

Compliance

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

MLN Connects

Events

- PEPPER Updates for Critical Access & Short-Term Hospitals Webinar - June 23
- 2026 National Provider Compliance Conference - August 11-12

MLN Connects - June 25, 2026

MLN Connects® Newsletter for Thursday, June 25, 2026

Proposed Payment Rule

- CY 2027 End-Stage Renal Disease Prospective Payment System Proposed Rule

News

- All Medicare Facility Types: Get Ready for the PEPPER Relaunch
- Clinical Diagnostic Laboratories: Report Your Data Through July 31
- Understanding Telehealth Enrollment Guide

Compliance

- Intermittent Urinary Catheters: Medicare Improperly Paid Suppliers
- Tracheostomy Supplies: Prevent Claim Denials

Claims, Pricers & Codes

- Medicare Part B Drug Pricing Files & Revisions: July Update

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: July 2026 Update

Publications & Multimedia

- Skilled Nursing Facility 3-day Rule Billing Fact Sheet – Revised

MLN Connects

MLN Connects - July 2, 2026

MLN Connects® Newsletter for Thursday, July 2, 2026

Proposed Payment Rules

- CY 2027 Hospital Outpatient Prospective Payment System & Ambulatory Surgical Center Proposed Rule
- CY 2027 Home Health Prospective Payment System Proposed Rule

News

- CMS Launches Medicare GLP-1 Bridge, Expanding Access to GLP-1 Medications
- Hospital Price Transparency: New Resources
- Clinical Diagnostic Laboratory Reporting: Are You an Applicable Lab?

Compliance

- Skilled Nursing Facilities: Accurately Report Your Related Party Costs

Claims, Pricers & Codes

- Non-Invasive Bone Growth Stimulators
- RARCs, CARCs, Medicare Remit Easy Print & PC Print: July Update

MLN Connects - July 9, 2026

MLN Connects® Newsletter for Thursday, July 9, 2026

News

- Long-Term Acute Care Hospitals: Download Your FY 2025 PEPPER
- Clinical Diagnostic Laboratories: Report Your Data Through July 31

Compliance

- Hospital Beds & Accessories: Prevent Claim Denials

Claims, Pricers & Codes

- Cervical Cancer Screening with HPV Testing: Use the Correct Code

MLN Connects

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: July 2026 Update
- DMEPOS Fee Schedule: July 2026 Quarterly Update
- Laboratory National Coverage Determination Edit Software: October 2026 Update

MLN Connects - July 16, 2026

MLN Connects® Newsletter for Thursday, July 16, 2026

Proposed Payment Rule

- CY 2027 Medicare Physician Fee Schedule Proposed Rule

News

- DMEPOS Competitive Bidding Program: Get Licensed & Accredited for Round 2028
- Inpatient Rehabilitation Facility: Download Your FY 2025 PEPPER
- PECOS: Protect Your Application

Compliance

- Optometry Services at Nursing Facilities: Bill Correctly

Claims, Pricers & Codes

- Screening for Hepatitis C Virus in Adults National Coverage Determination: Using HCPCS Code G0567

MLN Matters® Articles

- HCPCS Codes Used for Home Health Consolidated Billing Enforcement: October 2026 Quarterly Update
- Hospice Claims: Reporting a Face-to-Face Encounter for Recertification Using Telecommunications Technology

Publications & Multimedia

- Medicare Fraud & Abuse: 2 Updated Resources

From Our Federal Partners

- Domestically Acquired Cyclosporiasis Cases in Multiple U.S. States
- VA Payments: Enroll in Direct Deposit

MLN Connects

MLN Connects - July 23, 2026

MLN Connects® Newsletter for Thursday, July 23, 2026

News

- CMS Modernizes Nursing Home Oversight with New Risk-Based Survey Approach Designed to Highlight High Performance, Encourage Improvement
- Clinical Diagnostic Laboratories: Act Now Before Reporting Period Ends
- Medicare Providers: Join an Accountable Care Organization for Performance Year 2027
- Clinical Laboratories: Submit Your Comments on CLIA Regulations by September 14
- All Medicare Facility Types: Get Ready for the PEPPER Relaunch
- Medicare Beneficiary Date of Death: Manual Update

Compliance

- Enteral Nutrition: Prevent Claim Denials

Publications & Multimedia

- DMEPOS Payments for Inpatient Stays

MLN Connects

MLN Connects - July 30, 2026

MLN Connects® Newsletter for Thursday, July 30, 2026

Final Payment Rules

- FY 2027 Skilled Nursing Facility Prospective Payment System Final Rule
- FY 2027 Inpatient Psychiatric Facility Prospective Payment System Final Rule

News

- CMS Medicaid Fraud War Room Stops More Than $203 Million in Improper Payments During First 88 Days
- Clinical Diagnostic Laboratories: Last Chance to Report Your Data
- Clinical Laboratories: New Diagnostic Tests
- DMEPOS Requirement Updates
- Nursing Homes: Get Health & Fire Safety Deficiency Information

Claims, Pricers & Codes

- Seasonal Influenza & COVID-19 Vaccine Pricing for 2026-2027 Season

MLN Connects Special Edition: 3 Final Payment Rules - August 3, 2026

Special Edition: 3 Final Payment Rules

- FY 2027 Hospital Inpatient Prospective Payment System & Long-Term Care Hospital Prospective Payment System Final Rule
- FY 2027 Inpatient Rehabilitation Facilities Prospective Payment System Final Rule
- FY 2027 Hospice Wage Index, Payment Rate Update & Quality Reporting Program Requirements Final Rule

MLN Connects - August 6, 2026

MLN Connects® Newsletter for Thursday, August 6, 2026

News

- Readout: CMS Celebrates Delivery of the Health Technology Ecosystem, One Year After Launch
- Skilled Nursing Facility Value-Based Purchasing Program: Download Your August 2026 Performance Score Reports
- Home Health Agencies: Download Your 2025 PEPPER

MLN Connects

Compliance

- Global Surgery: Accurately Report Postoperative Visits
- Glucose Monitoring Supplies: Prevent Claim Denials

Claims, Pricers & Codes

- HCPCS Application Summaries & Coding Determinations: Drugs & Biologicals

Events

- PEPPER Updates for Long-Term Acute Care Hospitals, Inpatient Rehabilitation Facilities & Inpatient Psychiatric Facilities - August 25
- CCSQ Quarterly Stakeholder Webinar - August 26

MLN Connects - August 13, 2026

MLN Connects® Newsletter for Thursday, August 13, 2026

News

- CMS Announces Resources, Flexibilities to Assist with Public Health Emergency in State of Washington
- CMS Proposes New Requirements for Off-Campus Outpatient Departments of a Provider - Submit Comments by August 31
- Regulatory Alignment for Predictable & Immediate Device Coverage Pathway Procedural Notice - Inviting Comment by October 13
- Inpatient Psychiatric Facilities: Download Your 2025 PEPPER

Claims, Pricers & Codes

- Skilled Nursing Facility Prospective Payment System: FY 2027 Pricer Update

MLN Matters® Articles

- Inpatient Rehabilitation Facility Prospective Payment System: FY 2027 Web Pricer Update
- Medicare Part A Cost Report Overpayments: Default Recoupment Date Extension
- Medicare Severity Diagnosis-Related Groups Subject to Inpatient Prospective Payment System Replaced Devices Policy: FY 2027 Update

Publications & Multimedia

- Power Mobility Devices

MLN Connects

MLN Connects - August 20, 2026

MLN Connects® Newsletter for Thursday, August 20, 2026

News

- DMEPOS Competitive Bidding Program: Get Ready for Round 2028

Compliance

- Comprehensive Outpatient Rehabilitation Facility Services: Prevent Claim Denials

Claims, Pricers & Codes

- Encelto™ Cell Gene Therapy Drug: Get Billing Guidance
- CPCS Application Summaries & Coding Decisions: Non-Drug & Non-Biological Items & Services

Events

- CCSQ Quarterly Stakeholder Webinar - August 26
- CMS National Provider Enrollment Conference - November 18 & 19

MLN Matters® Articles

- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2027 Update (1 of 2)

Publications & Multimedia

- Understanding Telehealth & Teleradiology Enrollment

From Our Federal Partners

- Risk of Severe Arboviral Disease in Patients Receiving B Cell-Depleting or Modulating Medications

MLN Connects

MLN Connects - August 27, 2026

MLN Connects® Newsletter for Thursday, August 27, 2026

News

- Alabama: $144M to Improve Mental Health, Substance Abuse, Emergency, and Maternal Care & Expand the Health Care Workforce
- Alaska: $160M to Bring Cutting-Edge Technology, Drones Prescription Deliveries, Surgical Robotics & More
- North Dakota: Critical Funding to Launch the Coordinating & Connecting Care Initiative
- Ohio: $3.15M to Expand Pharmacy Connectivity Throughout Rural Communities
- Pennsylvania: $35M to Advance Screening Technology, Secure Additional Operating Rooms & Modernize Rural Health Care
- South Dakota: $90M to Modernize & Improve IT and Interoperability
- West Virginia: $4.2M to Expand Medical Transportation & Improve Patient Access to Care

Compliance

- Dermatologists: Bill Correctly for Evaluation and Management Services & Minor Surgical Procedures

Claims, Pricers & Codes

- Home Health Prospective Payment System Grouper: October Update

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Clinical Laboratory Improvement Amendments HCPCS Codes, Waived Tests & Reasonable Charge Payments: October 2026 Quarterly Update
- Hospice Payments: FY 2027 Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2027 Update (2 of 2)

MLN Matters

DMEPOS Fee Schedule: July 2026 Quarterly Update

Number: 14513

Release Date: July 1, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13846CP

CR 14513 updates the DMEPOS fee schedule on a quarterly basis, when necessary, to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies.

Make sure your billing staff knows about guidance on continuing to use the KF modifier on claims for HCPCS codes E0747, E0748, and E0760 for dates of service on or after May 18, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14513.

ICD-10 & Other Coding Revisions to National Coverage Determinations: October 2026 Update

Number: 14464

Release Date: May 26, 2026

Effective Date: October 1, 2026

Implementation Date: October 5, 2026

Transmittal Number: R13752OTN

CR 14464 provides a quarterly maintenance update of ICD-10 coding conversions and other coding updates specific to NCDs. No policy is being changed because of these updates.

Make sure your billing staff knows about updates to National Coverage Determinations (NCDs) with new or deleted ICD-10 diagnosis codes, effective October 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14464.

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.