DME Happenings

Jurisdiction D
June 2026

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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News

2026 Current Emergencies and Disasters

A Public Health Emergency (PHE) was declared on April 17, 2026, in response to Typhoon Sinlaku affecting the Commonwealth of the Northern Mariana Islands and the Territory of Guam. This declaration provides CMS with flexibility to support Medicare beneficiaries and the provider and supplier community in the impacted areas. The PHE is retroactively effective April 11, 2026.

In addition, a PHE was declared for the State of Hawaii on April 21, 2026. This declaration allows CMS to implement flexibilities to support beneficiaries and is retroactively effective March 10, 2026.

Review the CMS Current Emergencies webpage for the most current information, including affected areas and any applicable Medicare flexibilities.

CERT Awareness Month: 2026 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 Comprehensive Error Rate Testing (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, June 11, 2026 for claims submitted July 1, 2024 - June 30, 2025. Favorable CERT decisions ensure proper payment and lowers the national improper payment rate. Send questions to Noridian's CERT team.

Resources

- CERT RC C3HUB website
- 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 Comprehensive Error Rate Testing (CERT) documentation requests. This is the second of four articles in our CERT Awareness Month.

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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 for providing 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 cover sheet in front of your records

Follow up by accessing the CERT RC C3HUB website. 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 payment recoupment.

Resources:

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

CERT Awareness Month: Verify Your Medical Records Correspondence Address

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 Comprehensive Error Rate Testing (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 website "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 be updated 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 Comprehensive Error Rate Testing (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 Noridian's CERT team.

Resources

- CERT Background
- CERT Review Contractor (RC) C3HUB website
- CERT Reports
- CERT Task Force

CMS Releases Updated Advance Beneficiary Notice (ABN)

On March 13, 2026, the Centers for Medicare & Medicaid Services (CMS) announced that the Office of Management and Budget (OMB) approved the control number for the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131.

The newly updated ABN is effective immediately and is valid through March 31, 2029. DME suppliers may continue to use the expired version of the ABN until May 12, 2026, but must fully transition to the OMB approved form no later than that date.

ABNs are issued to Original Medicare (fee for service) beneficiaries when it is believed Medicare is likely to deny payment for an item or service, for example, when coverage criteria may not be met or frequency limits may apply. Proper use of the ABN helps ensure beneficiaries understand potential financial liability and allows suppliers to shift liability appropriately when Medicare denies the claim.

News

Key Reminders

- Only the official CMS R 131 ABN may be used; expired versions must be replaced by May 12, 2026.
- The ABN applies to Original Medicare and should not be used for Medicare Advantage (Part C) or Part D items and services.
- The ABN must be provided before the item is furnished and far enough in advance for the beneficiary to make an informed decision.

The updated ABN, instructions, and alternative formats (including large print and Spanish versions) are available on the CMS FFS ABN webpage. DME suppliers should review internal processes, update forms, and educate staff to ensure timely compliance with the newly updated ABN.

Continuous Glucose Monitor (CGM) Supply Allowance Calculator

Stay on top of your CGM supply billing with ease. Our CGM Supply Allowance Calculator was designed specifically to help the supplier community quickly and confidently determine the *next eligible date of service* for billing the CGM supply allowance.

With supply allowance codes A4238 and A4239, suppliers can bill up to three (3) units of service every ninety (90) days. Thanks to this simple, user friendly tool, you no longer need to calculate those dates manually.

Just enter the last date of service, and the calculator instantly provides the next eligible billing date. It's fast, accurate, and helps ensure compliance with billing guidelines.

The Continuous Glucose Monitor (CGM) Supply Allowance Calculator is available under the Tools section of our website.

Take the guesswork out of billing - try it today,

Enteral Nutrition: Documentation and Policy Requirements

Medicare covers enteral nutrition (EN) under the prosthetic device benefit when coverage, documentation, and payment requirements are met. Coverage criteria and documentation requirements are outlined in the Enteral Nutrition Local Coverage Determination (LCD L38955) and the related Policy Article (A58833). Claims that do not meet these requirements are subject to denial.

Enteral nutrition continues to be a focus area for the Comprehensive Error Rate Testing (CERT) program. Recent CMS compliance updates show a high improper payment rate

for enteral nutrition, with documentation deficiencies identified as the leading cause of errors.

According to CMS CERT reporting, insufficient documentation accounts for the largest portion of improper payments for enteral nutrition claims. Other contributing factors include lack of medical necessity and failure to meet policy requirements.

CERT reviews identified the following common errors:

- Failure to demonstrate that the beneficiary initially met coverage criteria
- Missing or insufficient documentation to support continued medical need
- Incomplete or invalid Standard Written Orders (SWOs)
- Lack of documentation supporting the medical necessity of an enteral pump
- Medical records that do not support the type of formula, calories ordered, or method of administration

During a CERT review, claims are evaluated on the documentation submitted. If required documentation is missing, unclear, or does not support coverage criteria, the claim is considered non payable.

Suppliers are responsible for ensuring that all required documentation is obtained, reviewed, and maintained prior to claim submission. Documentation must support each element required for coverage and payment, including:

- A permanent or long-term condition resulting in full or partial non-function of the digestive tract
- Documentation supporting adequate nutrition is not possible by oral intake
- Medical records supporting medical necessity and continued need for enteral nutrition
- A valid and complete Standard Written Order (SWO)
- Compliant refill request documentation
- Proof of delivery (POD) documentation

Medical records must clearly support the information reflected on the SWO. Orders alone are not sufficient on their own to establish medical necessity. Failure to meet requirements may result in claim denial, overpayments, or additional medical review. Use the Enteral Nutrition Documentation Checklist to ensure documentation requirements are met.

External Infusion Pumps: Key Information for Suppliers

Suppliers frequently have questions regarding coverage, documentation, and billing requirements for external infusion pumps. To support accurate claim submission and

reduce denials, we have compiled key points based on recent education sessions and updates.

Coverage & Documentation Requirements

Medicare covers external infusion pumps when specific medical necessity requirements are met. As outlined in the External Infusion Pumps Coverage Criteria, suppliers must ensure a complete Standard Written Order (SWO) is obtained before billing. Claims submitted without an SWO will be denied as *not reasonable and necessary*.

Suppliers must also maintain detailed documentation, including beneficiary authorization, medical records, SWO, refill requests, and Proof of Delivery (POD). The Documentation Checklist for External Infusion Pumps outlines required elements and provides links to the policy and additional resources.

Billing Clarifications & Common Supplier Concerns

Claims for K0552 (supplies for external non insulin infusion pumps, syringe type cartridges) are not separately payable when the drug is already provided in a pre packaged syringe type cartridge. This clarification helps suppliers determine when K0552 and A4222 (infusion supplies for external drug infusion pump, per cassette or bag) may or may not be billed together. Documentation must always support the method of drug delivery.

Reminders

Suppliers are encouraged to refer to the Local Coverage Determination (L33794) for medical necessity requirements and Policy Article A52507 for detailed billing guidance.

A reminder that suppliers can use policy based education to resolve many scenario based questions. Suppliers requiring claim specific guidance may contact the Supplier Contact Center for additional support.

Face-to-Face Encounter and WOPD Update Effective April 13, 2026, for Oxygen and Oxygen Equipment

CMS has updated the Master List and the Required Face-to-Face Encounter and Required Written Order Prior to Delivery (WOPD) List.

Effective April 13, 2026, Medicare selected additional HCPCS codes that require a face-to-face encounter and Written Order Prior to Delivery (WOPD):

- Eight Oxygen and Oxygen Equipment: E0424, E0431, E0433, E0434, E0439, E1390, E1391, E1392

News

For more information review CMS website for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Order and Face-to-Face Encounter Requirements.

Friendlier, Clearer Account Activity Reminders for NMP

We've refreshed our account activity warning emails to make them clearer and easier to act on. The 20-day notice has been removed, and instead users will receive two friendly reminders - on days 25 and 29 - before an account is disabled on day 30 if there's no login on the Noridian Medicare Portal (NMP). This approach provides more supportive guidance for users.

How to Avoid Coude Tip Catheter Comprehensive Error Rate Testing (CERT) Errors

Noridian has received notification of errors from CERT for the following type of claims:

Coude tip catheter (A4352)

CERT has identified the main causes of these errors due to:

- Order is written for a straight catheter instead of the billed Coude catheter.
- Clinical record missing documentation of beneficiary's inability to pass a straight tip catheter.

To be compliant with Local Coverage Determination (LCD) for Urological Supplies:

Documentation would include:

- Referring practitioner's orders or associated practitioner's orders for the billed intermittent Coude catheter (A4352).
- Documentation in the beneficiary's medical record of the medical necessity for that catheter. An example would be the inability to catheterize with a straight tip catheter.

This documentation must be available upon request. If documentation is requested and does not substantiate medical necessity, claims will be denied as not reasonable and necessary.

Resources:

- Urological Supplies Local Coverage Determination (LCD)
- Urological Supplies Policy Article
- Standard Documentation Requirements for All Claims Submitted to DME MACs

News

How to Avoid Proof of Delivery (POD) Comprehensive Error Rate Testing (CERT) Errors for Method Two

Noridian has received notification of errors from CERT for POD Method Two.

CERT has identified the main cause of these errors is due to:

- Invoice from supplier missing quantity of items delivered
- Invoice from supplier missing tracking number from shipping company
- Tracking document from shipping company missing evidence of delivery
- Invoice from supplier missing beneficiary address
- Tracking document from shipping company missing delivery address.

To be compliant with Standard Documentation Requirements for All Claims Submitted to DME MACs:

Documentation for Method Two delivery would include at a minimum:

- Beneficiary's name
- Delivery address
- 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
- A description of the item(s) being delivered. The description can be either a narrative description (e.g., lightweight wheelchair base), a HCPCS code, the long description of a HCPCS code, or a brand name/model number
- Quantity delivered
- Date delivered
- Evidence of delivery

This documentation must be available upon request. If documentation is requested and does not substantiate that the item(s) delivered are the same item(s) submitted for Medicare reimbursement and that the item(s) are intended for, and received by, a specific Medicare beneficiary, claim(s) will be denied.

Resources:

- Standard Documentation Requirements for All Claims Submitted to DME MACs

Introducing the Noridian Educational Experience (NEE)

Noridian is excited to announce the migration and refresh of all educational content from YouTube to the Noridian Educational Experience (NEE) platform, a modern solution designed to elevate provider and supplier education. This transition marks a

significant step toward delivering a streamlined, user-friendly experience for healthcare professionals seeking self-paced learning opportunities.

The NEE platform offers a comprehensive suite of training modules tailored to support ongoing learning and professional development. With an intuitive interface and flexible access, providers and suppliers can engage with a variety of courses and structured curriculums at their own pace. Many of these courses are eligible for Continuing Education Unit (CEU) credits, ensuring that participants not only gain valuable knowledge but also meet professional certification requirements.

By centralizing educational resources into one modern platform, Noridian aims to enhance accessibility, improve learning outcomes, and empower providers and suppliers with tools for success in an ever-evolving healthcare landscape.

July 2026 HCPCS Updates

CMS has released the July 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 July 1, 2026. Visit the CMS HCPCS Quarterly Update site to review the listing.

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

Medicare Coverage for PAP Devices: Understanding the LCD and Policy Article

Positive Airway Pressure (PAP) devices are a key treatment option for beneficiaries diagnosed with obstructive sleep apnea (OSA). Medicare outlines the coverage requirements for these devices through two primary documents: the Local Coverage Determination (LCD) and the Policy Article (PA). Together, these resources define the clinical criteria, documentation standards, and billing expectations that suppliers must follow to ensure proper reimbursement.

Overview of the LCD for PAP Devices

The Local Coverage Determination (LCD) for PAP devices establishes the clinical indications and coverage criteria that must be met before Medicare will reimburse for a PAP device. The following is outlined within the LCD:

- Coverage criteria for PAP therapy
- Reference to the National Coverage Determination (NCD 240.4) for CPAP therapy
- Requirements for initial coverage and continued coverage

- Documentation expectations for medical necessity

These elements ensure that PAP therapy is provided only when clinically appropriate and supported by adequate medical documentation.

The Policy Article (PA): Documentation & Billing Requirements

The Policy Article (PA) supplements the LCD by detailing coding, and documentation requirements for PAP devices. The PA includes:

- Coding guidelines for PAP devices and accessories
- Detailed documentation requirements for suppliers
- Clarification of continued medical necessity documentation
- Instructions for clinicians regarding chart notes and follow up documentation

The PA ensures that suppliers understand not only what is required clinically, but also how to document and bill correctly to avoid denials.

Key Documentation Requirements

Noridian provides several clinician tools to support compliance, including:

- Clinician Checklist - PAP
- Clinician Letters for Documentation of Continued Medical Necessity
- Standard Documentation Requirements Policy Article - A55426

These resources help ensure that suppliers gather all required information before submitting claims, reducing the risk of audits or claim denials.

Noridian PAP Device Resources

Additional resources can be found on the Noridian Medicare website under the Browse by DMEPOS Category > Positive Airway Pressure (PAP) Devices.

New User Registration Verification - Effective April 24, 2026

Users registering for a new user account on the Noridian Medicare Portal (NMP) will now be required to complete an NPI/PTAN verification prior to starting the registration process. This verification is to ensure that the NPI/PTAN being used to register is active in the Medicare Claims Processing System. If the NPI/PTAN is not active, users will need to work with their Provider Enrollment departments for their respective jurisdictions. Once the NPI/PTAN is active, users can then proceed with the registration process.

- JA: Novitas Solutions at 866-520-5193
- JD: Palmetto GBA at 866-238-9652
- JE: 855-609-9960

- JF: 877-908-8431

Additional information can be found in the NMP Registration Guide.

Prior Authorization Submission Updates in NMP

CMS has implemented several prior authorization programs in recent months, each with its own distinct requirements. To accommodate these variations, the Noridian Medicare Portal (NMP) was enhanced to offer a more streamlined, intuitive, and efficient submission process across all prior authorization programs.

The most critical update is ensuring the correct "Prior Authorization Type" is selected to accurately reflect the Prior Authorization Request (PAR) being submitted. Choosing the appropriate type helps prevent submission rejections, reduces processing delays, and ensures the request is routed to the correct Medical Review Team for timely review.

The Prior Authorization Type options include:

- Wasteful and Inappropriate Service Reduction (WISER)
- Outpatient Hospital Department (OPD)
- Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD)
- Ambulatory Surgical Center (ASC)
- Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT)

Note: Prior Authorization Type options available are dependent on the request's line of business.

To view the instructions for your program, visit the NMP Inquiry Guide for the selected program:

- WISeR
- OPD
- IRF RCD
- ASC
- RSNAT

Therapeutic Shoes for Persons with Diabetes: CERT Findings and Documentation Requirements

Medicare covers therapeutic shoes, inserts, andmodifications for beneficiaries with diabetes when all statutory and policyrequirements are met. Coverage requires certification by a physician managingthe beneficiary's diabetes, and documentation

supporting that the beneficiarymeets all coverage criteria. Claims that do not meet these requirements will bedenied.

Therapeutic shoes remain an area of focus for ComprehensiveError Rate Testing (CERT) due to a high volume of claims denied fordocumentation related errors. In many cases, CERT improper payment findings arethe result of missing, incomplete, or invalid documentation rather than lack ofbeneficiary eligibility.

Common causes of improper payments for therapeutic shoes:

- Missingor insufficient documentation of a qualifying foot condition
- Missingor insufficient documentation that the certifying physician is managingthe beneficiary's diabetes
- Invalidor incomplete Standard Written Orders (SWOs)
- Invalidor missing Statement of the Certifying Physician
- Insufficientdocumentation to support insert or modification coding

During a CERT review, claims are evaluated based on thedocumentation submitted. If the required documentation is not provided or doesnot clearly support coverage criteria, the claim is considered non payable.

Suppliers are responsible for ensuring that requireddocumentation is obtained, reviewed, and maintained prior to claim submission.Documentation must include:

- Adocumented diagnosis of diabetes mellitus
- Documentationof at least one qualifying foot condition
- Certificationthat the physician is treating the beneficiary under a comprehensive planof care for diabetes
- Avalid Standard Written Order (SWO)
- Aproperly completed and timely Statement of the Certifying Physician

Documentation must be clear, legible, andavailable upon request. Failure to meet these requirements may result in claimdenial, overpayment recovery, or additional review. Refer to the Therapeutic Shoes for Persons with Diabetes Documentation Checklist to assist with ensuring the proper documentation has been obtained for payment.

Updates to the Noridian Educational Experience (NEE)

The Noridian Educational Experience (NEE) is now available to providers and suppliers across all jurisdictions. This expansion ensures consistent access to high-quality, self-paced education regardless of location. NEE is a modern, centralized platform that streamlines provider education into one user-friendly experience, making it easier to find and complete training that supports day-to-day operations and compliance needs.

With 24/7 access to a growing library of courses, providers can complete training at their own pace across key Medicare topics. Many courses offer Continuing Education Unit (CEU) credit, supporting ongoing professional development. NEE now serves as Noridian's primary destination for self-paced education, replacing YouTube tutorials as content is modernized and enhanced to improve accessibility, consistency, and overall learning outcomes.

As part of ongoing efforts to improve the user experience, NEE registration has been simplified. Providers and suppliers are no longer required to enter a National Provider Identifier (NPI) and Provider Transaction Access Number (PTAN) combination. Instead, registration now requires only the NPI. This enhancement reduces complexity, streamlines the registration process, and helps users more quickly access available training resources.

Where to Find CMS Resources on Public Health Emergencies

CMS maintains dedicated webpages to help Medicare providers and suppliers stay informed during declared public health emergencies (PHEs), including natural disasters and other emergencies that may impact access to care or Medicare requirements.

The CMS Current Emergencies webpage is the primary source for information on active PHEs and Medicare emergency response activities. This page includes details on the type of emergency, impacted geographic areas, and links to CMS announcements, approved Medicare flexibilities, and Section 1135 waivers. Suppliers should monitor this page routinely during emergency situations to determine whether CMS has issued guidance that could affect claims submission or other Medicare requirements.

Refer to the CMS Current Emergencies page for active public health emergencies PHE declarations that provide targeted support and flexibility for Medicare beneficiaries and provider and supplier communities in the affected areas. Resources on the Current Emergencies page direct users to relevant waiver determinations and CMS communications specific to each event.

You Spoke, We Listened: Enhancing Accessibility for POE Webinars

At Noridian, we are committed to continuously improving the provider education experience by listening to your feedback and making meaningful enhancements.

Beginning June 1, 2026, attendees of Provider Outreach and Education (POE) webinars will have new accessibility options designed to support a more inclusive and customizable learning experience. During each webinar, participants will have the ability

to turn on closed captioning in real time, helping ensure key information is accessible to all attendees.

In addition, users can personalize their viewing experience by adjusting the caption text size and color to best fit their needs. These enhancements provide greater flexibility and readability, allowing each participant to engage with the content in the way that works best for them.

We appreciate your feedback and encourage you to continue sharing your input as we work to enhance our services.

Medical Policies and Coverage

2026 HCPCS Code Update - April Edition - Correct Coding

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, 2026 HCPCS Code Update - April 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

April 2026 HCPCS Updates

CMS has released the April 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 April 1, 2026. Visit the CMS HCPCS Quarterly Update site to review the listing.

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

Correct Coding - Partial Hand Prostheses - Revised

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

View the locally hosted 2026 DMD articles.

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Medical Policies and Coverage

Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Functional Electrical Stimulation (FES) - Coverage and HCPCS Coding - Revised, has been created and published to our website.

View the locally hosted 2026 DMD articles.

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KF Modifier Use - Correct Coding - Revised

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

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Knee Orthoses: LCD and Policy Article Coverage for Osteoarthritis

Revisions have finalized for the Knee Orthoses Local Coverage Determination (LCD) L33318 and its related Policy Article (A52465). These updates expand coverage for knee braces, particularly for patients with osteoarthritis, and align policy with current clinical practice. The change followed a reconsideration process and public comment period, incorporating feedback from clinicians, suppliers, and advocacy groups.

Under the new guidance, knee orthoses are covered not only for instability but also for osteoarthritis when patients are ambulatory, and documentation shows pain or functional impairment. Coverage applies if the orthosis provides varus or valgus adjustment, and the patient is willing to use the device. Practitioners must ensure medical records clearly demonstrate diagnosis, limitations, and expected benefit.

This revision is considered a significant step forward for patient access, correcting a long-standing gap in Medicare coverage. By recognizing orthoses as a valid treatment

for osteoarthritis, the policy improves mobility and pain management options for Medicare beneficiaries.

You can review the LCD and Policy Article on our Active LCDs webpage

LCD and Policy Article Revisions Summary for April 9, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LCD and Policy Article Revisions Summary for April 9, 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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LCD and Policy Article Revisions Summary for April 16, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LCD and Policy Article Revisions Summary for April 16, 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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LCD and Policy Article Revisions Summary for May 14, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, LCD and Policy Article Revisions Summary for May 14, 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

Lymphedema Compression Treatment Items - Correct Coding and Billing - Revised

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

View the locally hosted 2026 DMD articles.

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

Open Meeting Agenda - Power Mobility Devices and Wheelchair Options/Accessories Proposed Local Coverage Determinations (LCDs)

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Open Meeting Agenda - Power Mobility Devices and Wheelchair Options/Accessories Proposed Local Coverage Determinations (LCDs), has been created and published to our website.

View the locally hosted 2026 DMD articles.

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- Locate/select article title

Payment Rules - Continuous Passive Motion Machines - Revised

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Payment Rules - Continuous Passive Motion Machines - Revised, 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 March 5, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for March 5, 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

Policy Article Revisions Summary for April 23, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for April 23, 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

Policy Article Revisions Summary for April 30, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for April 30, 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

Medical Policies and Coverage

Policy Article Revisions Summary for May 28, 2026

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Policy Article Revisions Summary for May 28, 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

Recording and Transcript Published - March 25, 2026 Virtual Open Meeting

The Durable Medical Equipment (DME) Medicare Administrative Contractor (MAC) Joint Publication article, Recording and Transcript Published - March 25, 2026 Virtual Open Meeting, has been created and published to our website.

View the locally hosted 2026 DMD articles.

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MLN Connects

MLN Connects - March 5, 2026

MLN Connects® Newsletter for Thursday, March 5, 2026

News

- DMEPOS: Temporary Enrollment Moratorium on Medical Supply Companies
- CMS to Lower Drug Costs & Improve Care by Extending Deadline for GENEROUS Model Application
- Laboratories: We've Transitioned to Paperless Operations
- No-Pay Medicare Summary Notice Mailing Frequency Changed to Every 180 Days

Compliance

- Opioid Use Disorder: Learn about Services to Help Your Patients Continue Treatment
- Major Hip & Knee Replacement or Reattachment of Lower Extremity: Prevent Claim Denials

Claims, Pricers & Codes

- National Correct Coding Initiative: April Update

Publications & Multimedia

- 2026 Medicare Part C and Part D Reporting Requirements & Data Validation - Revised

MLN Connects - March 12, 2026

MLN Connects® Newsletter for Thursday, March 12, 2026

News

- CMS Strengthens Patient Protections & Accountability in Organ Donation System
- Hospitals: Submit Data for OPPS Drug Acquisition Cost Survey by March 31
- Hospital Price Transparency: Enforcement of 2026 Requirements Starts April 1
- Clinical Diagnostic Laboratories: Get Ready to Report Starting May 1
- Optimal Health for All Within Nation's Health & Long-Term Care Systems
- Emergency Preparedness: Find Out How to Prevent Deficiencies

MLN Connects

Compliance

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

Claims, Pricers & Codes

- Quality Payment Program: Claim Adjustments to Correct Conversion Factor
- HCPCS Application Summaries & Coding Determinations: Non-Drug and Non-Biological Items & Services

Publications & Multimedia

- Medicare Payment Systems - Revised

Information for Patients

- Medicare.gov Enhanced Log In

MLN Connects - March 19, 2026

MLN Connects® Newsletter for Thursday, March 19, 2026

News

- CMS Announces Manufacturer Participation in Third Cycle of Medicare Drug Price Negotiation
- Quality Payment Program: Medicare Shared Savings Program ACOs Must Submit Quality Data by March 31
- Hospitals: Apply for Additional Residency Positions by March 31
- Hospitals: It's Not Too Late to Submit Data for OPPS Drug Acquisition Cost Survey
- Short-Term Acute Care Hospitals: Download Your Quarter 4 FY 2025 PEPPER
- Medicare Shared Savings Program: Application Deadlines for January 1, 2027, Start Date
- ESRD Prospective Payment System: Furnishing Drugs & Biological Products Included in Bundled Payment
- Advance Beneficiary Notice of Noncoverage: Updated Form
- Important Message from Medicare & Detailed Notice of Discharge: Updated Forms

Claims, Pricers & Codes

- Inpatient Psychiatric Facilities Prospective Payment System: April 2026 Coding Updates

MLN Connects

Events

- Average Sales Price Data Collection System Training Webinar - April 14

MLN Matters® Articles

- Cardiac Contractility Modulation for Heart Failure - Revised
- ICD-10 & Other Coding Revisions to National Coverage Determinations: April 2026 Update - Revised

Publications & Multimedia

- Billing Medicare Part B for Insulin with New Limits on Patient Monthly Coinsurance - Revised

MLN Connects - March 26, 2026

MLN Connects® Newsletter for Thursday, March 26, 2026

News

- CMS Rule Phases Out Fax Machines, Snail Mail to Save Taxpayers $781.98M a Year
- Hospitals: OPPS Drug Acquisition Cost Survey Deadline Extended to April 7
- Clinical Diagnostic Laboratories: Get Ready to Report Starting May 1
- Nutrition-Related Health Conditions: Recommend Medicare Preventive Services

Compliance

- Acute Care Hospital Outpatient Services for Hospice Enrollees: Reduce Improper Payments

Claims, Pricers & Codes

- Stem Cell Transplant National Coverage Determination: Reprocessing Certain Part A Claims
- Medicare Part B Drug Pricing Files & Revisions: April Update

Events

- Quarter 4 FY 2025 PEPPER for Short-Term Acute Care Hospitals Webinar - April 7

MLN Matters® Articles

- Hospital Outpatient Prospective Payment System: April 2026 Update

MLN Connects

Publications & Multimedia

- CMS Burden Reduction Conference Videos
- Medicare Coverage of Diabetes Supplies - Revised

From Our Federal Partners

- VA Family Member Programs: Updated Guidance for Decision Reviews & Appeals

MLN Connects - April 2, 2026

MLN Connects® Newsletter for Thursday, April 2, 2026

News

- HHS & CMS Announce Healthcare Advisory Committee Members to Improve Patient Care and Modernize the U.S. Healthcare System
- CMS Marks Milestone in Expanding Patient-Centered Innovation with Substance Access Beneficiary Engagement Incentive
- Accountable Care Organizations: Apply to the New LEAD Model
- New ASPIRE Model to Deliver Support to Children and Youth with Complex Medical Needs
- Hospitals: OPPS Drug Acquisition Cost Survey Deadline Extended to April 7
- ESRD Prospective Payment System: XPHOZAHTM Included in Bundled Payment
- Clinical Diagnostic Laboratory Reporting: Are You an Applicable Lab?

Compliance

- Evaluation and Management Services & Intravitreal Injections: Bill Correctly
- Therapeutic Footwear: Prevent Claim Denials

Claims, Pricers & Codes

- Method II Critical Access Hospitals: Reprocessing Certain Claims with Reassigned Billing Rights

Events

- Quarter 4 FY 2025 PEPPER for Short-Term Acute Care Hospitals Webinar - April 7

MLN Connects

MLN Matters® Articles

- HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2026 Quarterly Update
- Hospital Outpatient Prospective Payment System: April 2026 Update - Revised
- National Coverage Determination 20.40: Renal Denervation for Uncontrolled Hypertension - Revised

MLN Connects - April 9, 2026

MLN Connects® Newsletter for Thursday, April 9, 2026

Proposed Payment Rules

- Skilled Nursing Facility Prospective Payment System Proposed Rule: FY 2027
- Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule: FY 2027
- Inpatient Psychiatric Facility Prospective Payment System Proposed Rule: FY 2027
- Hospice Wage Index and Payment Rate Update & Hospice Quality Reporting Program Requirements: FY 2027

News

- Hospital Price Transparency: Get Guidance on New Requirements
- Short-Term Acute Care Hospitals: Download Your Quarter 4 FY 2025 PEPPER
- Clinical Diagnostic Laboratories: Get Ready to Report Starting May 1

Compliance

- Skilled Nursing Facilities: Accurately Report Your Related Party Costs

Claims, Pricers & Codes

- Integrated Outpatient Code Editor Version 27.1

Events

- Clinical Lab Fee Schedule Data Collection Webinar - April 16
- Medicare Cost Report E-Filing System Webinar - April 22

MLN Connects

MLN Matters® Articles

- DMEPOS Fee Schedule: April 2026 Quarterly Update
- National Coverage Determination 20.19: Ambulatory Blood Pressure Monitoring - Revised

From Our Federal Partners

- Medetomidine in the U.S. Illegal Fentanyl Supply Increasing Risk for Overdose & Severe Withdrawal Syndrome

MLN Connects Special Edition: IPPS & LTCH PPS Payment | Interoperability Standards & Prior Authorization for Drugs - April 13, 2026

Special Edition: IPPS & LTCH PPS Payment | Interoperability Standards & Prior Authorization for Drugs

Proposed Payment Rule

- Hospital Inpatient Prospective Payment System & Long-Term Care Hospital Prospective Payment System Proposed Rule: FY 2027

News

- CMS Proposes Major Reforms to Speed Up Patient Access to Drugs, Increase Transparency, & Reduce Administrative Burden

MLN Connects - April 16, 2026

MLN Connects® Newsletter for Thursday, April 16, 2026

News

- CMS Launches First Wave of HealthTech Ecosystem Tools, Fast-Tracking a Fully Digital, Patient-Centered Health System
- HETS Action Required: Enroll Third-Party Vendors for Access by May 11
- ACCESS Model Application Period Extended to May 15; First Applicants Accepted to Join
- DMEPOS Therapeutic Shoes: Document Qualifying Conditions

MLN Connects

MLN Matters® Articles

- Ambulatory Surgical Center Payment System: April 2026 Update
- Critical Access Hospitals: Certified Registered Nurse Anesthetist Bypass for Reason Codes 31006 & 31007
- Prospective Payment System Hospital Interim Billing: New Monthly Adjustment Process
- Cardiac Contractility Modulation for Heart Failure - Revised

Publications & Multimedia

- Annual Wellness Visit - Revised
- Clinical Laboratory Fee Schedule - Revised

MLN Connects Special Edition: Overview of the CMS Interoperability Standards & Prior Authorization for Drugs Proposed Rule Webinar - April 16

Overview of the CMS Interoperability Standards & Prior Authorization for Drugs Proposed Rule Webinar - April 16

Thursday, April 16 from 12-1 pm ET

Register for this webinar.

CMS recently published the CMS Interoperability Standards and Prior Authorization for Drugs proposed rule (CMS-0062-P), which includes important proposals to streamline drug prior authorization and modernize health data exchange. This rule builds on prior CMS interoperability efforts and proposes to:

- Require impacted payers to support electronic prior authorization for drugs
- Improve timeliness of prior authorization decisions
- Increase transparency into the drug prior authorization process
- Advance the use of modern health IT standards, including HL7® FHIR®

To help the public better understand these proposals and their potential impact, CMS will host an informational webinar to provide an overview of the proposed rule and highlight key provisions, including proposed updates to interoperability standards and prior authorization requirements. We encourage all interested parties to attend and learn more about how these proposals may affect patients, payers, providers, and the broader health care system.

Questions? Email CMSInteroperability@cms.hhs.gov.

MLN Connects

UPDATED LINK: MLN Connects Special Edition: Overview of the CMS Interoperability Standards & Prior Authorization for Drugs Proposed Rule Webinar - April 16

UPDATED LINK: Overview of the CMS Interoperability Standards & Prior Authorization for Drugs Proposed Rule Webinar - April 16

We're re-sending this special edition to update the webinar link for today's event. See the updated announcement

MLN Connects - April 23, 2026

MLN Connects® Newsletter for Thursday, April 23, 2026

News

- 2026 CMS Interoperability Standards & Prior Authorization Proposed Rule Resources
- Updated Behavioral Health Strategy
- Clinical Diagnostic Laboratories: Get Ready to Report Starting Next Week
- HETS Action Required: Enroll Third-Party Vendors for Access by May 11
- Open Payments: Review Your Data by May 15
- Hospice Levels of Care & How to Bill for Service Intensity Add-On Payments
- Hospitals: Accurately Report Allogeneic Hematopoietic Stem Cell Acquisition Costs

Compliance

- Lower Limb Orthoses: Prevent Claim Denials

Claims, Pricers & Codes

- Vaccine Coding for Institutional Claims: Reporting Condition Code A6
- HCPCS Application Summaries & Coding Determinations: Drugs & Biologicals

Events

- HCPCS Public Meeting - June 1-2

MLN Matters® Articles

- Low-Volume Hospital Payment Adjustment & the Medicare-Dependent Hospital Program: FY 2026 Extensions

MLN Connects

Publications & Multimedia

- Clinical Laboratory Fee Schedule Data Collection & Reporting Webinar Recording
- Medicare Preventive Services - Revised

MLN Connects - April 30, 2026

MLN Connects® Newsletter for Thursday, April 30, 2026

News

- CMS & FDA Announce RAPID Coverage Pathway to Accelerate Patient Access to Life-Changing Medical Devices
- Clinical Diagnostic Laboratories: Required Reporting Starts May 1
- HETS Action Required: Enroll Third-Party Vendors for Access by May 11
- Nurses May Qualify for Up to $40,000 in Student Loan Repayment
- Reduce Chronic Disease & Improve Health with Physical Activity and Nutrition

Compliance

- Manual Wheelchairs: Prevent Claim Denials

Claims, Pricers & Codes

- Ultrasound Abdominal Aortic Aneurysm Screening: Updated Coding Information

Events

- CCSQ Quarterly Stakeholder Webinar - May 12

MLN Matters® Articles

- Vaccine Administration National Fee Schedule: July 2026 Quarterly Update
- Stay of Enrollment - Revised

Publications & Multimedia

- Clinical Laboratory Fee Schedule: Reporting Private Payor Data
- Fix Death Date Errors in Medicare Records

MLN Connects

MLN Connects Special Edition: Moving Prior Authorization into the 21st Century - May 6, 2026

by CMS Administrator Dr. Mehmet Oz

A common practice imposed by health insurers on patients and providers is their intrepid need to second-guess clinician treatment decisions by requiring prior authorizations before paying a claim. The current prior authorization process creates unnecessary delays for patients, burdens health care providers with excessive paperwork, and erodes trust between payers and health care providers, even though all share the same goal: delivering high-quality patient care.

It is way past time to axe the fax, kill the clipboard, and put patients over paperwork.

More Information:

- Full blog
- Electronic Prior Authorization webpage
- Video
- Timeline

MLN Connects - May 7, 2026

MLN Connects® Newsletter for Thursday, May 7, 2026

News

- Electronic Prior Authorization Improvements: Get Involved & Start Testing
- Medicare GLP-1 Bridge Starts July 1
- CMS Extends Deadlines for GENEROUS Model Applications for Drug Manufacturers & States
- HETS Action Required: Enroll Third-Party Vendors for Access by May 11
- Open Payments: Review Your Data by May 15
- Hospitals: Report Clinical Diagnostic Laboratory Data by July 31
- DMEPOS: Send Enrollment Appeals & Rebuttals to Your National Provider Enrollment Contractor
- Medicare Shared Savings Program: Application Toolkit Materials

Compliance

- Global Surgery: Accurately Report Postoperative Visits

MLN Connects

Events

- CCSQ Quarterly Stakeholder Webinar - May 12

MLN Connects - May 14, 2026

MLN Connects® Newsletter for Thursday, May 14, 2026

News

- CMS Announces Early Adopters to Advance Solutions for Electronic Prior Authorization, Accelerating Momentum Ahead of 2027 Requirements
- CMS Announces Aggressive Nationwide Crackdown on Fraud with Six-Month Hospice & Home Health Agency Enrollment Moratoria
- Clinical Diagnostic Laboratories: Report Your Data Through July 31
- Care Compare: CY 2024 Doctors & Clinicians Preview Period Open until June 11
- CMS Identifies Participants in Mandatory Ambulatory Specialty Model
- National Mental Health Awareness Month

Compliance

- Remote Patient Monitoring: Use & Bill Correctly
- Suction Pumps: Prevent Claim Denials

Claims, Pricers & Codes

- Bone Growth Stimulators Reclassified as Class II Devices: Get Updated Billing Information

MLN Matters® Articles

- Acute Kidney Injury & ESRD Billing: Ending the AX Modifier Requirement - Revised

From Our Federal Partners

- 2026 Multi-country Hantavirus Cluster Linked to Cruise Ship

MLN Connects

MLN Connects - May 21, 2026

MLN Connects® Newsletter for Thursday, May 21, 2026

News

- Critical Access Hospitals: Download Your FY 2025 PEPPER
- Clinical Laboratory Fee Schedule Preliminary Gapfill Rates: Submit Comments by July 13
- Clinical Diagnostic Laboratory Reporting: Are You an Applicable Lab?
- Hospitals: Accurately Report Allogeneic Hematopoietic Stem Cell Acquisition Costs
- Nursing Homes: Payroll Based Journal Manual & FAQ Updates
- National Physical Fitness & Sports Month

Events

- Clinical Laboratory Fee Schedule Annual Public Meeting - June 10

MLN Matters® Articles

- Clinical Laboratory Fee Schedule & Clinical Laboratory Improvement Amendments HCPCS Codes, Waived Tests & Reasonable Charge Payments: July 2026 Quarterly Update

Publications & Multimedia

- Clinical Laboratory Fee Schedule: Data Reporting Template & NPI TIN Association Videos

From Our Federal Partners

- 2026 Hantavirus Outbreak: Testing for Potential Infection

MLN Connects - May 28, 2026

MLN Connects® Newsletter for Thursday, May 28, 2026

News

- PEPPER Relaunch for All Facility Types: Get Ready Now
- Clinical Diagnostic Laboratories: Report Your Data Through July 31
- DMEPOS Benefit Category Determinations

MLN Connects

Compliance

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

From Our Federal Partners

- Ebola Disease Outbreak in the Democratic Republic of the Congo & Uganda

MLN Matters

DMEPOS Fee Schedule: CY 2026 Update

Related CR Release Date: December 19, 2025

MLN Matters Number: MM14326

Effective Date: January 1, 2026

Related Change Request (CR) Number: CR 14326

Implementation Date: January 5, 2026

Related CR Transmittal Number: R13519CP

CR 14326 tells you about:

- Fees for new codes
- Annual covered item fee updates

Make sure your billing staff knows about the updated payment policies to the DMEPOS fee schedule effective January 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14326.

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

Number: 14177 Revised

Revised Release Date: January 30, 2026

Effective Date: June 9, 2025

Implementation Date: October 22, 2025

Transmittal Numbers: R13374CP, R13374NCD, R13611CP & R13611NCD

What's Changed? CMS revised this article to remove HCPCS code E0465 and the ICD-10 diagnosis codes; Medicare Administrative Contractors will manage all ICD-10 diagnosis codes locally. CMS also updated the CR release date, transmittal numbers, and transmittal links. Substantive content changes are in dark red (page 2).

CR 14177 updates Medicare coverage guidance for:

- 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.

MLN Matters

Medicare Deductible, Coinsurance & Premium Rates: CY 2026 Update

Related CR Release Date: December 5, 2025

MLN Matters Number: MM14279

Effective Date: January 1, 2026

Related Change Request (CR) Number: CR 14279

Implementation Date: January 5, 2026

Related CR Transmittal Number: R13504GI

CR 14279 tells you about:

- Deductibles
- Coinsurance rates
- Premiums

Make sure your billing staff knows about CY 2026 Medicare Part A and Medicare Part B.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14279.

Contacts, Resources, and Reminders

Jurisdiction D 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.

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.

Contacts, Resources, and Reminders

How do I request a Telephone Reopening?

To request a reopening via telephone, call 1-877-320-0390.

What are the hours for Telephone Reopenings?

Monday - Friday 8 a.m. - 6 p.m. CT

Closures:

- Holiday Schedule
- Training Closures

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

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

Verified by Customer Service Representative (CSR) or IVR:

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

Verified by CSR:

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

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

What may I request as a Telephone Reopening?

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

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

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

What is not accepted as a Telephone Reopening?

The following will not be accepted as a Telephone Reopening and must be submitted as a redetermination with supporting documentation:

- Overutilization denials that require supporting medical records
- Certificate of Medical Necessity (CMN) issues (applies to Telephone Reopenings only)
- Durable Medical Equipment Information Form (DIF) issues (applies to both Written and Telephone Reopenings)
- Oxygen break in service (BIS) issues
- Overpayments or reductions in payment. Submit request on Overpayment Refund Form
- Medicare Secondary Payer (MSP) issues
- Claims denied for timely filing (older than one year from initial determination)
- Complex Medical Reviews or Additional Documentation Requests (ADRs)
- Change in liability
- Recovery Auditor-related items
- Certain modifier changes or additions: EY, GA, GY, GZ, K0 - K4, KX, RA (cannot be added), RB, RP
- Certain HCPCS codes: E0194, E1028, K0108, K0462, L4210, All HCPCS in Transcutaneous Electrical Nerve Stimulator (TENS) LCD, All National Drug Codes (NDCs), miscellaneous codes and codes that require manual pricing

The above is not an all-inclusive list.

What do I do when I have a large amount of corrections?

If a supplier has at least 10 of the same correction, that are able to be completed as a reopening, the supplier should notify a Telephone Reopenings representative. The representative will gather the required information for the supplier to submit a Special Project.

Contacts, Resources, and Reminders

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.