NOVEMBER 16, 2022

eJOURNAL

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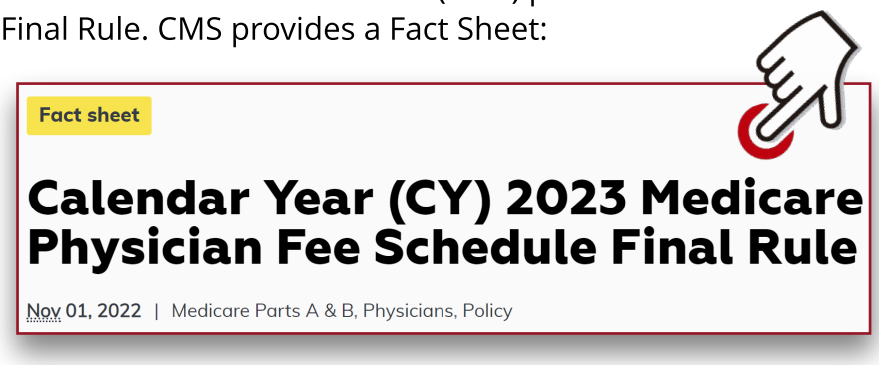
2023 Medicare PFS

Final Rule Published

2023 MEDICARE PHYSICIAN FEE SHEDULE (PFS) FINAL RULE PUBLISHED

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) published the 2023 Medicare Physician Fee Schedule (PFS) Final Rule. CMS provides a Fact Sheet:

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


Fact sheet

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

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

Topics discussed in the Medicare PFS Final Rule include:

- Ratesetting and Conversion Factor
- Cancer Screening Coverage
- Evaluation and Management (E/M), including Split (or Shared) Visits
- Telehealth Services
- Expanded Access to Behavioral Health Services
- Audiology and Dental Care Services
- Finalization of JW modifier for Reporting Discarded Drugs

Scheduled to be published in the Federal Register on November 18, 2022, the CMS 42 CFR document with the final rule is available through the following link:

https://public-inspection.federalregister.gov/2022-23873.pdf


This document is scheduled to be published in the Federal Register on 11/18/2022 and available online at federalregister.gov/d/2022-23873, and on govinfo.gov

de: 4120-01-P]

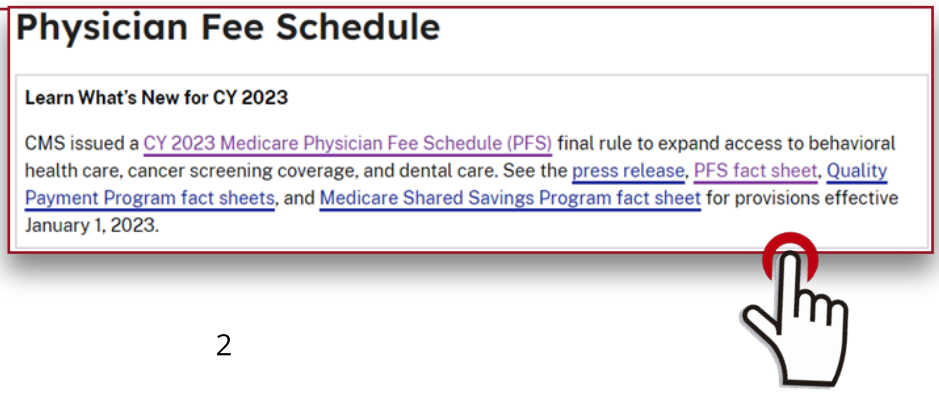
DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 410, 411, 414, 415, 423, 424, 425, and 455

[CMS-1770-F, CMS-1751-F2, CMS-1744-F2, CMS-5531-IFC]

Files related to the PFS update may be accessed and downloaded through the following link:https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched


Physician Fee Schedule

Learn What's New for CY 2023

CMS issued a CY 2023 Medicare Physician Fee Schedule (PFS) final rule to expand access to behavioral health care, cancer screening coverage, and dental care. See the press release, PFS fact sheet, Quality Payment Program fact sheets, and Medicare Shared Savings Program fact sheet for provisions effective January 1, 2023.

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

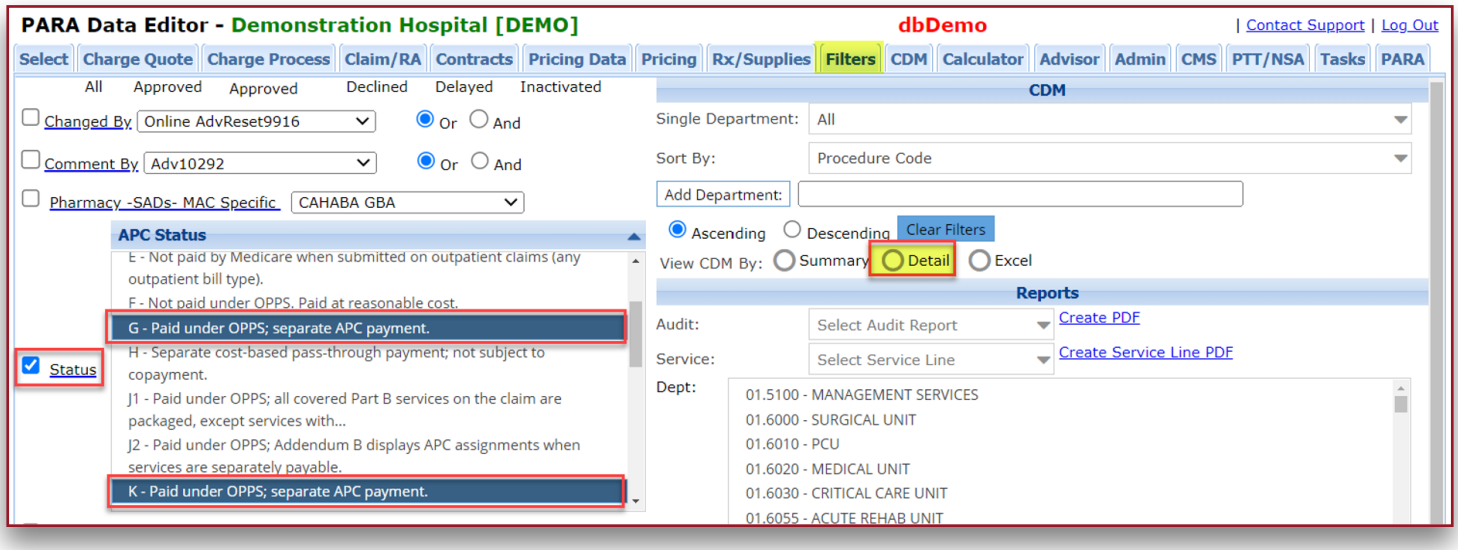
BEGINNING JULY 1, 2023, MEDICARE WILL REQUIRE HOSPITAL OUTPATIENT DEPARTMENTS, ASC'S, AND PHYSICIAN CLINICS (EXCEPT RHCS AND FQHCS) TO REPORT A NEW MODIFIER, "JZ", WHEN CLAIMING REIMBURSEMENT FOR SEPARATELY PAYABLE DRUGS WHEN AN ENTIRE SINGLE-USE VIAL OR PACKAGE IS ADMINISTERED WITHOUT WASTAGE.

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.

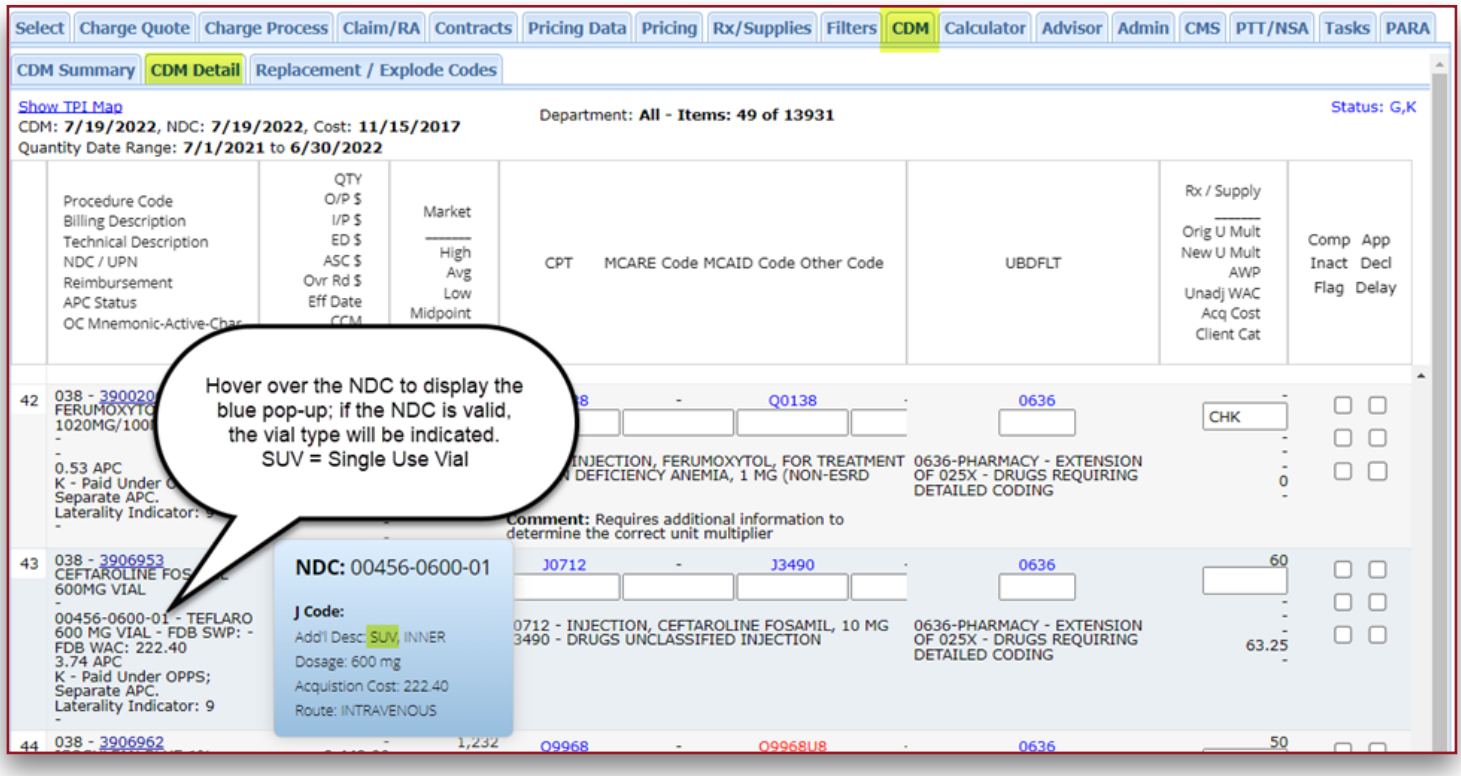
Effective July 1, 2023, modifier JZ will be required when reporting drugs or biologics assigned OPPS status indicator G or K on outpatient claims when the entire vial was administered and no wastage of the same drug is reported on the same claim. Then, effective October 1, 2023, CMS plans to apply claim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

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.

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.

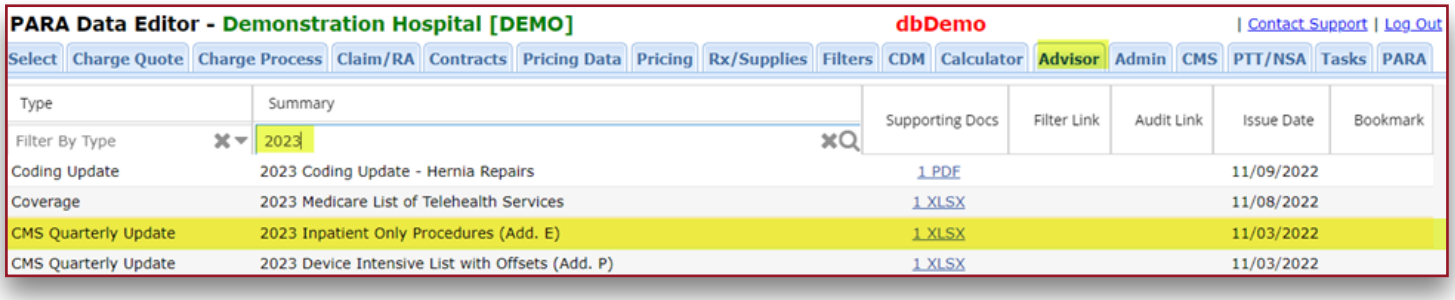
In the proposed rule, CMS proposed that an initial invoice for the refund to be sent to manufacturers in October 2023. However, we believe it would be beneficial to create system efficiencies related to the reconciliation and invoicing system of the discarded drug refunds and the new inflation rebate 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.

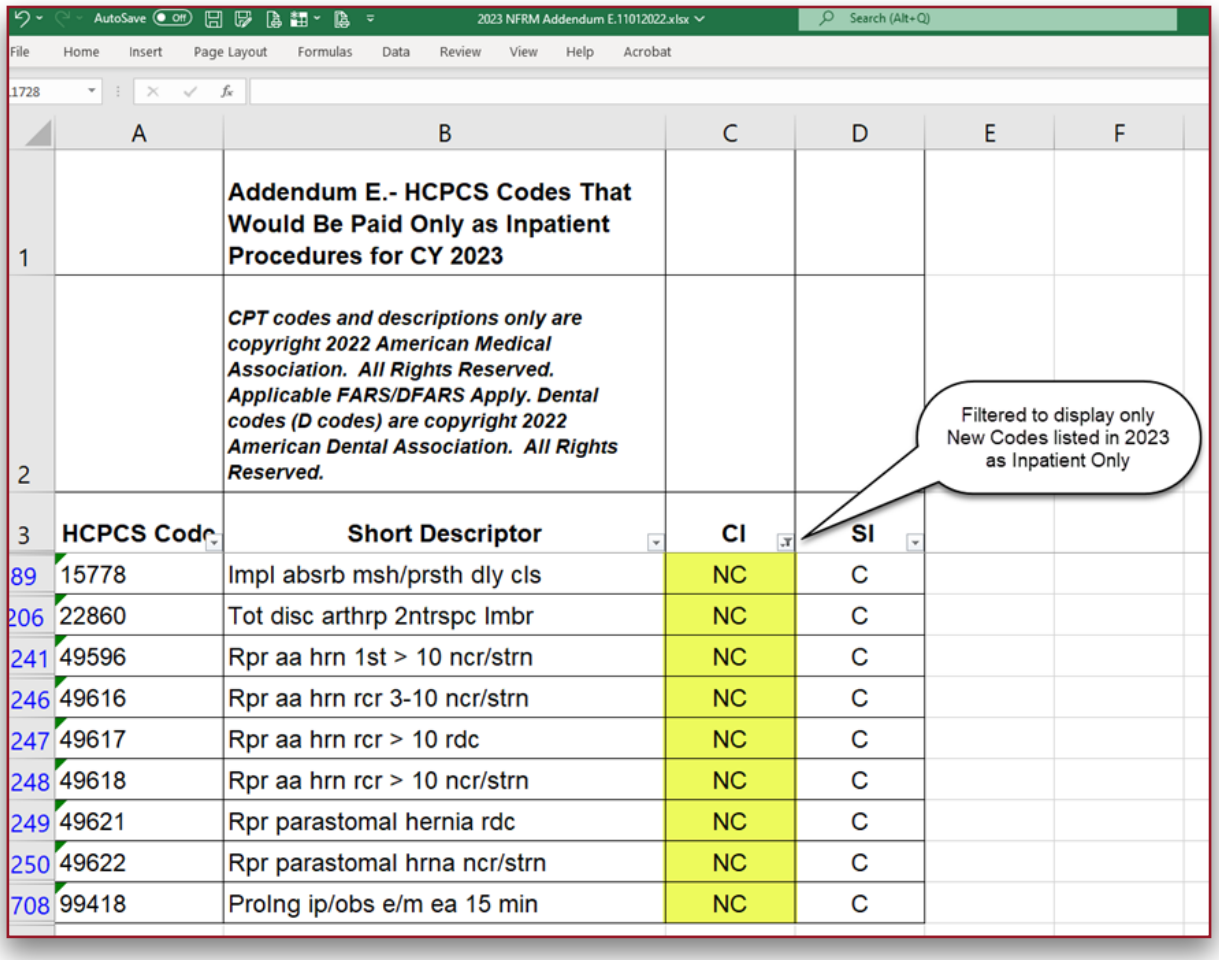
2023 OPPS UPDATE: INPATIENT ONLY CHARGES

In the 2023 OPPS Final Rule, Medicare added nine codes to OPPS Addendum E, the "Inpatient only" list. Medicare will not cover these services when billed on an outpatient claim except if the patient expires before admission to inpatient status or when the provider transfers the patient to another facility.

2023 Inpatient Only Procedures Addendum E may be located by searching "2023" in the Advisor tab of the **PARA Data Editor** (PDE).



The nine newly added Inpatient Only HCPCS procedures are identified with the letters "NC" in the column labeled "N" (Change Indicator) as shown below:



2023 OPPS UPDATE: INPATIENT ONLY CHARGES

Medicare provides guidance on these exceptions in the Medicare Claims Processing Manual, Chapter 4 – Part B Hospital, Paragraph 180.7 – Inpatient-only Services:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

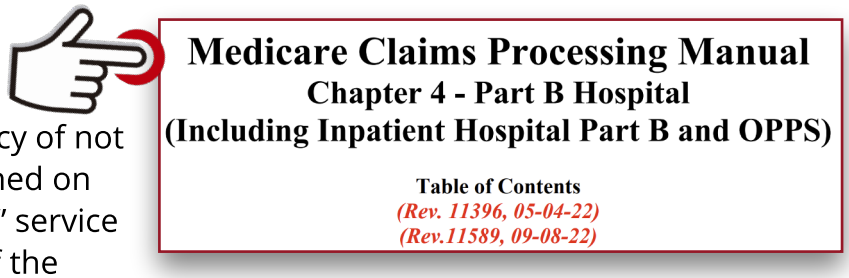

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 11396, 05-04-22)
(Rev.11589, 09-08-22)

"There are two exceptions to the policy of not paying for outpatient services furnished on the same day with an "inpatient-only" service that would be paid under the OPPS if the inpatient service had not been furnished:

Exception 1: If the "inpatient-only" service is defined in CPT to be a "separate procedure" and the other services billed with the "inpatient-only" service contain a procedure that can be paid under the OPPS and that has an OPPS SI=T on the same date as the "inpatient-only" procedure or OPPS SI = J1 on the same claim as the "inpatient-only" procedure, then the "inpatient-only" service is denied but CMS makes payment for the separate procedure and any remaining payable OPPS services. The list of "separate procedures" is available with the Integrated Outpatient Code Editor (I/OCE) documentation. See http://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/.

Exception 2: If an "inpatient-only" service is furnished but the patient expires before inpatient admission or transfer to another hospital and the hospital reports the "inpatient only" service with modifier "CA", then CMS makes a single payment for all services reported on the claim, including the "inpatient only" procedure, through one unit of APC 5881, (Ancillary outpatient services when the patient dies.) Hospitals should report modifier CA on only one procedure."

CMS summarized the CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule changes in its Newsroom Fact Sheet available through the following link:

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


Newsroom Press Kit Data Contact Blog Podcast

Fact sheet

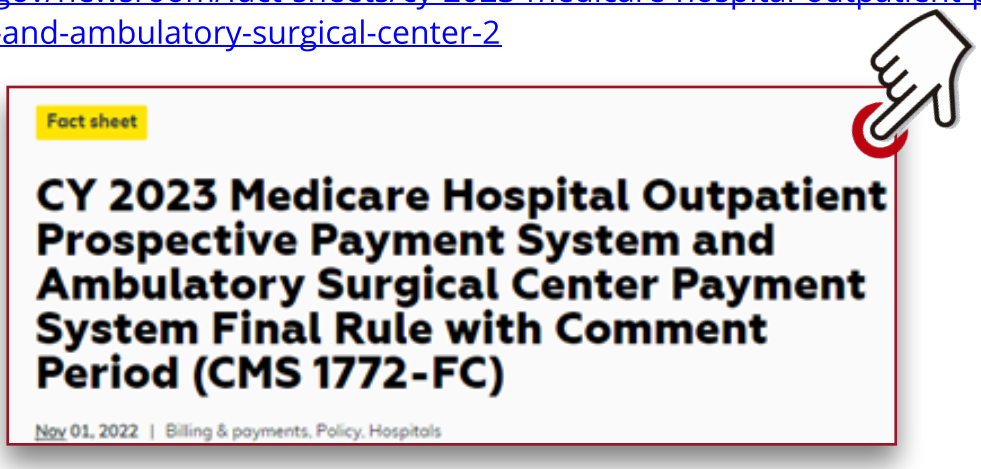
CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

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

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

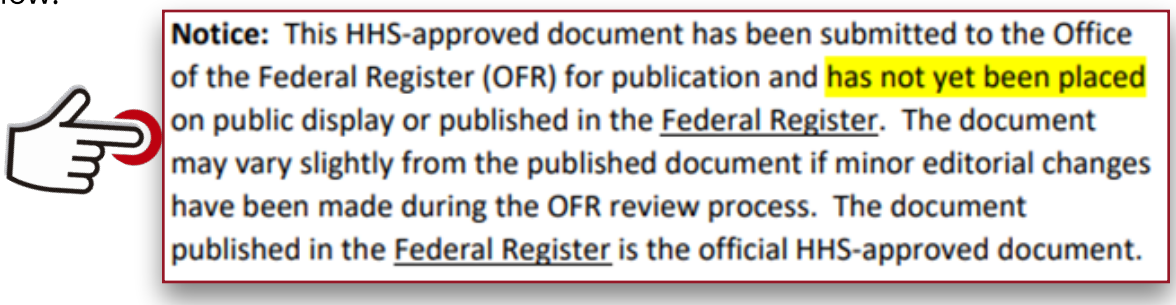
CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

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

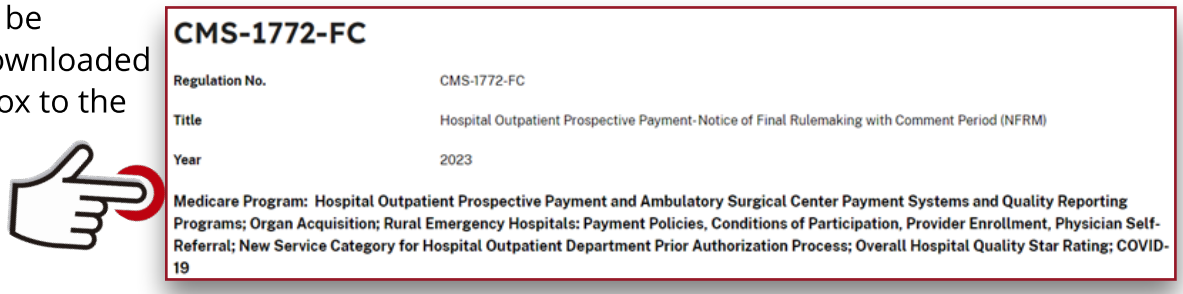
Topics discussed in the OPPS Final Rule include:

- 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.

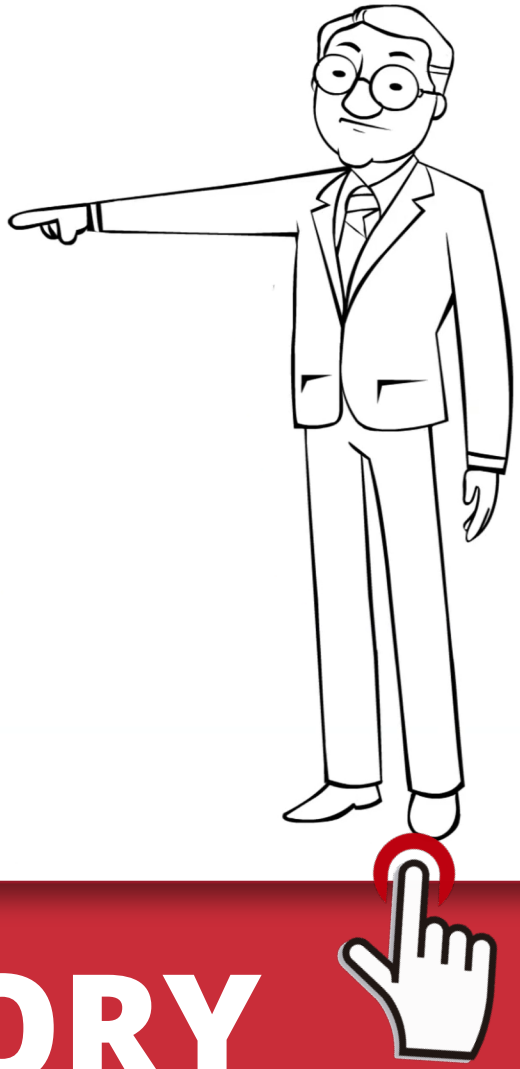
Files related to the update, including Cost Statistic Files, 2023 OPPS Addenda files, and Wage Index links, may be accessed and downloaded by clicking the box to the right.


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

The No Surprises Act (NSA) Is Complicated



Simple Solutions For Complex Problems

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INTRODUCTORY VIDEO

CLICK ABOVE TO WATCH THE VIDEO EXPLAINING THE NSA

AND SCAN THE QR CODE TO SEE HOW YOUR HOSPITAL COULD SAVE THOUSANDS

SCAN ME!

AND JOIN *the WEBINAR*. More Information On The Next Page

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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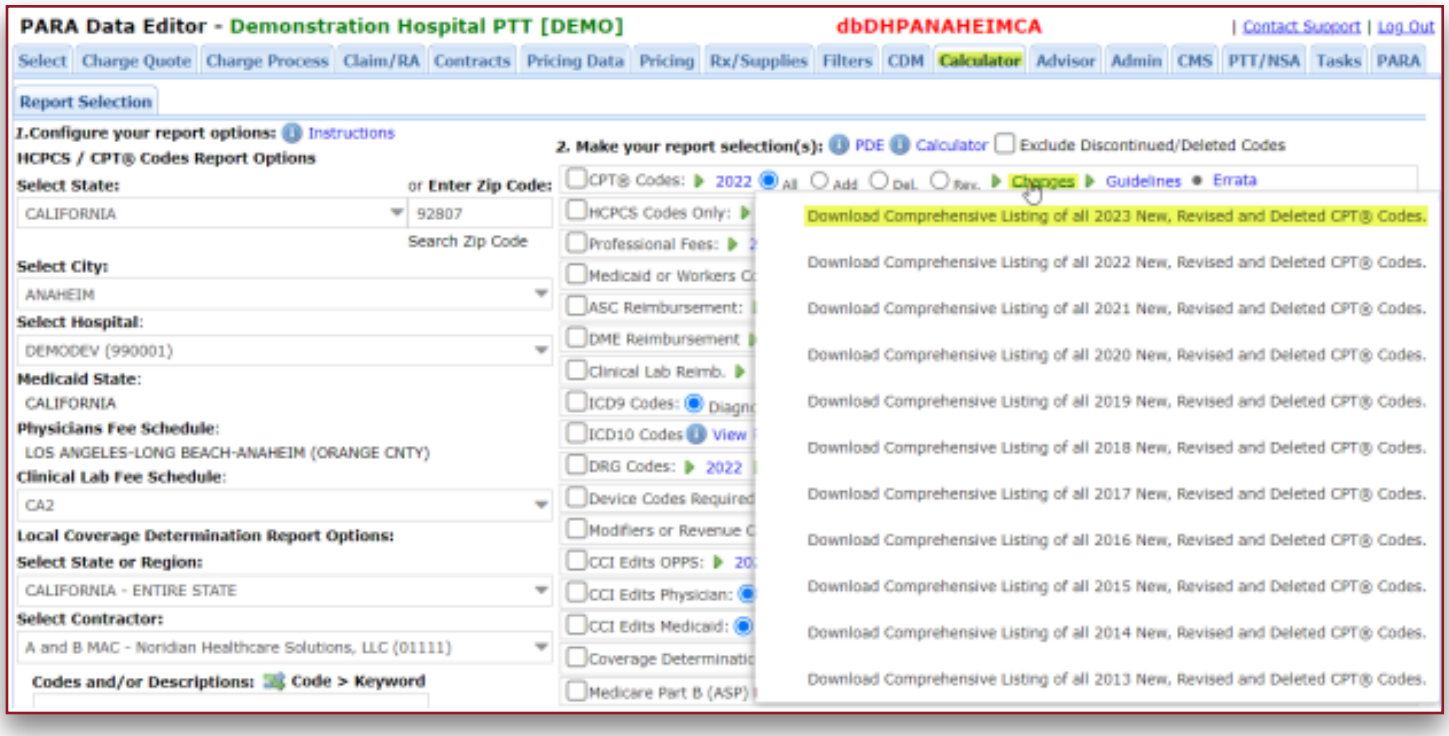
2023 CPT® INFO ACCESSIBLE ON THE PARA DATA EDITOR

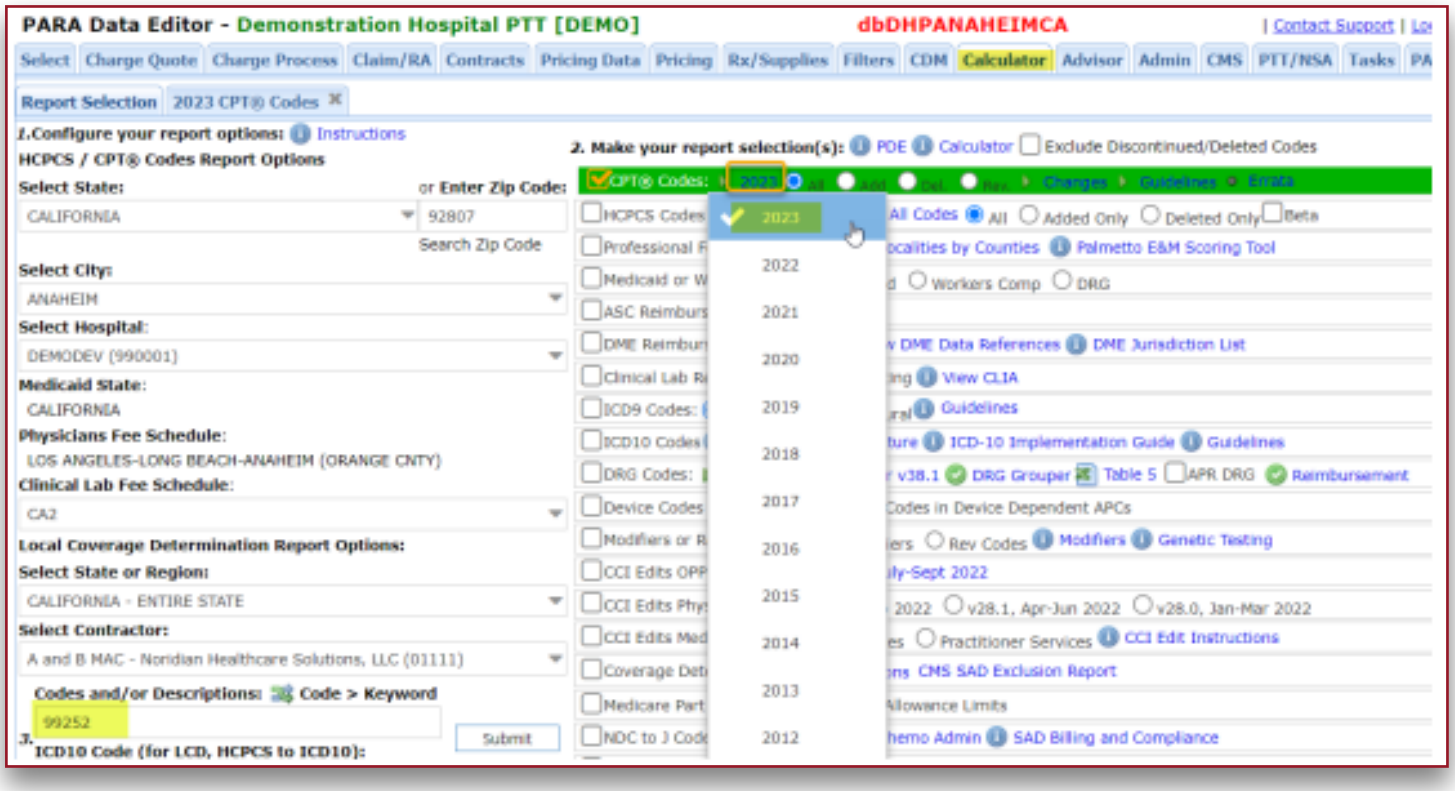
NEW CPT® CODES AND CHANGES TO ESTABLISHED CODES FOR 2023 ARE NOW AVAILABLE IN THE PARA DATA EDITOR (PDE). PARA DATA EDITOR USERS CAN ACCESS CPT® 2023 APPENDIX B, WHICH SUMMARIZES THE CY2023 CODE CHANGES, ON THE CALCULATOR TAB.

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.

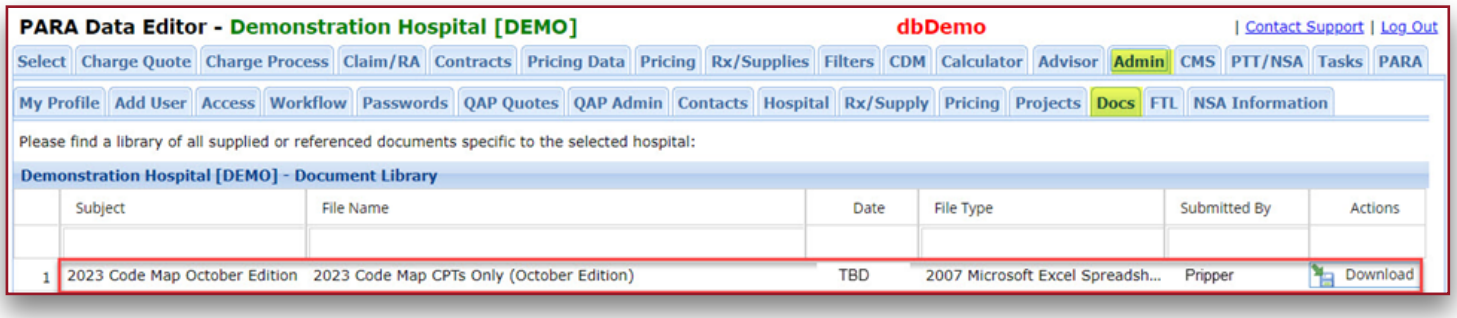
The **PARA Data Editor (PDE)** contains a copy of each client chargemaster; we use the powerful features of the PDE to identify any line item in the chargemaster with a HCPCS code assigned that will be deleted as of December 31, 2022.

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:



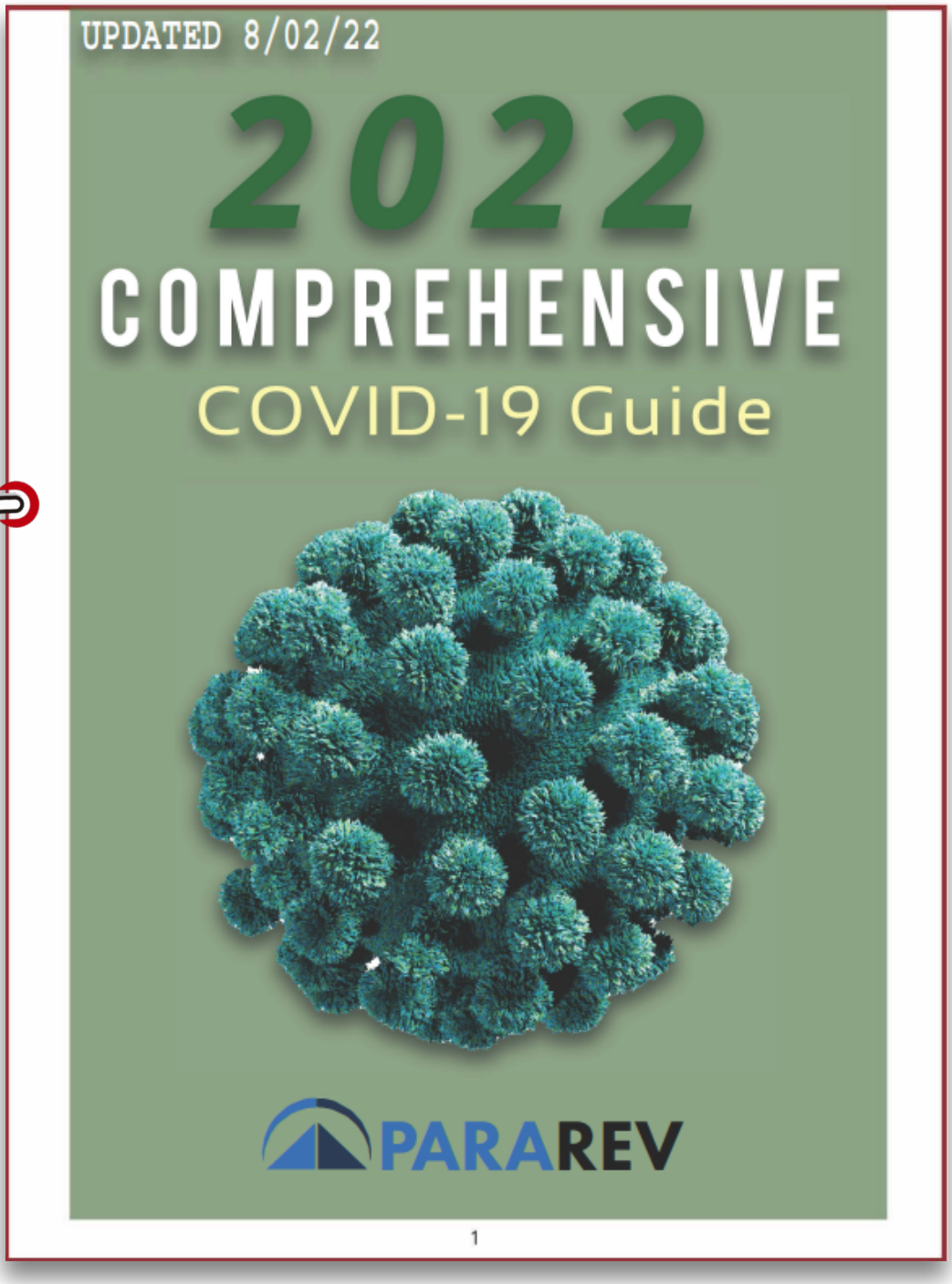
In addition, **ParaRev** consultants will publish concise papers on coding update topics in order to ensure that topical information is available in a manner that is organized and easy to understand. **ParaRev** clients may rest assured that they will have full support for year-end HCPCS coding updates 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 10, 2022

News

- Teaching Hospitals: Phase 2 Section 131 Reviews — Submission Deadline November 18
- Medicare Participation for CY 2023
- CMS Innovation Center's Strategy to Support Person-centered, Value-based Specialty Care
- DMEPOS: Appeals & Rebuttals Contractor Clarification
- Lung Cancer: Help Your Patients Reduce Their Risk

Compliance

- What's the Comprehensive Error Rate Testing Program?

Claims, Pricers, & Codes

- Home Health Prospective Payment System Grouper: January Update
- HCPCS Application Summaries & Coding Decisions: Drugs & Biologicals
- HCPCS Application Summary for Continuous Glucose Monitoring: Updated

MLN Matters® Articles

- Telehealth Home Health Services: New G-Codes

From Our Federal Partners

- Increased Respiratory Virus Activity, Especially Among Children
- Ebola Virus Disease Outbreak in Central Uganda: Update
-

TRANSMITTALS

14

There were FOURTEEN new or revised Transmittals released this week.

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

TRANSMITTAL R11702CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11702	**Date: November 10, 2022**
	Change Request 12957

Note: This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 11664, dated October 27, 2022, is being rescinded and replaced by Transmittal 11702, dated, November 10, 2022, to add new policy language and to remove the sensitive and controversial disclaimer. All other information remains the same.

SUBJECT: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the CY 2023 30-day period payment rates, the national per-visit amounts, and the cost-per-unit payment amounts used for calculating outlier payments under the HH PPS. The attached recurring update notification applies to Pub. 100-04, Medicare Claims Processing Manual, chapter 10, section 70.5.

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.

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:
Recurring Update Notification

TRANSMITTAL R11701PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11701	**Date: November 10, 2022**
	Change Request 12865

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 11580, dated September 1, 2022, is being rescinded and replaced by Transmittal 11701, dated November 10, 2022, to revise the language in the manual instruction from "on or before December 27, 2020" to "as of December 27, 2020.". All other information remains the same.

SUBJECT: Incorporation of Recent Provider Enrollment Regulatory Changes into Chapter 10 of CMS Publication (Pub.) 100-08

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to incorporate into Chapter 10 of Pub. 100-08 certain provider enrollment policies included in the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) Final Rule.

EFFECTIVE DATE: January 6, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 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
R	10/10.1/10.1.1/Definitions
R	10/10.2/10.2.1.14/Skilled Nursing Facilities (SNFs)
R	10/10.4/10.4.2.2/Denial Reasons
R	10/10.4/10.4.7.3/Revocation Reasons
R	10/10.6/10.6.15/Risk-Based Screening
R	10/10.6/10.6.21/Miscellaneous Enrollment Topics

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

TRANSMITTAL R11700CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11700	**Date: November 10, 2022**
	Change Request 12888

Transmittal 11583, dated September 1, 2022, is being rescinded and replaced by Transmittal 11700, dated, November 10, 2022, to add business requirement 12888.7.2. All other information remains the same.

SUBJECT: Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to announce the changes that will be included in the January 2023 quarterly release of the edit module for clinical diagnostic laboratory services. This Recurring Update Notification applies to Chapter 16, Section 120.2, Publication 100-04.

EFFECTIVE DATE: January 1, 2023 - Unless noted differently in requirements.
**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.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:

For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11688OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11688	**Date: November 9, 2022**
	Change Request 12270

SUBJECT: User Enhancement Change Request (UECR): Enhance the Multi-Carrier System (MCS) Detail History Screen

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to enhance the MCS Detail History screen accessed through the mnemonic HI, by adding addition screen toggle capabilities from this screen.

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

III. FUNDING:
For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R11692NCD

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-03 Medicare National Coverage Determinations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11692	**Date: November 9, 2022**
	Change Request 12950

SUBJECT: National Coverage Determination (NCD) 200.3 - Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide business instructions for the National Coverage Determination (NCD) 200.3 - Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD).

EFFECTIVE DATE: April 7, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 12, 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
R	1/200/3/Table of Contents
N	1/200/3/Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (AD)

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:

Business Requirements
Manual Instruction

TRANSMITTAL R11698OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11698	**Date: November 9, 2022**
	Change Request 12966

SUBJECT: Modern Solution to SuperOp Claim Counter Maximum Implementation

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to modernize the SuperOp Claim Counter in the Viable Information Processing Systems (ViPS) Medicare System (VMS) to prevent or avoid future claim counter maximum issues by transitioning to a batch claim counter.

EFFECTIVE DATE: April 1, 2023 - Full Implementation of 12966.1, 12966.1.1, 12966.1.2, 12966.1.3, 12966.1.4, 12966.1.5, 12966.1.6, 12966.1.7 and 12966.2; July 1, 2023 - Development and Coding for 12966.3, 12966.4, 12966.5, 12966.5.1, and 12966.5.2; October 1, 2023 - Full Implementation of 12966.3, 12966.4, 12966.5, 12966.5.1, and 12966.5.2
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2023 - Full Implementation of 12966.1, 12966.1.1, 12966.1.2, 12966.1.3, 12966.1.4, 12966.1.5, 12966.1.6, 12966.1.7 and 12966.2; July 3, 2023 - Development and Coding for 12966.3, 12966.4, 12966.5, 12966.5.1, and 12966.5.2; October 2, 2023 - Full Implementation of 12966.3, 12966.4, 12966.5, 12966.5.1, and 12966.5.2

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

III. FUNDING:
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IV. ATTACHMENTS:

TRANSMITTAL R116950TN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11695	**Date: November 9, 2022**
	Change Request 12988

SUBJECT: New State Codes for North Carolina

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to assign new State Codes to North Carolina. The new State Codes are in addition to the State Code the state already possesses.

EFFECTIVE DATE: April 1, 2023
**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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IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R11693BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11693	**Date: November 9, 2022**
	Change Request 12973

SUBJECT: International Classification of Disease (ICD-10) Code Update for Coverage of Intravenous Immune Globulin (IVIG) Treatment of Primary Immune Deficiency Diseases in the Home

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement a maintenance coding update of Chapter 15, Section 50.6 of the Medicare Benefit Policy Manual (BPM), Publication (Pub) 100-02, Coverage of IVIG for Treatment of Primary Immune Deficiency Diseases in the Home.

This CR will add a newly established ICD-10-CM diagnosis code applicable to this section of the BPM and remove outdated ICD-9-CM diagnosis codes. No policy related changes are included with this coding update CR. Any policy changes will continue to be effectuated separately via the current, longstanding public notice and comment rulemaking and/or National Coverage Determination (NCD) process.

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 12, 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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	15/50.6 – Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

III. FUNDING:
For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

TRANSMITTAL R11689OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11689	**Date: November 9, 2022**
	Change Request 12530

SUBJECT: User Enhancement Change Request (UECR): Add the Common Working File (CWF) Disposition Code to the Multi-Carrier System (MCS) Medicare Secondary Payer (MSP) 'I' Records Detail Screens, the MCS Desk Top Tool (MCSDT) and the MSP CWF Transaction Reject Report H99RB552

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to display the CWF disposition code, in addition to the error code currently displayed and received on the CWF MSP maintenance transaction response record, otherwise known as the HUSP transaction file. The disposition code shall be displayed on the MCS I Records Detail screen, accessed within the MCS using the mnemonic IM. The MCSDT MSP I Record Detail window and the MSP CWF Transaction Reject report H99RB552, shall also be updated to display the disposition code. This will assist the MAC in the claim adjudication process by further defining what action needs to be taken to resolve an error received from the CWF.

EFFECTIVE DATE: April 1, 2023
**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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IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R116997PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11697	**Date: November 9, 2022**
	Change Request 12881

SUBJECT: Update to Process and Responsibility for Tracking Medicare Contractors' Prepayment and Post Payment Reviews in the RAC Data Warehouse (RACDW)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the process for Medicare Administrative Contractors (MAC) to upload Post Payment claims monthly into the RACDW.

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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/3.5/3.5.4/Tracking Medicare Contractors' Prepayment and Postpayment Reviews

III. FUNDING:
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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

TRANSMITTAL R11696PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11696	**Date: November 9, 2022**
	Change Request 12942

SUBJECT: Updates to Chapter 4 of Publication (Pub.) 100-08, to Include the Addition of a Congressional Inquiries Section, Updates to the Vetting Leads with CMS Process, and Various Other Updates

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update various sections in Chapter 4 of Pub. 100-08. The primary updates in this CR include adding a section regarding the Congressional Inquiry process and updating the Vetting Leads with CMS section. Various other sections of Chapter 4 in Pub. 100-08 are also being revised.

EFFECTIVE DATE: December 12, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 12, 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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/Table of Contents
R	4/4.2/4.2.3/Durable Medical Equipment Medicare Administrative Contractor Fraud Functions
R	4/4.6/Vetting Leads with CMS
R	4/4.7/4.7.4.1/Production of Medical Records and Documentation for an Appeals Case File
N	4/4.8/4.8.3/Congressional Inquiries
R	4/4.11/4.11.2/Administrative Actions
R	4/4.11/4.11.5.1/Civil Monetary Penalties Delegated to CMS

III. FUNDING:
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TRANSMITTAL R11694PI

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-08 Medicare Program Integrity	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11694	**Date: November 9, 2022**
	Change Request 12867

This Transmittal is no longer sensitive and is being re-communicated. This instruction may now be posted to the Internet. Transmittal 11597, dated September 15, 2022, is being rescinded and replaced by Transmittal 11694, dated, November 9, 2022, to make editorial changes to the manual instruction. All other information remains the same.

SUBJECT: Medicare Enrollment of Rural Emergency Hospitals (REHs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Chapter 10 of CMS Publication (Pub.) 100-08 with instructions regarding the processing of REH enrollment applications.

EFFECTIVE DATE: October 28, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 28, 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)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	10/10.2/10.2.1.8.1/Rural Emergency Hospitals (REHs)

III. FUNDING:
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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

TRANSMITTAL R11686OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11686	**Date: November 9, 2022**
	Change Request 11900

SUBJECT: User Enhancement Change Request (UECR): ViPS Medicare System (VMS) - Reset Beneficiary and Provider Healthcare Integrated General Ledger Accounting System (HIGLAS) Flags

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to develop a job that will reset Beneficiary and Provider Healthcare Integrated General Ledger Accounting System (HIGLAS) Flags to spaces in the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) User Acceptance Testing (UAT) regions.

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

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IV. ATTACHMENTS:

One Time Notification

TRANSMITTAL R11685CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11685	**Date: November 9, 2022**
	Change Request 12965

SUBJECT: Billing for Hospital Part B Inpatient Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide billing instructions for hospital Part B inpatient services.

EFFECTIVE DATE: July 1, 2022 - for claims received on or after 07/01/2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 12, 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
R	4/240/240.1 - Editing Of Hospital Part B Inpatient Services: Reasonable and Necessary Part A Hospital Inpatient Denials

III. FUNDING:
For Medicare Administrative Contractors (MACs):
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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

MEDLEARNS

2

There were TWO new or revised MedLearns released this week.

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

MEDLEARN MM12957

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Home Health Prospective Payment System: CY 2023 Update

MLN Matters Number: MM12957 Related Change Request (CR) Number: 12957

Related CR Release Date: November 10, 2022 Effective Date: January 1, 2023

Related CR Transmittal Number: R11702CP Implementation Date: January 3, 2023

Related CR Title: Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2023

Provider Types Affected

This MLN Matters Article is for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for home health services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about these changes:

- CY 2023 30-day period payment rates
- National per-visit amounts
- Cost-per-unit payment amounts used for calculating outlier payments under the Home Health Prospective Payment System (HH PPS)

Background

CMS updates the rates it pays to HHAs for providing HH services annually as Section 1895(b)(3)(B) of the Social Security Act (the Act) requires.

Market Basket Update

Based on IHS Global Insight Inc.'s third quarter 2022 forecast (with historical data through fourth quarter 2021), the HH market basket percentage increase for CY 2023 is 4.1%, based on Section 1895(b)(3)(B)(iii) of the Act. We reduce that 4.1% increase by a productivity adjustment, as mandated by Section 3401 of the Affordable Care Act. We estimate this reduction at 0.1% for CY 2023. This means that the HH payment update percentage for CY 2023 is a 4.0% increase.

Section 1895(b)(3)(B)(v) of the Act requires us to decrease the home health update by 2% for those HHAs that don't submit quality data. The payment update for these HHAs is 2.0%.

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Changes to the Laboratory National Coverage Determination (NCD) Edit Software for January 2023

MLN Matters Number: MM12888 Revised
Related Change Request (CR) Number: 12888
Related CR Release Date: November 10, 2022
Effective Date: January 1, 2023
Related CR Transmittal Number: R11700CP
Implementation Date: January 3, 2023

Note: We revised this Article due to a revised CR 12888. The CR revision didn't affect the substance of the Article. We did revise the CR release date, transmittal number, and the web address of the CR. All other information is the same.

Provider Types Affected

This MLN Matters Article is for laboratories billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- Changes to the Laboratory NCD Edit Module for January 2023
- How to access the NCD spreadsheet that lists relevant changes

Background

This Article tells you of changes in the January 2023 quarterly release of the edit module for clinical diagnostic laboratory services. CMS updates the laboratory edit module as necessary to reflect coding updates and substantive changes to NCDs. The laboratory negotiated rulemaking committee developed the NCDs for clinical diagnostic laboratory services.

The NCDs with coding updates in January are:

- Urine Culture, Bacterial (190.12)
- Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) (190.13)
- Blood Counts (190.15)
- Partial Thromboplastin Time (PTT) (190.16)
- Prothrombin Time (PT) (190.17)
- Serum Iron Studies (190.18)
- Collagen Crosslinks, Any Method (190.19)

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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.

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