NOVEMBER 23, 2022

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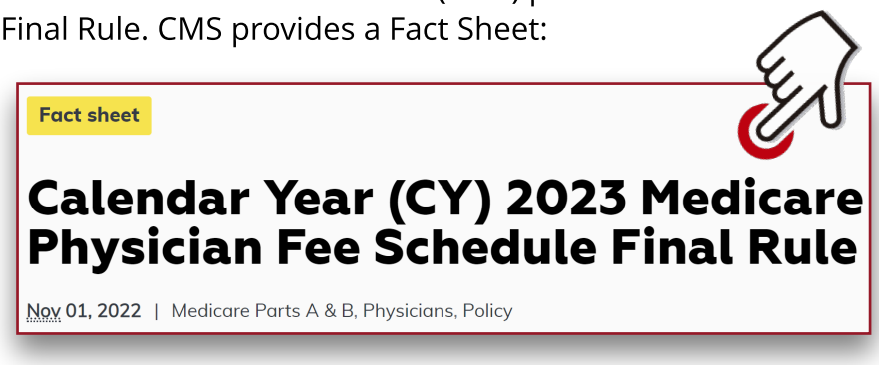
2023 Medicare Updates

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]

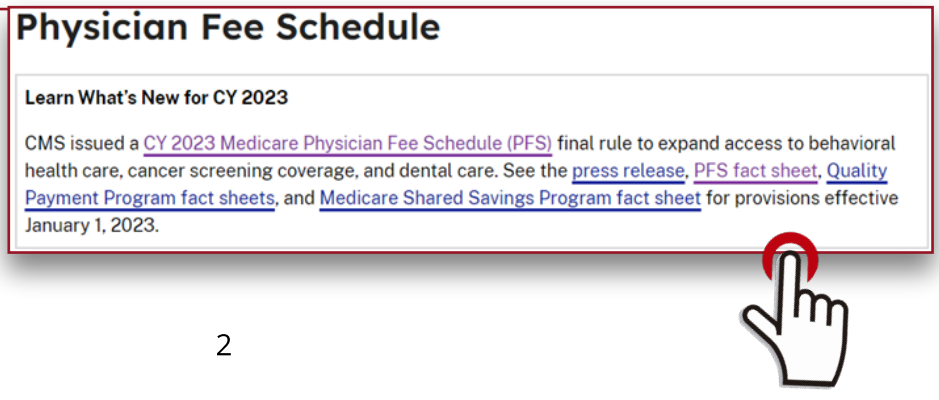
DEPARTMENT OF HEALTH AND HUMAN SERVICES

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.

CMS ALLOWS "DIRECT ACCESS" AUDIOLOGY SERVICES IN 2023

In the 2023 Medicare Physician Fee Schedule, CMS changed the coverage rules to allow audiologists to bill for services without a referral from a physician or non-physician practitioner. Historically, Medicare covered audiologists performing diagnostic services to beneficiaries only on the order/referral from a physician.

Effective January 1, 2023, audiologists may perform certain services for Medicare beneficiaries without a physician or practitioner order once every 12 months per beneficiary. CMS established a list of 36 CPT® codes for Medicare beneficiaries without an order from a physician. Audiologists reporting direct access services must append a new modifier, AB, to one of 36 codes approved for direct access services.

Modifier	Description
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary

In addition, CMS will add 17 audiology service codes to the telehealth list effective 1/1/2023. (See the last page of this paper for more details.)

CMS summarized the change permitting direct access in its news release upon publication of the 2023 MPFS Final Rule:

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

> "CMS finalized a policy to allow beneficiaries direct access to an audiologist without an order from a physician or NPP for non-acute hearing conditions. The finalized policy will use a new modifier — instead of using a new HCPCS G-code as we proposed — because we were persuaded by the commenters that a modifier would allow for better accuracy of reporting and reduce burden for audiologist. The service(s) can be billed using the codes audiologists already use with the new modifier, and include only those personally furnished by the audiologist. The finalized direct access policy will allow beneficiaries to receive care for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. This modification in our finalized policy necessitates multiple changes to our claims processing systems, which will take some time to fully operationalize, but audiologists may use modifier AB, along with the finalized list of 36 CPT codes, for dates of service on and after January 1, 2023.

CMS ALLOWS "DIRECT ACCESS" AUDIOLOGY SERVICES IN 2023

The list of 36 CPT® are provided here:

LIST OF AUDIOLOGY SERVICES PERMITTED FOR DIRECT ACCESS (MODIFIER AB)

CPT®	Description
92550	Tympanometry and reflex threshold measurements
92552	Pure tone audiometry (threshold); air only
92553	Pure tone audiometry (threshold); air and bone
92555	Speech audiometry threshold
92556	Speech audiometry threshold; with speech recognition
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92562	Loudness balance text, alternate binaural or monaural
92563	Tone decay test
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing, threshold
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing
92571	Filtered speech test
92572	Staggered spondaic word test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (vra)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming
92620	Evaluation of central auditory function, with report; initial 60 minutes
92621	Evaluation of central auditory function, with report; each additional 15 minutes (list separately in addition to code for primary procedure)
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour

CMS ALLOWS "DIRECT ACCESS" AUDIOLOGY SERVICES IN 2023

The list of 36 CPT® are provided here:

LIST OF AUDIOLOGY SERVICES PERMITTED FOR DIRECT ACCESS (MODIFIER AB)

CPT®	Description
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure)
92640	Diagnostic analysis with programming of auditory brainstem implant, per hour
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report

In addition, CMS add 17 audiology codes to the list of telehealth services effective 1/1/2023:

CY 2023 Medicare Physician Fee Schedule Final Rule 2022-23873.pdf (federalregister.gov)

> "A commenter stated that the Veteran's Administration has shown, for many years, that audiology services can be safely provided, via telehealth, without sacrificing patient outcomes or quality of care, and that the technology required to perform these procedures via telehealth, in many cases with the assistance of an audiology assistant or technician at a remote location, is readily available. Commenters requested that many audiology services that are not currently available on the Medicare Telehealth Services List be added on a Category 3 basis.
>
> Response: We appreciate the information provided by commenters, and we may consider this information in future rulemaking. Given support of commenters, as well as information provided, we are finalizing the addition of audiology CPT codes 92550, 92552, 92553, 92555, 92556, 92557, 92563, 92565, 92567, 92568, 92570, 92587, 92588, 92601, 92625, 92626, and 92627 to the Medicare Telehealth Services List on a Category 3 basis, as proposed."

NEW MODIFIER JZ REQUIRED WHEN REPORTING PAYABLE DRUGS

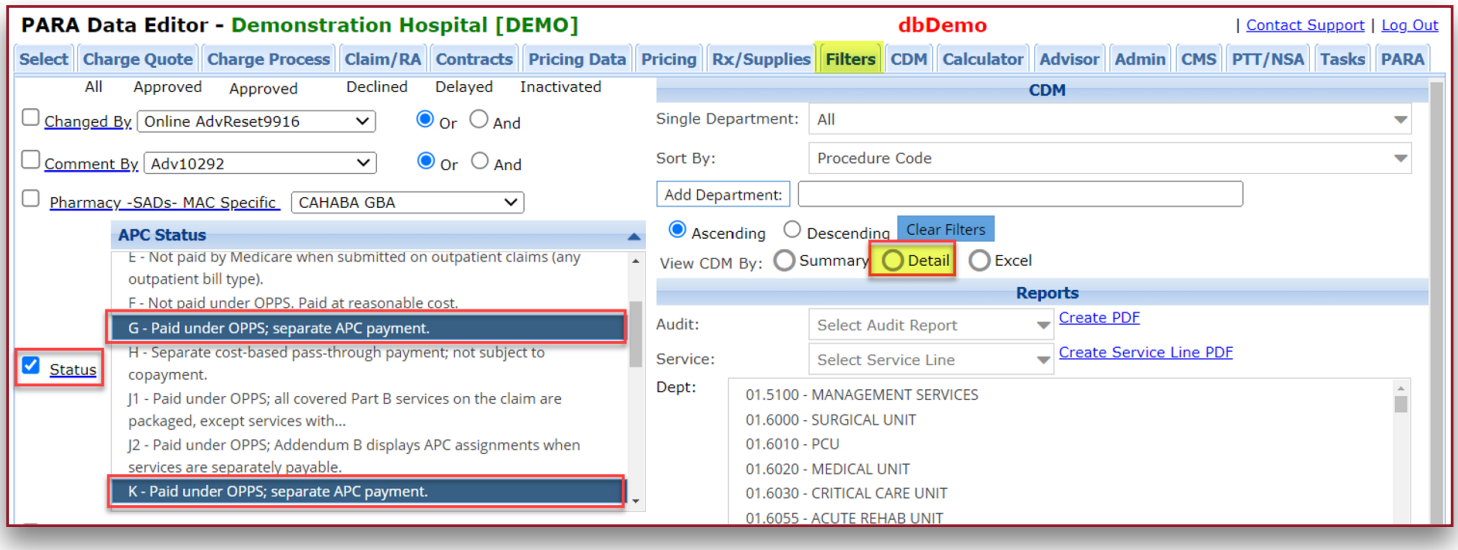
BEGINNING JULY 1, 2023, MEDICARE WILL REQUIRE HOSPITAL OUTPATIENT DEPARTMENTS, ASC'S, AND PHYSICIAN CLINICS (EXCEPT RHCS AND FQHCS) TO REPORT A NEW MODIFIER, "JZ", WHEN CLAIMING REIMBURSEMENT FOR SEPARATELY PAYABLE DRUGS WHEN AN ENTIRE SINGLE-USE VIAL OR PACKAGE IS ADMINISTERED WITHOUT WASTAGE.

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.

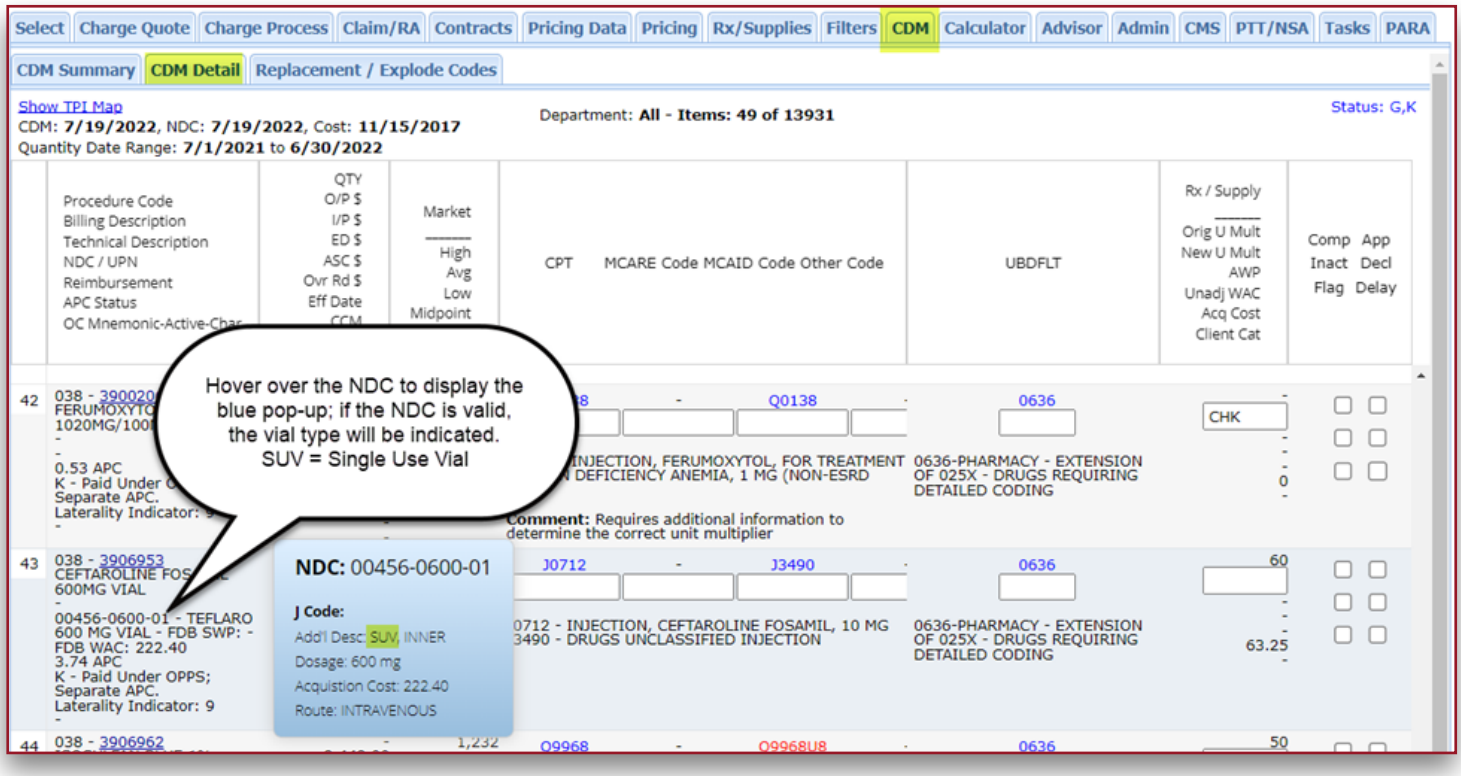
Effective July 1, 2023, modifier JZ will be required when reporting drugs or biologics assigned OPPS status indicator G or K on outpatient claims when the entire vial was administered and no wastage of the same drug is reported on the same claim. Then, effective October 1, 2023, CMS plans to apply claim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

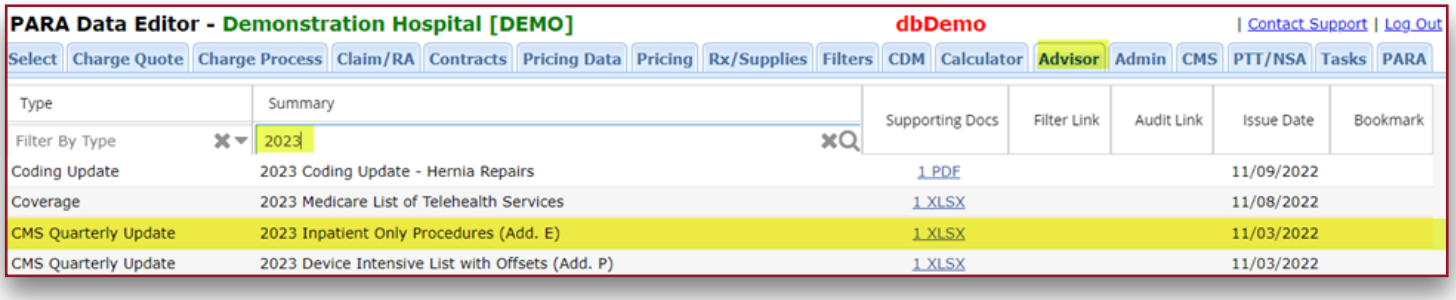
In the proposed rule, CMS proposed that an initial invoice for the refund to be sent to manufacturers in October 2023. However, we believe it would be beneficial to create system efficiencies related to the reconciliation and invoicing system of the discarded drug refunds and the new inflation rebate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

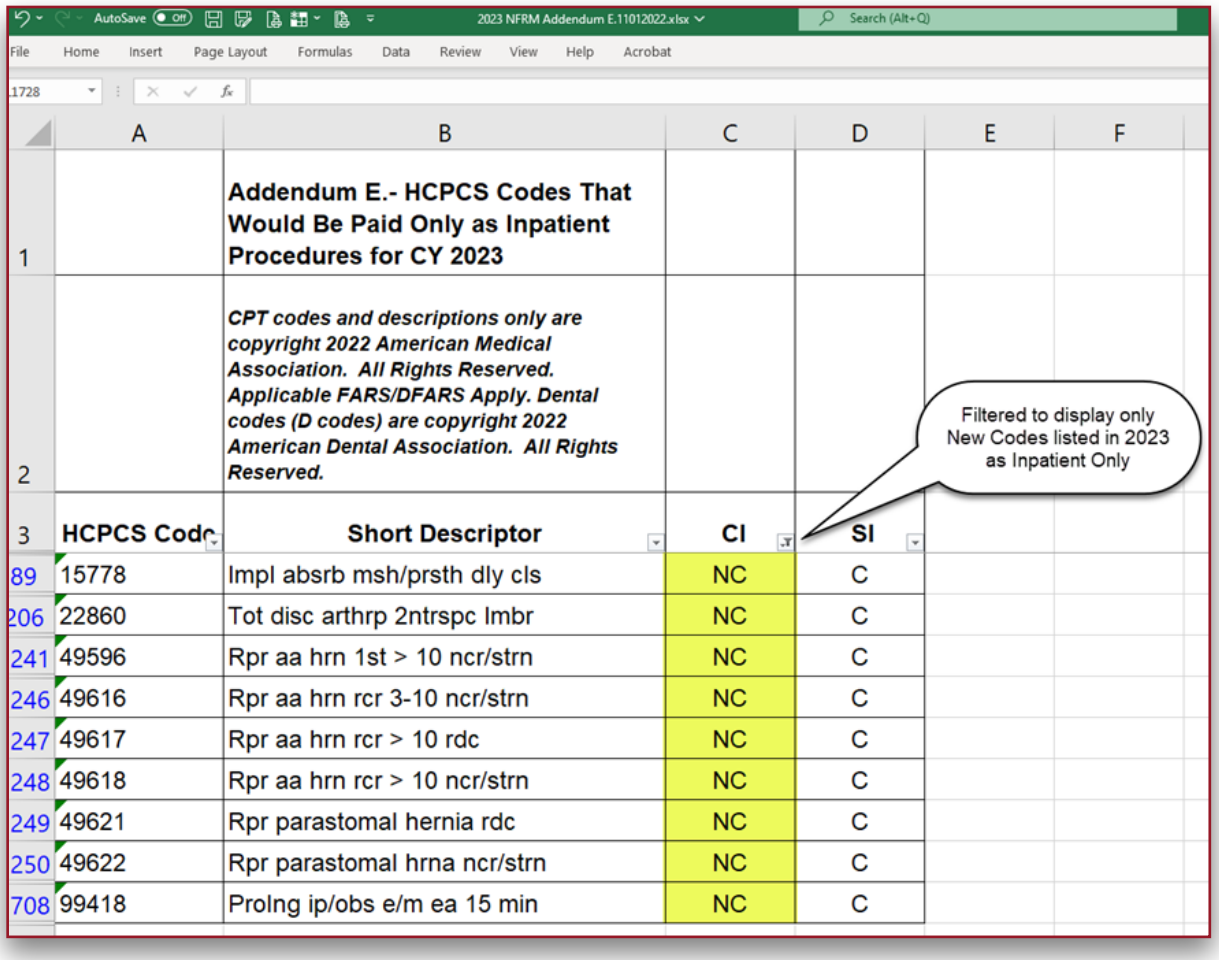
2023 OPPS UPDATE: INPATIENT ONLY CHARGES

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

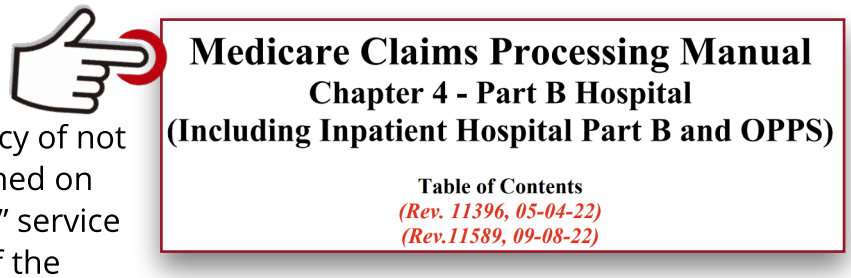

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

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

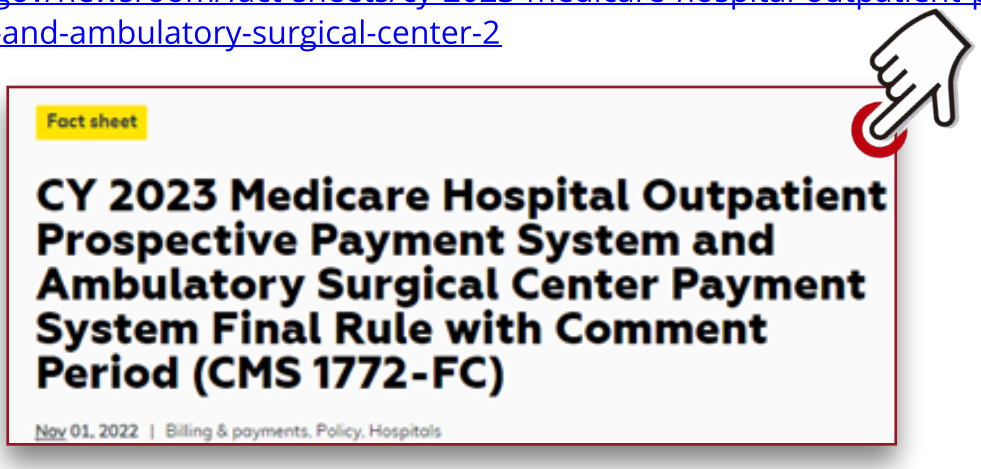
CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

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

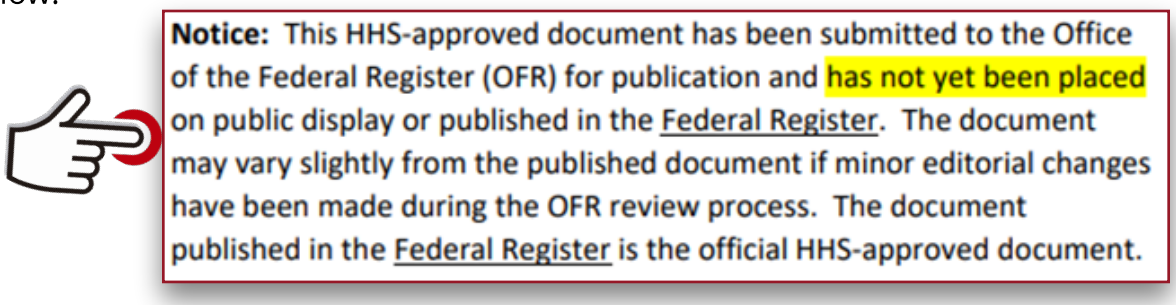
CY 2023 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule with Comment Period (CMS 1772-FC)

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

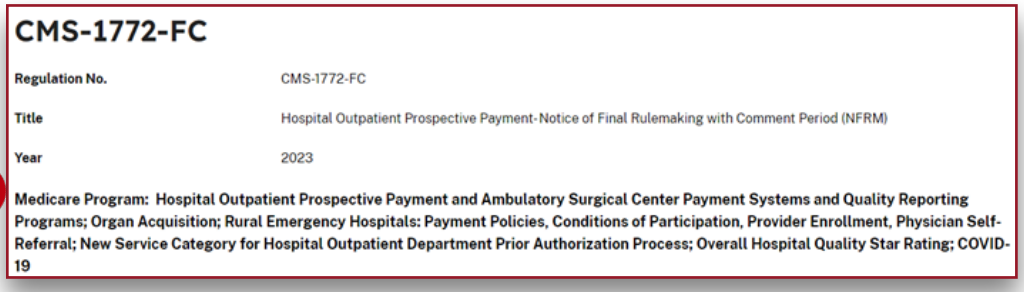
Topics discussed in the OPPS Final Rule include:

- 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.

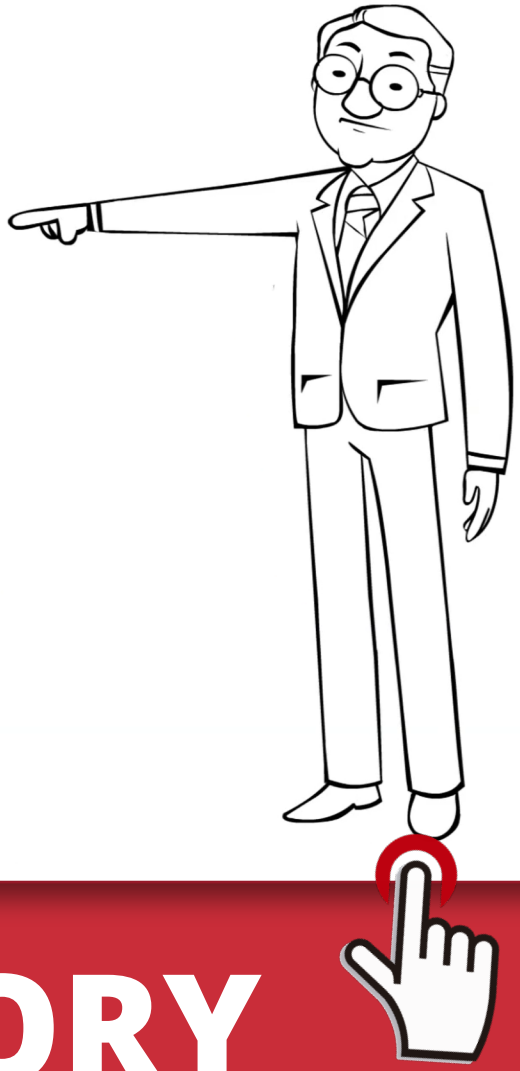
Files related to the update, including Cost Statistic Files, 2023 OPPS Addenda files, and Wage Index links, may be accessed and downloaded by clicking the box to the right.


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



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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

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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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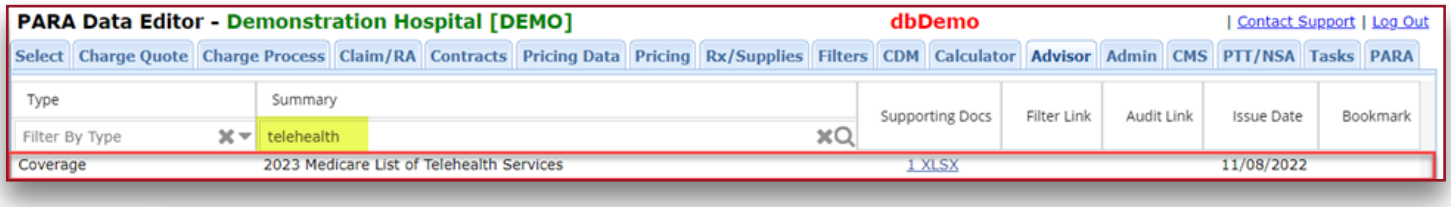
MEDICARE UPDATES 2023 TELEHEALTH SERVICES FOR 2023

In the Medicare Physician Fee Schedule Final Rule (MPFS), Medicare updated its list of services that may be provided via telehealth. While new codes were added to the 2023 telehealth list, Medicare also addressed services that were temporarily permitted during the Public Health Emergency (PHE).

Some services will be permitted via telehealth technology until the end of next year, December 31, 2023, regardless of when the PHE ends, other services indicate "Temporary Addition for the PHE; Expires with PHE plus 151 days." Medicare also indicates services that may be provided through audio-only communication.

The 2023 Medicare List of Telehealth Services Excel spreadsheet may be downloaded from the **Para Data Editor** Advisor tab. Search "telehealth" in the Summary field as shown:



Excerpt:

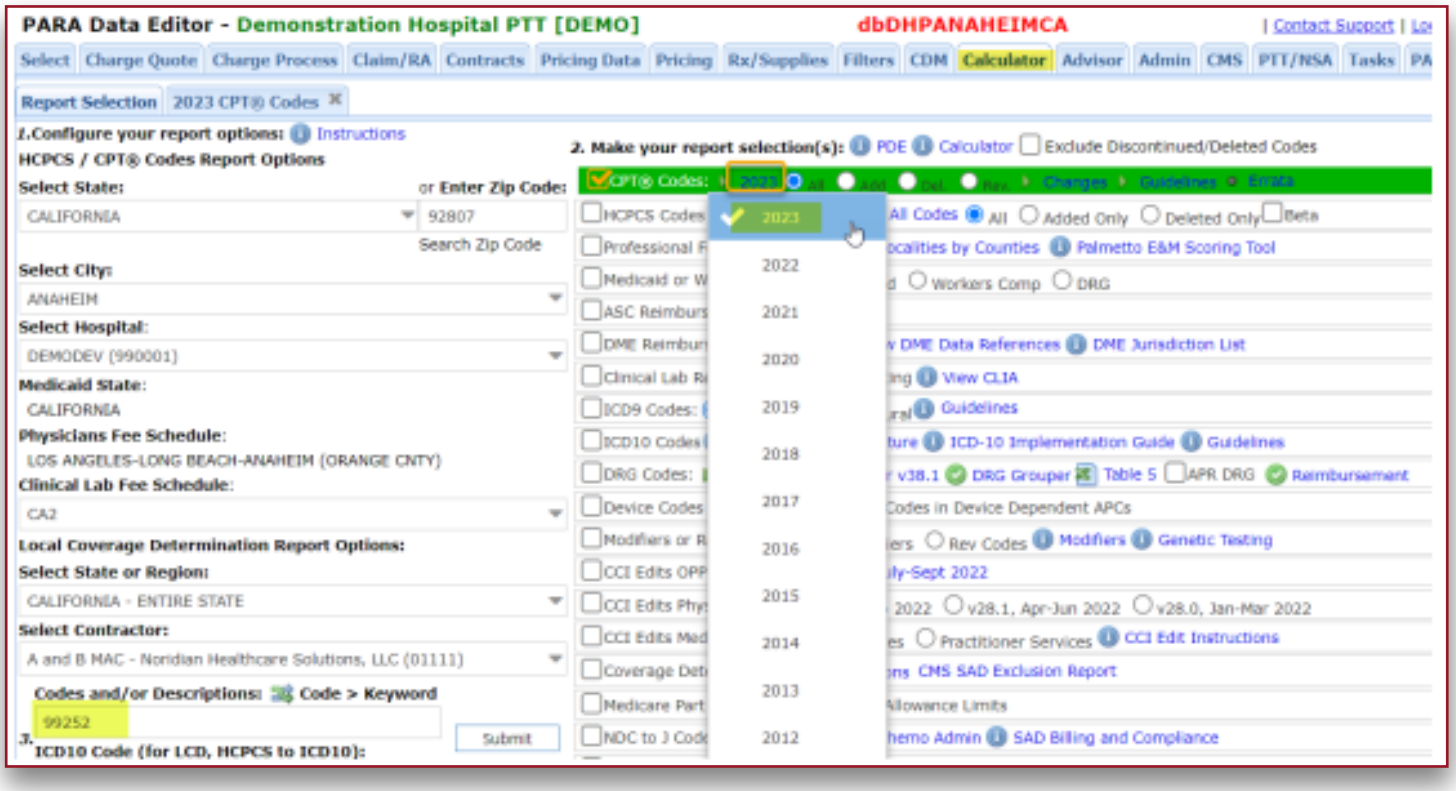
	LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2023 - updated November 1, 2022			
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirement	Medicare Payment Limitations
99348	Home visit est patient			
99349	Home visit est patient	Available Through December 31, 2023		
99350	Home visit est patient	Available Through December 31, 2023		
99406	Behav chng smoking 3-10 min		Yes	
99407	Behav chng smoking > 10 min		Yes	
99441	Phone e/m phys/qhp 5-10 min	Temporary Added 04/30/2020 for PHE; Expires with PHE plus 151 days	Yes	
99442	Phone e/m phys/qhp 11-20 min	Temporary Added 04/30/2020 for PHE; Expires with PHE plus 151 days	Yes	
99443	Phone e/m phys/qhp 21-30 min	Temporary Added 04/30/2020 for PHE; Expires with PHE plus 151 days	Yes	
99468	Neonate crit care initial	Temporary Addition for the PHE; Expires with PHE plus 151 days		
99469	Neonate crit care subsq	Available Through December 31, 2023		
99471	Ped critical care initial	Temporary Addition for the PHE; Expires with PHE plus 151 days		

Telehealth providers should continue to report the Place of Service indicator that would be used if the patient was provided an in-person visit. Modifier 95 should be appended to identify the service as telehealth. (Facilities should not append modifier 95 to HCPCS G0463, however – they may report Q3014 to claim reimbursement for telehealth outpatient visits with a facility-based practitioner.)

In CY 2023, Medicare payment for the Telehealth Originating Site Facility Fee, HCPCS Q3014, will be 80% of the lower of the billed charge or $28.64, based on the Medicare Economic Index (MEI) – 3.8%. Beneficiaries will be responsible for deductibles and Medicare coinsurance.

See ParaRev paper 2023 Medicare Physician Fee Schedule (PFS) Final Rule Published for additional information as well as links to the Federal Register and CMS Physician Fee Schedule website.

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.

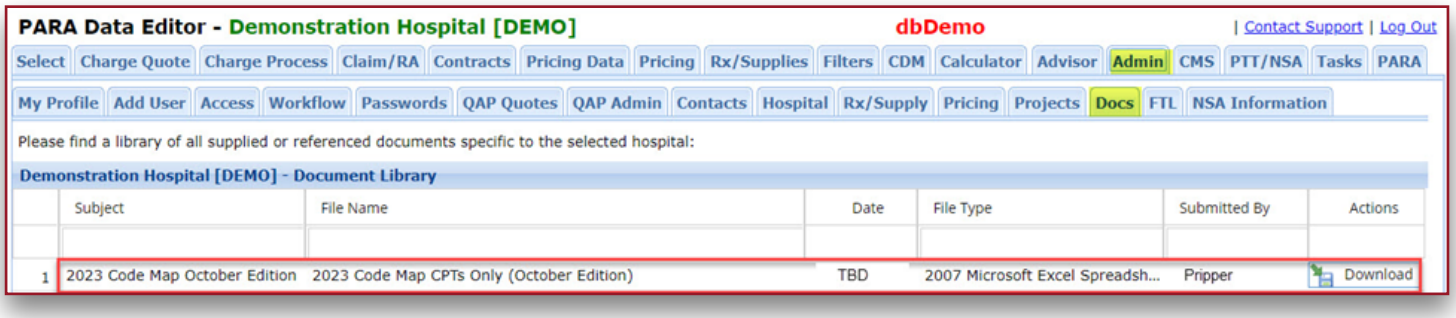
The **PARA Data Editor (PDE)** contains a copy of each client chargemaster; we use the powerful features of the PDE to identify any line item in the chargemaster with a HCPCS code assigned that will be deleted as of December 31, 2022.

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:



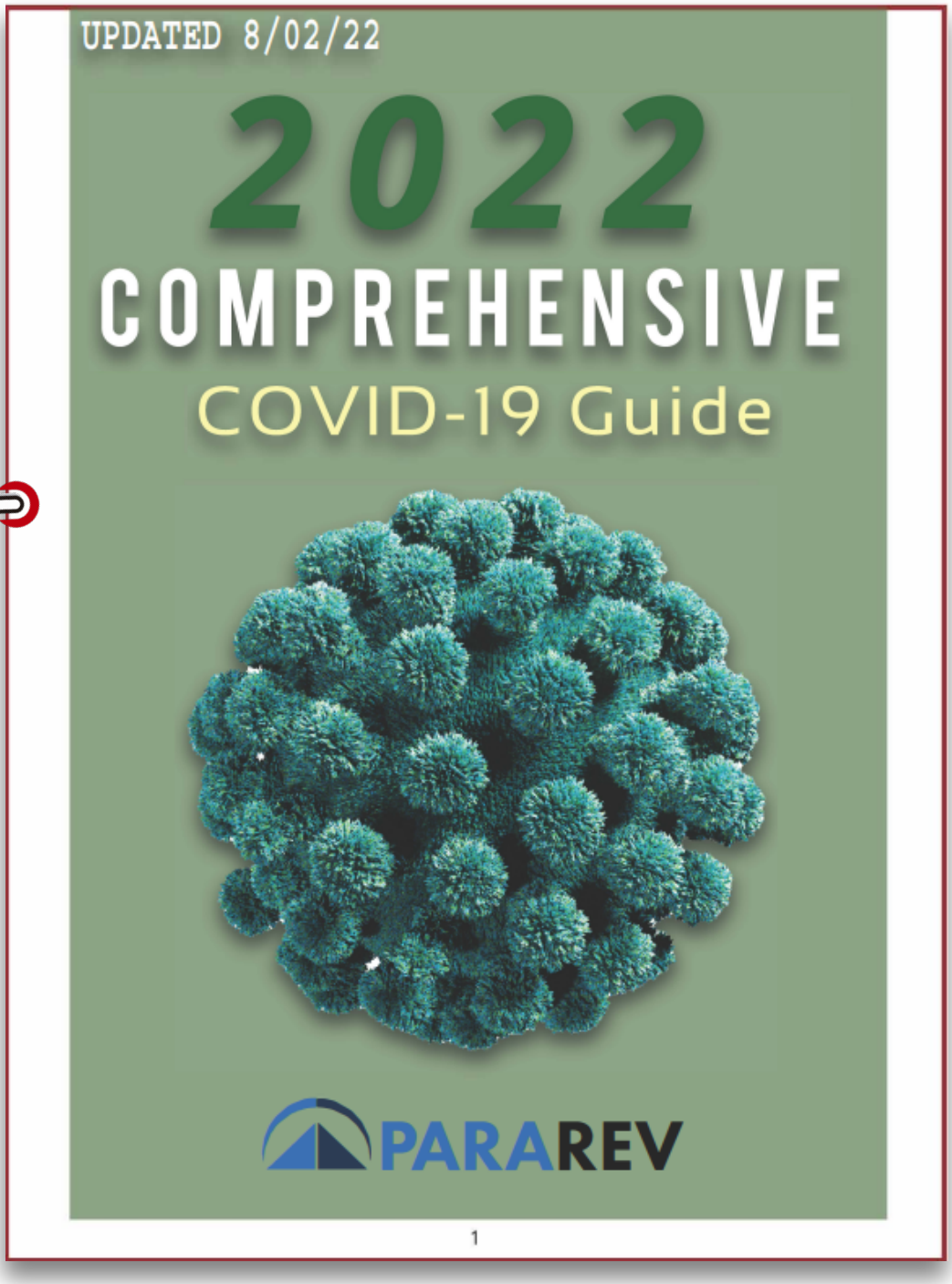
In addition, **ParaRev** consultants will publish concise papers on coding update topics in order to ensure that topical information is available in a manner that is organized and easy to understand. **ParaRev** clients may rest assured that they will have full support for year-end HCPCS coding updates 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 17, 2022

News

- Hospital Price Transparency: Download Machine-Readable File Sample Formats & Data Dictionaries
- Medical Review After the COVID-19 Public Health Emergency: New FAQ
- Flu Shots & COVID-19 Vaccines: Each Visit is an Opportunity

Claims, Pricers, & Codes

- DMEPOS: Corrected 2022 Fee Schedule Amounts
- Hospital Part B Inpatient Services Billing
- Outpatient Prospective Payment System Payment Rate for HCPCS Code Q5124

Events

- HCPCS Public Meeting: November 29 – December 1

MLN Matters®Articles

- Provider Enrollment Instructions: Seventh General Update
- ICD-10 & Other Coding Revisions to National Coverage Determinations (NCDs): April 2023 Update

Publications

- Home Health & Hospice: Medicare Provider Resources
- Independent Diagnostic Testing Facility (IDTF) — Revised

Multimedia

- Quality in Focus Videos to Increase Quality of Care

TRANSMITTALS

10

There were TEN new or revised Transmittals released this week.

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

TRANSMITTAL R11719OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11719	**Date: November 23, 2022**
	Change Request 13001

SUBJECT: Update the Common Working File (CWF) to Apply Error Code 7282 to all Applicable Detail Lines of a Claim

I. SUMMARY OF CHANGES: The purpose of this change request is to update the CWF to apply error code 7282 to all applicable detail lines of a claim in one cycle.

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 R11718CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11718	**Date: November 23, 2022**
	Change Request 12999

SUBJECT: Update to Rural Health Clinic (RHC) All Inclusive Rate (AIR) Payment Limit for Calendar Year (CY) 2023

I. SUMMARY OF CHANGES: This recurring update notification updates the payment limit for CY 2023 Rural Health Clinics (RHCs) in Chapter 9, Section 20.2 - "Payment Limit under the AIR" of the Claims Processing Manual.

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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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11706CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11706	**Date: November 17, 2022**
	Change Request 12990

SUBJECT: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 29.1, Effective April 1, 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

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
N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11714CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11714	**Date: November 18, 2022**
	Change Request 12924

Transmittal 11644, dated October 13, 2022, is being rescinded and replaced by Transmittal 11714, dated, November 18, 2022, to remove business requirement 12924.1.5. All other information remains the same.

SUBJECT: Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to add new claims edits in response information returned from the Home Health (HH) Grouper, so HH claims receive clearer error messages. It also creates a new informational unsolicited response (IUR) to Medicare systems to correct partial episode payments.

EFFECTIVE DATE: April 1, 2023 - Claims processed on or after this date.
**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
R	10/80/HH Grouper Program
R	10/80.1/HH Grouper Input/Output Record Layout
R	10/80.2/HH Grouper Decision Logic and Updates

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.

TRANSMITTAL R11704CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11704	**Date: November 17, 2022**
	Change Request 12938

SUBJECT: Combined Common Edits/Enhancements Modules (CCEM) Code Set Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to direct the Medicare shared system maintainers to obtain the most recent external code sets, and use them to update the necessary tables and/or reference files as part of the CCEM software utilized by the A/B Medicare Administrative Contractors (MACs). This recurring update notification applies to publication 100-04, chapter 24, section 50.3.4.

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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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11703CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11703	**Date: November 17, 2022**
	Change Request 12937

SUBJECT: Implement Operating Rules - Phase III Electronic Remittance Advice (ERA) Electronic Funds Transfer (EFT): Committee on Operating Rules for Information Exchange (CORE) 360 Uniform Use of Claim Adjustment Reason Codes (CARC), Remittance Advice Remark Codes (RARC) and Claim Adjustment Group Code (CAGC) Rule - Update from Council for Affordable Quality Healthcare (CAQH) CORE

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to instruct the contractors and Shared System Maintainers (SSMs) to update systems based on the CORE 360 Uniform use of CARC, RARC and CAGC rule publications. These system updates are based on the CORE Code Combination List to be published on or about February 1, 2023. This recurring update notification applies to chapter 22, section 80.2.

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
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III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11707CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11707	**Date: November 17, 2022**
	Change Request 12979

SUBJECT: Correction to Stem Cell Transplantation Instructions in Chapter 3, Section 90.3

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update stem cell transplantation instructions to restore information that was omitted in error in an earlier transmittal.

EFFECTIVE DATE: December 20, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: December 20, 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.

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R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/90.3/Stem Cell Transplantation

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 R11711CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11711	**Date: November 17, 2022**
	Change Request 12949

SUBJECT: April 2023 Healthcare Common Procedure Coding System (HCPCS) Quarterly Update Reminder

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to remind the Medicare contractors that the quarterly update to the HCPCS file is available for them to download. The complete HCPCS file is updated and released quarterly. The file contains existing, new, revised and discontinued HCPCS codes for the April 2023 quarter. Contractors must download the file via the CMS mainframe in March 2023. The recurring update notification applies to chapter 23, section 20 of the Medicare Claims Processing Manual. This CR only reminds the Medicare contractors that the Quarterly update to the HCPCS file will be available for them to download.

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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III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11708CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11708	**Date: November 17, 2022**
	Change Request 12982

SUBJECT: Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2023 Medicare Physician Fee Schedule (MPFS) Final Rule and to announce the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

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
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11709OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11709	**Date: November 17, 2022**
	Change Request 10693

SUBJECT: User Enhancement Change Request (UECR): Update the Multi-Carrier System (MCS) Comment Screen

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to allow a user to make corrections on the Comment screen, add comments to a finalized claim and to auto populate specific data to fields on the screen which currently require manual entry.

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

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 MM12924

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Home Health Claims: New Grouper Edits

MLN Matters Number: MM12924 Revised

Related CR Release Date: November 18, 2022

Related CR Transmittal Number: R11714CP

Related Change Request (CR) Number: 12924

Effective Date: April 1, 2023-Claims processed on or after this date

Implementation Date: April 3, 2023

Related CR Title: Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response

Note: We revised this Article due to a revised CR 12924. CMS won't return claims with this message, "Primary diagnosis identified as a code first code with condition present." We removed that from the Article. Also, we revised 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 Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- New Grouper Edits
- New HH Informational Responses
- Revised processing of some Notices of Admission (NOA)

Background

New Grouper Edits

The HH Grouper program has various data validity edits that make sure it uses consistent and accurate data when calculating payment groups on HH claims. Of these edits, currently only a principal diagnosis not assigned to a clinical group causes HH claims to be returned to the provider. Other principal diagnosis code errors aren't returned to the provider. In some cases, this causes processing problems.

New edits will identify various error conditions helpful to providers in improving claims accuracy. If the diagnosis coding issues are identified, we return the claim to the provider for correction.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

MEDLEARN MM12982

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Medicare Physician Fee Schedule Final Rule Summary: CY 2023

MLN Matters Number: MM12982	Related Change Request (CR) Number: 12982
Related CR Release Date: November 17, 2022	Effective Date: January 1, 2023
Related CR Transmittal Number: R11708CP	Implementation Date: January 3, 2023

Related CR Title: Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

Provider Types Affected

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

Provider Action Needed

Make sure your billing staff knows about the following CY 2023 MPFS updates:

- Telehealth originating site facility fee payment amount
- Expansion of coverage for colorectal cancer screening
- Coverage of Audiology services
- Other covered services

Background

This Article gives a summary of the policies in the CY 2023 MPFS. CMS issued the 2023 Physician Fee Schedule final rule updating payment policies and Medicare payment rates for services we pay providers under the MPFS in CY 2023. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. We summarize the payment policies under the MPFS in CY 2023 in this Article.

Medicare Telehealth Services

For CY 2023, we're adding new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. We're keeping many services that are temporarily available as telehealth services for the duration of

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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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.