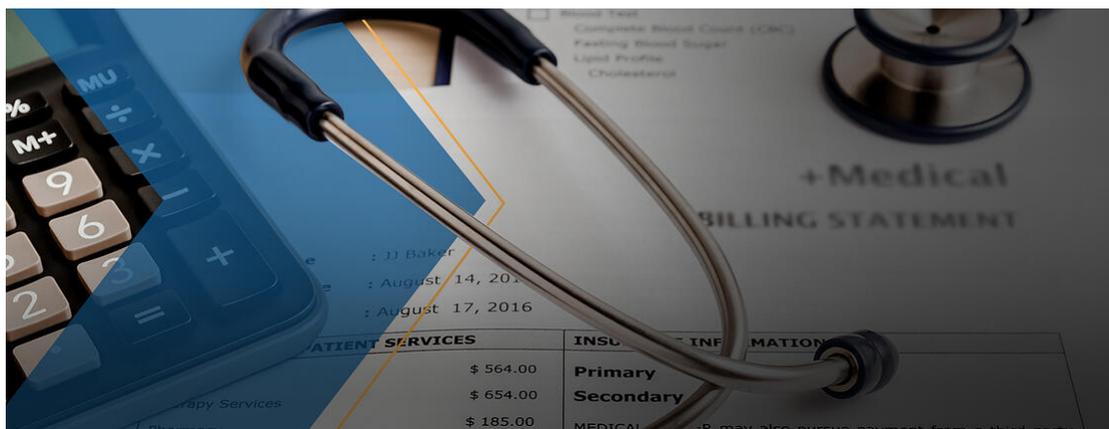


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2 Percent Medicare Sequestration Begins July 1, 2022

CMS has phased the sequestration back in with a 1 percent sequestration that began April 1, 2022, and the full 2 percent sequestration that began July 1, 2022. It is imperative that providers update their systems to reflect the proper sequestration beginning July 1. Any provider requiring assistance with this update may contact [Stefanie Knaub](#) or [Angela Briggs](#). The CMS MLN with this announcement can be read [here](#).

Health and Human Services Extends Public Health Emergency

Effective July 15, 2022, the Public Health Emergency related to COVID-19 was extended another 90 days with a new expiration date of October 13, 2022. The extension of the Public Health Emergency also extends the Qualifying Hospital Stay waiver and the 100-day benefit period waiver for another 90 days. Please note that there is a possibility that the blanket waivers could end prior to the end of the PHE. It is recommended to check the [CMS site](#) regularly for updates. The Declaration of the extension can be found [here](#).

Novitas Solutions: Claims Processing Issue Identified

Novitas Solutions has identified a claims processing issue related to cancel claims for 2022 dates of service. Cancel claims were posted to the Common Working File (CWF), causing SNFs to receive duplicate claim editing rejections (U5600) incorrectly. Novitas stopped posting canceled claims to the CWF on March 21, and they are working with FISS on a solution to the cancel claims that have already been posted. Providers can track the status of Novitas Solutions claims processing issues [here](#).

New Medicare Code Edit 20 for Unspecified Diagnosis Codes

CMS has implemented a new Medicare Edit 20 related to the usage of unspecified diagnosis codes. The new edit applies when you enter an unspecified diagnosis code that is:

- Either a Complication or Comorbidity, or Major Complication or Comorbidity
- Includes other codes in that code subcategory that further specify the anatomic site

This edit tells you that a more specific code is available to report. It's your responsibility to decide if a more specific code from that subcategory is available in the medical record documentation by a clinical provider.

Providers must use the claim Remarks Field to let Medicare know if:

- You can't get more information to find the laterality from the available medical record documentation by any other clinical provider.
- There's documentation in the record that the physician is clinically unable to decide the laterality because of the nature of the disease or condition.

Use the Remarks Field to specifically enter the following Remarks:

- **UNABLE TO DET LAT 1 (NTE*ADD*UNABLE TO DET LAT 1~in Loop 2300)** to show you're unable to get additional information to specify laterality
- **UNABLE TO DET LAT 2 (NTE*ADD*UNABLE TO DET LAT 2~in Loop 2300)** to show the physician is clinically unable to decide laterality

This language will let your MAC bypass the Edit 20 and process the claim. The official MLN Matters article can be found [here](#).

Questions about these updates? Need support to meet requirements?

Contact [Stefanie Knaub](#), RKL Senior Living Services Partner, at 717.590.8648.

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