Medicare B News

Jurisdiction E
July 2026

NORIDIAN HEALTHCARE SOLUTIONS

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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ACM B Questions And Answers - April 8, 2026

The following questions and answers (Q&As) are cumulative from the Part B Ask the Contractor Meeting (ACM). Some questions have been edited for clarity and answers may have been expanded to provide further details. Related questions were combined to eliminate redundancies. If a question was specific just for that office, Noridian addressed this directly with the provider. This session included pre-submitted questions and verbal questions posed during the event. Please note our disclaimer stated that these are accurate as of this publishing and may have future updates.

Updates and Reminders:

For coding advice, seek external sources such as the AMA, AAPC, or specialty societies

Watch our Noridian website for CMS Telehealth updates

Local Coverage Determination (LCD) L35170 "Botox Toxin Injections" updating policy

Pre-Submitted Questions

Q1. Should modifier 93 or 95 be appended to G2211 when a telemedicine visit is billed?
A1. Yes; whichever is appropriate. The place of service provides the information when a telehealth visit is performed. Modifier 93 is only appended when the patient does not consent to a video visit and whenever only an audio visit is performed. Modifier 95 is appended in limited circumstances when the patient is in their home and the provider is at the hospital (POS 19 or 22); or for outpatient therapy performed by a PT, OT, or SLP.

Q2. If the full scope of CPT 64582 (insertion and open implantation of hypoglossal nerve neurostimulator array, etc.), does not include a separate distal respiratory sensor electrode array (e.g., Inspire V); do we append modifier 52 for reduced services?
A2. Append modifier 52 and bill an appropriate reduced rate if the full scope of CPT 64582 is not performed. Do not bill the "standard fee". Note that the code calls for "distal respiratory sensor electrode or electrode array", so either of these would fulfill the requirement and not necessarily an "array".

Confirm that this follows the Local Coverage Determination (LCD) policy "Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea" or HGNS covered indications, requirements, and limitations. New codes were added April 2026 (effective January 1, 2026):

- C8007 - Open implantation if HGNS array and pulse generator, not requiring insertion of separate distal respiratory sensor electrode or electrode array
- C8008 - revision or replacement
- C8009 - removal of HGNS

- C8011, C8012 and C8013 - Genio apparatus for placement, revision, and removal introduced

Q3. When comorbidities are omitted from the surgeon's op report, can diagnosis codes be added based on past medical records or should the surgeon be queried for an addendum?
A3. If the surgeon didn't consider the comorbidities for the procedure performed, the addition of the diagnoses would not be appropriate. Only diagnoses that are part of the current procedure or treatment should be included. If the comorbidity is part of the procedure, the surgeon should be queried for an addendum.

Q4. What documentation is required for assistant at surgery (modifier 80 or AS) when procedure has a payment restriction indicator of "0" or "2"?
A4. Documentation must provide a clinical picture of the patient and include the procedures or services performed to support the use of modifier 80 (physician) or AS (non-physician practitioner). This includes the name of the surgical assistant and evidence the assistant surgeon actively participated in the procedure.

Clearly document the assistant's role during the operative session and that they provided more than ancillary services. If the documentation shows the assistant is acting more as a nursing role rather than surgical assistant and the surgeon could perform the procedure alone, a procedure with indicator zero may not be covered. The primary surgeon's signature is always required on these claims.

Q5. Did our office read previously that Noridian does not cover "Chemotherapy education"? Can an eligible practitioner bill an Evaluation and Management (E/M) for a patient with a treatment plan for newly diagnosed cancer?
A5. Correct; however, Chemotherapy education is bundled into the E/M and not separately billed. This includes the prognosis, expectations, community resources, etc.

Q6. Can or should an "Independent historian" be applied when a parent provides history for a child (e.g., newborn, toddler) who are unable to provide reliable history?
A6. Yes. When a patient is unable to provide a reliable history, the CPT E/M guidelines state a parent, guardian, surrogate, spouse, or witness, may provide medically necessary history. The AMA has some great guidelines for the question under pages 17-42 at this link AMA Evaluation and Management (E/M) Descriptors and Guidelines.pdf. If this is not for a Medicare fee-for-service beneficiary, check with that payer's policy.

Q7. For a bilateral ptosis levator eyelid repair (CPT 67904) performed in an outpatient hospital setting, the facility obtained a Part A prior authorization (PA) for one unit. Since modifiers cannot be included in the Part A PA request, as the physician billing under Part B:
1. Do we only need one PA (requested by Part A) for both the facility and our physician?
2. Can we bill CPT code 67904 with modifier 50, even though it doesn't appear on the

approval?
A7. Yes, just one PA needed for both facility and provider with the Prior Authorization Coversheet for Blepharoplasty. CPT 67904 must be billed with modifiers RT or LT for one eye or modifier 50 for bilateral. When billed with modifier 50, the payment will be 150% of the fee schedule.

Per the Fee Schedule Indicator List for Column B:

1=150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with "2" in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code.

If the code is reported as a bilateral procedure and is reported with other procedure codes on the same day, apply the bilateral adjustment before applying any multiple procedure rules.

Q8. Since Medicare did not adopt the AMA telehealth codes (CPTs 98000-98015), if a parent has an "audio only call" with a pediatrician, does the patient need to be present?
A8. Yes; if Medicare is billed. Medicare requires the patient to be present as a condition for payment for telehealth visits. Read Section 190.4 at CMS Internet Only Manual (IOM) Publication 100-04, Medicare Claims Processing Manual, Chapter 12.pdf. See also the answer provided for A6. If this is not for a Medicare beneficiary, check with that payer's policy.

Q9. Our institutional providers (i.e., hospital-employed clinicians) sometimes provide telehealth services to our patient population. The provider is in Place of Service (POS) 22 and the patient is at home. Please clarify if modifier 95 is needed for audio-visual Evaluation and Management (E/M) services.
A9. Correct. When a provider is in the hospital setting and providing a telehealth visit to a patient who is in their home, modifier 95 would be appended as it indicates synchronous telemedicine service via real-time audio and video telecommunications.

Q10. Is it mandatory to use the official CMS Advance Beneficiary Notice (ABN) form for Medicare non-covered or medically unnecessary Durable Medical Equipment (DME) services? Can providers use an in-house ABN waiver instead if it includes all the required elements?
A10. Yes to the first question and no to the second. Providers must use the official CMS ABN form regardless of the reasoning; however, no ABN needs to be provided (unless voluntary), when a procedure or service is statutorily non-covered. New ABN was just released (effective immediately) with updated expiration date 3/31/2029! Providers have a grace period until May 12 of this year (2026) to update and use the new CMS-R-131

form. Read more under CMS Fee-for-Service (FFS) Advance Beneficiary Notice of Noncoverage (ABN).

Q11. Is there a primary CPT list that add-on CPTs 61781 (stereotactic computer-assisted navigation procedure on skull, brain, or meninges; real time tracking; intradural), 61782 (…; extradural), and 61783 (…; spinal) are billed and allowed?
A11. The only CMS primary code list exists on the Medicare National Correct Coding Initiative (NCCI), Add-on Code Edits list at CMS NCCI Add-On Code Edits. These CPTs have an indicator of "CCCCC", meaning the contractor would determine the primary code.

Q12. If the provider billed an Annual Wellness Visit (AWV) and documentation lacks the required components (e.g., missing visual acuity screening, etc.), is modifier GZ (item or service expected to be denied as not reasonable and necessary) appended to G0438 or G0439 appropriate?
A12. Yes. However, if there had been documentation stating that there was no visual acuity screening because the patient had seen their optometrist, or another appropriate reason the service was not included; then this could be a payable service.

Q13. Would high level risk for Evaluation and Management (E/M) purposes be supported when a provider documents clinical recommendation discussion for cytotoxic chemotherapy that has not been initiated yet?
A13. It will depend on the circumstances and documentation. The assessment of the level of risk is affected by the nature of the event under consideration. The treating provider needs to document the level of risk discussed with the patient in the medical record.

Q14. Why was "Focal Dystonia" taken out of the Noridian Botox Policy and considered "limb spasticity"? Dystonia is dynamic and fluctuating, often triggered by voluntary action or strong emotions.
A14. Some types of dystonia are FDA approved while others are not. This February 2026 updated "Botulinum Toxin Injection (BTI)" policy (L35170) provides coverage for those with FDA approval. For those without FDA approval or who do not contain substantial literature to support, coverage would be denied upon claim submission. However, providers may appeal and submit robust peer-reviewed literature for review.

The management of Focal Hand Dystonia (FHD), BTI is considered reasonable and necessary and consisting of focal injections of the toxin into the muscles responsible for the abnormal postures, and initial BTIs for FHD will be considered reasonable and necessary when the following requirements are met:

- Objective documentation of the clinical features consistent with the diagnosis of FHD; AND
- Moderate to severe chronic FHDs measured on objective clinical scale*; AND

- The injections are used with guidance either by ultrasound or by electromyography (EMG) with or without electrostimulation.

The objective assessment must be performed and documented at baseline, after each diagnostic procedure, and at each follow-up assessment using the same scale during each assessment. For example, scales that could be used include the Fahn-Marsden rating scale, Unified Dystonia Rating Scale, Arm Dystonia Disability Scale (ADDS); Tubiana-Chamagne Scale; and Writer's Cramp Rating Scale.

Q15. What are examples of recent dementia diagnoses for Fluorodeoxyglucose-Positron Emission Tomography Positron Emission Tomography (FDG-PET) scans?
A15. For advanced imaging coverage such as FDG-PET scans, a 'recent diagnosis of dementia' typically means there is physician-documented, with patient's progressive cognitive decline over at least six months, but the exact type of dementia remains uncertain.

Q16. Does CPT 96574 Photodynamic Therapy (PDT) require the provider to apply the medication and turn on the PDT machine, or can a medical assistant perform these tasks and the provider bills?
A16. CPT 96574 debridement requires both the application of the photosensitizing medication and the illumination or activation, using the PDT light source. This is only performed by a **physician** or other qualified **non-physician practitioner** professional. Therefore, a medical assistant (MA) is not permitted to perform these components.

Q17. Will Noridian be correcting the Local Coverage Determination (LCD) L40050 titled "Allergen Immunotherapy (AIT) with Subcutaneous Immunotherapy (SCIT)" and Billing and Coding Article A59976 for claims with venom-related allergen that are incorrect?
A17. The indications and efficacy for SCIT with aeroallergens (i.e., inhaled allergens, such as pollens, dust mites, animal dander, etc.) are considered in this LCD. SCIT with other allergens, such as venoms, is **not considered** in this LCD. Therefore, no changes to the current policy (along with the billing and coding article) will be made. The updated proposed policy's comment period ended February 28, 2026.

Q18. When a urinalysis (81003 QW) is provided in the office on the same day (morning) and a telehealth E/M visit (afternoon) with the patient in their home, can we bill on the same claim for two different POS?
A18. No. Bill on separate claims with POS 11 for 81003 QW and another claim for the telehealth E/M with POS 10.

Q19. Per the Botulinum Toxin Injection policy (L35170), what are examples of approved objective assessment scales to use for the Migraine indication? Does it have to be an actual formal scale like the Migraine Disability Assessment (MIDAS) scale?
A19. The LCD policy does not require a specific scale. The provider can use whatever

scale they prefer. The results must be documented in the record with the type of scale and score.

Q20. Can providers bill CPTs 27245 (Open treatment of femoral fracture; intramedullary implant) and 20680 (Removal of implant; deep [e.g., buried wire, pin, screw, metal band, nail, rod, or plate]) if the removal requires separate work beyond exposure for new fixation and hardware that has failed or been displaced?
A20. Depends. Per AAPC's Codify page, if the hardware broke away from the fracture site and the surgeon created a separate incision to access, Medicare may reimburse both services. Append modifier 59 (distinct procedural service) to CPT 20680.

Verbal Questions Asked During ACM

Q21. When making the decision for surgery, can we apply chemotherapy that hasn't been initiated yet into high risk?
A21. The decision for chemotherapy is sufficient for the risk categorization and must be documented in the medical record.

Q22. When we have patients who need pain medication following a procedure, in the Ambulatory Surgical Center (ASC), we add the catheter and then attach the external disposable pump (ON-Q*). When the medication in the pump is depleted, we detach and then attach a new pump. Since the C9804 is not refilling the pump, can we bill again for the replacement?
A22. Yes. C9804 is the elastomeric infusion pump (e.g., ON-Q* Pump with Bolus), including catheter and all disposable system components, with non-opioid medical device (must be a qualifying Medicare non-opioid medical device for post-surgical pain relief in accordance with Section 4135 of the CAA, 2023) is covered separately for the first time. This is per the "NOPAIN Act" starting January 1, 2025 and continuing through December 31, 2027, as long as it's provided with a covered surgical service. Per CMS Medicare Prospective Payment Systems-Non-Opioid Treatments and Code of Federal Regulations (CFR) 42 Chapter IV, B, Part 416.174.

Q23. We have a multispecialty group consisting of pain management, neurology, and rheumatology. If the rheumatologist created a care plan consisting of infusions, can another physician in the group from a different specialty be the supervising physician when billing infusions?
A23. The specialties must be within the same scope. The covering physician must be able to self-perform all regularly required services.

Q24. We have HCPCS G2211 add-on code that may be reported with new and established patient office and outpatient evaluation and management (E/M) services. These claims are denying when we are also billing an E/M visit with modifier 25 on a different claim. How do we avoid these denials?
A24. To avoid these denials, the add on code must be billed with the primary code on the same claim. Add on codes are never billed alone.

Q25. We have patients who use a type of Botulinum Toxin Injection (Xeomin) for chronic migraines due to an adverse reaction, but we can't find coverage criteria for this. Is this available?
A25. Although coverage criteria are not available, providers are encouraged to document this in the record and include supporting literature upon appeal. As you are aware, there are three distinct serotype A botulinum toxin therapeutic products, onabotulinumtoxinA (BOTOX®), abobotulinumtoxinA (DYSPORT®) and incobotulinumtoxinA (XEOMIN®); along with the serotype B botulinum toxin product, rimabotulinumtoxinB (MYOBLOC®).

However, these products are not interchangeable, and CMS states it's the physician's responsibility to select the appropriate product and dose in accordance with FDA-approval indications for use, compendia-supported uses, and supported by peer-reviewed specific scientific literature.

Q26. For patients with dual diagnoses of chronic migraine and cervical dystonia with Botox, we've been told we can't bill CPTs 64615 and 64616 (Under destruction by neurolytic agent procedures on the somatic nerves) together. Are there modifiers that can be used?
A26. Per the National Correct Coding Initiative (NCCI), these two codes cannot be billed together. Refer to the NCCI Policy Manual for proper coding. When a pair of codes have a "zero indicator", no modifier is allowed.

Q27. We are billing CPT 77301 (Intensity Modulated Radiation Therapy or IMRT) planning, not patient-facing. We find out later the patient went on vacation and was hospitalized due to injury. The planning was billed on a date of service that she was in the hospital. When we bill the professional component, which place of service should we use?
A27. Bill CPT 77301 with modifier 26 (professional component) in the office and the technical component split with the facility.

News

Cataract Surgery Medical Necessity

Medical necessity is not solely based on the opacity of the lens(es) when it comes to cataract surgery. For lens extraction to be considered medically necessary (and covered by Medicare), one or more of the following conditions must exist:

1. Cataract causes symptomatic impairment of visual function not correctable with a tolerable change in glasses or contact lenses, lighting, or non-operative means resulting in specific activity limitations and/or participation restrictions including, but not limited to:
    - Reading, watching television, driving, or meeting vocational or recreational needs.
2. Presence of concurrent intraocular disease (e.g. diabetic retinopathy) that requires monitoring or treatment, which is hindered by the cataract.
3. Lens-induced conditions that threaten vision or ocular health, including but not limited to phacomorphic or phacolytic glaucoma.
4. High likelihood of accelerated cataract formation due to an existing or planned ocular procedure (e.g., pars plana vitrectomy, iridocyclectomy, or trauma-related surgery) or treatments such as external beam radiation.
5. Cataract significantly impairing visualization or interfering with the performance of vitreoretinal surgery.
6. Intolerable anisometropia or aniseikonia resulting from lens extraction in the first eye, which cannot be corrected with glasses or contact lenses, despite satisfactory monocular visual acuity.

Noridian may, at its discretion, approve cataract surgery for conditions not specifically listed above. Coverage determinations will be based on documentation demonstrating medical necessity and alignment with accepted standards of care.

Review Noridian's Local Coverage Determination (LCD) for Cataract Surgery in Adults (L34203) and the Billing and Coding Article (A57195) for documentation requirements to support medical necessity.

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

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CERT Awareness Month: Verify Your Medical Records Correspondence Address

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

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

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

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

Resource:

- CERT Background

CERT Awareness Month: We Appreciate Your Efforts

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

Thank you for your attention to this national MAC effort to promote CERT documentation awareness and compliance. We created this article series to help you understand CERT processes. For additional information, contact Noridian's CERT team.

Resources

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

News

CMS MLN Evaluation and Management Updates

The CMS Medicare Learning Network (MLN) has updated the Evaluation and Management (E/M) Booklet to include HCPCS code G2211 as an add-on code for home visit services. In addition, CMS revised the code description for G0136, changing the focus from social determinants of health risk assessment to a physical activity and nutrition assessment. Services that meet the requirements for G0136 may be performed in conjunction with E/M visits, Annual Wellness Visits (AWVs), or behavioral health office visits.

CMS also published the CMS MLN Advance Care Planning Fact Sheet providing clarification related to E/M codes 99497 and 99498.

Refer to the CMS MLN Publications website for various coding and compliance resources.

DMEPOS Fee Schedules and Labor Payment - 2nd Quarter 2026 Update

Updates to the DMEPOS Jurisdiction listing for 2nd quarter 2026 have been published. This resource, updated quarterly, shows which Medicare Administrative Contractors (MACs) have jurisdiction over which Healthcare Common Procedural Coding System (HCPCS) codes.

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.

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 MSP Portal Functionality

Effective June 19, 2026, providers will have the capability through the Noridian Medicare Portal (NMP) to submit Medicare Secondary Payer (MSP) adjustment requests for all Part B MSP claims. Similar to the appeals process, supporting documentation must be uploaded, and MSP has up to 45 calendar days to respond.

Use the new **MSP inquiry form submission** feature for requests such as:

- Not related to no-fault, workers' comp, liability, and Medicare Set-Asides
- Medicare paid primary or secondary in error
- Incorrect MSP type (2-digit) submitted on previously processed claim

A confirmation number is provided upon submission and supports improved processing efficiency and reduced administrative burden. Save time with this electronic submission of the MSP correspondence and no mailing or faxing required.

Do not use for non-MSP redeterminations, new CMS-1500 claim submissions, refunds, Veteran's Administration (VA), TRICARE PACMED, or U.S. Family Health Plan (USFHP) cases.

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.

Postoperative Evaluation and Management (E/M) Visits Reminder

The Office of Inspector General (OIG) found that practitioners must report post-operative evaluation and management visits:

- Practice in group of 10 or more practitioners
  - Exempt from required reporting if practice has less than 10 practitioners
- One of nine states: Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island

For more information, see the Global Surgery (PDF) booklet for information on how to report postoperative visits inpatient and outpatient settings.

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.

More information can be found on the Discarded Drug Page.

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.

News

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

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.

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.

News

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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.

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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.

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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.

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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.

Medical Policies and Coverage

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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)

Medical Policies and Coverage

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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.

Contractor Pricing Update - CPT/HCPCS 77520, 77522, 77523, and 77525 Effective July 1, 2026

Date Posted: April 24, 2026

This article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

Noridian will be updating our pricing for the following CPT/HCPCS codes effective on July 1, 2026:

- 77520: Proton treatment delivery; simple, without compensation
- 77522: Proton treatment delivery; simple, with compensation
- 77523: Proton treatment delivery; intermediate
- 77525: Proton treatment delivery; complex

These updates result from review of inputs and addition of former technical component of radiology service now bundled into these codes.

Please reference the Contractor (C-Status) Fee Schedule on our website for updates on all contractor priced codes.

Contractor Pricing Update - CPT/HCPCS 77520, 77522, 77523, and 77525 Effective January 1, 2026

Date Posted: May 22, 2026

This article has been published for notice under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

This notification is a revision to the previous notification published on April 24, 2026.

Noridian will be updating our pricing for the following CPT/HCPCS codes effective on January 1, 2026:

- 77520: Proton treatment delivery; simple, without compensation
- 77522: Proton treatment delivery; simple, with compensation
- 77523: Proton treatment delivery; intermediate
- 77525: Proton treatment delivery; complex

These updates result from review of inputs and addition of former technical component of radiology service now bundled into these codes.

2026 JE MPFS

State/Locality	77520	77522	77523	77525
Hawaii 01	$1,213.26	$1,213.26	$1,384.54	$1,555.82
Nevada 00	$1,071.06	$1,071.06	$1,221.85	$1,372.63
Northern California 05	$1,501.93	$1,501.93	$1,714.33	$1,926.73
Northern California 09	$1,535.68	$1,535.68	$1,752.90	$1,970.12
Northern California 51	$1,404.93	$1,404.93	$1,603.47	$1,802.02
Northern California 52	$1,502.24	$1,502.24	$1,714.64	$1,927.04
Northern California 53	$1,404.49	$1,404.49	$1,603.03	$1,801.57
Northern California 54	$1,169.97	$1,169.97	$1,335.07	$1,500.17
Northern California 55	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 56	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 57	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 58	$1,169.31	$1,169.31	$1,334.41	$1,499.51

State/Locality	77520	77522	77523	77525
Northern California 59	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 60	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 61	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 62	$1,172.17	$1,172.17	$1,337.27	$1,502.37
Northern California 63	$1,240.50	$1,240.50	$1,415.69	$1,590.89
Northern California 64	$1,236.25	$1,236.25	$1,410.84	$1,585.43
Northern California 65	$1,536.93	$1,536.93	$1,754.15	$1,971.37
Northern California 66	$1,295.75	$1,295.75	$1,478.78	$1,661.80
Northern California 67	$1,309.56	$1,309.56	$1,494.55	$1,679.53
Northern California 68	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 69	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 70	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Northern California 75	$1,169.31	$1,169.31	$1,334.41	$1,499.51
Southern California 17	$1,261.47	$1,261.47	$1,439.53	$1,617.58
Southern California 18	$1,262.91	$1,262.91	$1,441.11	$1,619.31
Southern California 71	$1,169.36	$1,169.36	$1,334.46	$1,499.56
Southern California 72	$1,275.62	$1,275.62	$1,455.78	$1,635.94
Southern California 73	$1,215.00	$1,215.00	$1,386.58	$1,558.15
Southern California 74	$1,243.69	$1,243.69	$1,419.33	$1,594.98

2026 JE MPFS Qualifying Alternative Payment Model for eligible participants

State/Locality	77520	77522	77523	77525
Hawaii 01	$1,219.32	$1,219.32	$1,391.45	$1,563.58

State/Locality	77520	77522	77523	77525
Nevada 00	$1,076.40	$1,076.40	$1,227.94	$1,379.48
Northern California 05	$1,509.42	$1,509.42	$1,722.88	$1,936.34
Northern California 09	$1,543.34	$1,543.34	$1,761.64	$1,979.95
Northern California 51	$1,411.94	$1,411.94	$1,611.47	$1,811.00
Northern California 52	$1,509.73	$1,509.73	$1,723.19	$1,936.65
Northern California 53	$1,411.50	$1,411.50	$1,611.03	$1,810.56
Northern California 54	$1,175.81	$1,175.81	$1,341.73	$1,507.65
Northern California 55	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 56	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 57	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 58	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 59	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 60	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 61	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 62	$1,178.02	$1,178.02	$1,343.94	$1,509.87
Northern California 63	$1,246.69	$1,246.69	$1,422.75	$1,598.82
Northern California 64	$1,242.42	$1,242.42	$1,417.88	$1,593.34
Northern California 65	$1,544.60	$1,544.60	$1,762.90	$1,981.21
Northern California 66	$1,302.21	$1,302.21	$1,486.15	$1,670.09
Northern California 67	$1,316.09	$1,316.09	$1,502.00	$1,687.91
Northern California 68	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 69	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Northern California 70	$1,175.15	$1,175.15	$1,341.07	$1,506.99

State/Locality	77520	77522	77523	77525
Northern California 75	$1,175.15	$1,175.15	$1,341.07	$1,506.99
Southern California 17	$1,267.76	$1,267.76	$1,446.71	$1,625.65
Southern California 18	$1,269.20	$1,269.20	$1,448.30	$1,627.39
Southern California 71	$1,175.19	$1,175.19	$1,341.12	$1,507.04
Southern California 72	$1,281.98	$1,281.98	$1,463.04	$1,644.10
Southern California 73	$1,221.06	$1,221.06	$1,393.49	$1,565.93
Southern California 74	$1,249.89	$1,249.89	$1,426.41	$1,602.93

No provider action is needed as Noridian will identify and reprocess affected claims.

Date of Service (DOS) Policy

This article has been published under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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.

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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.

Medical Policies and Coverage

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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).

Medical Policies and Coverage

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV). 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: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, and NMI), and 01312 (NV).

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.

Understanding Radiopharmaceutical Fee Schedule Amounts and Billing Expectations

This article has been published under contract numbers: 01112 (NCA), 01182 (SCA), 01212 (AS, GU, HI, NMI), and 01312 (NV).

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

- Understanding Radiopharmaceutical Fee Schedule Amounts and Billing Expectations

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

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

ASC Payment System: April 2026 Update

Number: 14445

Release Date: April 7, 2026

Effective Date: April 1, 2026

Implementation Date: April 6, 2026

Transmittal Number: R13704CP

CR 14445 tells you about:

- New Hospital Outpatient Prospective Payment System (OPPS) device pass-through category payable in Ambulatory Surgical Centers (ASCs)
- New HCPCS codes and payment status changes for:
  - ASC surgical procedures
  - Drugs, biologicals, and radiopharmaceuticals
  - Skin substitute products
  - Qualifying non-opioid treatments for pain relief

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

View the complete CMS Medicare Learning Network (MLN) Matters (MM)14445.

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).

MLN Matters

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.

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.

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.

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.

MLN Matters

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.

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.

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.

Contacts, Resources, and Reminders

Noridian Part B 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 B News" Articles

The purpose of "Medicare B News" is to educate the Noridian Medicare Part B 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 AB 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 B 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 B 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 B 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 B 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 B ACMs do not address Medicare Part A or Durable Medical Equipment (DME) inquiries.

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

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