MAY 18, 2022

eJOURNAL

PARAREV

Hospital ED

Visit Documentation

CMS Oncology Care Model

New HCPCS

BILLING OBSERVATION AT THE PAYER'S DIRECTION

Q. Often times our case managers will file a request for authorization for inpatient stays to private insurances, and later we receive a denial for the inpatient stay. Instructions from insurance are often to bill the stay as observation. For private commercial insurance we feel it is appropriate to change account class for billing purposes despite the lack of a distinct observation order.

For Managed Care Medicaid and Medicare plans, however, we feel this is a grey area. CMS is explicit that a valid observation order is required to bill a claim as an observation stay. When we receive this instruction from a Medicare Advantage plan, is it acceptable to take the insurance companies decision regarding the account and charges and go ahead and bill as observation without a distinct observation order? Or should we treat these accounts just as if they were billed straight to Medicare or Medicaid agencies? Would it be appropriate to include observation hours on the claim in this case, or should we simply bill for ancillary services on an outpatient type of bill?

A. We can certainly understand your reluctance to bill a Medicare replacement plan for observation care without an order for observation in the medical record.You may be interested to peruse a report published by the OIG on 4/22/2022 which recaps this sort of problem.The OIG found that Medicare Advantage plans sometimes delayed or denied Medicare Advantage beneficiaries' access to services, even though the requests met Medicare coverage rules.

Here's a link and an excerpt: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp

BILLING OBSERVATION AT THE PAYER'S DIRECTION

What OIG Recommends

Our findings about the circumstances under which MAOs denied requests that met Medicare coverage rules and MAO billing rules provide an opportunity for improvement to ensure that Medicare Advantage beneficiaries have timely access to all necessary health care services, and that providers are paid appropriately. Therefore, we recommend that CMS:

(1) issue new guidance on the appropriate use of MAO clinical criteria in medical necessity reviews;

(2) update its audit protocols to address the issues identified in this report, such as MAO use of clinical criteria and/or examining particular service types; and

(3) direct MAOs to take steps to identify and address vulnerabilities that can lead to manual review errors and system errors.

CMS concurred with all three recommendations.

Unfortunately, we cannot offer any relief from the obligation to bill only those services which are supported in the medical record.The hospital may choose to appeal the denial of inpatient care, as sometimes an appeal will be successful.But that's not going to be a solution in all circumstances.

If the hospital does not wish to appeal a payor's decision on inpatient vs. observation status, but simply go along with their instruction to bill an observation stay, we recommend documenting the payer's instructions clearly in the account notes.

Ask for the instruction and the basis for their denial of inpatient status in writing, if you haven't been given that much. If the instruction came to the hospital verbally, i.e. over a phone call, document who the payer representative was and what they told the billers to do. If possible, confirm any verbal instructions with a follow-up email to the payer.

BILLING OBSERVATION AT THE PAYER'S DIRECTION

For example:

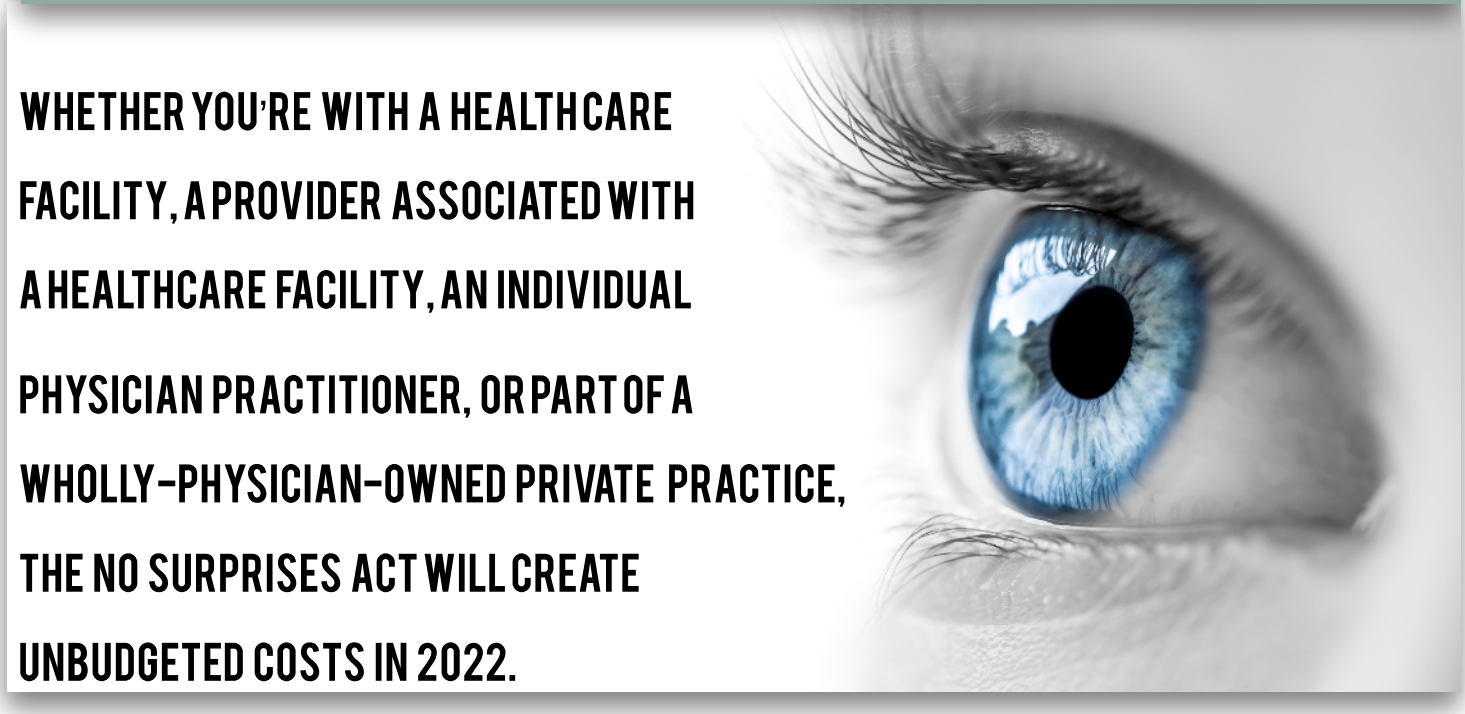
> "Per our conversation with [name of payer rep] today, [Payer Name] will not cover the subject account as an inpatient stay.Your instructions are to change the patient status to observation care, even though our medical record does not contain an order for observation care. Consequently, we will submit a new claim converting the hours of inpatient care to observation care reported under revenue code 0762 with HCPCS G0378. Please let me know if we have misunderstood any part of your requirements to obtain payment for the services we originally reported as an inpatient stay."

The Medicare Claims Processing Manual explains how a hospital may report observation hours for the period of an inpatient stay that precedes a physician's order for observation care when the hospital determines a change to observation status is appropriate, prior to discharge (condition code 44.)In short, it says the hospital can bill a charge for the inpatient hours preceding an observation order under revenue code 0762 *without a HCPCS*:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c01.pdf

> **50.3.2 - Policy and Billing Instructions for Condition Code 44**
>
> (Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD10; ASC X12: November 4, 2014)
>
> ...
>
> While hospitals may not report observation services under HCPCS code G0378 for the time period during the hospital encounter prior to a physician's order for observation services, in Condition Code 44 situations, as for all other hospital outpatient encounters, hospitals may include charges on the outpatient claim for the costs of all hospital resources utilized in the care of the patient during the entire encounter. For example, a beneficiary is admitted as an inpatient and receives 12 hours of monitoring and nursing care, at which point the hospital changes the status of the beneficiary from inpatient to outpatient and the physician orders observation services, with all criteria for billing under Condition Code 44 being met. On the outpatient claim on an uncoded line with revenue code 0762, the hospital could bill for the 12 hours of monitoring and nursing care that were provided prior to the change in status and the physician order for observation services, in addition to billing HCPCS code G0378 for the observation services that followed the change in status and physician order for observation services. For other rules related to billing and payment of observation services, see chapter 4, section 290 of this mmanual, and Pub.100-02, Medicare Benefit Policy Manual, chapter 6, Section 20.6.

CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED



While some provisions of the NSA are not being enforced in 2022, the requirement to present a Good Faith Estimate (GFE) to an uninsured (or self-pay) individual is being enforced. HHS estimates that it will take an average of one hour for a business operations specialist to determine a patient's insurance status, inform uninsured (or self-pay) individuals of their right to receive a GFE of expected charges, and provide a GFE. CMS published a report on the estimated costs for providers.

The report can be found at this link: [CMS-10791 | CMS]

Supporting Statement—Part A
Requirements Related to Surprise Billing; Part II
CMS-10791/OMB control number-
1210-0169

A. Background

On December 27, 2020, the Consolidated Appropriations Act, 2021 (CAA), which includes the No Surprises Act, was signed into law. The No Surprises Act provides Federal protections against surprise billing and limits out-of-network cost sharing under many of the circumstances in which surprise bills arise most frequently.

CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED

Within the Supporting Statement, Medicare provides tables which offer an example of some of the costs and burdens associated with providing a GFE. Here are a couple of examples:

TABLE 2: Estimated One-Time and Hour Burden for Providers Associated with Facilities to Enter into Agreements to Provide Notice of Right to a Good Faith Estimate

Year	Estimated Number of Respondents	Estimated Number of Responses	Burden Per Response (Hours)	Total Burden (Hours)	Total Estimated Cost
2021	245,336	245,336	4	981,344	$91,770,384

HHS assumes that the associated facility will draft the notices informing uninsured (or self-pay) individuals of their right to receive a good faith estimate of expected charges. Information regarding the availability of good faith estimates for uninsured (or self-pay) individuals must be written in a clear and understandable manner and made available in accessible formats and in the language(s) spoken by

TABLE 5: Estimated One-Time Cost and Hour Burden for Individual Physician Practitioners to Draft and Post Notice of Good Faith Estimate Notice*

Year	Estimated Number of Respondents (Occupation Type)	Estimated Number of Responses	Burden Per Response (Hours)	Total Annual Burden (Hours)	Printingand MaterialCosts	Total Estimated Cost
2021	145,887(All Physicians)	145,887	2.5	364,717	$14,589*	$61,797,674
2021	116,709** (Additional burden for Subset of Physicians with Websites)	116,709	1	116,709	-	$13,278,038
Total	-	-	3.5	481,426	-	$75,075,712***

*HHS estimates that 80 percent (116,709) of individual physician practitioners have a website. Therefore, estimated cost includes computer programming cost to update individual physician practitioners' websites with right to good faith estimate notice to uninsured (or self-pay) individuals. HHS assumes that each individual physician practitioner will incur a printing cost of $0.05 per page and materials for a total equivalent cost of $0.10. Total printing and material costs of $14,589 are included.

**Note that the 116,709 computer programmers are accounted for in the total number of 145,887 individual physician practitioners that must comply with the requirement.

*** This is calculated as the sum of $75,075,712(cost for individual physician practitioners to draft notice of right to GFE) + $13,278,038 (cost for computer programmers to post notice of right to

CMS ESTIMATES BURDEN OF PROVIDING GFE TO UNINSURED

The **PARA Data Editor** offers a feature to enable **ParaRev** clients to create estimates and print the documents required for compliance with the new rules. The knowledgeable **ParaRev** team can get your staff educated and up-to-date on the provisions of the NSA which are being enforced in 2022 so you can be compliant.

ParaRev is developing further enhancements to assist clients with additional No Surprises Act requirements which will be enforced in 2023. Providers will be required to work with facilities to provide one consolidated GFE for scheduled services to the uninsured (or self-pay) individual.

In addition, new rules which require all health care providers (facilities and practitioners) to provide a GFE to the individual's health plan will be enforced in 2023. This will allow the plan to send an advanced EOB to the insured individual. The GFE and Advanced EOB will be provided to all insured individuals regardless of contract status between the plan and provider.

Contact one of **ParaRev's Account Executives** for more information about the NSA tool available to cut labor costs when providing estimates to individuals or health plans.

Violet-Archuleta-Chiu
Senior Account Executive

800.999.3332 X219

Sandra LaPlace
Account Executive

800.999.3332 X225

NEW HCPCS FOR CMS ONCOLOGY CARE MODEL

CMS has released a new HCPCS to become effective July 1, 2022 to facilitate payments to medical practices participating in the "Oncology Care Model" (OCM), a new program under the CMS Innovation Center.The payment rate for the new HCPCS, G9678, has not yet been announced.

HCPC	LONG DESCRIPTION
G9678	Oncology care model (OCM) monthly enhanced oncology services (MEOS) payment for OCM enhanced services. G9678 payments may only be made to OCM practitioners for OCM beneficiaries for the furnishment of enhanced services as defined in the OCM participation agreement

Under the OCM, physician practices have entered into payment arrangements that include financial and performance accountability for episodes of care surrounding chemotherapy administration to cancer patients.The practices participating in OCM have committed to providing enhanced services to Medicare beneficiaries such as care coordination, navigation, and national treatment guidelines for care.

CMS is also partnering with commercial payers in the model.The 5 participating payers are:

- Aetna
- BlueCross BlueShield of South Carolina
- Cigna Life & Health Insurance Company
- Priority Health
- The University of Arizona Health Plan

Details regarding participation in the OCM are available on the CMS Innovation Center webpage at the link below:

https://innovation.cms.gov/innovation-models/oncology-care

CMS CORRECTS PART-B ONLY CAH CLAIMS PROCESSING

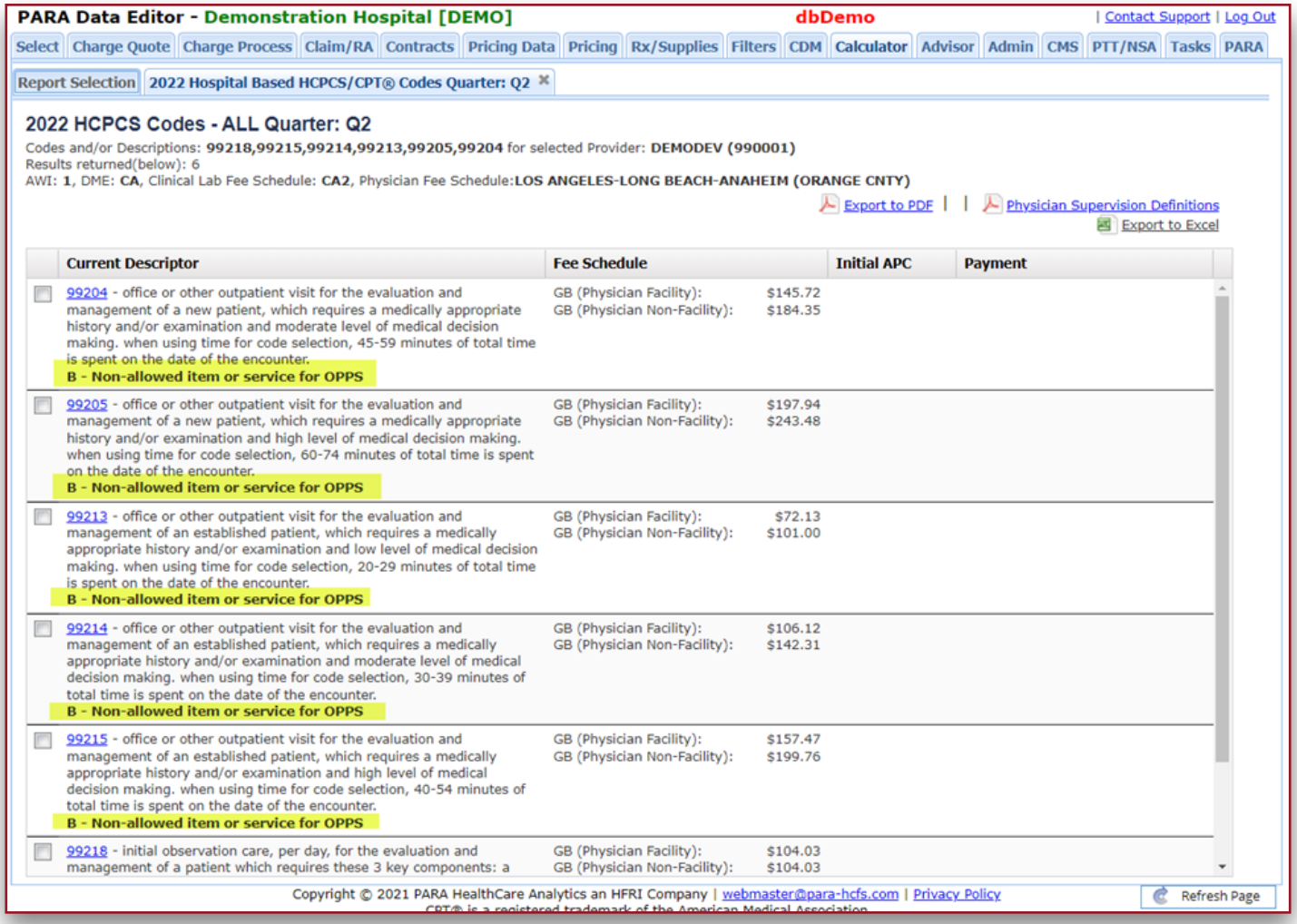
Medicare recently published Change Request 12636 directing Medicare Administrative Contractors to correct reimbursement processing for Critical Access Hospital (CAH) claims billed on Type of Bill (TOB) 12X for inpatient care provided to a beneficiary with Part B coverage only.

The MACs are not required to change claims processing, however, until October 1, 2022.The Change Request instructs contractors to allow payment for CAH ancillary services, including status B facility fees, using the reasonable cost (percent of charges) methodology.

The Change Request indicates that CAHs may have been improperly denied reimbursement for certain facility fee HCPCS billed on TOB 12X, specifically HCPCS which have been assigned OPPS Status Indicator B.

OPPS Status Indicator B codes can be valid for CAH claims, but are not recognized by OPPS when submitted on an outpatient OPPS hospital type of bill 12x or 13x. Typically, status B codes are not eligible for OPPS hospital claims because an alternate code may be reported (such as G0463 -HOSPITAL OUTPATIENT CLINIC VISIT FOR ASSESSMENT AND MANAGEMENT OF A PATIENT) for facility fees.Medicare permits CAHs to report OPPS status B HCPCS for facility fees.

Here are a few HCPCS examples:



PARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Support | Log Out

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx/Supplies | Filters | CDM | Calculator | Advisor | Admin | CMS | PTT/NSA | Tasks | PARA

Report Selection | 2022 Hospital Based HCPCS/CPT® Codes Quarter: Q2

2022 HCPCS Codes - ALL Quarter: Q2

Codes and/or Descriptions: **99218,99215,99214,99213,99205,99204** for selected Provider: **DEMODEV (990001)**
Results returned(below): 6
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:**LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)**

Export to PDF | Physician Supervision Definitions | Export to Excel

Current Descriptor	Fee Schedule		Initial APC	Payment
99204 - office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 45-59 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$145.72 $184.35		
99205 - office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 60-74 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$197.94 $243.48		
99213 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. when using time for code selection, 20-29 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$72.13 $101.00		
99214 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 30-39 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$106.12 $142.31		
99215 - office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. **B - Non-allowed item or service for OPPS**	GB (Physician Facility): GB (Physician Non-Facility):	$157.47 $199.76		
99218 - initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: a	GB (Physician Facility): GB (Physician Non-Facility):	$104.03 $104.03		

Copyright © 2021 PARA HealthCare Analytics an HFRI Company | webmaster@para-hcfs.com | Privacy Policy
CPT® is a registered trademark of the American Medical Association

Refresh Page

CMS CORRECTS PART-B ONLY CAH CLAIMS PROCESSING

Medicare's Change Request instructs MACs to pay CAH claims for OPPS status B ancillary *facility* services at 101% of the reasonable cost of those service – in other words, on the percent-of-charges methodology otherwise applicable to most covered CAH outpatient facility fees.

(The instruction points out that professional fees billed by a CAH on the UB/837iunder revenue codes 096x, 097x, or 098x are paid under the Medicare Physician Fee Schedule – there is no change to claims processing for professional fees.)

Furthermore, Medicare stipulated that "Medicare contractors should not search their files to retroactively pay claims. However, contractors shall adjust claims brought to their attention."

The CAH ancillary service(s) TOB 12x must include the appropriate revenue codes to distinguish facility fees from professional fees. Most covered facility fees services on a CAH TOB 012X should be paid at 101 percent of the reasonable costs of the services. There are a few exceptions, such as mammography, which are paid under the Medicare Physician Fee Schedule when billed by a CAH or OPPS facility.

Consequently, this new guidance indicates that some Part-B only claims on TOB 012X may have been short paid due to improper line-item denials.

A link and an excerpt from the transmittal is provided below:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11339otn

Critical Access Hospitals which have submitted Part B-Only inpatient claims on TOB 12X should keep an eye on reimbursement and resubmit the claim for corrected processing after 10/1/2022.

EFFECTIVE DATE: October 1, 2022 - Unless otherwise specified, the effective date is for claims processed on or after CR implementation.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022

I. GENERAL INFORMATION

A. Background: Medicare allows for ancillary services when provided in a CAH. CAH ancillary services are submitted on a TOB 12X and based on 101 percent of reasonable costs like TOB 85x, excluding professional services that are separately billable by the performing clinician. It has been brought to CMS' attention when a CAH submits a TOB 12x no-reimbursement is being made for all ancillary services which have a pricing indicator 'B'.

This change request instructs contractors to allow for CAH ancillary services at reasonable cost when appropriate. The CAH ancillary service(s) TOB 12x should include the appropriate revenue codes. For facility services, not including physician or other practitioner services, payment will be based on 101 percent of the reasonable costs of the services. Services are paid based on the Medicare Physician Fee Schedule only when the physician or other practitioner has reassigned their benefits, and should be billed on TOB 85x with the appropriate Healthcare Common Procedure Coding System (HCPCS) code and revenue codes of 096x, 097x or 098x.

The Part A Medicare Administrative Contractor will not correct the claim payment unless brought to their attention:

12636.2	Medicare contractors should not search their files to retroactively pay claims. However, contractors shall adjust claims brought to their attention.

HOSPITAL ED VISIT DOCUMENTATION

AN AUDIT OF OUTPATIENT HOSPITAL CLAIMS SERVES AS A REMINDER THAT FACILITY DOCUMENTATION FOR AN ED VISIT CHARGE IS ALWAYS REQUIRED, EVEN IF THE ED VISIT IS PERFUNCTORY.

If an ED visit is charged, the record must support that an evaluation was performed, even (and perhaps especially) when the patient complaint requires a specific service such as unscheduled outpatient dialysis. Some ESRD patients cannot or will not always comply with their scheduled dialysis procedures at an ESRD provider. Patients who miss one or more scheduled dialysis procedures may become ill and seek an unscheduled outpatient dialysis procedure by visiting the emergency department at a non-ESRD provider.

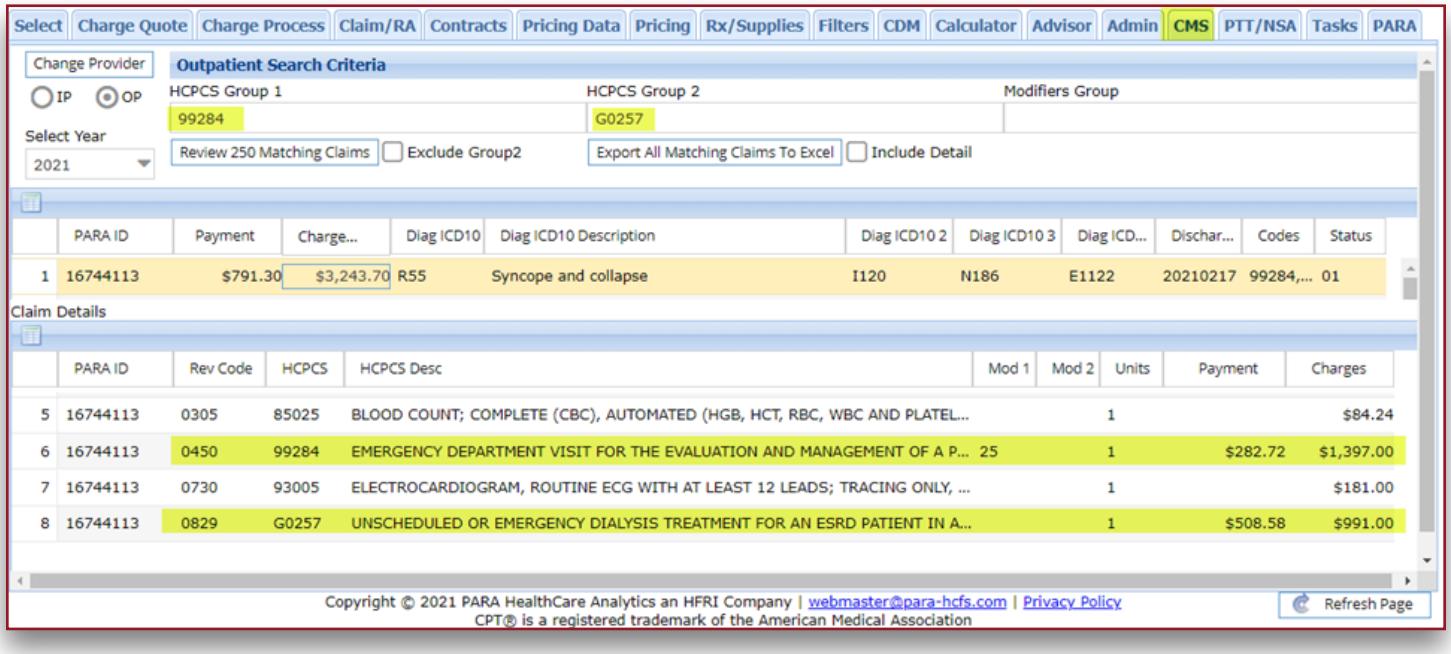
The Health and Human Services (HHS) Office of the Inspector General (OIG) audited a community hospital in the Midwest and found three emergency department visits were insufficiently documented, resulting in recoupment of overpayments.The ED visits were billed with unscheduled outpatient dialysis (G0257.)

HOSPITAL ED VISIT DOCUMENTATION

https://oig.hhs.gov/oas/reports/region5/51800045.pdf

> " … The Hospital incorrectly billed Medicare for 4 of the 20 outpatient claims that we reviewed. For these four outpatient claims, review of the medical records showed that the Hospital incorrectly billed Medicare for evaluation and management services that were not substantiated by the medical records. Three of these patients were presented to the emergency room for dialysis treatment, and no other conditions were treated or discussed, but the hospital incorrectly billed for evaluation and management that were not provided according to the medical records."

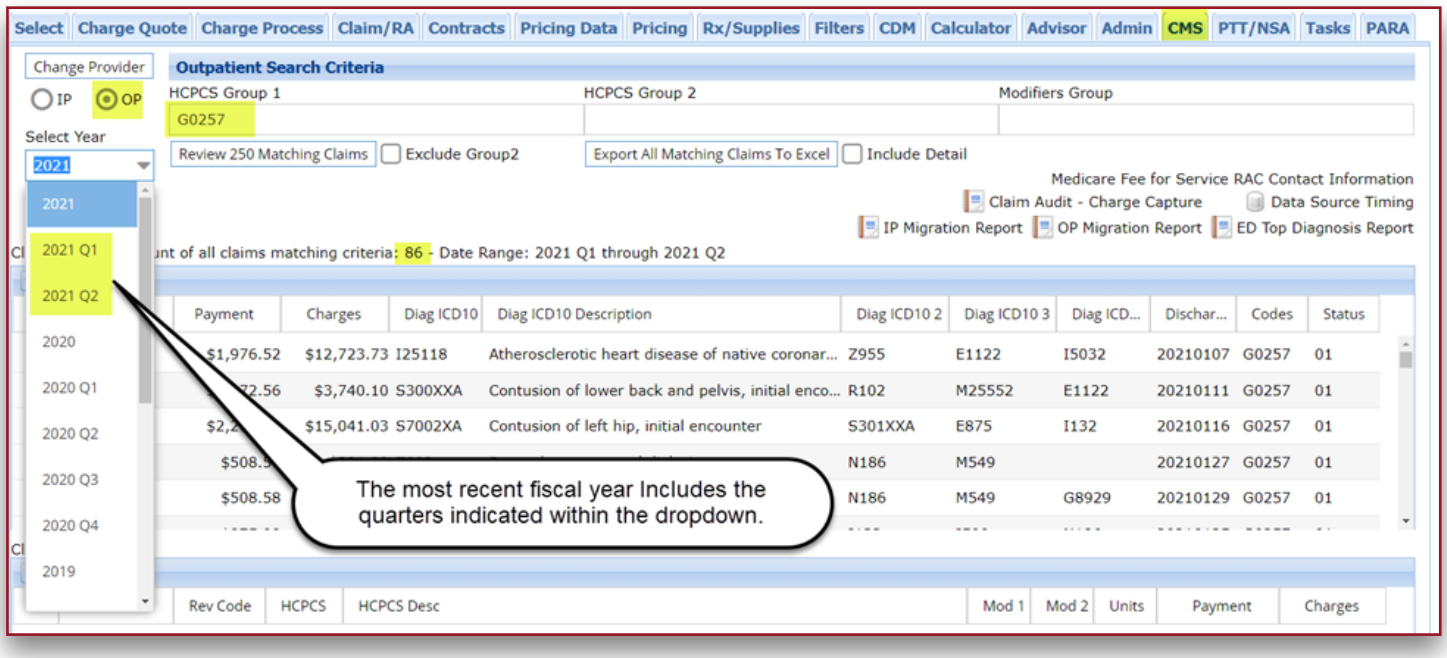
The **PARA Data Editor** CMS tab offers hospitals the ability to query outpatient Medicare claims data reported during a prior period. Data on the CMS tab can be searched to find claims which report an ED visit and an unscheduled dialysis procedure – an example is displayed below:



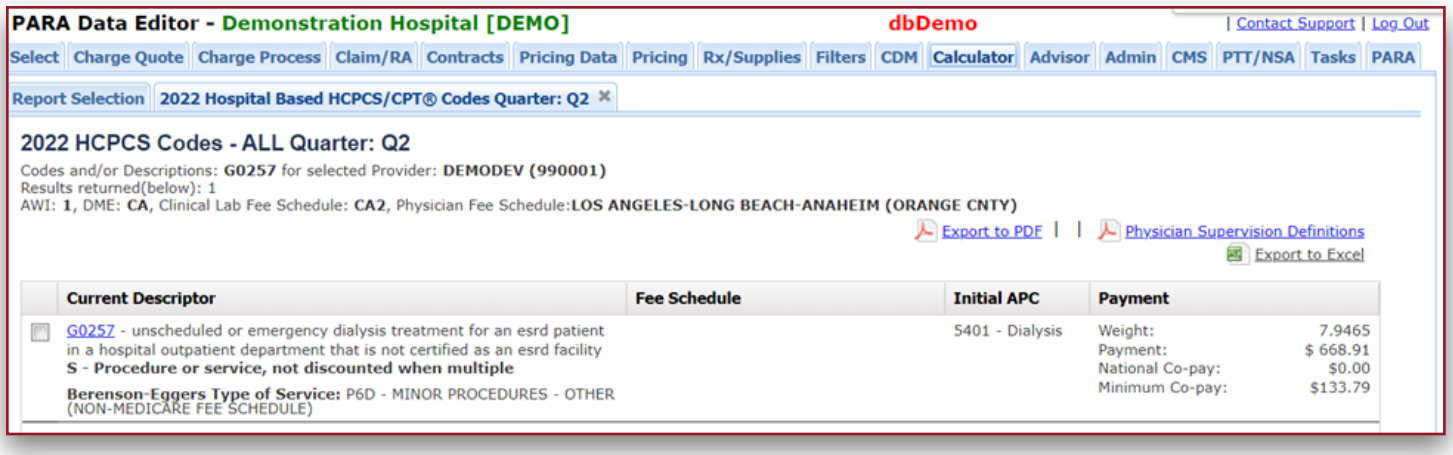
The hospital has taken corrective action in response to the audit. More recent data available on the CMS tab indicates that the audited hospital has changed its billing practices since the audited period, which covered January 1, 2016 through December 31, 2017. The percentage of claims for G0257 reported together with an ED visit in 2018 was 76%, but that percentage had dropped to 36% during the first six months of 2021, although the total count of claims for unscheduled dialysis remained relatively constant.

Medicare covers outpatient dialysis to treat an ESRD patient outside of the patient's scheduled dialysis program, but if an ED visit is also reported, the hospital medical records must support the emergency department evaluation and management charge. If the ED visit is perfunctory, and an evaluation and management code is not fully documented, the E&M code is not separately reportable.

HOSPITAL ED VISIT DOCUMENTATION



The audit discovered overpayments of only $853 in the audit period (January 1, 2016 through December 31, 2017), but the results of that sample were extrapolated across all payments received for unaudited claims during the audit period, resulting in a recoupment demand of a much larger value. **ParaRev** clients can use the **PARA Data Editor** CMS tab to evaluate the frequency at which their facility reported G0257 to Medicare using the CMS tab of the **PARA Data Editor**. The report will return the count of claims reported within the period indicated.Enter G0257 in the HCPCS Group 1 field, as indicated below – each claim may be examined to identify other services reported and reimbursed:



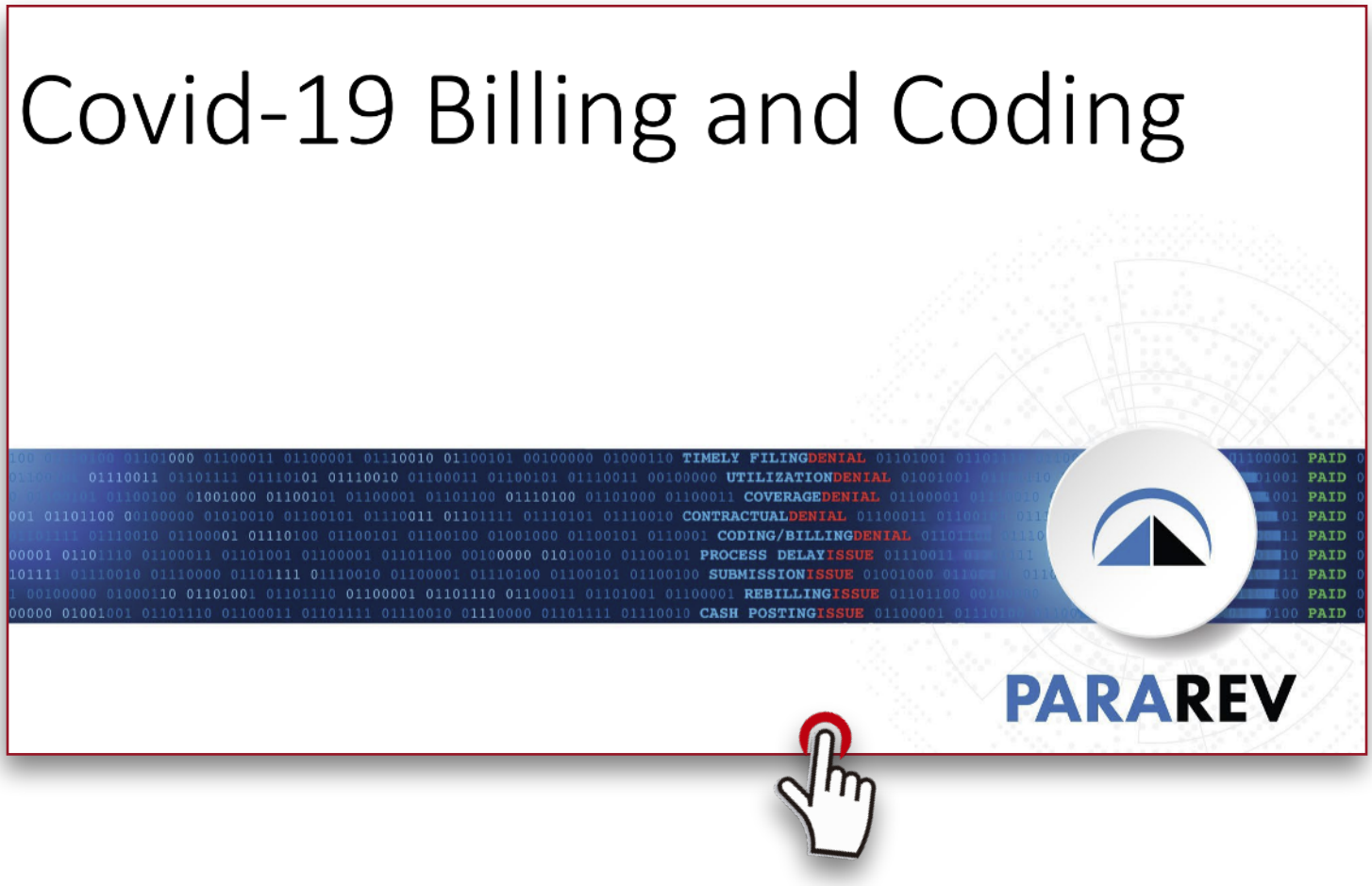
Claims data on the **PARA Data Editor** CMS tab are scrubbed of all protected health information, such as account ID and patient name, but accurately reflect the charges, ICD10s, and date of discharge.

NEW PRESENTATION: COVID-19 BILLING AND CODING DETAILED GUIDANCE

ParaRev has created a new, informative presention filled with details on the proper and effective COVID-19 billing and coding.

And, now it's here for you to download and review.

Then contact one of our Account Executives for more information and details on how ParaRev can help.



NEW UPDATE

RARC CODES RELATED TO THE NO SURPRISES ACT

Under HIPAA, all payers, including Medicare, are required to use claims adjustment reason codes (CARCs) and remittance advice remark codes (RARCs) approved by X12 recognized code set maintainers, instead of proprietary codes to explain any adjustment in the claim payment.

RARCs are used to provide additional explanation for an adjustment already described by a CARC or to convey information about remittance processing. The following RARCs related to the No Surprises Act have been approved by the RARC Committee and were effective as of March 1, 2022

The No Surprises Act Provisions that Apply to the Claim	
RARC #	RARC Text
N864	Alert: This claim is subject to the No Surprises Act provisions that apply to emergency services.
N865	Alert: This claim is subject to the No Surprises Act provisions that apply to nonemergency services furnished by nonparticipating providers during a patient visit to a participating facility.
N866	Alert: This claim is subject to the No Surprises Act provisions that apply to services furnished by nonparticipating providers of air ambulance services.
How Cost Sharing Was Calculated under the No Surprises Act	
RARC #	RARC Text
N862	Alert: Member cost share is in compliance with the No Surprises Act, and is calculated using the lesser of the QPA or billed charge.
N867	Alert: Cost sharing was calculated based on a specified state law, in accordance with the No Surprises Act.
N868	Alert: Cost sharing was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.
N869	Alert: Cost sharing was calculated based on the qualifying payment amount, in accordance with the No Surprises Act.
N870	Alert: In accordance with the No Surprises Act, cost sharing was based on the billed amount because the billed amount was lower than the qualifying payment amount.
Initial Payment Amount	
RARC #	RARC Text
N871	Alert: This initial payment was calculated based on a specified state law, in accordance with the No Surprises Act.
N877	Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate.
Final Payment Amount	
RARC #	RARC Text
N863	Alert: This claim is subject to the No Surprises Act (NSA). The amount paid is the final out-of-network rate and was calculated based on an All Payer Model Agreement, in accordance with the NSA.

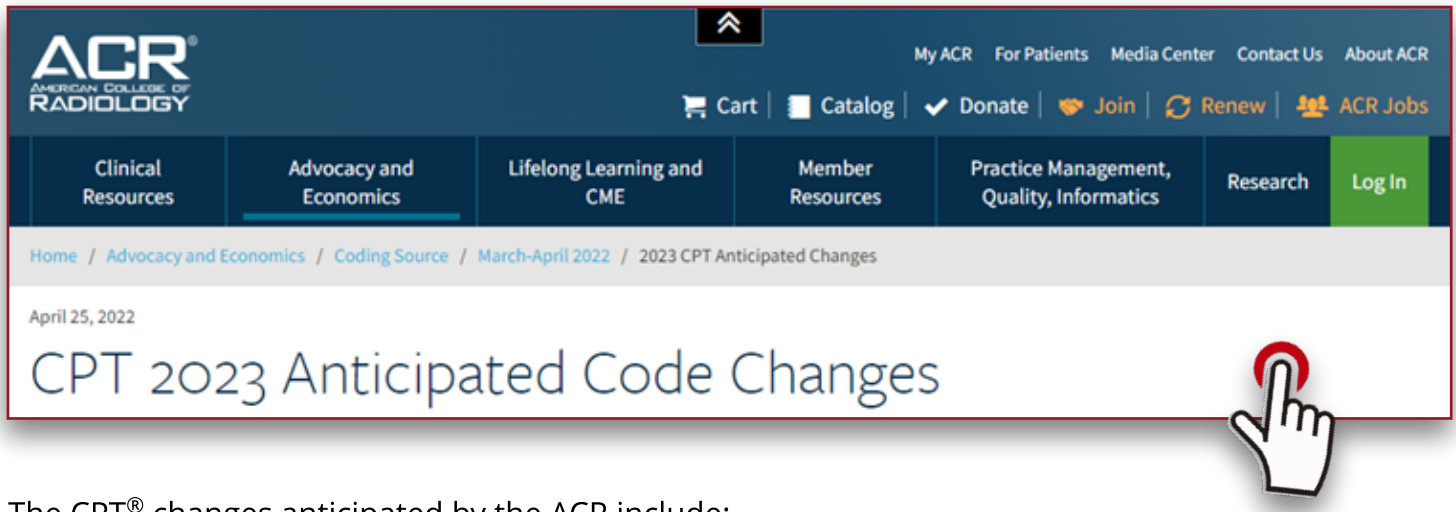
RARC CODES RELATED TO THE NO SURPRISES ACT

N872	Alert: This final payment was calculated based on a specified state law, in accordance with the No Surprises Act.
N873	Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.
N874	Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act.
N875	Alert: This final payment equals the amount selected as the out-ofnetwork rate by a Federal Independent Dispute Resolution Entity, in accordance with the No Surprises Act.
Denial of Payment	
RARC #	RARC Text
N876	Alert: This item or service is covered under the plan. This is a notice of denial of payment provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost sharing.
Notice and Consent	
RARC #	RARC Text
N878	Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, but notice and consent was not provided and obtained in a manner consistent with applicable Federal law. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.
N879	Alert: The notice and consent to balance bill, and to be charged out-ofnetwork cost sharing, that was obtained from the patient with regard to the billed services, is not permitted for these services. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.
Miscellaneous	
RARC #	RARC Text
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).
N859	Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).

ACR REPORTS 2023 ANTICIPATED CODE CHANGES

The *ACR Radiology Coding Source*™section of the American College of Radiology website offers a narrative of anticipated coding changes in both radiology and evaluation and management CPT® codes for 2023. The article is available at the following link:

https://www.acr.org/Advocacy-and-Economics/Coding-Source/March-April-2022/2023-CPT-Anticipated-Changes



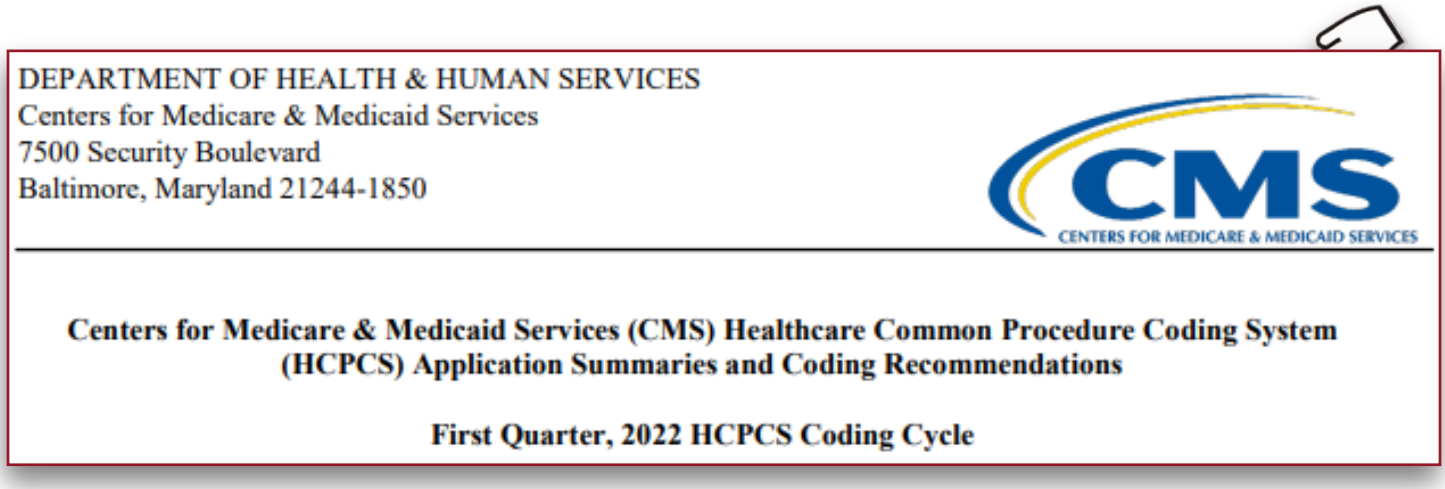
The CPT® changes anticipated by the ACR include:

- New Category I codes for percutaneous arteriovenous fistula creation and neuromuscular ultrasound
- Category III codes which will be released on July 1, 2022 for CT Tissue Characterization (formerly 0689T and 0690T) and Quantitative Magnetic Resonance Cholangiopancreatography (MRCP)
- Revision of the E/M Services Guidelines to reflect changes to the Inpatient and Observation Care Services, Consultations, Emergency Department Services, Nursing Facility Services, Home and Residence Services, and Prolonged Services subsections
- Revised codes for somatic nerve injections, pulmonary angiography, and paravertebral spinal nerves and branches.

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

CMS ISSUED A DOCUMENT REPORTING HCPCS CODING DECISIONS IN RESPONSE TO MANUFACTURER APPLICATIONS FOR NEW CODE ASSIGNMENT EACH QUARTER. THE FIRST QUARTER 2022 REPORT INCLUDES A NUMBER OF HCPCS FOR DRUGS AND BIOLOGICS, WHICH WILL BECOME EFFECTIVE JULY 1, 2022.

https://www.cms.gov/files/document/2022-hcpcs-application-summary-quarter-1-2022-drugs-and-biologicals.pdf



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations

First Quarter, 2022 HCPCS Coding Cycle

A summary of the decisions is provided below in three sections – Medicine, Wound Care, and Radiopharmaceuticals.

Medicine

- **FYARRO®** -- which is currently reported with temporary HCPCS C9091, will be assigned HCPCS J9331 – "Injection, sirolimus protein-bound particles, 1 mg." This drug is used to treat advanced unresectable or metastatic malignant perivascular epithelioid cell tumor (PEComa)

- **LEQVIO®** -- will be assigned HCPCS J1306 – Injection, inclisiran, 1 mg. LEQVIO® is indicated as an adjunct to diet and maximally tolerated statin therapy for the treatment of adults with heterozygous familial hypercholesterolemia (HeFH)] or clinical atherosclerotic cardiovascular disease (ASCVD), who require additional lowering of low-density lipoprotein cholesterol (LDL-C)

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

- **SUSVIMO™**, an intraocular injection used to treat patients with age-related macular degeneration, will be assigned two HCPCS, one for the injection, and another for the implant. The recommended dose of SUSVIMO™ is 2 mg (0.02 mL of 100mg/mL solution) continuously delivered via the SUSVIMO™ ocular implant with refills administered every 24 weeks (approximately 6 months). The new HCPCS are: J2779 "Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg", and C9093 "Injection, ranibizumab, via intravitreal implant (susvimo), 0.1 mg"

- **RYPLAZIM®**, which is indicated for the treatment of patients with plasminogen deficiency type 1 (hypoplaminogenemia), will be assigned HCPCS J2998 "Injection, plasminogen, human-tvmh, 1 mg". Apparently this medication is considered a self-administered drug unless delivered by IV infusion; modifier JA "administered intravenously" must be appended when delivered by IV infusion to qualify for Medicare coverage

- **XIPERE™** (Triamcinolone acetonide) is a synthetic glucocorticoid (glucocorticoids are often referred to as corticosteroids) with immunosuppressive and anti-inflammatory activity. The newly assigned HCPCS will be J3299 "Injection, triamcinolone acetonide (xipere), 1 mg"

- **VYVGART™**, is indicated for the treatment of adult patients with generalized myasthenia gravis who are anti-acetylcholine receptor antibody positive. This drug may have been reported with miscellaneous/unclassified codes previously. The newly assigned HCPCS is J9332 "Injection, efgartigomod alfa-fcab, 2 mg"

- **cutaquig®**, which prevents infections of a wide variety of bacterial and viral agents in immunodeficient adults by temporarily restoring IgG levels in circulating plasma, will be assigned HCPCS J1551, "Injection, immune globulin (cutaquig), 100 mg"

- **TEZSPIRE™** is an add-on maintenance treatment of adult and pediatric patients aged 12 years and older with uncontrolled asthma while receiving treatment with medium- or high-dose inhaled corticosteroids (ICS) plus at least one additional controller medication with or without oral corticosteroids (OCS). The newly assigned HCPCS will be J2356, "Injection, tezepelumab-ekko, 1 mg"

- **APRETUDE**, which reduces the risk of sexually acquired HIV-1 infection, is an intramuscular injection kit that must be administered by a healthcare provider. The new HCPCS assigned by CMS will be J0739, "Injection, cabotegravir, 1 mg".

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

Skin Substitutes and Wound Care Products

- **Celera™ Dual Membrane and Celera™ Dual Layer** skin substitutes will be assigned new HCPCS Q4259 "Celera dual layer or celera dual membrane, per square centimeter." Previously, this product may have been reported with Q4100 "Skin Substitute, Not Otherwise Specified."

- **Signature APatch**, a wound protection barrier/cover will be assigned HCPCS Q4260 "Signature APatch, per square centimeter"

- **TAG,** a wound protection barrier/cover, will be assigned HCPCS Q4261, "Tag, per square centimeter".

Radiopharmaceuticals

- **Illucix®**, a radioactive prostate cancer PET imaging product, will be assigned HCPCS A9596 "Gallium ga-68 gozetotide, diagnostic, (illuccix), 1 millicurie". Providers using this agent in PET scans are hopeful that the new HCPCS will offer better reimbursement for this expensive radiopharmaceutical. (The payment status will be announced with the next update to the OPPS Addendum B, expected in June, 2022.)

- **TAUVID™**, a radioactive diagnostic agent used in PET imaging of the brain to evaluate patients for Alzheimer's disease will be assigned HCPCS A9601 "Flortaucipir f 18 injection, diagnostic, 1 millicurie"

CMS ANNOUNCES NEW HCPCS EFFECTIVE JULY 1, 2022

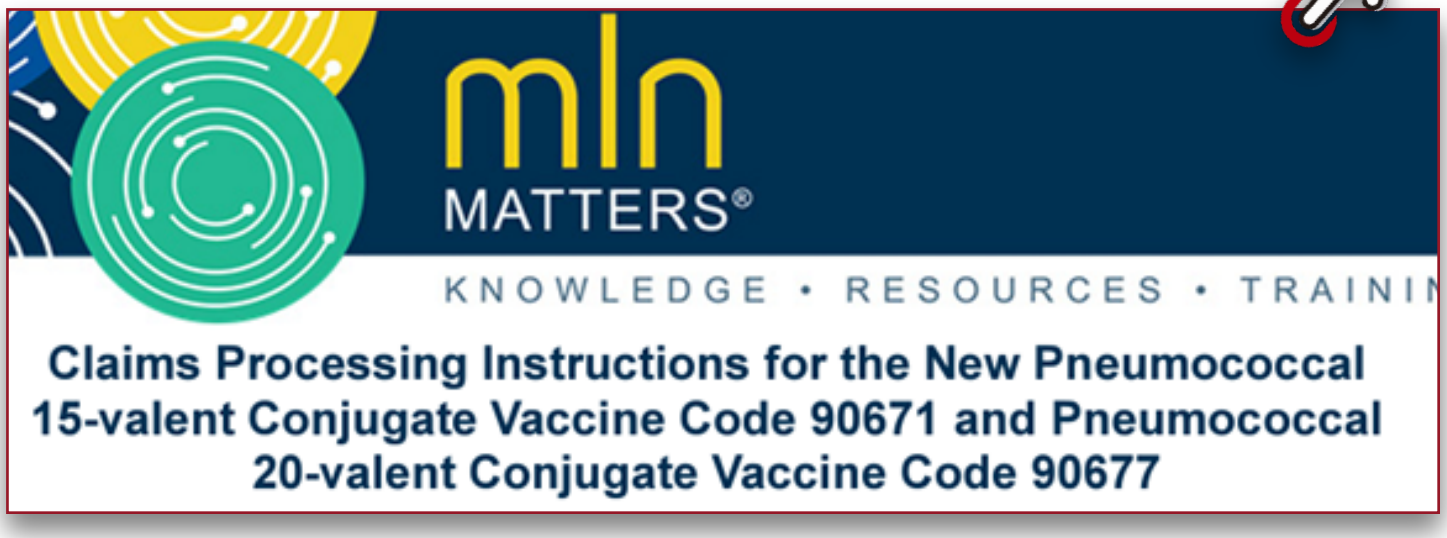
The CMS document also listed the applications for which it declined to assign a HCPCS for various reasons:

- **RETHYMIC®** - used only in inpatient settings
- **Lidocidex™** - a compounded drug (CMS does not issue HCPCS for compounded drugs)
- **Cocoon Dual-Layer and Single-Layer Membranes** – due to differences in the HCPCS application and information submitted to the FDA
- **PalinGen® Dual Layer Membranes** are dehydrated, human allografts derived from the placenta – due to differences in the HCPCS application and information submitted to the FDA
- **Esano AAA**, a triple layer decellularized, dehydrated human amniotic membrane allograft for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **Sanopellis** are dehydrated, human allografts derived from the placenta for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **3L Biovance® Tri-Layer and 3L Biovance®**, a human amniotic membrane allograft for wound care, due to differences in the HCPCS application and information submitted to the FDA
- **Pemetrexed**, a single agent in the treatment of locally advanced and metastatic non-squamous non-small cell lung cancer, due to an incomplete HCPCS application.

CMS ADDS HCPCS FOR NEW PNEUMOCOCCAL, HEP B VACCINES

The MLN article for the pneumococcal vaccines is available at the following link:

https://www.cms.gov/files/document/mm12439-claims-processing-instructions-new-pneumococcal-15-valent-conjugate-vaccine-code-90671-and.pdf



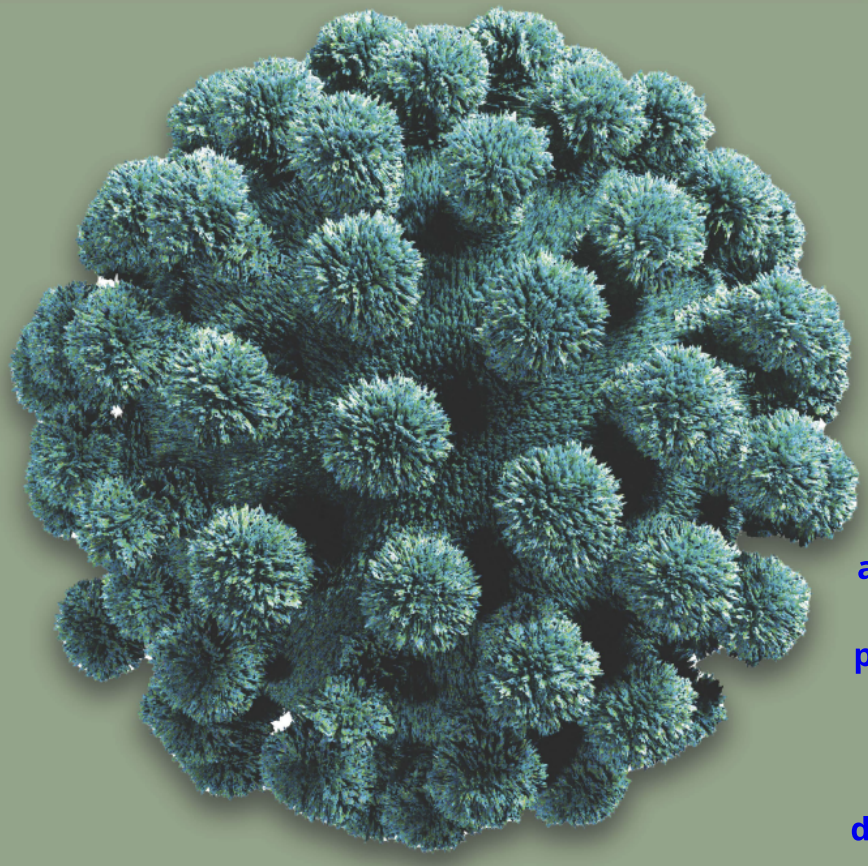
The transmittal which announced the hepatitis B vaccine is available at the following link (no MLN yet.)

https://www.cms.gov/files/document/r11322cp.pdf

Number	Requirement
12686.8	Contractors shall hold claims for Hepatitis B code 90759 with DOS January 11, 2022 thru July 4, 2022, received prior to July 5 , 2022. Contractors shall release held claims within 10 business days of the implementation.

UPDATED 3/15/22

2022 COMPREHENSIVE COVID-19 Guide



Click anywhere on this page to be taken to the full online document.

PARAREV

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, May 12, 2022

News

- Comprehensive Error Rate Testing Documentation Center Moved on April 13
- Physicians, Teaching Hospitals, Physician Assistants, & Advanced Practice Nurses: Open Payments Review & Dispute Ends May 15
- Ambulance Prior Authorization Model Expands June 1
- Clinical Laboratory Fee Schedule 2023 Preliminary Gapfill Rates: Submit Comments by July 11
- Medicare Cards Without Full Names
- CMS Releases Chronic Pain Experience Journey Map
- Biosimilars Curriculum: Resources for Teaching Your Students
- Women's Health: Talk to Your Patients About Preventive Services

Compliance

- Home Health Low Utilization Payment Adjustment Threshold: Bill Correctly

Events

- HCPCS Public Meeting — June 7–10

MLN Matters® Articles

- Calendar Year 2023 Modifications/Improvements to Value-Based Insurance Design (VBID) Model – Implementation
- Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as Certain Colorectal Cancer Screening Tests
- National Coverage Determination (NCD) 210.14 Reconsideration – Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)
- Quarterly Update for Clinical Laboratory Fee Schedule (CLFS) and Laboratory Services Subject to Reasonable Charge Payment
- Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)
- Mental Health Visits via Telecommunications for Rural Health Clinics & Federally Qualified Health Centers — Revised
- Affordable Connectivity Program Lowers Cost of Broadband Services for Eligible Households

TRANSMITTALS

7

There were SEVEN new or revised Transmittal released this week.

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

TRANSMITTAL R1121OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11421	**Date: May 17, 2022**
	Change Request 12647

Transmittal 11340, dated April 7, 2022, is being rescinded and replaced by Transmittal 11421, dated, May 17, 2022 to revise section A of the supporting information portion of the business requirements adding CWF and FISS edit information. All other information remains the same.

SUBJECT: Updates to Current Inpatient Claim Edits

I. SUMMARY OF CHANGES: This instruction updates current Skilled Nursing Facility (SNF) edits to bypass services related to an emergency room encounter and there is also a 250 revenue code present on the same claim, which is currently being done by the Medicare Administrative Contractor (MAC). This CR also makes updates to certain duplicate edits since the implementation of SNF Patient Driven Payment Model (PDPM.). Finally, this CR will update an Inpatient Prospective Payment System (IPPS) edit to allow MACs to bypass after claims review.

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.

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.

TRANSMITTAL R11414CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11414	**Date: May 12, 2022**
	Change Request 12734

SUBJECT: Claims Processing Manual Update - Pub. 100-04 for Elimination of Certificates of Medical Necessity (CMNs) and Durable Medical Equipment Forms (DIFs)

I. SUMMARY OF CHANGES: The Purpose of this Change Request (CR), CMS is eliminating all remaining CMNs and DIFs effective for claims with dates of service on or after January 1, 2023. This is an update to the Pub. 100-04: Claims Processing manual explaining the planned change. Other Internet Only Manuals that include instructions on CMNs and DIFs will be updated independently.

EFFECTIVE DATE: June 13, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: June 13, 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	17/70 - Claims Processing Requirements - General
R	19/90 - DME General Information
R	20/10 - Where to Bill DMEPOS and PEN Items and Services
R	20/30 - General Payment Rules
R	20/50 - Payment for Replacement of Equipment
R	20/100 - General Documentation Requirements
R	22/60 - Remittance Advice Codes
R	24/50 - Technical Requirements
R	27/20 - Common Working File (CWF) Operations
R	36/50 - Special Billing Instructions for the DMEPOS Competitive Bidding Program
R	37/1.1.2 – Requirements for Processing VA Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Claims

TRANSMITTAL R11412OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11412	**Date: May 12, 2022**
	Change Request 10714

SUBJECT: User Enhancement Multi-Carrier System (MCS) - Update the Procedure Code File Maintenance Screen Movement Functionality

I. SUMMARY OF CHANGES: The A/B Medicare Administrative Contractors (MACs), Part B MACs have requested an enhancement to allow movement between multiple procedure code file maintenance screens through the use of the Program Function (PF) 2 key on a computer's keyboard.

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.

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 R11408CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11408	**Date: May 12, 2022**
	Change Request 12747

SUBJECT: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - July 2022 Update

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to amend the payment files, which were issued to contractors based upon the 2022 Medicare Physician Fee Schedule (MPFS) Final Rule. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.1.

EFFECTIVE DATE: July 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 5, 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
N/A	N/A

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

IV. ATTACHMENTS:

Recurring Update Notification

TRANSMITTAL R11411MSP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-05 Medicare Secondary Payer	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11411	**Date: May 12, 2022**
	Change Request 12687

SUBJECT: Automation of the Medicare Duplicate Primary Payment (DPP) Process

I. SUMMARY OF CHANGES: CMS and associated stakeholders designed and developed a new automated Duplicate Primary Payer (DPP) process. This instruction fully describes this process.

EFFECTIVE DATE: October 1, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 1, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & implementation)
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2022 - For CWF (requirements/coding/preliminary unit testing); for FISS (design/coding); for MCS (analysis/design/coding); for VMS (analysis & coding); January 3, 2023 - For CWF (testing/implementation); FISS (continued development/testing/implementation); MCS (continued coding/testing/implementation); and VMS (testing & 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)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/TOC
N	7/20/20.5.1 - Automation of the Duplicate Primary Payer (DPP) Process

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 R11409OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11409	**Date: May 12, 2022**
	Change Request 12239

SUBJECT: User Enhancement - Update the Multi-Carrier System (MCS) to Display the Full History of a Claims' Audit Trail Location

I. SUMMARY OF CHANGES: This Change Request (CR) is being issued to update the MCS to display the full history of a Medicare Part B claims' movement through the processing system, otherwise known as the claim audit trail location.

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.

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 R11413OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11413	**Date: May 12, 2022**
	Change Request 11590

SUBJECT: User CR: ViPS Medicare System (VMS) - Improve Transportation within VMS Subsystems

I. SUMMARY OF CHANGES: This change request will update various VMS subsystems to improve transportation and scrolling capabilities.

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

MEDLEARNS

1

There was ONE new or revised MedLearn released this week.

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

MEDLEARN SE22002

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Elimination of Certificates of Medical Necessity & Durable Medical Equipment Information Forms

MLN Matters Number: SE22002

Related Change Request (CR) Number: 12734

Article Release Date: May 12, 2022

Effective Date: June 13, 2022

Related CR Transmittal Number: R11414CP

Implementation Date: June 13, 2022

Provider Types Affected

This MLN Special Edition Article is for providers, suppliers, billers, and vendors who bill Durable Medical Equipment (DME) Medicare Administrative Contractors (MACs) for services and supplies they provide to Medicare patients.

Provider Action Needed

CMS is discontinuing Certificates of Medical Necessity (CMNs) and DME Information Forms (DIFs) effective January 1, 2023.

Make sure your billing and IT staff knows about these changes for CMNs and DIFs:

- For services on or after January 1, 2023: Don't submit CMN or DIF forms or their electronic claim data elements with the claims or we'll reject your claims and return them to you
- For services before January 1, 2023: Submit CMN and DIF forms or their electronic claim data elements with the claims if required

What You Need to Know

Originally, we required the CMN and DIF forms to help document medical necessity and other coverage criteria for selected DME. Suppliers got a signed CMN from the treating physician or created and signed a DIF to submit with the claim. Information from these forms is now available either on the claim or in the medical record.

We'll not accept CMNs and DIFs on claims for dates of service on or after January 1, 2023. If we get a claim with a date of service on or after January 1, 2023, we'll reject the claim and return it to you.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®