

2025 Medicare Updates

MD AAHAM

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Provider Outreach and Education



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Your Presenter



Diane Hess
Education Specialist

Acronym List

Acronym	Definition
CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DME	Durable Medical Equipment
FDA	Food and Drug Administration
FFS	Fee for Service
FY	Fiscal Year
HH+H	Home Health and Hospice
HIV	Human Immunodeficiency Virus
ICD-10	International Classification of Diseases, 10th Revision
MAC	Medicare Administrative Contractor
MLN	Medicare Learning Network
PrEP	Pre-Exposure Prophylaxis

Agenda

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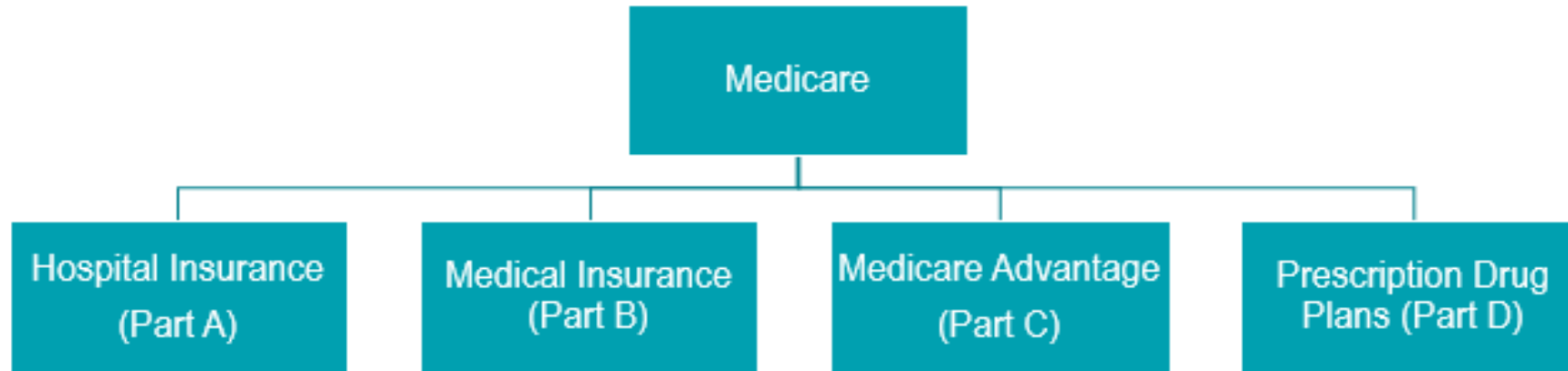
Review of the Comprehensive Error Rate Testing (CERT) Program

Novitas Solutions, Inc.

Who We Are and What We Offer



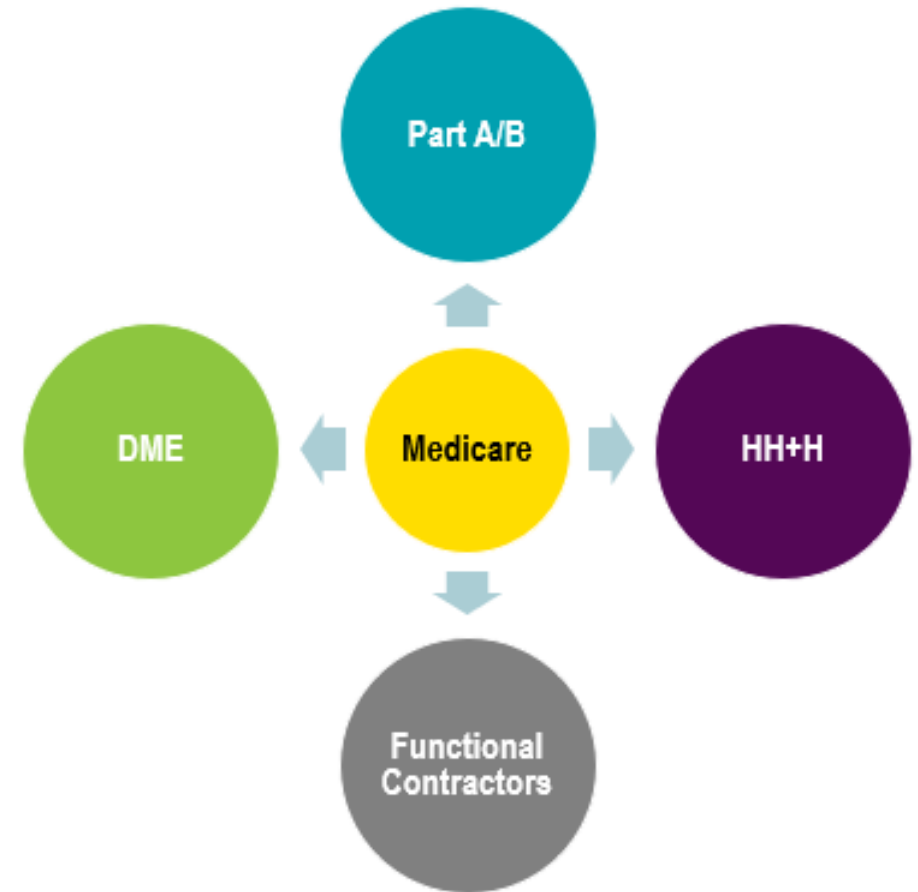
Medicare Program



- Background:
 - [CMS](#) is the federal agency that provides health coverage for the Medicare program
 - The Medicare program is the largest health insurance program in the United States
- Purpose:
 - Provides insurance coverage to individuals able to enroll:
 - Age 65 and older
 - Disabled individuals under the age of 65
 - Individuals with permanent kidney failure (End Stage Renal Disease)
- Note: MACs do not have information or answer questions on Medicare Advantage plans
- References:
 - [Centers for Medicare & Medicaid Services](#)
 - [What Medicare Part A Covers](#)
 - [What Medicare Part B Covers](#)
 - [Medicare Advantage Plan Directory](#)
 - [Prescription Drug Plan Directory](#)

CMS Contractors

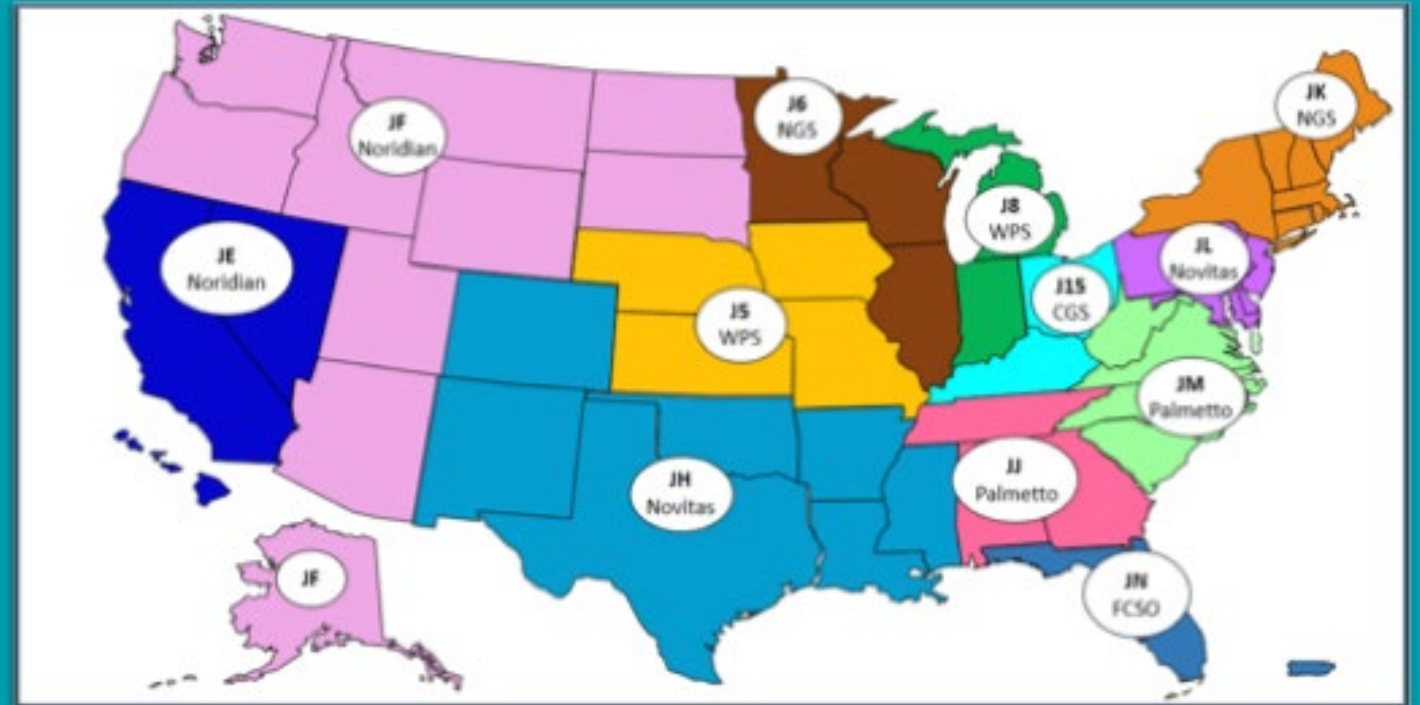
- Medicare Administrative Contractor (MAC) definition:
 - MACs are multi-state, regional contractors responsible for processing Medicare claims for a defined geographic area or “jurisdiction”:
 - Part A: hospital insurance
 - Part B: medical insurance
 - Durable Medical Equipment, Orthotics, and Prosthetics (DMEPOS)
 - Home Health and Hospice (HH+H)
- Functional Contractors definition:
 - Other CMS contractors who assist with:
 - Facilitating program integrity activities
 - Performing administrative functions
 - Promoting equitable access to high quality and affordable health care
- Reference:
 - [What's a MAC](#)



MAC Jurisdictions: Part A/B

- Novitas Solutions:
 - Part A/B Jurisdiction H (JH):
 - AR, CO, LA, MS, NM, OK, and TX
 - Indian Health Services (IHS)
 - Part A/B Jurisdiction L (JL):
 - DC, DE, MD, NJ, PA
- Two main office locations:
 - Jacksonville, FL
 - Mechanicsburg, PA
- [CMS jurisdiction maps](#)

Map of Medicare Part A/B MAC Jurisdictions



What MACs Do



Novitas Solutions

Medicare Administrative Contractor

Jurisdiction L (JL)

Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania as well as Arlington and Fairfax counties in Virginia, and the cities of Alexandria, Fairfax, and Falls Church in Virginia for Part B services only



www.novitas-solutions.com

Provider Resources

Assistance is available!

Education

[Events and Registration](#)

[On-Demand Learning](#)

Provider Enrollment

[Enrollment Application Forms](#)

[Tutorials](#)

[Submission Options](#)

Novitasphere Portal

[Portal Enrollment](#)

[Features and Functionality](#)

Electronic Billing – EDI

[EDI Enrollment](#)

[PC-ACE Software](#)

[Electronic Remittance Advice](#)

Additional Help

[New Provider Roadmap](#)

[Self-Service Tools](#)

[Fee Schedules](#)

Contact Us

Get connected!

Customer Contact Center

1-877-235-8073

Monday – Friday 8 a.m. – 4 p.m. ET/CT/MT

[Phone numbers and mailing addresses](#)

Electronic Mailing List

[Latest news and updates](#)

Social Media

Follow us on:

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Novitas Portal - Novitasphere

- Novitasphere is a secure internet portal that is available to providers, billing services, and clearinghouses for FREE! ([JH](#)) ([JL](#))
- Novitasphere provides numerous tools to help prevent billing errors and other compliance concerns including (not an all-inclusive list):
 - Patient eligibility details
 - MBI lookup tool
 - Claim status
 - Appeals
 - Claim corrections (Part B only)
 - Comparative billing reports (Part B only)
 - Submit/Retrieve Documents
- Live Chat feature
- Dedicated Help Desk- 1-855-880-8424



Educational Opportunities

- Live webinars focused on specialty specific and widespread topics incorporating real-time Medicare requirements, processes, and instructions regarding how to prevent frequent and costly errors:
 - Topics change monthly
 - Workshop series:
 - StayConnected:
 - ❑ Series of topic/service-related events focused on outlining CMS requirements, including coverage, billing, etc.
 - Medicare Navigator:
 - ❑ Series of events focused on assisting providers navigate to, identify, perform, submit, etc., necessary Medicare tasks
 - Event Calendar ([JH](#)) ([JL](#))
- We developed a full repository of on-demand educational resources available when it is most convenient to you:
 - Click-and-play videos ([JH](#)) ([JL](#))
 - Webinar recordings ([JH](#)) ([JL](#))
- **Free:**
 - All educational opportunities are free



Medicare Initiatives and Reminders

CMS News and Publication Resources

- [CMS Newsroom](#):
 - Updates fact sheets to press releases
 - Latest Medicare news and information
- [CMS Transmittals](#):
 - CMS uses transmittals to communicate new or changed policies or procedures that will be incorporated into the CMS Online Manual System
 - Not every change request will have an MLN article or newsletter
- [MLN Matters Articles](#):
 - Articles explain national Medicare policies on coverage, billing, and payment rules for specific provider types
 - If there's an Article or a newsletter message, you'll find it in the "Provider Education" column.
- [MLN Connects](#):
 - Weekly email newsletter issued by CMS that includes a compilation of Medicare news, educational events, MLN Matters articles, MLN products, and much more
 - Sometimes CMS explains information in an MLN Connects newsletter message instead of an MLN Matters Article
- [Medicare Coverage Database \(MCD\)](#):
 - Starting point to search for Medicare coverage documents
 - Includes National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), Proposed LCDs, Local Coverage Articles, and Draft Articles

Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update



What

- Medicare deductible, coinsurance and premium rate updates



When

- Effective date: January 1, 2025
- Implementation date: January 6, 2025



Who

- Physicians, hospitals and suppliers

- Key information:
 - 2025 Part A – Hospital Insurance:
 - Deductible: \$1,676.00
 - Coinsurance:
 - ❑ \$419.00 a day for 61st-90th day
 - ❑ \$838.00 a day for 91st-150th day (lifetime reserve days)
 - ❑ \$209.50 a day for 21st-100th day (Skilled Nursing Facility coinsurance)
 - 2025 Part B – Medical Insurance:
 - Deductible: \$257.00 a year
 - Coinsurance: 20 percent
- Reference:
 - [Medicare Learning Network \(MLN\) Matters Article: MM13796 "Medicare Deductible, Coinsurance, & Premium Rates: CY 2025 Update"](#)
 - Deductible/Co-Insurance/Therapy Threshold: ([JH](#)) ([JL](#)) ([JN](#))

2025 Annual Update of Per-Beneficiary Threshold Amounts



What

- 2025 Annual Update of Per Beneficiary Threshold Amounts



When

- Effective Date: January 1, 2025
- Implementation Date: January 6, 2025



Who

- All providers and physicians/Nonphysician practitioners submitting claims to Medicare

- Key Information:

- For CY 2024, the KX modifier threshold amounts are:
 - \$2,410 for PT and SLP services combined, and
 - \$2,140 for OT services.
- The Medical Record (MR) threshold amount :
 - PT and SLP services combined remains at \$3,000
 - OT services remains at \$3,000
 - Note: These threshold amounts will remain in place until CY2028 at which time will be updated by the Medicare Economic Index (MEI)

- Reference:

- [Change Request \(CR\) 13826 - 2025 Annual Update of Per-Beneficiary Threshold Amounts](#)

2025 Annual Update to Therapy Code List



What

- 2025 Annual Update to Therapy Code List



When

- Effective Date: January 1, 2025
- Implementation: January 6, 2025



Who

- All providers and physicians/Nonphysician practitioners submitting claims to Medicare

- Key Information:

- This provides an update to the list of codes that sometimes or always describe therapy service
- The additions, changes, and deletions to the therapy code list reflect those made in the CY 2025 HCPCS/CPT-4

- Action item:

- Allow physicians and certain Nonphysician Practitioners (NPPs), including nurse practitioners, physician assistants, and clinical nurse specialists to provide these services outside a therapy plan of care when appropriate
- When furnished under a plan of care, modifier must be used (GP, GO or GN) to reflect that it's under a physical therapy, occupational therapy, or speech-language pathology plan of care, respectively

2025 Annual Update to Therapy Code List (cont.)

- Action items:
 - CMS is adding 3 CPT codes and long descriptors as “sometimes therapy” codes:
 - G0541- Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; initial 30 minutes
 - G0542- Caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service) (Use G0542 in conjunction with G0541)
 - G0543- Group caregiver training in direct care strategies and techniques to support care for patients with an ongoing condition or illness and to reduce complications (including, but not limited to, techniques to prevent decubitus ulcer formation, wound care, and infection control) (without the patient present), face-to-face with multiple sets of caregivers
- Reference:
 - [Change Request \(CR\) 13823 - 2025 Annual Update to Therapy Code List](#)

Summary of Policies in CY 2025 Hospital OPPS and ASC Final Rule



What

- CY 2025 Hospital OPPS and ASC Final Rule



When

- Effective date: January 1, 2025



Who

- Physicians, hospitals, suppliers and other providers billing MACs for Medicare services

- Key Points:

- Final rule summarizes the following topics:

- Updates to OPPS and ASC payment rates
- Updates to intensive outpatient program (IOP) and partial hospitalization program (PHP) rates
- Access to non - opioid treatments for pain relief
- Certain diagnostic radiopharmaceuticals
- Add-on payment for domestically produced Technetium-99m (Tc-99m)
- Individuals formerly in the custody of penal authorities
- Obstetrical (OB) Condition of Participation (CoP) and provisions for OB services
- Quality reporting

- Reference:

- [CY 2025 Medicare Hospital OPPS and ASC Payment System Final Rule\(1809-FC\)](#)

Summary of Policies in 2025 Medicare Physician Fee Schedule Final Rule



What

- Calendar Year 2025 Medicare Physician Fee Schedule



When

- Effective date: January 1, 2025
- Implementation: January 6, 2025



Who

- Physicians
- Non-Physician Practitioner

- Key Points:

- Final rule summarizes the following topics:

- Telehealth
- Caregiver training
- Therapy
- Cardiovascular risk assessment and management
- Evaluation and management
- Behavioral health
- Advanced primary care management
- Global surgery payment
- Dental and oral health

- References:

- [Medicare Learning Network \(MLN\) Article: MM13887: Summary of Policies in CY 2025 Medicare Physician Fee Schedule Final Rule](#)
- [MLN Connects December 5, 2024 – Medicare Physician Fee Schedule Final Rule Summary: CY 2025](#)
- [Final Rule](#)

International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs) and Update to the Appropriate Use Criteria (AUC) Program



- Maintenance update of ICD-10 conversions and other coding updates specific to 6 NCDs



- Effective Date: January 1, 2025, or as indicated in the business requirements table



- Physicians, providers and suppliers

- Key information:

- Make sure your billing staff knows about:
 - Newly available codes
 - Recent coding changes
 - NCD coding information

- References:

- [Medicare Learning Network \(MLN\) Matters Article: MM13706 “ICD-10 & Other Coding Revisions to National Coverage Determinations: January 2025 Update”](#)
- [International Classification of Diseases, 10th Revision \(ICD-10\) and Other Coding Revisions to National Coverage Determinations \(NCDs\) and Update to the Appropriate Use Criteria \(AUC\) Program--January 2025](#)

Coding for Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging Ends December 31



What

- CMS will stop processing AUC coding



When

- Effective Date: January 1, 2024
- Implementation Date: January 3, 2025



Who

- Physicians, providers, suppliers, and other Medicare providers billing MACs for advanced diagnostic imaging services they provide to Medicare patients

- Key information:
 - In nearly 2024, CMS announced a pause in the AUC program for advanced diagnostic imaging
 - Effective with claims received on and after January 1, 2024, providers and suppliers were instructed to stop including AUC consultation coding
 - CMS will stop processing these codes after December 31, 2024:
 - G codes 1000–1024
 - Modifiers MA–MH and QQ
- References:
 - [Medicare Learning Network \(MLN\) Matters Article: MM13485 “Appropriate Use Criteria for Advanced Diagnostic Imaging: CY 2024 Update”](#)
 - [2024-12-19 MLN Connects Weekly Edition Newsletter: Coding for Appropriate Use Criteria Program for Advanced Diagnostic Imaging Ends December 31](#)

Prior Authorization Review Timeframe Change



What

- Prior authorization review timeframe change



When

- Effective Date: January 1, 2025
- Implementation Date: January 1, 2025



Who

- Part A Hospital Outpatient Departments

- Key information:
 - CMS is changing the review timeframe for standard prior authorization decisions from 10 business days to 7 calendar days for requests submitted on or after January 1, 2025
 - Timeframe for expedited requests remains 2 business days
- References:
 - [CMS Prior Authorization \(PA\) Program for Certain Hospital Outpatient Department \(OPD\) Services Operational Guide](#)
 - [2024-11-14 MLN Connects Weekly Edition Newsletter: Prior Authorization Review Timeframe Change](#)

ICD-10-CM Diagnosis Codes: Fiscal Year 2025



- ICD-10-CM code updates for 2025



- Effective Date: October 1, 2024



- Physicians, hospitals, suppliers and other providers billing for Medicare services

- Key information:
 - 2025 ICD-10-CM codes are to be used for discharges occurring from October 1, 2024, through September 30, 2025, and for patient encounters occurring from October 1, 2024, through September 30, 2025
- Reference:
 - [ICD-10 website](#)

Annual Clotting Factor Furnishing Fee Update 2025



What

- Update to the clotting factor furnishing fee



When

- Effective date: January 1, 2025
- Implementation date: January 6, 2025



Who

- Laboratory physicians, suppliers and other providers billing Medicare Administrative Contractors (MACs) for laboratory services

- Key Points:
 - Clotting factor furnishing fee for 2025 is \$0.258 per unit
- Reference:
 - [Change Request \(CR\): CR 13742 Annual Clotting Factor Furnishing Fee Update 2025](#)
- Additional Updates:
 - Hymravzi (marstacimab-hncq) is now considered to be a clotting factor:
 - Not listed on the ASP drug file or NOC pricing files
 - Furnishing fee applies
 - Reference:
 - [CMS Pub. 100-04, Medicare Claims Processing Manual, Chapter 17 –Drugs and Biologicals, Section 80.4.1 - Clotting Factor Furnishing Fee](#)

January 2025 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files



What

- Quarterly update to ASP drug pricing files



When

- Effective date: January 1, 2025
- Implementation date: January 6, 2025



Who

- Providers and suppliers billing ASP and not otherwise classified (NOC) HCPCS codes

• Key Points:

- File: January 2025 ASP and ASP NOC -- Effective Dates of Service: January 1, 2025, through March 31, 2025
- File: October 2024 ASP and ASP NOC -- Effective Dates of Service: October 1, 2024, through December 31, 2024
- File: July 2024 ASP and ASP NOC -- Effective Dates of Service: July 1, 2024, through September 30, 2024
- File: April 2024 ASP and ASP NOC -- Effective Dates of Service: April 1, 2024, through June 30, 2024
- File: January 2024 ASP and ASP NOC -- Effective Dates of Service: January 1, 2024, through March 31, 2024
- References:
 - [Change Request \(CR\): CR 13802 - January 2025 Quarterly Average Sales Price \(ASP\) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files](#)
 - [ASP Pricing Files](#)

Technical Revision to Section 50.4.2 “Unlabeled Use of Drug” in the Medicare Benefit Policy (MBP) Manual



What

- Technical change made to the MBP Manual, Pub. 100-02 Chapter 15, section 50.4.2



When

- Effective January 9, 2025



Who

- Part A and Part B providers

- Key Information:

- Effective January 9, 2025, manual text reference in the [Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15 - Covered Medical and Other Health Services, Section 50.4.2 “Unlabeled Use of Drug”](#) is being revised from 50.5 (Self-Administered Drugs and Biologicals) to 50.4.5 (Off-Label Use of Drugs and Biologicals in an AntiCancer Chemotherapeutic Regimen):
 - In the case of drugs used in an anti-cancer chemotherapeutic regimen, unlabeled uses are covered for a medically accepted indication as defined in [§50.4.5](#)

- Reference:

- [Change Request \(CR\) 13829 - Technical Revision Only to the Medicare Benefit Policy \(MBP\) Manual, Publication \(Pub\) 100-02, Chapter 15, section 50.4.2](#)

Changes to the Laboratory National Coverage Determination Edit Software: January 2025 Update



What

- Changes to the laboratory national coverage determination (NCD) edit software for January 2025



When

- Effective date: January 1, 2025
- Implementation date: January 6, 2025



Who

- Laboratory physicians, suppliers and other providers billing Medicare Administrative Contractors (MACs) for laboratory services

- Key Points:

- 26 NCDs with relevant coding changes in the NCD spreadsheets:
 - NCDs 190.12-190.34
- Reference:
 - [Change Request \(CR\): CR 13785 “Changes to the Laboratory National Coverage Determination Edit Software: January 2025 Update”](#)

Medicare Change of Status Notice (MCSN) Manual Instructions



- Guidance for expedited determinations when a beneficiary is reclassified from an inpatient to an outpatient receiving observation services



- Effective date; November 15, 2024
- Implementation date: February 14, 2025



- Part A Hospitals (including critical access hospitals)

- Key information:
 - When hospitals reclassifies Medicare patients from an inpatient to an outpatient receiving observation services beneficiary has the right to appeal their status change to a Beneficiary and Family Centered Care-Quality Improvement Organization (BFCC-QIO)
 - Eligibility requirements for the expedited determination process:
 - Reclassification must happen while the patient is still in the hospital and 1 of the following applies:
 - The patient has Medicare Part B and their hospital stay was at least 3 days
 - The patient doesn't have Part B
 - MCSN must be delivered to all eligible patients as soon as possible, but no later than 4 hours prior to discharge:
 - Eligible patients with Part B must reach their 3rd day in the hospital before receiving the MCSN
 - Review the references for additional information on:
 - Overview of the MCSN process and expedited determination process
 - Delivery requirements
 - BFCC-QIO and hospital responsibilities
- Reference:
 - [Change Request \(CR\) 13846 "Medicare Change of Status Notice \(MCSN\) Manual Instructions"](#)
 - [Medicare Learning Network MM 13846 Medicare Change of Status Notice Instructions \(Expedited Determinations When a Patient is Reclassified from an Inpatient to an Outpatient Receiving Observation Services\)](#)

Provider Enrollment Application Fee: CY 2025



What

- Calendar Year 2025 Provider Enrollment Application Fee



When

- Effective date: January 1, 2025



Who

- Institutional Providers

• Key Points:

- Effective January 1, 2025, the application fee is \$730 for institutional providers who are:
 - Initially enrolling in the Medicare or Medicaid programs or the Children's Health Insurance Program (CHIP)
 - Revalidating their Medicare, Medicaid, or CHIP enrollment
 - Adding a new Medicare practice location
- CMS requires this institutional provider fee with any of these enrollment applications submitted from January 1 through December 31, 2025

• References:

- [2024-12-12 MLN Connects Weekly Edition Newsletter: Institutional Provider Enrollment Application Fee: CY 2025](#)
- [CMS Application Fee Chart](#)
- [Medicare Application Fee Factsheet](#)

New Interest Rate for Medicare Overpayments and Underpayments

1st Quarter Notification for FY 2025



What

- New interest rate for 1st quarter Medicare overpayments and underpayments



When

- Effective date: October 18, 2024
- Implementation date: October 18, 2024



Who

- All providers and suppliers

- Key Points:
 - New interest rate for 1st quarter Medicare overpayments and underpayments:
 - 12.375 percent
- References:
 - [Change Request \(CR\) 13853 - Notice of New Interest Rate for Medicare Overpayments and Underpayments -1st Quarter Notification for FY 2025](#)



Quarterly Credit Balance Reports No Longer Required



What

- Modification of the quarterly Credit Balance Report requirement



When

- Effective December 1, 2024



Who

- Part A providers

- As of December 1, 2024, Credit Balance Reports are **no longer** required to be submitted on a quarterly basis
- Provider are still required to report self-identified overpayments:
 - Providers are encouraged to perform adjustments when a self-identified overpayment is identified:
 - If the providers adjustment is not finalizing, then submit the credit balance report:
 - Include a corrected UB-04 with the credit balance submission
- Reference:
 - [2024-12-19 MLN Connects Weekly Edition Newsletter: Quarterly Credit Balance Reports No Longer Required](#)

Unsolicited Voluntary Refunds Notification 2024

- Providers may at times receive incorrect payment (e.g., for services/items not covered, erroneously billed, etc.):
 - A refund should be sent to the MAC by the provider
 - Otherwise, an overpayment, which is a debt due to the Medicare program, will be established when the error is identified by the MAC
- Medicare expects providers to exercise care when billing and accepting payment and expects that providers will promptly bring incorrect payments to the MAC's attention
- These submissions acknowledge your awareness of this expectation and confirm a measure of compliance
- Please be aware that the [Medicare Program Integrity Manual, Pub. 100-08, Chapter 4, Section 4.2.2.8.1.3](#) states:
 - The acceptance of a voluntary refund in no way affects or limits the rights of the Federal Government or any of its agencies or agents to pursue any appropriate criminal, civil, or administrative remedies arising from or relating to these or any other claims
- Reference:
 - [Unsolicited Voluntary Refunds Notification 2024](#)

Keep Your Patients Healthy



Discuss Preventive Services With Your Patient

- Definition:
 - Preventive services can be defined as patient counseling and screenings to prevent illness, disease, and other health-related problems
- Purpose:
 - Providers play a crucial role in promoting, providing, and educating Medicare patients about potentially life-saving preventive services and screenings:
 - Encourage your Medicare patients to take advantage of covered preventive services
 - Medicare covers many preventive services at little or no cost to your patients
- Resources:
 - [CMS Preventive Services Page](#)
 - [CMS Preventive Services Video](#)
 - [Medicare Claims Processing Manual, Pub. 100-04, Chapter 18 – Preventive and Screening Services](#)

Preventive Services and Screenings Covered by Medicare

- Alcohol Misuse Screening & Counseling
- Annual Wellness Visit
- Bone Mass Measurements
- Cardiovascular Disease Screening Tests
- Cervical Cancer Screening
- Colorectal Cancer Screening
- Counseling to Prevent Tobacco Use
- COVID-19 Vaccine & Administration
- Depression Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Flu Shot & Administration
- Glaucoma Screening
- Hepatitis B Screening
- Hepatitis B Shot & Administration
- Hepatitis C Screening
- HIV Prep
- HIV Screening
- IBT for Cardiovascular Disease
- IBT for Obesity
- Initial Preventive Physical Exam
- Lung Cancer Screening
- Mammography Screening
- Medical Nutrition Therapy
- Medicare Diabetes Preventive Program
- Pneumococcal Shot & Administration
- Prolonged Preventive Services
- Prostate Cancer Screening
- Screening Pap Test
- Screening Pelvic Exam
- STI Screening & HIBC to Prevent STIs
- Ultrasound AAA Screening

Interactive Preventive Services Tool

- [Preventive Services Tool](#)

Medicare Preventive Services						
Overview •		📍 Telehealth Eligible Services •		Resources		
✕ Select a Service			FAQs			
Alcohol Misuse Screening & Counseling ^T	Annual Wellness Visit ^T	Bone Mass Measurement	Cardiovascular Disease Screening Test	Cervical Cancer Screening	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use ^T
COVID-19 Vaccine & Administration	Depression Screening ^T	Diabetes Screening	Diabetes Self-Management Training ^T	Flu Shot & Administration	Glaucoma Screening	Hepatitis B Screening
Hepatitis B Shot & Administration	Hepatitis C Screening	HIV PrEP ^T	HIV Screening	IBT for Cardiovascular Disease ^T	IBT for Obesity ^T	Initial Preventive Physical Exam
Lung Cancer Screening ^T	Mammography Screening	Medical Nutrition Therapy ^T	Medicare Diabetes Prevention Program	Pneumococcal Shot & Administration	Prolonged Preventive Services ^T	Prostate Cancer Screening
Screening Pap Test	Screening Pelvic Exam	STI Screening & HIBC to Prevent STIs ^T	Ultrasound AAA Screening			

Telehealth and Preventive Services

- Preventive services eligible for telehealth will have the “telehealth eligible” icon

The diagram illustrates the process of identifying telehealth-eligible preventive services. It starts with a green square containing a white 'T' in a circle. An arrow points to a screenshot of a website titled "Medicare Preventive Services". The website has a header with "Telehealth Eligible Services" and "Select a Service". Below the header is a grid of service cards. Each card lists a service and includes a small 'T' in a circle icon. The services listed are: Alcohol Misuse Screening & Counseling, Annual Wellness Visit, Bone Mass Measurement, Cardiovascular Disease Screening Test, Cervical Cancer Screening, Depression Screening, Diabetes Screening, Diabetes Self-Management Training, Flu Shot & Administration, Glaucoma Screening, Hepatitis C Screening, HIV Screening, IBT for Cardiovascular Disease, IBT for Obesity, and Initial Preventive Physical Exam. A second arrow points from a blue square containing a blue 'T' in a circle and the text "Telehealth Eligible" to a detailed view of the "Alcohol Misuse Screening & Counseling" service. This view includes the service title, a link to "National Coverage Determination 210.8", a description, and a list of HCPCS & CPT Codes: G0442 (Annual alcohol misuse screening, 5 to 15 minutes) and G0443 (Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes).

Medicare Preventive Services				
Select a Service			FAQs	
Alcohol Misuse Screening & Counseling	Annual Wellness Visit	Bone Mass Measurement	Cardiovascular Disease Screening Test	Cervical Cancer Screening
Depression Screening	Diabetes Screening	Diabetes Self-Management Training	Flu Shot & Administration	Glaucoma Screening
Hepatitis C Screening	HIV Screening	IBT for Cardiovascular Disease	IBT for Obesity	Initial Preventive Physical Exam

Alcohol Misuse Screening & Counseling
[National Coverage Determination 210.8](#)
Also known as **Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse**

HCPCS & CPT Codes

G0442 — Annual alcohol misuse screening, 5 to 15 minutes

G0443 — Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

Influenza Vaccine Payment Allowances – Amount Update for 2024 – 2025 Season



- Notification of availability of payment allowance for seasonal influenza virus vaccines



- Effective Date: August 1, 2024
- Implementation Date: September 30, 2024



- All providers, physicians, and suppliers submitting claims to Medicare

- Key information:
 - Recurring update notification provides the availability of payment allowances for the seasonal influenza virus
 - Allowable for the 2024 – 2025 season are located:
 - [CMS Seasonal Influenza Vaccines Pricing](#)
- References:
 - [Change Request \(CR\) 13718 – Influenza Vaccine Payment Allowances – Annual Update for 2024 – 2025 Season](#)
 - [2024-08-22 MLN Connects Weekly Edition Newsletter: Seasonal Flu Vaccine Pricing 2024-2025 Season](#)

COVID-19 Vaccine – Updated Prices for 2024 – 2025 Season



What

- Notification of updated payment allowances for COVID-19 Vaccines



When

- August 22, 2024 for Pfizer-BioNTech and Moderna
- August 30, 2024 for Novavax



Who

- All providers and physicians

- Key information:

- CMS updated COVID-19 [vaccine pricing](#) for the 2024–2025 season
- CPT codes 91318–91322 effective August 22, 2024:
 - No change to payment allowances from last season
- CPT code 91304 effective August 30, 2024:
 - Payment allowance updated
- CPT code 90480 is used to bill the administration fee
- COVID claims with dates of service on and after the effective date of the updated prices paid at the prior year's amount will be reprocessed
- All fees are paid based on the national payment allowance

- Reference:

- [2024-09-12 MLN Connects Weekly Edition Newsletter: COVID-19: Updated Vaccines for 2024–2025 Season](#)

Pre-Exposure Prophylaxis (PrEP) Using Antiretroviral Drugs to Prevent HIV

- Beginning September 30, 2024, Medicare covers PrEP for preventing HIV in individuals at increased risk of getting HIV, without cost-sharing
- Medicare covers:
 - FDA-approved Pre-exposure Prophylaxis (PrEP) using antiretroviral drugs to prevent HIV in individuals at increased risk of acquiring HIV:
 - Administration of injectable PrEP using antiretroviral drugs to prevent HIV
 - Supplying or dispensing the drug regardless of the route of administration (oral and injectable)
 - Up to 8 individual counseling visits every 12 months, including:
 - HIV risk assessment (initial or continued assessment of risk)
 - HIV risk reduction
 - Medication adherence
 - Up to 8 HIV screening tests every 12 months
 - Single screening for hepatitis B virus
- Can be billed by pharmacy, physicians, health care practitioners, and institutional settings:
 - If a physician or health care practitioner buys an injectable PrEP drug, submit claims to Medicare
 - Pharmacies can bill for PrEP for HIV drugs if they are enrolled as one of the following:
 - DMEPOS supplier, submit claims to DME MAC
 - Part B pharmacy supplier, submit claims to A/B MAC
 - Effective January 1, 2025, CMS added a new HCPCS code Q0521 for pharmacies billing for Pre-exposure Prophylaxis (PrEP) for HIV drugs

PrEP to Prevent HIV

- If physician or health care practitioner prescribes PrEP drug, at least one valid ICD-10 diagnosis code should be included to help pharmacies submit their claims:
 - There are multiple diagnosis codes that may be appropriate, including codes for:
 - Z29.81 – Encounter for HIV pre-exposure prophylaxis
 - Z11.4 – Encounter for screening for human immunodeficiency virus
 - Increased risk factors
- References:
 - [Fact Sheet](#)
 - [Technical FAQs for pharmacies](#)
 - [Information for your patients](#)
 - [PrEP for HIV & related preventive services](#)
 - Allowable for physician/health care practitioner billing [Pre-exposure Prophylaxis \(PrEP\) using antiretroviral therapy to prevent HIV infection](#)
 - [MLN Connects Newsletter: October 3, 2024 - CMS Covers PrEP to Prevent HIV](#)
 - [MLN Connects Newsletter: October 17, 2024 - PrEP for HIV Billing: CMS Requires Diagnosis Codes](#)
 - [MLN Connects Newsletter: November 14, 2024 – PrEP for HIV Pharmacy Claims: New HCPCS Code & FAQ Update](#)
 - [Medicare Learning Network \(MLN\) Matters Article: MM13843 “National Coverage Determination 210.15: Pre-Exposure Prophylaxis \(PrEP\) for HIV Prevention”](#)

Hepatitis B Vaccine: Billing Requirement



What

- Hepatitis B Vaccine



When

- Effective date: January 1, 2025
- Implementation: January 1, 2025



Who

- Physicians

- Key Points:
 - Beneficiaries will no longer be required to obtain a written order form a physician to receive the hepatitis B vaccine
- References:
 - [2024-11-21 MLN Connects Weekly Edition Newsletter: Hepatitis B Vaccine: Billing Requirement update effective January 1](#)
 - [CMS-1807-F - CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies](#)

Review of the Comprehensive Error Rate Testing (CERT) Program



Comprehensive Error Rate Testing (CERT) Program

- Purpose:
 - CMS implemented the CERT program to measure improper payments in the Medicare Fee-for-Service (FFS) program
- CERT Process:
 - The CERT Program selects a random sample of claims during each reporting period
 - CMS calculates a national improper payment rate and contractor-and-service-specific improper payment rates
 - An independent medical contractor reviews the sample to determine if paid properly under Medicare coverage, coding, and billing rules
- CERT resources:
 - [2024 Medicare Fee-for-Service Supplemental Improper Payment Data](#)
 - [CERT specialty webpage](#)
 - [CERT Insider's Guide](#)
 - [CERT Fast Facts](#)



CERT Contractor

- Review contractor:
 - Empower AI, Inc. (formerly known as NCI Information Systems, Inc.)
 - Samples claims
 - Requests and receives all medical records
 - Furnishes provider customer service and education support
 - Reviews medical records
- Statistical contractor:
 - The Lewin Group, Inc.
 - Calculates improper payment rates and amounts
 - Designs sampling strategy
 - Maintains live data dashboard
- [C3Hub](#):
 - Designed to provide Medicare providers, suppliers, and contractors with information about the CERT Program and to facilitate coordination, collaboration, and communications between all stakeholders

Fiscal Year (FY) 2024 Medicare FFS Estimated Improper Payment Rate

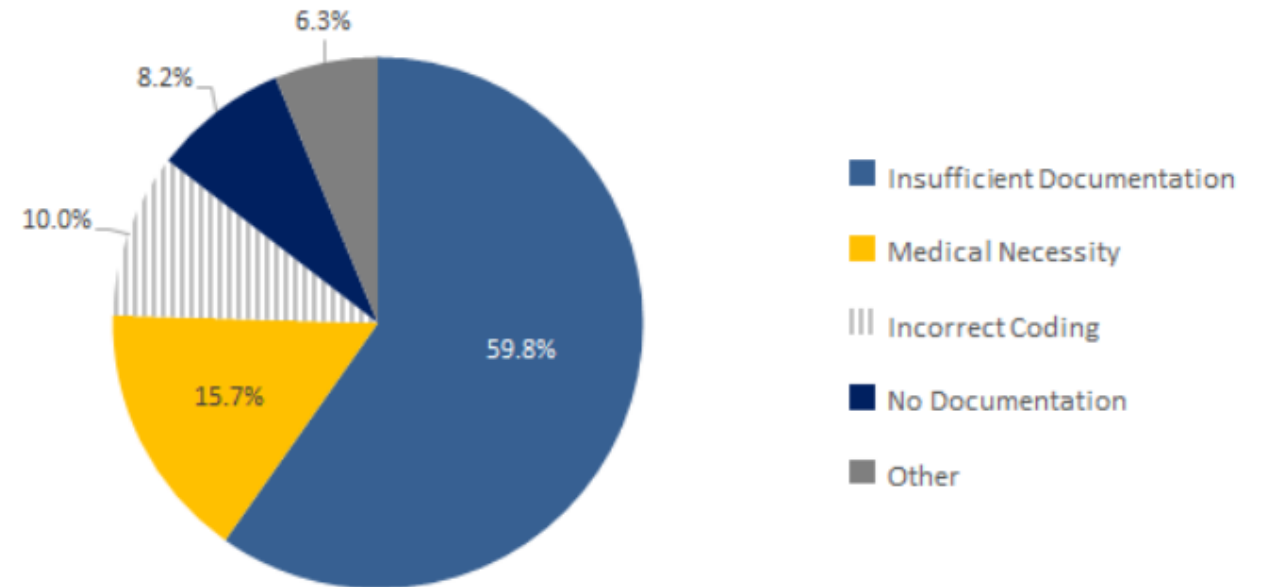
Claim Type	Improper Payment Rate	Improper Payment Amount
Overall	7.66%	\$31.70 Billion (B)
Part A providers [excluding Hospital inpatient prospective payment system (IPPS)]	7.56%	\$14.19 B
Part B providers	10.35%	\$11.45 B
Hospital IPPS	3.89%	\$5.17 B
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	21.41%	\$1.92 B

- For report year 2024, the top error categories were:
 - Skilled nursing facilities
 - Evaluation and management services
 - Hospital inpatient and outpatient services
 - Laboratory testing
- Reference:
 - [2024 Medicare Fee-for-Service Supplemental Improper Payment Data](#)

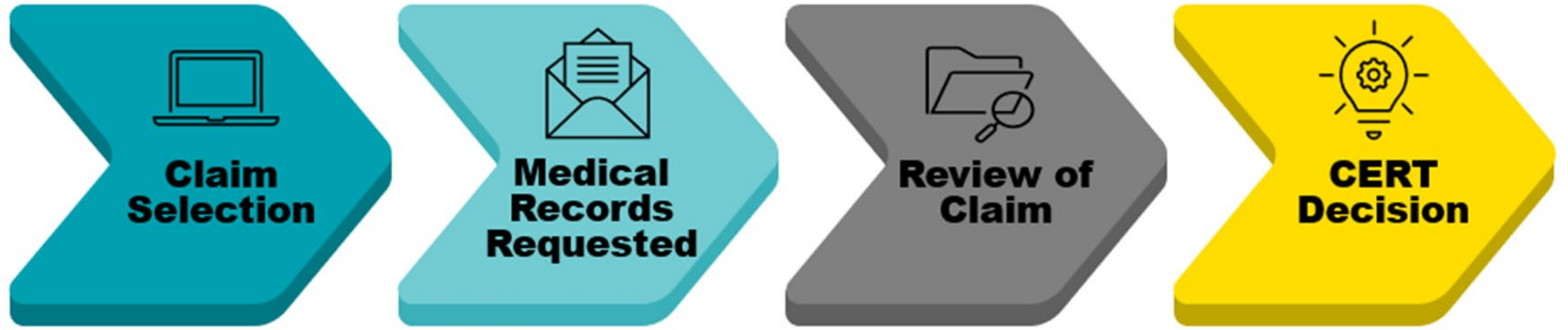
Improper Payments Categories and Percentages

- Improper payment categories:
 - No documentation
 - Insufficient documentation
 - Medical necessity
 - Incorrect coding
 - Other
- Improper payments can include:
 - Payments to an ineligible recipient
 - Payments for an ineligible service
 - Duplicate payments
 - Payments for services not received
 - Payments for an incorrect amount
- Reference:
 - [2024 Medicare Fee-for-Service Supplemental Improper Payment Data](#)

Figure 2: Improper Payment Rate Error Categories by Percentage of 2024 National Improper Payments⁴



CERT Process



● **CERT contractor will select claims for review from random sample**

● **Medical records will be requested from the provider of service**

● **CERT will review the records received**

● **CERT will determine if the claim processed correctly or if a claim error**

ADR Requests


- Additional documentation requests (ADRs) are mailed to the provider's address on file under the "Medical Records Corresponding mailing Address" in PECOS
- Not responding to a medical record request will cause a claim error and denial of the claim and recoupment of Medicare payment:
 - Respond to medical record requests within 45 days
 - Respond to CERT requests reduce claim denials and lower error rates
- Confirm or update your address:
 - [How to change or add a practice mailing address](#)
 - [Novitas Solutions YouTube Tutorial](#)
 - [C3HUB Letter and Contact Information](#)

Important CERT Reminders

- Failure to respond to a Comprehensive Error Rate Testing (CERT) request for medical records will cause a denial of your claim
- Medical record submissions:
 - Use only the barcoded coversheet and include the CID#:
 - Do not add your own cover sheet - this slows down the receipt and identification process
- Submission methods: Mail, Electronic Submission of Medical Documentation (esMD), CD, fax, or email attachment
- Reference:
 - [CERT specialty page](#)

PLACE THIS BARCODED COVER SHEET IN FRONT OF THE RECORD

**Medicare CERT Review Contractor
GS-00F-263CA CERT**

	Due Date: 5/23/2022	Medicare Part B Provider	
	Patient Name:	Patient Name	
	Claim Control Number:	0000000000000000	
	Request Date:	4/8/2022	Date(s) of Service: 10/15/2020 - 10/16/2020
	NPI/Provider #:	0000000000	Universe Date: 11/20/2020
	Contractor:	00000	Contractor Type: B
	Patient Date of Birth:	11/20/1950	
	Letter Sequence:	Initial Request	

CID: 0000000

Providers and suppliers are required to maintain documentation supporting the submission of Medicare claims and to submit this documentation upon request. The documents listed in the following chart may be needed to support Medicare payment of the claim with the date(s) of service specified above. Please provide all of the pertinent medical records/documentation and any additional documentation needed to support this claim. If any pertinent documentation is missing, incomplete, or requires explanation, please include this information in the comments section.

Key Takeaways

A photograph showing a person's hands writing in a spiral-bound notebook with a blue pen. The notebook is open on a wooden desk, and a laptop is visible in the background. The person is wearing a black watch on their left wrist and a ring on their right hand.

1. Provided the latest Medicare Administrative Contractor (MAC) news and updates
2. Supplied references to help you stay abreast on quarterly, annual and general Medicare initiatives and reminders
3. Spotlighted the importance of Medicare preventive services and how to take advantage of the various resources made available to you
4. Outlined the Comprehensive Error Rate Testing (CERT) Program

Join eNews Email

- Novitas Solutions eNews:
 - Receive current updates directly via email:
 - Part A and Part B News
 - Issued weekly
 - CMS MLN Connects issued Thursdays
 - Subscribing is quick and easy:
 - Click the Join E-Mail List (JH) (JL) from our website tool bar
 - Didn't receive verification or stopped receiving email notifications?
 - Follow these [simple steps](#) to allow emails



- [CMS MLN Connects Newsletter](#):
 - National fee-for-service news from across CMS:
 - Program and policy details
 - News and announcements
 - Press releases
 - Claim, pricer, and code information
 - Updates on new and revised MLN Matters Articles and publications

Thank You for Attending!

- Education Specialist:
 - Education Specialist, Provider Outreach and Education
 - Email address
- Stephanie Portzline:
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- Janice Mumma:
 - Supervisor, Provider Outreach and Education
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