Medicare A News

Jurisdiction E
July 2026

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACM Questions and Answers - March 5, 2027

Written Questions

Q1: For ambulance billing, what are the requirements for providers being listed on the claim? We have come across a few claims that now require the provider for certain codes. Is this correct? If so, which codes require the provider's information?
A1: For Medicare ambulance claims, a rendering/servicing practitioner National Provider Identifier (NPI) is generally not required. Ambulance services are billed under the ambulance supplier or hospital, not under an individual practitioner. Claims that "require a provider" are typically the result of claim-form placement rules, billing provider versus rendering provider distinctions, or non-ambulance services being billed on the same claim, not because specific ambulance HCPCS codes require a practitioner NPI. On its Part B ambulance pages, Noridian explicitly states in CMS-1500 claim item 24J (Rendering Provider) - "Not required for ambulance suppliers."

Q2: Is the work Relative Value Unit (RVU) included in the UB-04 revenue code 42X, 43X, or 44X reimbursement for hospital outpatient rehab (place of service 22) services performed by hospital-employed physical therapist (PT), occupational therapist (OT), or speech language therapist (SLP) providers? If not, can a hospital outpatient department bill for the facility charge using revenue code 42X, 43X, or 44X as well as billing on a CMS-1500 claim form for professional RVU work for PT, OT, and SLP providers professional services?
A2: No. Facility billing does not include work RVUs. RVUs are calculated only for services reimbursed under Medicare Physician Fee Schedule (MPFS). Hospital-employed therapists cannot bill separately for professional services. Hospital-based therapy services are paid under Outpatient Prospective Payment System (OPPS), which uses ambulatory payment classifications (APCs) based on the UB revenue codes (42X, 43X, 44X). The professional component is already accounted for within the hospital payment structure.

Q3: Can we include time spent in the care of the patient from providers operating within the scope of their practice and within their license who are not billable Medicare providers (i.e., Doctor of naturopathy, massage therapist)?
A3: Chronic Care Management (CCM) services may include time spent by the billing provider and by clinical staff who are employed by or under contract with the billing provider. When a clinician working under the billing provider performs services to manage the patient's chronic conditions, and those services are included in the established CCM care plan, that time may be counted toward the monthly CCM time.

Q4: On the 2026 HCPCS quarterly update file, code Q4106 (dermagraft) is clearly marked as discontinued. We can't default to Q4100 (skin substitute) as this not otherwise classified (NOC) code is also discontinued. However, on Addendum B, there is a proposed price and shows change to status indicate S1 along with the other skin substitutes. Also, it is still listed as covered on Local Coverage Determination (LCD)/Billing article A59628 starting January 1, 2026. Is there a proposed HCPCS change or crosswalk for Q4106? How is this submitted on a claim if Q4106 is discontinued?
A4: Use and billing of these questions are not well-defined by CMS, other than all presently cleared products by 510(k), PMA (Premarket Approval) and 361 pathways are now called "non-BLA" (non- Biologics License Application) products and consistent with their HCPCS granted code descriptor, they are dressings billed "incident to" at a set rate/sq cm by CMS.

However, they cannot be billed as skin substitutes in association with the skin sub application codes because they are not considered skin substitute allografts. At present, there are no Food and Drug Administration (FDA)-cleared BLA products eligible for billing as a biologic skin substitute.

Per the 2026 Physician Final Rule, they will be billed as "incident to"; but since they are not considered skin substitutes eligible for billing with the skin substitute CPT codes, they technically are nothing more than dressings. Dressings separately billable are DME products.

Q5: We are requesting direction from Noridian regarding a conflict between LCD billing requirements and American Hospital Association/CMS Coding guidelines for the Inspire Implant (Hypoglossal Nerve Stimulation for Obstructive Sleep Apnea (OSA)). The LCD requires a secondary body mass index (BMI) Z-code, but ICD-10 has no diagnosis that clinically supports assigning a BMI Z-code (Z68.1-Z68.24) for patients with normal BMI (18.5-25). AHA Coding Clinic guidance, Official Guidelines Section I.B.14, states that a related diagnosis (e.g., overweight or obesity) must be documented by the provider in order to assign a BMI Z-code. We understand the LCD's intent is to confirm BMI <35; however, for patients with a normal BMI, assigning a BMI Z-code would be clinically inappropriate, leaving these cases subject to final denial. Given these conflicting requirements, how should providers report BMI for patients with a normal BMI so claims are not denied?
A5: The LCD and Billing and Coding articles are being updated to address these concerns. A release date is not yet known, so Noridian advises providers to watch the website for notifications of those updates being implemented. On a related note, in its February 26, 2026, edition of the MLN Connects newsletter, CMS stated that it would be adding six new HCPCS codes to the April 2026 Integrated Outpatient Code Editor (IOCE) for hypoglossal nerve neurostimulators for the treatment of obstructive sleep apnea. The codes will be effective January 1, 2026.

Q6: For Method II billing concerning the outpatient facility claim and the inpatient facility claim, when we have a specialist do a history and physical (H&P) to determine inpatient eligibility, does that professional charge need to fall in Item 21 on a CMS-1500 claim form or does it fall as part of Method II and belong on the outpatient facility claim if it falls before the admission date and time?
A6: If a Critical Access Hospital (CAH) provider is Method II, the H&P to determine inpatient eligibility is billed on the outpatient UB-04 when it falls before the admission date. Professional services billed after admission are billed on the CMS-1500.

Q7: We are a CAH. When a beneficiary has Medicare on the day of inpatient admission and changes to a Medicare Advantage plan during their inpatient stay, is the claim for the entire stay billed to Medicare or split between Medicare and the Medicare Advantage plan? When a beneficiary has a Medicare Advantage plan on the day of inpatient admission and changes to a Medicare during their inpatient stay, is the claim for the entire stay billed to the Medicare Advantage or split between the Medicare Advantage plan and Medicare?
A7: If a facility is exempt from the prospective payment system, such as a CAH, children's hospital, cancer hospital, or a Maryland waiver hospital, then the facility splits their claim and bills each payer accordingly.

Q8: According to article titled Billing and Coding Guidelines for CV-016; Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring), it states "When submitting claims for the recording only (CPT code 93225) or for the analysis with report only (CPT code 93226) use the date the service (DOS) performed as the DOS." Is the intent of this to ensure that the DOS is accurate when billing both services on the same claim or is it expected that each charge is on a separate claim because they are on different days?
A8: We are unable to address the article referenced as "CV 016," as we do not know its origin or ownership. However, Noridian would like to highlight the CMS guidance outlined in MLN SE17023. According to coding convention, when the technical (TC) and professional (PC) components of a service are performed by different providers, each provider is expected to submit a separate Medicare claim for the component they furnished. Conversely, when a single provider performs both the PC and TC components, that provider should bill the global code instead once all services included in the code descriptor have been completed.

Q9: According to the Noridian Part B Electrocardiographic Monitoring Services Billing page, it states, "Electrocardiographic monitoring codes must be billed in sets." Can Noridian clarify if "set" is related to the previous question (Question 8) and should be billed together?
A9: When Noridian refers to services being "billed in sets," this pertains to the set of codes describing different components of the same service. If the PC and TC

components must be billed separately and the global code is not appropriate, the expectation is that the TC and PC components correspond to the same CPT code. It would not be appropriate to bill the TC component of one CPT code together with the PC component of a different CPT code on the same Medicare claim. In this case, since the PC/TC components are described by different CPT codes altogether, one would still expect the same concept to apply. An example of this type of scenario is posted on the table on our Noridian Medicare webpage. The set of codes that make up the different components of the same service are listed in rows.

Q10: Regarding echocardiogram orders versus documentation and what to bill, for professional billing, is the expectation to bill the same CPT code for the technical and professional components based on what was ordered (medical necessity) and performed or is the professional coding based on what was interpreted by the reading provider? Example: A limited echo is ordered (93308) and performed. However, the physician reports on all components required for a full study (93306), even though he says "poorly visualized" for most of them. Should the provider report 93308 or 93306?
A10: Coding rules dictate that if the PC/TC components of a service were billed separately to Medicare, it would be the same CPT code with the 26 and TC modifiers added respectively. The same concept applies if CPT code 93306 was ordered and the technical component of that service was performed by the echo tech. Then the expectation is the professional component of CPT 93306 would be performed and subsequently billed. If the provider performs more than what the code descriptor includes, this does not mean a different CPT code for the PC component would be billed.

Q11: Does the Medicare Advantage (MA) rate for supplemental payments need to be revised yearly?
A11: Yes, eligible Federally Qualified Health Centers (FQHCs) report actual MA revenue and visits on their cost reports. At the end of each cost reporting period the MAC uses actual MA revenue and visit data along with the FQHCs final all-inclusive payment rate to determine the FQHC;s final actual supplemental per visit payment. Once this amount (per visit basis) is determined it will serve as the interim rate for the next full rate year. Actual aggregated supplemental payments will then be reconciled with aggregated interim supplemental payments, and any underpayment or overpayment thereon will then be accounted for in determining final Medicare FQHC program liability at cost settlement.

Q12: Will there be a dedicated portal for the Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD), that is beginning May 1, 2026, or will the Noridian Medicare Portal (NMP) be modified to allow RCD documentation submission and unique tracking number (UTN) tracking? Will there be any RCD webinars prior to the implementation?
A12: Yes. This question and answer is relevant for California IRFs and Units (IRUs) who

are participating in the RCD. Functionality within the NMP to accommodate the choice selection period will go live on March 16, with the remaining functionality to go live on May 1. Noridian has already begun a weekly webinar series on IRF RCD that will run in March and April. Content on the JEA section of the Noridian website has just been published for IRF RCD, as well as updates to the NMP user manual. Please check out these new resources if your work overlaps IRF services in the state of California.

Q13: As a CAH Method II facility, please clarify how Certified Registered Nurse Anesthetist (CRNA) professional charges are to be billed. Our facility does not qualify for the pass-through exception due to the number of surgeries we do. We have not had an active CRNA cert on file with Medicare since July 1, 2020. Do we continue to bill our CRNA professional charges on the UB004 claim? If so, which revenue code should we be using? Should the QZ modifier be used? Or since we do not qualify for the pass-through exception, do we bill the CRNA professional charges on a 1500 claim form even though we are Method II?

A13: As a Method II CAH without the CRNA pass through exemption, you must continue billing CRNA professional services on the UB 04 (TOB 85X) using revenue code 0964. Because you do not qualify for the pass-through exemption, CRNA services are paid under the Method II professional rate calculation, and QZ should be used when the CRNA is non-medically directed. See the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 250.3.3.2 for more information.

Q14. Please provide clarification when billing CPT 63047 (posterior spinal decompression procedure) to Medicare for both the technical and professional charge. Does Medicare require a laterality modifier even though this CPT code is a unilateral code? Does Medicare allow a surgery assist by a Nurse Practitioner for this CPT code?

A14: CPT code 63047 code description encompasses both unilateral and bilateral procedures. It is considered a "non-paired" structure code and describes physician services. The concept of PC/TC does not apply since physician services cannot be split into professional and technical components. Laterality modifiers would not apply since this code reimburses as a unilateral or bilateral service.

Q15: Which modifiers should be used when a surgery assist is done by a Nurse Practitioner (NP)?

A15: Surgery assist performed for Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist would append modifier AS.

Q16: LCD L35170 states that providers must use each drug according to FDA-approved indications unless there are valid, documented reasons for using an unapproved/off-label form. It also instructs providers to consult each neurotoxin's package insert for FDA-approved indications, and to reference FDA manufacturer recommendations or the AHFS for appropriate dosing. According to the FDA prescribing information for Botox,

the recommended total dose for chronic migraine is 155 units, with allowable range of 155-195 units. Given the additional discretionary 40 units above the recommended 155-unit dose, are there any restrictions on where these units may be injected within the head/neck muscle groups? May providers follow pain protocol and inject based on the patient's reported areas of pain?
A16: The location of injection in the head/neck muscles are limited to those listed in LCD. Other muscles injected would not be presumed to be reasonable and necessary and may deny. Such cases may be reviewed on appeal with supporting documentation to determine if they are reasonable and necessary.

Q17: Do we use Q-codes for non-graft wound dressings (e.g., gel, powder, ointment, foam, liquid, or injected skin substitutes)?
A17: Skin substitute Q codes must not be used for non graft wound dressings such as gels, powders, ointments, foams, liquids, or injected products, because these items are not considered skin substitute grafts and are treated solely as supplies, which are not separately payable in physician offices and are packaged under facility billing. Under the 2026 CMS Final Rule, all non BLA skin substitute products are now classified as "incident to" supplies rather than biologics, and CMS confirms that no currently marketed products meet FDA 351 BLA graft criteria, making the skin substitute application codes inapplicable and unbillable at this time. CMS has issued no new instructions for billing these "incident to" supplies, and none of these products may be billed with skin substitute codes under current policy.

Q18: Seeking clarification on documentation of formal shared decision making (SDM). Does the non-implanting physician who performs SDM need to complete a separate document such as an evaluation and management (E/M) note or referral note on the discussion they had with the patient about anticoagulation, or can the implanting physician verify in their evaluation note that SDM occurred, by who, and that criteria has been met to proceed? Ultimately it is the implanting provider that is attesting the patient's "must have" indications have been met. The National Coverage Determination (NCD) states that SDM must be an independent non-interventional physician. However, other NCDs such as 20.4 for implantable cardioverter defibrillators, allow qualified nonphysician practitioners to complete SDM. For LAAO (Left Atrial Appendage Occlusion), can SDM be completed by an independent, non-interventional, qualified nonphysician practitioner? Can SDM be completed through a video visit?
A18: The NCD requires documentation establishing the appropriateness of the procedure, based on a full history and physical examination performed by a physician (as explicitly stated in the NCD) with full scope of practice and nationally recognized training and credentialing; Non physician practitioners (NPPs) do not meet this requirement. An independent, non interventional physician must use an evidence based decision tool to document alternatives and contraindications, with all findings, labs,

procedural data, dates, and times included in the medical record. This documentation must be complete, available to Medicare upon request, and cannot rely solely on references in the implanting physician's notes. Telemedicine is not permitted for this evaluation. The record must also document the qualifying facility's capabilities and compliance with the NCD, and all coverage criteria must be fully supported in the medical record by appropriately qualified physicians across all contributing specialties.

Verbal Questions

Q19: Regarding FQHC distant telehealth services and code G2025, the newest update indicates the extension of flexibilities through December 31, 2027, but claims are hitting RTP for edit 36477. When can we expect these claims to be released? We called Customer Service, but they indicated it could be up to 45 days to respond.
A19: Jan is reaching out to Tanya - Ultimate Health Services, Los Angelas CA

Q20: For Q8 on holter monitoring, the answer suggested billing technical and professional together. For that service, there are two charges: A hook and when the patient returns the monitor, there is a scan charge. These two charges are a set. Does Noridian expect both charges to be on the same claim or because they are on different dates of service, do they need to be on different claims?
A20: Based on MLN SE17023, CMS guidance addresses how to determine the correct date of service for each component of a Holter monitoring claim. It does not require that the services be submitted on a single claim or split across two claims.

Whether one or two claims are used can depend on whether different entities are responsible for the individual components. If separate organizations each perform and bill for only one part of the service, submitting separate claims may be necessary. Ultimately, the billing approach depends on how your clinic has structured its Holter monitoring process, including equipment ownership, setup responsibilities, and assigned roles.

Q21: Regarding question 13 on CRNA charges, is the QZ modifier required on the professional line of the claim? In the past, we did append the QZ but the claims were RTPing.
A21: Providers need to be approved to bill Method II. If a CAH would like to bill their CRNAs Method II, they will need to submit a request to do so no later than 30 days prior to their next fiscal year begin date. This request must include a request letter on hospital letterhead signed by an authorized official, a list of all CRNAs that will be billing Method II including their NPIs, and copies of the 855I or Approved Medicare Enrollment Record (from PECOS) for each CRNA. and The QZ modifier should be used when the CRNA is non-medically directed. See the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 250.3.3.2 for more information.

Q22: Is the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Lookup for all jurisdictions?
A22: Yes. It is for both JE and JF.

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.

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

News

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 2540-24 and 2540-10 Transition to Automated Tentative Settlements

Effective April 22, 2026, all CMS Form 2540-24 and 2540-10 cost reports received on or after this date will feature a redesigned Tentative Settlement (TS) letter. These calculations will now be automated through the System for Tracking Audit and Reimbursement (STAR), replacing the previous manual process. This automation applies to both as filed and amended cost reports.

The new TS letters will incorporate payment data from the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the applicable fiscal year end (FYE). All cost reports, whether submitted electronically or by mail, will be processed through STAR. TS letters will continue to be sent to each provider's designated STAR contact, maintaining the existing communication protocol.

Important Guidance for Worksheet E-1 Reporting

With this transition, it is essential that providers follow the cost report instructions carefully when recording interim lump sum and biweekly payments on Worksheet E-1. Accurate reporting is critical to ensure correct tentative settlements.

Key requirements:

- Do not record lump sum payments on Worksheet E-1, Line 1.
    - Lump sum payments must be reported on the subscripts of Lines 3.01 and/or 3.50.
- Bi-Weekly Payments (PT, PIP, TOPS) should be added to the Net Reimbursement amount from the PS&R and recorded on Worksheet E-1 **Line 1**

- Payments should be recorded as issued, organized separately by date, Part A or Part B, and provider unit, not grouped together.
- The automated calculation interfaces with the CMS financial system and will only include or exclude lump sum payments if they are recorded correctly.
- If a provider is submitting an amended cost report, they should also include previous tentative settlement amounts on Worksheet E-1. This ensures continuity and accuracy in the automated calculation process.

Failure to comply with these instructions may result in an incorrect tentative settlement.

If you have any questions, please contact our Provider Contact Center (PCC) for assistance.

CMS to Implement Consistency Editing for Provider-Based Department Claims on July 6, 2026

On February 19, 2026, CMS declared in Change Request (CR) 14382 that it would implement consistency edits for provider-based department (PBD) claims on July 6, 2026, with an effective date of July 1. No new policy is being implemented as a result of this CR.

The new edit will tighten consistency of processing on outpatient off-campus PBD claims that are required to contain a modifier ER, PO, or PN. There are few exceptions to this rule. Any PBD claims that are missing one of these modifiers will Return to Provider (RTP).

Read the full CR 14382.

ESRD Transition to Automated Tentative Settlements

Effective May 29, 2026, cost reports received on or after this date will feature a redesigned Tentative Settlement (TS) letter. These calculations will now be automated through the System for Tracking Audit and Reimbursement (STAR), replacing the previous manual process. This automation applies to both as-filed and amended cost reports.

The new TS letters will incorporate payment data from the Healthcare Integrated General Ledger Accounting System (HIGLAS) for the applicable fiscal year end (FYE). All cost reports, whether submitted electronically or by mail, will be processed through STAR. TS letters will continue to be sent to each provider's designated STAR contact, maintaining the existing communication protocol.

Failure to comply with these instructions may result in an incorrect tentative settlement.

If you have any questions, please contact our Provider Contact Center (PCC) for assistance.

First Quarter Top Return to Provider (RTP) Claim Errors

Reason Code **W7021**- Critical Access Hospital (CAH) Method II claims, the claim contains a medical visit code assigned status indicator V or J2 on same DOS as procedure assigned status indicator "T" or "S" but modifier 25 not reported.

How to avoid or correct this error:

- CR14288 January 2026 Integrated Outpatient Code Editor (I/OCE) Specifications Version 27.0
- New Documentation: Sub section Medical Visit Processing for CAHs added to expand on visit logic applicable for edit 21
- January 2026 Integrated Outpatient Code Editor - Refer to section 6.9 Medical Visit Processing for CAHs

Reason Code **U5065** - MBI is invalid; Claim from date is prior to the MBI effective date on the CWF crosswalk File and the MBI is the oldest occurrence in the HICXWALK File for the Beneficiary at CWF.

- Verify the MBI utilizing the MBI Lookup Inquiry- Portal Guide- Noridian
- Correct to the current MBI, and resubmit claim

Reason Code **34963** - Attending Physician on Claim Page 05 is invalid or not present in the PECOS Enrolled Physicians file, Type C Records or Attending Physician NPI is present on the PECOS Enrolled Physicians file, but the first four characters of the last name do not match or the claim has a Through Date of Service equal or greater than the Termination Date on the PECOS Enrolled Physician Inquiry screen (MAP1B52).

- JEA Reason Code Guidance Page

Reason Code **38105** - Whether any revenue code lines are equal or not, outpatient types of bill (13X, 14X, 83X, or 85X) cannot have overlapping dates when the provider numbers are equal unless:

- One of the claims is for a Pap smear only
- One of the claims is for mammography screening only
- The outpatient claim has a span code 74, and the ASC claim has a date of service within the span code 74 dates
- The 14X and 83X are from a Maryland waiver provider (MWI = Y), and the 14X contains lab only while the 83X does not contain labs
- One of the claims is for repetitive Part B services only for CAH (85X) type of bill
    - JEA Reason Code Guidance Page

News

Heart Assist Registry Transplant Organ Type

The Centers for Medicare & Medicaid Services (CMS) would like to inform the provider community about a recent update related to transplant program data and claims processing. Change Request (CR) 14262 was implemented to improve data accuracy between the Provider Enrollment, Chain and Ownership System (PECOS) and the Fiscal Intermediary Shared System (FISS). The goal of this effort is to ensure that transplant program organ type information is consistent across both systems, helping reduce claim processing issues and improve overall data integrity.

As part of this change, transplant program information from the Quality, Certification and Oversight Reports (QCOR) system was loaded into PECOS. However, it has been brought to our attention that providers associated with the Heart Assist Registry (HAR) organ type were not included in this data load. As a result, some claims have been returned to providers (RTP), creating unnecessary delays and administrative burden.

To address this issue and prevent further claim disruptions, Medicare Administrative Contractors (MACs) will manually update PECOS to include the HAR organ type for all applicable providers. These updates will be based on the list of approved facilities available on the CMS Ventricular Assist Devices (VAD) webpage.

If MACs identify additional providers that are certified with the HAR organ type but are not listed, they will follow the same manual process to ensure those providers are accurately recorded in PECOS. This action is critical to ensure claims process correctly and without delay.

Hospice: Download Your FY 2025 PEPPER

CMS released the FY 2025 Program for Evaluating Payment Patterns Electronic Reports (PEPPERs) for hospices. PEPPER helps hospices review their billing data to make sure claims are accurate. They can use it to:

- Spot billing patterns that may need improvement
- Identify areas that may need audits or closer monitoring
- Find Diagnosis-Related Groups that may be under-coded or over-coded
- Track areas where patient stays are getting longer

How to Get Your PEPPER

Authorized Officials (AOs), Access Managers (AMs), and Staff End Users (SEUs) can now download their organization's PEPPER from the PEPPER Portal.

How to become an SEU and access your organization's PEPPER:

- Sign in to the CMS I&A System using your existing NPPES or PECOS credentials
- Request the PEPPER business function under your organization
- Your request must be approved by your AO or AM
- Once approved, SEUs can log in to the PEPPER Portal and download their organization's PEPPER

Step by step instructions for AOs and AMs are available in the I&A Quick Reference Guide and Frequently Asked Questions (FAQs).

For assistance, users may contact the PECOS External User Services (EUS) Help Desk.

More Information:

- Review the Hospice PEPPER User Guide
- Register for the webinar on Wednesday, June 24, 2026, at 1:00 p.m. ET

Hospitals: Report Clinical Diagnostic Laboratory Data by July 31

Hospitals: If you bill on a 14x type of bill, you likely meet the definition of an applicable laboratory under the Clinical Laboratory Fee Schedule (CLFS). Use these resources to check your status:

- Determining Applicable Status of a Hospital Outreach Laboratory (PDF) quick reference guide
- Is My Lab an Applicable Lab? video

If you're an applicable lab, you must report your data by July 31, 2026. Visit the CLFS & PAMA Reporting and Resources webpage for more information.

Source:

- CMS *MLN Connects* dated May 7, 2026

Hyaluronic Acid Knee Injections: Common Billing Errors

Common Billing and Documentation Issues

- Incorrect billing units: Ensure units billed match the dosage administered and the drug's billing guidelines, especially for single-dose vs. multi-dose vials.
- Modifier misuse: Do not report the JW modifier for multi-dose vials. Use modifiers appropriately based on CMS guidance.

- Insufficient documentation: Medical records must support the medical necessity of the injection, including diagnosis, prior treatment history, and rationale for therapy.
- Coding inaccuracies: Confirm correct HCPCS codes are reported for the specific product used, along with any applicable modifiers.

Similar issues have been identified in other injectable services, including IVIG, ophthalmology injections, and vitamin B12 injections. Common themes include incorrect units, modifier errors, and lack of documentation to support services billed.

To reduce errors and prevent denials, providers should:

- Verify correct drug billing units and HCPCS codes prior to claim submission
- Review proper use of modifiers for drug wastage and administration
- Ensure documentation clearly supports medical necessity and details the service provided
- Conduct internal audits of injectable drug billing and coding practices

If local coverage policies are not available, review CMS guidance, Noridian billing resources, and professional coding references to confirm correct billing practices.

Hyperbaric Oxygen Therapy (HBOT) Billing Pitfalls: Why NCD 20.29 Still Triggers Denials

One of the most common Medicare billing issues in HBOT is failure to meet coverage requirements under NCD 20.29, particularly related to non covered diagnoses. Medicare strictly limits HBOT to a defined list of conditions, and claims will be denied if the diagnosis does not match or if HBOT is used as a primary rather than adjunctive therapy. A high-risk area is diabetic wounds, where all criteria must be met (Type I/II diabetes, Wagner Grade III or higher), and documented failure of at least 30 days of standard wound care with no measurable improvement. A frequent provider pitfall is initiating HBOT too early without sufficient documentation of failed conservative treatment, resulting in avoidable denials.

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.

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

Method II CAHs bill for facility and professional outpatient services only when physicians or practitioners reassign their billing rights to the CAH. CAHs must submit the reassignment application through PECOS or the paper Form CMS-855I.

Certain CAH claims were incorrectly returned with Fiscal Intermediary Shared System (FISS) reason codes 31006 and 31007 indicating that providers don't have a reassignment on file in PECOS. CMS has agreed to temporarily turn off reason codes 31006 and 31007 for all dates of service. To address this issue, Medicare Administrative Contractors (MACs) stopped returning these claims with dates of service in 2025 and 2026. They will reprocess claims that were incorrectly returned since January 1, 2026. Payments should be issued in approximately two weeks.

CAHs do not need to take any action. You can get claims status information on your MAC portal and through FISS Direct Data Entry. If you identify any discrepancies with your PECOS record, contact Noridian.

Physicians and practitioners: Make sure you accurately reassign benefits to CAHs; see the Information for Critical Access Hospitals booklet for more information.

National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Lookup Tool

Noridian is excited to announce its new National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Lookup Tool. This tool will allow providers to enter a procedure code and see what services it normally can't be billed with. Noridian encourages providers to utilize this tool to assist with resolving bundling denials they

may receive. Details of this new tool can be found on National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Lookup page.

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

Reminder: Proper Use of JW and JZ Modifiers for Drug Billing

Accurate billing for drugs and biologicals requires careful attention to CMS guidelines, particularly when addressing unused or discarded amounts from single-use vials or packages. The use of the JW and JZ modifiers plays a critical role in ensuring compliance and proper reimbursement.

CMS requires providers to accurately report the administration and any discarded portions of drugs or biologicals from single-dose containers. When billing:

- Providers must report any unused portion that is appropriately discarded, or
- Indicate there was zero amount discarded

In addition, billed units must align with the smallest dosage available from the manufacturer that can appropriately meet the patient's needs while minimizing wastage. This expectation reinforces the importance of both precision and compliance in drug billing practices.

Modifier JW is used to report the amount of drug that is discarded and not administered to any patient.

Use JW:

- Measurable amount of drug remaining in single-use vial or package
- Unused portion properly discarded and not used for another patient

In these cases:

- Administered amount and discarded amount are typically billed on separate claim lines
- JW modifier is appended to the line that reflects the discarded portion

Correct use of the JW modifier ensures transparency in billing and allows for appropriate reimbursement of drug wastage when applicable.

Modifier JZ is used to indicate that no amount of drug was discarded or not administered to any patient.

Use JZ:

- Entire dose from a single-use vial or package is administered, or
- No billable discarded amount

CMS requires the JZ modifier in scenarios where no wastage is present to clearly attest that zero drug wastage occurred.

This requirement ensures complete reporting, even when wastage is not applicable.

The Difference Between Outpatient Therapy Recertifications and Re-evaluations

These concepts are often confused or used interchangeably, yet they serve very different regulatory and clinical purposes. Understanding the distinction is critical to medical review compliance, CERT risk reduction, and accurate billing.

Certification is the physician's/nonphysician practitioner's (NPP) approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care.

Outpatient therapy recertification is a regulatory requirement tied to Medicare for payment and coverage, not a clinical service. Medicare requires that the patient's plan of care be periodically reviewed, dated, and signed by a physician or qualified nonphysician practitioner at least every 90 days, including services provided in comprehensive outpatient rehabilitation facilities, unless delayed certification provisions apply. Recertification confirms the practitioner's approval of the plan of care and the medical necessity for continued services. It does not require a patient encounter and is not separately billable.

In contrast, re-evaluation provides additional objective information not included in other documentation. Re-evaluation is separately payable and is periodically indicated during an episode of care when the professional assessment of a clinician indicates a significant improvement, or decline, or change in the patient's condition or functional status that was not anticipated in the plan of care. Although some state regulations and state practice acts require re-evaluation at specific times, for Medicare payment, reevaluations must also meet Medicare coverage guidelines. The decision to provide a reevaluation shall be made by a clinician.

In summary, recertification is a time-based administrative requirement necessary to maintain coverage, while re evaluation is a patient specific, clinical decision driven by changes in functional status or progress. Clearly distinguishing and appropriately documenting each process is essential to support medical necessity, ensure accurate billing, and reduce audit and review risk.

Reference

CMS Internet Only Manual (IOM), Publication 100-02 Medicare Benefit Policy Manual, Chapter 15, Section 220

News

Respiratory Care in Skilled Nursing Facility

Respiratory care services furnished to a beneficiary residing in a Skilled Nursing Facility (SNF) will be included in the Part A stay. As such, these services are bundled in the facility's payment and are not separately billable. When a beneficiary is no longer eligible for Part A benefits (i.e., benefits exhausted), respiratory care services are not payable under Part B in the SNF setting and will be denied.

CMS provides clear guidance in the CMS Internet Only Manual (IOM), Publication 100-04, Medicare Claims Processing Manual, Chapter 7, section 10.1.1

- Directs the Standard System Maintainer (SSM) to prevent payment for SNF inpatient claims (Type of Bill (TOB) 22x) that include revenue code 041x (respiratory services)
- This edit reinforces that respiratory services are included in the SNF Part A bundled payment and are not payable separately

Additionally, CMS IOM, Publication 100-04, Medicare Claims Processing Manual, Chapter 4, Section 240.2 clarifies that when a beneficiary's Part A benefits are exhausted, claims submitted under TOB 012X that include revenue code 041X are not payable. In these scenarios, the services will be denied.

Noridian's Local Coverage Determination (LCD) - Respiratory Care (L34149) outlines the coverage of indications, limitations and medical necessity requirements. The associated Billing and Coding article (A57224) provides further direction on appropriate claim submission. The TOB 22x is not identified as a payable bill type for respiratory care services, consistent with CMS IOM requirements that services are bundled during a SNF Part A stay.

In limited situations involving A to B rebill, respiratory care services may be considered for Part B payment if all applicable criteria are met. However, if the beneficiaries of Part A benefits are exhausted, respiratory services will remain non-payable under Part B and will be denied.

Denial Information

When respiratory services are billed outside of Medicare coverage guidelines, the claim will be denied as a contractual obligation (non-covered charge).

- The denial will include remark code M28, which states:

  "This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available."

This guidance reinforces the importance of understanding bundled payment rules and Medicare billing restrictions when providing respiratory care services in SNF and inpatient settings.

News

Temporary Pause on Certain Claim Denial Codes for Critical Access Hospitals

CMS has directed Medicare Administrative Contractors (MACs) to temporarily stop using two claim denial reason codes-31006 and 31007-effective immediately. This pause follows a March 20, 2026, CMS notification and will remain in place until CMS determines that providers have had enough time to meet the new claims processing requirements.

These reason codes were created as part of Change Request (CR) 13900, which added new checks to confirm that physicians have properly reassigned their Medicare benefits to Critical Access Hospitals (CAHs). The goal of the change was to ensure that reassignment information is on file when CAHs submit claims for professional services.

However, CMS has learned that many providers did not have reassignment records on file in the Provider Enrollment, Chain, and Ownership System (PECOS) for services provided between July 1, 2025, and December 31, 2025. This appears to have happened because some CAHs understood the new requirements to apply only to services starting January 1, 2026, not earlier dates.

Due to this misunderstanding, CMS has decided to temporarily turn off reason codes 31006 and 31007 for all dates of service. This pause will give providers more time to submit claims correctly and allow MACs to offer additional education and guidance to CAHs.

CMS is planning on activating the reason codes again and CAHs need to make sure that they have completed all their reassignments in PECOS prior to that activation or they will find their claims returned to providers.

Tips for Completing the Redetermination Form

The following suggestions will help support the appeal process by clearly identifying what is being requested for review. When instructions are unclear or all lines are selected, it becomes difficult to determine the specific request. When questioning underpayment of the paid lines on the claim, please include the expected reimbursement amount.

Paper/Electronic submission

- List the HCPCS/Procedure codes you are appealing
- Paid lines should only be listed if appealing the paid amount
- Clearly state what you are requesting in the comment section
- Provide complete contact information

- Verify documentation is attached and for the correct beneficiary

Portal submission

- Only select the lines you are appealing
- Paid lines should only be selected if appealing the paid amount
- Clearly state what you are requesting in the comment section
- Verify documentation is attached and for the correct beneficiary

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.

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.

2026 CPT/HCPCS Billing and Coding Article Updates - Effective April 1, 2026

Date Posted: April 2, 2026

The following Billing and Coding Articles have been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Changes: The following Billing and Coding Articles have been updated to include and/or remove CPT/HCPCS codes as well as update descriptions. For description changes, either the short and/or long code description was changed. Note: Depending on which descriptor was used, there may not be any changes to the code display in the article.

MCD Number	Billing and Coding Article Title	New CPT/HCPCS Codes	Deleted CPT/HCPCS Codes	CPT/HCPCS Codes Descriptor changes
A57187	Billing and Coding: Immune Globulin Intravenous (IVIg)	J1553	N/A	N/A

Visit the Billing and Coding Articles webpage or the Active LCD webpage to view the Billing and Coding Article or access it via the CMS Medicare Coverage Database (MCD).

Anesthesia/Sedation for Chronic Pain Management Procedures

This article has been published under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

The Noridian Contractor Medical Directors (CMDs) have published the following Medical Director Education Article on our website:

- Anesthesia/Sedation for Chronic Pain Management Procedures

Visit the Noridian Medical Director Education Articles webpage to view the document.

This article can also be found in the attachments section of the following LCDs in the CMS MCD:

- Epidural Steroid Injection for Pain Management (L39240)
- Facet Joint Interventions for Pain Management (L38801)
- Sacroiliac Joint Injections and Procedures (L39462)

Medical Policies and Coverage

Anterior Segment Intraocular Nonbiodegradable Drug-eluting System - Published for Review and Comments

Date Posted: May 21, 2026

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: DL40359

LCD Title: Anterior Segment Intraocular Nonbiodegradable Drug-eluting System

Comment period: May 21, 2026 - July 4, 2026

Visit the CMS MCD to access Proposed LCDs not released to final LCDs.

Providers may address details for comment submission. When sending comments, reference the specific policy to which they are related. See the Proposed LCDs webpage for email and mail specifics.

Billing and Coding: Botulinum Toxin Injections (A57185) - R13 - Effective April 9, 2026

Date Posted: April 9, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 9, 2026

Summary of Changes:

Updates were made to the article text under the "Cosmetic Use" and "Modifiers JW and JZ" sections.

Under the ICD-10-CM Codes that Support Medical Necessity section the HCPCs codes describing the specific serotypes have been added to the Group Paragraphs.

Under the ICD-10-CM Codes that Support Medical Necessity section, the group for Paralytic ptosis was removed.

Under the CPT/HCPCS Codes section in Group one the following CPT codes have been added: 76881, 76882 and 76536.

Under the ICD-10-CM Codes that Support Medical Necessity Section, ICD-10 Code N32.81 was added to Group 11.

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Medical Policies and Coverage

Billing and Coding: Cervical Fusion (A59624) - R5 - Effective April 9, 2026

Date Posted: April 9, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 9, 2026

Summary of Changes: Under **ICD-10-CM Codes that Support Medical Necessity, Group 1** Codes, added: M47.11, M47.12, M47.13, M47.21, M47.22, and M47.23.

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: Facet Joint Interventions for Pain Management (A58403) - R8 - Effective May 21, 2026

Date Posted: May 21, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 21, 2026

Summary of Changes:

Under Group 1: Medical Necessity ICD-10-CM Codes Asterisk Explanation, added "injection/aspiration (not ablation)" to the following statement:

*To be used for facet cyst injection/aspiration (not ablation).

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57948) - R11 - Effective January 1, 2026

Date Posted: April 23, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2026

Summary of Article Changes: Effective 01/01/2026 - Under Coding Guidelines added HCPCS code C8007 to the Implantation codes list, added HCPCS code C8008 to Revision or replacement codes list, and added HCPCS code C8009 to Removal Codes list.

Effective 1/1/2026 Under CPT/HCPCS Codes, added HCPCS codes C8007, C8008, C8009, under Group 1.

References to Modifier 52 have been removed.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57948) - R12 - Effective January 1, 2026

Date Posted: May 28, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2026

Summary of Article Changes: Effective 01/01/2026

Under Article Text: Added back references to the -52 modifier, with the added statement for dates of services prior to 01/01/2026

Under CPT/HCPCS Modifiers: Group 1: Paragraph - The modifier -52 should be used only when billing for HGNS performed before January 1, 2026.

Group 1: Modifier - Added the 52 modifier.

Under ICD-10 codes that support Medical Necessity: In the previous revision ICD-10 codes Z68.35, Z68.36, Z68.37, Z68.38 and Z68.39 were removed as they were added in error.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Medical Policies and Coverage

Billing and Coding: Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (A57948) - R12 - Effective January 1, 2026

Date Posted: June 18, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2026

Summary of Article Changes: Effective 01/01/2026

Under Article Text:

Removed from the reduced services statements "for dates of service prior to 01/01/2026"

Under CPT/HCPCS Modifiers:

Removed the paragraph statement.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Implantable Automatic Defibrillators (A56340) Retirement - Effective April 6, 2026

Date Posted: April 2, 2026

This Billing and Coding article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 6, 2026

Summary: Retirement of this Billing and Coding article is due to significant updates made to billing and coding instructions related to NCD 20.4. which can be found in the Internet Only Manual (IOM), Medicare Claims Processing Manual (MCPM), Chapter 32, Section 270 and Change Request (CR) related to Transmittal Numbers: R13483CP & R13641CP MM 14253.

Provider offices remain responsible for correct performance, coding, billing, and medical necessity under Medicare. This responsibility for correct claims submission is unchanged whether or not there is a billing and coding article in place.

Visit the CMS Medicare Coverage Database (MCD) to access the Retired articles.

Medical Policies and Coverage

Billing and Coding: Implantable Infusion Pumps for Chronic Pain (A55239) - R25 - Effective April 1, 2026

Date Posted: April 2, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Article Changes: Updated pricing for Prialt (Ziconotide) and Ropivacaine per quarterly ASP Drug File Update:

Effective 04/01/2026 - 06/30/2026

Prialt (Ziconotide) = $10.464

Ropivacaine = $0.046

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Influenza Diagnostic Tests (A59055) Retirement - Effective January 31, 2026

Date Posted: April 16, 2026

This Billing and Coding article has been retired under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 31, 2026

Summary: This billing and coding article is being retired due to current guidance for these codes being included in the following policies:

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT)

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing

Visit the CMS Medicare Coverage Database (MCD) to access the Retired articles.

Medical Policies and Coverage

Billing and Coding: Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (A57079) - R4 - Effective October 1, 2019

Date Posted: April 2, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: October 1, 2019

Summary of Changes:

Under **ICD-10-CM Codes that Support Medical Necessity Group 1 Codes**, added asterisk * to G56.01, G56.02, and G56.03.

Under **Group 1: Medical Necessity ICD-10-CM Codes Asterisk Explanation**, added "*Use G56.01, G56.02, or G56.03 for 20526."

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: Intervertebral Disc Repair (A59882) - R2 - Effective April 13, 2025

Date Posted: June 4, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 13, 2025

Summary of Changes:

Under CPT/HCPCS Codes, Group 1 Paragraph, added:

If using an unspecified CPT/HCPCS code, add the description of "intradiscal injection." Both the procedure and associated drug(s) will be denied.

Use of CPT/HCPCS 62290 for services defined in this policy will be considered incorrect coding.

Under CPT/HCPCS Codes, Group 1 Codes, added: 22899, 64999

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: IUD (Hormone-Eluting) for Endometrial Hyperplasia - CPT 58999 (A55061) - R6 - Effective July 1, 2026

Date Posted: June 25, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: July 1, 2026

Summary of Article Changes:

Revision Effective Date: 07/01/2026

Removed coding guidance in Article Text section as all coding guidance is in the applicable tables.

Deleted the following ICD-10 Code: N85.00

Added the following ICD-10 Codes to Group 1: N84.0, N92.0, N92.1, N92.4, N95.0

Added the following to Group 1 Paragraph: Dual diagnosis required. Must bill Group 2 diagnosis with any of the diagnosis codes in Group 1.

Moved the following ICD-10 Code from Group 1 to Group 2: N85.01

Added the following ICD-10 Codes to Group 2: N85.02

Added the following Group 2: Medical Necessity ICD-10-CM Codes Asterisk Explanation: Codes listed with an asterisk (*) are only to be used if beneficiary is not a surgical candidate.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Micro-Invasive Glaucoma Surgery (MIGS) (A57863) - R10 - Effective June 1, 2026

Date Posted: June 11, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 1, 2026

Summary of Article Changes: Effective 06/01/2026

Under CPT/HCPCS: Group 1 Paragraph:

The following statement was added:

Due to the laterality of eye procedures, modifiers RT, LT or 50 must be used to indicate the eye(s) being treated.

Under Modifier section:

Added RT, LT and 50.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: MolDX: BluePrint® Test (A55115) - R6 - Effective April 1, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** added 0630U. This revision is due to the 2026 Q2 CPT/HCPCS Code Update and is effective 4/1/2026.

Under ***Article Text*** revised 1st bullet to remove "81479-unlisted molecular pathology procedure". Revised 5th and 8th bullets to remove "DEX Z-Code™ " and replaced with "DEX Z-Code®". Added "NOTE: When entering the DEX Z-Code on the SV101-7 documentation field for Part B claims please do not add additional characters and/or information on the line" and "Specific tests that have been evaluated for compliance with coverage criteria set in policy (and are thus covered or not covered) can be found in the DEX® registry". Under ***CPT/HCPCS Codes Group 1: Codes*** deleted 81479. This revision is effective 4/1/2026

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Minimal Residual Disease Testing for Solid Tumor Cancers (A58454) - R18 - Effective June 25, 2026

Date Posted: June 25, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: Multiple dates

Summary of Changes:

Under ***Article Text*** revised Table 1 row 3 to add "NeXT Personal - Personalized WGS Assay Design + Plasma Series Bundle (Personalis, Inc)". Under ***subheading Additional Test-specific Indications***, Limitations and Instructions revised 3rd sentence to add "or stage IV (NeXT Personal)". This revision is due to a new covered test that has successfully completed a TA and is effective for 3/16/2026.

Under ***Article Text*** revised Table 1 row 9 to add "TrueMRD Assay Design + single Plasma Test (Veracyte, Inc)". Revised Table 1 row 10 to add "TrueMRD single Plasma Test (Veracyte, Inc)". Under ***subheading Additional Test-specific Indications, Limitations and Instructions*** revised 2nd sentence to add "and muscle invasive bladder cancer (TrueMRD)". This revision is due to a new covered test that has successfully completed a TA and is effective for 11/24/2025.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Molecular Biomarkers to Risk-Stratify Patients at Increased Risk for Prostate Cancer (A58718) - R7 - Effective June 25, 2026

Date Posted: June 25, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 11, 2026

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Paragraph*** added "ExoDX Prostate assay (PLA 0005U), performed on non-DRE urine specimens". Under CPT/HCPCS Codes Group 1: Codes added 0005U. Under ***CPT/HCPCS Codes Group 2: Paragraph*** added "ExoDX Prostate assay (PLA 0005U), performed on non-DRE urine specimens". Under ***CPT/HCPCS Codes*** Group 2: Codes added 0005U. This revision is effective 5/11/2026.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Molecular Diagnostic Tests (MDT) (A57526) - R28 - Effective April 1, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Changes:

Under CPT/HCPCS Codes Group 1: Codes added 0616U, 0617U, 0618U, 0619U, 0620U, 0621U, 0622U, 0623U, 0624U, 0625U, 0626U, 0627U, 0628U, and 0630U. This revision is due to the 2026 Q2 CPT/HCPCS Code Update and is effective 4/1/2026.

Under Article Text added "Specific tests that have been evaluated for compliance with coverage criteria set in policy (and are thus covered or not covered) can be found in the DEX® registry." This revision is effective 4/1/2026.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Molecular Syndromic Panels for Infectious Disease Pathogen Identification Testing (A58720) - R35 - Effective April 1, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Changes:

Under ***CPT/HCPCS Group 8: Codes*** added 0629U. This revision is due to the 2026 Q2 CPT/HCPCS Code Update and is effective 4/1/2026.

Under ***Article Text*** added "Specific tests that have been evaluated for compliance with coverage criteria set in policy (and are thus covered or not covered) can be found in the DEX® registry". This revision is effective 4/1/2026.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Next-Generation Sequencing for Solid Tumors (A57901) - R9 - Effective June 4, 2026

Date Posted: June 4, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: Multiple dates

Summary of Changes:

Under ***Article Text*** added "Specific tests that have been evaluated for compliance with coverage criteria set in policy (and are thus covered or not covered) can be found in the DEX® registry ". This revision is effective 6/4/2026.

Under ***CPT/HCPCS Codes Group 1: Codes*** deleted 0391U. This revision is due to retirement of the test in the DEX® Registry and is effective 4/18/2026.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Next-Generation Sequencing Lab-Developed Tests for Myeloid Malignancies and Suspected Myeloid Malignancies (A57891) - R13 - Effective May 14, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 14, 2026

Summary of Changes:

Under ***Article Text*** revised 2nd sentence to remove "81170" and replace with "code". Added "Specific tests that have been evaluated for compliance with coverage criteria set in policy (and are thus covered or not covered) can be found in the DEX® registry". Under ***CPT/HCPCS Codes Group 2: Codes*** added 81479. Under ***ICD-10 Codes that Support Medical Necessity Group 1: Codes*** deleted C92.01, C92.11, C92.21, C92.31, C92.41, C92.51, C92.61, C92.A1, C92.Z1, C92.91, C93.01, C94.01, C94.21, and C94.41. These codes were included in error. Testing of patients clinically in remission is

governed under a separate policy (MolDX: Minimal Residual Disease Testing for Cancer).

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MolDX: Repeat Germline Testing (A57331) - R21 - Effective April 1, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 1, 2026

Summary of Changes:

Under ***CPT/HCPCS Codes Group 1: Codes*** added 0628U. This revision is due to the 2026 Q2 CPT/HCPCS Code Update and is effective 4/1/26.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCDs or access it via the CMS MCD.

Billing and Coding: MRI and CT Scans of the Head and Neck (A57204) - R16 - Effective January 1, 2026

Date Posted: May 14, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2026

Summary of Changes: Under ICD-10 codes that Support Medical Necessity Group 1 added: S01.01XA, S01.01XD and S01.01XS.

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Medical Policies and Coverage

Billing and Coding: Respiratory Care (A57224) - R22 - Effective January 1, 2026

Date Posted: June 11, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: January 1, 2026

Summary of Article Changes:

Added the following statement under Article Text Section:

For Type of Bill (TOB) 018X, Respiratory care is included in Payment Driven Payment Model (PDPM); Exception allows CAH to be paid separately.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence (A53359) - R13 - Effective April 06, 2026

Date Posted: April 16, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 6, 2026

Summary of Article Changes: Effective 4/6/2026 added ICD-10 codes T85.111D, T85.111S, T85.113D, T85.113S, T85.113S, T85.121A, T85.121D, T85.121S, T85.123A, T85.123D, T85.123S, T85.191A, T85.191D, T85.191S, T85.193D, T85.193S.

Added CPT codes to Group 2: 64596, 64597, 64598

Effective 06/17/2025 added category III HCPCS codes 0786T, 0787T, 0788T, 0789T to Group 1.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Sacral Nerve Stimulation for Urinary and Fecal Incontinence (A53359) - R14 - Effective April 6, 2026

Date Posted: June 25, 2026

This Billing and Coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 6, 2026

Summary of Article Changes: Effective 04/06/2026

Under CPT Codes:

Moved 0787T, 0788T and 0789T from Group 1 to Group 2.

Under ICD-10 codes that support Medical Necessity:

Group 1 paragraph - Updated the sentence to add 0786T, 0788T and 0789T.

Added *Note: Diagnosis criteria does not apply to 0787T.

Visit the Noridian Billing and Coding Articles webpage to view the complete listing of Billing and Coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD.

Billing and Coding: Superficial Radiation Therapy (SRT) for the Treatment of Nonmelanoma Skin Cancers (NMSC) (A60181) - R2 - Effective March 1, 2026

Date Posted: April 16, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: March 1, 2026

Summary of Changes: Under Article Text, added the following:

"A qualified physician for this service is one that has training and expertise that must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty (i.e., Radiation Oncology or Dermatology) OR a dermatologist that has didactic and clinical experience in radiation treatment."

"Documentation of qualifications when requested of training and expertise that must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty (i.e., Radiation Oncology or

Dermatology) OR documentation that the dermatologist has didactic and clinical experience in radiation treatment."

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Billing and Coding: Urine Drug Testing (A55001) - R25 - Effective June 1, 2026

Date Posted: May 7, 2026

This Billing and Coding Article has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 1, 2026

Summary of Changes:

Revision Effective Date: 06/01/2026

Under ICD-10-CM Codes That Support Medical Necessity:

Added: F11.120, F12.10, F12.20, F12.21, F13.10, F13.20, F13.21, F14.10, F14.120, F14.20, F14.21, F15.10, F15.20, F15.21, F19.10, F19.21

Visit the Noridian Active LCDs webpage to view the document or access it via the CMS Medicare Coverage Database (MCD).

Botulinum Toxin Injections LCD - Published for Review and Comments

Date Posted: April 2, 2026

This proposed Local Coverage Determination (LCD) has been published for review and comments for contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database (MCD) Number: DL35170

LCD Title: Botulinum Toxin Injections

Comment period: April 2, 2026 - May 16, 2026

Visit the CMS MCD to access Proposed LCDs not released to final LCDs.

Providers may address details for comment submission. When sending comments, reference the specific policy to which they are related. See the Proposed LCDs webpage for email and mail specifics.

Medical Policies and Coverage

Date of Service (DOS) Policy

This article has been published under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

The Noridian Contractor Medical Directors (CMDs) have published the following Medical Director Education Article on our website:

- Date of Service (DOS) Policy

This article clarifies the MACs' approach to processing claims and offers guidance on appropriate documentation to adhere to the DOS rule.

Visit the Noridian Medical Director Education Articles webpage to view the document.

Epidural Steroid Injections for Pain Management (L39240) - R4 - Effective April 9, 2026

Date Posted: April 9, 2026

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 9, 2026

Summary of Changes:

Coverage Indications, Limitations and/or Medical Necessity:

Revised: "Repeat ESI when the first injection directly and significantly provided improvement of the condition being treated may be considered medically reasonable and necessary when the medical record documents at least 50% of sustained improvement in pain relief and/or improvement in function measured from baseline using SAME scale* for at least three months." to "Repeat ESI when the first injection directly and significantly provided improvement of the condition being treated may be considered medically reasonable and necessary when the medical record documents a minimum of consistent 50% improvement in pain for at least three (3) months or at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale."

Visit the Noridian Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Medical Policies and Coverage

Epidural Steroid Injections for Pain Management (L39240) - R4 - Effective April 16, 2026

Date Posted: April 16, 2026

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 16, 2026

Summary of Changes:

Under Bibliography, reference #31, updated broken link.

Visit the Noridian Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Epidural Steroid Injections for Pain Management (L39240) - R5 - Effective April 16, 2026

Date Posted: May 14, 2026

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 16, 2026

Summary of Changes:

Under Bibliography, reference #31, additional update was made to the broken link.

Visit the Noridian Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

Facet Joint Injections: Clarifying Diagnostic versus Therapeutic Confusion

A common issue in Medicare billing for pain management is confusion between diagnostic and therapeutic facet joint injections, which are intended to follow a structured, stepwise process.

- Diagnostic injections, such as medial branch blocks, are performed to confirm the facet joint as the source of pain, requiring clear documentation of measurable pain relief (a defined percentage) to support progression to further treatment like radiofrequency ablation.
- A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same

level. The second diagnostic procedure may only be performed for a minimum of two weeks after the initial diagnostic procedure.
- These procedures are not meant for long-term relief, yet providers sometimes document or bill them as therapeutic services without demonstrating diagnostic intent or response.

From a Medicare standpoint, this distinction is essential, as coverage depends on proper sequencing, medical necessity, and documented outcomes; failure to clearly differentiate the purpose of each injection is a frequent source of denials and audit findings, as each encounter must align with LCD requirements and demonstrate its role in the patient's overall treatment plan.

MolDX Local Coverage Determinations (LCDs) Finalized - Effective August 10, 2026

Date Posted: June 25, 2026

The following MolDX Local Coverage Determinations (LCDs) have completed the Open Public Meeting comment period and are now finalized under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database Number	MolDX LCD Title
L40197	MolDX: Biomarker Testing in Metabolic Dysfunction-Associated Steatotic Liver Disease and Metabolic Dysfunction-Associated Steatohepatitis

Medicare Coverage Database Number	MolDX Billing and Coding Article Title
A60217	Billing and Coding: MolDX: Biomarker Testing in Metabolic Dysfunction-Associated Steatotic Liver Disease and Metabolic Dysfunction-Associated Steatohepatitis

Medicare Coverage Database Number	Response to Comments
A60450	Response to Comments: MolDX: Biomarker Testing in Metabolic Dysfunction-Associated Steatotic Liver Disease and Metabolic Dysfunction-Associated Steatohepatitis

Effective Date: August 10, 2026

View Active MolDX LCDs on our website or the CMS MCD.

MolDX: Prognostic and Predictive Molecular Classifiers for Bladder Cancer (L38647) - R4 - Effective April 16, 2026

Date Posted: April 16, 2026

This MolDX Local Coverage Determination (LCD) has been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: April 16, 2026

Summary of Changes:

Under ***Bibliography*** revised the broken hyperlink for the 4th reference, deleted duplicate reference #16, and changes were made to citations to reflect AMA citation guidelines. Formatting, punctuation, and typographical errors were corrected throughout the LCD. This revision is effective on 04/16/2026.

Visit the Noridian Molecular Diagnostic Services webpage to view the Active MolDX LCD or access it via the CMS Medicare Coverage Database (MCD).

Open Public Meeting Announcement Anterior Segment Intraocular Nonbiodegradable Drug-eluting System - June 25, 2026

Date Posted: May 21, 2026

This article has been published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Noridian Healthcare Solutions will be hosting an Open Public Meeting on June 25, 2026, from 2 - 4 pm CT.

Advance registration is required.

- Registration deadline to present comments on the LCD will close on June 18, 2026, at 11:59 pm CDT.
- General Registration deadline to participate by listen-only mode will close on June 24, 2026, at 11:59 pm CDT.

Proposed Local Coverage Determination (LCD) and Billing and Coding Article:

- Anterior Segment Intraocular Nonbiodegradable Drug-eluting System
- Billing and Coding: Anterior Segment Intraocular Nonbiodegradable Drug-eluting System

View meeting details and register now from the Open Meeting webpage.

Open Public Meeting Announcement Botulinum Toxin Injections - April 30, 2026

Date Posted: April 2, 2026

This article has been published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Noridian Healthcare Solutions will be hosting an Open Public Meeting on April 30, 2026, from 2 - 4 pm CT.

Advance registration is required (link will be added when posted).

- Registration deadline to present comments on the LCD will close on April 23, 2026, at 11:59 pm CT.
- General Registration deadline to participate by listen-only mode will close on April 29, 2026, at 11:59 pm CT.

Proposed Local Coverage Determination (LCD):

- Botulinum Toxin Injections - DL35170

View meeting details and register now from the Open Meeting webpage.

Policy Revision(s) for Local Coverage Determination and Associated Billing and Coding Article - Effective April 16, 2026

Date Posted: April 16, 2026

The following Local Coverage Determinations (LCDs) and associated Billing and Coding Articles have been revised under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Medicare Coverage Database Number	LCD Title and Revision Number
L38801	Facet Joint Interventions for Pain Management

Medicare Coverage Database Number	Billing and Coding Article Title and Revision Number
A58403	Billing and Coding: Facet Joint Interventions for Pain Management

Effective Date: April 16, 2026

Summary of Changes:

CONTRACTOR INFORMATION:

Added: JF contractor information

This update is to consolidate JE and JF to have one unified document and policy number.

Visit the Noridian Active LCDs webpage or Noridian Billing and Coding Articles webpages to view the document or access it via the CMS Medicare Coverage Database (MCD).

Request for Volunteers for a Contractor Advisory Committee (CAC)

We are seeking volunteers to participate as Subject Matter Experts for a planned joint Medicare Administrative Contractor (MAC) Contractor Advisory Committee (CAC) meeting scheduled for **August 20, 2026**.

The meeting will focus on laboratory tests used in the evaluation of Neurodegenerative Disorders.

We are specifically seeking CAC members with expertise in the following areas:

- Methodologists who can review and discuss the methodological quality of studies
- Researchers specializing in neurodegenerative disorders
- Neurologists
- Neuropathologists
- Neuroradiologists
- Primary care physicians who manage patients with suspected or documented neurodegenerative disorders

- Patient advocates with experience in chronic or neurodegenerative diseases

Interested individuals should submit their resume/CV for consideration to cacmeeting@noridian.com by **June 30, 2026**. We will contact selected candidates shortly. Please note that participation is subject to review, and individuals may not be selected due to potential conflicts of interest or other eligibility considerations.

Visit the Noridian CAC Meeting webpage for overview.

Self-Administered Drug Exclusion List (A53032) - R45 - Effective June 13, 2026

Date Posted: April 30, 2026

This billing and coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: June 13, 2026

Summary of Changes:

Effective 01/01/2023: Under Excluded CPT/HCPCS Codes, removed asterisk from C9399, J3490, J3590 Risankizumab-rzaa (Skyrizi™) subcutaneous use

Effective 06/13/2026: Under Excluded CPT/HCPCS Codes, added J3490, J3590, C9399 Nemolizumab-ilto (Nemluvio)

Visit the Self-Administered Drugs (SADs) webpage to view the Self-Administered Drug Exclusion List.

To view the complete listing of billing and coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Billing and Coding Articles webpage.

Self-Administered Drug Exclusion List (A53032) - R46 - Effective September 16, 2013

Date Posted: June 4, 2026

This billing and coding article has been revised and published for notice under contract numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: September 16, 2013

Summary of Changes:

Under Excluded CPT/HCPCS Codes, added J3110 Injection, Teriparatide, 10 MCG, back to the SAD listing as it was removed in error with the previous revision.

Visit the Self-Administered Drugs (SADs) webpage to view the Self-Administered Drug Exclusion List.

To view the complete listing of billing and coding articles and/or access the Active, Future, or Retired articles available in the CMS MCD, visit the Billing and Coding Articles webpage.

Temporary Nontherapeutic Ambulatory Cardiac Monitoring Devices Final LCD - Effective June 21, 2026

Date Posted: May 7, 2026

This Local Coverage Determination (LCD) has completed the Open Public Meeting and Contractor Advisory Committee (CAC) comment period and is now finalized under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories). Responses to comments received may be found as a link at the bottom of the final LCD.

Medicare Coverage Database (MCD) Number/Contractor Determination Number: L40255

LCD Title: Temporary Nontherapeutic Ambulatory Cardiac Monitoring Devices

Effective Date: June 21, 2026

Summary of LCD:

This LCD will expand coverage for temporary nontherapeutic ambulatory cardiac monitoring devices (TNACMD) to reflect the emergence of new technologies and to ensure Medicare beneficiaries have access to appropriate diagnostic tools for arrhythmia detection.

Visit the Proposed LCDs webpage to access this LCD.

Treatment of Varicose Veins of the Lower Extremities (L34209) - R13 - Effective May 14, 2026

Date Posted: May 14, 2026

This Local Coverage Determination (LCD) has been revised under contractor numbers: 01111 (CA), 01211 (AS, GU, HI, NMI), 01311 (NV), and 01911 (CA, HI & Territories).

Effective Date: May 14, 2026

Summary of Changes:

Removed broken link from #13 in the bibliography.

Visit the Noridian Active LCDs webpage to view the Active LCD or access it via the CMS MCD.

MLN Connects

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 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

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 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

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 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

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.

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

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

Publications & Multimedia

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

MLN Connects

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 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

Events

- CCSQ Quarterly Stakeholder Webinar - May 12

MLN Connects

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 - 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?

MLN Connects

- 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

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 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 Matters

AKI & ESRD Billing: Ending the AX Modifier Requirement - Revised

Number: 14354

Revised Release Date: April 17, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Numbers: R13588CP & R13740CP

What's Changed? CMS revised this article to add HCPCS code G0491 to the billing requirements for acute kidney injury hemodiafiltration claims. CMS also updated the CR release date, transmittal numbers, and transmittal links. Substantive content changes are in dark red (page 3).

CR 14354 explains:

- No need to submit the AX modifier on claims eligible for certain add-on payment adjustments under the ESRD PPS
- Must adhere to new billing instructions for hemodiafiltration and Acute Kidney Injury (AKI) claims

Make sure your billing staff knows about these updates, starting July 1, 2026, to billing instructions for ESRD Prospective Payment System (PPS) claims and to the Medicare Claims Processing Manual, Chapter 8, sections 20, 40, and 50. ESRD facilities

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14354.

CCM for Heart Failure - Revised

Number: 14311

Revised Release Date: April 3, 2026

Effective Date: October 28, 2025

Implementation Date: April 6, 2026

Transmittal Numbers: R13538CP, R13538NCD, R13716CP & R13716NCD

What's Changed? CMS revised this article to add information for HCPCS codes C1824, C1898, and K1030. CMS also updated the CR release date, transmittal numbers, and transmittal links. Substantive content changes are in dark red (pages 5 and 6).

CR 14311 tells you about:

- Criteria
- Coverage with evidence development (CED) study criteria
- Claims processing requirements

Make sure your billing staff knows about national coverage for cardiac contractility modulation (CCM).

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14311.

CLFS & CLIA HCPCS Codes, Waived Tests & Reasonable Charge Payments: July 2026 Quarterly Update

Number: 14476

Release Date: May 7, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13763CP

CR 14476 tells you about:

- Annual and quarterly Clinical Laboratory Improvement Amendments (CLIA) edits and new waived test updates
- New and deleted CPT codes

Make sure your billing staff knows about Clinical Laboratory Fee Schedule (CLFS) updates, effective July 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14476.

Critical Access Hospitals: Certified Registered Nurse Anesthetist Bypass for Reason Codes 31006 & 31007

Number: 14417

Release Date: April 10, 2026

Effective Date: July 1, 2025

Implementation Date: October 5, 2026

Transmittal Number: R13726OTN

CR 14417 explains system edits to prevent CAH certified registered nurse anesthetist (CRNA) outpatient service claims from getting reason codes 31006 and 31007 if they have a valid pass-through on file.

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14417.

MLN Matters

DMEPOS Fee Schedule: April 2026 Quarterly Update

Number: 14425

Release Date: March 26, 2026

Effective Date: April 1, 2026

Implementation Date: April 6, 2026

Transmittal Number: R13685CP

CR 14425 tells you about:

- Added and deleted codes
- Fees for new codes

Make sure your billing staff knows about these updates, effective April 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14425.

ESRD Prospective Payment System: July 2026 Quarterly Update

Number: 14483

Release Date: May 28, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13770CP

CR 14483 tells you about:

- Adding and removing certain renal dialysis items and services
- Updating the average unit cost for renal dialysis drugs that are oral equivalents to injectable drugs
- Revising the average dispensing fee of the National Drug Codes (NDCs) qualifying for outlier payment to $0.47 per month

Make sure your billing staff know about changes to the outlier services list under the ESRD Prospective Payment System (PPS) starting July 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14483.

MLN Matters

HCPCS Codes Used for Skilled Nursing Facility Consolidated Billing Enforcement: July 2026 Quarterly Update

Number: 14427

Release Date: March 26, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13684CP

CR 14427 tells you about:

- Angiography, Lymphatic, Venous & Related Procedures Category
- Chemotherapy Category
- Added codes
- Terminated codes

Make sure your billing staff knows about coding updates.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14427.

Hospital OPPS: April 2026 Update - Revised

Number: 14380 Revised

Release Date: March 27, 2026

Effective Date: April 1, 2026

Implementation Date: April 6, 2026

Transmittal Numbers: R13686CP & R13702CP

What's Changed? CMS revised this article to change the status indicator for HCPCS code Q0599 from status indicator "E1" to status indicator "K." CMS also updated the CR release date, transmittal numbers, and transmittal links. Substantive content changes are in dark red (page 5).

CR 14380 tells you about:

- New COVID-19 monoclonal antibody products and administration codes
- New proprietary laboratory analyses (PLA) codes and Hospital OPPS device categories
- Status indicator revisions and ambulatory payment classification assignments
- Drugs, biologicals, and radiopharmaceuticals
- Skin substitute products

Make sure your billing staff knows about this Hospital Outpatient Prospective Payment System (OPPS)

updates, effective April 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14380.

Hospital OPPS: July 2026 Update

Number: 14477

Release Date: June 16, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13832CP

CR 14477 tells you about:

- New COVID-19 monoclonal antibody products and administration codes
- CPT proprietary laboratory analyses (PLA) coding changes
- New and reassigned Category III CPT codes
- Device pass-through and device offset information
- Ambulatory payment classification (APC) assignment and status indicator changes
- Drugs, biologicals, and radiopharmaceuticals
- Non-opioid treatments for pain relief
- Skin substitute products

Make sure your billing staff knows about these Hospital Outpatient Prospective Patient System (OPPS) updates, effective July 1, 2026.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14477.

MLN Matters

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.

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

Number: 14415

Release Date: April 14, 2026

Effective Date: January 31, 2026

Implementation Date: April 17, 2026

Transmittal Numbers: R13703OTN & R13735OTN

CR 14415 tells you about:

- The Consolidated Appropriations Act, 2026 extended through December 31, 2026:
  - Temporary changes for the low-volume hospital payment adjustment policies
  - MDH program
- The deadline to submit qualification or verification for the low-volume hospital payment adjustment for FY 2026 discharges is April 17, 2026
- Your Medicare Administrative Contractor (MAC) will apply the low-volume hospital payment adjustment prospectively for qualifying providers who submit qualification or verification after April 17, 2026

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14415.

MLN Matters

Method II Critical Access Hospital: Line-Level Rendering Provider Billing

Number: 14482

Release Date: May 28, 2026

Effective Date: June 29, 2026

Implementation Date: June 29, 2026

Transmittal Number: R13799CP

CR14482 tells you about:

- CAHs must bill professional services that have rendering NPIs at the line level
- Medicare must be able to determine the line-level rendering professional for each outpatient service on a combined billing claim

Make sure your billing staff knows about updates to the Medicare Claims Processing Manual, Chapter 4, sections 250.3.3.1 and 250.18

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14482.

National Coverage Determination 20.19: Ambulatory Blood Pressure Monitoring - Revised

Numbers: 11650 Revised & 14424

Release Dates: May 1, 2020 & March 27, 2026

Effective Date: July 2, 2019

Implementation Date: June 16, 2020 - local Medicare Administrative Contractor edits & October 5, 2020 - Medicare systems

Transmittal Numbers: R10073CP, R10073NCD & R13700CP

What's Changed? CMS revised this article to add information from CR 14424, which updates the Medicare Claims Processing Manual for Ambulatory Blood Pressure Monitoring services. CMS also added the CR 14424 release date and transmittal number.

CR 11650 informs contractors that for dates of service on and after July 2, 2019, CMS will cover Ambulatory Blood Pressure Monitoring for the diagnosis of hypertension in Medicare beneficiaries under updated criteria.

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)11650.

MLN Matters

National Coverage Determination 20.40: RDN for Uncontrolled Hypertension - Revised

Number: 14302 Revised

Release Date: March 19, 2026

Effective Date: October 28, 2025

Implementation Date: April 6, 2026

Transmittal Numbers: R13522CP, R13522NCD, R13612CP, R13612NCD, R13640CP, R13640NCD, R13695CP & R13695NCD

What's Changed? CMS revised this article. Place of service code 24 is allowable for professional claims. CMS won't pay physicians for HCPCS codes C1735 and C1736. CMS also updated the CR release date, transmittal numbers, and transmittal links. Substantive content changes are in dark red (pages 2 and 4).

CR 14302 tells you about:

- Criteria
- Coverage with evidence development (CED) study criteria
- Claims processing requirements

Make sure your billing staff knows about national coverage for renal denervation (RDN).

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14302.

PPS Hospital Interim Billing: New Monthly Adjustment Process

Number: 14416

Release Date: April 10, 2026

Effective Date: October 1, 2024

Implementation Date: October 5, 2026

Transmittal Number: R13725CP

CR 14416 tells you about:

- New monthly adjustment process for Prospective Payment System (PPS) hospital inpatient claims
- Enforcing correct interim billing procedures by verifying patient status and correctly applying benefit days

Make sure your billing staff knows about these updates, effective for hospital discharges on or after October 1, 2024.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14416.

MLN Matters

RHCs & FQHCs: Billing Distant Site Telehealth Services

Number: 14468

Release Date: May 27, 2026

Effective Date: October 1, 2026

Implementation Date: October 5, 2026

Transmittal Number: R13776OTN

CR 14468 provides instructions to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) on how to bill distant site telehealth services for dates of service on or after October 1, 2026.

Make sure your billing staff knows that RHCs and FQHCs must bill the individual CPT or HCPCS code for distant site telehealth services they provide instead of HCPCS code G2025.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14468.

Stay of Enrollment - Revised

Numbers: 13449 Revised & 14148

Release Dates: April 25, 2024 & March 17, 2026

Effective Dates: May 30, 2024 & May 18, 2026

Implementation Dates: May 30, 2024 & May 18, 2026

Transmittal Numbers: R12591PI & R13615OTN

What's Changed? CMS revised this article to add additional scenarios for when a stay of enrollment status may apply to DMEPOS suppliers. CMS also added the CR 14148 release date, effective date, implementation date, transmittal number, and transmittal link. Substantive content changes are in dark red (pages 1 and 4)

CR 13449 tells you about:

- A new provider enrollment status called a stay of enrollment
- Updates to the Medicare Program Integrity Manual, Chapter 10, section 10
- Scenarios where your National Provider Enrollment Contractor (NPE) may apply a stay of enrollment status to DMEPOS suppliers

Make sure your billing staff know about these changes.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)13449.

MLN Matters

Vaccine Administration National Fee Schedule: July 2026 Quarterly Update

Number: 14470

Release Date: April 20, 2026

Effective Date: July 1, 2026

Implementation Date: July 6, 2026

Transmittal Number: R13733CP

CR 14470 provides instructions for the Medicare contractors to download, test, and implement the National Fee Schedule for Vaccine Administration (VAXA) Quarterly Update for July 2026. The rates from the VAXA file will be applied to preventive service and monoclonal antibody claims beginning July 1, 2026.

Make sure your billing staff knows about coding updates for TOFIDENCE® (tocilizumab-bavi) for intravenous administration in hospitalized adults with COVID-19.

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14470.

Contacts, Resources, and Reminders

Noridian Part A Customer Service Contact

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

Email Addresses - Providers 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 PCC phone lines, will be unavailable for customer service.

Interactive Voice Response (IVR) - 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.

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 "Medicare A News" Articles

The purpose of "Medicare A News" is to educate the Noridian Medicare Part A provider 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.

Unsolicited or Voluntary Refunds Reminder

All Medicare providers need to be aware that the acceptance of a voluntary refund as repayment for the claims specified 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.

Background

Medicare carriers and intermediaries and A/B MACs receive unsolicited or voluntary refunds from providers. These voluntary refunds are not related to any open accounts receivable. Providers billing intermediaries typically make these refunds by submitting adjustment bills, but they occasionally submit refunds via check. Providers billing carriers usually send these voluntary refunds by check.

Related Change Request (CR) 3274 is intended mainly to provide a detailed set of instructions for Medicare carriers and intermediaries regarding the handling and reporting of such refunds. The implementation and effective dates of that CR apply to the carriers and intermediaries. But, the important message for providers is that the submission of such a refund related to Medicare claims in no way 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 those or any other claims.

Additional Information

The official CMS CR3274 instruction may be viewed in the Medicare Learning Network (MLN) Matters article MM3274.

Effective Date: January 1, 2005

Implementation Date: January 4, 2005

Sources: Transmittal 50, CR 3247 dated July 30, 2004; Internet Only Manual (IOM) Medicare Financial Management Manual, Publication 100-06, Chapter 5, Section 410

Do Not Forward Initiative Reminder

The Internet Only Manual (IOM) Medicare Claims Processing Manual, Publication 100-04 instructs Part A and Part B Medicare Administrative Contractors (A/B MACs) and carriers to use "return service requested" envelopes when mailing paper checks and remittance advices to providers.

When the post office returns a "return service requested" envelope, the A/B MAC/carrier applies a "do not forward" (DNF) flag to the provider's Medicare enrollment file. The A/B MAC/carrier will not generate any additional checks for that provider until the provider sends a properly completed change of address form back to the A/B MAC/carrier. We are not required to contact the provider to notify them that the flag has been added to their file.

Upon verifying the new address, the A/B MAC/carrier removes the DNF flag and can again generate payments for the provider. Electronic Funds Transfer (EFT) is required; therefore, when the address change update is completed, the provider will be set up to use EFT and will no longer receive paper checks.

Note: Because many providers get paid through EFT, there may be cases where a provider does not have a correct address on file, but the A/B MAC/carrier continues to pay the provider through EFT. It is still the provider's responsibility to submit and address change update so that remittance notices and special checks would be sent to the proper address.

Noridian encourages providers to enroll or make changes using Internet-based Provider Enrollment, Chain and Ownership System (PECOS) for faster processing time. Applications and changes completed online currently have an average processing time of 10 days. All Medicare providers may use the new enrollment process on the CMS Medicare Enrollment website. To log into this internet-based PECOS, providers will use their NPI Userid and password.

Policy

Effective October 1, 2002, A/B MACs/carriers must use "return service requested" envelopes for hardcopy remittance advices and checks, with respect to providers that have elected to receive hardcopy remittance advices. (PM B-02-023, CR 2038 dated April 12, 2002; Transmittal 1794, CR 2684 dated May 2, 2003)

Implementation Process

1. "Return service requested" envelopes are used for all hardcopy remittance advices starting October 1, 2002. These envelopes will be used for all providers.
2. "Return service requested" envelopes will not be used for beneficiary correspondence, such as Medicare Summary Notices (MSNs) or for overpayment demand letters.
3. When the post office returns a remittance advice due to an incorrect address, A/B MACs/carriers will follow the same procedures as followed for returned checks, that is:
    - Flag the provider's file DNF.
    - A/B MAC/carrier staff will notify provider enrollment team.
    - A/B MAC/carriers will cease generating any further payments or remittance advice to that provider or supplier until furnished with a new, verified address.
4. When the provider establishes a new, verified address, A/B MACs/carriers will remove the DNF flag and pay the provider any funds which are still being held due to a DNF flag. A/B MAC/carriers must also reissue any remittance advices, which have been held.
5. Previously, CMS only required corrections to the "pay to" address. However, with the implementation of this initiative, CMS requires corrections to all addresses before the contractor can remove the DNF flag and begin paying the provider or supplier again. Therefore, A/B MAC/carriers cannot release any payments to DNF providers until the provider enrollment department has verified and updated all addresses for that provider's location.

IRS-1099 Reporting

Provider or supplier checks returned and voided during the same year they were issued are not reported on the Internal Revenue Service (IRS) Form 1099 until the returned check is reissued (i.e., the DNF flag is removed and the A/B MAC/carrier reissues payment to the provider.) Checks returned and voided in the current year that were issued in prior years are not netted from the current year's IRS Form 1099.

Monies withheld because a DNF flag exists on a provider or supplier record are not reported on IRS-1099s until the calendar year in which payment is made (i.e., the point

at which the A/B MAC/carrier pays the provider once the DNF flag is removed.) If DNF amounts are erroneously included on IRS-1099 forms, A/B MACs/carriers will issue corrected IRS Form 1099s to affected providers.

Source: IOM Medicare Claims Processing Manual, Publication 100-04, Chapter 22, Section 50.1

Jurisdiction E Part A Quarterly Ask the Contractor Meetings (ACM)

ACMs are designed to open communication between providers and Noridian, which allows for timely identification of problems, and sharing information in an informal and interactive question and answer (Q&A) format. No Personal Health Information (PHI) is allowed.

Noridian representatives from various Part A departments are available to address your Medicare questions and concerns. All questions are entertained and the Q&As are posted on our website for provider convenience.

ACM dates, times, toll-free number, and Q&As are available on the Jurisdiction E Part A Ask the Contractor Meetings (ACM) webpage.

Attendees must register through a free web-based training tool (GoToWebinar) which requires an Internet connection and a toll-free telephone number (provided in confirmation email). Allow email registrations@noridian.com. Unless otherwise specified, ACMs are general in nature. No CEUs are provided.

By completing and submitting the Noridian Part A ACM Question Submission Form, providers may ask question(s), up to five (5) days prior, to be answered during the next ACM. Questions submitted with this form will be answered first. Lines will then be opened for additional questions, as time permits. **Do not include any Personal Health Information (PHI) or claim specific inquiries on this form. If you have claim specific questions, contact the Provider Contact Center.**

We look forward to your participation in these important calls.

Medicare Part A ACMs do not address Medicare Part B or Durable Medical Equipment (DME) inquiries.

If you are interested in attending a Part B or a DME ACM, select the appropriate link below for more information.

- Jurisdiction E Part B ACMs
- Jurisdiction D DME ACMs
- Jurisdiction A DME ACMs