

PARA Data Editor Calculator

The **Calculator** is a robust web-based research tool that allows the User unlimited access to search and report against a number of disparate data sources. Users have numeric and alpha query capabilities; the returned information can be exported to PDF, Excel or copied to the desktop clipboard for email applications. Users can save their preferences which are specific to their geographic and provider types; all codes, reimbursement, and claim edits are always the most current available.

The **Calculator** provides 25 different resources accessible 24/7, with up to four years of history for CPT® / HCPCS codes, DRG, ASC, Professional fees and twenty-three years of CPT® Assistant Archives.

1. CPT® Codes
2. HCPCS / CPT® Codes
3. Professional Fees
4. Medicaid / Workers Comp Fee Schedule
5. ASC Reimbursement
6. DME Reimbursement
7. Clinical Lab Reimbursement
8. ICD-9 Codes Diagnosis and Procedural
9. ICD-10 Codes
10. DRGs
11. Device Dependent Codes
12. Modifiers and Revenue codes
13. CCI OPPS Edits
14. CCI Physician Edits
15. CCI Medicaid Edits – Hospital and Physician
16. National Coverage Determination
17. Local Coverage Determination
18. Medicare Part B ASP Drug Payments
19. NDC to J Code Crosswalk
20. Interventional Radiology Mapping
21. CPT® Assistant – 1990 to current
22. HCPCS/CPT® to ICD-9 Crosswalk
23. Quick Claim Evaluation
24. National Provider ID
25. UB-04 Data Specifications Manual
26. HCPCS to Anesthesia Code Crosswalk

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator **Advisor** Admin RAC CAT PARA

Report Selection

1 Configure your report options: [Instructions](#)

HCPCS / CPT® Codes Report Options

Select State: CALIFORNIA or Enter Zip Code: 92807 [Search Zip Code](#)

Select City: Anaheim

Select Hospital: Regional Hospital (990001)

Medicaid State: CALIFORNIA

Physicians Fee Schedule: ANAHEIM/SANTA ANA, CA (by selected hospital)

Clinical Lab Fee Schedule: CA1

Local Coverage Determination Report Options

Select State or Region: CALIFORNIA - ENTIRE STATE

Select Contractor: A and B MAC - Noridian Healthcare Solutions, LLC (01111)

Codes and/or Descriptions: [Code > Keyword](#)

3 ICD10 Code (for LCD, HCPCS to ICD10):

☐ Check Here to execute Cross-Report Auto Load

[Click Here to save default selections](#)

[Click to review CMS: Reason Codes or Remark Codes](#)

[Click Here for CMS Advanced Search](#)

[Review the Payment Status Indicators for](#) 2017

[Click Here to review the CMS Place of Service](#)

[Click Here to download CMS PC Pricers](#)

[Search CMS Manuals](#)

2 Make your report selection(s): [PDE](#) [Calculator](#) ☐ Exclude Discontinued/Deleted Codes

☐ CPT® Codes: [2017](#) ☒ All ☐ Add ☐ Del. ☐ Rev. [Changes](#) [Guidelines](#) [Errata](#)

☐ HCPCS Codes Only: [2017](#) [Q1 - All Codes](#) ☒ All ☐ Added Only ☐ Deleted Only ☐ Beta

☐ Professional Fees: [2017](#) [View Localities by Counties](#) [Palmetto E&M Scoring Tool](#)

☐ Medicaid or Workers Comp: ☒ Medicaid ☐ Workers Comp ☐ DRG

☐ ASC Reimbursement: [2017](#)

☐ DME Reimbursement: [2017](#) [View DME Data References](#)

☐ Clinical Lab Reimb.: [2017](#) ☐ QW listing [View CLIA](#)

☐ ICD9 Codes: ☒ Diagnosis ☐ Procedural [Guidelines](#)

☐ ICD10 Codes: [View PCS Code Structure](#) [ICD-10 Implementation Guide](#) [Guidelines](#)

☐ DRG Codes: [2017](#) [DRG Grouper Version 34](#) ☒ DRG Grouper [2017 Table 5](#) ☐ APR DRG

☐ Device Codes Required for Procedure Codes in Device Dependent APCs

☐ Modifiers or Revenue Codes: ☒ Modifiers ☐ Rev Codes [Modifiers](#) [Genetic Testing](#)

☐ CCI Edits OPPS: [2017](#) [v23.0, Jan-Mar 2017](#) ☐ 2017 NCCI Manual

☐ CCI Edits Physician: ☒ v22.3, Oct-Dec 2016 ☐ v22.2, July-Sept 2016

☐ CCI Edits Medicaid: ☒ Hospital Services ☐ Practitioner Services [CCI Edit Instructions](#)

☐ Nat'l Coverage Determination: ☒ Lab (HCPCS) ☐ Articles (NCD ID, Keyword)

☐ Local Coverage Determination: ☒ Policies (HCPCS, ICD10) ☐ Articles (Article ID, Keyword) ☐ Policies by LCD ID

☐ Medicare Part B (ASP) Drug Payment Allowance Limits

☐ NDC to J Code Crosswalk: [View SAD Drug Listings by MAC](#) [J-Code Chemo Admin](#)

☐ Interventional Radiology

☐ CPT® Assistant (Newsletters & Articles 2013) [Click for Quick Access to updates](#)

☐ HCPCS/CPT® to ICD9 Lookup

☐ Quick Claim Evaluation: [2017](#) [Q1](#) [Instructions](#)

☐ National Provider ID (NPI ID, Keyword) ☒ Organization ☐ Individual CA

☐ 2014 UB-04 Data Specifications Manual

☐ HCPCS to Anesthesia Code Crosswalk: [2017 Anesthesia Conversion Factors](#)

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PARA Data Editor Calculator

Co-mingled multiple codes, wildcard and text queries

One of the most useful features within the **Calculator** is the ability to query using a “wildcard” or multiple codes, and/or text queries which are comma separated. Additionally, several different target data tables can be checked for simultaneous returns.

The query pasted below is for all codes which meet the following search criteria:

1. Codes in the range of 9637X
2. The specific 47001 and 85025 codes
3. Codes which contain the word “incision”

The query searched the available list of approximately 15,000 HCPCS codes and returned the details of 236 codes, at the same time the query was processed against the Physician Fee schedule, Medicaid Fee schedule, and Clinical Lab schedule.

The only limitation is that majority of searches are limited to 250 code returns due to the Users internet speed and computer capacity.

The **PARA** servers will return the search within seconds.

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator **Advisor** Admin RAC CAT PARA

Report Selection **2017 Hospital Based HCPCS/CPT® Codes Quarter: Q1**

2017 HCPCS Codes - ALL Quarter: Q1
Codes and/or Descriptions: **incision** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 210
AWI: 1, DME: CA, Clinical Lab Fee Schedule: CA1, Physician Fee Schedule: ANAHEIM/SANTA ANA, CA

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Current Descriptor	Fee Schedule	Initial APC	Payment
<input type="checkbox"/> 0447T - removal of implantable interstitial glucose sensor from subcutaneous pocket via incision Q2 - Paid or pkgd w status T		5051 - Level 1 Skin Procedures	Weight: 2.0407 Payment: \$153.05 National Co-pay: \$0.00 Minimum Co-pay: \$30.61
<input type="checkbox"/> 10060 - incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$110.75 GB (Physician Non-Facility): \$134.37	5051 - Level 1 Skin Procedures	Weight: 2.0407 Payment: \$153.05 National Co-pay: \$0.00 Minimum Co-pay: \$30.61
<input type="checkbox"/> 10061 - incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$202.40 GB (Physician Non-Facility): \$233.76	5052 - Level 2 Skin Procedures	Weight: 3.8998 Payment: \$292.49 National Co-pay: \$0.00 Minimum Co-pay: \$58.50
<input type="checkbox"/> 10080 - incision and drainage of pilonidal cyst; simple T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$116.91 GB (Physician Non-Facility): \$208.84	5071 - Level 1 Excision / Biopsy / Incision and Drainage	Weight: 7.185 Payment: \$538.88 National Co-pay: \$0.00 Minimum Co-pay: \$107.78
<input type="checkbox"/> 10081 - incision and drainage of pilonidal cyst; complicated T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$189.38 GB (Physician Non-Facility): \$308.80	5071 - Level 1 Excision / Biopsy / Incision and Drainage	Weight: 7.185 Payment: \$538.88 National Co-pay: \$0.00 Minimum Co-pay: \$107.78
<input type="checkbox"/> 10120 - incision and removal of foreign body, subcutaneous tissues; simple T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$117.91 GB (Physician Non-Facility): \$176.76	5052 - Level 2 Skin Procedures	Weight: 3.8998 Payment: \$292.49 National Co-pay: \$0.00 Minimum Co-pay: \$58.50
<input type="checkbox"/> 10121 - incision and removal of foreign body, subcutaneous tissues; complicated J1 - Paid under OPPS; other services on the claim become packaged.	GB (Physician Facility): \$207.09 GB (Physician Non-Facility): \$312.76	5072 - Level 2 Excision / Biopsy / Incision and Drainage	Weight: 16.4811 Payment: \$1236.10 National Co-pay: \$0.00 Minimum Co-pay: \$247.22
<input type="checkbox"/> 10140 - incision and drainage of hematoma, seroma or fluid collection J1 - Paid under OPPS; other services on the claim become	GB (Physician Facility): \$133.51 GB (Physician Non-Facility): \$187.21	5072 - Level 2 Excision /	Weight: 16.4811 Payment: \$1236.10

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PARA Data Editor Calculator

CPT® Codes

As a result of the relationship **PARA** has developed with the AMA, **PARA** receives the CPT® code set 4 – 5 months prior to implementation.

PARA parses the codes into the following segments:

1. CPT® Code
2. Current Descriptor
3. Change Type
4. Link for expanded information

As soon as the CMS proposed rule is published (usually in August), **PARA** will link the CPT® code set to the HCPCS code set to identify the codes to be used in future Medicare OPPS reimbursement.

The query string can be “mixed” and requires comma separation.

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Report Selection **2016 CPT® Codes**

2016 CPT® Codes
Codes and/or Descriptions: 9637,4700,PELVIS

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CPT Code	Current Descriptor	Change Type	
73501	Radiologic examination, hip, unilateral, with pelvis when performed; 1 view	ADDED	Click For Details
73502	Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views	ADDED	Click For Details
73503	Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views	ADDED	Click For Details
73521	Radiologic examination, hips, bilateral, with pelvis when performed; 2 views	ADDED	Click For Details
73522	Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views	ADDED	Click For Details
73523	Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views	ADDED	Click For Details
74174	Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing	UNCHANGED	Click For Details
74176	Computed tomography, abdomen and pelvis; without contrast material	UNCHANGED	Click For Details
74177	Computed tomography, abdomen and pelvis; with contrast material(s)	UNCHANGED	Click For Details
74178	Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions	UNCHANGED	Click For Details
77078	Computed tomography, bone mineral density study, 1 or more sites, axial skeleton (eg, hips, pelvis, spine)	CHANGED	Click For Details
77080	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)	UNCHANGED	Click For Details
77085	Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment	UNCHANGED	Click For Details
96370	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); each additional hour (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details
96371	Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)	UNCHANGED	Click For Details
96372	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	UNCHANGED	Click For Details
96373	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intra-arterial	UNCHANGED	Click For Details
96374	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug	UNCHANGED	Click For Details
96375	Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous	UNCHANGED	Click For Details

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The additional information available at the Details link include expanded descriptions, Cross References Parentheticals (additional coding guidelines), a list of CPT® Assistant documents that reference the code, and a change history.

PARA Data Editor Calculator

HCPCS Codes

The HCPCS query can be focused to a specific year, and **PARA** maintains a rolling history of codes from previous years as well.

The query can also be focused to a specific code type (HCPCS C Codes, Alpha HCPCS Codes, DME Codes, Surgical Codes, Radiology Codes, Laboratory Codes, Other Diagnostic /Therapeutic Service Codes).

The returned values include the code and its Current Descriptor, CMS Payment Status, Fee Schedule (Professional, DME, Clinical Lab), Initial APC, and APC weight, AWI adjusted payment, AWI national co-pay, and AWI minimum co-pay.








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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator **Advisor** Admin RAC CAT PARA

Report Selection **2016 Hospital Based HCPCS/CPT® Codes Quarter: Q2**

2016 HCPCS Codes - ALL Quarter: Q2
Codes and/or Descriptions: **96374,70450,pelvis** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 66
AWI: 1, DME: CA, Clinical Lab Fee Schedule: CA1, Physician Fee Schedule: ANAHEIM/SANTA ANA, CA

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	Current Descriptor	Fee Schedule	Initial APC	Payment
	26992 - incision, bone cortex, pelvis and/or hip joint (eg, osteomyelitis or bone abscess) C - Not Paid under OPPS. Admit Patient; Bill as Inpatient.	GB (Physician Facility): \$1083.77 GB (Physician Non-Facility): \$1083.77		
	27040 - biopsy, soft tissue of pelvis and hip area; superficial T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$226.24 GB (Physician Non-Facility): \$403.00	5073 - Level 3 Excision / Biopsy / Incision and Drainage	Weight: 12.7769 Payment: \$941.98 National Co-pay: \$0.00 Minimum Co-pay: \$188.40
	27041 - biopsy, soft tissue of pelvis and hip area; deep, subfascial or intramuscular T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$776.00 GB (Physician Non-Facility): \$776.00	5073 - Level 3 Excision / Biopsy / Incision and Drainage	Weight: 12.7769 Payment: \$941.98 National Co-pay: \$0.00 Minimum Co-pay: \$188.40
	27043 - excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$528.14 GB (Physician Non-Facility): \$528.14	5074 - Level 4 Excision / Biopsy / Incision and Drainage	Weight: 19.1832 Payment: \$1414.28 National Co-pay: \$0.00 Minimum Co-pay: \$282.86
	27045 - excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$841.94 GB (Physician Non-Facility): \$841.94	5074 - Level 4 Excision / Biopsy / Incision and Drainage	Weight: 19.1832 Payment: \$1414.28 National Co-pay: \$0.00 Minimum Co-pay: \$282.86
	27047 - excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$409.74 GB (Physician Non-Facility): \$537.31	5074 - Level 4 Excision / Biopsy / Incision and Drainage	Weight: 19.1832 Payment: \$1414.28 National Co-pay: \$0.00 Minimum Co-pay: \$282.86
	27048 - excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm T - Paid Under OPPS; Separate APC.	GB (Physician Facility): \$687.85 GB (Physician Non-Facility): \$687.85	5074 - Level 4 Excision / Biopsy / Incision and Drainage	Weight: 19.1832 Payment: \$1414.28 National Co-pay: \$0.00 Minimum Co-pay: \$282.86

The code is a link that will open expanded data fields that include additional APC assignments (if applicable), data on Geographic market group billing, Revenue code assignment, and Change History. Also included is a list of all other codes that also fall under the same APC as the selected code:

APC: 5312 HCPCS Crosswalk	
HCPCS	HCPCS Description
45303	Proctosigmoidoscopy dilate
45317	Proctosigmoidoscopy bleed
45332	Sigmoidoscopy w/fb removal
45334	Sigmoidoscopy for bleeding

PARA Data Editor Calculator

Professional Fees

The returns display the follows values:

1. HCPCS/CPT® description
2. Global Days – follow-up period after a surgical procedure
3. PC/TC Indicator –
4. Status Code –
5. Physician Supervision – Required attendance for the procedure
6. Facility Relative Value Unit –
7. Non-Facility RVU –
8. Malpractice RVU –
9. Facility Reimbursement –
10. Non-Facility Reimbursement –

The RVU and Reimbursement values are repeated for the Global, “26” Professional and “TC” technical modifiers.

The query accepts comma separated codes, wildcards, and text.

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Report Selection **2016 Physicians Fee Schedule**

2016 Physician Fee Schedule - Query: 72190,15430 [Export Query Results to Excel](#)

Schedule

Code - Description: 72190 - RADIOLOGIC EXAMINATION, PELVIS; COMPLETE, MINIMUM OF 3 VIEWS

Modifier: 26 « Select/toggle between Modifiers for this code

Locality: TC M/SANTA ANA, CA

Pricing Information

	Facility	Non Facility	OPPS Cap Facility	OPPS Cap Non Facility
Participating Amount:	45	45	N/A	N/A
Limiting Charge Amount:	49.16	49.16	N/A	N/A

Surgery Information [Show Descriptions](#)

Status Code	A
Multiple Surgery	0
Bilateral Surgery	0
Assistant at Surgery	0
Team Surgeons	0
Co-Surgeons	0
Physician Supervision of Diagnostic Procedures	09

Payment Policy Indicators

PC/TC Indicator	1
Global Days	XXX
Pre-Operative %	0
Intra-Operative %	0
Post-Operative %	0
Endoscopic Base Code	
Diagnostic Imaging	99
Conversion Factor	35.8043

Relative Value Units

Non-Facility Practice Expense	0.84
Non-Facility NA Indicator	
Facility NA Indicator	NA
Facility Practice Expense	0.84
Total Non-Facility (Transitioned)	1.07
Total Non-Facility (Implemented)	1.07
Work	0.21
Malpractice	0.02

Geographic Practice Cost Indices

Work	1.035
Practice Expense	1.216
Malpractice	0.908

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Medicaid / Workers Comp Fee Schedule

The Medicaid query returns the following values (if available), for the current year fee schedule:

1. Code
2. Category
3. Description
4. Unit Value
5. Base Rate
6. Child Rate
7. ER Rate
8. Rental Rate

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Report Selection **Medicaid Reimbursement**

Medicaid Reimbursement
Codes and/or Descriptions: 9928 for selected State: CALIFORNIA
Results Returned (below): 9

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Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
99281	MEDI-CAL as of 04152016 - Medicine	EMERGENCY DEPT VISIT	14.60	\$15.18	\$0.00	\$15.18	\$0.00	0%	\$0.00	\$15.18
99281	MEDI-CAL as of 04152016 - Podiatrist	EMERGENCY DEPT VISIT	12.61	\$10.34	\$0.00	\$0.00	\$0.00	0%	\$0.00	\$10.34
99282	MEDI-CAL as of 04152016 - Medicine	EMERGENCY DEPT VISIT	23.44	\$24.38	\$0.00	\$24.38	\$0.00	0%	\$0.00	\$24.38
99282	MEDI-CAL as of 04152016 - Podiatrist	EMERGENCY DEPT VISIT	23.42	\$19.20	\$0.00	\$0.00	\$0.00	0%	\$0.00	\$19.20
99283	MEDI-CAL as of 04152016 - Medicine	EMERGENCY DEPT VISIT	42.88	\$44.60	\$0.00	\$44.60	\$0.00	0%	\$0.00	\$44.60
99283	MEDI-CAL as of 04152016 - Podiatrist	EMERGENCY DEPT VISIT	42.83	\$35.12	\$0.00	\$0.00	\$0.00	0%	\$0.00	\$35.12
99284	MEDI-CAL as of 04152016 - Medicine	EMERGENCY DEPT VISIT	65.72	\$68.35	\$0.00	\$68.35	\$0.00	0%	\$0.00	\$68.35
99284	MEDI-CAL as of 04152016 - Podiatrist	EMERGENCY DEPT VISIT	65.65	\$53.83	\$0.00	\$0.00	\$0.00	0%	\$0.00	\$53.83
99285	MEDI-CAL as of 04152016 - Medicine	EMERGENCY DEPT VISIT	103.92	\$108.08	\$0.00	\$108.08	\$0.00	0%	\$0.00	\$108.08

The Workers Comp (if available) query returns the following:

1. Code
2. Description
3. Rate

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Report Selection **Workers Compensation**

Workers Compensation
Codes and/or Descriptions: EMERGENCY for selected State: CALIFORNIA
Results Returned (below): 4

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Code/Description	Reimbursement
31500 - Emergency Endotracheal Intubation'Emerg Endotrach	\$145.35
31603 - Emergency Transtracheal Tracheostomy'Emerg Transtr	\$566.87
99058 - Office Services Provided On An Emergency Basis'Off	\$28.63
99065 - Emergency Care Services	\$15.44

PARA Data Editor Calculator

ASC Reimbursement

The query accepts comma separated HCPCS/CPT® codes, wildcard and text terms.

The returned values for the selected year (rolling four year period):

1. HCPCS Code and Description
2. Ambulatory Surgical Reimbursement

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Report Selection **2016 ASC Reimbursement**

National ASC Reimbursement Levels - 2016 (Unadjusted)

Codes and/or Descriptions: **PELVIS**
Results Returned (below): 33

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HCPCS/CPT®	ASC Reimbursement
26990 - INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; DEEP ABSCESS OR HEMATOMA	\$1339.58
26991 - INCISION AND DRAINAGE, PELVIS OR HIP JOINT AREA; INFECTED BURSA	\$1339.58
27040 - BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; SUPERFICIAL	\$526.74
27041 - BIOPSY, SOFT TISSUE OF PELVIS AND HIP AREA; DEEP, SUBFASCIAL OR INTRAMUSCULAR	\$526.74
27043 - EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBCUTANEOUS; 3 CM OR GREATER	\$790.85
27045 - EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBFASCIAL (EG, INTRAMUSCULAR); 5 CM OR GREATER	\$790.85
27047 - EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBCUTANEOUS; LESS THAN 3 CM	\$790.85
27048 - EXCISION, TUMOR, SOFT TISSUE OF PELVIS AND HIP AREA, SUBFASCIAL (EG, INTRAMUSCULAR); LESS THAN 5 CM	\$790.85
27049 - RADICAL RESECTION OF TUMOR (EG, SARCOMA), SOFT TISSUE OF PELVIS AND HIP AREA; LESS THAN 5 CM	\$790.85
27059 - RADICAL RESECTION OF TUMOR (EG, SARCOMA), SOFT TISSUE OF PELVIS AND HIP AREA; 5 CM OR GREATER	\$790.85
27086 - REMOVAL OF FOREIGN BODY, PELVIS OR HIP; SUBCUTANEOUS TISSUE	\$790.85
27087 - REMOVAL OF FOREIGN BODY, PELVIS OR HIP; DEEP (SUBFASCIAL OR INTRAMUSCULAR)	\$1339.58
50390 - ASPIRATION AND/OR INJECTION OF RENAL CYST OR PELVIS BY NEEDLE, PERCUTANEOUS	\$526.74
50391 - INSTALLATION(S) OF THERAPEUTIC AGENT INTO RENAL PELVIS AND/OR URETER THROUGH ESTABLISHED NEPHROSTOMY, PYELOSTOMY OR URETEROSTOMY TUBE (EG, ANTICARCINOGENIC OR ANTIFUNGAL AGENT)	\$46.90
50395 - INTRODUCTION OF GUIDE INTO RENAL PELVIS AND/OR URETER WITH DILATION TO ESTABLISH NEPHROSTOMY TRACT, PERCUTANEOUS	\$1254.53
52007 - CYSTOURETHROSCOPY, WITH URETERAL CATHETERIZATION, WITH OR WITHOUT IRRIGATION, INSTALLATION, OR URETEROPYELOGRAPHY, EXCLUSIVE OF RADIOLOGIC SERVICE; WITH BRUSH BIOPSY OF URETER AND/OR RENAL PELVIS	\$1254.53
72191 - COMPUTED TOMOGRAPHIC ANGIOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S), INCLUDING NONCONTRAST IMAGES, IF PERFORMED, AND IMAGE POSTPROCESSING	\$132.45
72192 - COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL	\$62.90
72193 - COMPUTED TOMOGRAPHY, PELVIS; WITH CONTRAST MATERIAL(S)	\$132.45
72194 - COMPUTED TOMOGRAPHY, PELVIS; WITHOUT CONTRAST MATERIAL, FOLLOWED BY CONTRAST MATERIAL(S) AND FURTHER SECTIONS	\$132.45
72195 - MAGNETIC RESONANCE (EG, PROTON) IMAGING, PELVIS; WITHOUT CONTRAST MATERIAL(S)	\$152.96

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PARA Data Editor Calculator


DME Reimbursement

The returned values against a rolling four year period are as follows:

1. OPPS Billable – Yes or No
2. Jurisdiction – DMERC, Local Part B, or Joint
3. Category – the type of item (i.e., surgical dressings)
4. Mod – Modifier (i.e., NU – Purchased, New)
5. Mod 2 – Modifier (same values as Mod)
6. Mod Fee – Fee schedule value (based on selected state in Report Selection Tab)

If the OPPS Billable indicator is “yes” a hospital may bill on a UB04 without requiring a DME license number, the DME “L” code is required along with a 0274 revenue code.

The query accepts comma separated CPT®/HCPCS codes, wildcard and text search terms.

There is an informational icon  Data References pasted on the DME line for complete definitions.






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Report Selection 2016 DME Reimbursement

2016 DME Reimbursement

Codes and/or Descriptions: **WRIST** for selected Provider: **Regional Hospital (990001)** and the selected state: **CA**
Results Returned (below): 57

 Data References |  Export to PDF |  Export to Excel |  Copy to Clipboard |  Subscribe to Updates

OPPS Billable	Jurisdiction	Category	Mod	Mod 2	Mod Fee
A6504 - COMPRESSION BURN GARMENT, GLOVE TO WRIST, CUSTOM FABRICATED					
N/A	D = DMERC jurisdiction	SD = Surgical Dressings	-	-	\$0.00
E1805 - DYNAMIC ADJUSTABLE WRIST EXTENSION / FLEXION DEVICE, INCLUDES SOFT INTERFACE MATERIAL					
N/A	D = DMERC jurisdiction	CR = Capped Rental Items	RR	-	\$139.68
E1806 - STATIC PROGRESSIVE STRETCH WRIST DEVICE, FLEXION AND/OR EXTENSION, WITH OR WITHOUT RANGE OF MOTION ADJUSTMENT, INCLUDES ALL COMPONENTS AND ACCESSORIES					
N/A	D = DMERC jurisdiction	CR = Capped Rental Items	RR	-	\$111.52
L3763 - ELBOW WRIST HAND ORTHOSIS, RIGID, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$714.15
L3764 - ELBOW WRIST HAND ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$821.23
L3765 - ELBOW WRIST HAND FINGER ORTHOSIS, RIGID, WITHOUT JOINTS, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$1,085.82
L3766 - ELBOW WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINTS, ELASTIC BANDS, TURNBUCKLES, MAY INCLUDE SOFT INTERFACE, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$1,149.80
L3806 - WRIST HAND FINGER ORTHOSIS, INCLUDES ONE OR MORE NONTORSION JOINT(S), TURNBUCKLES, ELASTIC BANDS/SPRINGS, MAY INCLUDE SOFT INTERFACE MATERIAL, STRAPS, CUSTOM FABRICATED, INCLUDES FITTING AND ADJUSTMENT					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$384.67
L3807 - WRIST HAND FINGER ORTHOSIS, WITHOUT JOINT(S), PREFABRICATED ITEM THAT HAS BEEN TRIMMED, BENT, MOLDED, ASSEMBLED, OR OTHERWISE CUSTOMIZED TO FIT A SPECIFIC PATIENT BY AN INDIVIDUAL WITH EXPERTISE					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics	-	-	\$211.75

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PARA Data Editor Calculator

Clinical Lab Reimbursement

The query is available for a rolling four year period.

The query accepts comma separated CPT®/HCPCS codes, wildcard and text terms.

There is a “radio” button to select the period (year) or the complete code set with the QW (CLIA waived) tests.

The returned values are as follows:

1. CPT®/HCPCS code
2. Description
3. Modifier 1 Fee
4. QW Modifier Fee

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator Advisor Admin RAC CAT PARA

Report Selection 2016 Clinical Lab Reimbursement

2016 Clinical Lab Reimbursement

Codes and/or Descriptions: 85025,IGA,8100,829 for selected Provider: Regional Hospital (990001) and selected Clinical Lab Fee Schedule: CA1
Results Returned (below): 29

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HCPCS/CPT®	Modifier 1 Fee	QW Modifier Fee
81000 - URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; NON-AUTOMATED, WITH MICROSCOPY	\$4.32	
81001 - URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; AUTOMATED, WITH MICROSCOPY	\$4.32	
81002 - URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; NON-AUTOMATED, WITHOUT MICROSCOPY	\$3.48	
81003 - URINALYSIS, BY DIP STICK OR TABLET REAGENT FOR BILIRUBIN, GLUCOSE, HEMOGLOBIN, KETONES, LEUKOCYTES, NITRITE, PH, PROTEIN, SPECIFIC GRAVITY, UROBILINOGEN, ANY NUMBER OF THESE CONSTITUENTS; AUTOMATED, WITHOUT MICROSCOPY	\$3.06	\$3.06
81005 - URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE, EXCEPT IMMUNOASSAYS	\$2.95	
81007 - URINALYSIS; BACTERIURIA SCREEN, EXCEPT BY CULTURE OR DIPSTICK	\$1.32	\$1.32
82784 - GAMMAGLOBULIN (IMMUNOGLOBULIN); IGA, IGD, IGG, IGM, EACH	\$9.12	
82930 - GASTRIC ACID ANALYSIS, INCLUDES PH IF PERFORMED, EACH SPECIMEN	\$7.26	
82938 - GASTRIN AFTER SECRETIN STIMULATION	\$24.10	
82941 - GASTRIN	\$24.02	
82943 - GLUCAGON	\$19.46	
82945 - GLUCOSE, BODY FLUID, OTHER THAN BLOOD	\$5.35	
82946 - GLUCAGON TOLERANCE TEST	\$20.54	
82947 - GLUCOSE; QUANTITATIVE, BLOOD (EXCEPT REAGENT STRIP)	\$5.35	\$5.35
82948 - GLUCOSE; BLOOD, REAGENT STRIP	\$4.32	
82950 - GLUCOSE; POST GLUCOSE DOSE (INCLUDES GLUCOSE)	\$6.47	\$6.47
82951 - GLUCOSE; TOLERANCE TEST (GTT), 3 SPECIMENS (INCLUDES GLUCOSE)	\$14.19	\$14.19
82952 - GLUCOSE; TOLERANCE TEST, EACH ADDITIONAL BEYOND 3 SPECIMENS (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	\$5.34	\$5.34
82955 - GLUCOSE-6-PHOSPHATE DEHYDROGENASE (G6PD); QUANTITATIVE	\$13.21	

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PARA Data Editor Calculator

ICD-9 Codes Diagnosis and Procedural

The two part ICD-9 tables require separate queries to be sure the correct code type is returned.

The query format is comma separated codes, wildcard, and text, no decimals in the codes.

The values returned are as follows:

1. ICD-9 Code
2. Code Description
3. Status
4. Comments
5. The ICD-9 codes are mapped to the ICD-10, with the option to display the corresponding ICD-10 codes

Diagnosis Codes:

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Report Selection **ICD9 Diagnosis Codes**

ICD9 Diagnosis Codes
Codes and/or Descriptions: **2501**
Results Returned (below): 5

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ICD9 Code	Description	Status	Comments	ICD10 Code Map(s)
2501	DIABETES WITH KETOACIDOSIS	I		
25010	DIABETES WITH KETOACIDOSIS TYPE II OR UNSPECIFIED TYPE NOT STATED AS UNCONTROLLED	C		Show/Hide ICD10 Codes:
25011	DIABETES WITH KETOACIDOSIS TYPE I [JUVENILE TYPE] NOT STATED AS UNCONTROLLED	C		Show/Hide ICD10 Codes:
25012	DIABETES WITH KETOACIDOSIS TYPE II OR UNSPECIFIED TYPE UNCONTROLLED	C		Show/Hide ICD10 Codes:
25013	DIABETES WITH KETOACIDOSIS TYPE I [JUVENILE TYPE] UNCONTROLLED	C		Show/Hide ICD10 Codes: E1010 - Type 1 diabetes mellitus with ketoacidosis without coma E1065 - Type 1 diabetes mellitus with hyperglycemia

Procedure Codes:

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Report Selection **ICD9 Procedural Codes**

ICD9 Procedural Codes
Codes and/or Descriptions: **repair**
Results Returned (below): 250

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ICD9 Code	Description	Status	Comments	ICD10 Code Map(s)
021	REPAIR OF CEREBRAL MENINGES	I		
0212	OTHER REPAIR OF CEREBRAL MENINGES	C		Show/Hide ICD10 Codes:
0292	REPAIR OF BRAIN	C		Show/Hide ICD10 Codes:
0351	REPAIR OF SPINAL MENINGOCELE	C		Show/Hide ICD10 Codes:
0352	REPAIR OF SPINAL MYELOMENINGOCELE	C		Show/Hide ICD10 Codes:
0353	REPAIR OF VERTEBRAL FRACTURE	C		Show/Hide ICD10 Codes:

PARA Data Editor Calculator

ICD-10 Codes

With the transition to ICD-10 codes, it is important to begin to understand the code structure and returns. ICD-10 codes have a completely different format and descriptions than ICD9.

The query is text, comma separated.

Click on the link to view the ICD-10 code structure

[View PCS Code Structure](#)

The returns are as follows:

1. Code Value
2. Code Description
3. Code Type
4. ICD-9 code map

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Report Selection **ICD10 Codes**

ICD10 Codes
Codes and/or Descriptions: **fracture**

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ICD10 Code	Description	Type	ICD9 Code Map (s)
K0853	Fractured dental restorative material	Diagnosis	
K08530	Fractured dental restorative material without loss of material	Diagnosis	ICD9s
K08531	Fractured dental restorative material with loss of material	Diagnosis	ICD9s
K08539	Fractured dental restorative material, unspecified	Diagnosis	ICD9s
M484	Fatigue fracture of vertebra	Diagnosis	
M4840	Fatigue fracture of vertebra, site unspecified	Diagnosis	
M4840XA	Fatigue fracture of vertebra, site unspecified, initial encounter for fracture	Diagnosis	ICD9s
M4840XD	Fatigue fracture of vertebra, site unspecified, subsequent encounter for fracture with routine healing	Diagnosis	ICD9s
M4840XG	Fatigue fracture of vertebra, site unspecified, subsequent encounter for fracture with delayed healing	Diagnosis	ICD9s
M4840XS	Fatigue fracture of vertebra, site unspecified, sequela of fracture	Diagnosis	ICD9s
M4841	Fatigue fracture of vertebra, occipito-atlanto-axial region	Diagnosis	
M4841XA	Fatigue fracture of vertebra, occipito-atlanto-axial region, initial encounter for fracture	Diagnosis	ICD9s
M4841XD	Fatigue fracture of vertebra, occipito-atlanto-axial region, subsequent encounter for fracture with routine healing	Diagnosis	ICD9s
M4841XG	Fatigue fracture of vertebra, occipito-atlanto-axial region, subsequent encounter for fracture with delayed healing	Diagnosis	ICD9s
M4841XS	Fatigue fracture of vertebra, occipito-atlanto-axial region, sequela of fracture	Diagnosis	ICD9s
M4842	Fatigue fracture of vertebra, cervical region	Diagnosis	
M4842XA	Fatigue fracture of vertebra, cervical region, initial encounter for fracture	Diagnosis	ICD9s
M4842XD	Fatigue fracture of vertebra, cervical region, subsequent encounter for fracture with routine healing	Diagnosis	ICD9s
M4842XG	Fatigue fracture of vertebra, cervical region, subsequent encounter for fracture with delayed healing	Diagnosis	ICD9s
M4842XS	Fatigue fracture of vertebra, cervical region, sequela of fracture	Diagnosis	ICD9s
M4843	Fatigue fracture of vertebra, cervicothoracic region	Diagnosis	
M4843XA	Fatigue fracture of vertebra, cervicothoracic region, initial encounter for fracture	Diagnosis	ICD9s
M4843XD	Fatigue fracture of vertebra, cervicothoracic region, subsequent encounter for fracture with routine healing	Diagnosis	ICD9s

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PARA Data Editor Calculator

Diagnosis Related Groups

This query accepts comma separated codes, wildcards, and text.

The returns are as follows:

1. DRG Description
2. Major Diagnosis Category (MDC)
3. Type – Medical or Surgical
4. Relative Weight
5. Cumulative Mean Length of Stay
6. Arithmetic Mean Length of Stay
7. Transfer Penalty Indicator
8. Prior Year Mapped Codes

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Report Selection **2016 DRG Codes**

2016 DRG Codes
Codes and/or Descriptions: **17,neuro,cardiac**
Results Returned (below): 54

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DRG	MDC	Type	Relative Weight	Geometric Mean LOS	Arithmetic Mean LOS	Transfer Penalty	2015 DRGs Mapped
017 - AUTOLOGOUS BONE MARROW TRANSPLANT W/O CC/MCC	PRE - Pre-MDC	SURG	4.3794	10.1000	12.8000		
029 - SPINAL PROCEDURES W CC OR SPINAL NEUROSTIMULATORS	01 - Diseases and Disorders of the Nervous System.	SURG	3.0529	4.8000	6.2000	YES	
041 - PERIPH/CRANIAL NERVE & OTHER NERV SYST PROC W CC OR PERIPH NEUROSTIM	01 - Diseases and Disorders of the Nervous System.	SURG	2.1263	4.7000	6.0000	YES	
117 - INTRAOCULAR PROCEDURES W/O CC/MCC	02 - Diseases and Disorders of the Eye.	SURG	0.8303	2.0000	2.6000		
123 - NEUROLOGICAL EYE DISORDERS	02 - Diseases and Disorders of the Eye.	MED	0.7159	2.1000	2.6000		
175 - PULMONARY EMBOLISM W MCC	04 - Diseases and Disorders of the Respiratory System.	MED	1.4844	4.9000	5.9000	YES	
176 - PULMONARY EMBOLISM W/O MCC	04 - Diseases and Disorders of the Respiratory System.	MED	0.9371	3.3000	4.0000	YES	
177 - RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	04 - Diseases and Disorders of the Respiratory System.	MED	1.9031	6.0000	7.4000	YES	
178 - RESPIRATORY INFECTIONS & INFLAMMATIONS W CC	04 - Diseases and Disorders of the Respiratory System.	MED	1.3576	4.8000	5.8000	YES	
179 - RESPIRATORY INFECTIONS & INFLAMMATIONS W/O CC/MCC	04 - Diseases and Disorders of the Respiratory System.	MED	0.9656	3.6000	4.3000	YES	
216 - CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W MCC	05 - Diseases and Disorders of the Circulatory System.	SURG	9.4729	12.7000	15.5000	YES	
217 - CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W CC	05 - Diseases and Disorders of the Circulatory System.	SURG	6.2692	8.5000	9.7000	YES	
218 - CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W CARD CATH W/O CC/MCC	05 - Diseases and Disorders of the Circulatory System.	SURG	5.4906	6.5000	7.3000	YES	
219 - CARDIAC VALVE & OTH MAJ CARDIOTHORACIC PROC W/O CARD CATH W MCC	05 - Diseases and Disorders of the Circulatory System.	SURG	7.5689	9.6000	11.5000	YES	
220 - CARDIAC VALVE & OTH MAJ	05 - Diseases and Disorders of the						

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Also available are grouper versions 31 and 34, the current year's Table 5 DRG listing, and APR DRG report.

PARA Data Editor Calculator

Device Dependent APC Codes

The query is based on the CMS data table which relates a surgical procedure to the required Online Claim Editor Device Dependent HCPCS code.

The query is code, (comma separated), wildcard, and text.

The return fields are as follows:

1. Date – CMS implementation date
2. HCPCS/CPT® – Code and description
3. HCPCS Status – CMS Addendum B defined
4. Device A – Code and description
5. Device B – Code and description

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Select Quote A Price Charge Maintenance Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator Advisor Administration PARA

Report Selection Device Codes

Device Codes Required for Procedure Codes in Device Dependent APCs

Codes and/or Descriptions: **generator**
Results Returned (below): 35

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DATE	HCPCS/CPT®	Status	Device A	Device B
04/01/2005	33212 - Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular	T	C1786 - Pacemaker, Single Chamber, Rate-Responsive (Implantable)	
04/01/2005	33212 - Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular	T	C2620 - Pacemaker, Single Chamber, Non Rate-Responsive (Implantable)	
04/01/2005	33212 - Insertion or replacement of pacemaker pulse generator only; single chamber, atrial or ventricular	T	C2621 - Pacemaker, Other Than Single Or Dual Chamber (Implantable)	
10/01/2005	33213 - Insertion or replacement of pacemaker pulse generator only; dual chamber	T	C1785 - Pacemaker, Dual Chamber, Rate-Responsive (Implantable)	
10/01/2005	33213 - Insertion or replacement of pacemaker pulse generator only; dual chamber	T	C2619 - Pacemaker, Dual Chamber, Non Rate-Responsive (Implantable)	
10/01/2005	33213 - Insertion or replacement of pacemaker pulse generator only; dual chamber	T	C2621 - Pacemaker, Other Than Single Or Dual Chamber (Implantable)	
10/01/2005	33214 - Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	T	C1785 - Pacemaker, Dual Chamber, Rate-Responsive (Implantable)	C1779 - Lead, Pacemaker, Transvenous Vdd Single Pass
10/01/2005	33214 - Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	T	C2619 - Pacemaker, Dual Chamber, Non Rate-Responsive (Implantable)	C1898 - Lead, Pacemaker, Other Than Transvenous Vdd Single Pass
10/01/2005	33214 - Upgrade of implanted pacemaker system, conversion of single chamber system to dual chamber system (includes removal of previously placed pulse generator, testing of existing lead, insertion of new lead, insertion of new pulse generator)	T	C2621 - Pacemaker, Other Than Single Or Dual Chamber (Implantable)	
04/01/2005	33224 - Insertion of pacing electrode, cardiac venous system, for left ventricular pacing, with attachment to previously placed pacemaker or pacing cardioverter-defibrillator pulse generator (including revision of pocket, removal, insertion, and/or replacement of generator)	T	C1900 - Lead, Left Ventricular Coronary Venous System	

PARA Data Editor Calculator

CCI OPPS Edits / CCI Physician Edits

This two type query allows the User to view the last two periods of CCI edits for both the CMS Outpatient Claim Editor and the Physician 1500 Claim Editor.

The query can be a single code or wildcard for all edits tied to the code, or a comma separated series of codes which will make comparisons against all combinations of the code pairs.

The returned values are as follows:

1. Code Pairs – Codes and Descriptions
2. Edit Type – Comprehensive or Mutually Exclusive
3. GB Modifier Indicator – green, yellow or red

Based on the color of the GB Modifier Indicated the following actions are to be initiated:

1. Green – the code pair is ok to be billed on the same date/encounter.
2. Yellow – the code pair requires the application of a modifier to clear the claim edit.
3. Red – the code pair cannot be billed, one of the items requires removal from the claim.

Also available is a link to the NCCI Manual.

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM **Calculator** Advisor Admin RAC CAT PARA

Report Selection **CCI Edits OPPS (v22.0, Jan-Mar 2016)** CCI Edits Physician (v22.0, Jan-Mar 2016) CCI Edits Medicaid (Hospital Services)

CCI Edits OPPS (v22.0, Jan-Mar 2016)
Codes and/or Descriptions: **99291,71020,71010,93005,94002,94003**

Remove 'OK To Bill' Results | [Export to PDF](#) | [Export to Excel](#) | [Copy to Clipboard](#)

		Edit Type	GB Modifier Indicator
71010 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL	93005 - ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT		OK to bill
71010 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL	94002 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY		OK to bill
71010 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL	94003 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY		OK to bill
71020 - RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL	93005 - ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT		OK to bill
71020 - RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL	94002 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY		OK to bill
71020 - RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL	94003 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY		OK to bill
71020 - RADIOLOGIC EXAMINATION, CHEST, 2 VIEWS, FRONTAL AND LATERAL (Column 1)	71010 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
93005 - ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT	94002 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY		OK to bill
93005 - ELECTROCARDIOGRAM, ROUTINE ECG WITH AT LEAST 12 LEADS; TRACING ONLY, WITHOUT INTERPRETATION AND REPORT	94003 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY		OK to bill
94002 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, INITIAL DAY (Column 1)	94003 - VENTILATION ASSIST AND MANAGEMENT, INITIATION OF PRESSURE OR VOLUME PRESET VENTILATORS FOR ASSISTED OR CONTROLLED BREATHING; HOSPITAL INPATIENT/OBSERVATION, EACH SUBSEQUENT DAY (Column 2)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed

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PARA Data Editor Calculator

CCI Medicaid Edits

This query allows the User to view the Hospital and Practitioner services of CCI edits for both the CMS Outpatient Claim Editor and the Physician 1500 Claim Editor.

The query can be a single code or wildcard for all edits tied to the code, or a comma separated series of codes which will make comparisons against all combinations of the code pairs.

The returned values are as follows:

1. Code Pairs – Codes and Descriptions
2. Edit Type – Comprehensive or Mutually Exclusive
3. GB Modifier Indicator – green, yellow or red

Based on the color of the GB Modifier Indicated the following actions are to be initiated:

1. Green – the code pair is ok to be billed on the same date/encounter.
2. Yellow – the code pair requires the application of a modifier to clear the claim edit.
3. Red – the code pair cannot be billed, one of the items requires removal from the claim.

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[Report Selection](#) [CCI Edits Medicaid \(Hospital Services\)](#)

CCI Edits Medicaid (Hospital Services)
Codes and/or Descriptions: 00100,0178T,00120,0179T,J7949

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		Edit Type	GB Modifier Indicator
00100 - Anesthesia for procedures on salivary glands, including biopsy	J7949 - Invalid code		Invalid Code Pair
00100 - Anesthesia for procedures on salivary glands, including biopsy	00120 - Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified		OK to bill
00100 - Anesthesia for procedures on salivary glands, including biopsy (Column 1)	0178T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
00100 - Anesthesia for procedures on salivary glands, including biopsy (Column 1)	0179T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
00120 - Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified	J7949 - Invalid code		Invalid Code Pair
00120 - Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified (Column 1)	0179T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
0178T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report	J7949 - Invalid code		Invalid Code Pair
0178T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report (Column 1)	0179T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
0178T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; with interpretation and report (Column 2)	00120 - Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified (Column 1)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
0179T - Electrocardiogram, 64 leads or greater, with graphic presentation and analysis; tracing and graphics only, without interpretation and report	J7949 - Invalid code		Invalid Code Pair

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PARA Data Editor Calculator

National Coverage Determination

The query checks against the CMS Coverage data tables.

The query format is comma separated codes, or a HCPCS code in the top box and an ICD9 diagnosis code in the bottom, wildcard and text are **not** supported due to the great number of returns.

The value returns are as follows:

1. National Coverage Decision
2. CPT®/HCPCS – Code and description
3. ICD-10 – Code and description
4. Resolution Code
5. Effective Date
6. Termination Date



Single code query:

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM **Calculator** Advisor Admin RAC CAT PARA

Report Selection **National Coverage Determination - Lab**

National Coverage Determination - Lab ICD10
Codes and/or Descriptions: **87086,87088**
Results Returned (below): 0

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NCD	HCPCS/CPT®	ICD10	Resolution Code	Effective Date	Termination Date
190.12	87086 - CULTURE, BACTERIAL; QUANTITATIVE COLONY COUNT, URINE		1 - Code covered by Medicare	10/1/2015	1/1/1900
190.12	87088 - CULTURE, BACTERIAL; WITH ISOLATION AND PRESUMPTIVE IDENTIFICATION OF EACH ISOLATE, URINE		1 - Code covered by Medicare	10/1/2015	1/1/1900

PARA Data Editor Calculator

Local Coverage Determination

The query checks against the CMS Local Coverage data tables as defined by the Contractor chosen in the report selection tab. When using the “Select Contractor” drop-down be sure to save your default selections.

The query format is comma separated codes, or a HCPCS code in the top box and an ICD10 diagnosis code in the bottom for a focused query, wildcard and text are **not** supported.

The value returns are as follows:

1. Local Coverage Decision ID Number
2. CPT®/HCPCS – Code and description
3. ICD9 – Code and description
4. Title / Status – (i.e., covered)
5. Contractor Type / Name – (FI, MAC, Carrier)
6. Date Information

Single code query:

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Report Selection **Local Coverage Determination**

Local Coverage Determination
Codes: **97110**
Selected Contractor: 1
Results Returned (below): 1

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ID	HCPCS/CPT®	ICD10	Title	Status	Contractor Type	Contractor Name	Date Info
33531 ICD10s	97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCE, RANGE OF MOTION AND FLEXIBILITY		Outpatient Physical and Occupational Therapy Services	NOT ASSIGNED	A and B and HHH MAC	National Government Services, Inc. (13101)	Effective: 10/01/2015 Revision: 10/01/2015 End: 01/01/1900 Updated:

PARA Data Editor Calculator

Medicare Part B ASP Drug Payments

The query is conducted against the CMS Part B Average Sales Price data table.

The query format is comma separated code, wildcard and text.

The returned values are as follows.

1. CPT®/HCPCS Code and Description
2. Dosage
3. Payment Limit
4. ESRD Limit
5. Vaccine Average Wholesale Price Percent and Limit
6. Infusion Average Wholesale Price Percent
7. DME Infusion Limit
8. Blood Average Wholesale Price Percent and Limit
9. Notes

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CDM

Calculator

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Report Selection

Medicare Part B (ASP)

Medicare Part B (ASP) Drug Payment Allowance Limits

Codes and/or Descriptions: j91

Results Returned (below): 18

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HCPCS/CPT®	Dosage	Payment Limit	ESRD Limit	Vaccine AWP Percent	Vaccine Limit	Infusion AWP Percent	DME Infusion Limit	Blood AWP Percent	Blood Limit	Notes
J9100 - INJECTION, CYTARABINE, 100 MG	100 MG	\$1.74				95.00	\$8.19			
J9110 - INJECTION, CYTARABINE, 500 MG	500 MG	\$3.85				95.00	\$8.55			
J9120 - INJECTION, DACTINOMYCIN, 0.5 MG	0.5 MG	\$543.73								
J9130 - DACARBAZINE, 100 MG	100 MG	\$4.00								
J9140 - DACARBAZINE, 200 MG	200 MG	\$7.89								
J9150 - INJECTION, DAUNORUBICIN, 10 MG	10 MG	\$16.07								
J9151 - INJECTION, DAUNORUBICIN CITRATE, LIPOSOMAL FORMULATION, 10 MG	10 MG	\$56.31								
J9155 - INJECTION, DEGARELIX, 1 MG										
J9160 - INJECTION, DENILEUKIN DIFTITOX, 300 MICROGRAMS	300 MCG	\$1,424.51								Revised payment limit 10/28/05 (CR 4160).
J9165 - INJECTION, DIETHYLSTILBESTROL DIPHOSPHATE, 250 MG										
J9170 - INJECTION, DOCETAXEL, 20 MG	20 MG	\$344.65								
J9171 - INJECTION, DOCETAXEL, 1 MG										
J9175 - INJECTION, ELLIOTT'S B SOLUTION, 1 ML	1 ML	\$4.07								
J9178 - INJECTION, EPIRUBICIN HCL, 2 MG	2 MG	\$2.90								

PARA Data Editor Calculator

NDC to J Code Crosswalk

The National Drug Code to CMS HCPCS J code crosswalk is based on the Food and Drug Administration NDC table tied to the CMS J code reference table and the National Drug Data File.

The code query format is comma separated code, wildcard and text.

The values returned are as follows:

1. HCPCS J code
2. HCPCS Description
3. HCPCS Status
4. Drug Labeler
5. NDC Code
6. NDC Description
7. Drug Name
8. HCPCS Dosage
9. Package Size Quantity
10. Bill Units – Code unit multiplier
11. Route of Administration
12. Wholesale Acquisition Cost Unit
13. WAC Package
14. Suggested Wholesale Price Unit
15. SWP Package

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator Advisor Admin RAC CAT PARA

Report Selection **NDC to J Code**

NDC to J Code Crosswalk
Codes and/or Descriptions: J2270
Results Returned (below): 24

Pharmacy Cost Data Provided by [First Data Bank](#)
Data last updated: 4/22/2016



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HCPCS	HCPCS Desc	HCPCS Status	Labeler	NDC	NDC Desc	Addl Desc	Drug	HCPCS Dosage	FDB Pkg Size Qty	Bill Units	Route	FDB WAC Unit PKG	FDB SWP Unit
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	N	BD RX	76045000510	MORPHINE 4 MG/ML SYRINGE	P/F, LATEX-FREE	MORPHINE SULFATE	10 MG	1	0	INJECTION	2.19 2.19	0.00
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	N	BD RX	76045000610	MORPHINE 5 MG/ML SYRINGE	P/F, LATEX-FREE	MORPHINE SULFATE	10 MG	1	0	INJECTION	2.19 2.19	0.00
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	N	BD RX	76045000710	MORPHINE 8 MG/ML SYRINGE	P/F, LATEX-FREE	MORPHINE SULFATE	10 MG	1	0	INJECTION	2.19 2.19	0.00
J2270	INJECTION, MORPHINE SULFATE, UP TO 10 MG	N	BD RX	76045000810	MORPHINE 10 MG/ML SYRINGE	P/F, LATEX-FREE	MORPHINE SULFATE	10 MG	1	1	INJECTION	2.19 2.19	0.00

PARA Data Editor Calculator

Interventional Radiology Charge Mapping

The purpose of the query is to provide the User the acceptable codes as defined in CPT® between the radiology guidance and the surgical codes. If there is a CMS device mapped to the code(s) the HCPCS code for the device and description are displayed.

The query format is code (comma separated), wildcard and text.

The returns are as follows:

1. Surgical Procedure HCPCS Code and Description
2. Radiology Guidance Procedure Codes and Descriptions
3. CMS Device A Mapped Code and Description
4. CMS Device B Mapped Code and Description

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Report Selection **Interventional Radiology**

Interventional Radiology Charge Mapping

Codes and/or Descriptions: 3320
Results Returned (below): 0

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Surgical Procedure	Radiology Guidance Procedure	Device A Code/Description	Device B Code/Description
33202 - Insertion of epicardial electrode(s); open incision (eg, thoracotomy, median sternotomy, subxiphoid approach)	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	Device A code not found	Device B code not found
33203 - Insertion of epicardial electrode(s); endoscopic approach (eg, thoracoscopy, pericardioscopy)	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	Device A code not found	Device B code not found
33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C1786 - Pmkr, single, rate-resp	C1779 - Lead, pmkr, transvenous VDD
33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C2619 - Pmkr, dual, non rate-resp	Device B code not found
33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C2620 - Pmkr, single, non rate-resp	C1898 - Lead, pmkr, other than trans
33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C2621 - Pmkr, other than sing/dual	Device B code not found
33206 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); atrial	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C1785 - Pmkr, dual, rate-resp	Device B code not found
33207 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C2620 - Pmkr, single, non rate-resp	C1898 - Lead, pmkr, other than trans
33207 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C2619 - Pmkr, dual, non rate-resp	Device B code not found
33207 - Insertion or replacement of permanent pacemaker with transvenous electrode(s); ventricular	71090 - Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation	C1786 - Pmkr, single, rate-resp	C1779 - Lead, pmkr, transvenous VDD
33207 - Insertion or replacement of permanent	71090 - Insertion pacemaker, fluoroscopy and	C1785 - Pmkr, dual.	-

PARA Data Editor Calculator

CPT® Assistant – 1990 to Present

PARA licenses the CPT® Assistant from the American Medical Association, the tables are updated quarterly.

The query format is comma separated code, wildcard and text.

The query returns a list of articles-the User can then review the article description and click to view the details of the article.

CPT®/HCPCS code or text query:

The screenshot shows the PARA Data Editor Calculator interface. The top navigation bar includes tabs: Select, Quote A Price, Charge Maintenance, Contracts, Pricing Data, Pricing, Rx / Supplies, Filters, CDM, Calculator (highlighted), Advisor, Administration, and PARA. Below the navigation bar, the 'Report Selection' tab is active, and the search query is 'CPT® Assistant'. The results section states: '38 document(s) were found matching the query 'cast''. Below this, a list of documents is displayed with columns for Document, Title, and Click to Review. The list includes:

Document	Click to Review
1 Code 27165	Click to Review
2 Pedicle Flaps (Skin and/or Deep Tissues)–(Codes 15570-15576) (March 2010)	Click to Review
3 Radiology: Radiation Oncology (December 2008)	Click to Review
4 Orthotic Management and Prosthetic Management (February 2007)	Click to Review
5 Special Services, Procedures and Reports (August 2006)	Click to Review
6 Surgery: Musculoskeletal System (June 2006)	Click to Review
7 Coding Clarification: Medicine/Allergen Immunotherapy Services (June 2005)	Click to Review
8 Correction (April 2003)	Click to Review
9 OPPS Reporting Part III - HCPCS Supply Codes (March 2003)	Click to Review
10 Musculoskeletal System (December 2002)	Click to Review

Selection of specific article:

The screenshot shows the PARA Data Editor Calculator interface with the 'Document Details: OPPS Reporting Part III - HCPCS Supply Codes (March 2003)' article selected. The article title is displayed at the top. Below the title, the text reads: 'March 2003 page 9'. The main content area features a blue header with the title 'Coding Communication: OPPS Reporting Part III - HCPCS Supply Codes'. The text below the header discusses the use of HCPCS Level II codes describing a drug, device, or other supply item, eligible for separate reporting under Medicare's Outpatient Prospective Payment System (OPPS). It mentions that the CPT surgery section guidelines do not include listings of codes/procedures for which it is appropriate to report supply items (eg, surgical trays) separately. Reimbursement of those supplies and materials required to perform the procedure is a specific reimbursement issue, which varies from one fiscal intermediary to another. Centers for Medicare & Medicaid Services (CMS) has created specific instruction regarding the separate reporting of "supply" items, particularly when associated with the reporting of the casting/splinting CPT codes. Therefore, it is helpful to understand why/how the HCPCS Level II codes are used for OPPS.

OPPS Packaging of Services

If the term "packaging" is familiar, perhaps you recall its discussion in the surgery guidelines regarding the surgical "package" as defined by the CPT nomenclature. Both the CMS OPPS and CPT surgical package concepts involve very specific, yet sometimes differing, instruction related to the packaging of "supplies." In general, the cost of drugs, pharmaceuticals, and biologicals are packaged into the ambulatory

PARA Data Editor Calculator

HCPCS/CPT® to ICD-9 Crosswalk

This query is based on the 3M data tables, which provide a cross reference between HCPCS/CPT® codes and procedural ICD-9 codes.

The query format is comma separated code, wildcard and text.

The returns are as follows:

1. CPT®/HCPCS Code
2. CPT®/HCPCS Code Description
3. ICD-9 Code
4. ICD-9 Code Description

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Select Quote A Price Charge Maintenance Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator Advisor Administration PARA

Report Selection HCPCS/CPT® to ICD9 Lookup

HCPCS/CPT® to ICD9 Lookup

Codes and/or Descriptions: 32500,47001,93510,45378,12005
Results Returned (below): 18

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HCPCS/CPT®	ICD9
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	54.63 - ABD Wall Suture NEC
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	61.41 - Suture Scrotal Lacerat
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	64.41 - Suture Penile Laceration
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	71.71 - Suture Vulvar Laceration
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	71.79 - Vulvar/Perin Repair NEC
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	85.81 - Suture Breast Laceration
12005 - Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 12.6 cm to 20.0 cm	86.59 - Skin Closure NEC
32500 - Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	32.28 - Endosc Destruc Lung LES
32500 - Removal of lung, other than total pneumonectomy; wedge resection, single or multiple	32.29 - Destroy LOC Lung LES NEC
45378 - Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	45.23 - Colonoscopy
45378 - Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	45.25 - Clos Large Bowel Biopsy
45378 - Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or	46.85 - Dilation OF Intestine

PARA Data Editor Calculator

Quick Claim Evaluation

The Quick Claim Evaluation report allows the User to view a series of CPT® codes in a UB04 claim format within the Claim Evaluation module. The User enters a series of codes (comma separated) and the Calculator displays the following:

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM **Calculator** Advisor Admin RAC CAT PARA

Report Selection **2016 Quarter: Q2 OPPS Quick Claim Evaluation**

OPPS Quick Claim Evaluation
Valid search results are listed below.
A Quick Claim can be imported into the PDE Claim Evaluator for further review, just by clicking the 'Create Claim' button below.
Demonstration Hospital AWI: 1

[Instructions/Additional Info.](#) [PDF Export](#) [Create Claim](#) [CCI Color Legend](#)

HCPCS	Modifier	Status	Serv. Units	Rev. Code	Service Date	CCI	Reimb	MUE	OCE	Reimb Comment
71020 - Chest x-ray 2vw frontal&lati		Q3	1		04/28/16		\$60.80	4	4	Q3 - No Shared Composite Family - Value Individually
85025 - Complete cbc w/auto diff wbc		Q4	1		04/28/16		\$0.00	4	1	Status Q4 - Packaged No Pay
93005 - Electrocardiogram tracing		Q1	1		04/28/16		\$0.00	3	4	Status Q1 - Package to S, T, V status
96365 - Ther/proph/diag iv inf init		S	1		04/28/16		\$173.18	1		Pay at wage adjusted APC
Total:							\$233.98			

CCI Edits are performed against the codes, and any items that would require a modifier or those that cannot be billed in the same encounter will have a color-coded indicator.

The return includes:

1. CPT® code and Description
2. Modifiers
3. APC Status
4. Service Units
5. Revenue Code
6. Service Date
7. CCI Edit result
8. Medicare Reimbursement
9. Medically Unlikely Edits
10. OCE Quantity
11. Reimbursement Comment

The results can be exported to a PDF formatted report, or the User can “create” a claim within the Claim Evaluator Module.

PARA Data Editor Calculator

National Provider ID

The PDE User can search the National Provider ID Database for individual or Organization NPIs in any state. The query can be performed on an NPI ID number or a keyword. The example below was a keyword search on “Childrens” in California.

The return displays the following data points:

1. NPI Number
2. Name (of individual or organization)
3. Address
4. City
5. State
6. Zip Code
7. Phone Number
8. Fax Number

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Select	Charge Quote	Charge Process	Claim/RA	Contracts	Pricing Data	Pricing	Rx / Supplies	Filters	CDM	Calculator	Advisor	Admin	RAC	CAT	PARA
Report Selection		National Provider ID													
National Provider ID															
Codes and/or Descriptions: Childrens															
Results Returned (below): 187															
Export to PDF Export to Excel Copy to Clipboard															
NPI	Name	Address	City	State	Zip	Phone	Fax								
1386670974	CHILDRENS MEDICAL GROUP OF ORANGE COUNTY	500 S ANAHEIM HILLS RD Ste 110	ANAHEIM HILLS	CA	92807	(714) 282-2229	(714) 282-7145								
1639152820	CHILDRENS CARDIAC MEDICAL CLINIC	301 W HUNTINGTON DR #415	ARCADIA	CA	91007	(626) 445-5552	(626) 445-4411								
1992008643	KERN COUNTY PUBLIC HEALTH DEPARTMENT	1800 MOUNT VERNON AVE 2ND FLOOR	BAKERSFIELD	CA	93306	(661) 868-0531	(661) 868-0266								
1700912557	CHILDRENS BUREAU OF SOUTHERN CALIFORNIA		BALDWIN PARK	CA	91706	(626) 337-8811	(626) 856-5653								
1306967567	CAMARILLO CHILDRENS DENTAL GROUP		CAMARILLO	CA	93010	(805) 484-2705	(805) 484-5908								
1942335914	SUBACUTE CHILDREN'S HOSPITAL OF NORTHERN CALIFORNIA		CAMPBELL	CA	95008	(408) 340-1560	(408) 866-8144								
1417083049	CHILDRENS BUREAU OF SOUTHERN CALIFORNIA	460 E CARSON PLAZA DR Ste 212	CARSON	CA	90746	(310) 523-9500									
1013996305	CONSTANCE C CORSINO MD INC		CHINO	CA	91710	(909) 627-7433	(909) 627-8573								
1306988118	THE SAFOURA MASSOURI PROFESSIONAL DENTAL CORP	397 E ST STE #A	CHULA VISTA	CA	91910	(619) 425-9930	(619) 425-9887								
1538215678	CHILDRENS MEDICAL GROUP OF SOUTH BAY		CHULA VISTA	CA	91910	(619) 425-3951									
1922129766	RADY CHILDRENS HOSPITAL AND HEALTH CENTER		CHULA VISTA	CA	91911	(619) 420-5611	(619) 420-5531								
1285751222	SANJIV K MIDHA MD	348 MARKET ST Ste B	COLUSA	CA	95932	(530) 458-2300									
1528195716	CHILDRENS HOSPITAL OF ORANGE COUNTY		COSTA MESA	CA	92627	(714) 589-4861									
1316256670	SAN GABRIEL CHILDRENS CENTER		COVINA	CA	91724	(626) 859-2089									
1730381880	SAN GABRIEL CHILDRENS CENTER INC		COVINA	CA	91724	(626) 859-2089	(626) 859-6537								
1922145796	ANGEL VIEW CRIPPLED CHILDRENS FOUNDATION INC		DESERT HOT SPRINGS	CA	92240	(760) 329-6471									
1295872034	ANGEL VIEW CRIPPLED CHILDRENS FOUNDATION INC		DESERT HOT SPRINGS	CA	92240	(760) 329-6471									

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PARA Data Editor Calculator

UB-04 Data Specifications Manual

Limited access is available to select users to the searchable UB-04 Data Specification Manual:

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Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator **Advisor** Admin RAC CAT PARA

Report Selection 2012 UB-04 Data Specifications Manual

1 Configure your report options: [Instructions](#)

HCPCS / CPT® Codes Report Options

Select State: or Enter Zip Code:
[Search Zip Code](#)

Select City:

Select Hospital:

Medicaid State: CALIFORNIA

Physicians Fee Schedule: ANAHEIM/SANTA ANA, CA (by selected hospital)

Clinical Lab Fee Schedule:

Local Coverage Determination Report Options

Select State or Region:

Select Contractor:

Codes and/or Descriptions: [Code > Keyword](#)

3 ICD10 Code (for LCD, HCPCS to ICD10):

☐ Check Here to execute Cross-Report Auto Load

[Click Here to save default selections](#)

[Click to review CMS: Reason Codes or Remark Codes](#)

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- ☐ Local Coverage Determination ☒ Policies (HCPCS, ICD10) ☐ Articles (Article ID, Keyword) ☐ Policies by LCD ID
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Document Details: UB-04_2014_PATIENT DISCHARGE STATUS [Back to Previous](#)

Effective Date:? March 1, 2007 **Meeting Date:**

Form Locator 17
Page 1 of 16

Data Element

Patient Discharge Status

Definition:???? A code indicating the disposition or discharge status of the patient at the end service for the period covered on this bill, as reported in FL6, Statement Covers Period.

Reporting:???? ? UB-04:? Required
? 004010/004010A1: Situational. Required for inpatient claims/encounters.
? 005010: Required

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PARA Data Editor Calculator

HCPCS to Anesthesia Code Crosswalk

This crosswalk allows Users to enter a surgical CPT® code to determine the appropriate Anesthesia CPT® code. As with other crosswalk files, either code will display the same result:

PARA Data Editor - **Demonstration Hospital [Sales]** dbDemo [Contact Support](#) | [Log Out](#)

Select Charge Quote Charge Process Claim/RA Contracts Pricing Data Pricing Rx / Supplies Filters CDM Calculator **Advisor** Admin RAC CAT PARA

Report Selection 2012 UB-04 Data Specifications Manual

1 Configure your report options: [Instructions](#)

HCPCS / CPT® Codes Report Options

Select State: CALIFORNIA or Enter Zip Code: 92807
[Search Zip Code](#)

Select City: Anaheim

Select Hospital: Regional Hospital (990001)

Medicaid State: CALIFORNIA

Physicians Fee Schedule: ANAHEIM/SANTA ANA, CA (by selected hospital)

Clinical Lab Fee Schedule: CA1

Local Coverage Determination Report Options

Select State or Region: CALIFORNIA - ENTIRE STATE

Select Contractor: A and B MAC - Noridian Healthcare Solutions, LLC (01111)

Codes and/or Descriptions: [Code > Keyword](#)
45378

3 ICD10 Code (for LCD, HCPCS to ICD10):
 [Submit](#)

☐ Check Here to execute Cross-Report Auto Load

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Report Selection **HCPCS to Anesthesia Code**

HCPCS to Anesthesia Code Crosswalk - 2017 Q1

Codes and/or Descriptions: 45378

Results returned(below): 1 [Copy to Clipboard](#)

HCPC Code	Description	Anesthesia Code	Base Units	Status	CPT	AddB
45378	COLONOSCOPY, FLEXIBLE; DIAGNOSTIC, INCLUDING COLLECTION OF SPECIMEN(S) BY BRUSHING OR WASHING, WHEN PERFORMED (SEPARATE PROCEDURE)	00810	5	T	Y	Y