



Health Regulatory Change Analyzer

Available on both our Cheetah and MediRegs platforms and as a standalone product, the Health Regulatory Change Analyzer can flexibly support increased accuracy and efficiency.

Analyze regulatory changes in healthcare with our new point-in-time solution

Healthcare regulatory requirements are highly complex and constantly changing. It can be difficult to determine what regulations and guidance were in place at any particular point in time and to keep on top of these evolving changes. Wolters Kluwer's new **Health Regulatory Change Analyzer** makes regulatory changes instantly visible: deleted text is redlined, and added text is displayed in green.

The **Health Regulatory Change Analyzer** provides a central location for health law and compliance professionals to efficiently monitor and understand changes to the Code of Federal Regulations (CFR) and the Centers for Medicare and Medicaid Services (CMS) Manuals.

Accelerate healthcare regulatory research

- Point-in-time functionality for federal regulations and CMS Manual changes
 - CFR changes are available dating back to 2009
 - CMS Manual changes are available from 2008 to present
- Simple to click through, browse, search or use the calendar to navigate changes
- Embed links into customer content or print redlined changes

For more information or to schedule a demonstration, call 866-529-6600 or visit WoltersKluwerLR.com/HRCA

Point-in-Time functionality identifies changes to health regulations so health law professionals at all experience levels can quickly audit and research these changes.

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Health Regulatory Change Analyzer

Viewing Search Results as of Oct 1, 2011

cms & c Search... Search Comparing Oct 1, 2011 with Oct 1, 2014

CONTENTS

- Subpart C—Basic Hospital Functions (482.21-482.45)
- 482.21 Condition of participation: Quality assessment and performance improvement program.
- 482.22 Condition of participation: Medical staff.**
- 482.23 Condition of participation: Nursing services.
- 482.24 Condition of participation: Medical record services.
- 482.25 Condition of participation: Pharmaceutical services.

482.22 Condition of participation: Medical staff.

The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which body and is responsible for the quality of medical care provided to patients by the hospital.

(a) Standard: Eligibility and process for appointment to Composition of the medical staff. The medical staff must be composed of doctors of medicine or osteopathy. In osteopathy and, in accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment may also be composed of other practitioners appointed by the governing body.

(1) The medical staff must periodically conduct appraisals of its members.

(2) The medical staff must examine the credentials of all eligible credentials of candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations. A candidate who has been recommended by the medical staff and who has been appointed by the governing body is

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Viewing Search Results as of Oct 1, 2018

cms & c Search... Search Comparing Oct 1, 2018 (v2) with Oct 1, 2014

CONTENTS

- 20 - Services Included in Part A PPS Payment Not Billable Separately by the SNF (Updated through Rev. 4001, Issued: 03/16/18, Effective: 06/19/18, Implementation: 06/19/18)
- 30 - Billing SNF PPS Services (Prior to Rev. 4077; Issued: 06/26/18; Effective: 10/01/18; Implementation: 10/01/18)
- 40 - Special Inpatient Billing Instructions (Prior to Rev. 4077; Issued: 06/26/18; Effective: 10/01/18; Implementation: 10/01/18)**

Manual, Chapter 25.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §80.4, for requirements SNFs must meet and A/B MACs (A) must monitor to continue PIP reimbursement. Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about completing the claim.

40.6 - Total and Noncovered Charges

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

PDF

(Rev. 1252, Issued: 05-25-07; Effective: 10-01-07; Implementation: 08-27-07)

The day of admission counts as a utilization day, except in the situation where the patient was admitted with the expectation that he remain overnight but was transferred to another participating provider before midnight of the instance, the first provider completes the bill as follows:

Identify when changes in regulations occurred over time, and understand the specific changes in regulations with redlining. Now you can clearly see exactly what has changed at a glance.

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