NOVEMBER 9, 2022

eJOURNAL

PARAREV
A CorroHealth Company

WEBINAR

2023 OPPS & ASC Payments

Final Rules

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

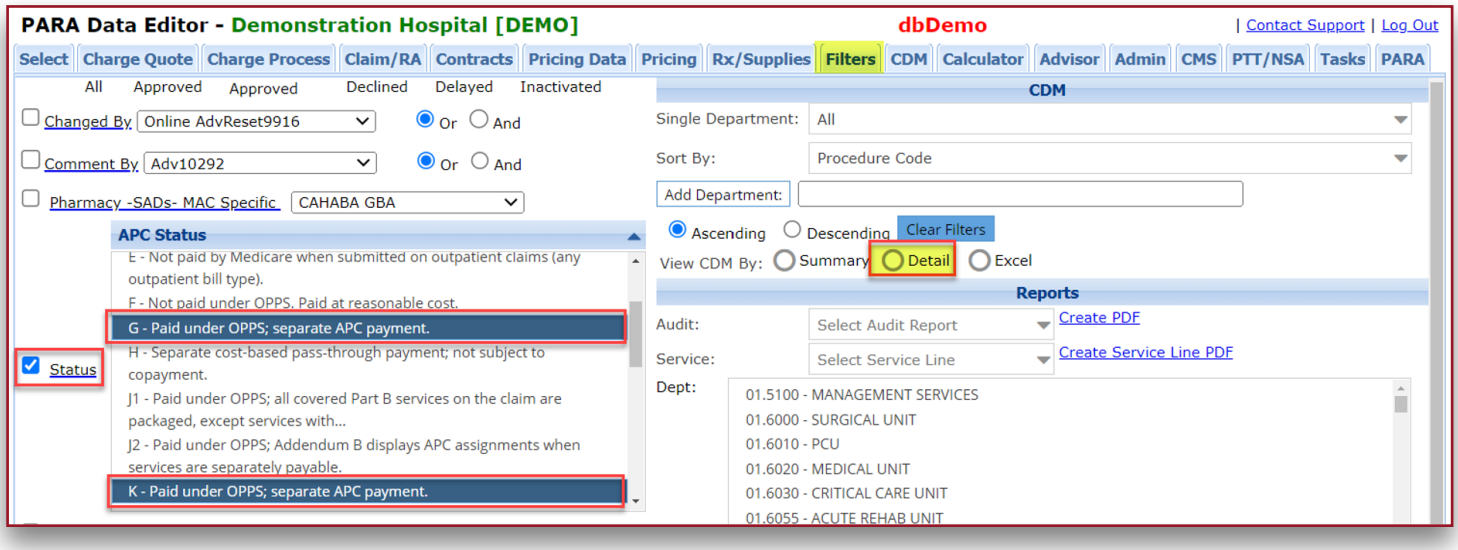
BEGINNING JULY 1, 2023, MEDICARE WILL REQUIRE HOSPITAL OUTPATIENT DEPARTMENTS, ASC'S, AND PHYSICIAN CLINICS (EXCEPT RHCS AND FQHCS) TO REPORT A NEW MODIFIER, "JZ", WHEN CLAIMING REIMBURSEMENT FOR SEPARATELY PAYABLE DRUGS WHEN AN ENTIRE SINGLE-USE VIAL OR PACKAGE IS ADMINISTERED WITHOUT WASTAGE.

Medicare will use the modifier in claiming refunds from pharmaceutical manufacturers for wasted units of expensive pharmaceuticals, as authorized under the Infrastructure Investment and Jobs Act (enacted in 2021.) To ensure that Medicare obtains the maximum refund, as authorized by the Act, CMS must ensure that wastage is properly reported with modifier JW. Since some providers have failed to report modifier JW at all, even though the obligation to do so has been in place since 2017, Medicare decided to require providers to report expensive drugs either way – with modifier JW on a separate line for the wasted portion, or modifier JZ to indicate the full vial was administered.

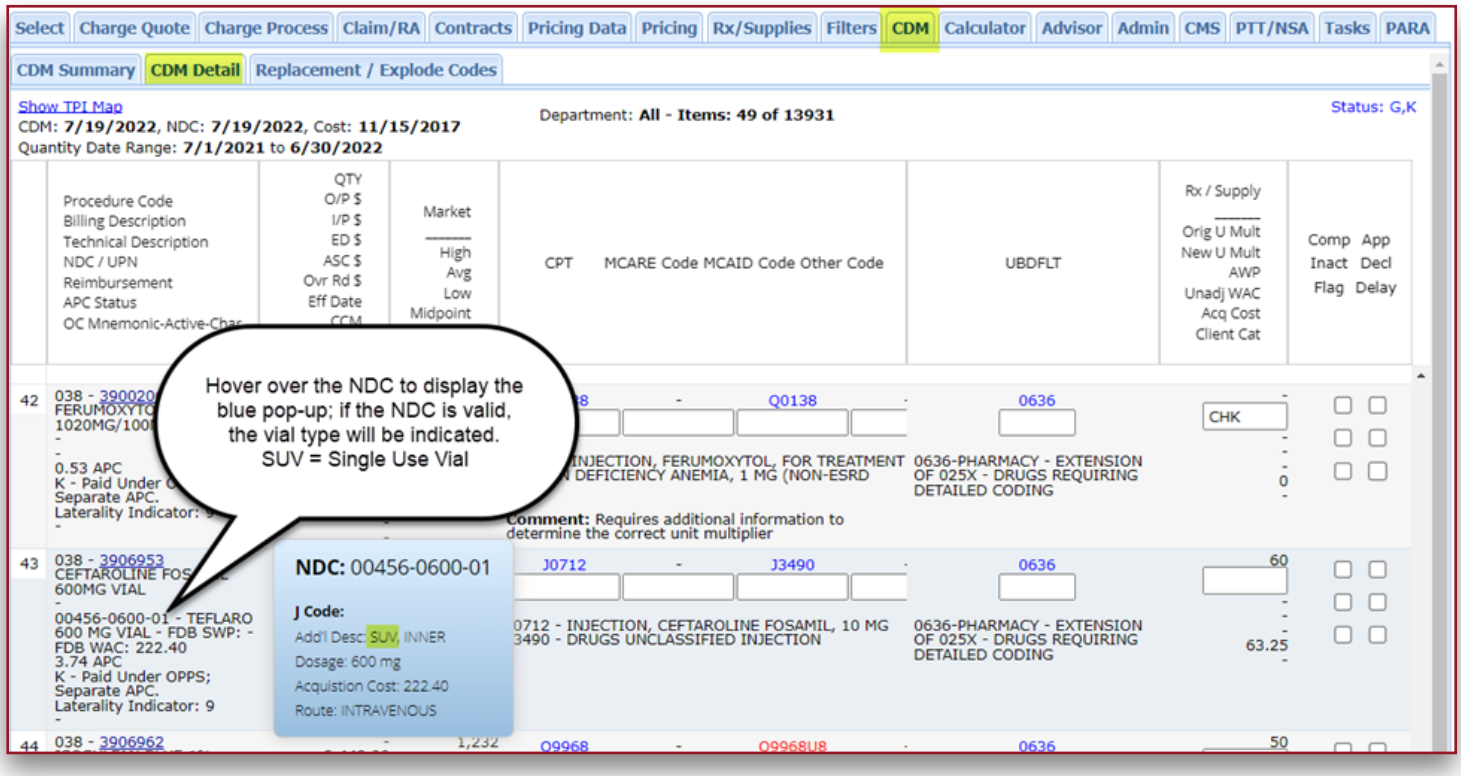
Effective July 1, 2023, modifier JZ will be required when reporting drugs or biologics assigned OPPS status indicator G or K on outpatient claims when the entire vial was administered and no wastage of the same drug is reported on the same claim. Then, effective October 1, 2023, CMS plans to apply claim edits which will require either modifier JW or modifier JZ on a claim with separately payable drugs.

Some providers have failed to report wastage with the JW modifier previously because they struggle with the obligation to capture documentation of waste in the medical record, as required, to verify that the wasted portion was truly discarded and not re-allocated to another patient. These providers must now invest in reporting wastage appropriately, or possibly forego all reimbursement for separately payable drugs when any portion is wasted, since claims will be rejected without either the JW or JZ modifier after October 1, 2023. We expect further guidance from Medicare on how to report separately payable drugs if no documentation of the wastage exists – in which case it would be inappropriate to report modifier JW, and also inappropriate to report JZ.

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS



After clicking "Detail", a list of the line items will be displayed on the CDM tab; if an NDC has been provided by the client, a pop-up window will indicate whether the drug is provided in a single-use vial.



NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

Ironically, the purpose of the new JZ modifier is to ensure that facilities report wastage when appropriate.Since many hospitals have not reported the JW modifier at all, Medicare is concerned that refunds for wastage will be reduced by omission of modifier JW. In requiring billing entities to affirm that an entire vial was administered without waste, Medicare will have greater confidence that wastage was reported completely and accurately.

The new modifier will be required on July 1, 2023, although edits will not reject claims which fail to report a status K or G drug without either modifier JG or JW will not be implemented until October 1, 2023. The requirement is detailed in the 2023 Medicare Physician Fee Schedule Final Rule:

https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1770-f

2023 MPFS Final Rule, Page 890:

After consideration of public comments, we are finalizing our proposal to codify our existing policy and require that billing providers report the JW modifier for all separately payable drugs with discarded drug amounts from single use vials or single use packages payable under Part B, beginning January 1, 2023. We are also finalizing our proposal to require billing providers to report the JZ modifier for all such drugs with no discarded drug amounts beginning no later than July 1, 2023, and we will begin claims edits for both the JW and JZ modifier beginning October 1, 2023.

Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule

Nov 01, 2022 | Medicare Parts A & B, Physicians, Policy

Share

On November 01, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates and policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023.

The calendar year (CY) 2023 PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation.

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

The Fact Sheet reporting the major provisions of the Medicare Physician Fee Schedule summarizes the requirement with additional detail at the link below:

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule

Nov 01, 2022 | Medicare Parts A & B, Physicians, Policy

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On November 01, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates and policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023.

The calendar year (CY) 2023 PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation.

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-9, November 15, 2021) amended section 1847A of the Act adding provisions that require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The refund amount is the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10%, of total allowed charges for the drug in a given calendar quarter. The proposals to implement section 90004 of the Infrastructure Act included: how discarded amounts of drugs are determined; a definition of which drugs are subject to refunds (and exclusions); when and how often CMS will notify manufacturers of refunds; when and how often payment of refunds from manufacturers to CMS is required; refund calculation methodology (including applicable percentages); a dispute resolution process; and enforcement provisions. This refund applies to refundable single-dose container or single-use package drugs beginning January 1, 2023.

CMS is finalizing as proposed the definition of a refundable single-dose container or single-use package drug as a drug or biological for which payment is made under Part B and that is furnished from a single-dose container or single-use package. CMS is finalizing exclusions to this definition as required by statute for drugs that are either radiopharmaceuticals or imaging agents, drugs that require filtration during the drug preparation process, and drugs approved on or after the date of enactment of the Infrastructure Act (that is, November 15, 2021) for which payment under Part B has been made for fewer than 18 months.

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

For drugs with unique circumstances, CMS solicited comment on whether an increased applicable percentage would be appropriate for drug that is reconstituted with a hydrogel and administered via ureteral catheter or nephrostomy tube into the kidneys; in this circumstance, there is substantial amount of reconstituted hydrogel that adheres to the vial wall during preparation and not able to be extracted from the vial for administration. Based on comments received, CMS is finalizing an increased applicable percentage of 35 percent for this drug.

CMS also solicited comments on whether there are other drugs with unique circumstances that may warrant an increase in the applicable percentage. As a result of public comments, CMS plans to collect additional information about drugs that may have unique circumstances along with what increased applicable percentages might be appropriate for each circumstance.

CMS will revisit additional increased applicable percentages through future notice and comment rulemaking.CMS is finalizing requirements for the use of the JW modifier, for reporting discarded amounts of drugs, and the JZ modifier, for attesting that there were no discarded amounts. CMS is finalizing that providers will be required to report the JW modifier beginning January 1, 2023 and the JZ modifier no later than July 1, 2023 in all outpatient settings.

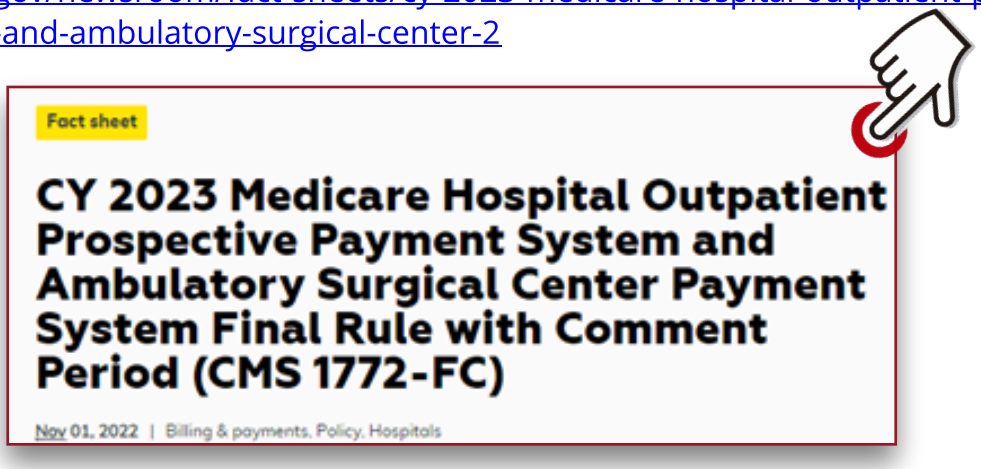
In the proposed rule, CMS proposed that an initial invoice for the refund to be sent to manufacturers in October 2023. However, we believe it would be beneficial to create system efficiencies related to the reconciliation and invoicing system of the discarded drug refunds and the new inflation rebate programs under the Inflation Reduction Act, and so we are not finalizing the timing of the initial report to manufacturers or date by which the first refund payments are due.

We are, however, finalizing that we will issue a preliminary report on estimated discarded drug amounts based on claims from the first two calendar quarters of 2023 no later than December 31, 2023 and will revisit the timing of the first report in future rulemaking.

CMS PUBLISHES 2023 OPS AND ASC PAYMENT SYSTEM FINAL RULE

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) published the 2023 Hospital Outpatient Prospective Payment System (OPPS) and ASC Payment System Final Rule with Comment Period. CMS provides a high-level Fact Sheet from the Final Rule:

https://www.cms.gov/newsroom/fact-sheets/cy-2023-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-2


Fact sheet

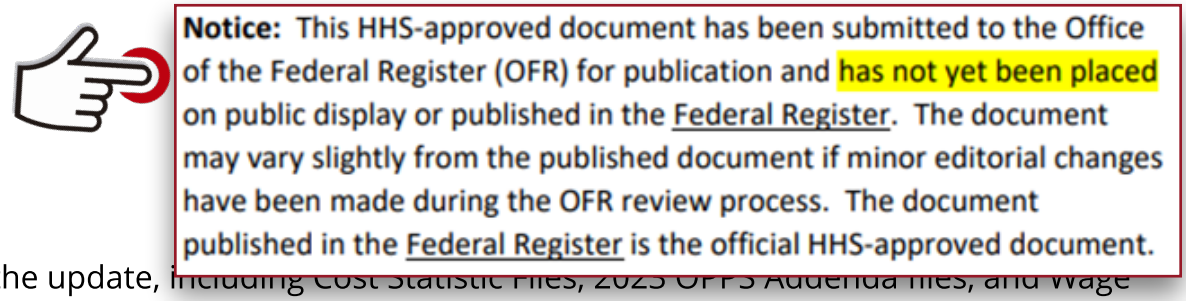
CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

Nov 01, 2022 | Billing & payments, Policy, Hospitals

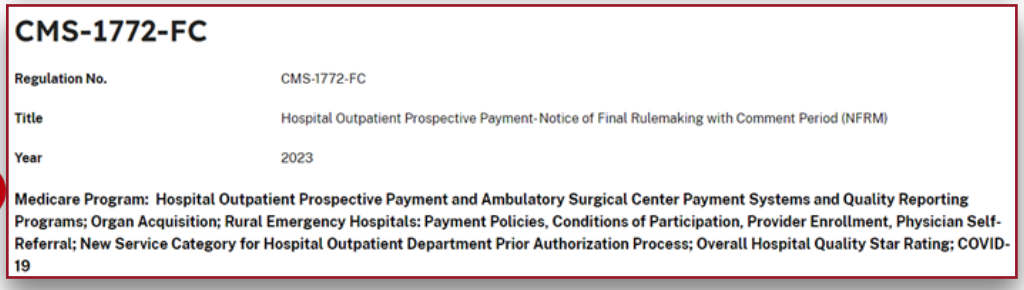
Topics discussed in the OPPS Final Rule include:

- Updates to OPPS and ASC payment rates
- Rural Emergency Hospitals (REH) Medicare Provider Type
- OPPS Payments for 340B Program
- OPPS Transitional Pass-Through Payments for Drugs, Biologicals and Devices
- Partial Hospitalization Program (PHP) Rate Settings and Per Diem Rates
- Finalization of Quality Policies

The CMS 1772-FC OPPS OFR Master document of the final rule is available by clicking the following box below:


Notice: This HHS-approved document has been submitted to the Office of the Federal Register (OFR) for publication and has not yet been placed on public display or published in the Federal Register. The document may vary slightly from the published document if minor editorial changes have been made during the OFR review process. The document published in the Federal Register is the official HHS-approved document.

Files related to the update, including Cost Statistic Files, 2023 OPPS Addenda files, and Wage Index links, may be accessed and downloaded by clicking the box to the right.


CMS-1772-FC

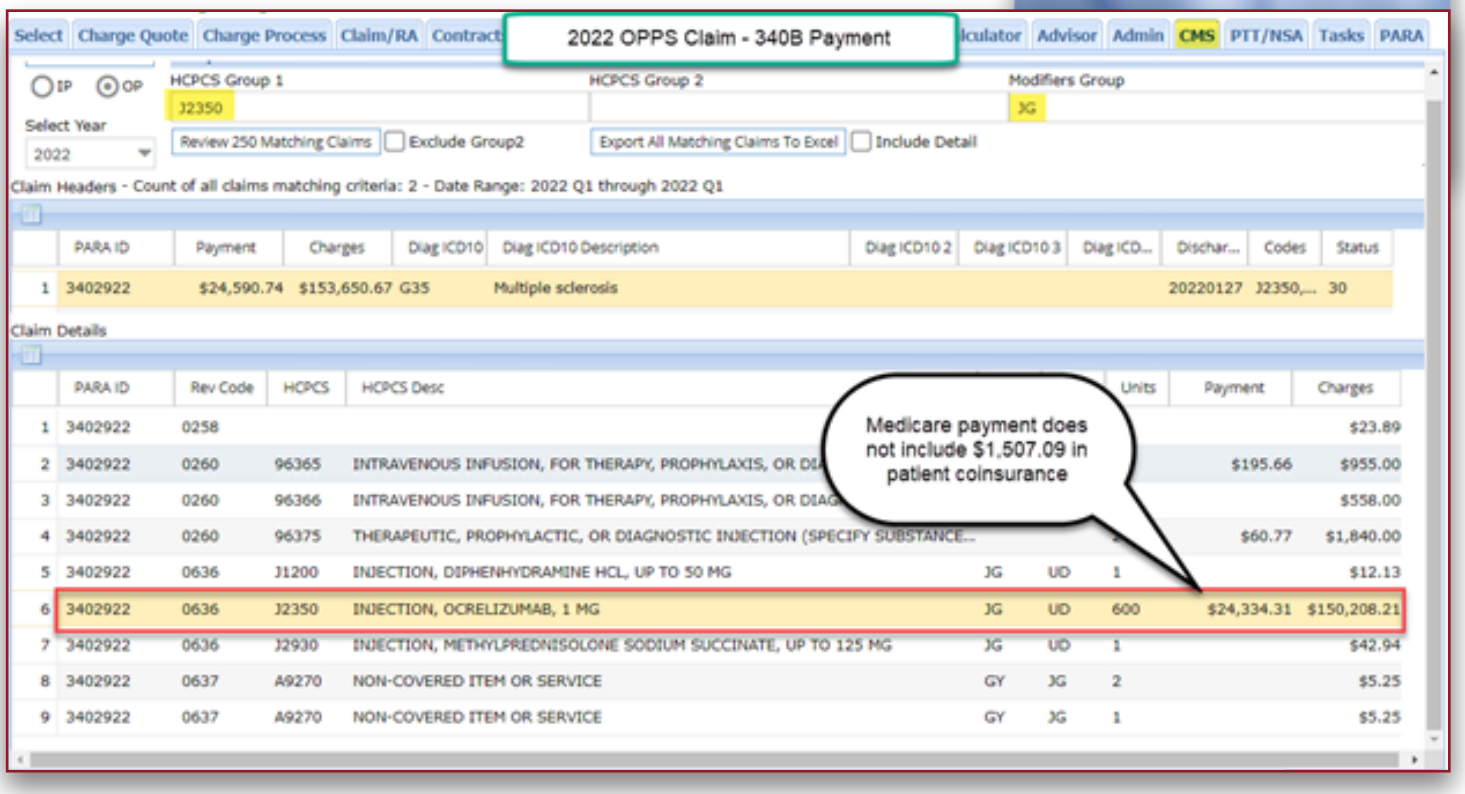
Regulation No.	CMS-1772-FC
Title	Hospital Outpatient Prospective Payment-Notice of Final Rulemaking with Comment Period (NFRM)
Year	2023

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating; COVID-19

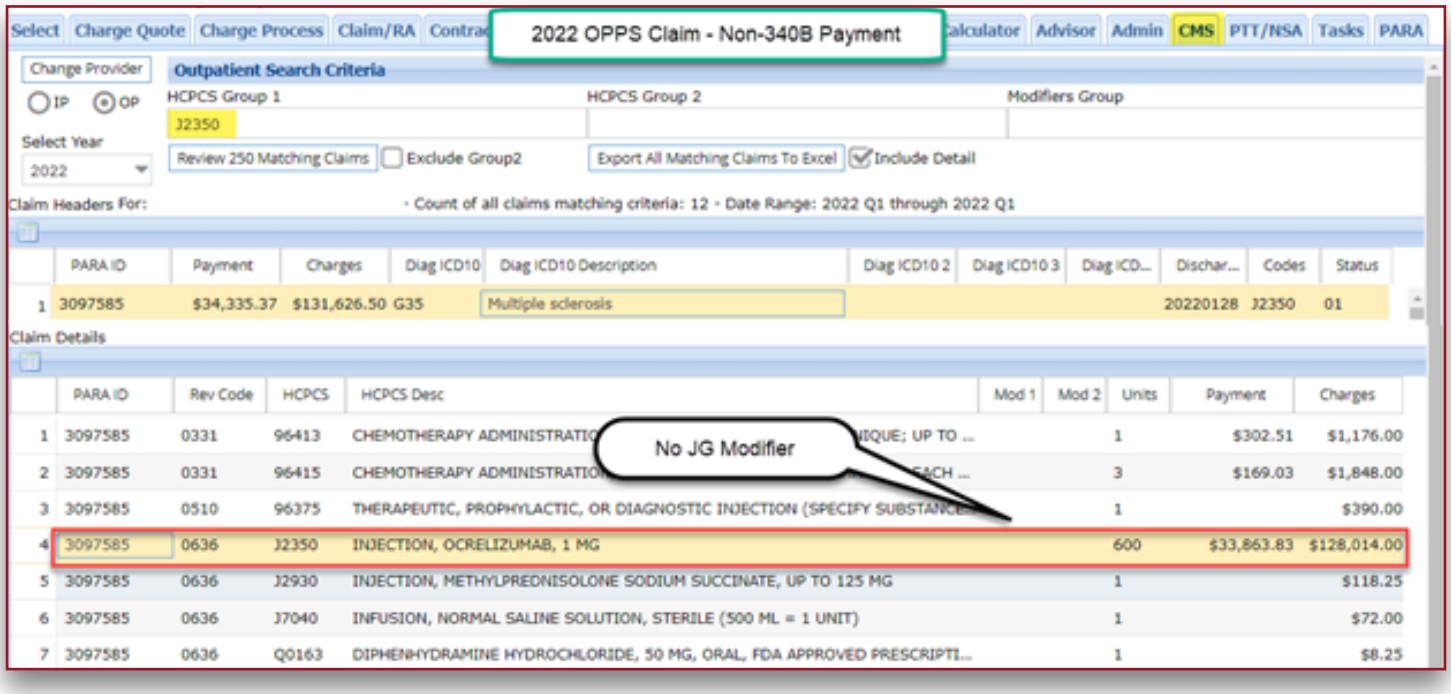
MEDICARE REIMBURSEMENT UPDATE -- FACILITY 340(B) DRUGS

Facilities which participate in the Health Resource Service Administration's 340B drug acquisition program received some good news in October – CMS will restore payments for separately payable drugs acquired under the 340B program on outpatient claims submitted on or after September 28, 2022 to the full OPPS rate, an increase of nearly 27% over the reimbursement rates previously applied.

The **PARA Data Editor CMS Claims** data tab illustrates the difference.Here are two claims processed by Medicare in January 2022 for 600 units of Ocrevus, J2350 – the first claim was paid the 340B rate due to modifier JG, paid at $24,334.31; the second non-340B claim was paid at $33,863.33:



MEDICARE REIMBURSEMENT UPDATE -- FACILITY 340(B) DRUGS



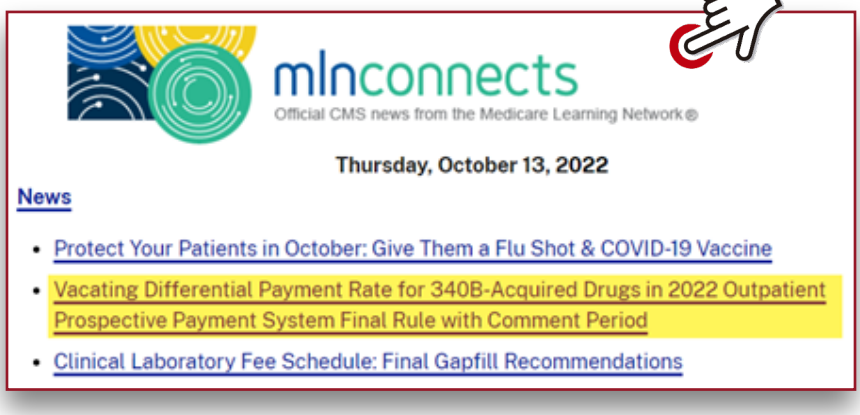
Although 340B hospitals may be happy with the news, all OPPS-paid hospitals are waiting for the other shoe to drop. Since CMS is obligated to restore payments for such drugs retroactively since 2018, and since Medicare cannot simply print more money to fund the repayment, Medicare may have to reduce OPPS reimbursements to all OPPS hospitals beginning in 2023. Medicare's approach to funding the repayment is expected to be revealed in the 2023 OPPS Final Rule in November, 2022.

Since 2018, Medicare had discounted payments for separately payable drugs acquired under the 340B program by nearly 27%. The methodology in calculating the discounted payment rate was both controversial and extremely harmful to 340B facilities offering outpatient infusion services, particularly expensive chemotherapy drugs.

The American Hospital Association sued CMS over its methodology in calculating the discounted reimbursement in 2018.After a lower court ruling was appealed, the case heard and unanimously decided in favor of the AHA by the Supreme Court of the United States (SCOTUS) in June of 2022.

MEDICARE REIMBURSEMENT UPDATE -- FACILITY 340(B) DRUGS

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2022-10-13-mlnc#_Toc116466499


mlnconnects
Official CMS news from the Medicare Learning Network®

Thursday, October 13, 2022

News

- Protect Your Patients in October: Give Them a Flu Shot & COVID-19 Vaccine
- Vacating Differential Payment Rate for 340B-Acquired Drugs in 2022 Outpatient Prospective Payment System Final Rule with Comment Period
- Clinical Laboratory Fee Schedule: Final Gapfill Recommendations

CMS is now faced with the extraordinary obligation to repay 340(b) hospitals for discounts taken in prior years.

Since CMS paid other services under OPPS with the money saved with its inappropriate 340(b) discounts, the obligation to repay OPPS providers for nearly four years of inappropriate discounts could result in lower OPPS reimbursement for all other services paid under OPPS.

CMS complains that it has no legal authority to recoup the reimbursement paid on other OPPS services since 2018 – the money the agency saved by paying less for 340B drugs has long been spent on other OPPS payments.

Medicare requested comment on the means of restoring 340(b) hospital payments in the 2023 OPPS Proposed Rule. Several commenters have echoed the AHA's position urging Medicare to "promptly reimburse all the hospitals that were affected by these unlawful cuts in previous years and to ensure the remainder of the hospital field is not penalized for the departments' prior unlawful policy.

The AHA published an article on its website regarding its legal victory on its website:

https://www.aha.org/news/headline/2022-10-04-after-court-ruling-aha-340b-case-hhs-says-it-will-start-adjusting-payment


After court ruling for AHA in 340B case, HHS says it will start adjusting payment rates for certain 340B hospitals within approximately two weeks

Oct 04, 2022 - 01:38 PM

This article will be updated following the publication of the 2023 OPPS Final Rule/

No Surprises Webinar

On January 1, 2020 the No Surprises Act was revised and signed into law to ensure all aspects of price transparency were covered and met by provider facilities and payer organizations. As needs change, policies shift, and regulations continue to be top of mind, we want to make sure that you are covered by solutions and well educated on changes being made.

On Tuesday, December 6, 2022 at 12PM EDT, CorroHealth will be providing an educational webinar covering the most recent happenings with NSA hosted once again by Barbara Johnson.

This month's webinar will focus on the networking required between the convening facility/provider and co-providers/facilities when working together to issue a consolidated Good Faith Estimate to uninsured patients. We will discuss CMS's Request For Information to determine how the providers and health plans will share information to issue an advanced EOB to insured patients.

We look forward to having you join us on the upcoming webinar. If you have any questions ahead of the webinar, feel free to contact us at info@corrohealth.com.

Click here to register or scan the QR code.

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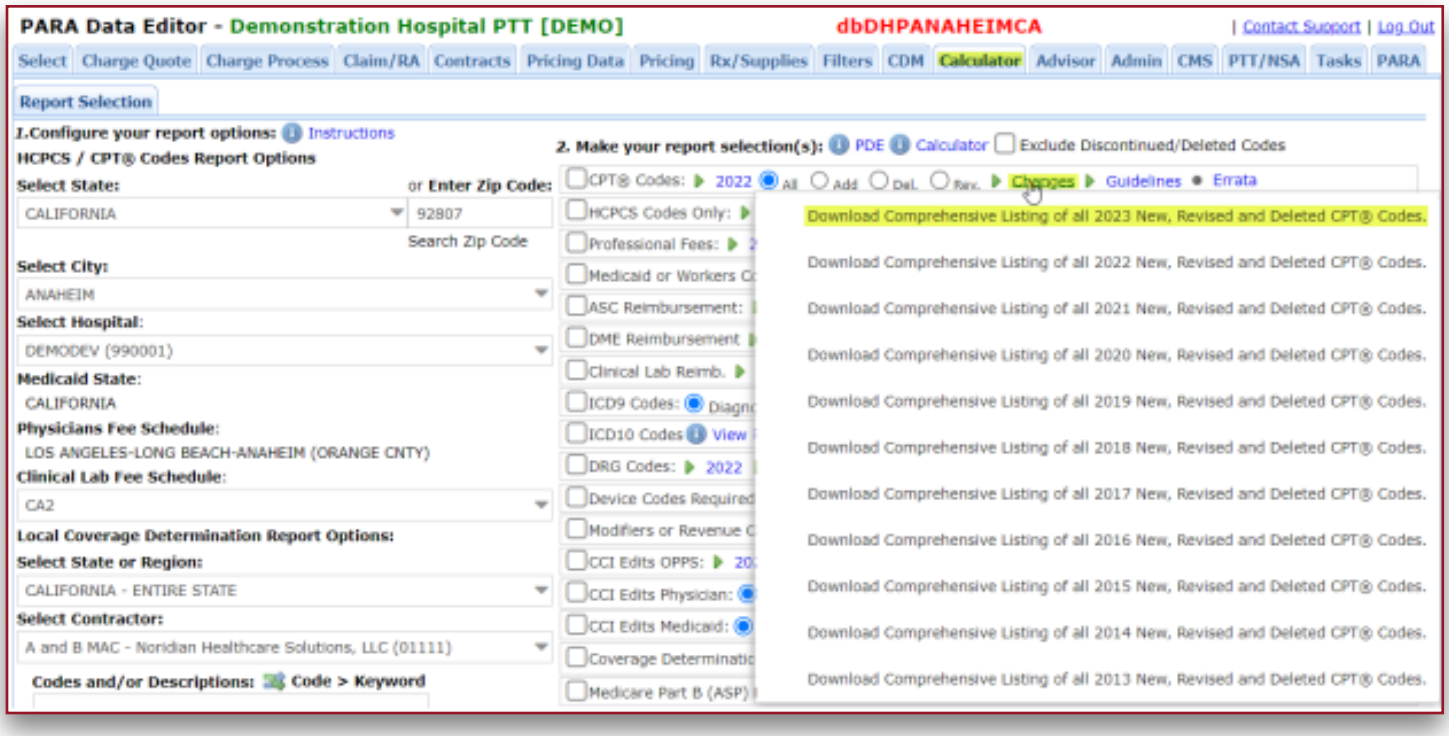
2023 CPT® INFO ACCESSIBLE ON THE PARA DATA EDITOR

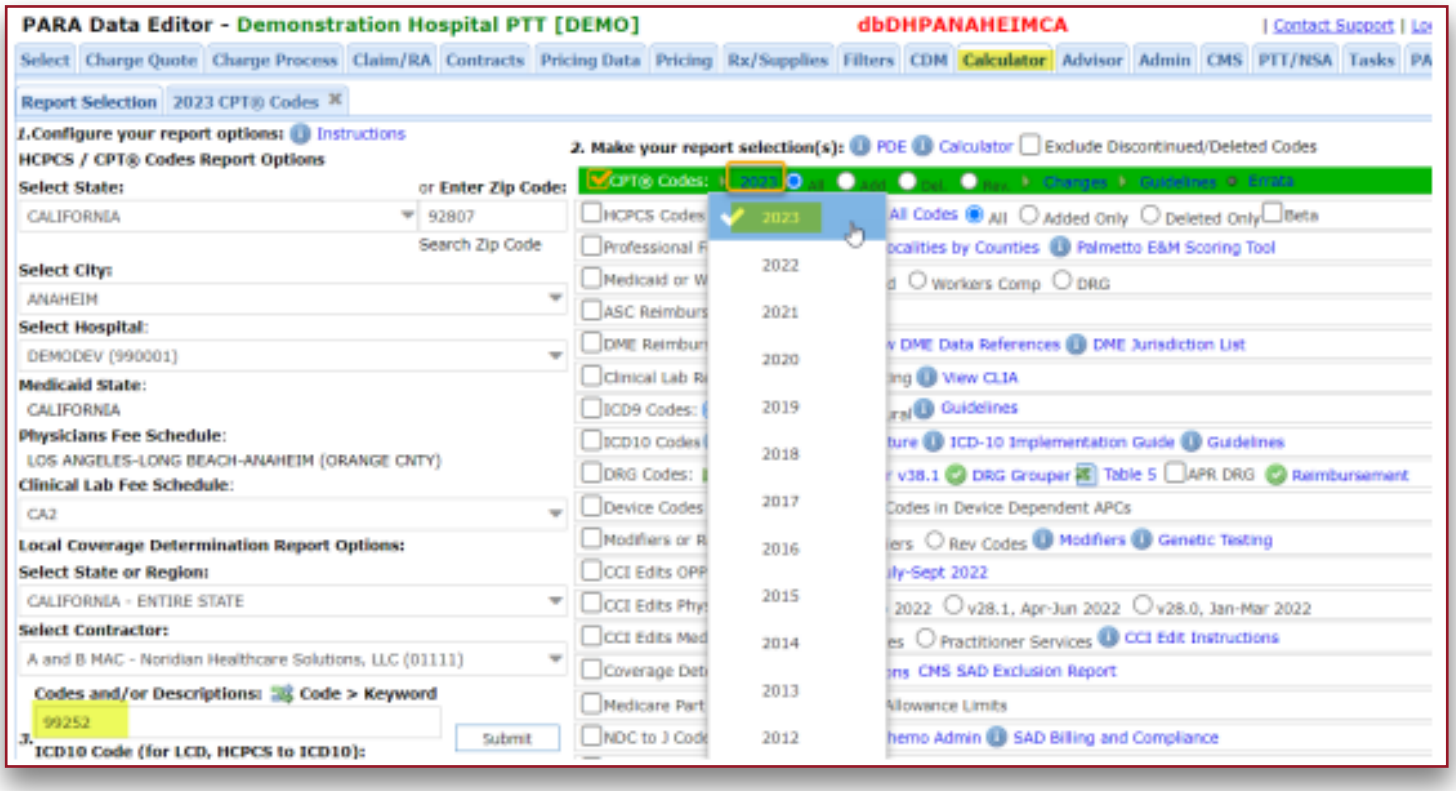
NEW CPT® CODES AND CHANGES TO ESTABLISHED CODES FOR 2023 ARE NOW AVAILABLE IN THE PARA DATA EDITOR (PDE). PARA DATA EDITOR USERS CAN ACCESS CPT® 2023 APPENDIX B, WHICH SUMMARIZES THE CY2023 CODE CHANGES, ON THE CALCULATOR TAB.

The Appendix can be found to the right of the CPT® report. Click on “Changes”, and select the top report, “Download Comprehensive listing of all 2023 New, Revised, and Deleted CPT® Codes".



PDE users can also view the description of the changed and deleted codes by selecting the CPT® Code report on the right, changing the CPT® code year to 2023, and submitting the code, a keyword, or the leading digits of a code in the “Codes or Descriptions” section on the left. The description of the code will populate and display whether it was changed or deleted. (2023 reimbursement information has not yet been published by CMS.)

2023 CPT® INFO ACCESSIBLE ON THE PARA DATA EDITOR



Reimbursement information will be made available as it is published by CMS in the 2023 Medicare Physician Fee Schedule and the 2023 OPPS Final Rule, both of which are expected before mid-November 2022.

PARA YEAR-END HCPCS UPDATE PROCESS

As usual, clients will be fully supported with information and assistance on the annual CPT® HCPCS coding updates for calendar year 2023.

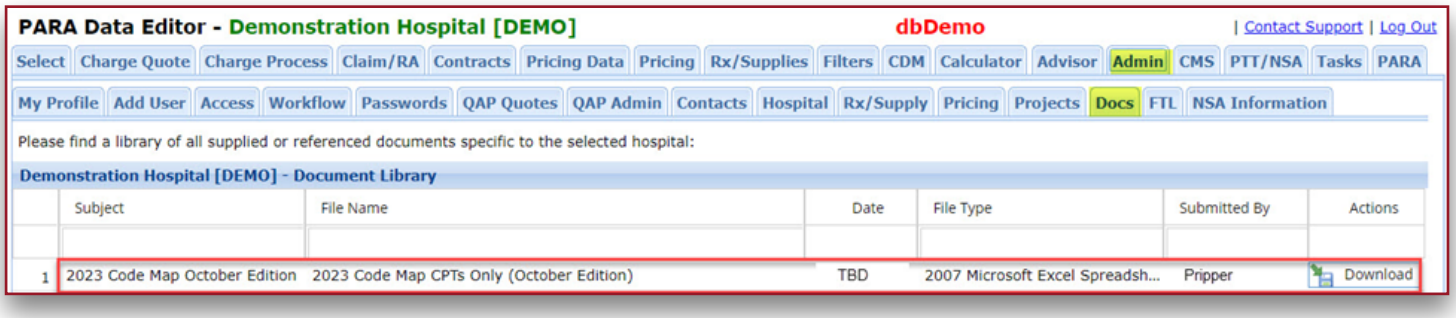
The **PARA Data Editor (PDE)** contains a copy of each client chargemaster; we use the powerful features of the PDE to identify any line item in the chargemaster with a HCPCS code assigned that will be deleted as of December 31, 2022.

ParaRev will not review chargemasters loaded into the PDE older than 12 months. For this reason, it is important that clients check to ensure that a recent copy of the chargemaster has been supplied to **ParaRev** for use in the year-end update.

ParaRev will produce Excel spreadsheets of each CDM line item, as well as our recommendation for alternate codes, in three waves as information is released from the following sources:

- The American Medical Association's publication of new, changed, and deleted CPT® codes; this information is released in **September** of each year. **ParaRev** will produce the first spreadsheet of CPT® updates for client review in **October** 2022
- Following the release of Medicare's 2023 OPPS Final Rule, typically in early **November**; **ParaRev** will perform analysis and produce the second spreadsheet to include both the CPT® information previously supplied, as well as alpha-numeric HCPCS updates (J-codes, G-codes, C-codes, etc.) from the Final Rule. Clients may expect this spreadsheet to be available in **November** 2022
- Following the publication of Medicare's 2023 Clinical Lab Fee Schedule (CLFS) – typically published in late **November**, **ParaRev** will prepare a final spreadsheet to be available in **December** 2022. This final spreadsheet ensures that **ParaRev** shares any late-breaking news or coding information, although we expect the December spreadsheet to be very similar to the November edition.

Clients will be notified by email as spreadsheets are produced and recorded on the **PARA Data Editor** "Admin" tab, under the "Docs" subtab. When the code maps are ready, the 2023 spreadsheet will appear just as they did in 2022:



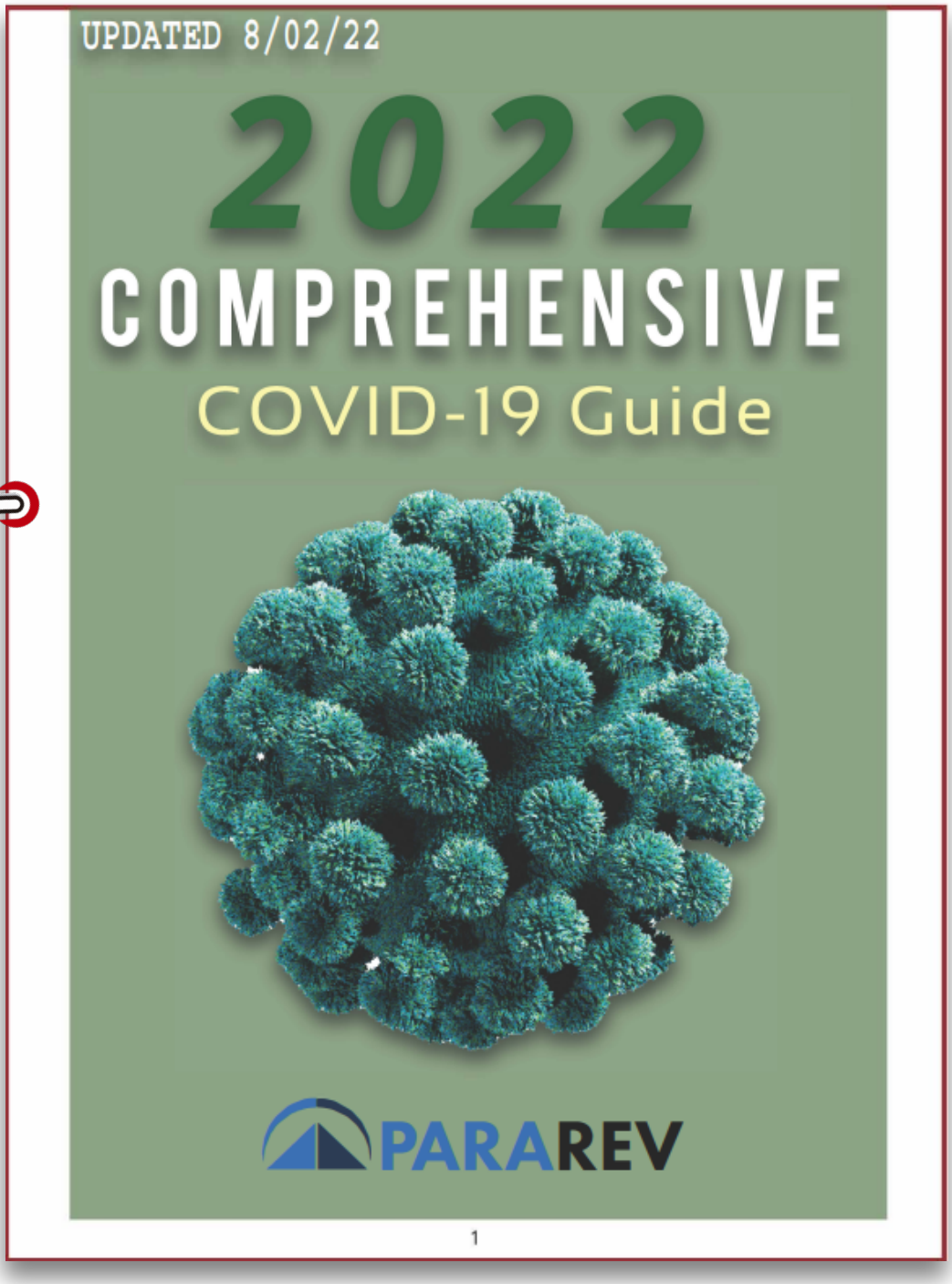
In addition, **ParaRev** consultants will publish concise papers on coding update topics in order to ensure that topical information is available in a manner that is organized and easy to understand. **ParaRev** clients may rest assured that they will have full support for year-end HCPCS coding updates to the chargemaster.

COMPLETELY UPDATED: COMPREHENSIVE COVID-19 GUIDE

THIS IS IT. PARAREV HAS COMPLETELY UPDATED ITS COMPREHENSIVE COVID-19 GUIDE. THE GUIDE CONTAINS DETAILED INFORMATION ABOUT BILLING AND CODING, TESTING AND OTHER GUIDANCE RELATED TO COVID-19.

It's online. You can download it by clicking the image to the right, or by clicking the URL here:

https://apps.para-hcfs.com/para/Documents/2022%20Comprehensive%20Covid-19%20Guide.pdf



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, November 3, 2022

News

- COVID-19 Vaccine: Novavax Booster Authorized
- Medicare Part B Immunosuppressive Drug: Get Information on New Benefit
- Part B Immunosuppressive Drug Benefit: Check Medicare Eligibility
- Skilled Nursing Facilities: October Care Compare Release
- Clinical Diagnostic Laboratories: Report Private Payor Rate Data Beginning January 1
- Diabetes: Recommend Preventive Services

Claims, Pricers, & Codes

- Home Health Consolidated Billing Enforcement: CY 2023 HCPCS Codes

Publications

- Medicare Provider Compliance Tips — Revised

Multimedia

- Hospice Quality Reporting Program: September Forum Materials

MLN CONNECTS

mlnconnects

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Tuesday, November 1, 2022

News

- HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule
- HHS Finalizes Physician Payment Rule Strengthening Access to Behavioral Health Services and Whole-Person Care


Newsroom Press Kit Data Contact Blog Podcast

Press release

HHS Continues Biden-Harris Administration Progress in Promoting Health Equity in Rural Care Access Through Outpatient Hospital and Surgical Center Payment System Final Rule

Nov 01, 2022 | Hospitals, Policy, Rural health

TRANSMITTALS

6

There were SIX new or revised Transmittals released this week.

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

TRANSMITTAL R11680OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11680	**Date: November 4, 2022**
	Change Request 10691

SUBJECT: User Enhancement Change Request (UECR): Update the Multi-Carrier System (MCS) to Include Additional Options for Requesting Duplicate Remittance Advices

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the MCS to allow a MAC to request duplicate remittance advices in an efficient manner.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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

TRANSMITTAL R11679OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11679	**Date: November 4, 2022**
	Change Request 10670

SUBJECT: User Enhancement Change Request (UECR): Enhance the Multi-Carrier System (MCS) Related Procedures Diagnosis Segments Screen

I. SUMMARY OF CHANGES: The purpose of this CR is to enhance the MCS Related Procedures Diagnosis Segments screen by allowing a user to narrow a search based upon a from and to date being entered. This would limit the procedure codes displayed that are related to an audit.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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

TRANSMITTAL R11682PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11682	**Date: November 4, 2022**
	Change Request 12880

SUBJECT: Seventh General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of Pub. 100-08 with provider enrollment instructions regarding ownership disclosures, electronic funds transfers (EFTs), special payment addresses, and other topics.

EFFECTIVE DATE: December 5, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 5, 2022

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

TRANSMITTAL R11676OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11676	**Date: November 4, 2022**
	Change Request 12960

SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--April 2023 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received. Previous NCD coding changes appear in ICD-10 quarterly updates that can be found at: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/ICD10.html, along with other CRs implementing new policy NCDs.

Edits to ICD-10 and other coding updates specific to NCDs will be included in subsequent quarterly releases and individual CRs as appropriate. No policy-related changes are included with the ICD-10 quarterly updates. Any policy-related changes to NCDs continue to be implemented via the current, longstanding NCD process.

EFFECTIVE DATE: April 1, 2023 - or as noted in individual business requirements
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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

III. FUNDING:

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TRANSMITTAL R11681OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11681	**Date: November 4, 2022**
	Change Request 12359

SUBJECT: User Enhancement Change Request (UECR): Update the Multi-Carrier System (MCS) Edit/Audit/Procedure Processing Criteria Report H99RBSCC

I. SUMMARY OF CHANGES: The purpose of this change request is to update the Edit/Audit/Procedure Processing Criteria Report H99RBSCC that was initially designed with the implementation of UECR 10659 implemented with the July 2019 release.

EFFECTIVE DATE: April 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023

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.

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R11677CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11677	**Date: November 4, 2022**
	Change Request 12961

SUBJECT: Update to the Federally Qualified Health Center (FQHC) Prospective Payment System (PPS) for Calendar Year (CY) 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the Prospective Payment System (PPS) base payment rate and the Geographic Adjustment Factors (GAFs) for the Federally Qualified Health Center (FQHC) Pricer. This Recurring Update Notification applies to Chapter 9, section 30 of the IOM.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

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.

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

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

MEDLEARNS

1

There was ONE new or revised MedLearns released this week.

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

MEDLEARN MM12880

mln MATTERS®

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Provider Enrollment Instructions: Seventh General Update

MLN Matters Number: MM12880 | Related Change Request (CR) Number: 12880

Related CR Release Date: November 4, 2022 | Effective Date: December 5, 2022

Related CR Transmittal Number: R11682PI | Implementation Date: December 5, 2022

Related CR Title: Seventh General Update to Provider Enrollment Instructions in Chapter 10 of CMS Publication (Pub.) 100-08

Provider Types Affected

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about updated provider enrollment instructions for:

- Ownership disclosures
- Electronic funds transfers (EFTs)
- Special payment addresses

Background

This Article summarizes the updates to the Medicare Program Integrity Manual. See the updated Chapter 10 of the Manual for the complete details.

Ownership Disclosures

CMS re-emphasizes the following:

- The provider or supplier must disclose ALL persons and entities that meet the definition of "owner" in Section 10.1.1 of this Chapter
- You must show the applicable ownership percentage for each owner if the provider enrollment application you're completing requires it
- There can't be indirect owners without direct owners
- The combined disclosed ownership percentages for the provider or supplier's organizational and individual owners can't be greater than 100%

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FOR YOUR INFORMATION

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PARAREV CorroHealth

FOR YOUR INFORMATION

ParaRev is excited to announce we have joined industry leader **CorroHealth** to enhance the reach of our offerings! **ParaRev** services lines are additive in nature strengthening **CorroHealth's** impact to clients' revenue cycle. In addition, you now have access to a robust set of mid-cycle tools and solutions from **CorroHealth** that complement **ParaRev** offerings.

In terms of the impact you'll see, there will be no change to the management or services we provide. The shared passion, philosophy and cultures of our organizations makes this exciting news for our team and you, our clients.

While you can review the **CorroHealth** site HERE, we can coordinate a deeper dive into any of these solutions. Simply let us know and we'll set up a meeting to connect.

As always, we are available to answer any questions you may have regarding this news. We thank you for your continued partnership.