FEBRUARY 9, 2022

eJOURNAL

PARAREV

OUR SERVICES

An Introduction To PARAREV

Technology Revenue Integrity

Medicare
Updated Payment Systems

FAQ
CMS Offers Detailed Answers

Lab Fees
Quarterly Updates To Fee Schedules

WHAT'S *in a* NAME?

A LOOK AT OUR SERVICES

PARAREV

SERVICE PROFILE

30%

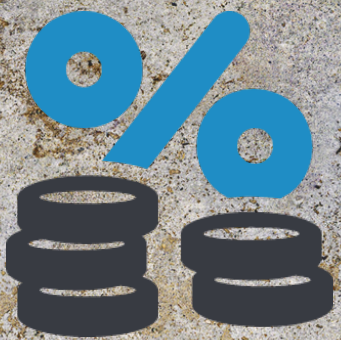
INCREASE IN COLLECTIONS. N SOME CASES UP TO 100% OR MORE

25%

CYCLE TIME IMPROVEMENT

75%

AVERAGE CASH COLLECTION RATE FOR SUPER AGED INSURANCE A/R



Increase Cash

Denial Control

Stop Revenue Leakage

Regulation / Compliance

WHATEVER YOUR REVENUE GOALS ARE, PARAREV AND ITS COMPREHENSIVE SUITE OF SERVICES IS PERFECTLY POSITIONED TO PROVIDE SIMPLE SOLUTIONS TO COMPLEX PROBLEMS.

PARAREV

REVENUE CAPTURE

TAKE BACK CONTROL OF YOUR ACCOUNTS RECEIVABLE AND ZERO BALANCE DENIALS MANAGEMENT WITH ASSISTANCE FROM PARAREV. WHETHER YOU'RE LOOKING FOR SHORT TERM HELP OR A LONG TERM PARTNERSHIP PARAREV WILL IMPROVE YOUR CASHFLOW AND REDUCE YOUR DENIALS.

REVCAP

REVENUE INTEGRITY

PROTECT YOUR FRONT-END REVENUE CYCLE WITH PARAREV. FROM CONTRACT ANALYSIS TO PRICING TRANSPARENCY AND MORE, PARAREV WILL ASSIST YOU IN ENSURING YOU'RE MAXIMIZING PROFITS WHILE MINIMIZING PATIENT DISSATISFACTION.

REVTEG


REVTEG
Revenue Integrity
REVENUE INTEGRITY
PARAREV REVENUE INTEGRITY PROGRAM
CONTRACT MANAGEMENT PROGRAM
MANAGED CARE REMIT RECONCILIATION
CONTRACT ANALYSIS
CODING & COMPLIANCE PROGRAM

CODING & COMPLIANCE PROGRAM

- PARAREV DATA MAINTENANCE
- LAB PAMA
- CLAIM REVIEW
- CHARGE MASTER REVIEW
- PURCHASE ITEM MASTER REVIEW

PRICING PROGRAM

- PHYSICIAN PRACTICE PRICING ANALYSIS
- PHARMACY PRICING ANALYSIS
- SUPPLY PRICING ANALYSIS
- MARKET-BASED PRICING

REVTEG

REVENUE TECHNOLOGY

STAY ON TOP OF THE LATEST REVENUE TECHNOLOGY AND MAXIMIZE YOUR TEAM'S PERFORMANCE WITH PARAREV'S REVENUE CYCLE TOOLS. FROM INNOVATIVE, DENIAL GUIDANCE SOFTWARE TO PRICE TRANSPARENCY TOOLS THAT CONNECTS YOUR PATIENTS TO THE ANSWERS THEY WANT, PARAREV HAS YOU COVERED.

REVTEK

ASC BILLING OPPORTUNITIES

Q. In order to comply with payer restrictions on locations and if a provider is willing to take lower reimbursement, how/could a provider billing as an ASC, rather than hospital outpatient? For example, a providers says they'll only cover a service if it's done as an ASC, rather than hospital outpatient. Is there a way to leverage our current ORs vs literally building an ASC that's attached to our hospital? Looking for direction and/or references on if there's a way to accomplish this.

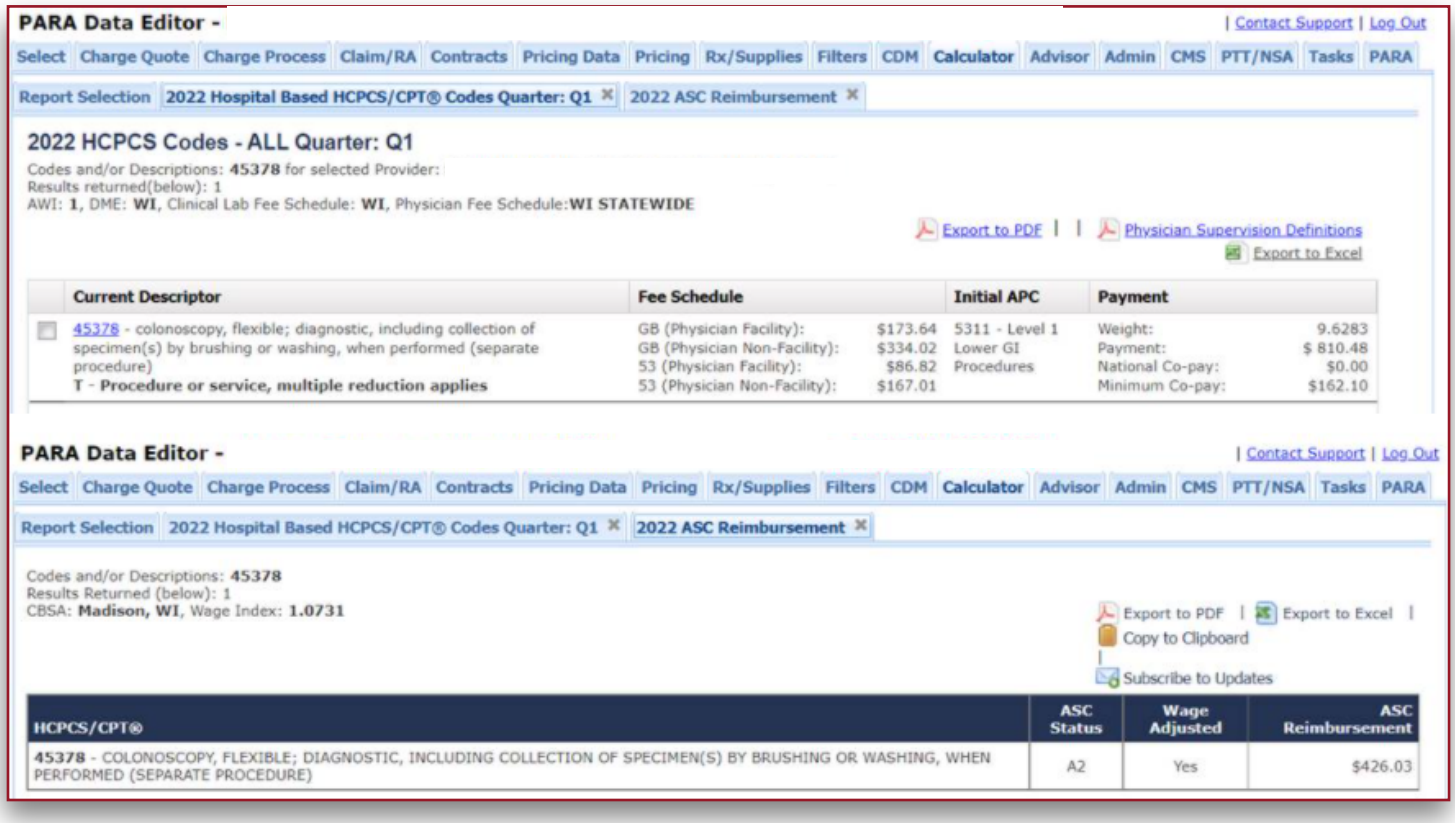
A. An ASC is a specific type of healthcare facility; it must meet state licensure requirements as an ASC and it must be enrolled with Medicare and other payors as an ASC to be eligible for payment as an ASC. ASCs report services on a professional fee claim form, the CMS1500/837i.

Some hospitals operate off-campus outpatient departments that look like an ASC, but the claims are still produced on a UB04. Some hospitals have entered into joint ventures with community physicians to operate an ASC.

It might be possible to negotiate a contract with a commercial payor that enables patients to access all ASC-limited services at the hospital. However, the payor would likely stipulate that reimbursement for such services would be at ASC rates, which are typically much lower than outpatient hospital reimbursement.

For example, Medicare will reimburse an OPPS hospital the allowable of $810 for a colonoscopy, CPT® 45378; the same procedure in an ASC would be paid at $426.03 in 2022.

ASC BILLING OPPORTUNITIES



PARA Data Editor - | Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | Advisor | Admin | CMS | PTT/NSA | Tasks | PARA

Report Selection | 2022 Hospital Based HCPCS/CPT® Codes Quarter: Q1 | 2022 ASC Reimbursement

2022 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **45378** for selected Provider:
Results returned(below): 1
AWI: **1**, DME: **WI**, Clinical Lab Fee Schedule: **WI**, Physician Fee Schedule:**WI STATEWIDE**

Export to PDF | Physician Supervision Definitions
Export to Excel

Current Descriptor	Fee Schedule		Initial APC	Payment	
45378 - colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) **T - Procedure or service, multiple reduction applies**	GB (Physician Facility): GB (Physician Non-Facility): 53 (Physician Facility): 53 (Physician Non-Facility):	$173.64 $334.02 $86.82 $167.01	5311 - Level 1 Lower GI Procedures	Weight: Payment: National Co-pay: Minimum Co-pay:	9.6283 $ 810.48 $0.00 $162.10

PARA Data Editor - | Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | Advisor | Admin | CMS | PTT/NSA | Tasks | PARA

Report Selection | 2022 Hospital Based HCPCS/CPT® Codes Quarter: Q1 | 2022 ASC Reimbursement

Codes and/or Descriptions: **45378**
Results Returned (below): 1
CBSA: **Madison, WI**, Wage Index: **1.0731**

Export to PDF | Export to Excel | Copy to Clipboard | Subscribe to Updates

HCPCS/CPT®	ASC Status	Wage Adjusted	ASC Reimbursement
45378 - COLONOSCOPY, FLEXIBLE; DIAGNOSTIC, INCLUDING COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WHEN PERFORMED (SEPARATE PROCEDURE)	A2	Yes	$426.03

ED LEVEL FOR LWBS

Q. I read your paper entitled "Emergency Department Charge Process", dated April 2016. On the top of page 2, the CMS FAQ section is what I have a question on. In regards to the scenario here; patient saw "Nurse First", then triaged. A nurse practitioner then ordered x-ray and EKG. patient then LWBS. We charged 99281 for this visit. Even through the patient did not see a physician face to face, is charging 99281 appropriate? In reviewing the CMS FAQ and verbiage stating "incident to", I think it's appropriate as long as the NP documented the reason for the x-ray and EKG. Is this appropriate? And what if there is no NP documentation and the order was based on review of Nurse First and Triage notes? Would 99281 still be appropriate?

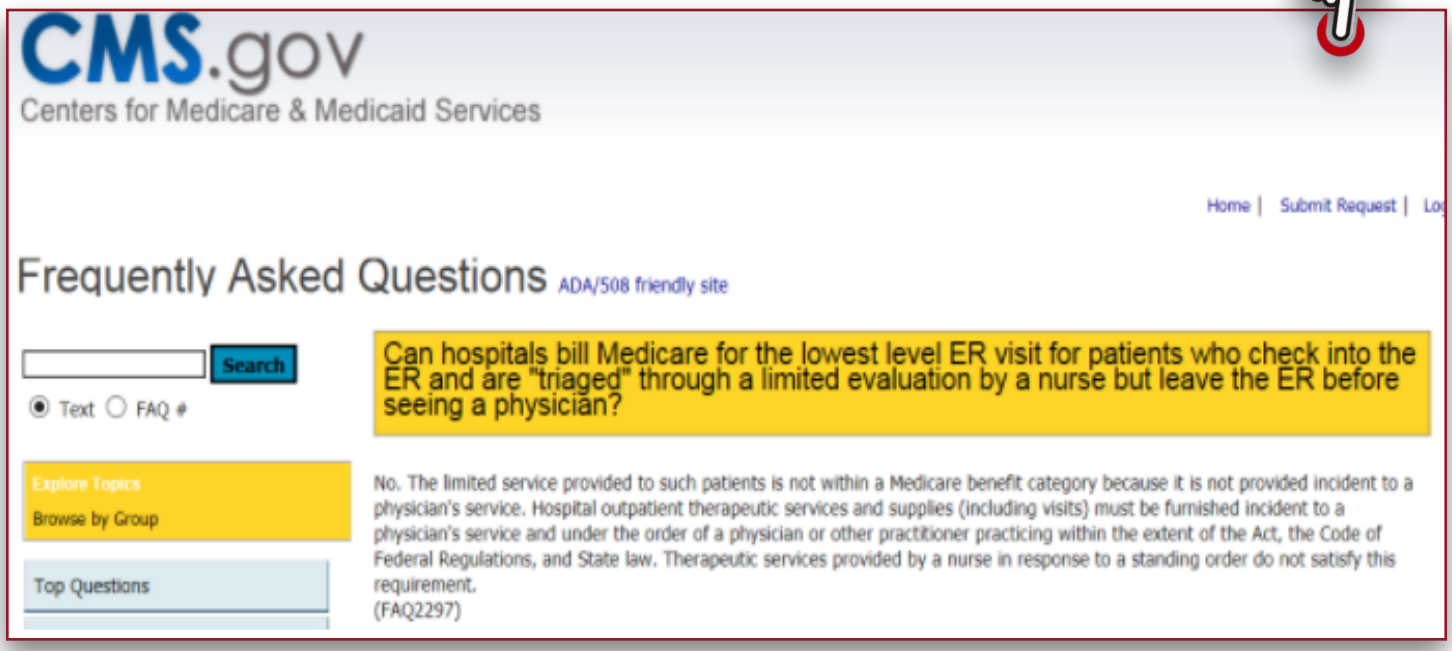
A. A provider (physician or mid-level) must have a face-to-face encounter with a patient and document a brief note before the facility can generate an ED E/M level charge. Billing for an ED E/M level is not appropriate even when applying the “incident to” scenario as this is not permitted in a hospital outpatient department. Medicare clarified in an August 2016 MedLearn article that to qualify as “incident to,” services must be part of your patient’s normal course of treatment, during which a physician personally performed an initial service and remains actively involved in the course of treatment.

In 2011 OPPS, CMS restated its position on "triage-only" visits confirming that it does not specify the type of staff who may provide services. "A hospital may bill a visit code based on the hospital's own coding guidelines which must reasonably relate the intensity of hospital resources to different levels of HCPCS codes. Services furnished must be medically necessary and documented.

”Triage is considered a required screening service and the facility could report a low-level E/M for the triage. **However**, in 2012 CMS indicated in a Facility FAQ, that hospital outpatienttherapeutic services and supplies (including visits) must be furnished incident to a physician's service and under the order of a physician or other qualified practitioner.CMS stated that an ED visit would not be paid because the patient encounter did not meet the incident to requirement. Services provided by a nurse in response to a standing order also do not satisfy this requirement.

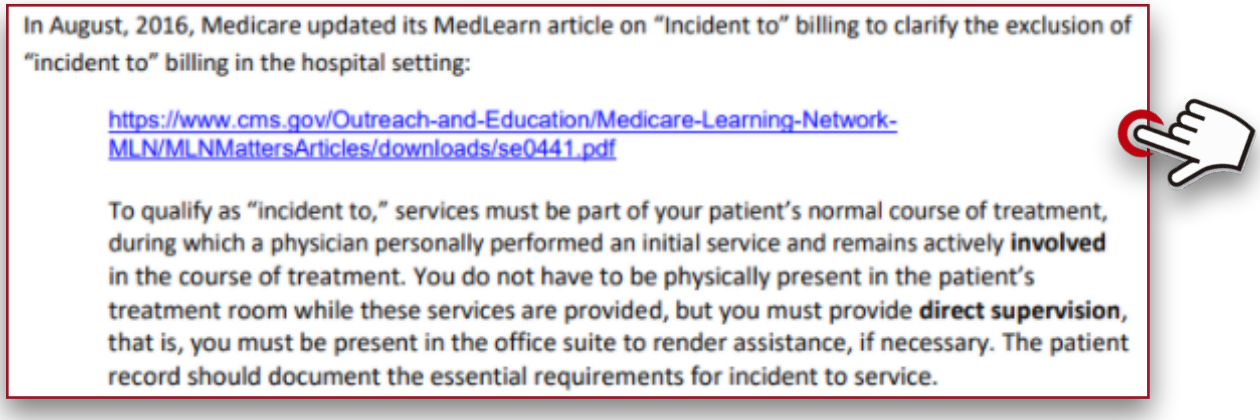
ED LEVEL FOR LWBS

Microsoft Word - Emergency - Charge Process -April 2016 Update (para-hcfs.com)



PARAREV has another paper that shares the MLN in which Medicare clarifies the "incident to" billing guidelines.

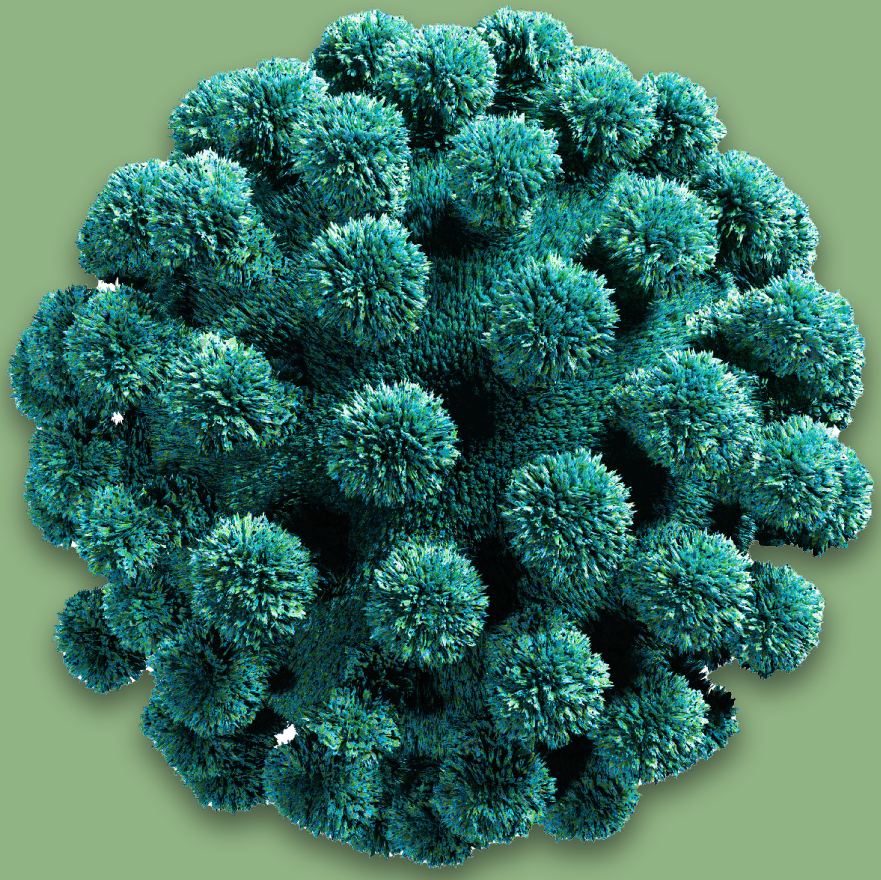
Incident_to_Billing_in_Clinic_and_Hospital_Settings_edited.pdf (para-hcfs.com)



When a facility has developed and approved "standards of care" (e.g., Labs, Imaging, EKG) based on presenting symptoms, nurses can initiate these standing orders before a patient is seen by a provider. Based on FAQ2297, the charges for these services can be billed even if the patient leaves without being seen by a provider. The financial benefit of billing for these ancillary services must be weighed against the potential customer service complaints your facility may receive from a patient who is already unsatisfied. To be consistent in billing practices, facilities should adopt a policy which sets standards for patient charges when they leave without being seen. Even if you don't charge for the service, it is beneficial to assign a zero-dollar charge code for patients who leave without being seen. This will reconcile the ED log and is also helpful for tracking ED statistics and performance.

UPDATED 1/12/22

2022 COMPREHENSIVE COVID-19 Guide



Click anywhere on this page to be taken to the full online document.

PARAREV

TUESDAY WEBINARS: COMPLYING WITH THE NO SURPRISES ACT

PARA experts are providing a free webinar each Tuesday designed to help hospitals understand and comply with the requirements under the No Surprises Act.

Every Tuesday

11:30 am PST

Sign Up By Clicking HERE,

Or Scan The QR Code

DID YOU MISS IT? NO SURPRISES ACT WEBINARS? CATCH UP HERE!

DID YOU MISS THE VERY IMPORTANT "NO SURPRISES ACT" WEBINARS AND Q&A'S? If you did you still have a chance to participate in the live versions (see previous page for links). And if you can't participate live, here are the links for the NSA Tool Demo Video , Webinars, Q&A sheets, and the Specific NSA Forms.

Our **PARAREV** team is always available to help. Please reach out on our website.

DEMO

- NSA No Surprises Act Tool Demonstration Video

WEBINARS

- NSA No Surprises Act Update Webinar- 12/21/21
- NSA No Surprises Act Update Webinar- 12/28/21
- NSA No Surprises Act Update Webinar- 1/04/22
- NSA No Surprises Act Update Webinar- 1/11/22

Q & A

- NSA No Surprises Act Update Q & A– 12/21/21
- NSA No Surprises Act Update Q & A– 12/28/21
- NSA No Surprises Act Update Q & A– 1/11/22
- PARA - NSA Update Q&A 1.18.22.pdf (para-hcfs.com)
- PARA - NSA Q&A 2022.2.1.pdf (para-hcfs.com)

FORMS

- PARA - NSA Template for Convening Facility or Provider Good Faith Estimate - updated 12.28.21
- PARA - NSA Template for Right to Receive a Good Faith Estimate of Expected Charges - updated 12.28.21
- PARA - NSA Template for Disclosure Notice - updated 12.28.21

LOGINS

- If you already have a PDE login – you have access to the NSA Tool by logging into the PDE and clicking on the PTT/NSA Tab and NSA Link Tab

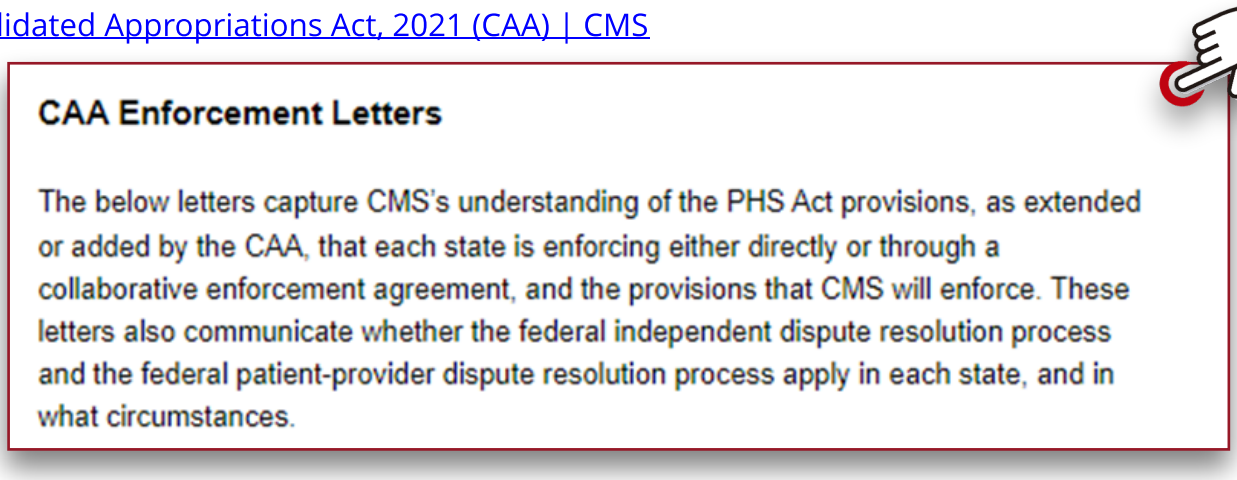
- Please make sure we have an updated email address for you – Fill out this FORM to confirm your email and to be added/updated onto the Distribution List.

STATE-LEVEL ENFORCEMENT OF NO SURPRISES ACT

The No Surprises Act (NSA) is a set of laws within the Consolidated Appropriations Act of 2021, which offers certain protections for patients against "surprise" medical bills. The law prohibits facilities and other providers from "balance billing" patients in certain situations, and the regulations require facilities to offer uninsured (or self-pay) patients a "Good Faith Estimate" of charges in advance of services.In addition, facilities and certain providers are required to provide patients with a standard Disclosure notice which informs the patient about these protections under state and federal law.

State agencies are partially responsible for enforcement of provider compliance with the NSA rules.Since the regulations became effective on 1/1/2022, CMS surveyed states to determine the state's authority and intention to enforce new provisions of the NSA. CMS has published state-specific letters which provide details on NSA enforcement at the state level and how the federal dispute resolution processes compare with existing state processes.The state-specific letter can be found on the CMS website at the link below:

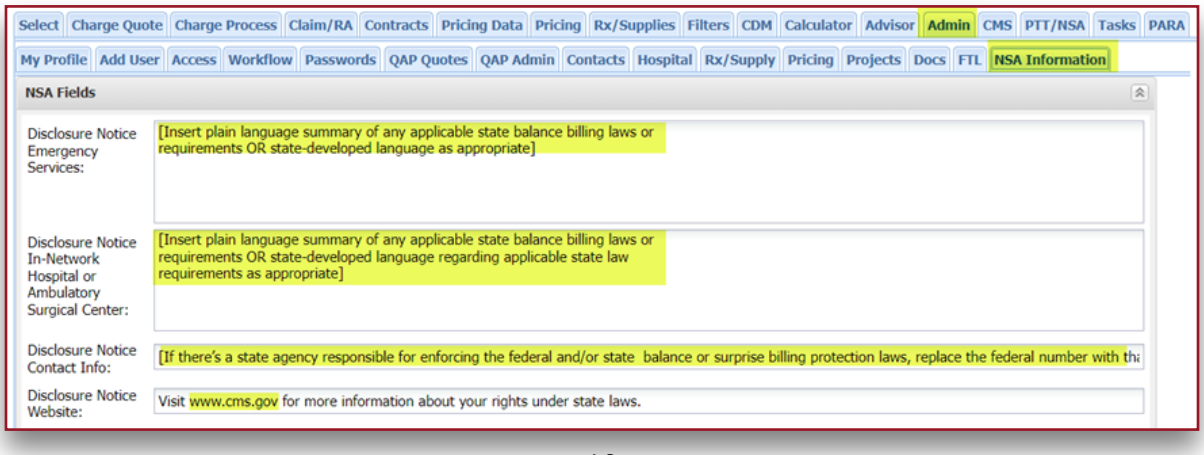
Consolidated Appropriations Act, 2021 (CAA) | CMS



CAA Enforcement Letters

The below letters capture CMS's understanding of the PHS Act provisions, as extended or added by the CAA, that each state is enforcing either directly or through a collaborative enforcement agreement, and the provisions that CMS will enforce. These letters also communicate whether the federal independent dispute resolution process and the federal patient-provider dispute resolution process apply in each state, and in what circumstances.

Information in the state letters may be useful in preparing the NSA Disclosure notice, particularly as it pertains to state enforcement authorities.Providers are encouraged to check back frequently if your state is not yet listed – state letters will continue to be added as the information is gathered by CMS.



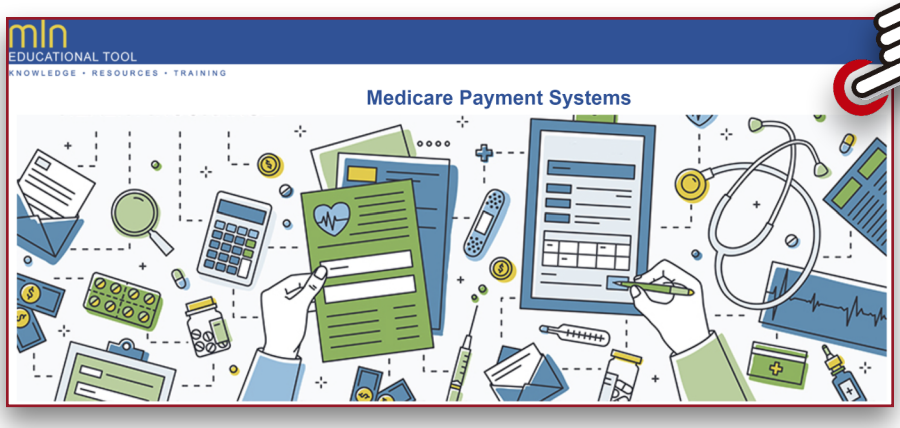
STATE ACCREDITATION SURVEYORS ASK FOR NSA DISCLOSURE NOTICES

The Washington State Department of Health paid a surprise accreditation survey visit to the hospital operated by East Adams Rural Healthcare on January 4, 2022.As part of their survey, the auditors asked to see the hospital's disclosure of patient rights ("Your Rights and Protections Against Surprise Medical Bills"), which is a new requirement effective January 1, 2022 under Medicare regulations.

East Adams was prepared for that request, and had the NSA disclosure notice process printed and staff trained to provide it to patients at registration.According to Kelly Wiggins, Interim Revenue Cycle Director at East Adams, "The resources **PARAREV** provided boosted us along to ensure that we were ready on January 1 for the new requirement."

PARAREV offers its clients a suite of services including price transparency, No Surprises Act (NSA) compliance, pricing, billing, coding, chargemaster reviews, and general consulting services.

UPDATED MEDICARE PAYMENT SYSTEMS



Medicare Payment Systems

Acute Care Hospital Inpatient Prospective Payment System (IPPS)

- Extended New COVID-19 Treatments Add-on Payment (NCTAP) under Inpatient Prospective Payment System (IPPS) to end of Fiscal Year (FY) in which the Public Health Emergency (PHE) ends
- Updated labor-related share to 67.6% if wage index is greater than 1.0 for discharges after October 1, 2021
- Implemented the reinstated "all urban" states imputed floor wage index policy, in a non-budget neutral manner, and with no expiration date
- Allowed hospitals that are treated as being located in a rural area under statute to reclassify through Medicare Geographic Classification Review Board (MGCRB) using their rural reclassified area
- Continued the 5% cap on any decrease in a hospital's FY 2022 final wage index for those hospitals receiving the transitional 5% cap in FY 2021
- FY 2022, adopted Health Readmissions Reduction Program (HRRP), a cross-program measure suppression policy, for Value-Based Purchasing (VBP) and Hospital-Acquired Condition (HAC) Reduction Program due to COVID-19 PHE
- FY 2023, suppressed 30-Day Pneumonia Readmission Measure and modified 5 condition and procedure-specific measures to exclude COVID-19 diagnosed patients from measure denominators
- FY 2023, adopted MedPAR data that aligns with applicable period HRRP calculations and all subsequent programs
- FY 2022, suppressed Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Medicare Spending per Beneficiary (MSPB) and 5 healthcare-associated infection measures
- FY 2022, revised scoring and payment methodology so hospitals won't get Total Performance Scores, but each hospital gets payment incentive multiplier equal to amount withheld FY (2%)
- FY 2023, suppressed Hospital 30-Day, All-Cause Risk-Standardized Mortality Rate Following Pneumonia because of COVID-19
- Extraordinary Circumstances Exception (ECE) policy adopted policy to suppress FY 2020 3rd and 4th quarter data from HAC Reduction Program FYs 2022, 2023, and 2024
- Changed name of Hospital Compare website to Care Compare
- Inpatient Quality Reporting (IQR) & Promoting Interoperability (PI) Programs adopted 5 new measures and removed 3 measures

FAQ: GOOD FAITH ESTIMATES IMPLEMENTATION

CMS HAS PUBLISHED A COMPREHENSIVE FREQUENTLY ASKED QUESTIONS DOCUMENT COVERING THE IMPLEMENTATION OF GOOD FAITH ESTIMATES FOR UNISURED AND SELF-PAY PATIENTS.

CLICK ON THE IMAGE BELOW TO VIEW THE ENTIRE, INFORMATIVE DOCUMENT.

Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation- Good Faith Estimates

Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals

Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 112 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021 (CAA 2021), and implementing regulations published in the Federal Register on October 7, 2021 as part of interim final rules with comment period, entitled "Requirements Related to Surprise Billing; Part II."

These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

UPCOMING "ASK THE CONTRACTOR" TELECONFERENCES Q1, 2022

Most Part A and B Medicare Administrative Contractors offer "Ask the Contractor" (ATC) teleconferences to provide hospitals and other providers an opportunity to ask questions about Medicare policies and procedures.

Some MACs permit providers to submit questions to their Medicare Administrative Contractor in advance.

Each MAC may hold separate ATC teleconferences for Part A, Part B, and DME suppliers; furthermore, each MAC mayfocus on certain topics during each ATC webinar.Not all MACs follow the same format.

Here are dates and links for upcoming ATC conferences for Part A MACs:

WPS Jurisdiction 5

- Iowa, Kansas, Missouri, and Nebraska
- Next ATC 1/25/2022
- Topic:Outpatient Rehabilitation Updates

http://wpsghalearningcenter.com/confirm-course?courseid=AM2awu6Lzvg1

NGS Jurisdiction 6 and K

- J6: Illinois, Minnesota, and Wisconsin;
- JK: Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont
- Last meeting held 12/16/2021

https://www.ngsmedicare.com/web/ngs/-/af_ask-the-contractor-teleconference_091421?lob=93617&state=97206&region=93624

- 2022 ATC conferences have not yet been announced

WPS - Jurisdiction 8

- Indiana and Michigan
- Past ATC conference recordings are available, but 2022 session schedule not yet announced

WPS J8 Part A Training Guides and Resources

Noridian Jurisdiction E - Medicare Part A

- California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands
- Next ATC March 23, 2022

https://med.noridianmedicare.com/web/jea/education/act

UPCOMING "ASK THE CONTRACTOR" TELECONFERENCES Q1, 2022

Noridian Jurisdiction F

- Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming
- Next ATC March 23, 2022

https://med.noridianmedicare.com/web/jfa/education/act

Novitas Jurisdiction H

- Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, Indian Health & Veteran Affairs
- Next ATC scheduled for February 23, 2022
- Topics will include Novitas Initiatives, Acute Hospital Provider Liable Billing, and Acute Hospital Outpatient Billing

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00008196

Palmetto - Jurisdiction J

- Alabama, Georgia, and Tennessee
- January 12, 2022; April 13, 2022

https://palmettogba.com/palmetto/jja.nsf/DID/AU9QTU8307

Novitas Jurisdication L

- Delaware, District of Columbia, Maryland, New Jersey and Pennsylvania
- Next ATC February 23, 2022
- Topics will include Novitas Initiatives, Acute Hospital Provider Liable Billing, and Acute Hospital Outpatient Billing

https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00008196

Palmetto - Jurisdiction M

- North Carolina, South Carolina, Virginia, and West Virginia
- Next ATC January 12, 2022; April 13, 2022

https://palmettogba.com/palmetto/jma.nsf/DID/89BJAR3017

First Coast Service Options - Jurisdiction N

- Search for “Ask the Contractor” found no results

https://medicare.fcso.com/FAQs/0453634.asp

OIG WILL AUDIT COVID-19 OUT OF NETWORK BILLING

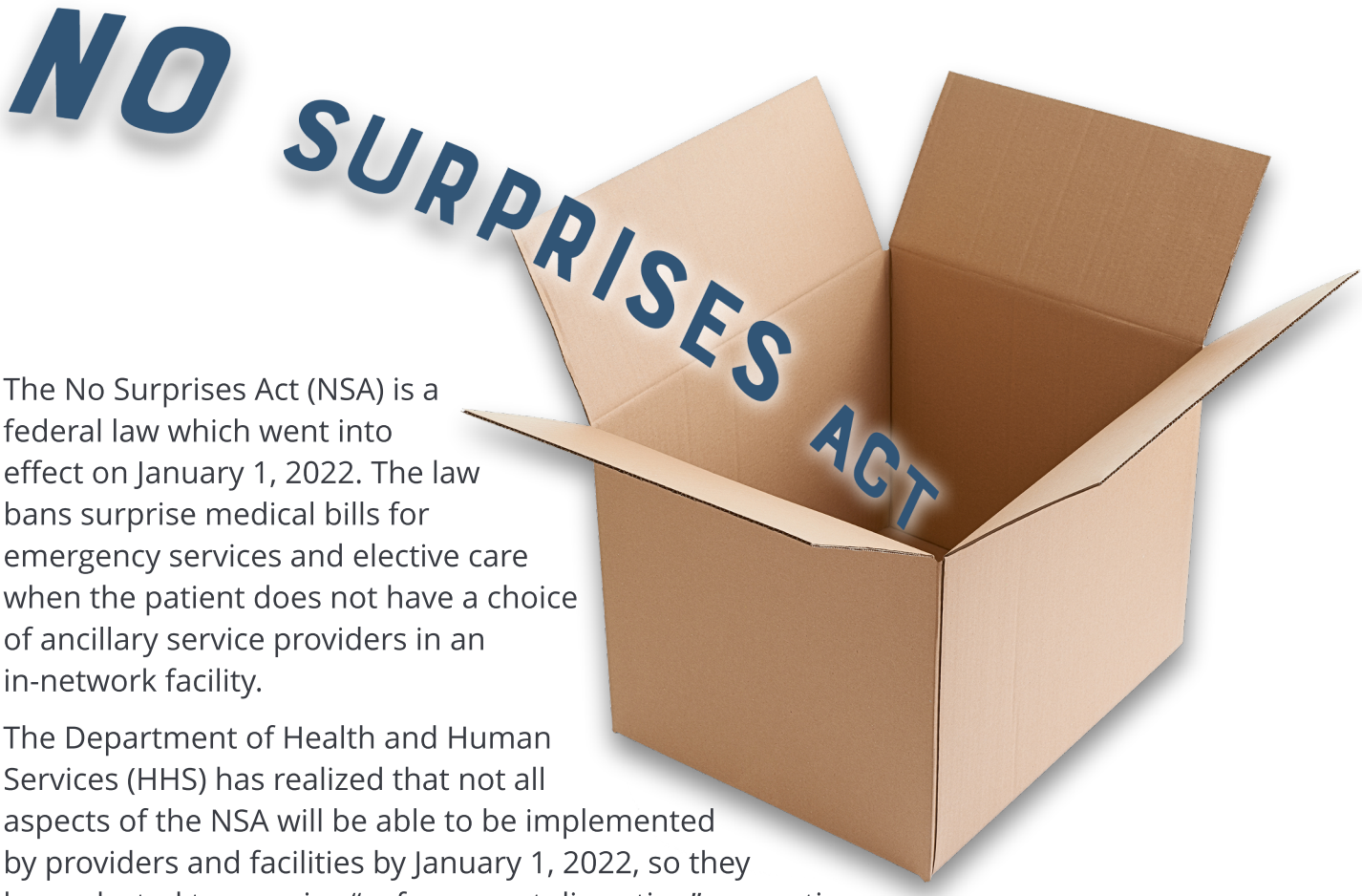
HEALTH AND HUMAN SERVICES (HHS) OFFICE OF THE INSPECTOR GENERAL (OIG) ANNOUNCED THEY WILL CONDUCT A NATIONWIDE AUDIT TO REVIEW HOW PROVIDERS CALCULATED OUT-OF-NETWORK BILLS FOR PATIENTS ADMITTED FOR COVID-19 TREATMENT.

The Provider Relief Fund (PRF), distributed through HHS and the Health Resources and Services Administration (HRSA) provides funding to health care providers for expenses and lost reimbursement because of COVID-19. As a condition for receiving the payments, a provider cannot collect more from an out-of-network patient treated for COVID-19 than the patient would have owed if the care was provided in-network.In their audit, the OIG will review the documentation on presumptive or actual COVID-19 positive patients to ensure providers who received PRF funds complied with the requirements of the program and did not incorrectly balance bill the patient.

https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000647.asp

2022 REQUIREMENTS -- UPDATED

UNPACKING THE "NO SURPRISES ACT".



The No Surprises Act (NSA) is a federal law which went into effect on January 1, 2022. The law bans surprise medical bills for emergency services and elective care when the patient does not have a choice of ancillary service providers in an in-network facility.

The Department of Health and Human Services (HHS) has realized that not all aspects of the NSA will be able to be implemented by providers and facilities by January 1, 2022, so they have elected to exercise "enforcement discretion" on portions of the act in 2022. To be in compliance in 2022, healthcare providers and health care facilities must be prepared to:

1. Publicize and disseminate a "Disclosure Notice" which informs beneficiaries of group health plans of their rights under the No Surprises Act; and
2. Publicize and disseminate a "Right to Receive a Good Faith Estimate" to uninsured or self-pay patients; and
3. Provide uninsured or self-pay patients with a good faith estimate (within a $400 threshold) of services that will be billed by the "convening" provider or facility.
4. Present a Notice and Consent form, with an estimate of charges, to a beneficiary of a group health plan who chooses to receive services from an out-of-network facility or provider and submit a claim to the health plan.

2022 REQUIREMENTS -- UPDATED

DISCLOSURE NOTICE

As of January 1, 2022, the disclosure notice must be prominently displayed on websites, in public areas of an office or facility, and on a one-page (double-sided) notice provided in-person or through mail or e-mail, as chosen by the patient. The disclosure notice must be provided to all commercially insured patients after January 1, 2022, or before that date if the elective service will be provided after January 1, 2022. The notice must be provided before requesting a payment from the insured or before a claim is submitted on behalf insured.
[eCFR :: 45 CFR Part 149 — Surprise Billing and Transparency Requirements]

(d) ***Timing of disclosure to individuals.*** A health care provider or health care facility is required to provide the notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer no later than the date and time on which the provider or facility requests payment from the individual, or with respect to an individual from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer.

(e) ***Exceptions.*** A health care provider is not required to make the disclosures required under this section -

(1) If the provider does not furnish items or services at a health care facility, or in connection with visits at health care facilities; or

(2) To individuals to whom the provider furnishes items or services, if such items or services are not furnished at a health care facility, or in connection with a visit at a health care facility.

(c) ***Required methods for disclosing information.*** Health care providers and health care facilities must provide the disclosure required under this section as follows:

(1) With respect to the required disclosure to be posted on a public website, the information described in paragraph (b) of this section, or a link to such information, must appear on a searchable homepage of the provider's or facility's website. A provider or facility that does not have its own website is not required to make a disclosure under this paragraph (c)(1).

(2) With respect to the required disclosure to the public, a provider or facility must make public the information described in paragraph (b) of this section on a sign posted prominently at the location of the provider or facility. A provider that does not have a publicly accessible location is not required to make a disclosure under this paragraph (c)(2).

(3) With respect to the required disclosure to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a provider or facility must provide the information described in paragraph (b) of this section in a one-page (double-sided) notice, using print no smaller than 12-point font. The notice must be provided in-person or through mail or email, as selected by the participant, beneficiary, or enrollee.

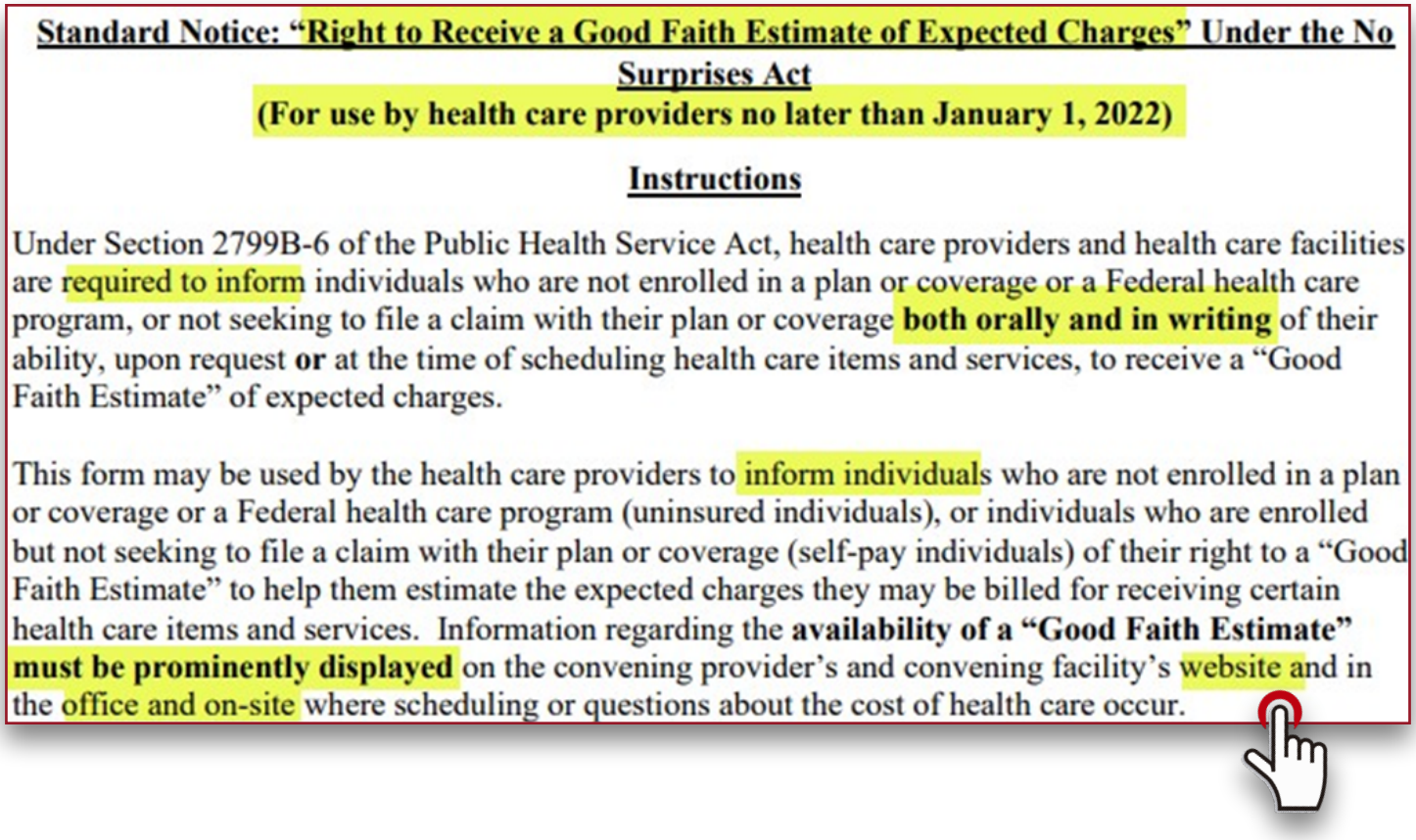
2022 REQUIREMENTS -- UPDATED

In states where there are state laws that protect patients against surprise billing, providers and facilities can use a state disclosure notice if it meets or exceeds the federal guidelines. If a provider or facility drafts their own disclosure notice it must include these three points:

1. Restrictions on providers and facilities regarding balance billing in certain circumstances
2. Any applicable state laws protecting against balance billing
3. Contact information for appropriate state and federal agencies if the individual believes their rights have been violated

RIGHT TO RECEIVE A GOOD FAITH ESTIMATE NOTICE

All uninsured or self-pay individuals must be made aware, both orally and in writing, of their right to receive a good faith estimate for any services that will be rendered beginning January 1, 2022. The form must be prominently displayed on websites, in offices, and where scheduling or questions about the cost of health care may occur.



Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing** of their ability, upon request **or** at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the **availability of a "Good Faith Estimate" must be prominently displayed** on the convening provider's and convening facility's website and in the office and on-site where scheduling or questions about the cost of health care occur.

GOOD FAITH ESTIMATES TO UNINSURED/SELF PAY

When discussing the good faith estimate it is important to know a few terms:

- A **health care provider (provider)** is defined as a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law.

- A **health care facility (facility)** is defined as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center that is licensed as an institution pursuant to State laws or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

- The **convening provider or facility** is the one who receives the initial request for a good faith estimate from an uninsured or self-pay individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service.

- A **co-provider or co-facility** furnishes items or services that are customarily provided in conjunction with the convening provider.

An uninsured patient is an individual who does not have benefits for an item or service under a group health plan; whereas a self-pay patient is an individual who has benefits under a group health plan but chooses not to have a claim submitted to their plan. The good faith estimate presented to an uninsured or self-pay patient must include services reasonably expected to be provided by the convening provider or facility.

At this time, estimates for services provided by co-providers and co-facilities do not have to be provided by the convening provider or facility.

The following list was provided in the interim final rule published in the Code of Federal Regulations. CMS followed up with a Fact Sheet that clarifies HHS will not be enforcing the requirement of including services provided by co-providers or co-facilities.

A good faith estimate must include:

- Patient name and date of birth
- Description of the primary item or service
- Itemized list of items or services reasonably expected to be furnished
    - Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and
    - Items or services reasonably expected to be furnished by co-providers or co-facilities

2022 REQUIREMENTS -- UPDATED

- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling

[eCFR :: 45 CFR Part 149 — Surprise Billing and Transparency Requirements]

(c) ***Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual.***

(1) A good faith estimate issued to an uninsured (or self-pay) individual must include:

(i) Patient name and date of birth;

(ii) Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);

(iii) Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including:

(A) Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and

(B) Items or services reasonably expected to be furnished by co-providers or co-facilities (as specified in paragraphs (b)(2) and (c)(2) of this section);

(iv) Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;

(v) Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility;

(vi) List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. The good faith estimate must include a disclaimer directly above this list that includes the following information: Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services; notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services; and include instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services;

2022 REQUIREMENTS -- UPDATED

Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period | CMS

The Good Faith Estimate process that requires facilities and providers to transmit estimates to health plans, is still on hold.

NOTICE AND CONSENT

The Notice and Consent is being enforced for those rare instances when the patient has a choice of providers and chooses to receive services from an out-of-network facility or provider. Situations when a patient does not have a choice of providers and cannot be requested to sign a consent waiving their balance billing protections in an in-network facility are:

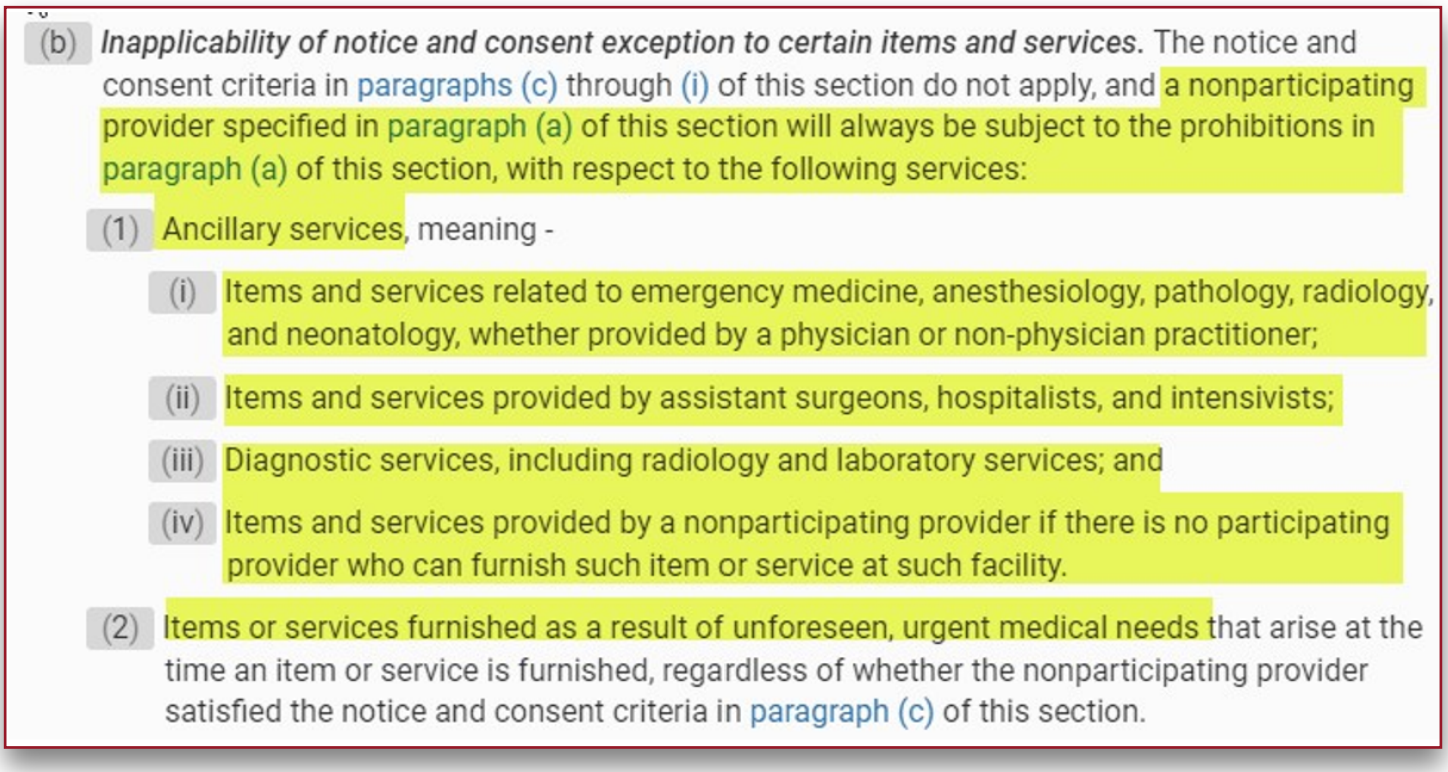
- When receiving services that are considered ancillary services:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
  - Items and services provided by assistant surgeons, hospitalists, and intensivists
  - Diagnostic services, including radiology and laboratory services
  - Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility

Balance billing is prohibited in all emergency situations, even those that arise during a service that is being provided under a written consent. Any charges related to that emergency cannot be balance billed until the patient is deemed stable, as defined in the NSA – able to transport to another facility by non-medical transportation.

In the event the patient requires a higher level of care that requires transport, the EMTALA guidelines take precedence. A patient admitted to an out-of-network facility from an emergency department who is then considered stable, must be presented with a notice and consent if they choose to continue treatment in the out-of- network facility. If the consent is signed, the out-of-network facility can balance bill for charges incurred after the provider documents that patient is stable, as defined in the NSA – able to transport to another facility by non-medical transportation. Ancillary services cannot balance bill even after the patient is considered stable.

2022 REQUIREMENTS -- UPDATED

[eCFR :: 45 CFR Part 149 Subpart E — Health Care Provider, Health Care Facility, and AirAmbulance Service Provider Requirements]



(b) ***Inapplicability of notice and consent exception to certain items and services.*** The notice and consent criteria in paragraphs (c) through (i) of this section do not apply, and a nonparticipating provider specified in paragraph (a) of this section will always be subject to the prohibitions in paragraph (a) of this section, with respect to the following services:

(1) Ancillary services, meaning -

(i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

(ii) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(iii) Diagnostic services, including radiology and laboratory services; and

(iv) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(2) Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria in paragraph (c) of this section.

The Notice and Consent form, with an estimate of all charges, must be presented to the patient for a signature.

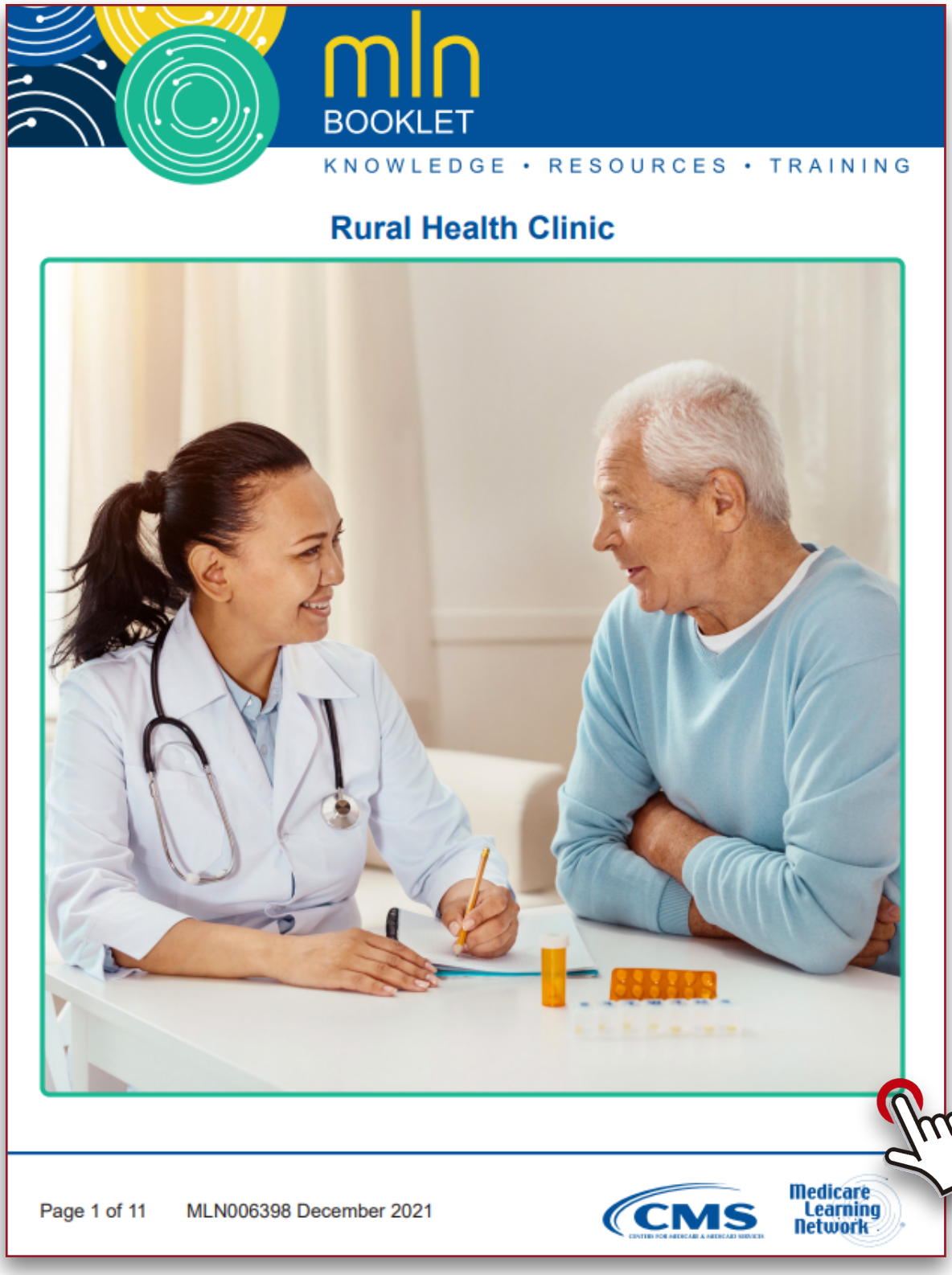
- This form must be available in the 15 most common languages in the geographical area. If the individual's preferred language is not among those 15, a qualified interpreter must be made available to assist the patient with understanding their rights.

- The form must be provided at least 72 hours prior to scheduled services, when they are scheduled at least 72 hours out. When services are scheduled and performed on the same day, the document is required to be presented at least 3 hours before the services are rendered.

- The patient must be provided with a signed copy and a signed copy must be maintained in the medical record in the same manner as all other required documented.

NEW CMS PUBLICATION ON RURAL HEALTH CLINICS

CMS has published a new booklet detailing new changes for 2022 for Rural Health Clinics. You can download the booklet here by clicking anywhere on the graphic.



MEDICARE TO PRIORITIZE RURAL EMERGENCY HOSPITAL RULES

SECTION 125 OF THE CONSOLIDATED APPROPRIATIONS ACT OF 2021 (CAA) CREATED THE RURAL EMERGENCY HOSPITAL (REH) MODEL AS A NEW MEDICARE PROVIDER TYPE.

This new provider type will be eligible for enhanced Medicare fee-for-service rates at 5% above OPPS rates, plus an "Additional Facility Payment" (AFP) designed to bolster the financial viability of providing emergency care in rural areas.The designation is effective as of January 1, 2023.

Current Critical Access Hospitals (CAHs) and rural Prospective Payment System (PPS) hospitals with fewer than 50 beds may convert to REH status to furnish certain outpatient hospital services in rural areas, including emergency department and observation services, but an REH may not offer acute care inpatient services. An REH may offer non-emergency outpatient services and subacute skilled nursing care, however.

New requirements for "Rural Emergency Hospitals" are among the priorities discussed in the Department of Health and Human Services (HHS) Regulatory Plan for Fiscal Year 2022.A link and an excerpt are provided below:

https://www.reginfo.gov/public/jsp/eAgenda/StaticContent/202110/Statement_0900_HHS.pdf

> *The Department also plans to issue a proposed rule on Requirements for Rural Emergency Hospitals. This rule would establish health and safety requirements as Conditions of Participation (CoPs) for Rural Emergency Hospitals (REHs) participating in Medicare or Medicaid, in accordance with Section 125 of the Consolidated Appropriations Act, 2021, and will establish payment policies and payment rates for REHs. This rule will aim to address barriers to health care, unmet social needs, and other health challenges and risks faced by rural communities.*
>
> Excerpts from the Consolidated Appropriations Act are provided below:

https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf– Beginning on page 1779

> *'(2) RURAL EMERGENCY HOSPITAL.—The term 'rural emergency hospital' means a facility described in paragraph (3) that—*
>
> *(A) is enrolled under section 1866(j), submits the additional information described in paragraph (4)(A) for purposes of such enrollment, and makes the detailed transition plan described in clause (i) of such paragraph available to the public, in a form and manner determined appropriate by the Secretary;(B) does not provide any acute care inpatient services, other than those described in paragraph (6)(A);*

MEDICARE TO PRIORITIZE RURAL EMERGENCY HOSPITAL RULES

...

(6) DISCRETIONARY AUTHORITY.—A rural emergency hospital may—

(A) include a unit of the facility that is a distinct part licensed as a skilled nursing facility to furnish post-hospital extended care services; and

(B) be considered a hospital with less than 50 beds for purposes of the exception to the payment limit for rural health clinics under section 1833(f).

Interested readers may wish to review a summary of the new provider type prepared by the National Rural Health Association at the following link:

https://www.ruralhealth.us/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2021/04-15-21-NRHA-Rural-Emergency-Hospital-overview.pdf

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NATIONAL RURAL HEALTH ASSOCIATION

RURAL EMERGENCY HOSPITAL (REH) MODEL SUMMARY

Significant considerations of the REH:[1]

- No provision of acute care inpatient services
- An average per patient length of stay not to exceed 24 hours
- Have a transfer agreement in place with a Level I or II trauma center
- Maintain a staffed emergency department, including staffing 24 hours a day, seven days a week by a physician, nurse practitioner, clinical nurse specialist or physician assistant
- Meet CAH-equivalent Conditions of Participation (CoPs) for emergency services
- Meet applicable state licensing requirements, to be developed
- Be permitted to operate a distinct part skilled nursing facility (SNF) or off-campus provider-based departments, however neither are eligible for the enhanced payments available to REHs
- Develop an implementation plan for conversion to REH status
- For those facilities that maintain a SNF, the REH must comply with CoPs applicable to SNFs
- May convert back to a CAH or PPS hospital
- Must meet quality reporting standards as determined by the Secretary
- May be an originating site (where the patient is) for telehealth services

DEBT LIMIT BILL BRINGS RELIEF FOR MEDICARE PROVIDERS

The United States Congress passed a bill on December 9, 2021 which enables the Senate to use special expedited procedures to increase the debt limit.

Additional provisions of the bill make changes to several important issues for Medicare providers. The text of the bill is available at the link below:

https://www.congress.gov/bill/117th-congress/senate-bill/610/actions

One Hundred Seventeenth Congress
of the
United States of America

AT THE FIRST SESSION
Begun and held at the City of Washington on Sunday, the third day of January, two thousand and twenty one

An Act

To address behavioral health and well-being among health care professionals.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting Medicare and American Farmers from Sequester Cuts Act".

The new law enacts the following changes for Medicare providers:

- **Extends the moratorium of the usual 2% sequestration discount** applied to Medicare payments until March 31, 2022, and reduces the discount on Medicare payments from 2% to 1% for three months, until June 30, 2022

- **Extends a Medicare Physician Fee Schedule payment increase** through calendar 2022;

DEBT LIMIT BILL BRINGS RELIEF FOR MEDICARE PROVIDERS

- **Stops further reductions to the Clinical Lab Fee Schedule** in 2022 through 2025;
- **Avoids a 15% Cut to CLFS payment rates for many common lab tests** which was to become effective 1/1/2022, as part of the phase-in of rates developed from data collected in 2016
- **Delays the Private Payer lab rate reporting deadline** for the January-June 2019 period another year to be due the first quarter of 2023;
- **Delays the implementation of Medicare's Radiation Oncology Model** until 2023

Salient excerpts of the changes to Medicare laws and regulations pertaining are provided on the following pages.New language is provided in *highlighted italics*.

Sequestration–changes to 2 USC 901a Enforcement of budget goal:

(6) Implementing direct spending reductions

…

(B) On the dates OMB issues its sequestration preview reports for each of fiscal years 2022 through 2030, pursuant to section 904(c) of this title, the President shall order a sequestration, effective upon issuance such that-

(C) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2022 shall be applied to such payments so that with respect to the period beginning on April 1, 2022, and ending on June 30, 2022, the payment reduction shall be 1.0 percent.

"(D) Notwithstanding the 2 percent limit specified in subparagraph (A) for payments for the Medicare programs specified in section 256(d), the sequestration order of the President under such subparagraph for fiscal year 2030 shall be applied to such payments so that—

"(i) with respect to the first 6 months in which such order is effective for such fiscal year, the payment reduction shall be 2.25 percent; and"(ii) with respect to the second 6 months in which such order is so effective for such fiscal year, the payment reduction shall be 3 percent.

The Medicare Physician Fee Schedule- (Changes to TITLE 42 / CHAPTER 7 / SUBCHAPTER XVIII / Part B / § 1395w-4)

(t) Supporting physicians and other professionals in adjusting to Medicare payment changes during ~~2021~~ *2021 or 2022*

DEBT LIMIT BILL BRINGS RELIEF FOR MEDICARE PROVIDERS

(1) In general

In order to support physicians and other professionals in adjusting to changes in payment for physicians' services during ~~2021~~ *during 2021 and 2022*, the Secretary shall increase fee schedules under subsection (b) that establish payment amounts ~~for such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent~~ *for*

(A) such services furnished on or after January 1, 2021, and before January 1, 2022, by 3.75 percent; and

(B) such services furnished on or after January 1, 2022, and before January 1, 2023, by 3.0 percent.

Clinical Lab Fee Schedule– changes to TITLE 42 / CHAPTER 7 / SUBCHAPTER XVIII / Part B / § 1395m-1 revising the phase-in of reductions that would have reduced CLFS rates on many codes by as much as 15% in 2022:

- (b) Payment rates for clinical diagnostic laboratory tests
- ...

(3) Phase-in of reductions from private payer rate implementation

(A) In general

Payment amounts determined under this subsection for a clinical diagnostic laboratory test for each of 2017 ~~through 2024~~ *through 2025* shall not result in a reduction in payments for a clinical diagnostic laboratory test for the year of greater than the applicable percent (as defined in subparagraph (B)) of the amount of payment for the test for the preceding year.

(B) Applicable percent defined

In this paragraph, the term "applicable percent" means-

(i) for each of 2017 through 2020, 10 percent;

(ii) for~~2021~~ *for each of 2021 and 2022*, 0 percent; and

(iii) for each of ~~2022 through 2024~~ *2023 through 2025*, 15 percent.

DEBT LIMIT BILL BRINGS RELIEF FOR MEDICARE PROVIDERS

Lab PAMA reporting-(Changes to 42USC 1395m-1(a)(1)(B) Improving policies for clinical diagnostic laboratory tests)

(B) Revised reporting period

·In the case of reporting with respect to clinical diagnostic laboratory tests that are not advanced diagnostic laboratory tests, the Secretary shall revise the reporting period under subparagraph (A) such that-

(i) no reporting is required during the period beginning ~~January 1, 2020~~, and ending ~~December 31, 2021~~ *December 31, 2022*;

(ii) reporting is required during the period beginning ~~January 1, 2022~~ *January 31, 2023*, and ending ~~March 31, 2022~~ *March 31, 2023*; and

(iii) reporting is required every three years after the period described in clause (ii).

The Radiation Oncology program-(Changes to the December 27, 2020 Consolidated Appropriations Act, Public Law 116-26):

> **SEC. 133. DELAY TO THE IMPLEMENTATION OF THE RADIATION ONCOLOGY MODEL UNDER THE MEDICARE PROGRAM.** Notwithstanding any provision of section 1115A of the Social Security Act (42 U.S.C. 1315a), the Secretary of Health and Human Services may not implement the radiation oncology model described in the rule entitled "Medicare Program; Specialty Care Models To Improve Quality of Care and Reduce Expenditures" (85 Fed. Reg. 61114 et seq.), or any substantially similar model, pursuant to such section before ~~January 1, 2022~~ *January 1, 2023.*

MLN CONNECTS

PARA invites you to check out the mlnconnects page available from the Centers For Medicare and Medicaid (CMS). It's chock full of news and information, training opportunities, events and more! Each week PARA will bring you the latest news and links to available resources. Click each link for the PDF!

Thursday, February 3, 2022

News

- COVID-19: Letter to Health Care Facility Administrators on Health Care Worker Vaccination Rule
- COVID-19 Vaccine & Monoclonal Antibody Products: Changes for Medicare Advantage Plan Claims Started January 1 — Reminder

Compliance

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

Claims, Pricers, & Codes

- SNF Consolidated Billing Codes for CY 2022

Events

- Provider Compliance Virtual Focus Group — February 24

MLN Matters® Articles

- Expedited Review Process for Hospital Inpatients in Original Medicare
- Internet-Only Manual Updates for Critical Care Evaluation and Management Services
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic, Non-Healing Wounds — Revised

Publications

- Medicare Preventive Services — Revised

TRANSMITTALS

1

There was ONE new or revised Transmittal released this week.

To go to the full Transmittal document simply click on the screen shot or the link.

TRANSMITTAL R11256OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11256	**Date: February 9, 2022**
	Change Request 12501

Transmittal 11102, dated November 10, 2021, is being rescinded and replaced by Transmittal 11256, dated, February 9, 2022, to remove the provider education requirement. All other information remains the same.

SUBJECT: Update to Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) Claims Containing Non-Covered days

I. SUMMARY OF CHANGES: This Change Request (CR) contains updates/corrections to the SNF PDPM claims to adhere to current policy.

EFFECTIVE DATE: April 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 4, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

MEDLEARNS

0

There was ZERO new or revised MedLearn released this week.

To go to the full Transmittal document simply click on the screen shot or the link.