OCTOBER 5, 2022

eJOURNAL

PARAREV
A CorroHealth Company

Drug HCPCS

Updates For 2022

Pediatric Facility Coding

Optimizing Coding And Charge Capture

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: I have an ER visit where we are an in-network hospital, but our ER provider was out of network. We received an EOB with the N830 RARC code, but it seems we got an out of network payment for provider. Should I expect in-network payment, or a QPA amount? I am asking about the out of network provider - that should be paid at in network rates correct?

Answer: The in-network facility should expect to receive the contracted rate for an ED visit. The health plan is required to pay the OON ED provider the difference between the Out-Of Network rate and the cost-sharing amount. The OON ED provider cannot balance bill the patient for anything over the copayment, coinsurance, or amounts paid toward a deductible. If the OON ED provider is not satisfied with the reimbursement from the plan, they are to negotiate a higher reimbursement with the plan. If they cannot agree upon an amount, then the IDR process is initiated to allow a third party to determine an acceptable reimbursement. **eCFR :: 45 CFR Part 149 -- Surprise Billing and Transparency Requirements.**

> The plan or issuer: (B) Pays a total plan or coverage payment directly to the nonparticipating provider or nonparticipating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services (as determined in accordance with **paragraphs (b)(3)(ii)** and **(iii)** of this section), less any initial payment amount made under **paragraph (b)(3)(iv)(A)** of this section. The total plan or coverage payment must be made in accordance with the timing requirement described in section 2799A-1(c)(6) of the PHS Act, or in cases where the out-of-network rate is determined under a specified State law or All-Payer Model Agreement, such other timeframe as specified by the State law or All-Payer Model Agreement.

RARC N830 = Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es). A list of RARCs related to the NSA can be found here: **Remittance Advice Remark Codes Related to the No Surprises Act (cms.gov)**

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: If a plan is out of network and they pay us an amount that seems too low, are they required to tell us their in-network rate?

Answer: There are no provisions in the NSA that require a plan to reveal their in-network rates.

Question: My NSA link requires a diagnosis code?

Answer: A diagnosis code is one of the required data elements in an estimate.
eCFR :: 45 CFR Part 149 Subpart G -- Protection of Uninsured or Self-Pay Individuals

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

(1) A good faith estimate issued to an uninsured (or self-pay) individual must include:
(i) Patient name and date of birth;
(ii) Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);
(iii) Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including:
(A) Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and
(B) Items or services reasonably expected to be furnished by co-providers or co-facilities (as specified in **paragraphs (b)(2)** and **(c)(2)** of this section);
(iv) Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;.

Question: Are we required to supply a GFE for our clinic services?

Answer: A GFE is required for an uninsured individual who has services scheduled at least 3 days in advance. Generally, all providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a GFE from an uninsured (or self-pay) individual must provide such individual with a GFE. No specific specialties, facility types, or sites of service are exempt from this requirement.

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: Do you have any information on where we should be using the notice and consent in regards to NSA and when those would apply? Only during emergency services and or an out of network provider at an in network facility?

We are seeking clarity as you noted that "NSA is intended to protect the patient from surprise balance bills when they are receiving scheduled services at an in-network facility/provider. They are offered no protection from balance billing when they schedule services at an out-of-network facility/provider. "

Answer: Patients who electively seek non-emergency services at an out-of-network facility, have no protections under the NSA, so the patient can be balance billed without signing a Notice and Consent. The Notice and Consent is issued to a patient who presents to an in-network facility when the out-of network provider wishes to balance bill a patient, when balance billing is not prohibited. Emergency Services can never be balance billed.

Ancillary providers cannot balance bill patients who seek services at an in-network facility. Ancillary services are defined as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

A provider or emergency facility can issue a Notice and Consent for post-stabilization services only if all the following requirements are met:

	Requirement	Additional Details
1.	An individual is stable enough to travel using nonmedical or nonemergency medical transport to an available in-network provider/facility located within a reasonable travel distance given the individual's medical condition.	• Determined by attending emergency physician or treating provider. • Provider determination is binding on a facility.
2.	The individual or their authorized representative is in a condition where they can receive information and provide informed consent.	• Determined by attending emergency physician or treating provider. • An authorized representative CAN'T be a provider affiliated with the facility or an employee of the facility, unless such provider or employee is a family member of the participant, beneficiary, or enrollee.
3.	The provider/facility provides written notice and obtains written consent from the individual to waive balance billing protections, in compliance with all related statutory and regulatory requirements.	• Details provided starting on slide **51**.
4.	The provider/facility complies with state laws.	• This may include state laws that further restrict balance billing for post-stabilization services.

CMS released a slide deck that explains the prohibitions on balance billing. The link below will take you to that slide deck.

The No Surprises Act's Prohibitions on Balancing Billing (cms.gov)

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: How do we know how the payer determined how much to reimburse?

Answer: The payer determines the Qualifying Payment Amount (QPA) and shares that information on the claim.

- The July 2021 interim final rules require that plans and issuers:
- Provide the QPA for each item or service involved
    - Provide a statement certifying that:
      (1) The QPA applies for purposes of the recognized amount, and
      (2) each QPA was determined in compliance with the methodology outlined in the July 2021 interim final rules
    - Provide a statement concerning initiating the 30-day open negotiations period and initiating the federal IDR process within 4 days of the end of open negotiations
    - Provide contact information for the appropriate office or person to initiate open negotiations

Upon request of the provider, the payer must inform them of how the QPA was determined.

- Information about whether the QPA includes contracted rates that were not set on a fee-for service basis for the specific items and services at issue and whether the QPA was determined using underlying fee schedule rates or a derived amount
- Information to identify which database was used to determine the QPA, if applicable
- If a related service code was used to determine the QPA for a new service code, information to identify which related service code was used
- If applicable, a statement that the plan's or issuer's contracted rates include risk-sharing, bonus, penalty, or other incentive-based or retrospective payments or payment adjustments for the items and services involved that were excluded to calculate the QPA

A payer can use databases to determine the QPA.

- Where a plan or issuer does not have sufficient information to calculate a median contracted rate, the plan or issuer must determine the QPA using an eligible database.
- A third-party database may be an eligible database if it satisfies all of the following conditions:
    - No conflicts of interest. • Sufficient information regarding in-network allowed amounts paid for relevant items/services furnished in the applicable geographic region.
    - Ability to distinguish amounts paid to participating providers and facilities by commercial payers from all other claims data.
- State all-payer claims databases have been deemed eligible

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: I have one more question regarding insurance being out of network for lab services. Out of network insurance is not paying and denying stating that "services rendered by out of network provider not covered" and the amount is not made patient responsibility. Can this be bill to patient or we need to dispute?

Answer: There are some factors to consider when discussing ancillary services and balance billing. Here are some scenarios:

- Specimen collected by an in-network (IN) provider and sent to an out-of-network (OON) Lab
  - The OON Lab is considered an ancillary service which is always prohibited from balance billing the patient. Must dispute payment with payer.
- Specimen collected and processed by the OON Lab
  - There are no protections in the NSA for a patient who electively receives services at an OON facility/provider. Patient can be balance billed.
- Specimen collected by an OON provider and sent to an OON Lab
  - The OON Lab is considered an ancillary service which is always prohibited from balance billing the patient. Must dispute payment with payer.
- Specimen collected and processed by an IN Lab, but a non-covered service by the plan
  - There are no protections in the NSA for non-covered services. The patient can be balance billed.

We have provided a link to a CMS slide deck that discusses the prohibitions on balance billing and provided two excerpts which discuss Lab services and balance billing.

The No Surprises Act's Prohibitions on Balancing Billing (cms.gov)

Scope of non-emergency services that are considered part of visit to a facility

Out-of-network providers can't balance bill for **non-emergency items and services that are part of a visit** at an in-network health care facility. This includes the following:

1. Equipment and devices;
2. Imaging services;
3. Telemedicine services;
4. Lab services;
5. Preoperative services and postoperative services.

These items or services don't need to happen physically within the in-network health care facility to be treated as part of a visit (e.g., offsite laboratory services).

Reminder: The No Surprises Act's ban on balance billing for non-emergency services only apply to plan covered services. If a non-emergency service is not covered under the in-network benefits and terms of coverage under an individual's health plan, then the No Surprises Act's rules on balance billing do not apply for these services.

NO SURPRISES ACT QUESTIONS AND ANSWERS

No Surprises Act Update Q&A

Non-emergency services for which individuals may never be balance billed

Ancillary services, which individuals typically have little control over, are **ALWAYS** subject to balance billing prohibitions.

The No Surprises Act defines **ancillary services** as:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, provided by either a physician or non-physician practitioner;
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services; and
- Items and services provided by an out-of-network provider when there is no in-network provider who can provide the item or service at the in-network health care facility.

It is never appropriate for an ancillary service to issue a Notice and Consent to the patient. I have provided an excerpt from the slide deck referenced above.

Recap of when out-of-network providers or facilities can and cannot use notice-and-consent exceptions (continued)

Non-emergency services	
Use of Notice and Consent Exception Not Allowed	**When providing ancillary services, defined as:** • Emergency medicine, anesthesiology, pathology, radiology, neonatology items or services provided by physician or non-physician practitioner; • Items or services provided by assistant surgeons, hospitalists, and intensivists; • Diagnostic services, including radiology and laboratory services; **Items or services of an out-of-network provider if there is no in-network provider who can provide the item or service at the facility.** **When providing items or services due to unforeseen urgent medical needs in the course of care delivery.** **Additional situations banned by state law.**

Qualitox Lab sent this letter to providers stating they will invoice the provider for lost revenue since they can't bill the patient. That letter can be viewed here: **No Surprises Act (qualitoxlab.com)** Contact your legal team if you receive a similar letter from an ancillary provider.

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: Does the posted notice (on websites and in facilities) meet the requirement of providing the "Right to Receive a Good Faith Estimate of Expected Charges" in WRITING or must the written notice be presented to the patient in the manner they choose – email vs mail? Included is an excerpt from CMS-10791 document which leads me to this question.

> **Appendix 1 Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act (For use by health care providers no later than January 1, 2022) Instructions Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage both orally and in writing of their ability, upon request or at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges**.

Answer: To clarify Information regarding the **availability of a "Good Faith Estimate" must be prominently displayed** on the convening provider's and convening facility's website and in the office and on-site where scheduling or questions about the cost of health care items or services occur.

Separately, the good faith estimate (GFE) must be provided in written form either on paper or electronically (for example, electronic transmission of the GFE through the convening provider's patient portal or electronic mail), pursuant to the uninsured (or self-pay) individual's requested method of delivery.

GFEs provided to uninsured (or self-pay) individuals that are transmitted electronically must be provided in a manner that the uninsured (or self-pay) individual can both save and print, and must be provided and written using clear and understandable language and in a manner calculated to be understood by the average uninsured (or self-pay) individual.

If a patient requests that the GFE information is provided in a format that is not paper or electronic delivery, like orally over the phone or in person, the provider/facility may provide the GFE information orally but must follow-up with a written paper or electronic copy in order to meet the regulatory requirements.

NO SURPRISES ACT QUESTIONS AND ANSWERS

Question: How does the NSA apply to LTACH facilities?

Answer: This is the response to a similar question answered by CMS:

Generally, all providers and facilities that schedule items or services for an uninsured (or self-pay) individual or receive a request for a GFE from an uninsured (or self-pay) individual must provide such individual with a GFE.

No specific specialties, facility types, or sites of service are exempt from this requirement. The terms "health care provider (provider)" and "health care facility (facility)" are defined in regulations for purposes of the GFE requirements for uninsured (or self-pay) individuals as:

- "Health care provider (provider)" means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law, including a provider of air ambulance services;
- "Health care facility (facility)" means an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any State in which State or applicable local law provides for the licensing of such an institution pursuant to such law or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

There may be variations in practice patterns, such as whether a specific provider or facility furnishes services to uninsured (or self-pay) individuals, along with the types of items or services provided. There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.

For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services, for which coverage is often not provided by a plan or issuer and thus even individuals with coverage must self-pay.

Question: If the disclosure form that is required to be given to each patient with a group health plan - how do we prove this was given and the patient continued to go through with the appointment?

Answer: CMS is not giving any guidance on how to prove that a Disclosure notice was given. Facilities and Providers need to contact their compliance department to draft policies/procedure and guidelines to educate, train, and monitor staff for compliance.

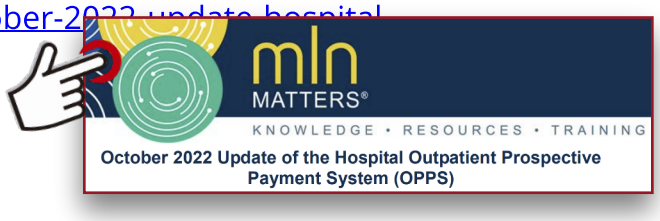
2022 NEW DRUG HCPCS CODES

THE FOLLOWING TABLE LISTS DRUGS THAT WERE ASSIGNED HCPCS CODES EFFECTIVE OCTOBER 1, 2022. THE HCPCS CODES WITH THE MANUFACTURER NAME AND NDC NUMBER ARE LISTED BELOW. THESE NEW CODES WILL NEED TO BE ADDED TO THE CHARGEMASTER IF THE USE OF THESE DRUGS IS APPLICABLE.

New HCPCS Code	Long Descriptor	Manufacturer/ Trade Name	SI	APC	NDC
C9142	Injection, bevacizumab-maly, biosimilar, (alymsys), 10 mg	Amneal Pharmaceuticals Inc	G	9048	70121-1755-01 70121-17-5401
C9101	Injection, oliceridine, 0.1 mg	Trevena, Inc.	G	9049	71308-0011-10 71308-0021-10 71308-03-0110
A9602	Fluorodopa f-18, diagnostic, per millicurie	The Feinstein Institutes for Medical Research	G	9053	13267-03-4657 13267-03-4556
A9607	Lutetium lu 177 vipivotide tetraxetan, therapeutic, 1 millicurie	Advanced Accelerator Applications USA, Inc	G	9054	69488-0010-61
A9800	Gallium ga-68 gozetotide, diagnostic, (locametz), 1 millicurie	Advanced Accelerator Applications USA, Inc	G	9055	69488-0017-61
J9298	Injection, nivolumab and relatlimab-rmbw, 3 mg/1 mg	Bristol-Myers Squibb Company	G	9057	00003-7125-11

Below is the link to the October 2022 update to Hospital Outpatient Prospective Payment System (OPPS):

https://www.cms.gov/files/document/mm12885-october-2022-update-hospital-outpatient-prospective-payment-system-opps.pdf



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.

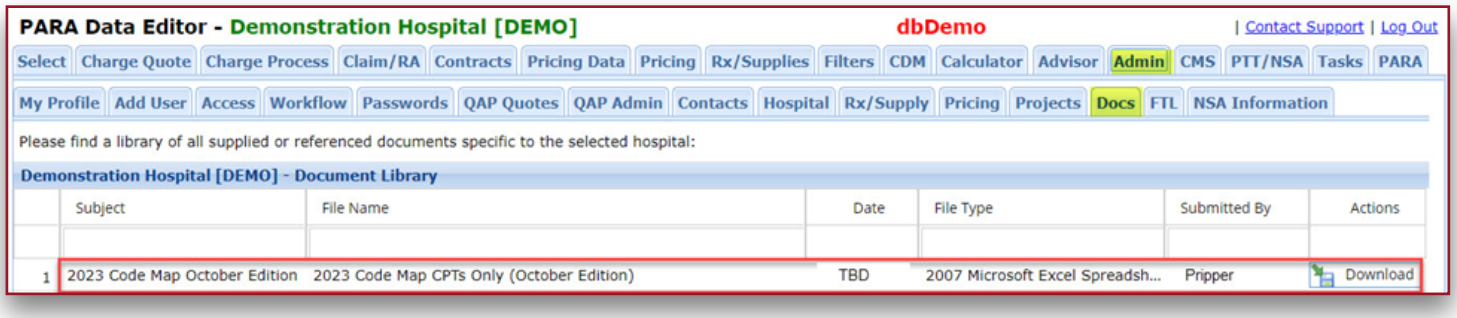
The **PARA Data Editor (PDE)** contains a copy of each client chargemaster; we use the powerful features of the PDE to identify any line item in the chargemaster with a HCPCS code assigned that will be deleted as of December 31, 2022.

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 theCPT® 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.

MEDICARE TO RECOUP OVERPAYMENTS CAUSED BY SYSTEM EDITS

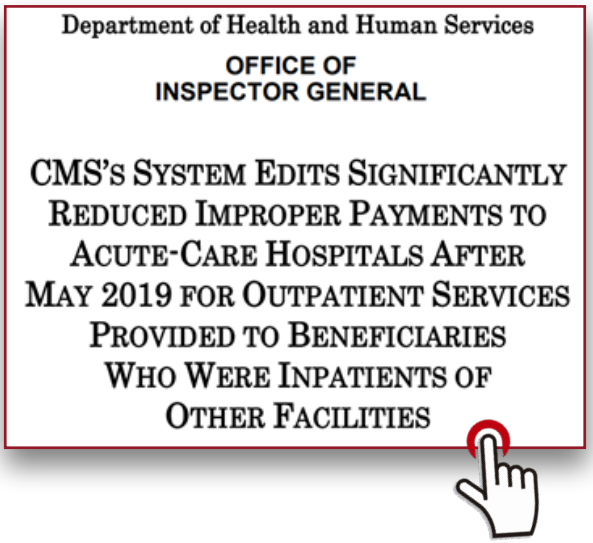
IN SEPTEMBER 2022, THE OFFICE OF INSPECTOR GENERAL PUBLISHED RECOMMENDATIONS TO CMS REGARDING OVERPAYMENTS MADE FOR OUTPATIENT SERVICES BETWEEN JANUARY 2013 THROUGH AUGUST 2016.

The audit looked for inpatient claims from long-term care hospitals (LTCHs), inpatient psychiatric facilities (IPFs), inpatient rehabilitative facilities (IRFs) and critical access hospitals (CAHs) that overlapped outpatient service dates Medicare Part B paid to acute-care hospitals.

Inpatient facilities must directly provide all services during a beneficiary inpatient stay and arrange for services it cannot provide to be performed by acute-care hospitals as outpatient services which must be submitted to Medicare on the inpatient facility's inpatient claim. Medicare should not pay an acute-care hospital for services when the beneficiary is an inpatient of another facility.

While now corrected, the OIG discovered $39.3 million in over payments resulting from CMS system edits not working properly and made the following recommendations:

- Medicare Administrative Contractors (MACs) should recover $39.3 million in overpayments from acute-care hospitals
- Acute-care hospitals must refund Medicare beneficiaries up to $9.8 million from incorrect deductions and coinsurances collected
- Notify affected providers so they may identify, report and return inappropriate payments in accordance with the 60-day rule
- Continue to monitor common working file (CWF) edits to ensure the edits are effective in preventing payments to acute-care hospitals while the beneficiaries are inpatients of other facilities
- Identify claims that were paid after the audit period to recoup any additional over payments made as described in the audit



CMS provided corrective actions and concurred with four of the five OIG recommendations. CMS will consider actions regarding improper payments made after the audit period.

The full OIG report is available through the following link:

https://oig.hhs.gov/oas/reports/region9/92203007.pdf

OPTIMIZING CODING AND CHARGE CAPTURE IN PEDIATRIC FACILITIES

Hospitals across the country are losing millions of dollars in revenue due to deficient charging and coding processes for outpatient visits including emergency department (ED), outpatient clinics, Observation units and urgent care centers.

According to the American Academy of Pediatrics data, of the more than 141 million emergency department visits in the United States, approximately 20% were for children younger than 15 years old. Children have a unique anatomic, physiologic, developmental, and medical need that differs from adult emergency care.

These differences should be considered when treating the patient; and, when charging and coding for the encounter. Over the past decade, 1 in 10 Children's Hospitals engaged CorroHealth to perform an audit of 125 facility-selected charts.

These audits were focused on identifying projected impact of the CorroHealth coding technology and services offering through the Advanced Coding Solution. Analysts accessed medical records, UB-04s, itemized statements and charge masters to complete the review. The results of these audits identified several challenges facing Children's Hospitals.

The details of these findings are on the next page.

OPTIMIZING CODING AND CHARGE CAPTURE IN PEDIATRIC FACILITIES

Challenge 1

Skewed Level Distribution

Understanding the Scenario:

Providers in children's emergency departments (EDs) are presented with the unique scenario where the parent or guardian is often the one detailing symptoms. Parents of children with chronic or congenital conditions prefer to stay within the children's hospital system to maintain continuity of care. In other situations, parents utilize the emergency department instead of a primary care facility given the 24/7 access to care. Due to this, children's hospital EDs tend to see both very low-acuity patients (i.e. runny nose, congestion, ear infections) and very high-acuity patients (i.e. chronic health conditions with co-morbidities).

Assessments Results/Analysis:

Across all children's facilities, CorroHealth experts found significant under coding for Facility E&M levels. This area ranked among the highest and most common for revenue improvement. CorroHealth analysts found skewed distribution of level of service assignment in which high-acuity patients were under coded. Failure to distinguish relatively high resource patients from those with less resource-intensive visits continues to be a struggle in the emergency department.

Challenge 2

Compassion vs. Sustainable Care

Understanding the Scenario:

Showing compassion to a family with a sick child can be at odds with a hospital's financial health. Children's hospitals are more apt to give services away given children are involved. These hospitals tend to not charge facility procedures to the patient. This not only means revenue loss, but also does not provide an accurate account of treatment during the encounter.

Assessments Results/Analysis:

Analysis revealed a significant number of errors related to charge capture and coding of procedures. The errors and omissions were both CPT coding and inaccurate assignment of infusions and hydrations. The Current Procedural Terminology (CPT) hierarchy for reporting infusion, injection and hydration services is among the most complicated set of coding rules coders face. It requires careful examination of the entire clinical record to appropriately report these services.

Challenge 3

Lack of Coding Standardization

Understanding the Scenario:

There is no national standard for hospital assignment of E&M code levels for the emergency department. CMS requires each hospital to establish its own guidelines. With coding guidelines set at the hospital's discretion, under coding is more prevalent. Hospitals are more conservative on Facility E/M assignment rather than risk a 3rd party audit.

Assessments Results/Analysis:

Various CorroHealth assessments revealed a lack of consistency within the hospital's own coding and charging guidelines. A consistent pediatric methodology would provide a compliant Facility E/M distribution and ensure unique pediatric resources are appropriately assigned.

Addressing the Challenges Children's Hospital Findings

The Challenge

In 2012, a Midwest Children's Hospital made a significant technology investment and moved to the EPIC platform. By implementing EPIC's integrated charge capture system there would be a consistent charging for facility, professional and observation for the system. While the Epic solution was implemented and fully operational, leadership wanted to ensure they were fully optimizing revenue integrity, quality, and compliance.

The Analysis

The CorroHealth team performed a full review of the hospital's documentation, coding, and charges for a set of 125 patient records. The analysis identified an additional $24 per encounter in potential improvement utilizing our proprietary pediatric methodology.

The Solution

After a full review of the chart analysis, the children's hospital decided to roll-out a full-service offering from CorroHealth. The solution provided both the Advanced Coding Solution platform and the coding professionals necessary to handing coding for facility, professional and observation encounters. Analytics within the Advanced Coding Solution identified missing stop times on 25% of injections and infusions (I&I). The analytics further identified issues in observations with over 70% of the I&I stop times missing. Injections and infusions were only one area addressed with the insights from the solution. The combination of proper coding and charge capture, data driven analytics, and care team education and engagement helped the Children's facility outpace their financial goals

Children's Hospital Findings:

On average, the findings from CorroHealth audit and analysis of Children's Hospitals EDs found the following missed revenue opportunities

- **$184 per patient** from incorrect coding of facility E&M levels
- **$40 per patient** in facility procedure charge errors
- **$25 per patient** from documentation improvement opportunities
- **$276 per patient** in observation services charging improvements

For a facility with annual patient volumes of 30,000 ED patients and 1,500 observation patients, this would equate to **an annual gross revenue improvement opportunity of $7.9M.**

OCTOBER, 2022 OPPS PAYABLE DRUGS REIMBURSEMENT

In the October 2022 update to OPPS, Medicare announced changes to payment rates for separately payable drugs identified as OPPS status indicators G and K. A link and an excerpt are provided below:

https://www.cms.gov/files/document/mm12885-october-2022-update-hospital-outpatient-prospective payment-system-opps.pdf

c. Drugs and Biologicals with Payments Based on Average Sales Price (ASP)

> For CY 2022, payment for most nonpass-through drugs, biologicals, and therapeutic radiopharmaceuticals that weren't required through the 340B Program is made at a single rate of ASP + 6% (or ASP + 6% of the reference product for biosimilars). In CY 2022, a single payment of ASP + 6% for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these passthrough items (or ASP + 6% of the reference product for biosimilars). We'll update payments for drugs and biologicals based on ASPs on a quarterly basis as later-quarter ASP submissions are available.
>
> Effective October 1, 2022, payment rates for many drugs and biologicals have changed from the values published in the CY 2022 OPPS/ASC final rule with comment period because of the new ASP calculations based on sales price submissions from the fourth quarter of CY 2021. In cases where adjustments to payment rates are necessary, we'll add changes to the payment rates in the October 2022 Fiscal Intermediary Standard System (FISS) release. ...

The following table lists the changes in per- unit OPPS reimbursement, sequenced by the highest rate of change. In the interest of brevity, we list only those HCPCS for which the payment rate increased or decreased more than 10% below.

Values are rounded to the nearest penny.

HCPCS Code	Short Descriptor	July 2022 Payment Rate	October 2022 Payment Rate	Per Unit Increase/ (Decrease)	% Change
J7169	Inj andexxa, 10 mg	$286.10	$102.646	-$183.46	-64%
J9027	Clofarabine injection	$48.40	$28.773	-$19.62	-41%
J9305	Inj. pemetrexed nos 10mg	$78.39	$47.747	-$30.65	-39%
J9050	Carmustine injection	$760.83	$468.032	-$292.79	-38%
J9044	Inj, bortezomib, nos, 0.1 mg	$14.87	$10.021	-$4.85	-33%
J0594	Busulfan injection	$2.04	$1.387	-$0.65	-32%
90375	Rabies ig im/sc	$286.02	$213.236	-$72.78	-25%

OCTOBER, 2022 OPPS PAYABLE DRUGS REIMBURSEMENT

HCPCS Code	Short Descriptor	July 2022 Payment Rate	October 2022 Payment Rate	Per Unit Increase/ (Decrease)	% Change
J9025	Azacitidine injection	$0.67	$0.503	-$0.17	-25%
Q0138	Ferumoxytol, non-esrd	$0.70	$0.533	-$0.17	-24%
Q0139	Ferumoxytol, esrd use	$0.70	$0.533	-$0.17	-24%
J7329	Inj, trivisc 1 mg	$13.31	$10.258	-$3.05	-23%
Q5122	Inj, nyvepria	$217.69	$171.378	-$46.31	-21%
J9395	Injection, fulvestrant	$14.02	$11.048	-$2.97	-21%
J0630	Calcitonin salmon injection	$2,231.39	$1,777.336	-$454.05	-20%
J9070	Cyclophosphamide 100 mg inj	$26.87	$21.923	-$4.95	-18%
J9264	Paclitaxel protein bound	$14.69	$12.143	-$2.55	-17%
J2506	Inj pegfilgrast ex bio 0.5mg	$155.83	$131.414	-$24.41	-16%
Q5117	Inj., kanjinti, 10 mg	$38.49	$32.699	-$5.79	-15%
Q5108	Injection, fulphila	$165.27	$141.114	-$24.15	-15%
Q2050	Doxorubicin inj 10mg	$129.99	$111.985	-$18.01	-14%
J9120	Dactinomycin injection	$633.77	$557.404	-$76.36	-12%
J1327	Eptifibatide injection	$2.13	$1.870	-$0.26	-12%
Q5116	Inj., trazimera, 10 mg	$45.48	$40.006	-$5.47	-12%
J9400	Inj, ziv-aflibercept, 1mg	$8.09	$7.127	-$0.96	-12%
J0716	Centruroides immune f(ab)	$5,190.15	$4,583.506	-$606.64	-12%
J9036	Inj. belrapzo/bendamustine	$19.37	$17.115	-$2.26	-12%
Q5120	Inj pegfilgrastim-bmez 0.5mg	$153.33	$135.548	-$17.79	-12%
J9041	Inj., velcade 0.1 mg	$44.01	$39.051	-$4.96	-11%
J1744	Icatibant injection	$216.72	$193.004	-$23.71	-11%
J0894	Decitabine injection	$1.59	$1.415	-$0.17	-11%
J9357	Valrubicin injection	$1,437.85	$1,284.597	-$153.25	-11%
J7318	Inj, durolane 1 mg	$10.36	$9.266	-$1.09	-11%
J7182	Factor viii recomb novoeight	$1.26	$1.132	-$0.13	-10%
C9046	Cocaine hcl nasal solution	$1.23	$1.107	-$0.12	-10%
Q5119	Inj ruxience, 10 mg	$44.03	$39.741	-$4.29	-10%
J9226	Supprelin la implant	$42,302.58	$38,268.923	-$4,033.66	-10%

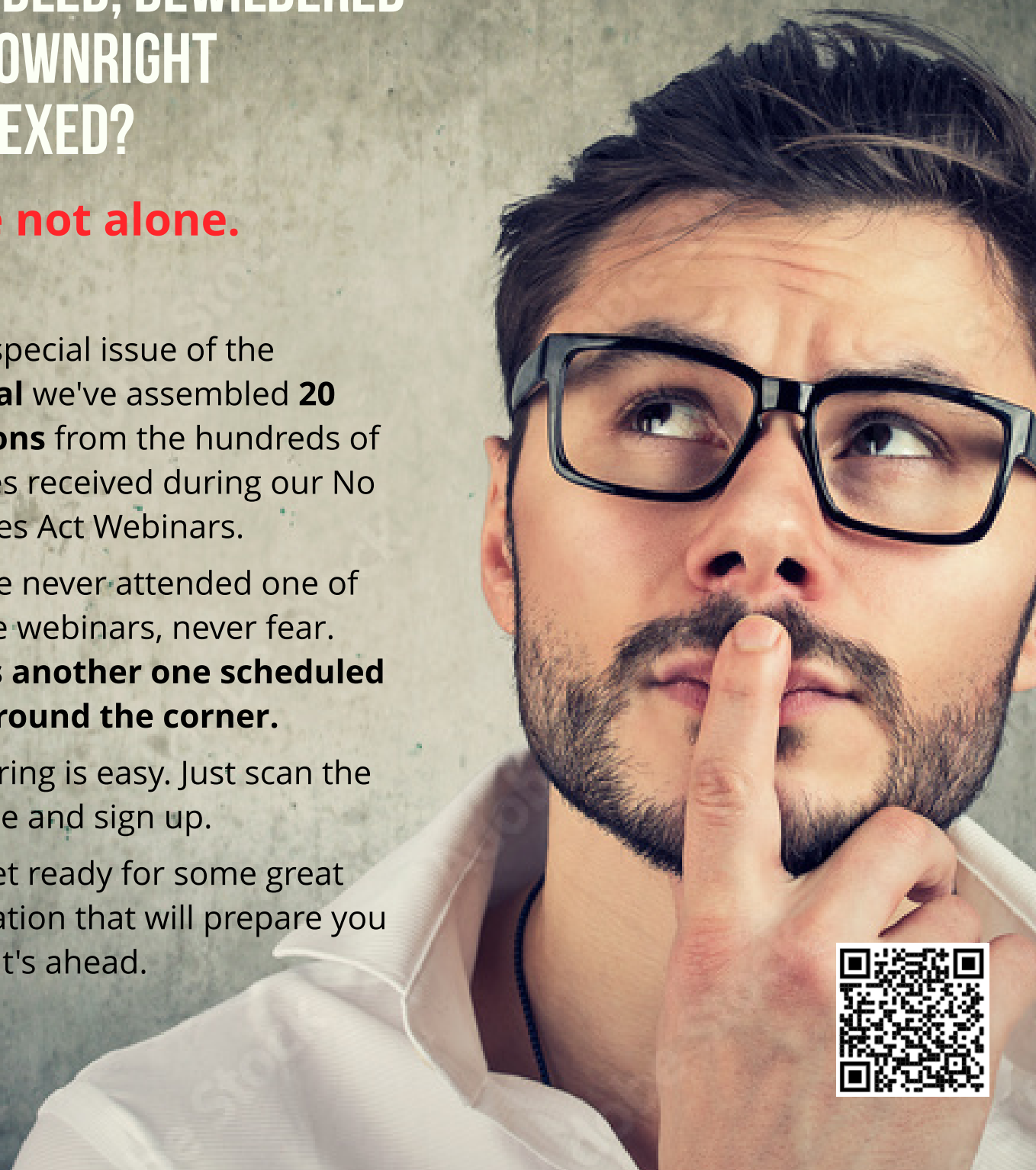
OCTOBER, 2022 OPPS PAYABLE DRUGS REIMBURSEMENT

HCPCS Code	Short Descriptor	July 2022 Payment Rate	October 2022 Payment Rate	Per Unit Increase/ (Decrease)	% Change
J9246	Inj., evomela, 1 mg	$18.02	$16.337	-$1.68	-9%
J2560	Phenobarbital sodium inj	$40.30	$44.926	$4.63	11%
J9065	Inj cladribine per 1 mg	$21.66	$24.305	$2.65	12%
J7324	Orthovisc inj per dose	$131.88	$149.474	$17.59	13%
J9280	Mitomycin injection	$47.16	$54.294	$7.13	15%
Q5110	Nivestym	$0.34	$0.400	$0.06	18%
Q5101	Injection, zarxio	$0.23	$0.273	$0.04	18%
90675	Rabies vaccine im	$291.79	$348.527	$56.74	19%
Q5113	Inj herzuma 10 mg	$42.96	$52.971	$10.02	23%
J9017	Arsenic trioxide injection	$12.33	$15.371	$3.04	25%
J2770	Quinupristin/dalfopristin	$337.47	$493.970	$156.51	46%
J9293	Mitoxantrone hydrochl / 5 mg	$35.79	$53.338	$17.55	49%
J1451	Fomepizole, 15 mg	$4.69	$7.015	$2.33	50%
J9245	Inj melpha hydroch nos 50 mg	$181.51	$297.102	$115.60	64%
J1742	Ibutilide fumarate injection	$78.18	$277.364	$199.18	255%

NO SURPRISES ACT QUESTIONS AND ANSWERS

HAS THE NO SURPRISES ACT GOT YOU WONDERING, DAZED, CONFUSED, BEFUDDLED, BEWILDERED AND DOWNRIGHT PERPLEXED?

You're not alone.



In this special issue of the **eJournal** we've assembled **20 questions** from the hundreds of inquiries received during our No Surprises Act Webinars.

If you've never attended one of our free webinars, never fear. **There's another one scheduled right around the corner.**

Registering is easy. Just scan the QR Code and sign up.

Then get ready for some great information that will prepare you for what's ahead.

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

AND NOW, THERE'S MORE!

Here's a sneak peek of the slide deck used in our regular **No Surprises Act Webinar**, along with **TEN MORE** questions and answers that are sent in each week!

If you haven't yet signed up for our webinar, click the QR code on the previous page and register. It's important. It's informative. And, most of all, it's free!

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

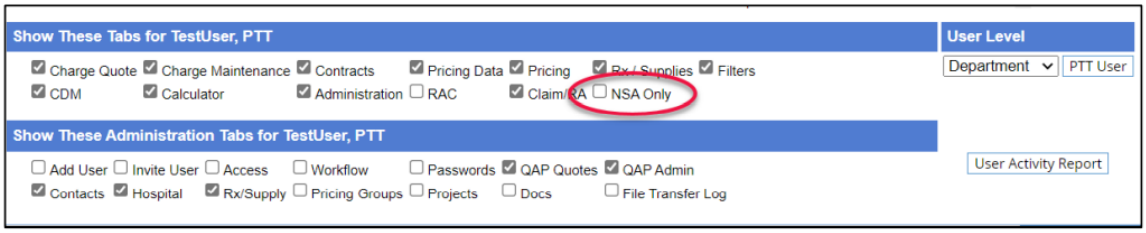
Gaining Access to the NSA Tool

Users will log-in to the PARA Data Editor (PDE) at
www.pararevenue.com

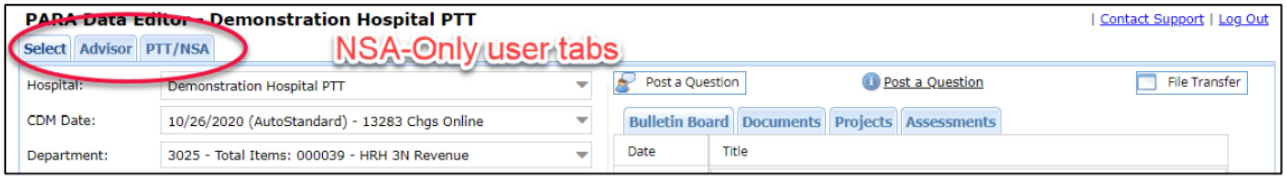
Gaining Access to the NSA Tool

Administrative users will have full access to the PDE to:

- add users
- edit documents



NSA-Only users will only have access to the NSA tools



NNO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Customizing Text in Documents

How to customize text in documents

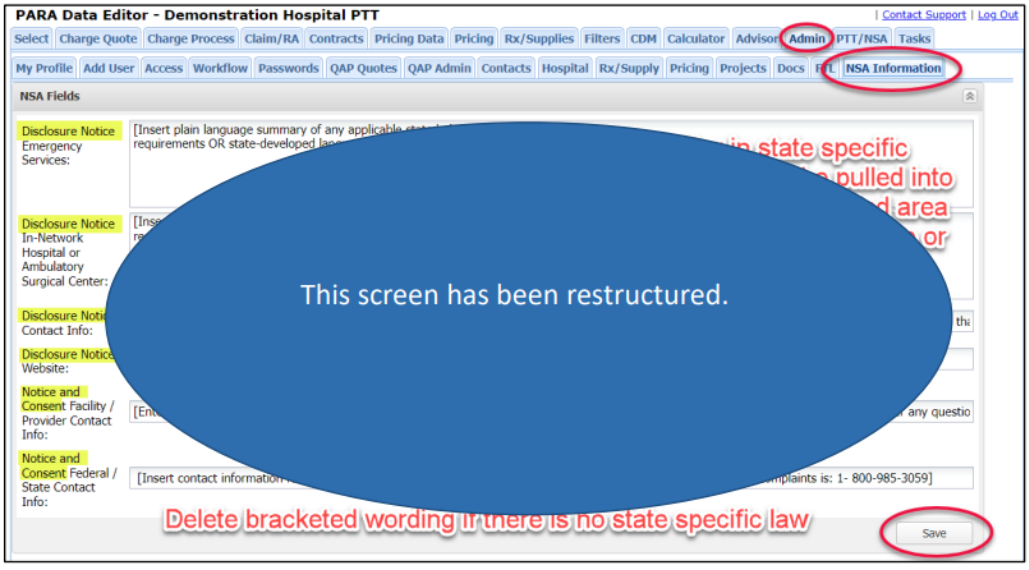
PARAREV Customizing Text in Documents

Administrative users will edit text as needed

NSA Fields will be edited before first use and as needed to reflect changes

Clients who have previously edited the fields of the Disclosure Notice, will now find that document in a PDF form

Clients can upload a customized Disclosure Notice via File Transfer. It will be saved as a PDF and made available for printing



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

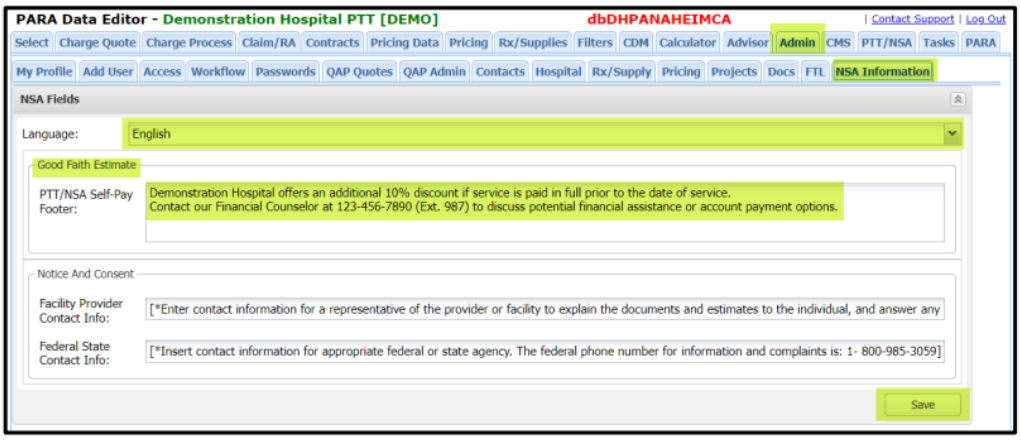
PARAREV Customizing Text in Documents

User with access to the Admin tab will be able to enter text that will display on all good faith estimates

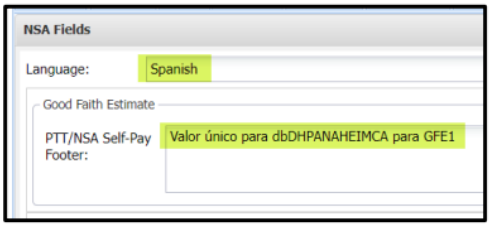
This field must be left blank if the client chooses not to add a standard phrase

User with access to the Admin tab must input data to include facility/provider contact information and appropriate federal or state contact information for the Notice and Consent

NEW SCREEN

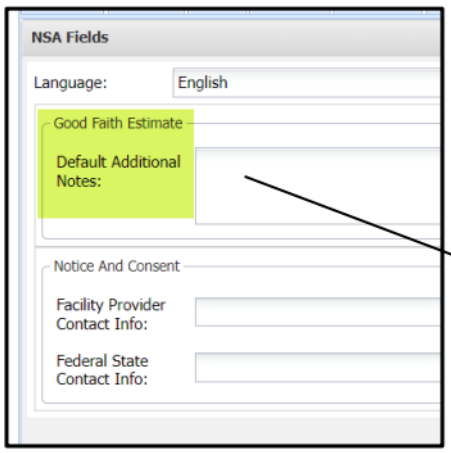


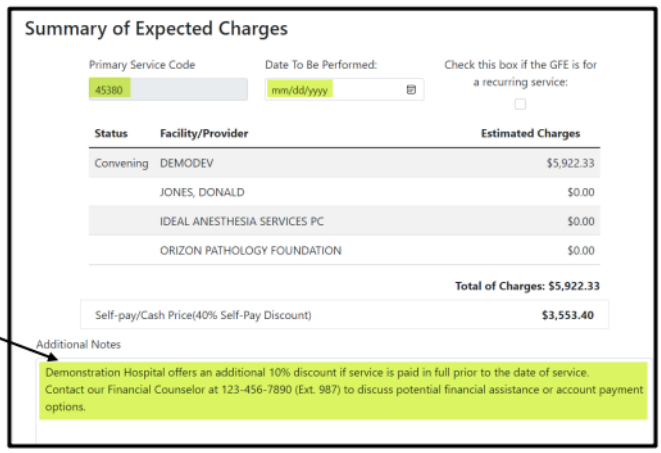
The forms can be edited in Spanish by choosing Spanish from the drop down box in the Language section. The text must be entered in Spanish as the tool does not translate.



PARAREV Customizing Text in Documents

The Default Additional Notes entered in the GFE text box will display on the Summary of Expected Charges screen during the creation of the GFE. It can be edited or deleted, and additional text can be entered at this point.

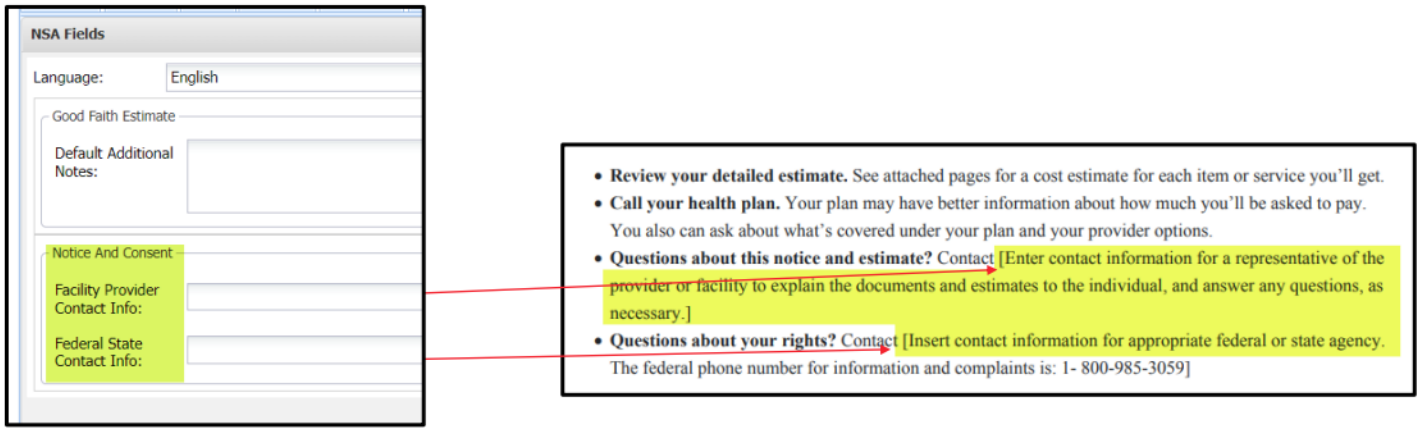




NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Customizing Text in Documents

Placement of text in the Notice and Consent



Notice and Consent is presented to a patient when the non-participating provider asks the patient to accept financial liability for all billed charges, when permitted.

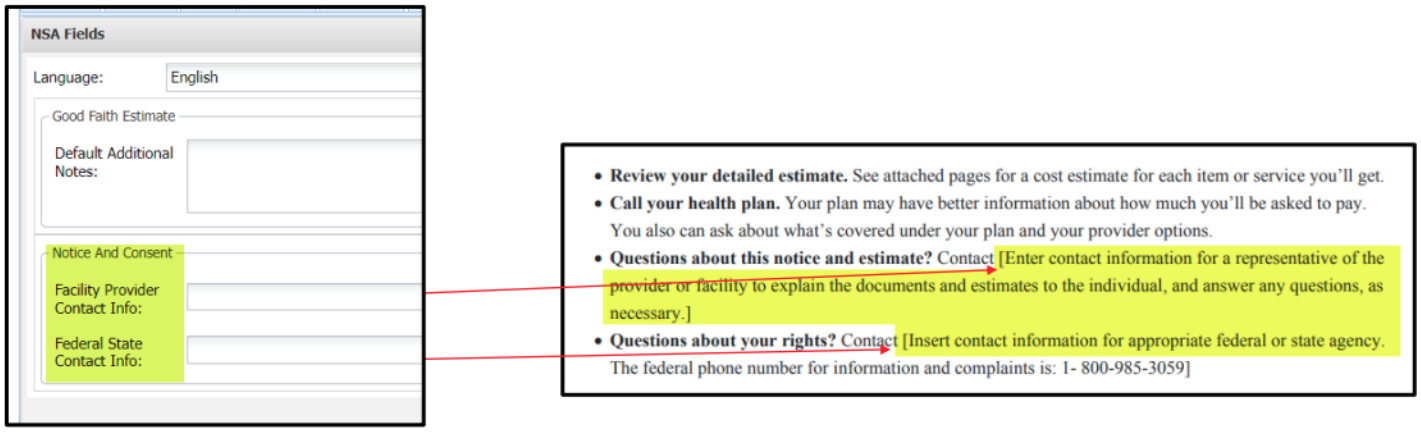
PARAREV Printing Required Notices

How to print required notices

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Customizing Text in Documents

Placement of text in the Notice and Consent



Notice and Consent is presented to a patient when the non-participating provider asks the patient to accept financial liability for all billed charges, when permitted.

PARAREV Printing Required Notices

The Disclosure Notice and the Right to Receive a Good Faith Estimate of Charges are located on the PTT/NSA tab under the NSA Link.

Documents are accessed and printed from this screen.

Clients may submit customized versions through FILE TRANSFER to have them available to print.

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating A Custom Claim

How to create a custom claim

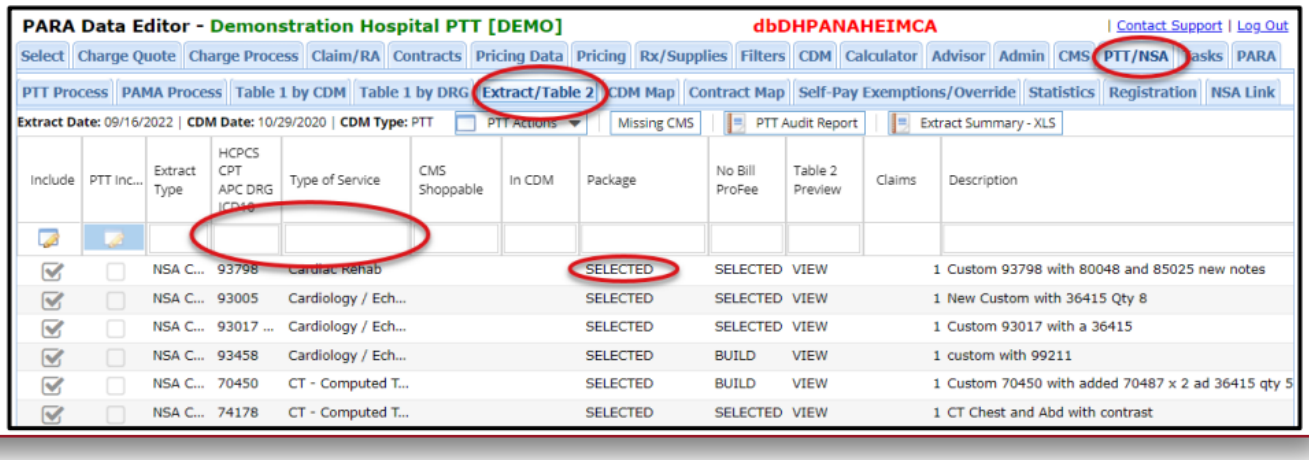
PARAREV Creating A Custom Claim

User opens “Extract/Table 2” under “PTT/NSA” tab

Key in primary service code in the “HCPCS/CPT/APC/DRG/ICD10” column OR

Key a service description in the “Type of Service” column

Click the word in the “Package” column to add or begin the process of creating a custom claim

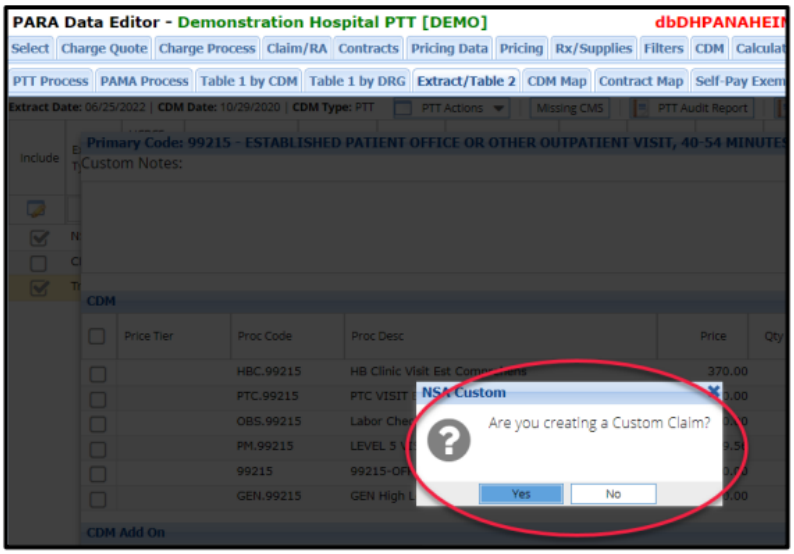


NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

Creating A Custom Claim

NEW STEP IN THE PROCESS

The user will encounter a new step in the process which will ask for verification that the user is creating a Custom Claim. The response must be YES.



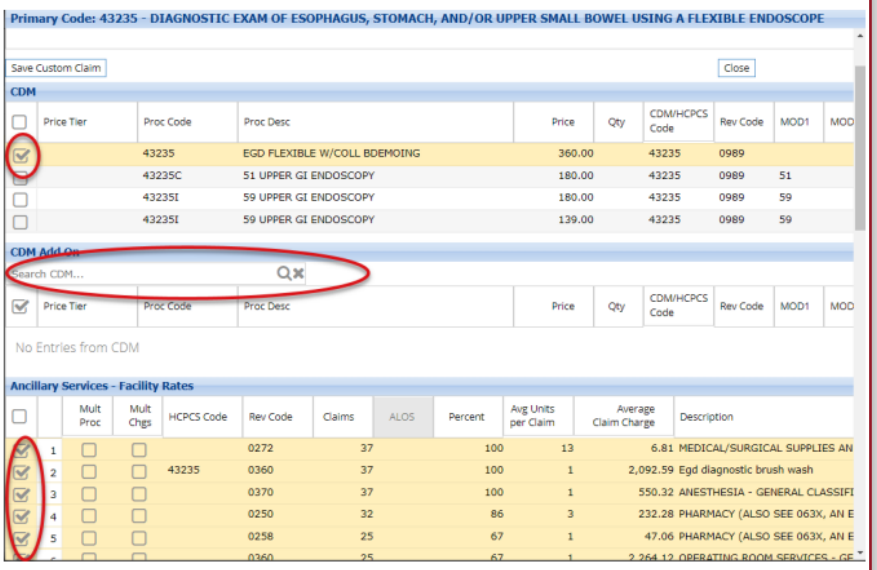
Creating A Custom Claim

The line in the "CDM" section that best describes the scheduled service must be checked

- Proceeding without checking one of the primary service lines will create an error in the GFE

Uncheck items in the "Ancillary Services" section and re-enter them via the "CDM Add On" search box

- Manually adding the ancillary services allows for editing of the quantity and causes the current price of the service to flow to the estimate
- Review the "Percent" column and choose the items with at least 40% usage when creating the Custom Claim
- Reasonably anticipated ancillary services not present on the screen can also be added via the CDM Add-On process



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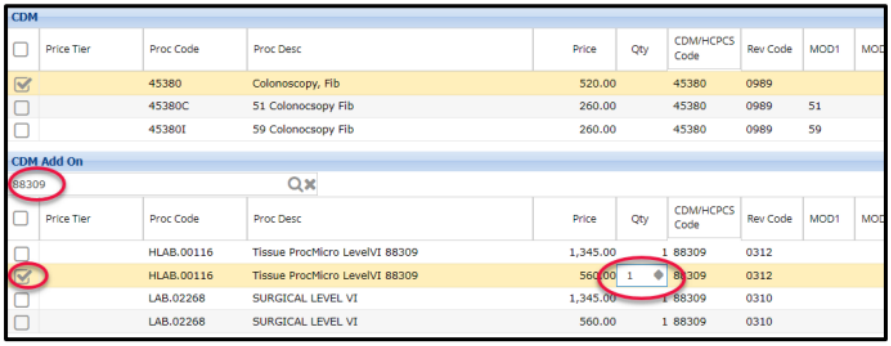
Creating A Custom Claim

Process to add ancillary services

- Key in the desired code
- Check the appropriate line item
- Open the quantity box
- Key in the desired quantity

  Or

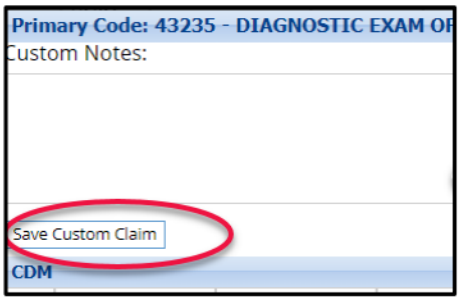
- Adjust quantity with the arrows



Creating A Custom Claim

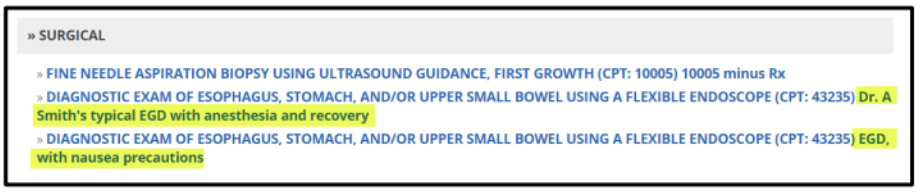
Key a title of the Custom Claim in the "Custom Notes" text box.

Click the "Save Custom Claim" button.



*Title will display behind the primary code and description.

Note the inconsistent naming of custom claims in the demonstrations. Strongly encourage creating a consistent guide to naming custom claims.



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

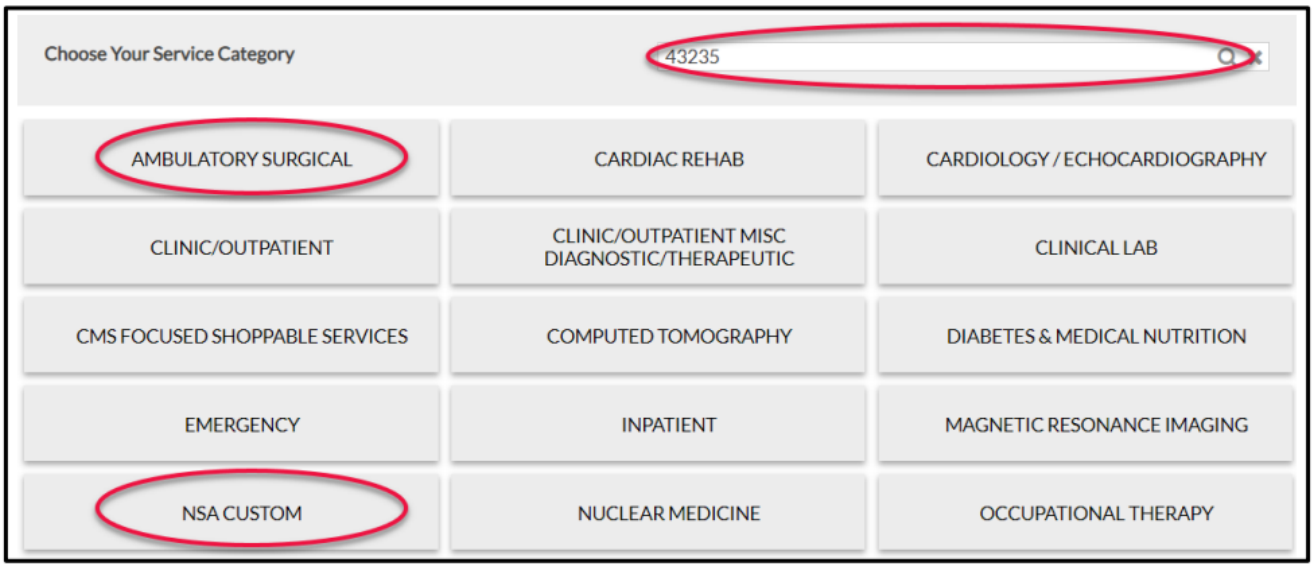
PARAREV Creating an Estimate for Uninsured GFE

How to create a Good Faith Estimate for the Uninsured

PARAREV Creating an Estimate for Uninsured GFE

Begin an estimate by:

- Entering the primary code into the search field OR
- Opening a service line tile OR
- Opening the NSA Custom tile



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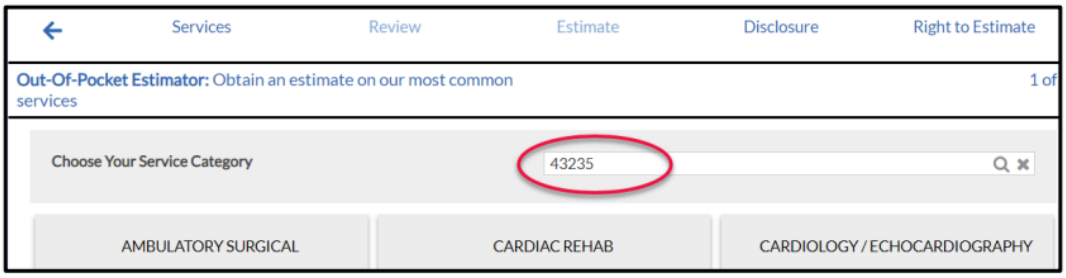
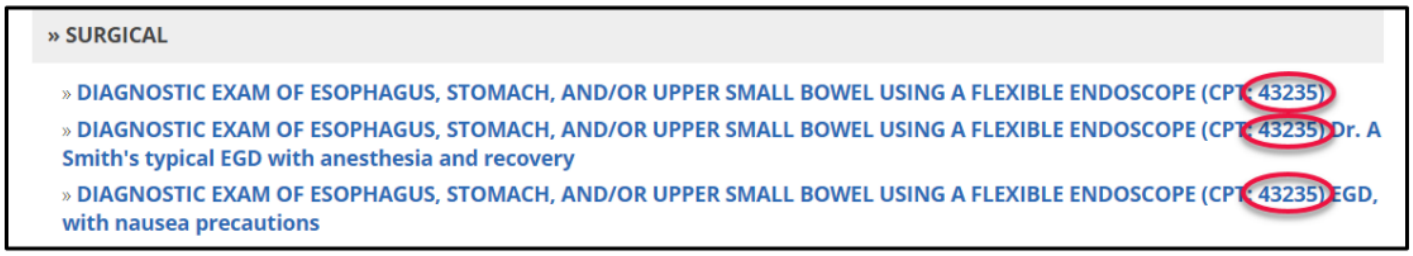
PARAREV Creating an Estimate for Uninsured GFE

Choosing a service via the search field will open all pre-built and custom-built claims with that code

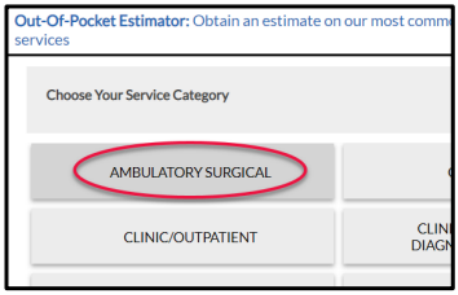


Choose the service by clicking on the hyperlink

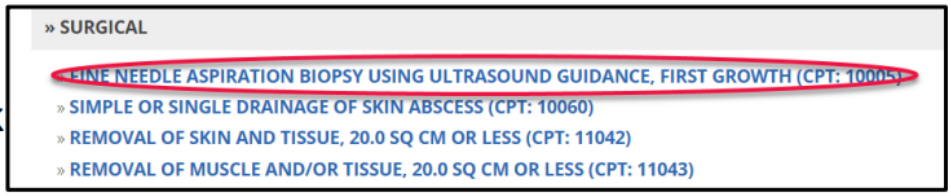


PARAREV Creating an Estimate for Uninsured GFE

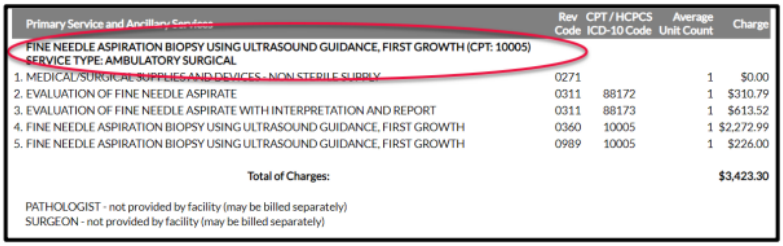
Opening a Service Line tile will open all pre-built claims



Choose the service by clicking on the hyperlink



Review the estimate

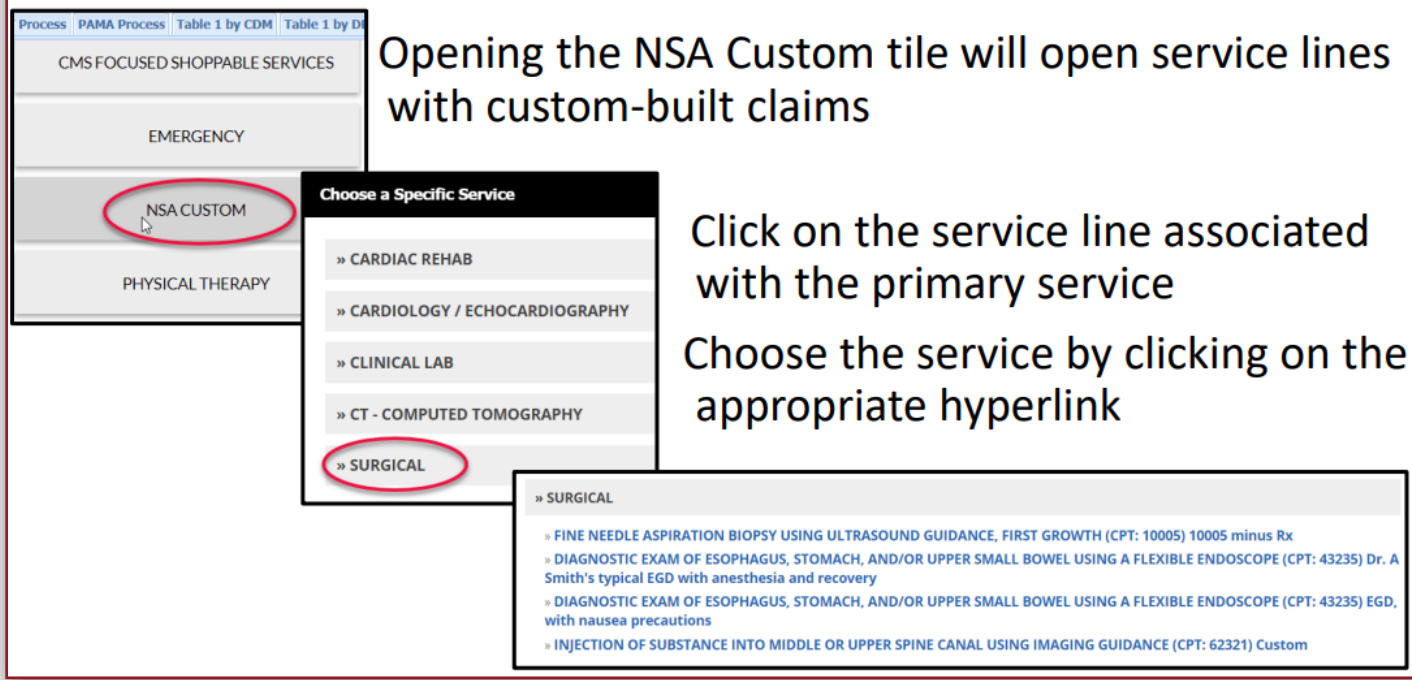


Primary Service and Ancillary Services	Rev Code	CPT / HCPCS ICD-10 Code	Average Unit Count	Charge
FINE NEEDLE ASPIRATION BIOPSY USING ULTRASOUND GUIDANCE, FIRST GROWTH (CPT: 10005) SERVICE TYPE: AMBULATORY SURGICAL				
1. MEDICAL/SURGICAL SUPPLIES AND DEVICES - NON STERILE SUPPLY	0271		1	$0.00
2. EVALUATION OF FINE NEEDLE ASPIRATE	0311	88172	1	$310.79
3. EVALUATION OF FINE NEEDLE ASPIRATE WITH INTERPRETATION AND REPORT	0311	88173	1	$613.52
4. FINE NEEDLE ASPIRATION BIOPSY USING ULTRASOUND GUIDANCE, FIRST GROWTH	0360	10005	1	$2,272.99
5. FINE NEEDLE ASPIRATION BIOPSY USING ULTRASOUND GUIDANCE, FIRST GROWTH	0989	10005	1	$226.00
Total of Charges:				$3,423.30

PATHOLOGIST - not provided by facility (may be billed separately)
SURGEON - not provided by facility (may be billed separately)

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Uninsured GFE



Opening the NSA Custom tile will open service lines with custom-built claims

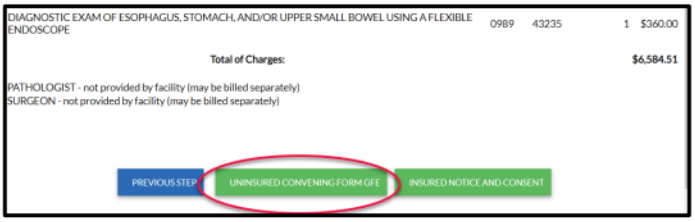
Click on the service line associated with the primary service

Choose the service by clicking on the appropriate hyperlink

PARAREV Creating an Estimate for Uninsured GFE

The "Uninsured Convening Form GFE" is used by the convening facility/provider when the patient is uninsured or self-pay and either requesting an estimate or scheduling a service

- The convening facility/provider is the one scheduling the primary service
- Not required if services are performed same day or within 2 days
- Required within 1 business day if services are scheduled 3-9 days out
- Required within 3 business days if service is scheduled 10 or more days out
  - Must be re-created if any aspect of the service changes
- Required within 3 business days if the patient is requesting an estimate, but not yet scheduling
  - Must be re-created if the patient schedules the service



Click on the "UNINSURED CONVENING FORM GFE" to create a GFE as the Convening Facility.

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for the Uninsured

Key in patient demographic

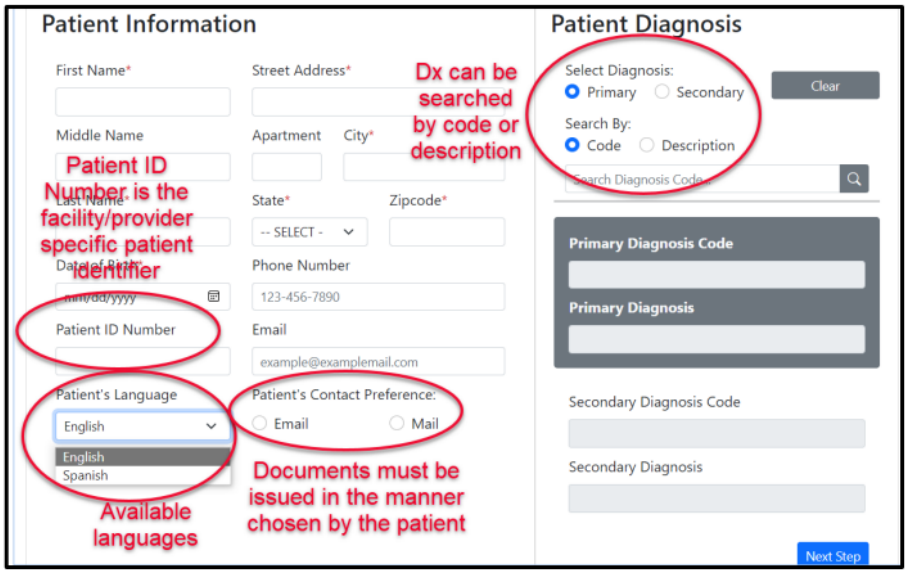
Patient ID Number is the hospital specific identifier

- This can be left blank in the event the patient does not have a number and is just shopping for prices

All notices must be sent to the patient in the manner they choose

- Checking the appropriate box populates the information to the GFE for easy reference

Different languages (as they are made available) can be chosen from a drop down



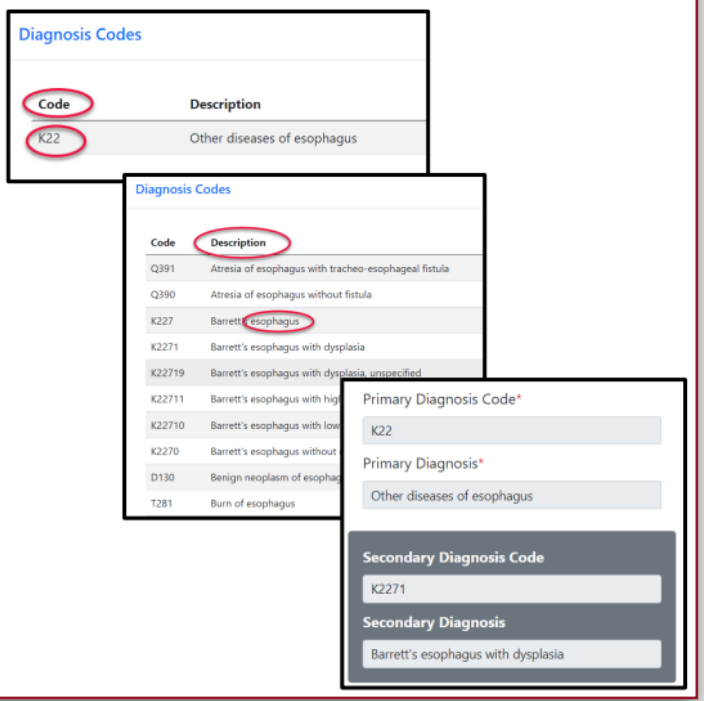
PARAREV Creating an Estimate for Uninsured GFE

Choosing a diagnosis by the code will display that specific code

- Do not use dots (.) when entering codes

Choosing a diagnosis by description will bring up any diagnosis with that word in the description

Click on the appropriate diagnosis to populate it in the diagnosis field



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

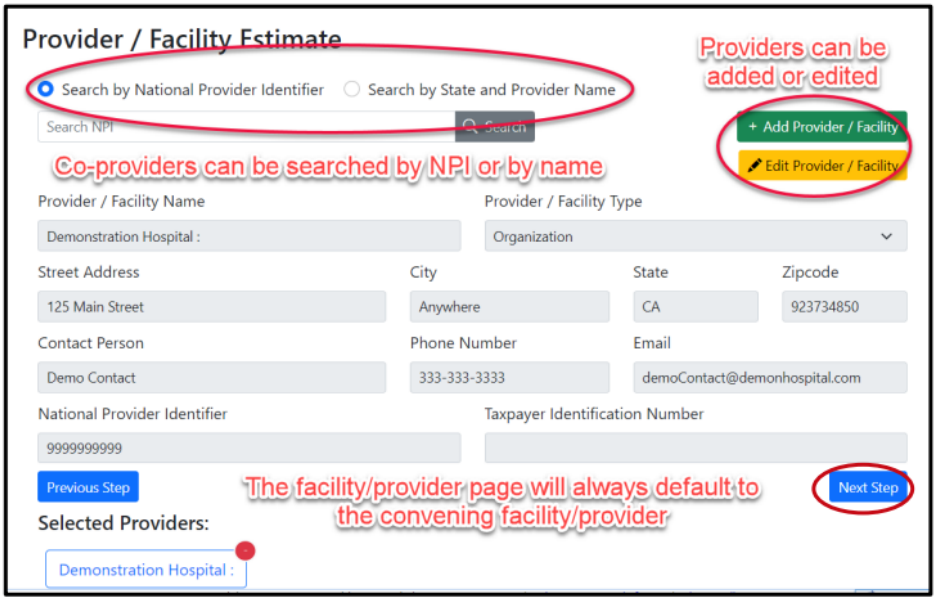
PARAREV Creating an Estimate for Uninsured GFE

Enforcement of the requirement to include charges for a co-provider are on hold until the process can be established to share that information from the co-provider to the convening facility.

Any known co-providers should be identified so the patient can go to that provider for an estimate of charges, if they choose.

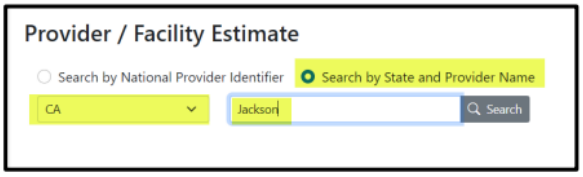
The 2023 requirement for the uninsured Good Faith Estimate is to create one document with all reasonably expected charges from all providers.

Advance to the next screen by clicking on "Next Step."



PARAREV Creating an Estimate for Uninsured GFE

Searching for a co-provider by state and name will produce a list of all providers with the word in the group name or provider's first or last name

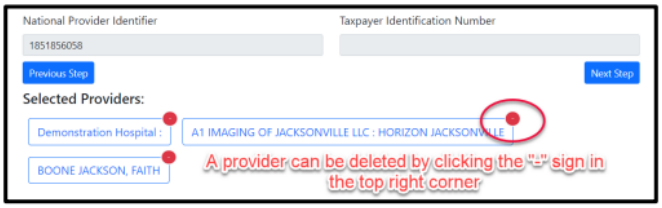


Choose the appropriate provider by clicking anywhere on that line

Npi	Name	Phone	ProviderType
1124287990	A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE	9493364336	Organization
1255700555	ACTION JACKSON PHYSICAL THERAPY, P.C.	5102925385	Organization
1447546114	ADAMS-JACKSON, MICHELLE	9516775599	Individual
1427162437	ALPARCE, JACKSON	9093937222	Individual
1326145756	ANITA C. JACKSON, M.D., INC	9516944688	Organization
1861860009	ARELLANO-JACKSON, RAQUEL	9099049757	Individual
1124270137	ASK, KINZER, SIMPSON, AND RODA A PROFESSIONA DENTAL CORP : JACKSON CREEK DENTAL GROUP	2092232712	Organization

Providers can be deleted by clicking on the minus (-) sign in the top right corner

Click "Next Step" to advance to the next screen



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

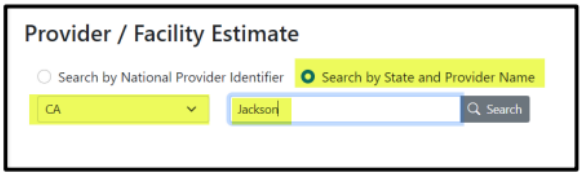
PARAREV Creating an Estimate for Uninsured GFE

All charges default to the convening facility/provider.
The drop-down arrows are used to change the provider and status to indicate which services will be rendered by the co-provider(s)

Service Item	Service Code	Rev Code	Expected Charges	Qty	Provider	Status
PHARMACY (ALSO SEE 063X, AN E:		0250	$ 361.56	2	Demonstrati	Convening
PHARMACY (ALSO SEE 063X, AN E:		0258	$ 644.55	3	Demonstrati	Convening
INSERTION OF NEEDLE INTO VEIN	36415	0300	$ 42.00	1	Demonstrati	Convening
BLOOD TEST, BASIC GROUP OF BL(	80048	0301	$ 220.20	1	Demonstrati	Convening
COMPLETE BLOOD CELL COUNT (R	85027	0305	$ 127.20	1	Demonstrati	Convening
COV-19 AMP PRB HGH THRUPUT	U0003	0306	$ 150.00	1	Demonstrati	Convening
DIAGNOSTIC EXAM OF ESOPHAGL	43235	0360	$ 3,572.50	1	Demonstrati	Convening
ANESTHESIA - GENERAL CLASSIFIC		0370	$ 556.60	1	Demonstrati	Convening
INJ, PROPOFOL, 10 MG	J2704	0636	$ 6,892.00	50	Demonstrati	Convening
RECOVERY ROOM - GENERAL CLAS		0710	$ 1,031.00	1	Demonstrati	Convening
DIAGNOSTIC EXAM OF ESOPHAGL	43235	0989	$ 360.00	1	BOONE JACK	CoProvider

PARAREV Creating an Estimate for Uninsured GFE

Searching for a co-provider by state and name will produce a list of all providers with the word in the group name or provider's first or last name



Choose the appropriate provider by clicking anywhere on that line

Npi	Name	Phone	ProviderType
1124287990	A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE	9493364336	Organization
1255700555	ACTION JACKSON PHYSICAL THERAPY, P.C.	5102925385	Organization
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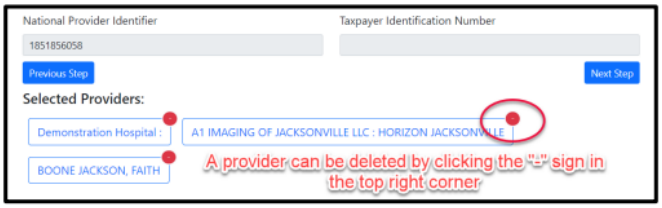
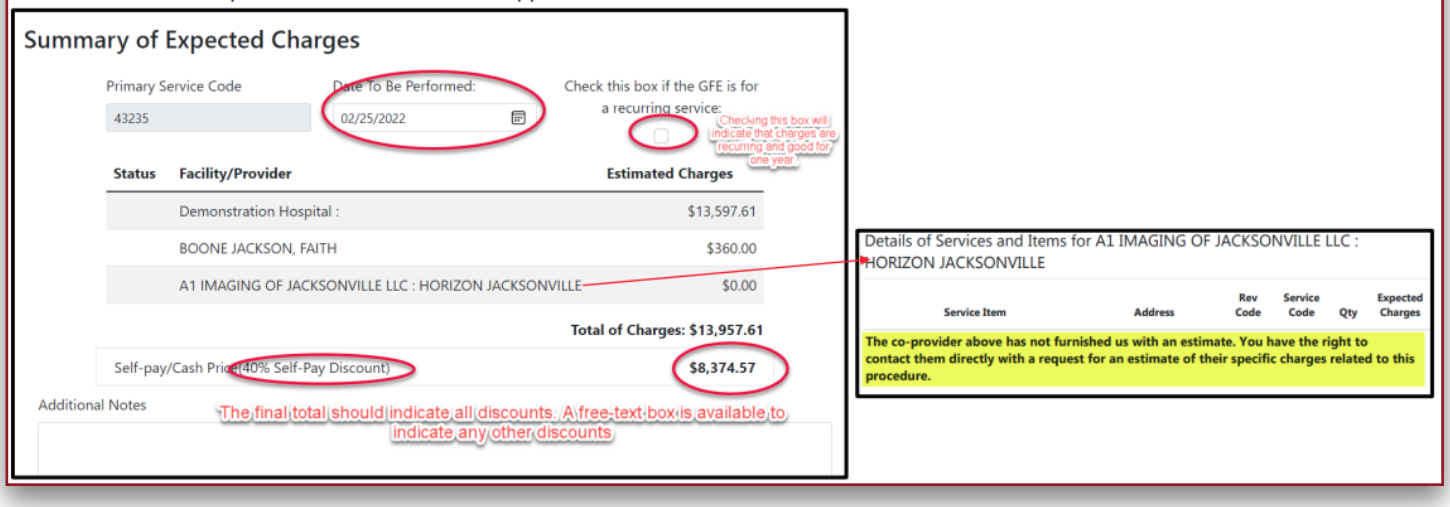
Click "Next Step" to advance to the next screen



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Uninsured GFE

The scheduled date of the service is entered by opening the calendar icon
Charges for recurring services can be provided on one GFE for up to a year
The final total of charges should indicate all discounts
A summary of each provider's charges are listed
A notice to contact a provider for an estimate will appear of the GFE document



PARAREV Creating an Estimate for Uninsured GFE

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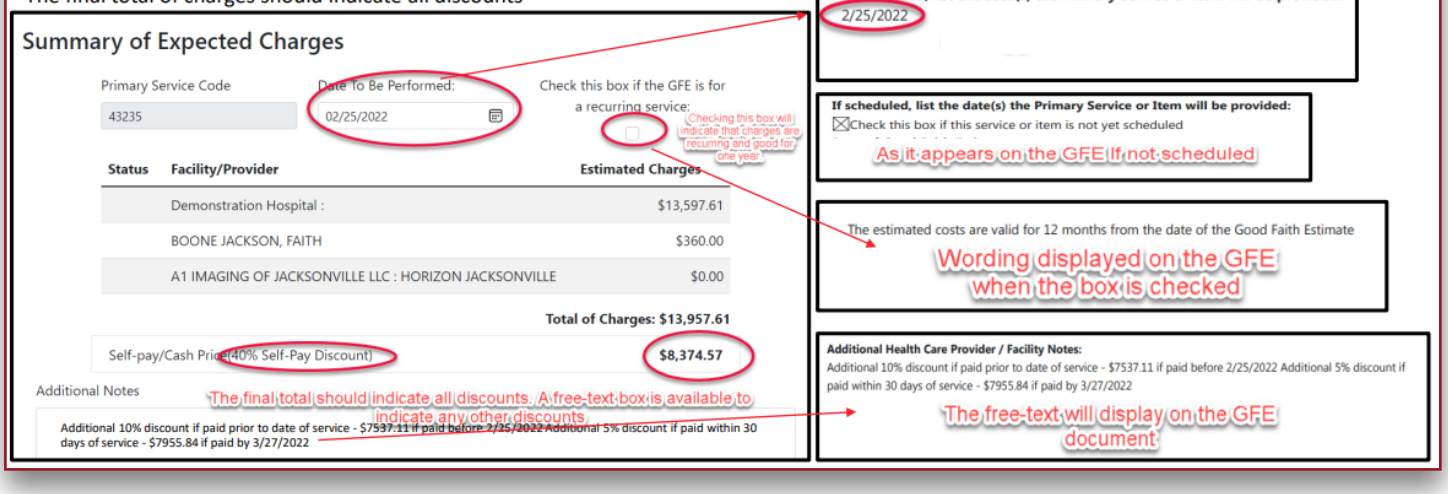
The final total of charges should indicate all discounts



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

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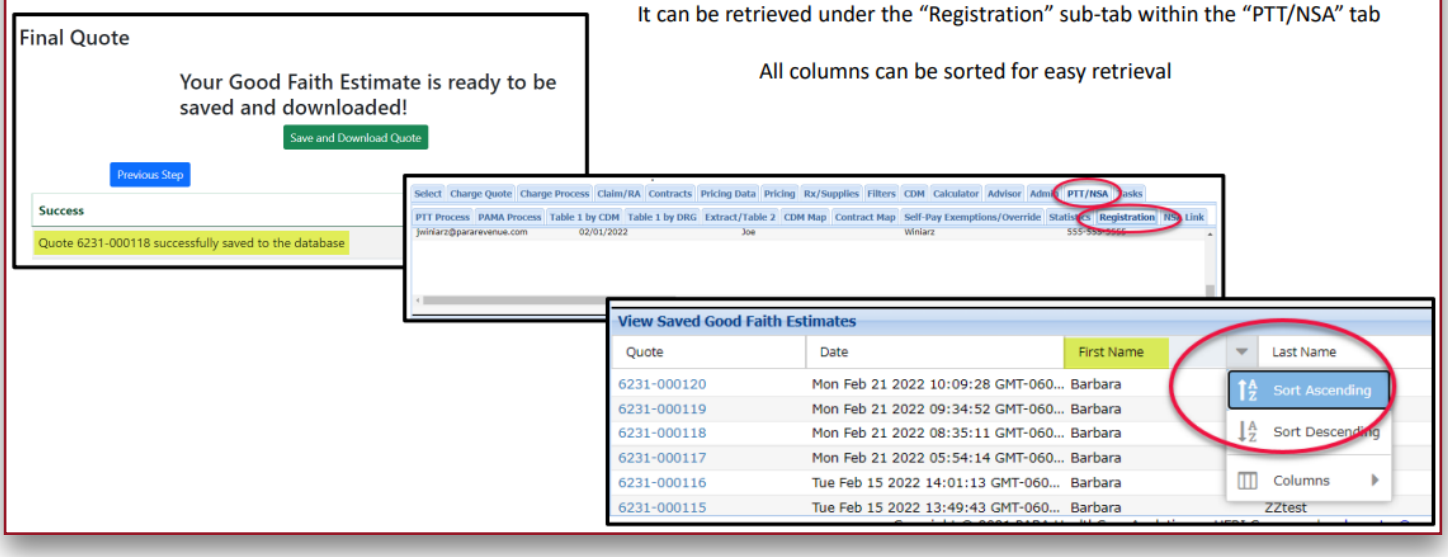
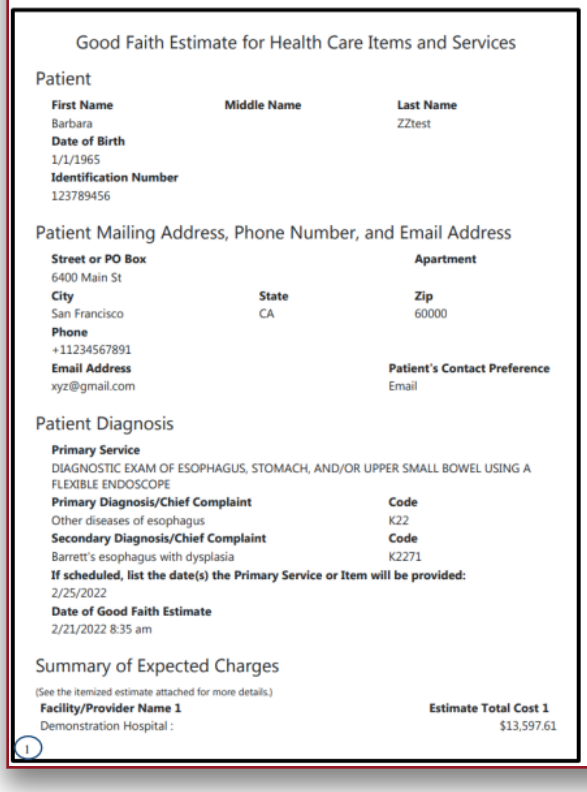


PARAREV Completed Uninsured GFE Document



Good Faith Estimate for Health Care Items and Services

Patient

First Name Barbara
Middle Name
Last Name ZZtest
Date of Birth 1/1/1965
Identification Number 123789456

Patient Mailing Address, Phone Number, and Email Address

Street or PO Box 6400 Main St
Apartment
City San Francisco
State CA
Zip 60000
Phone +11234567891
Email Address xyz@gmail.com
Patient's Contact Preference Email

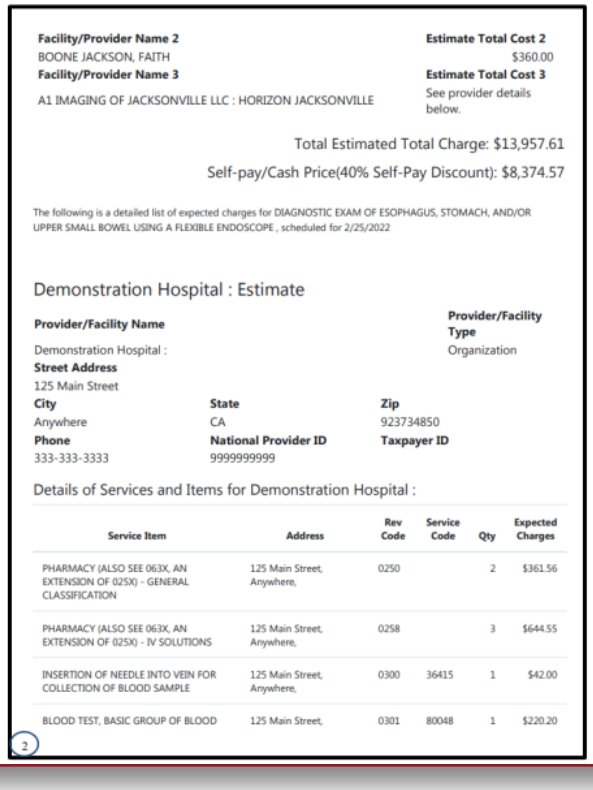
Patient Diagnosis

Primary Service DIAGNOSTIC EXAM OF ESOPHAGUS, STOMACH, AND/OR UPPER SMALL BOWEL USING A FLEXIBLE ENDOSCOPE
Primary Diagnosis/Chief Complaint Other diseases of esophagus
Code K22
Secondary Diagnosis/Chief Complaint Barrett's esophagus with dysplasia
Code K2271
If scheduled, list the date(s) the Primary Service or Item will be provided: 2/25/2022
Date of Good Faith Estimate 2/21/2022 8:35 am

Summary of Expected Charges

(See the itemized estimate attached for more details.)
Facility/Provider Name 1 Demonstration Hospital :
Estimate Total Cost 1 $13,597.61

1



Facility/Provider Name 2 BOONE JACKSON, FAITH
Estimate Total Cost 2 $360.00
Facility/Provider Name 3 A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE
Estimate Total Cost 3 See provider details below.

Total Estimated Total Charge: $13,957.61

Self-pay/Cash Price(40% Self-Pay Discount): $8,374.57

The following is a detailed list of expected charges for DIAGNOSTIC EXAM OF ESOPHAGUS, STOMACH, AND/OR UPPER SMALL BOWEL USING A FLEXIBLE ENDOSCOPE , scheduled for 2/25/2022

Demonstration Hospital : Estimate

Provider/Facility Name Demonstration Hospital :
Provider/Facility Type Organization
Street Address 125 Main Street
City Anywhere
State CA
Zip 923734850
Phone 333-333-3333
National Provider ID 9999999999
Taxpayer ID

Details of Services and Items for Demonstration Hospital :

Service Item	Address	Rev Code	Service Code	Qty	Expected Charges
PHARMACY (ALSO SEE 063X, AN EXTENSION OF 025X) - GENERAL CLASSIFICATION	125 Main Street, Anywhere,	0250		2	$361.56
PHARMACY (ALSO SEE 063X, AN EXTENSION OF 025X) - IV SOLUTIONS	125 Main Street, Anywhere,	0258		3	$644.55
INSERTION OF NEEDLE INTO VEIN FOR COLLECTION OF BLOOD SAMPLE	125 Main Street, Anywhere,	0300	36415	1	$42.00
BLOOD TEST, BASIC GROUP OF BLOOD	125 Main Street,	0301	80048	1	$220.20

2

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Completed Uninsured GFE Document

Service Item	Address	Rev Code	Service Code	Qty	Expected Charges
CHEMICALS (CALCIUM, TOTAL)	Anywhere,				
COMPLETE BLOOD CELL COUNT (RED CELLS, WHITE BLOOD CELL, PLATELETS), AUTOMATED TEST	125 Main Street, Anywhere,	0305	85027	1	$127.20
COV-19 AMP PRB HGH THRUPUT	125 Main Street, Anywhere,	0306	U0003	1	$150.00
DIAGNOSTIC EXAM OF ESOPHAGUS, STOMACH, AND/OR UPPER SMALL BOWEL USING A FLEXIBLE ENDOSCOPE	125 Main Street, Anywhere,	0360	43235	1	$3,572.50
ANESTHESIA - GENERAL CLASSIFICATION	125 Main Street, Anywhere,	0370		1	$556.60
INJ, PROPOFOL, 10 MG	125 Main Street, Anywhere,	0636	J2704	50	$6,892.00
RECOVERY ROOM - GENERAL CLASSIFICATION	125 Main Street, Anywhere,	0710		1	$1,031.00

Total Estimated Total Cost: $13,597.61

BOONE JACKSON, FAITH Estimate

Provider/Facility Name
BOONE JACKSON, FAITH

Provider/Facility Type
Individual

Street Address
2380 SALVIO ST # 200

City CONCORD
State CA
Zip 945202193
Phone
National Provider ID 1851856058
Taxpayer ID

Details of Services and Items for BOONE JACKSON, FAITH

Service Item	Address	Rev Code	Service Code	Qty	Expected Charges

3

Service Item	Address	Rev Code	Service Code	Qty	Expected Charges
DIAGNOSTIC EXAM OF ESOPHAGUS, STOMACH, AND/OR UPPER SMALL BOWEL USING A FLEXIBLE ENDOSCOPE	2380 SALVIO ST # 200, CONCORD,	0989	43235	1	$360.00

Total Estimated Total Cost: $360.00

A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE Estimate

Provider/Facility Name
A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE

Provider/Facility Type
Organization

Street Address
100 BAYVIEW CIR

City NEWPORT BEACH
State CA
Zip 926602983
Phone 9493364336
National Provider ID 1124287990
Taxpayer ID

Details of Services and Items for A1 IMAGING OF JACKSONVILLE LLC : HORIZON JACKSONVILLE

Service Item	Address	Rev Code	Service Code	Qty	Expected Charges

The co-provider above has not furnished us with an estimate. You have the right to contact them directly with a request for an estimate of their specific charges related to this procedure.

Additional Health Care Provider / Facility Notes:
Additional 10% discount if paid prior to date of service - $7537.11 if paid before 2/25/2022 Additional 5% discount if paid within 30 days of service - $7955.84 if paid by 3/27/2022

Disclaimer

This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

4

PARAREV Completed Uninsured GFE Document

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. This means that the **final cost of services may be different than this estimate**.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises/consumers or call 1-800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

5

A signature is not required on a GFE

An uninsured or self-pay individual cannot decline a GFE

The GFE is required to initiate a patient-provider dispute if the billed charges are $400 or more above the estimate provided in the GFE

Suggested scripting when it is discovered that an individual is uninsured or self-pay: "You have the right to receive a good faith estimate of reasonably expected charges. Would you like that estimate in a hard copy or electronically?"

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

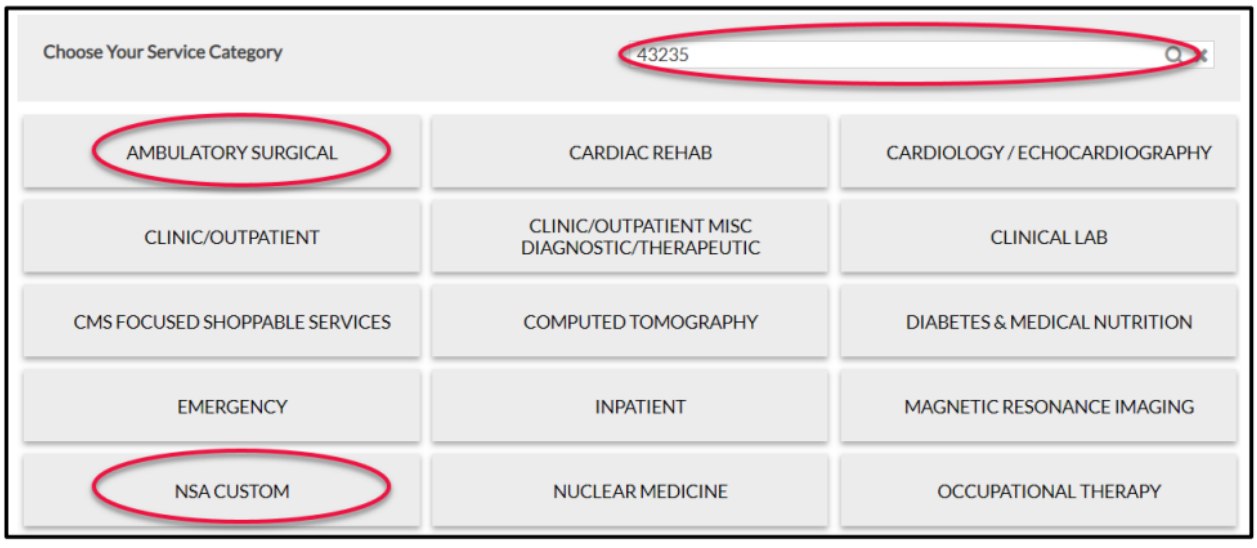
PARAREV Creating a Notice and Consent

How to create a Notice and Consent

PARAREV Creating an Estimate for Notice and Consent

Begin an estimate by:

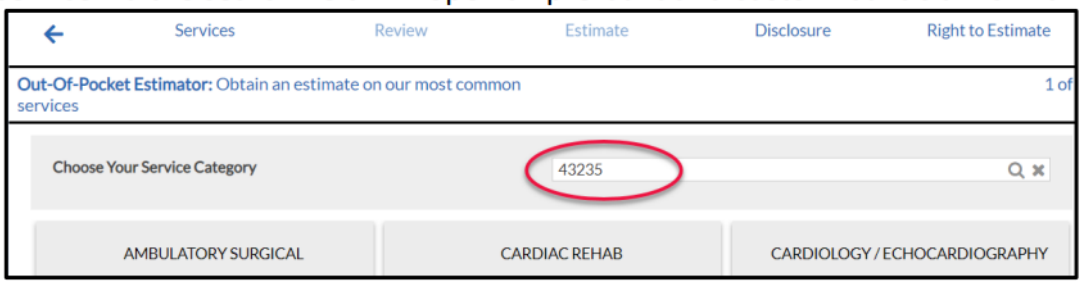
- Entering the primary code into the search field OR
- Opening a service line tile OR
- Opening the NSA Custom tile



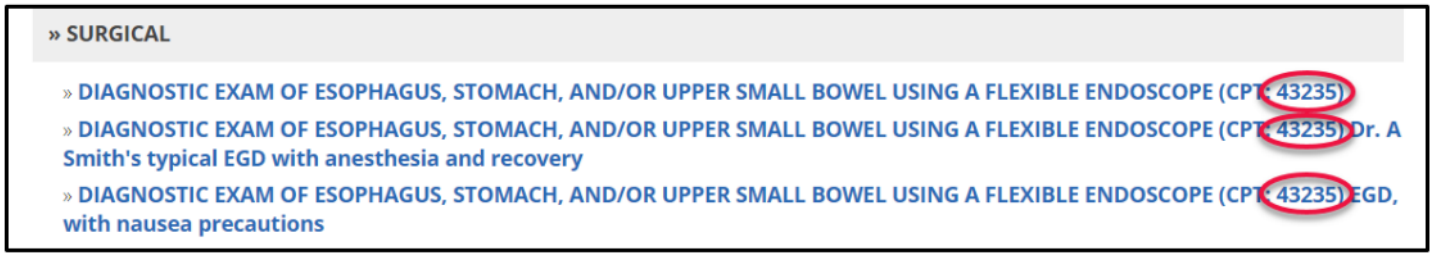
NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Notice and Consent

Choosing a service via the search field will open all pre-built and custom-built claims with that code



Choose the service by clicking on the hyperlink

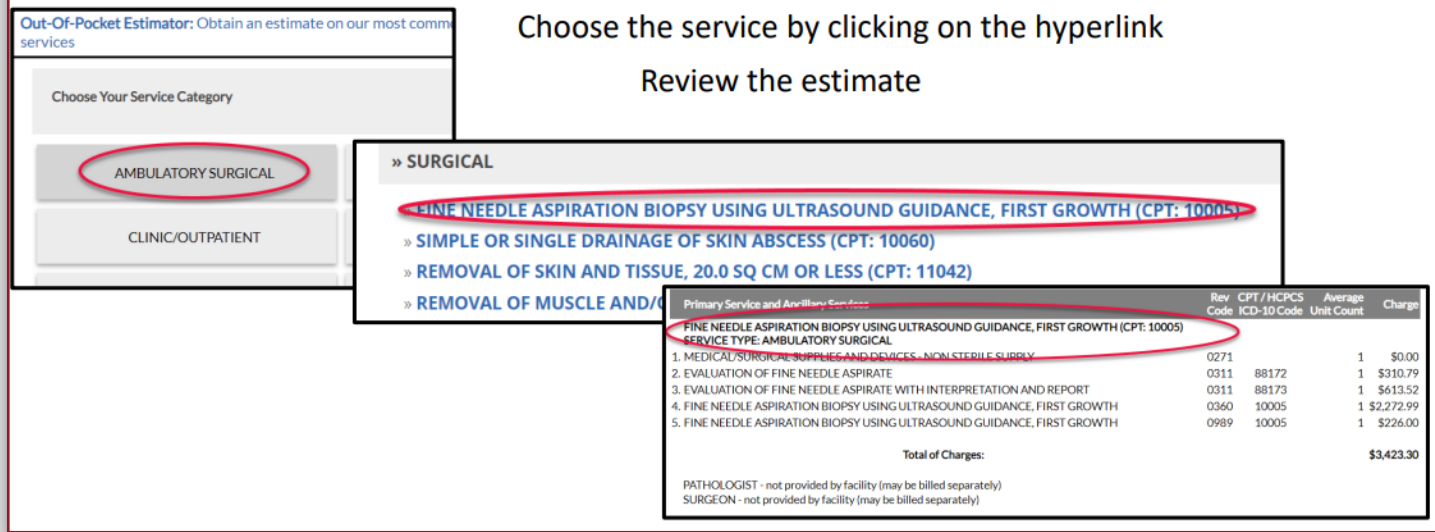


PARAREV Creating an Estimate for Notice and Consent

Opening a Service Line tile will open all pre-built claims

Choose the service by clicking on the hyperlink

Review the estimate



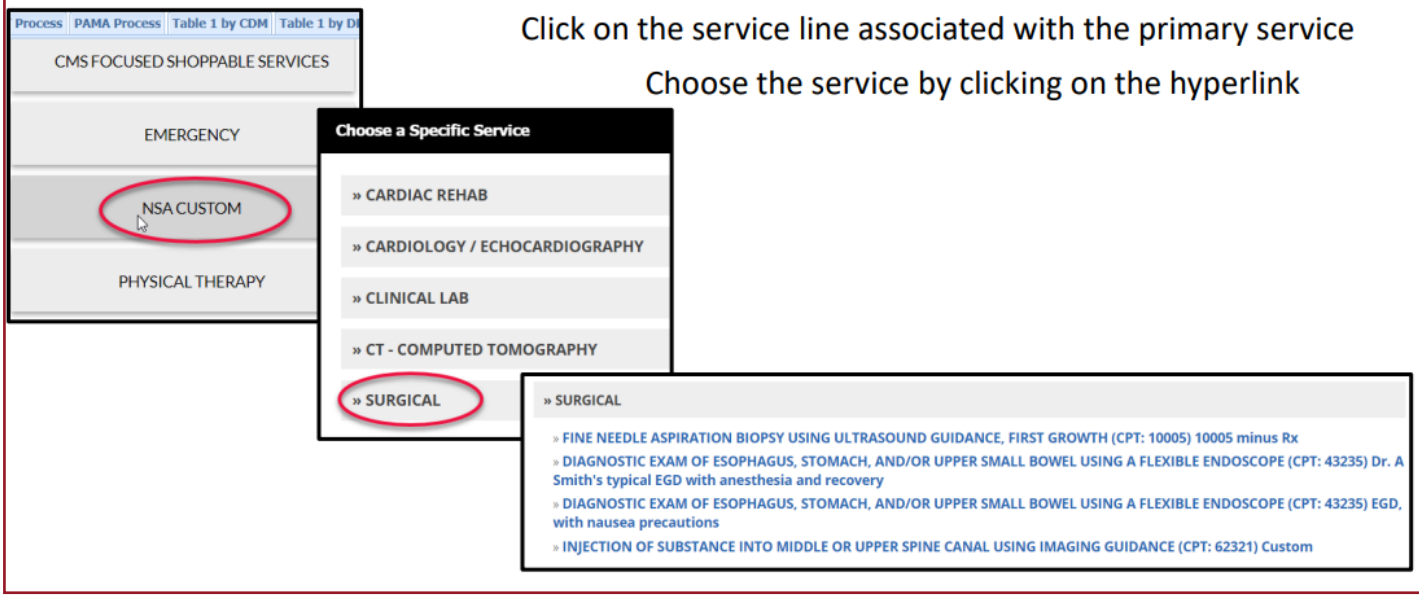
NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Notice and Consent

Opening the NSA Custom tile will open service lines with custom-built claims

Click on the service line associated with the primary service

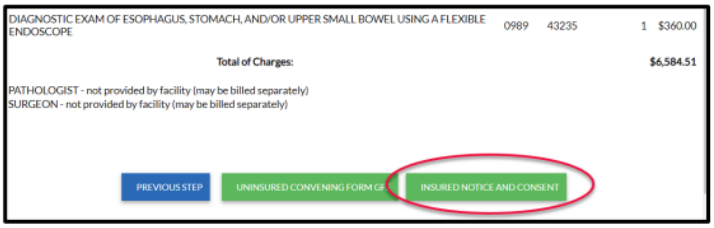
Choose the service by clicking on the hyperlink



PARAREV Creating an Estimate for Notice and Consent

The "Insured Notice and Consent" is used by the Out-Of-Network facility/provider when the patient chooses to receive services from an OON facility/provider

- Cannot be used in Emergency Services until stabilized
- Cannot be used by Ancillary Services in a participating facility
- Cannot be used by a non-participating provider unless there is a participating provider within the participating facility who can render the same service
- Can be presented by the participating facility on behalf on the non-participating provider
- Must be provided 72 hours before service is rendered if the service is scheduled at least 72 hours in advance
- For services rendered on the same day, the document must be provided at least 3 hours before services are rendered



Click on the "INSURED NOTICE AND CONSENT" to create the estimate of out-of-network charges

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Notice and Consent

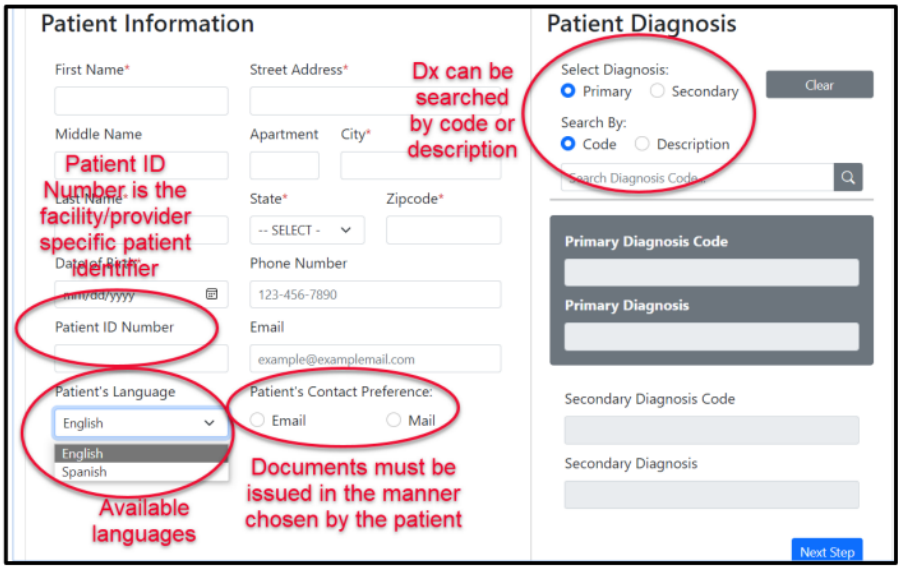
Patient ID Number is the hospital specific identifier

All notices must be sent to the patient in the manner they choose

- Checking the appropriate box populates the information to the GFE for easy reference

Different languages (as they are made available) can be chosen from a drop down

- The Notice and Consent must be issued to the patient in their chosen language if it is one of the 15 most common languages spoken in the region



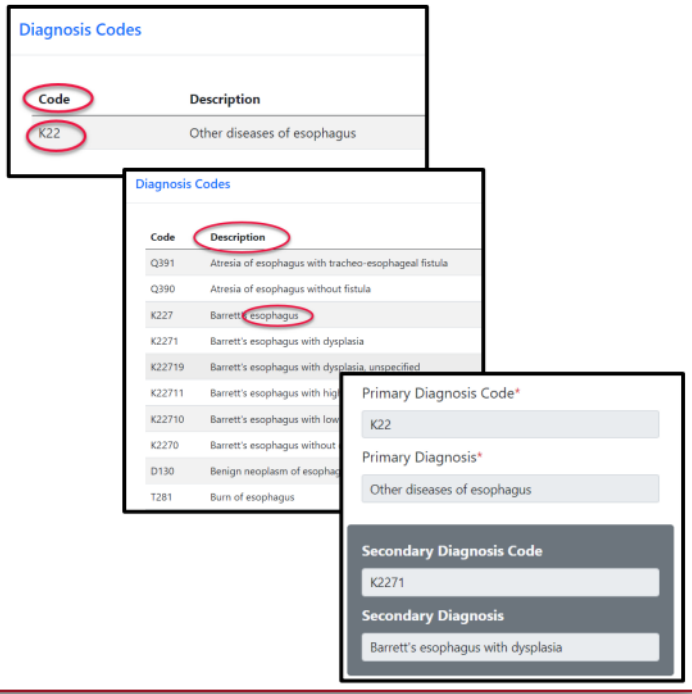
PARAREV Creating an Estimate for Notice and Consent

Choosing a diagnosis by the code will display that specific code

- Do not use dots (.) when entering codes

Choosing a diagnosis by description will bring up any diagnosis with that word in the description

Click on the appropriate diagnosis to populate it in the diagnosis field



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

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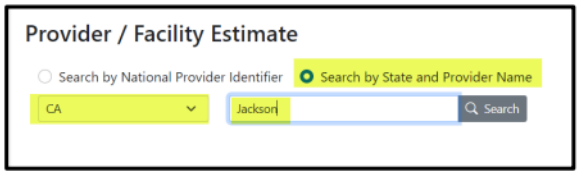
Searching for a co-provider by state and name will produce a list of all providers with the word in the group name or provider's first or last name



Choose the appropriate provider by clicking anywhere on that line

Npi	Name	Phone	ProviderType
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1255700555	ACTION JACKSON PHYSICAL THERAPY, P.C.	5102925385	Organization
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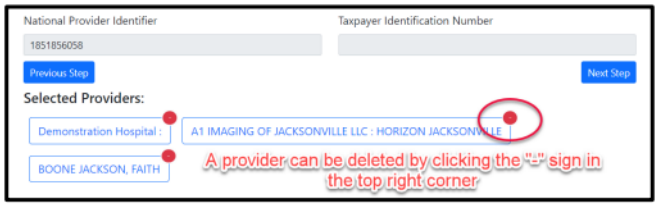
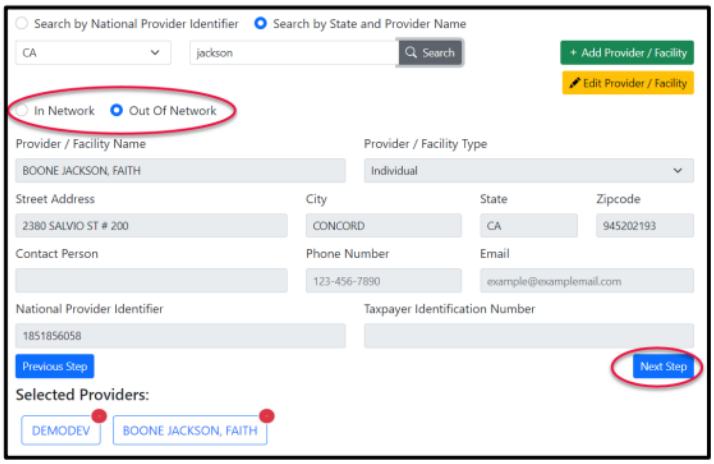


PARAREV Creating an Estimate for Notice and Consent

When adding the OON co-provider(s), choose "Out Of Network" for each provider to indicate the OON status with the patient's health plan.

Specific provider information is populated on the screen by clicking on the provider's name at the bottom of the screen.

When the information is accurate, advance the screen by clicking "Next Step."



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Creating an Estimate for Notice and Consent

All charges default to the convening facility/provider.
The drop-down arrows are used to change the provider and status to indicate which services will be rendered by the co-provider(s)

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PHARMACY (ALSO SEE 063X, AN E:		0258	$ 644.55	3	Demonstrati	Convening
INSERTION OF NEEDLE INTO VEIN	36415	0300	$ 42.00	1	Demonstrati	Convening
BLOOD TEST, BASIC GROUP OF BL(	80048	0301	$ 220.20	1	Demonstrati	Convening
COMPLETE BLOOD CELL COUNT (R	85027	0305	$ 127.20	1	Demonstrati	Convening
COV-19 AMP PRB HGH THRUPUT	U0003	0306	$ 150.00	1	Demonstrati	Convening
DIAGNOSTIC EXAM OF ESOPHAGL	43235	0360	$ 3,572.50	1	Demonstrati	Convening
ANESTHESIA - GENERAL CLASSIFIC		0370	$ 556.60	1	Demonstrati	Convening
INJ, PROPOFOL, 10 MG	J2704	0636	$ 6,892.00	50	Demonstrati	Convening
RECOVERY ROOM - GENERAL CLA:		0710	$ 1,031.00	1	Demonstrati	Convening
DIAGNOSTIC EXAM OF ESOPHAGL	43235	0989	$ 360.00	1	BOONE JACK	CoProvider

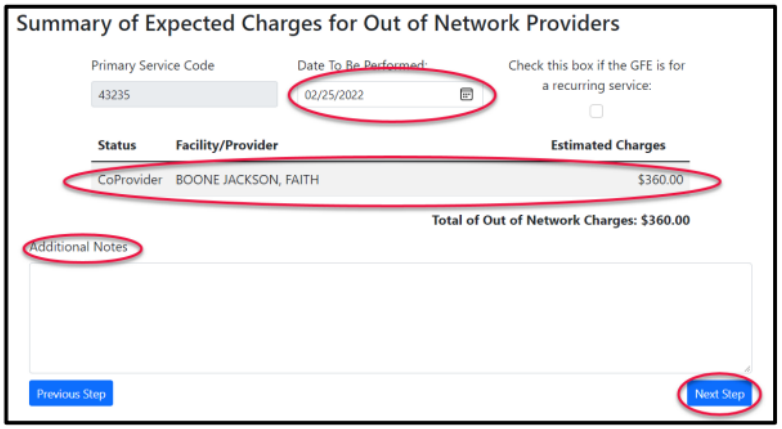
PARAREV Creating an Estimate for Notice and Consent

The scheduled date of service is entered by opening the calendar icon or keying in the date

The only charges listed in the summary are related to the OON co-provider

The "Additional Notes" can be used as a free-text box to communicate other notes to the patient as appropriate

After verifying accuracy of the summary, advance the screen by clicking "Next Step"



NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

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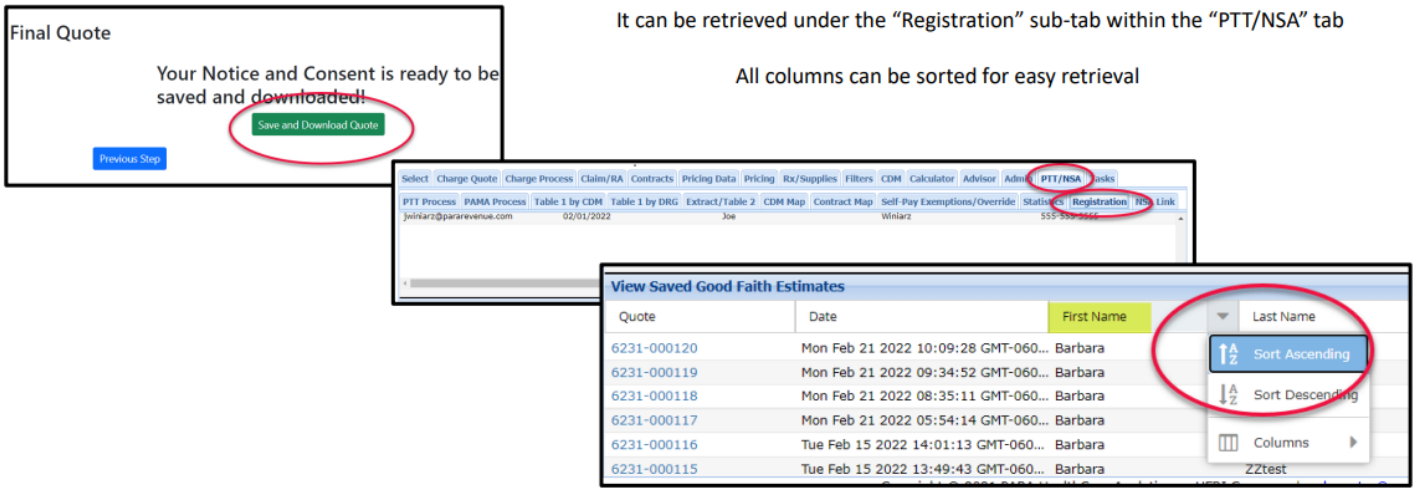


PARAREV Completed Notice and Consent Document

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider before scheduling care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.
If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services.

Getting care from this provider or facility will likely cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.
If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills
- You may owe the full costs billed for the items and services you get.
- Your health plan might not count any of the amount you pay towards your deductible and out- of-pocket limit. Contact your health plan for more information.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

1

Estimate of what you could pay if you give up your protections

Patient Name: Barbara ZZtest

Out-of-network provider(s)or facility name: FAITH BOONE JACKSON

Total cost estimate of what you may be asked to pay: $360.00

- **Review your detailed estimate.** See attached pages for a cost estimate for each item or service you'll get.
- **Call your health plan.** Your plan may have better information about how much you'll be asked to pay. You also can ask about what's covered under your plan and your provider options.
- **Questions about this notice and estimate?** Contact
- **Questions about your rights?** Contact

Prior authorization or other care management limitations

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover the items or services before you can get them. If your plan requires prior authorization, ask them what information they need for you to get coverage.

Understanding your options

You can get the items or services described in this notice from the following providers who are in-network with your health plan:

Form must be printed and the names of in-network providers entered in this space. (A future upgrade will allow the provider information to be populated.)

More information about your rights and protections

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

2

NO SURPRISES ACT: PARAREV'S NSA TOOL SLIDE DECK

PARAREV Completed Notice and Consent Document

By signing, I understand that I'm giving up my federal consumer protections and may have to pay more for out-of-network care

With my signature, I'm agreeing to get the items or services from (select all that apply):

☐BOONE JACKSON, FAITH

With my signature, I acknowledge that I'm consenting of my own free will and I'm not being coerced or pressured. I also acknowledge that:

- I'm giving up some consumer billing protections under federal law.
- I may have to pay the full charges for these items and services, or have to pay additional out-of-network cost-sharing under my health plan.
- I was given a written notice on **2/28/2022 3:56 pm** that explained my provider or facility isn't in my health plan's network, described the estimated cost of each service, and disclosed what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all of the amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You don't have to sign this form. If you don't sign, this provider or facility might not treat you, but you can choose to get care from a provider or facility in your health plan's network.

Patient's Signature: or Guardian / Authorized Representative's Signature:

Print Name of Patient: Print Name of Guardian / Authorized Representative

Date and Time of Signature: Date and Time of Signature:

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

3

The amount is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. This means that **the final cost of services may be different than this estimate.**

More details about your total cost estimate

Patient Name: Barbara ZZtest

Out-of-network provider(s)or facility name: FAITH BOONE JACKSON

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. **This means that the final cost of services may be different than this estimate.**

Contact your health plan to find out if your plan will pay any portion of these costs, and how much you may have to pay out-of-pocket.

BOONE JACKSON, FAITH Estimate

Details of Services and Items for BOONE JACKSON, FAITH

Date of Service	Name of Provider or Facility	Service Code	Description	Estimated Amount to be Billed
	BOONE JACKSON, FAITH	43235	DIAGNOSTIC EXAM OF ESOPHAGUS, STOMACH, AND/OR UPPER SMALL BOWEL USING A FLEXIBLE ENDOSCOPE	$360.00

Total Estimated Total Cost: $360.00

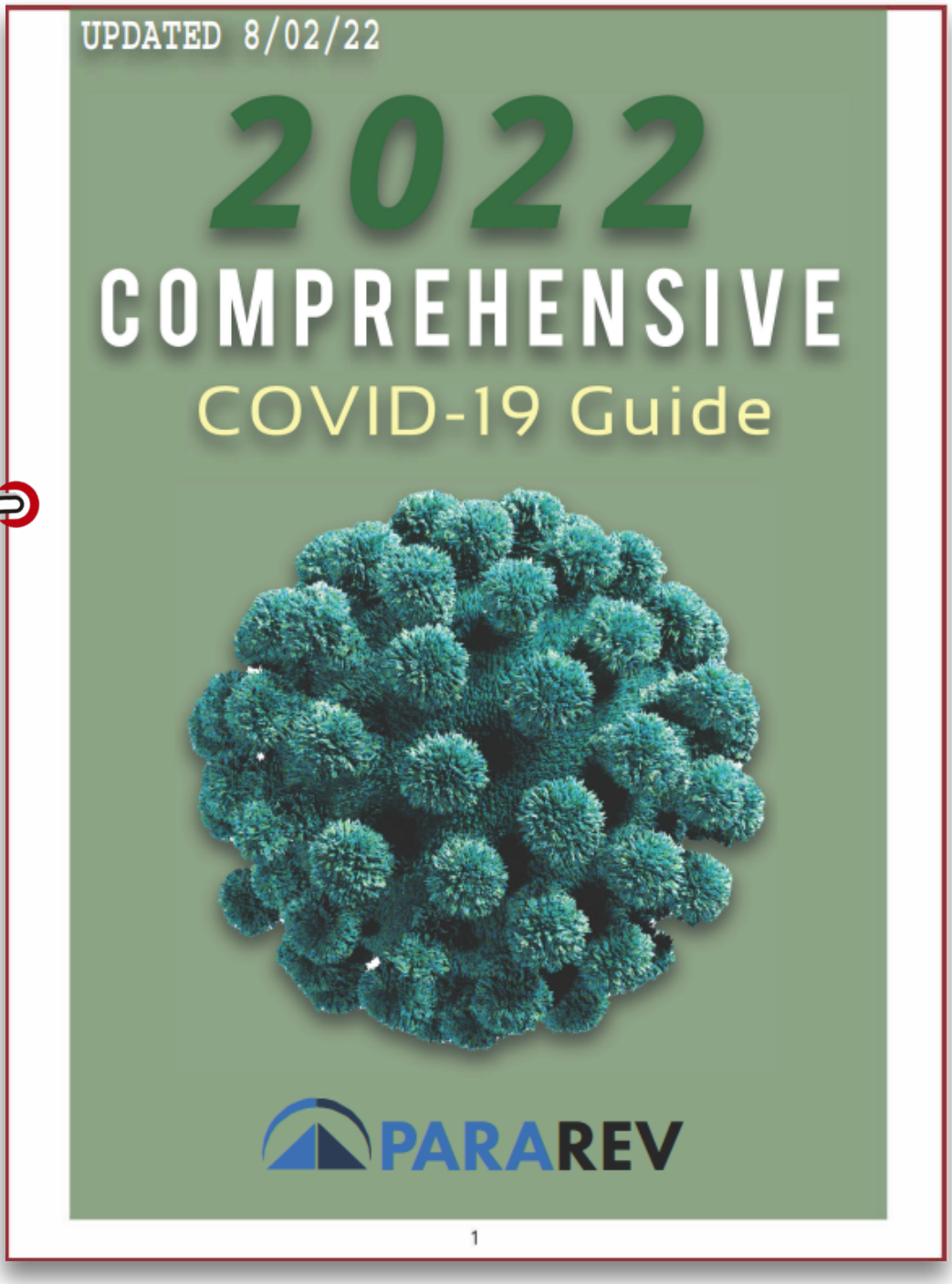
4

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, September 29, 2022

News

- Resources & Flexibilities to Assist with Public Health Emergency in Puerto Rico
- Resources & Flexibilities to Assist with Public Health Emergency in Florida
- 2023 Medicare Parts A & B Premiums and Deductibles
- Clinical Laboratory Fee Schedule Payment Determinations & Voting Results: Submit Comments by October 24
- DMEPOS: Change to Enrollment Contractor After November 6
- Hispanic or Latino Patients: Help Address Disparities

Claims, Pricers, & Codes

- ICD-10 Coordination & Maintenance Committee: Meeting Materials & Deadlines
- HCPCS Application Summary for Non-Drug & Non-Biological Items and Services

TRANSMITTALS

9

There were NINE new or revised Transmittals released this week.

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

TRANSMITTAL R17P240

Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 40, Form CMS-2552-10

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 17 **Date: January 2022**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	40-1 - 40-2 (2 pp.)	40-1 - 40-2 (2 pp.)
Table of Contents	40-5 - 40-6 (2 pp.)	40-5 - 40-6 (2 pp.)
4000.2 - 4000.2 (Cont.)	40-9 - 40-10 (2 pp.)	40-9 - 40-10 (2 pp.)
4002.1 (Cont.) - 4004.1 (Cont.)	40-25.2 - 40-33.1 (14 pp.)	40-25.2 - 40-33.1 (12 pp.)
4004.1 (Cont.) - 4004.1 (Cont.)	40-35 - 40-38 (4 pp.)	40-35 - 40-38 (4 pp.)
4004.2 - 4004.2 (Cont.)	40-39 - 40-40 (2 pp.)	40-39 - 40-40 (2 pp.)
4005.1 (Cont.) - 4005.1 (Cont.)	40-57 - 40-58 (2 pp.)	40-57 - 40-58 (2 pp.)
4005.2 (Cont.) - 4005.2 (Cont.)	40-58.3 - 40-62 (8 pp.)	40-58.3 - 40-62 (8 pp.)
4013 (Cont.) - 4013 (Cont.)	40-89 - 40-92 (4 pp.)	40-89 - 40-92 (42 pp.)
4017 - 4018 (Cont.)	40-107 - 40-110 (4 pp.)	40-107 - 40-110 (4 pp.)
4019.6 (Cont.) - 4020	40-115 - 40-116 (2 pp.)	40-115 - 40-116 (2 pp.)
4020 (Cont.) - 4020 (Cont.)	40-121 - 40-122 (2 pp.)	40-121 - 40-122 (2 pp.)
4022 (Cont.) - 4022 (Cont.)	40-126.1 - 40-126.2 (2 pp.)	40-126.1 - 40-126.2 (2 pp.)
4024.2 - 4024.5 (Cont.)	40-133 - 40-140 (8 pp.)	40-133 - 40-140 (8 pp.)
4025.3 (Cont.) - 4025.4	40-151 - 40-152 (2 pp.)	40-151 - 40-152 (2 pp.)
4028.3 - 4028.3 (Cont.)	40-163 - 40-164 (2 pp.)	40-163 - 40-164 (2 pp.)
4030.1 (Cont.) - 4030.1 (Cont.)	40-171 - 40-172.6 (8 pp.)	40-171 - 40-172.6 (8 pp.)
4030.1 (Cont.) - 4030.1 (Cont.)	40-175 - 40-176.2 (6 pp.)	40-175 - 40-176.2 (6 pp.)
4030.2 - 4030.2 (Cont.)	40-177 - 40-178 (2 pp.)	40-177 - 40-178 (2 pp.)
4030.2 (Cont.) - 4030.2 (Cont.)	40-180.1 - 40-180.2 (2 pp.)	40-180.1 - 40-180.2 (2 pp.)
4031.1 (Cont.) - 4033.2 (Cont.)	40-183 - 40-192 (12 pp.)	40-183 - 40-192 (12 pp.)
4033.2 (Cont.) - 4033.3	40-195 - 40-196 (2 pp.)	40-195 - 40-196 (2 pp.)
4033.3 (Cont.) - 4033.3 (Cont.)	40-199 - 40-199.1 (2 pp.)	40-199 - 40-199.1 (2 pp.)
4033.4 (Cont.) - 4033.7	40-201 - 40-208 (10 pp.)	40-201 - 40-208 (10 pp.)
4033.7 (Cont.) - 4034	40-211 - 40-212 (2 pp.)	40-211 - 40-212 (2 pp.)
4034 (Cont.) - 4034 (Cont.)	40-216.1 - 40-216.2 (2 pp.)	40-216.1 - 40-216.2 (2 pp.)
4040.1 (Cont.) - 4040.1 (Cont.)	40-219 - 40-220 (2 pp.)	40-219 - 40-220 (2 pp.)
4040.4 - 4041	40-225 - 40-226 (2 pp.)	40-225 - 40-226 (2 pp.)
4041 (Cont.) - 4042	40-229 - 40-230 (2 pp.)	40-229 - 40-230 (2 pp.)
4044.1 - 4046	40-237 - 40-242 (6 pp.)	40-237 - 40-242 (6 pp.)
4055 (Cont.) - 4056	40-257 - 40-258 (2 pp.)	40-257 - 40-258 (2 pp.)
4067 (Cont.) - 4071.4	40-283 - 40-298 (18 pp.)	40-283 - 40-298 (18 pp.)
4072.2 - 4072.3	40-307 - 40-308 (2 pp.)	40-307 - 40-308 (2 pp.)
4090 (Cont.) - 4090 (Cont.)	40-503 - 40-510 (8 pp.)	40-503 - 40-510 (8 pp.)
	40-523.4 - 40-524 (2 pp.)	40-523.4 - 40-524 (2 pp.)
	40-535 - 40-538 (4 pp.)	40-535 - 40-538 (4 pp.)
	40-541 - 40-544 (4 pp.)	40-541 - 40-544 (4 pp.)
	40-547 - 40-556 (10 pp.)	40-547 - 40-556 (10 pp.)
	40-559 - 40-562 (4 pp.)	40-559 - 40-562 (4 pp.)
	40-569 - 40-572 (6 pp.)	40-569 - 40-572 (6 pp.)
	40-575 - 40-578 (4 pp.)	40-575 - 40-578 (4 pp.)
	40-583.2 - 40-584 (2 pp.)	40-583.2 - 40-584 (2 pp.)
	40-589 - 40-590 (2 pp.)	40-589 - 40-590 (2 pp.)
	40-595 - 40-598 (4 pp.)	40-595 - 40-598 (4 pp.)
	40-603 - 40-604 (2 pp.)	40-603 - 40-604 (2 pp.)
	40-609 - 40-610 (2 pp.)	40-609 - 40-610 (2 pp.)

Pub. 15-2-40

TRANSMITTAL R11624OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11624	**Date: October 4, 2022**
	Change Request 12863

Transmittal 11582, dated September 1, 2022, is being rescinded and replaced by Transmittal 11624, dated, October 4, 2022 to revise the implementation date extending it to January 6, 2023. All other information remains the same.

SUBJECT: Mobile Personal Identity Verification (PIV) Station

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for First Coast Service Options (FCSO) to install a CMS-supplied mobile PIV station computer at the FCSO office located at 532 Riverside Ave, Jacksonville, FL 32202.

EFFECTIVE DATE: October 3, 2022
**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
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 R207SOMA

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 207 **Date: September 30, 2022**

SUBJECT: Revisions to State Operation Manual (SOM), Appendix PP Guidance to Surveyors for Long Term Care Facilities

I. SUMMARY OF CHANGES: Revisions are being made to the regulatory language at F801 regarding food director qualifications, and to regulatory language at 483.90 physical environment specifically the fire safety evaluation system. There are no associated guidance changes.

NEW/REVISED MATERIAL - EFFECTIVE DATE: September 30, 2022
IMPLEMENTATION DATE: October 1, 2022

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Appendix PP/F801 Staffing/§483.60(a)(2)(i)
R	Appendix PP/ Physical Environment/§483.90(a)(1)(iii)

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2016 operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

TRANSMITTAL R11623OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11623	**Date: September 30, 2022**
	Change Request 12589

Transmittal 11240, dated January 27, 2022, is being rescinded and replaced by Transmittal 11623, dated, September 30, 2022 to add business requirements 12589.3, 12589.3.1, and 12589.3.2. All other information remains the same.

SUBJECT: Updates to the Common Working File (CWF) for Editing and Claims Processing to Allow Medicare Fee-For-Service (FFS) Coverage of Kidney Acquisition Costs for Medicare Advantage (MA) Beneficiaries Provided by Maryland Waiver (MW) Hospitals

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the CWF edits and claims processes to allow Medicare FFS coverage and add-on payment of kidney acquisition costs for MA beneficiaries provided by MW hospitals.

EFFECTIVE DATE: January 1, 2021 - Effective for claims with an admission date on or after January 01, 2021.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 2022 - For CWF analysis, requirements, and initial coding.; October 3, 2022 - For CWF coding completion, testing, and implementation.

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):
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 R11622OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11622	**Date: September 29, 2022**
	Change Request 12656

Transmittal 11374, dated April 22, 2022, is being rescinded and replaced by Transmittal 11622, dated, September 29, 2022 to add business requirements 12656.4 through 12656.7. These new business requirements will add the Other Amount Indicator "B2" for co-insurance reduction amount to the claim, modify edits that affect the co-insurance reduction amount, and report the applied co-insurance amount in the co-insurance field. All other information remains the same.

SUBJECT: Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests

I. SUMMARY OF CHANGES: This Change Request (CR) implements the gradual reduction in coinsurance until coinsurance is completely waived for certain Colorectal Cancer screening procedures that become a diagnostic or therapeutic service. This reduction and eventual waiver of coinsurance is authorized by Section 122 of Division CC of the Consolidated Appropriations Act (CAA) of 2021.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022 - Coding; January 3, 2023 - Testing and Full Implementation

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:

For Medicare Administrative Contractors (MACs):
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TRANSMITTAL R11618CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11618	**Date: September 29, 2022**
	Change Request 12932

SUBJECT: Instructions for Downloading the Medicare ZIP Code File for January 2023

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to describe the process for updating the two Medicare ZIP Code files (ZIP5 and ZIP9) for the January 2023 quarter. This instruction also describes the revision to and the process for downloading the Calendar Year-End ZIP Code files. The attached Recurring Update Notification applies to Chapter 15, Section 20.1.5(B).

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

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

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

III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11617CP

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11617	**Date: September 29, 2022**
	Change Request 12898

SUBJECT: Instructions for Retrieving the January 2023 Home Infusion Therapy (HIT) Services Payment Rates Through the CMS Mainframe Telecommunications System

I. SUMMARY OF CHANGES: This Change Request (CR) provides the Medicare contractors with instructions for downloading the annually updated Home Infusion Therapy (HIT) Services payment rates. This recurring update notification applies to chapter 32, section 411.

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

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

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

III. FUNDING:
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IV. ATTACHMENTS:
Recurring Update Notification

TRANSMITTAL R11619CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11619	**Date: September 29, 2022**
	Change Request 12918

SUBJECT: October Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

I. SUMMARY OF CHANGES: The purpose of this change request is to update on a quarterly basis the DMEPOS fee schedules, when necessary, in order to implement fee schedule amounts for new and existing codes, as applicable, and apply changes in payment policies. The update process for the DMEPOS fee schedule is located in publication 100-04, Medicare Claims Processing Manual, chapter 23, section 60.

EFFECTIVE DATE: October 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 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/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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III. FUNDING:
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IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL RR11616COM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-09 Medicare Contractor Beneficiary and Provider Communications	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11616	**Date: September 29, 2022**
	Change Request 12906

SUBJECT: The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Years (FYs) 2019 and 2020 for Inpatient Prospective Payment System (IPPS) Hospitals with Updated Data for Hospitals in the 9th Circuit

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide updated data for determining the disproportionate share adjustment for certain IPPS hospitals. The SSI/Medicare beneficiary data for hospitals are available electronically and contain the name of the hospital, CMS certification number, SSI days, Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients.

The data complies with the US Supreme Court decision in *Azar vs Empire Health Foundation,* which upheld the Secretary's interpretation of the Disproportionate Share (DSH) statute for hospitals in the 9th Circuit. The data for hospitals outside the 9th Circuit is unchanged.

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

MEDLEARNS

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There were THREE new or revised MedLearns released this week.

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

MEDLEARN MM12656

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Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter As Certain Colorectal Cancer Screening Tests

MLN Matters Number: MM12656 | Related Change Request (CR) Number: 12656

Related CR Release Date: September 29, 2022 | Effective Date: January 1, 2022

Related CR Transmittal Number: R11622OTN | Implementation Date: January 1, 2023

Note: We revised this article to reflect a revised CR 12656 that added new business requirements to add the Other Amount Indicator "B2" for co-insurance reduction amount to the claim, modify edits that affect the co-insurance reduction amount, and report the applied coinsurance amount in the co-insurance field. The changes did not afffect the contents of this article. We did change the CR release date, transmittal number and the CR web address. All other information remains the same.

Provider Types Affected

This MLN Matters Article is for physicians, hospitals, and other providers billing Medicare Administrative Contractors (MACs) for colorectal screening tests they do for Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- Reduced coinsurance for certain screening flexible sigmoidoscopies and screening colonoscopies

Background

Section 122 of Division CC of the Consolidated Appropriations Act (CAA) of 2021, Waiving Medicare Coinsurance for Certain Colorectal Cancer Screening Tests, amends section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies. This special coinsurance applies regardless of the code you bill for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure. It's effective when provided in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test. The reduced coinsurance is being phased-in beginning January 1, 2022.

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MEDLEARN MM12918

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DMEPOS Fee Schedule: October 2022 Quarterly Update

MLN Matters Number: MM12918	Related Change Request (CR) Number: 12918
Related CR Release Date: September 29, 2022	Effective Date: October 1, 2022
Related CR Transmittal Number: R11619CP	Implementation Date: October 3, 2022

Related CR Title: October Quarterly Update for 2022 Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Fee Schedule

Provider Types Affected

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

Provider Action Needed

Make sure your billing staff knows about:

- The October 2022 quarterly update for the DMEPOS fee schedule
- Fee schedule amounts for new and existing codes

Background

CMS updates the DMEPOS fee schedules on a quarterly basis, when necessary, to implement fee schedule amounts for new and existing codes and apply changes in payment policies. This quarter's updates are as follows:

The Coronavirus (COVID-19) Aid, Relief, and Economic Security (CARES) Act, 2020

Fees in the July 2022 fee schedule update continue to show CARES Act requirements. Sections 3712 (a) and (b) of the CARES Act require the following:

- For items and services subject to fee schedule adjustments provided in rural or noncontiguous areas, the fee schedule amounts will continue based on a blend of 50% of the adjusted fee schedule amounts and 50% of the unadjusted fee schedule amounts (no change from the current fee schedule amounts) through December 31, 2020, or the duration of the COVID-19 public health emergency (PHE), whichever is later
- For items and services subject to fee schedule adjustments provided in non-rural contiguous non-competitive bidding areas (CBAs), the fee schedule amounts will be based on a blend of 75% of the adjusted fee schedule amounts and 25% of the

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Inpatient Prospective Payment System Hospitals in the 9th Circuit: Updated Fiscal Years 2019 and 2020 Supplemental Security Income Medicare Beneficiary Data

MLN Matters Number: MM12906 Related Change Request (CR) Number: 12906

Related CR Release Date: September 29, 2022 Effective Date: November 1, 2022

Related CR Transmittal Number: R11616COM Implementation Date: November 1, 2022

Related CR Title: The Supplemental Security Income (SSI) Medicare Beneficiary Data for Fiscal Years (FYs) 2019 and 2020 for Inpatient Prospective Payment System (IPPS) Hospitals with Updated Data for Hospitals in the 9th Circuit

Provider Types Affected

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

Provider Action Needed

Make sure your billing staff knows that the data for:

- IPPS hospitals in the Ninth Circuit's jurisdiction is updated based on Supreme Court decision in *Azar v. Empire Health Foundation*
- All other hospitals is unchanged

Background

Medicare makes an additional payment to IPPS hospitals serving a disproportionate share of low-income patients. You get the additional payment by multiplying the federal portion of the Diagnosis-Related Group (DRG) payment by the disproportionate share hospital (DSH) adjustment factor. Also, for discharges occurring starting on or after October 1, 2014, the additional payment is decided by multiplying the DRG payment by the DSH adjustment factor reduced by 75%. (See 42 CFR 412.106.)

CR 12906 provides updated data for determining the disproportionate share adjustment for certain IPPS hospitals. The SSI/Medicare patient data for hospitals are available electronically. The data contains the hospital name, CMS certification number, SSI days, Medicare days, and the ratio of days for patients entitled to Medicare Part A attributable to SSI recipients.

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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.

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