OCTOBER 12, 2022

# eJOURNAL

PARAREV
A CorroHealth Company


## Preparing For 2023

CorroHealth Academy

## 2023 CPT® Information

Optimizing Coding And Charge Capture

## Drug Reimbursement

October, 2022 OPPS Payables

## SLISHMAN TRACTION BOOT APPLICATION


**Question: When a Slishman traction boot is applied, is there a billable CPT® for the application itself? We are not finding any resources online to help with this question.**

**Answer:** We couldn't find a device that exactly matched your description of a "Slishman traction boot." There's a device called a "Slishman traction splint" online – I hope that's the device you're inquiring about, but it's not a boot – if this isn't the right device, please let us know.

Here's a picture we found online:


There are several factors to consider that would affect coding for the application of this device:

1. The application of strapping and splints are integral components of fracture or dislocation care – therefore if the facility will report a fracture repair CPT®/HCPCS code, it would be inappropriate to separately report the application of a splint. The hospital could bill for the splint itself as a supply, however

2. If the encounter serves to stabilize the leg, but the facility will not report a fracture repair code, and the provider or nursing staff fabricate the splint from "raw" materials on hand in the facility, one of the strapping/splinting codes could be reported (such as 29505 - APPLICATION OF LONG LEG SPLINT (THIGH TO ANKLE OR TOES.)

## SLISHMAN TRACTION BOOT APPLICATION

3. If an "off-the-shelf" prefabricated splint is applied (i.e. HCPCS L4370 – Pneumatic Full Leg Splint, Prefabricated, Off-The-Shelf), the facility should report the L-code only. The application of a prefabricated splint does not typically require a high degree of medical expertise, therefore it is included in the evaluation and management/visit charge, such as the ED visit (99281-99285.) We do not recommend reporting both the L-code for a prefabricated splint together with the CPT® code for the application of a long-leg splint.

Unfortunately, the Slishman Traction Splint has not been assigned a HCPCS, and we aren't comfortable recommending any of the other HCPCS for long-leg splints because those HCPCS clearly describe items that are not the same as this device. Since the splint is prefabricated, we are not comfortable with reporting the strapping code 29505, either.

We searched Medicare's DME lookup tool for the words "slishman", but found no product with an assigned HCPCS; there was, however, another traction boot listed, with coding advice:

https://www4.palmettogba.com/pdac_dmecs/initProductClassificationResults.do

| ProductName | Manufacturer/Distributor | ModelNumber | HCPCS Code | Effective Begin Date | Effective End Date | Comments |
|---|---|---|---|---|---|---|
| BUCKS TRACTION BOOT | MEDLINE INDUSTRIES INC | ORT31100 | A9900 OR E0944 | 10/09/2007 | | USE HCPCS CODE A9900 WHEN PROVIDED ON INITIAL ISSUE. USE HCPCS CODE E0944 WHEN PROVIDED AS A REPLACEMENT. |

Unfortunately, we don't think the codes offered in the lookup too will work on an outpatient hospital claim. Here are the descriptions for the two HCPCS offered in that lookup tool:

A9900 -- MISCELLANEOUS DME SUPPLY, ACCESSORY, AND/OR SERVICE COMPONENT OF ANOTHER HCPCS CODE)

E0944 PELVIC BELT/HARNESS/BOOT

We found additional information regarding those codes in Medicare's 2022 DME Jurisdiction List. Although facilities may bill DME HCPCS for either a prosthetic or an orthotic on an outpatient claim when used in connection with other medical services, the DME jurisdiction list says that codes in the E0942 to E0945 range are billable to Part B if used with another implanted device. Here's an excerpt from that list: (see next page)

# SLISHMAN TRACTION BOOT APPLICATION

| | A | B | C | D |
|---|---|---|---|---|
| 1 | NOTE: Deleted codes are valid for dates of service on or before the date of deletion. | | | |
| 2 | NOTE: Updated codes are in bold. | | | |
| 3 | NOTE: The jurisdiction list includes codes that are not payable by Medicare. Please consult the Medicare | | | |
| 4 | contractor in whose jurisdiction a claim would be filed in order to determine coverage under Medicare. | | | |
| 5 | NOTE: All HCPCs code listed have DME or joint MAC Jurisdiction. Any other codes not listed as DME MAC only or dual DME MAC/Part B MAC | | | |
| 6 | jurisdiction shall be considered to be A/B MAC (Part B) only jurisdiction. | | | |
| 7 | **HCPCS** | **DESCRIPTION** | **JURISDICTION** | **COMMENT** |
| 164 | A9900 | Miscellaneous DME Supply or | Part B MAC if used with implanted DME. If | |
| 165 | | Accessory | other, DME MAC. | |
| 223 | E0942 - E0945 | Orthopedic Devices | DME MAC | |
| 224 | E0946 - E0948 | Fracture Frame | DME MAC | |

We checked the Integrated Outpatient Code Editor (IOCE) Data_HCPCS file – it says that both A9900 and E0944 are billable to only a DMERC, not the A/B MAC. That means the hospital would have to enroll as a DME supplier and bill the DME code separately in order to be reimbursed, which we do not recommend due to the onerous DME compliance requirements. Here's an excerpt from that file:

| | A | B | C | D | AW | AX | AY | AZ |
|---|---|---|---|---|---|---|---|---|
| 1 | HCPC | LO_VERSIOI | HI_VERSIOI | DESCRIPTION | DMERC_BILLABLE_ONLY | Billable to Durable Medical Equipment Regional Carrier (DMERC) only (Edit 61). | | |
| 27370 | A9900 | 59 | 86 | Supply/accessory/service | 1 | 0 Values: | | |
| 29934 | E0944 | 59 | 86 | Pelvic belt/harness/boot | 1 | 0 0 = not applicable | | |
| 38158 | | | | | | 1 = applicable | | |
| 38159 | | | | | | | | |

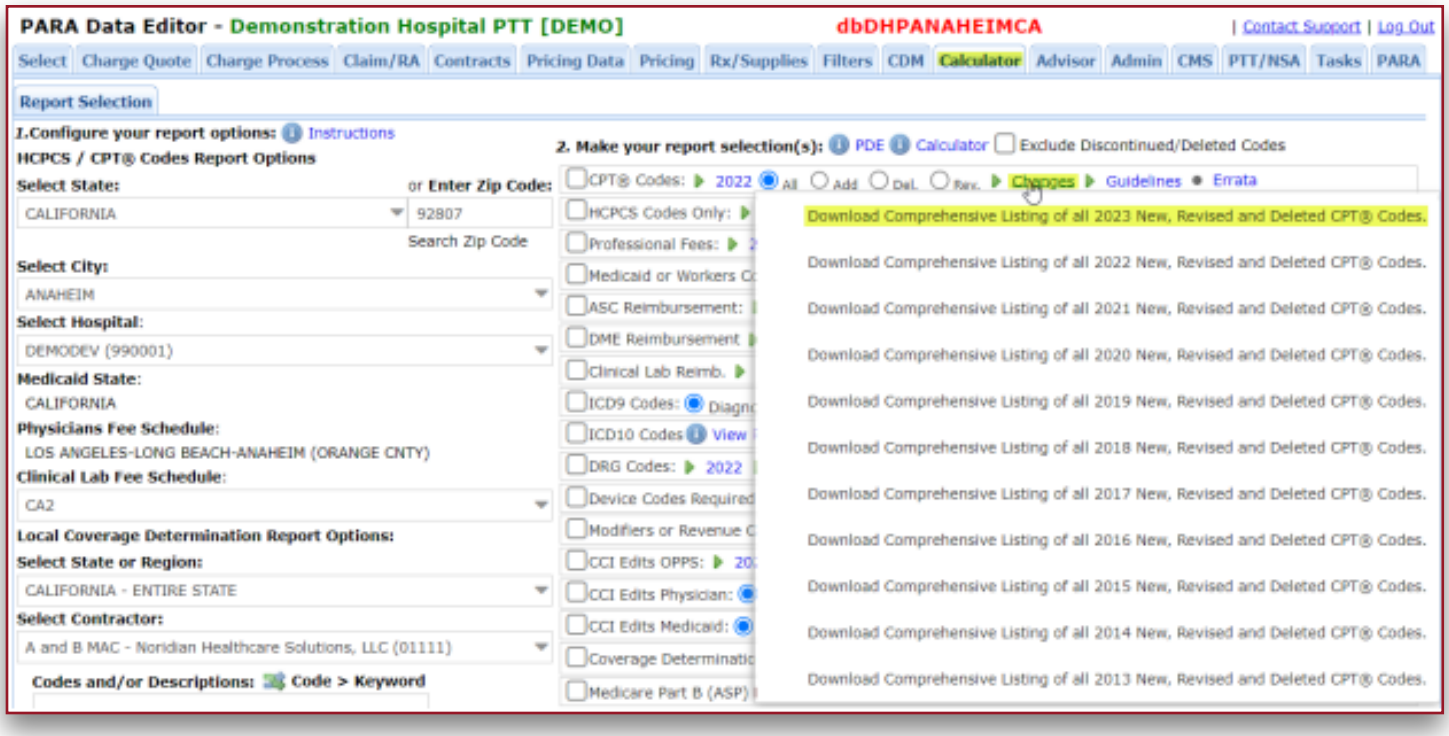
Therefore we do not recommend reporting the application procedure separately, but considering it as a component of the evaluation and management charge, such as the ED visit (99281-99285.)

The hospital may bill the splint itself as a supply item under revenue code 0270 without a HCPCS.

## 2023 CPT® INFO ACCESSIBLE ON THE PARA DATA EDITOR

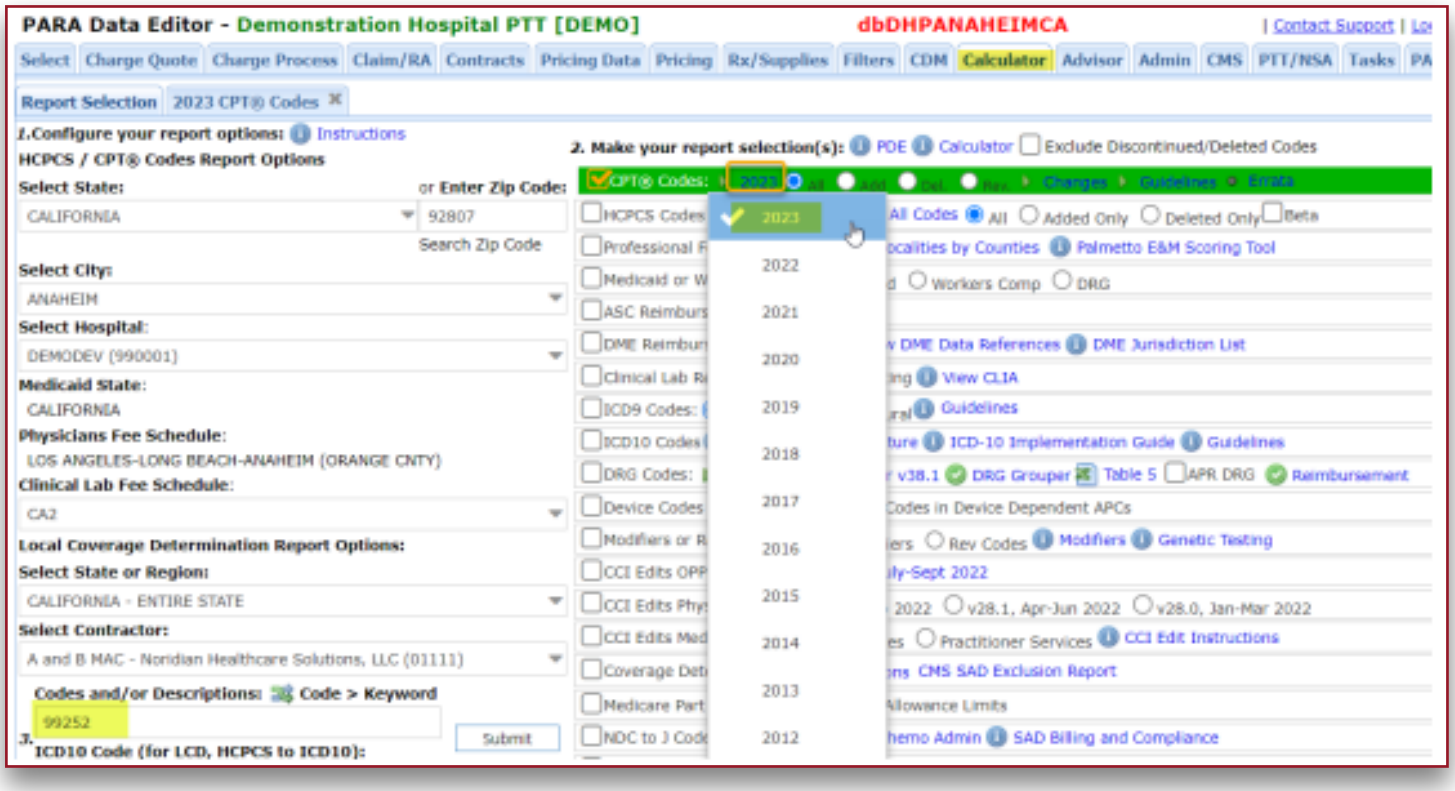
### NEW CPT® CODES AND CHANGES TO ESTABLISHED CODES FOR 2023 ARE NOW AVAILABLE IN THE PARA DATA EDITOR (PDE.) PARA DATA EDITOR USERS CAN ACCESS CPT® 2023 APPENDIX B, WHICH SUMMARIZES THE CY2023 CODE CHANGES, ON THE CALCULATOR TAB.

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




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

## 2023 CPT® INFO ACCESSIBLE ON THE PARA DATA EDITOR




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

## 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<br>70121-17-5401 |
| C9101 | Injection, oliceridine, 0.1 mg | Trevena, Inc. | G | 9049 | 71308-0011-10<br>71308-0021-10<br>71308-03-0110 |
| A9602 | Fluorodopa f-18, diagnostic, per millicurie | The Feinstein Institutes for Medical Research | G | 9053 | 13267-03-4657<br>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

## PREPARE FOR 2023 WITH CORROHEALTH ACADEMY


# 2023 IS RAPIDLY APPROACHING. THERE ARE MANY CHANGES THAT WILL AFFECT CODING, PRICING, REIMBURSEMENT AND COMPLIANCE. GET AHEAD OF THE CURVE BY ENROLLING IN CORROHEALTH ACADEMY.

Now open to everyone, CorroHealth Academy is a library of on-demand sessions provides insights into pressing topics in the coding industry.

These sessions also provide continuing education credits for AAPC and a certificate of completion.

## Upcoming 2022 Sessions

**October 26:** Respiratory/Pulmonary
**November 23:** HCC/Risk Adjustment
**December 28:** CPT® 2023

Scan QR code

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CorroHealth

# 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.

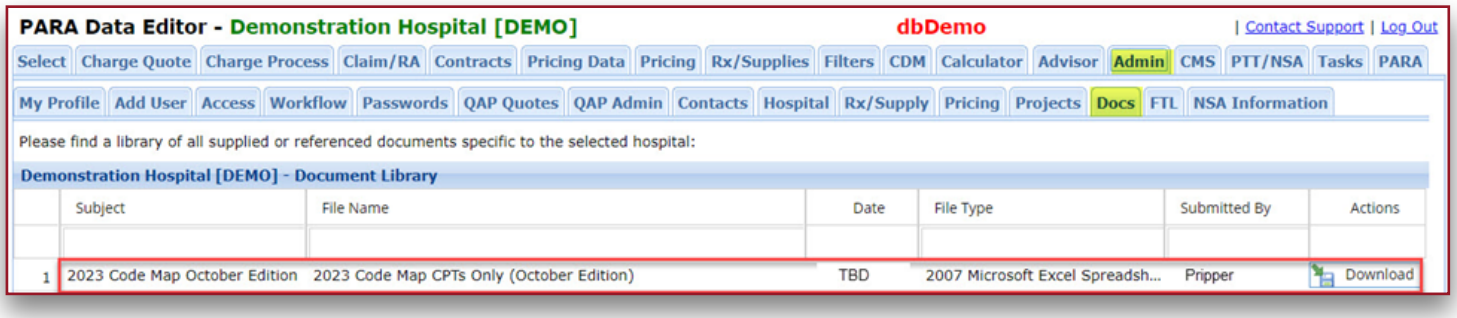
The **PARA Data Editor (PDE)** contains a copy of each client chargemaster; we use the powerful features of the PDE to identify any line item in the chargemaster with a HCPCS code assigned that will be deleted as of December 31, 2022.

**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

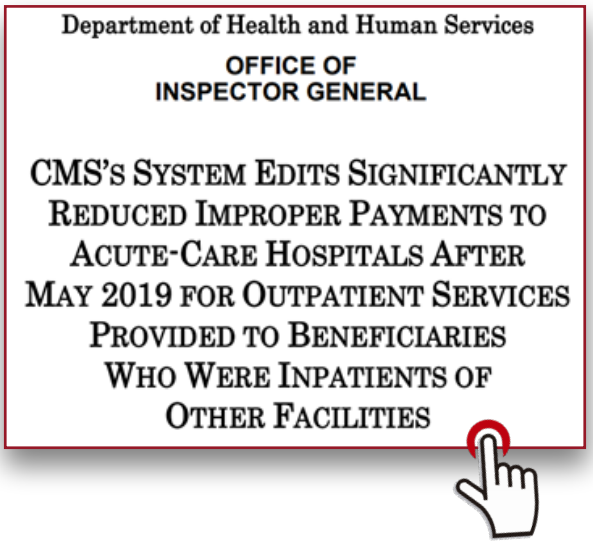
## IN SEPTEMBER 2022, THE OFFICE OF INSPECTOR GENERAL PUBLISHED RECOMMENDATIONS TO CMS REGARDING OVERPAYMENTS MADE FOR OUTPATIENT SERVICES BETWEEN JANUARY 2013 THROUGH AUGUST 2016.

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.

## OPTIMIZING CODING AND CHARGE CAPTURE IN PEDIATRIC FACILITIES

# 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?

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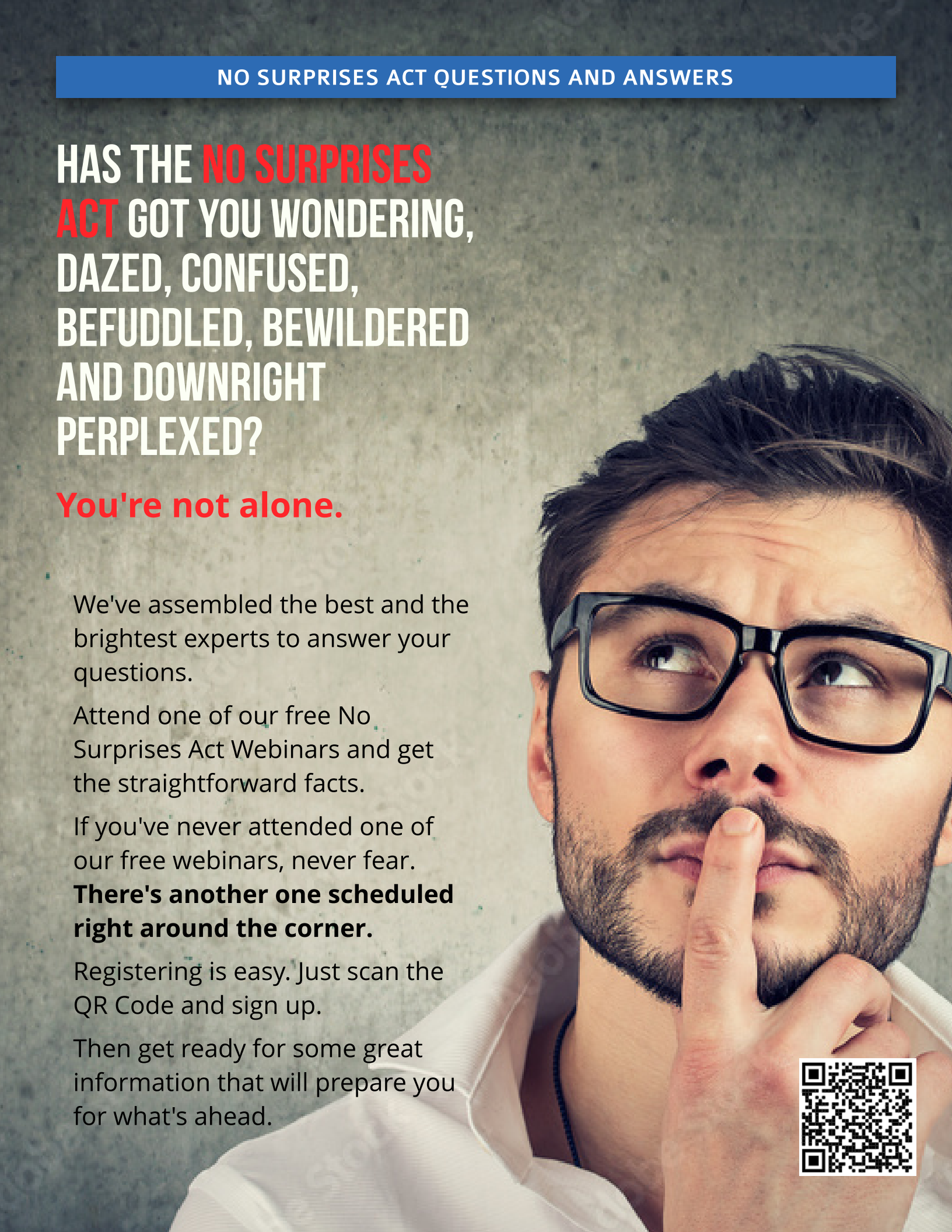
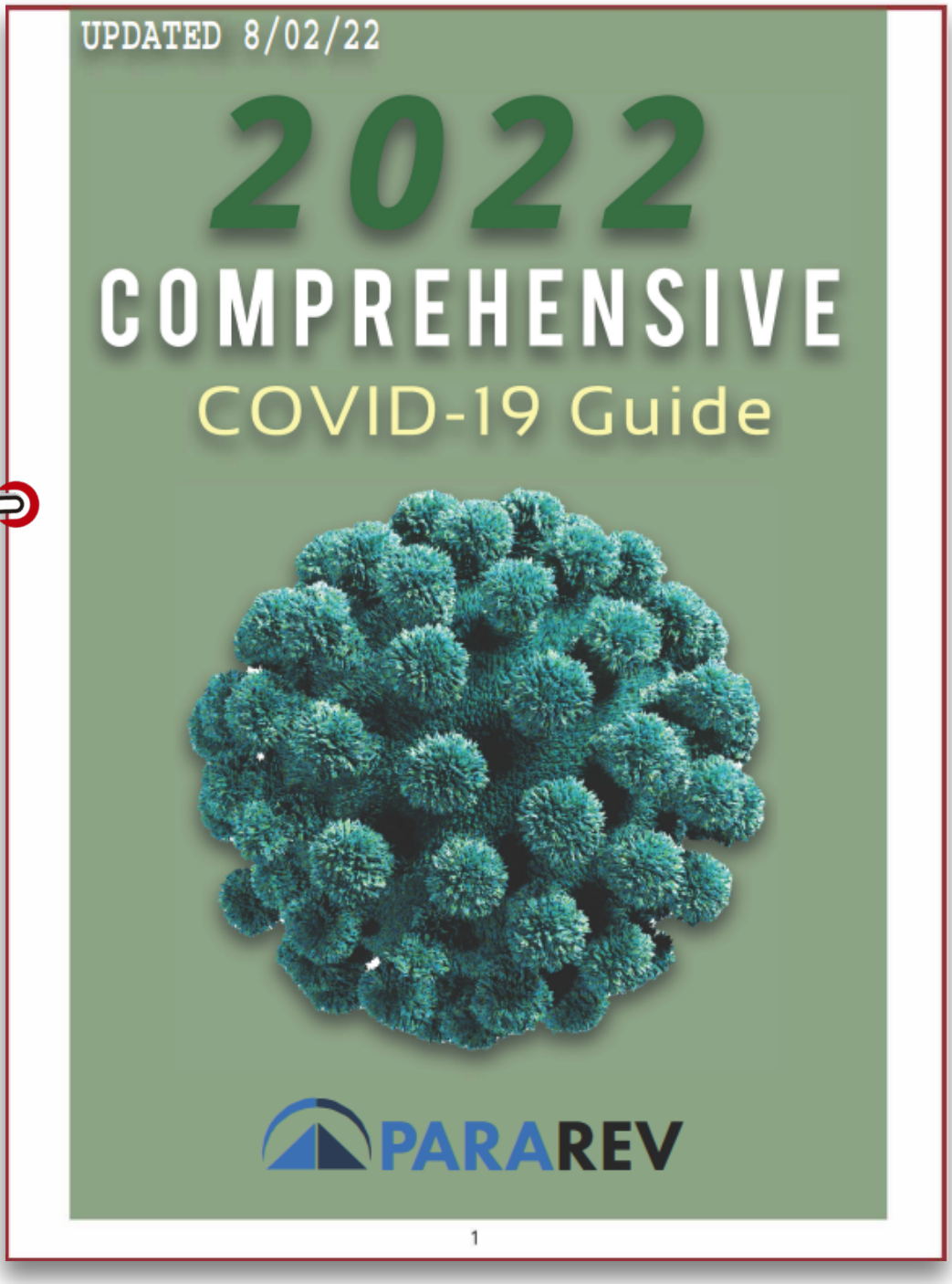


## COMPLETELY UPDATED: COMPREHENSIVE COVID-19 GUIDE

# 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, October 6, 2022

**News**

- Resources & Flexibilities to Assist with Public Health Emergency in South Carolina
- Implementation of Inflation Reduction Act Provision Addressing Medicare Payments for Biosimilars
- CMS Asks for Public Input on Establishing First, National Directory of Health Care Providers and Services
- Inflation Reduction Act Lowers Health Care Costs for Millions of Americans
- Help Promote Efficiency, Reduce Burden, & Advance Equity: Submit Comments by November 4
- Inpatient Rehabilitation Facilities: IRF-PAI & September Care Compare Release
- Long-Term Care Hospitals: September Care Compare Release
- Help Detect Breast Cancer Early

**Claims, Pricers, & Codes**

- October 2022 Integrated Outpatient Code Editor (I/OCE) Specifications Version 23.3

**MLN Matters® Articles**

- Ambulatory Surgical Center Payment System: October 2022 Update
- DMEPOS Fee Schedule: October 2022 Quarterly Update
- Inpatient Prospective Payment System Hospitals in the 9th Circuit: Updated Fiscal Years 2019 and 2020 Supplemental Security Income Medicare Beneficiary Data

**Information for Patients**

- 2023 Medicare & You Handbook

**MLN Matters® Articles**

- Ambulatory Surgical Center Payment System: October 2022 Update

# TRANSMITTALS

# 10

**There were TEN new or revised Transmittals released this week.**

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

## TRANSMITTAL 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.) |
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| 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.) |
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| | 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 R11637PI

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-08 Medicare Program Integrity | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11637** | **Date: October 7, 2022** |
| | **Change Request 12731** |

**SUBJECT: Provider Enrollment Appeals and Rebuttals - Revised Instructions and Model Letters**

**I. SUMMARY OF CHANGES:** The purpose of this CR is to clarify Medicare Administrative Contractor (MAC) procedures for processing provider enrollment appeals and rebuttals. This CR clarifies MAC External Monthly Reporting Requirements for Rebuttals and Appeals. This CR also provides clarifying instruction regarding Model Letters. In addition, this CR creates additional appeals and rebuttal model letters.

**EFFECTIVE DATE: December 9, 2022**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: December 9, 2022**

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 10/10.4/10.4.8/10.4.8.1/Deactivation Rebuttals |
| R | 10/10.6/10.6.19/Other Medicare Contractor Duties |
| R | 10/10.7/10.7.1/Acknowledgement Letters |
| R | 10/10.7/10.7.9/Revocation Letters |
| R | 10/10.7/10.7.12/Deactivation Model Letter |
| R | 10/10.7/10.7.13/Rebuttal Model Letters |
| R | 10/10.7/10.7.14/Model Opt-out Letters |
| R | 10/10.7/10.7.15/Revalidation Notification Letters |

**III. FUNDING:**

**For Medicare Administrative Contractors (MACs):**
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current

## TRANSMITTAL R11639CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11639** | **Date: October 7, 2022** |
| | **Change Request 12852** |

**SUBJECT: Provider Specific File (PSF) changes for Direct Medical Education (DME), Direct Graduate Medical Education (DGME), Organ Acquisition Cost (OAC) and Kidney Acquisition Costs (KAC)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to enhance the Provider Specific File (PSF) that will feed the Fiscal Intermediary Shared System (FISS) in order to improve the logic needed for Direct Medical Education (DME), Direct Graduate Medical Education (DGME), Organ Acquisition Cost (OAC) and Kidney Acquisition Costs (KAC) related to the Medicare Advantage (MA) capitation rates per relevant statute.

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

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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 3/Addendum A/ Provider Specific File |

**III. FUNDING:**

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**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

## TRANSMITTAL R11633CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11633** | **Date: October 6, 2022** |
| | **Change Request 12889** |

**SUBJECT: New Fiscal Intermediary Shared System (FISS) Consistency Edit to Validate Attending Physician National Provider Identifier (NPI)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to implement a new consistency edit to validate that the attending physician NPI is not being fictitiously substituted with organization NPI to bypass HIPAA standards.

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

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

| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 1/80.3.2.2 - Consistency Edits for Institutional Claims |

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# TRANSMITTAL R11634CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11634** | **Date: October 6, 2022** |
| | **Change Request 12924** |

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

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

**EFFECTIVE DATE: April 1, 2023 - Claims processed on or after this date.**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: April 3, 2023**

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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 10/80/HH Grouper Program |
| R | 10/80.1/HH Grouper Input/Output Record Layout |
| R | 10/80.2/HH Grouper Decision Logic and Updates |

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

**IV. ATTACHMENTS:**

**Business Requirements**
**Manual Instruction**

# TRANSMITTAL R11630CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11630** | **Date: October 6, 2022** |
| | **Change Request 12871** |

**SUBJECT: Instructions to the Fiscal Intermediary Shared System [FISS] to Add Additional Multiple Procedure Indicators 6 and 7 Into the Physician Fee Schedule Payment Policy Indicator File Record Layout**

**I. SUMMARY OF CHANGES:** In the past, CMS instructed contractors to add to their systems Current Procedural Terminology (CPT) Category III codes with multiple procedure indicators 6 and 7. These codes are payable on professional claims on a fee schedule basis and on institutional claims for Critical Access Hospital (CAH) services on a cost basis. Multiple procedure indicators 6 and 7 apply a reduction to the technical component of these services when paid on a fee schedule basis.

When A/B MACs (A) attempted to load the codes into the Fiscal Intermediary Shared System (FISS), they were unable to do so. Currently, FISS does not recognize the multiple procedure indicators of 6 and 7, which apply to these codes, as a valid value since it is not contained in the CMS payment indicator file.

The purpose of this Change Request (CR) is to instruct the FISS to add additional multiple procedure indicators 6 and 7 into the Physician Fee Schedule Payment Policy Indicator File Record Layout. This will allow codes to be loaded, but will not affect the cost-based payment on CAH claims. In addition, this CR updates Pub 100-04, Medicare Claims Processing Manual, Chapter 23, Section 50.6.

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

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| R/N/D | CHAPTER / SECTION / SUBSECTION / TITLE |
|---|---|
| R | 23/50.6 Physician Fee Schedule Payment Policy Indicator File Record Layout |

**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

## TRANSMITTAL R11629OTN

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11629** | **Date: October 6, 2022** |
| | **Change Request 12184** |

**SUBJECT: User CR: Fiscal Intermediary Shared System (FISS) Enhancement to View All Changes for All Adjustment Types**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to expand the FISS functionality that allows the MACs to compare the fields of an original claim and adjustment. This functionality was added with CR 9071. Currently, this functionality is limited to bill types XX7 and XXQ. This UCR is a MAC request to expand this capability to allow comparison for all adjustments.

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

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

**III. FUNDING:**
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**IV. ATTACHMENTS:**

**One Time Notification**

## TRANSMITTAL R11628CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11628** | **Date: October 6, 2022** |
| | **Change Request 12941** |

**SUBJECT: Shared System Support Hours for Application Programming Interfaces (APIs)**

**I. SUMMARY OF CHANGES:** The purpose of this Change Request (CR) is to provide hours for the Fiscal Intermediary Shared System (FISS) and Multi-Carrier System (MCS) Maintainers to support maintenance, enhancements, and MAC onboarding of the existing APIs in the FISS and MCS using Agile development practices.

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

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

**III. FUNDING:**
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**IV. ATTACHMENTS:**

**Recurring Update Notification**

## TRANSMITTAL R11627CP

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-04 Medicare Claims Processing | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11627** | **Date: October 6, 2022** |
| | **Change Request 12940** |

**SUBJECT: Quarterly Update to Home Health (HH) Grouper**

**I. SUMMARY OF CHANGES:** This change request provides the January 2023 update to the HH Grouper software. This recurring update notification applies to chapter 10, section 80.

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

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|---|---|
| N/A | |

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**IV. ATTACHMENTS:**
**Recurring Update Notification**

# TRANSMITTAL 411636OTN

| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 11636** | **Date: October 5, 2022** |
| | **Change Request 12842** |

**Transmittal 11546, dated August 4, 2022, is being rescinded and replaced by Transmittal 11636, dated, October 5, 2022, to remove ICD-10 dx codes added in error to NCD 150.3, business requirement 12842.4, and restore ICD-10 dx C91.92 removed in error to NCD 110.23, business requirement 12842.3. All other information remains the same.**

**SUBJECT: International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)--January 2023 Update--2 of 2**

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

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

**EFFECTIVE DATE: January 1, 2023 - or as noted in individual business requirements**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: September 6, 2022 - business requirements 12842.2, 12842.8; January 3, 2023**

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|---|---|
| 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

# MEDLEARNS

# 3

**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 MM12889**

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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 MM12924**

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# Home Health Claims: New Grouper Edits

MLN Matters Number: MM12924

Related Change Request (CR) Number: 12924

Related CR Release Date: October 6, 2022

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

Related CR Transmittal Number: R11634CP

Implementation Date: April 3, 2023

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

## Provider Types Affected

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

## Provider Action Needed

Make sure your billing staff knows about:

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

## Background

### New Grouper Edits

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

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

These new Grouper edits apply to Types of Bill 032X (except 032A, 032D, and 0320). With this process, we may return some claims to you with 1 of the following messages:



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**MEDLEARN MM12842**

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# International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determinations (NCDs)—January 2023 Update – 2 of 2

MLN Matters Number: MM12842 Revised

Related CR Release Date: October 5, 2022

Related CR Transmittal Number: R11636OTN

Related Change Request (CR) Number: 12842

Effective Date: January 1, 2023, unless otherwise specified in CR 12842

Implementation Date: January 3, 2023

**Note: We revised this Article due to a revised CR 12842. As a result, we deleted the bullet point for NCD 150.3 on page 2. Also, we changed 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, providers and suppliers billing MACs for services they provide to Medicare patients.

## Provider Action Needed

Make sure your staff knows about:

- Newly available codes
- Separate NCD coding revisions
- Coding feedback

Previous NCD coding changes are available. Also, see the NCD spreadsheets for CR 12842.

CMS isn't including any policy changes in this ICD-10 quarterly update. We cover NCD policy changes using the current, longstanding NCD process.

## Background

CR 12842 is a maintenance update of ICD-10 conversions and other coding updates specific to NCDs. These NCD coding changes are the result of newly available codes, coding revisions to NCDs released separately, or coding feedback received.

The translations from ICD-9 to ICD-10 aren't consistent one-to-one matches, nor are all ICD-10



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

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

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