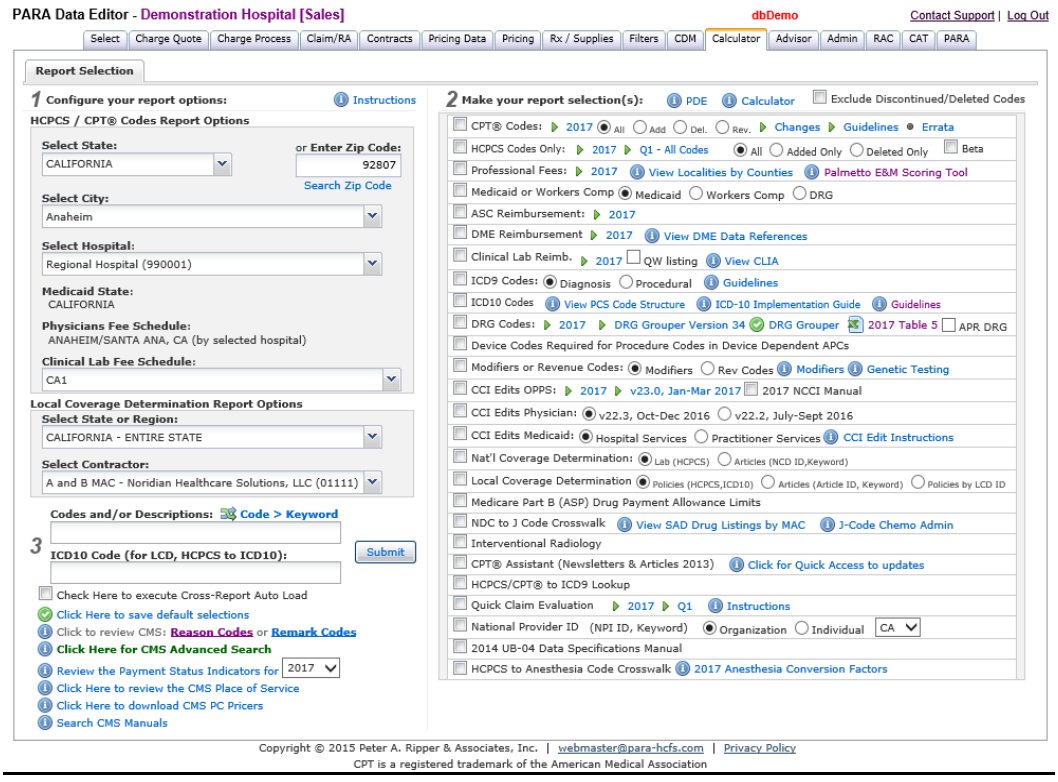
PARA Data Editor Calculator

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



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.

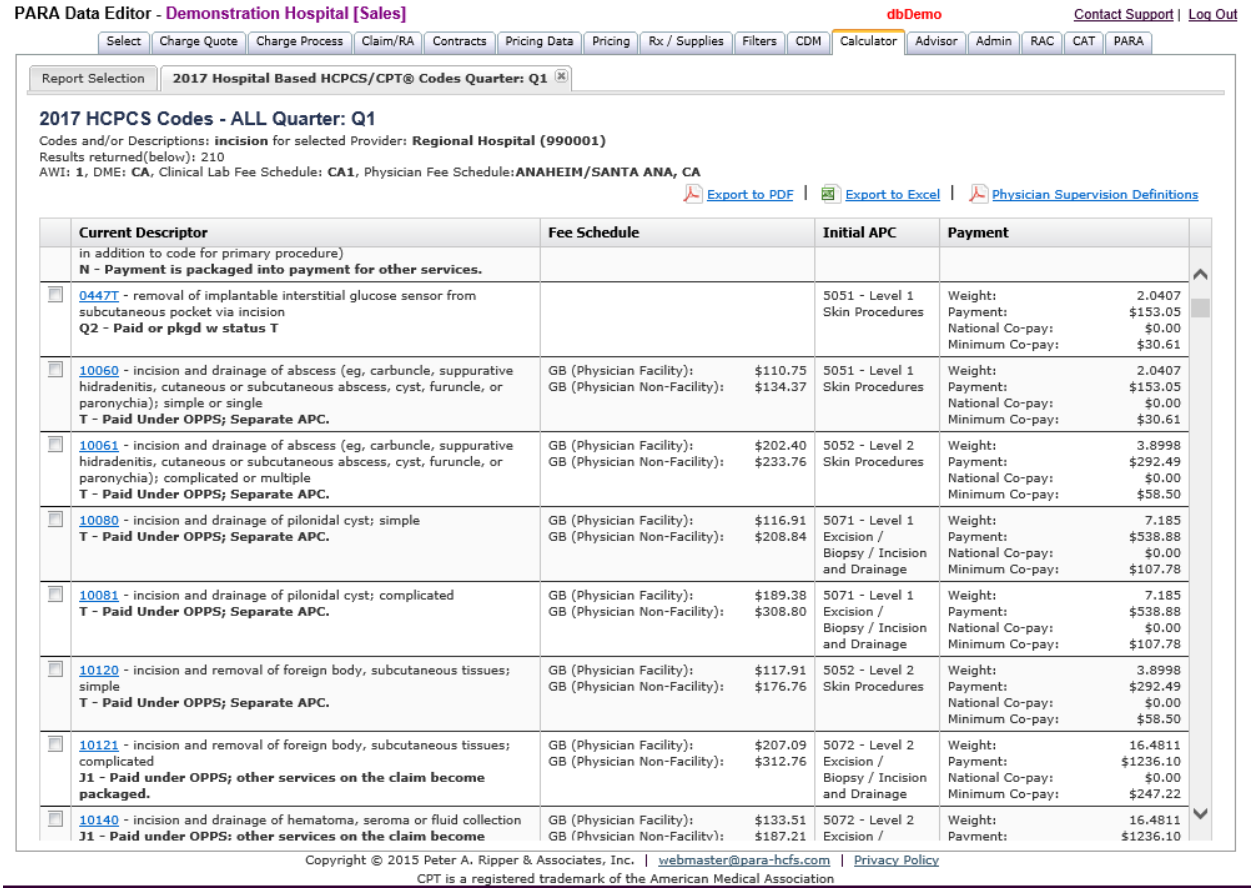
The query pasted below is for all codes which meet the following search criteria:

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.



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 | 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**

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule	Initial APC	Payment
in addition to code for primary procedure) **N - Payment is packaged into payment for other services.**			
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
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
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
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
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
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
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
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

CPT® Codes

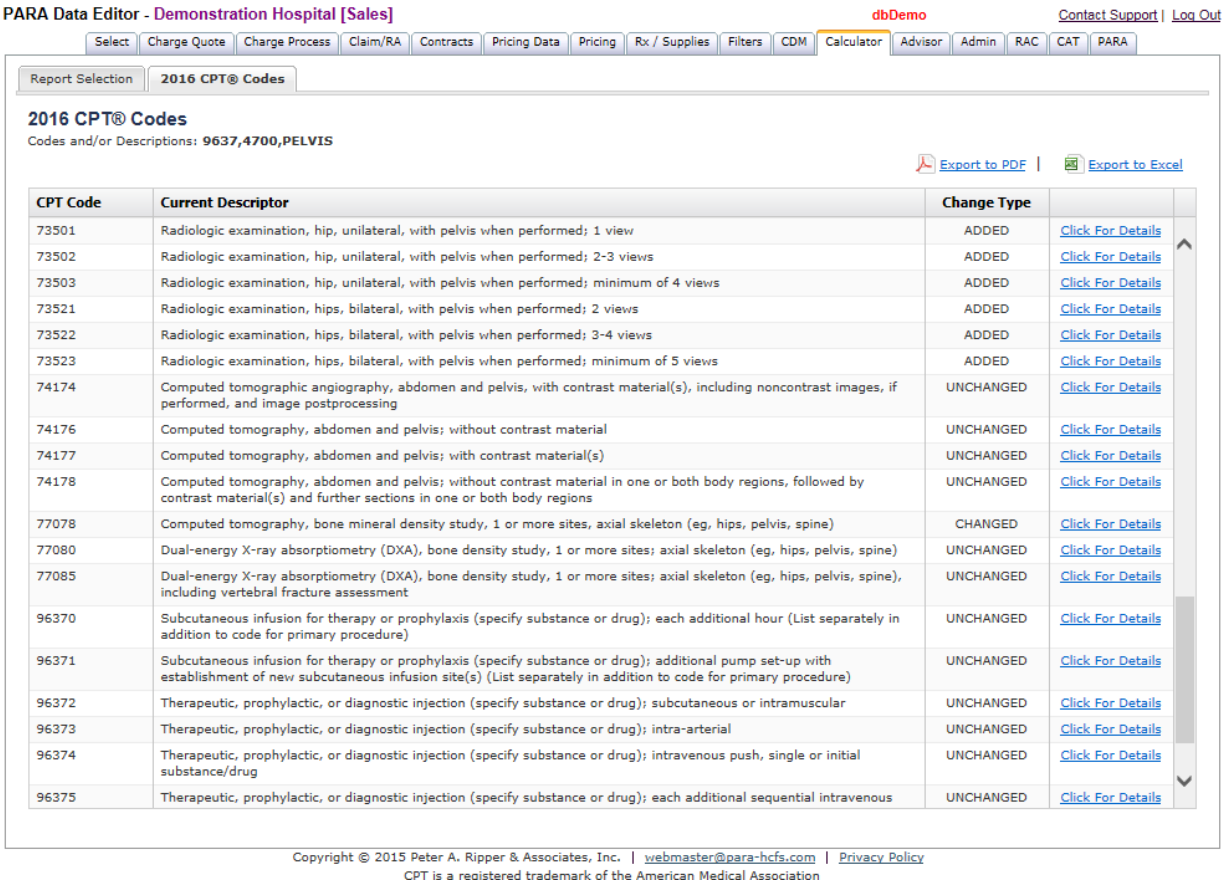
As a result of the relationship **PARA** has developed with the AMA, **PARA** receives the CPT® code set 4 – 5 months prior to implementation.

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.



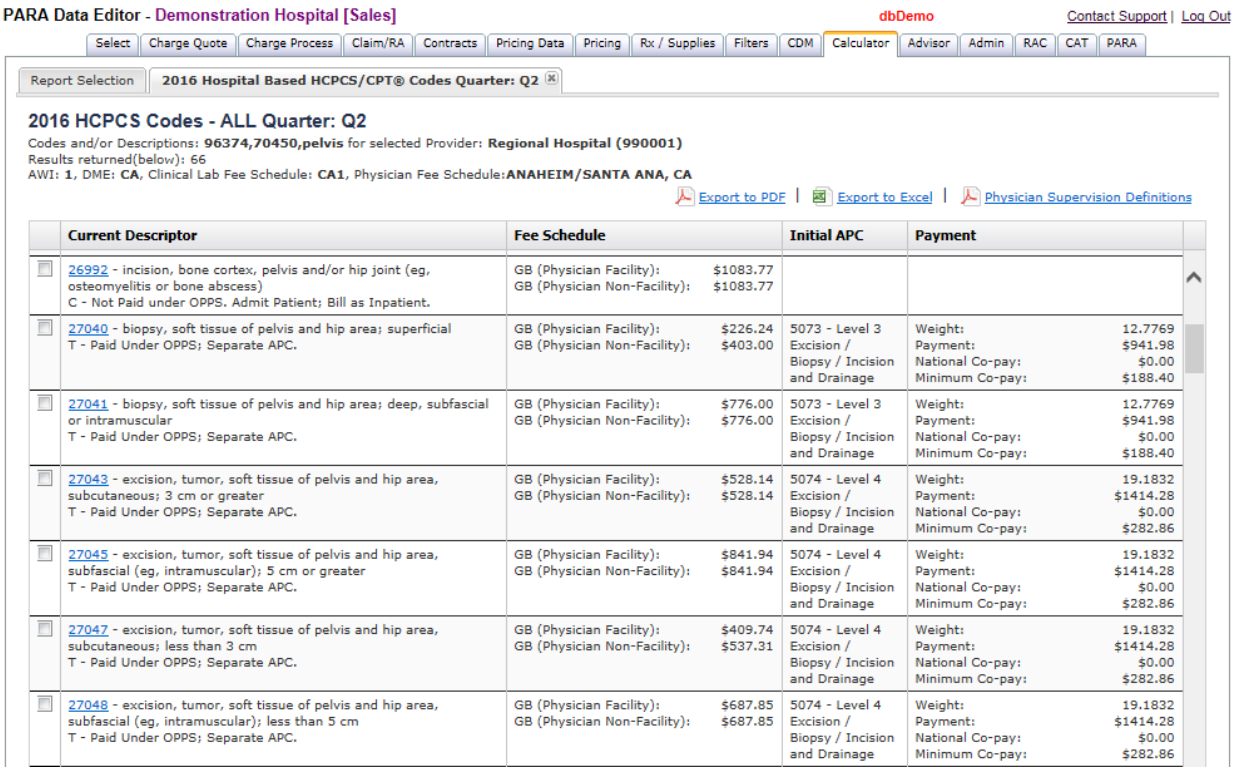
The additional information available at the Details link include expanded descriptions, Cross References Parentheticals (additional coding guidelines), a list of CPT® Assistant documents that reference the code, and a change history.

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.

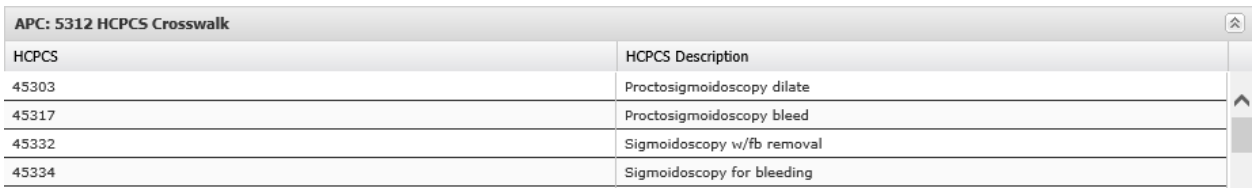
The query can also be focused to a specific code type (HCPCS C Codes, Alpha HCPCS Codes, DME Codes, Surgical Codes, Radiology Codes, Laboratory Codes, Other Diagnostic /Therapeutic Service Codes).

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.



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

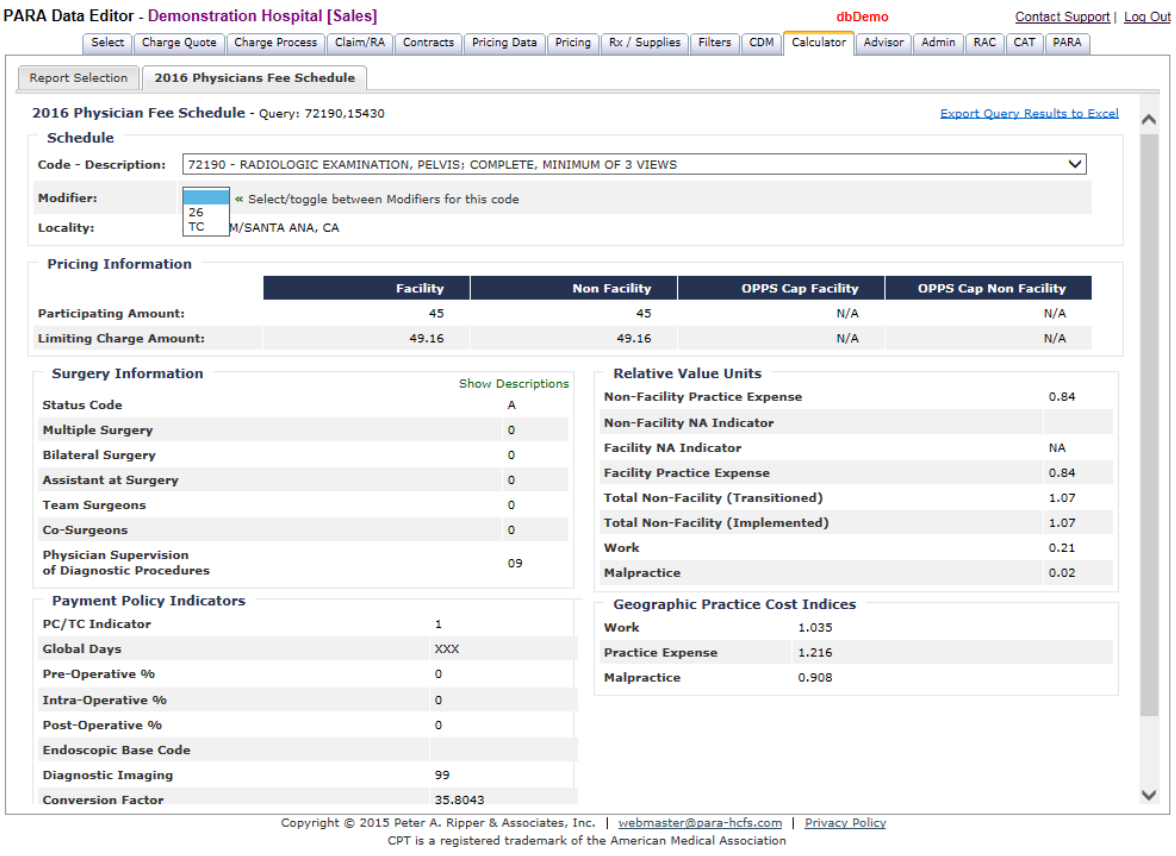
Professional Fees

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.

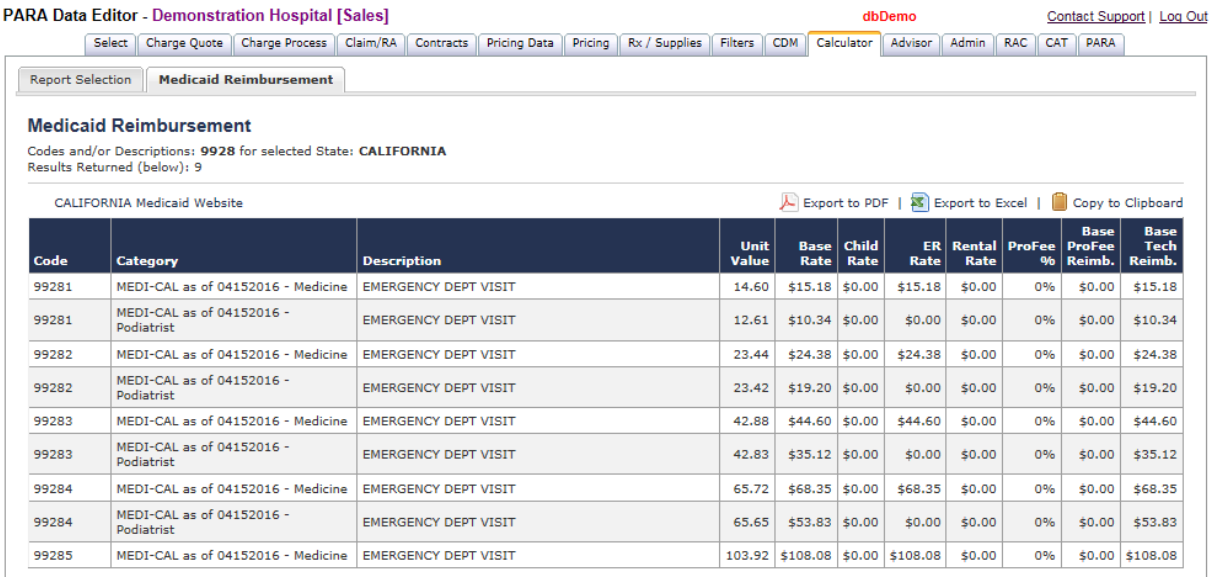
The query accepts comma separated codes, wildcards, and text.



Medicaid / Workers Comp Fee Schedule

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

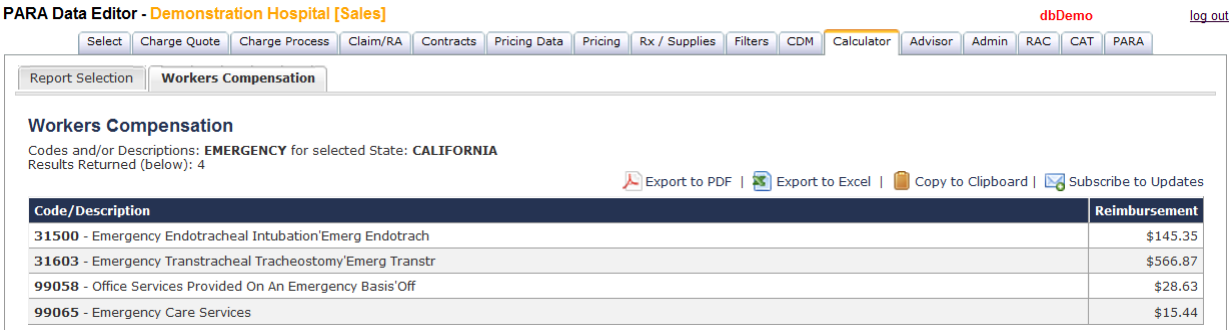
1. Code
2. Category
3. Description
4. Unit Value
5. Base Rate
6. Child Rate
7. ER Rate
8. Rental Rate



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



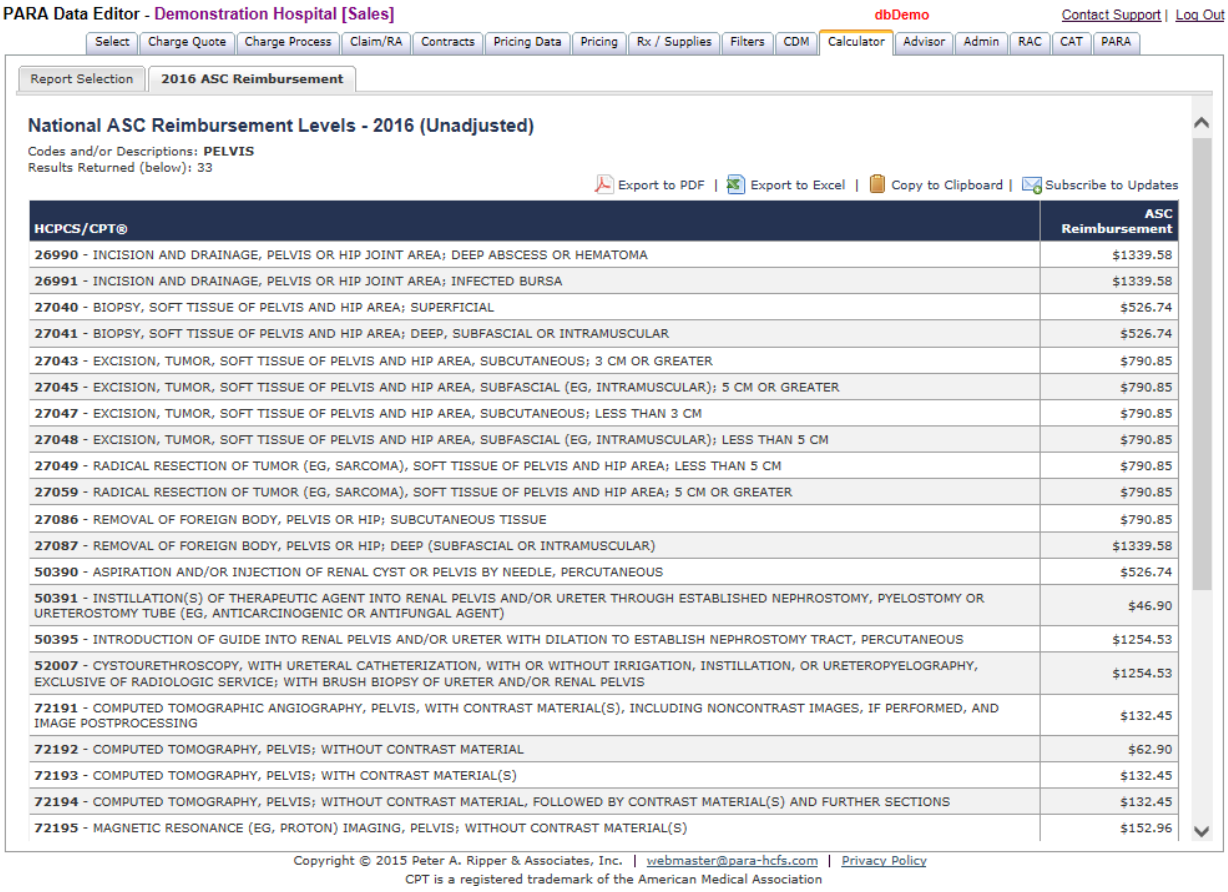
Code/Description	Reimbursement
31500 - Emergency Endotracheal Intubation'Emerg Endotrach	$145.35
31603 - Emergency Transtracheal Tracheostomy'Emerg Transtr	$566.87
99058 - Office Services Provided On An Emergency Basis'Off	$28.63
99065 - Emergency Care Services	$15.44

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

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 - INSTILLATION(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, INSTILLATION, 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

DME Reimbursement

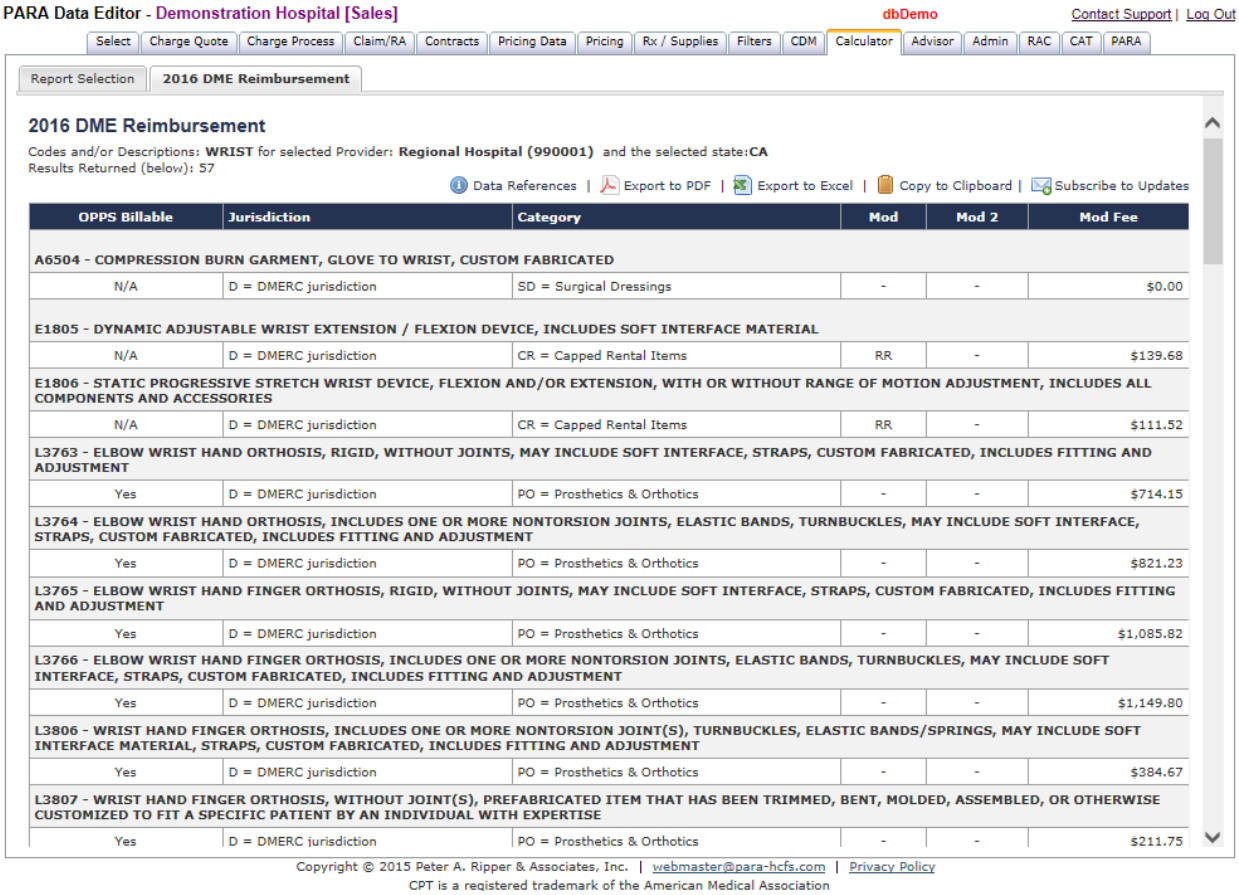
The returned values against a rolling four year period are as follows:

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.


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 | 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

Clinical Lab Reimbursement

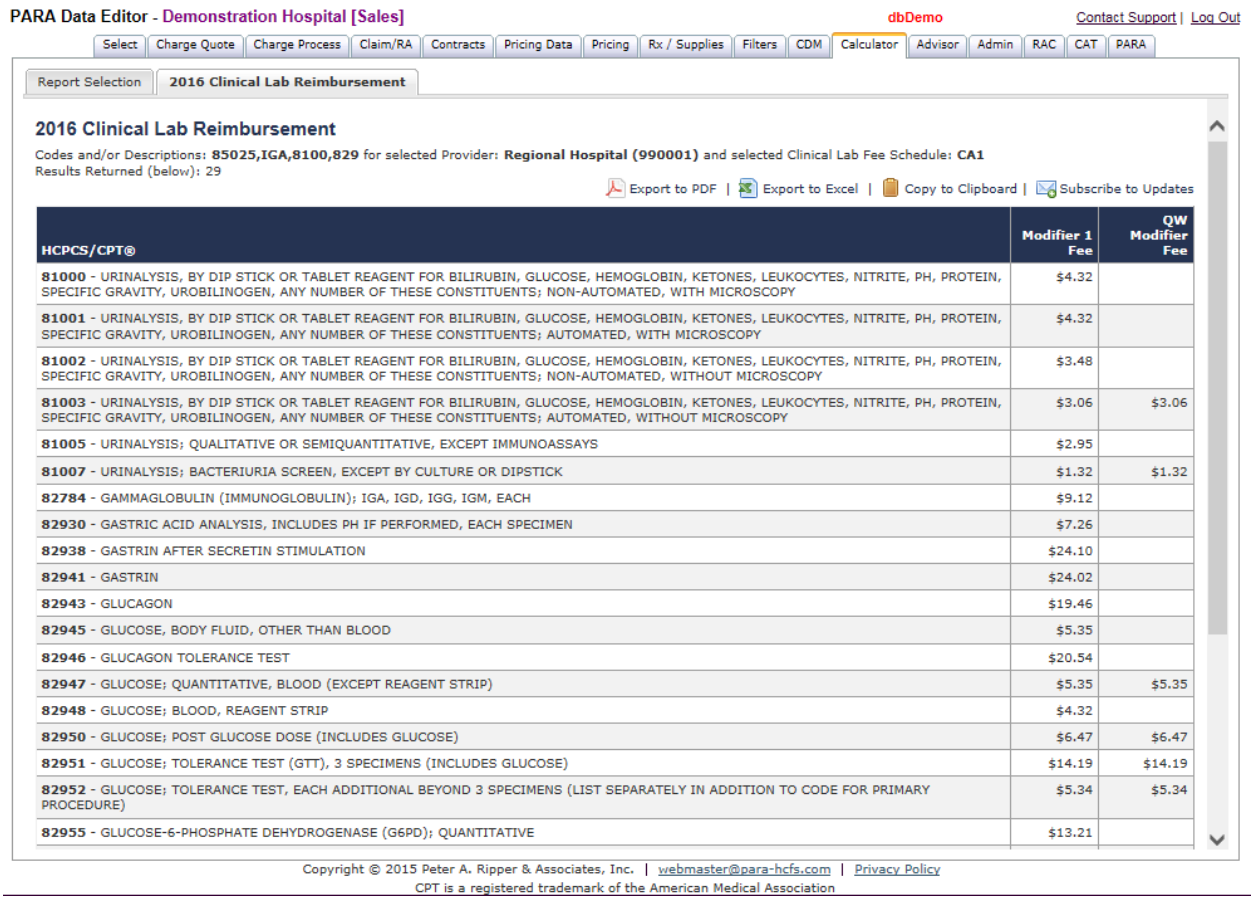
The query is available for a rolling four year period.

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



ICD-9 Codes Diagnosis and Procedural

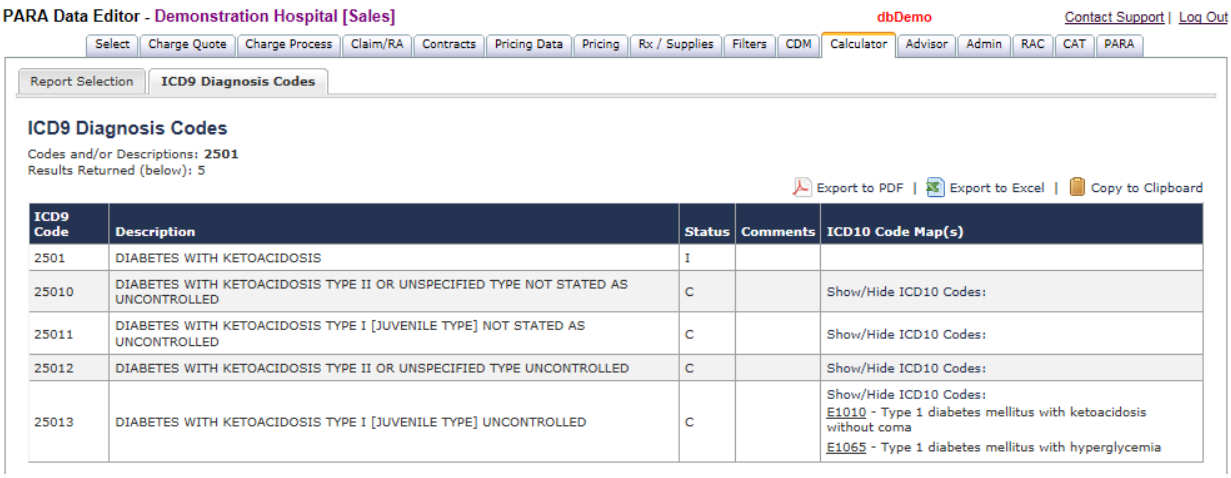
The two part ICD-9 tables require separate queries to be sure the correct code type is returned.

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

The values returned are as follows:

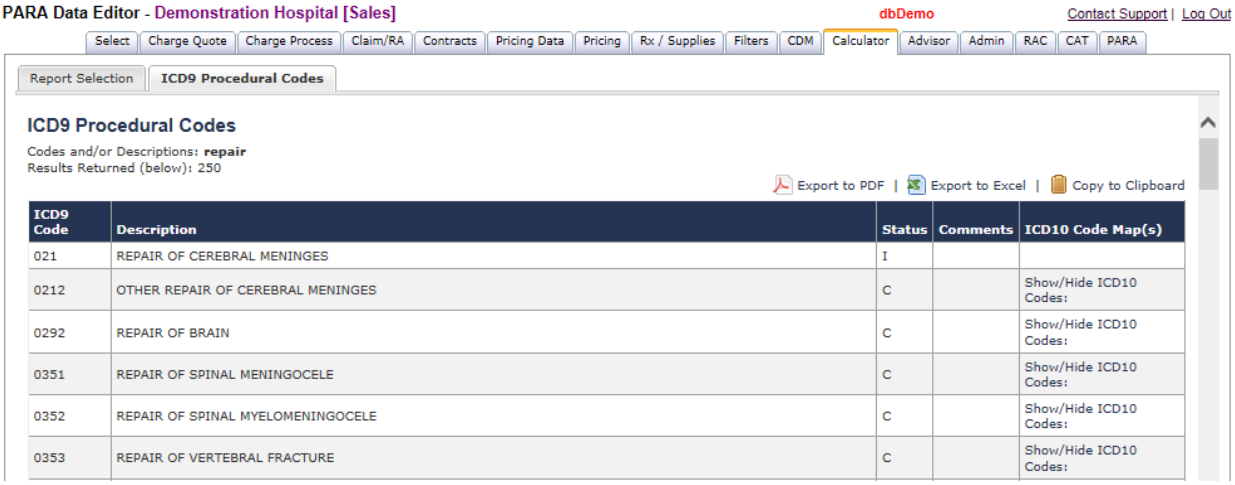
1. ICD-9 Code
2. Code Description
3. Status
4. Comments
5. The ICD-9 codes are mapped to the ICD-10, with the option to display the corresponding ICD-10 codes

Diagnosis Codes:



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:



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:

ICD-10 Codes

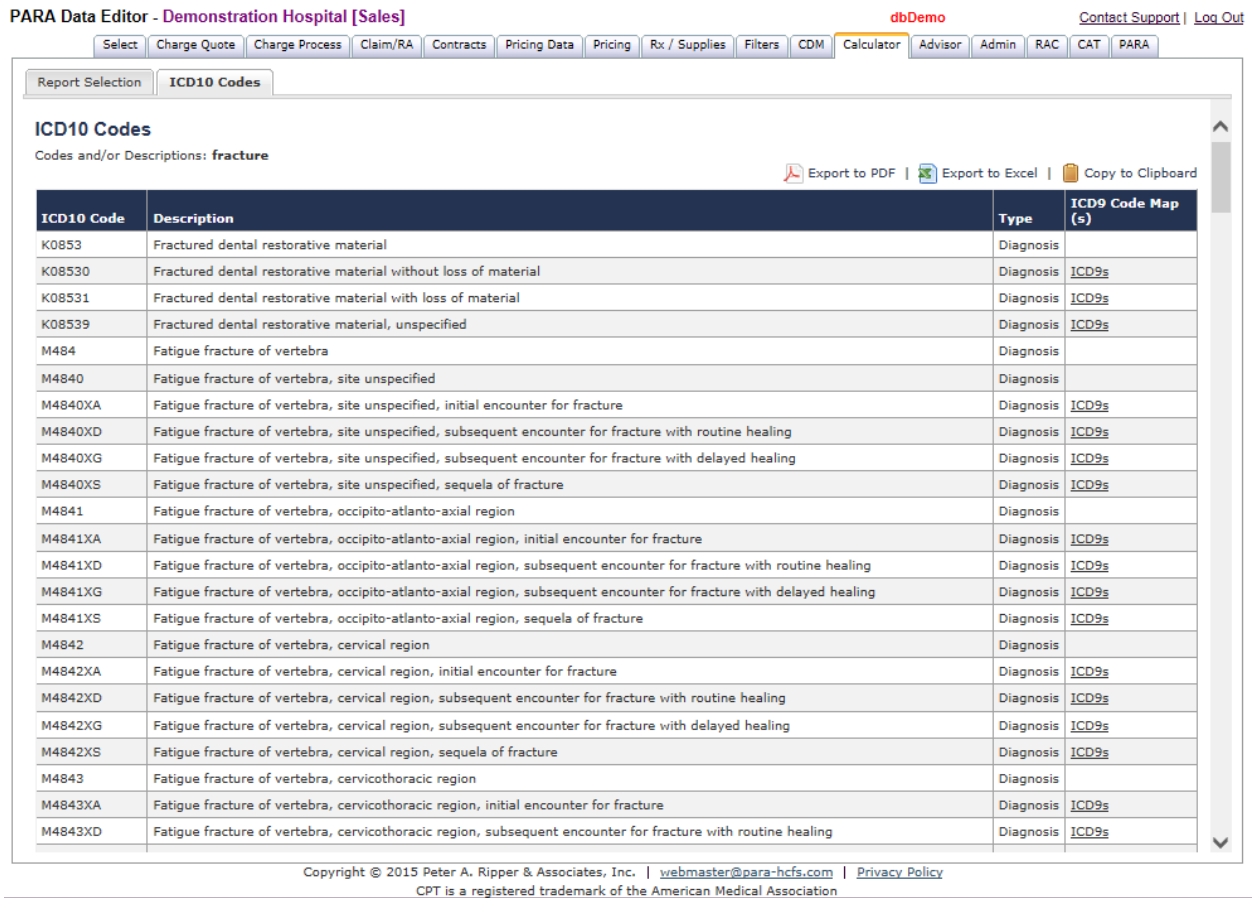
With the transition to ICD-10 codes, it is important to begin to understand the code structure and returns. ICD-10 codes have a completely different format and descriptions than ICD9.

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



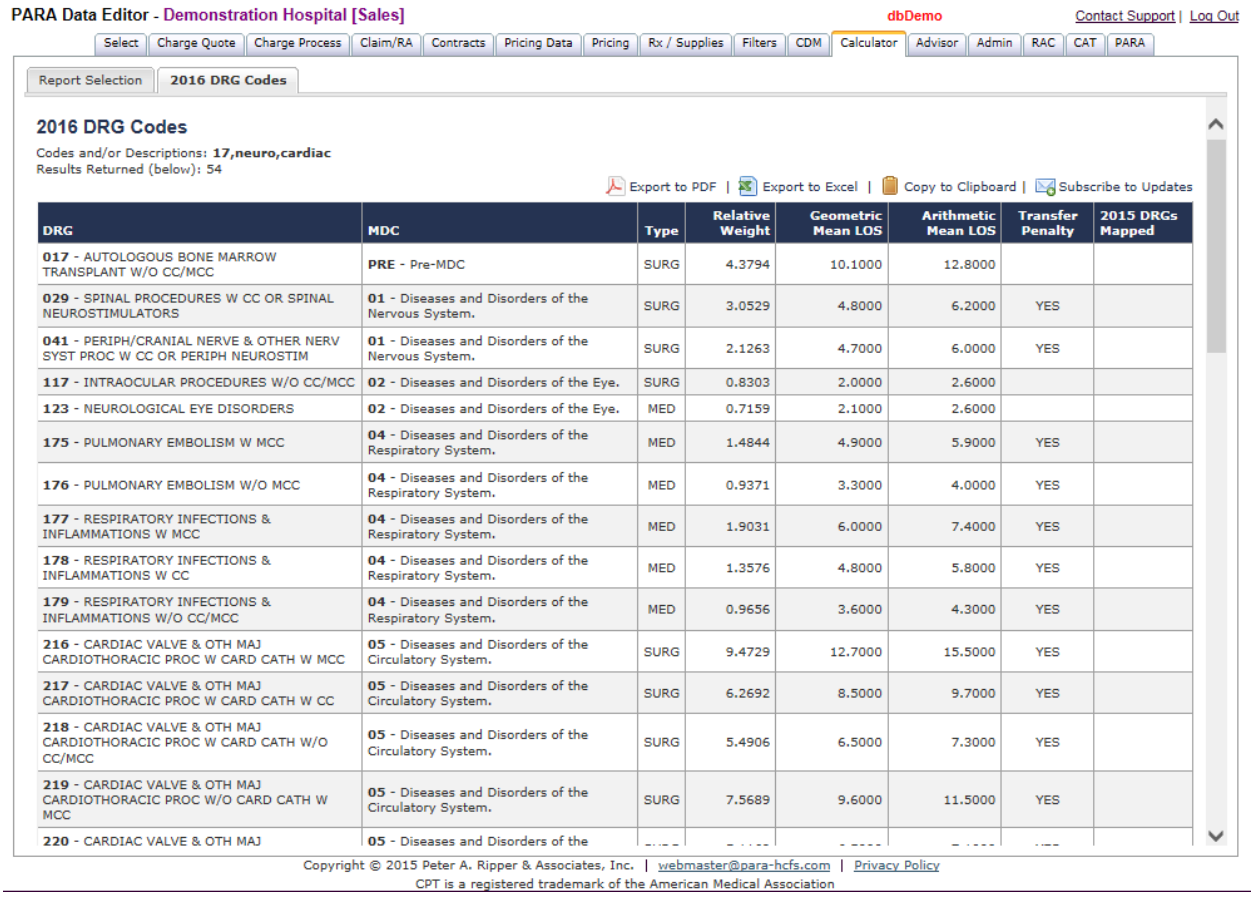
ICD10 Code	Description	Type	ICD9 Code Map (s)
K0853	Fractured dental restorative material	Diagnosis	
K08530	Fractured dental restorative material without loss of material	Diagnosis	ICD9s
K08531	Fractured dental restorative material with loss of material	Diagnosis	ICD9s
K08539	Fractured dental restorative 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

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



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 | 2016 DRG Codes

2016 DRG Codes

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

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

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						

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

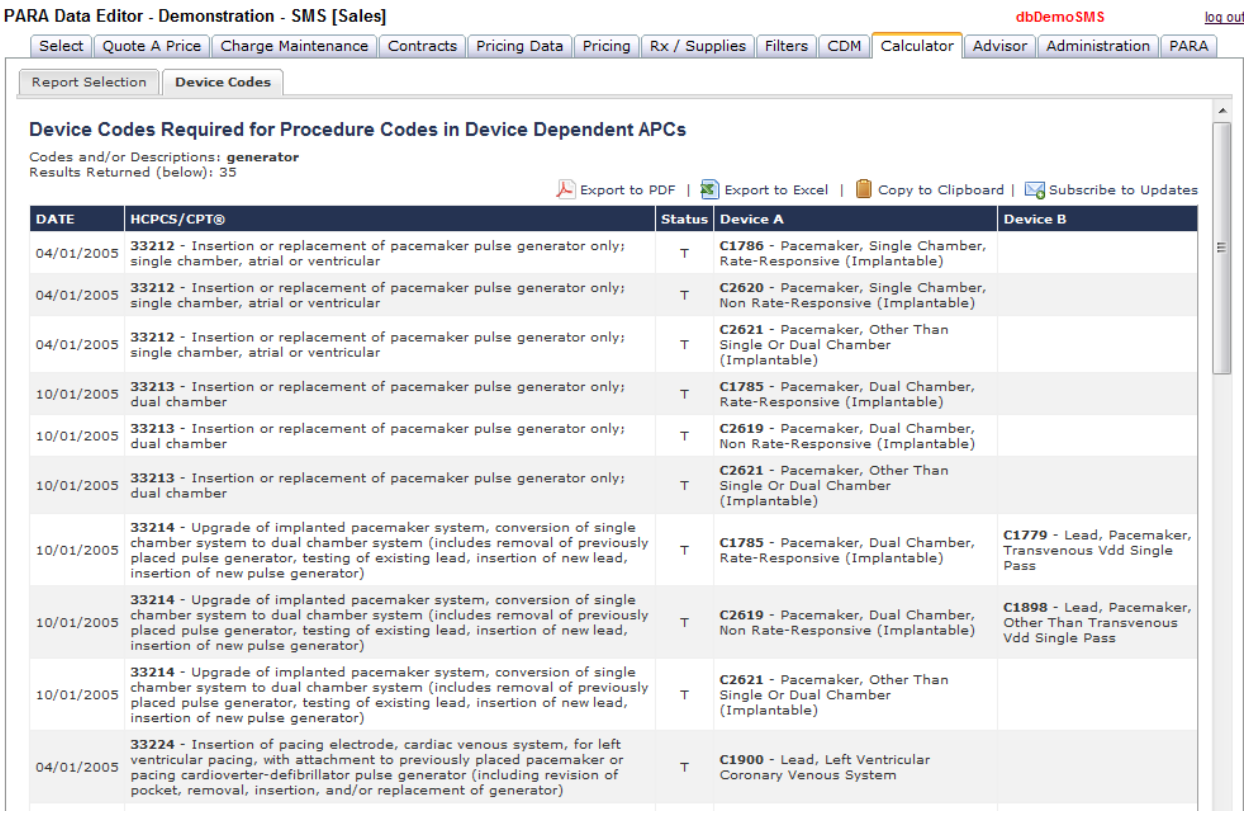
Device Dependent APC Codes

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



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	

Modifiers and Revenue codes

The query check box has a “radio button” selection, one for modifiers and also revenue codes.

The query supports codes (comma separated), wildcard, and text. The revenue code query requires the leading “0” as the first position.

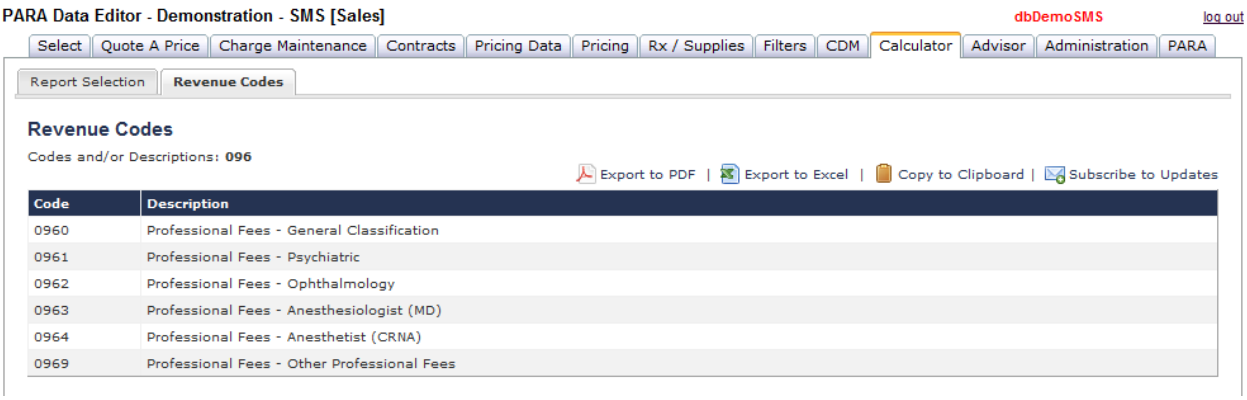
The return value for the both queries is as follows:

1. Modifier / Revenue Code
2. Description

Modifiers:

Modifier	Description
27	Multiple Outpatient Hospital Evaluation & Management Encounters on Same Date
47	Anesthesia by Surgeon
57	Decision for Surgery
73	Discontinued Out-Patient Procedure Prior to Anesthesia Administration
74	Discontinued Out-Patient Procedure After Anesthesia Administration
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
78	Return to the Operating Room for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician during the Postoperative Period

Revenue Codes:



Code	Description
0960	Professional Fees - General Classification
0961	Professional Fees - Psychiatric
0962	Professional Fees - Ophthalmology
0963	Professional Fees - Anesthesiologist (MD)
0964	Professional Fees - Anesthetist (CRNA)
0969	Professional Fees - Other Professional Fees

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.

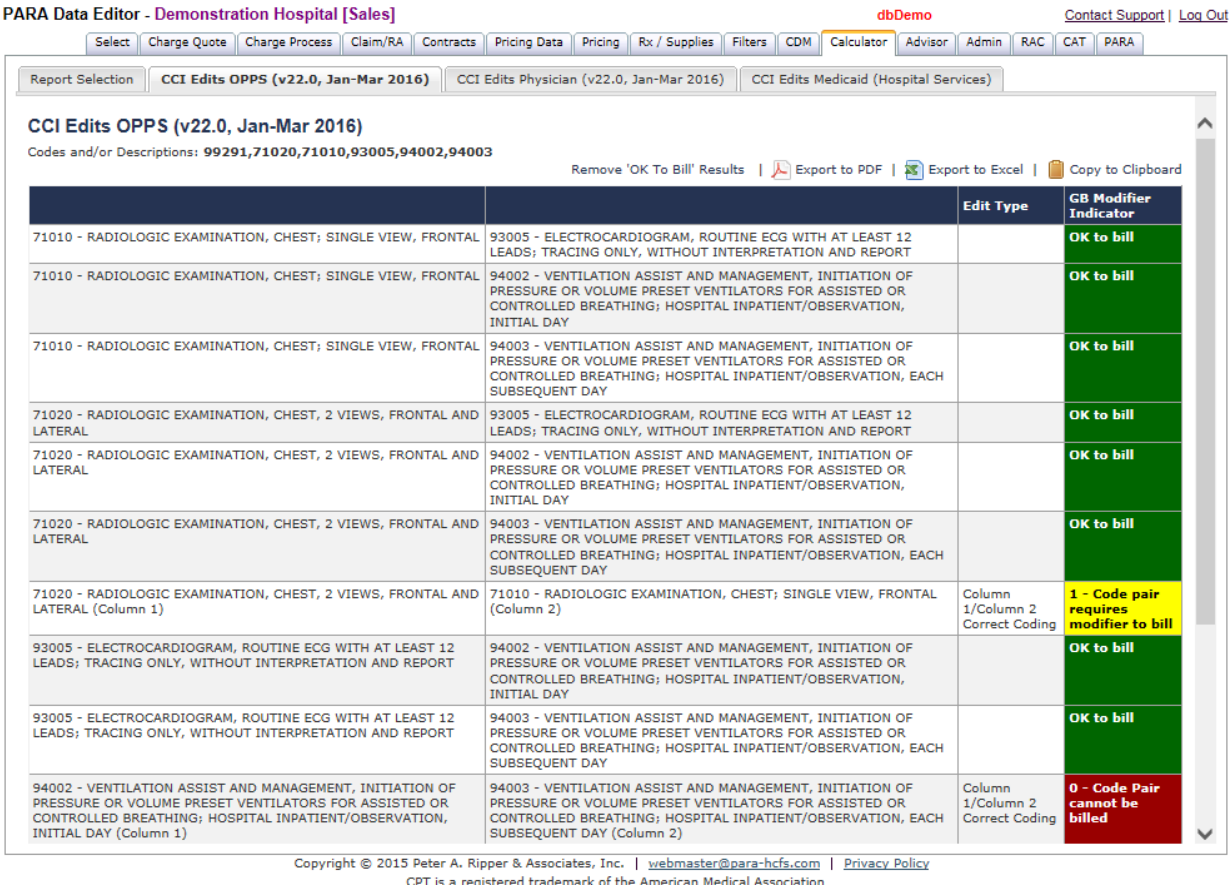
The returned values are as follows:

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.



		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

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.

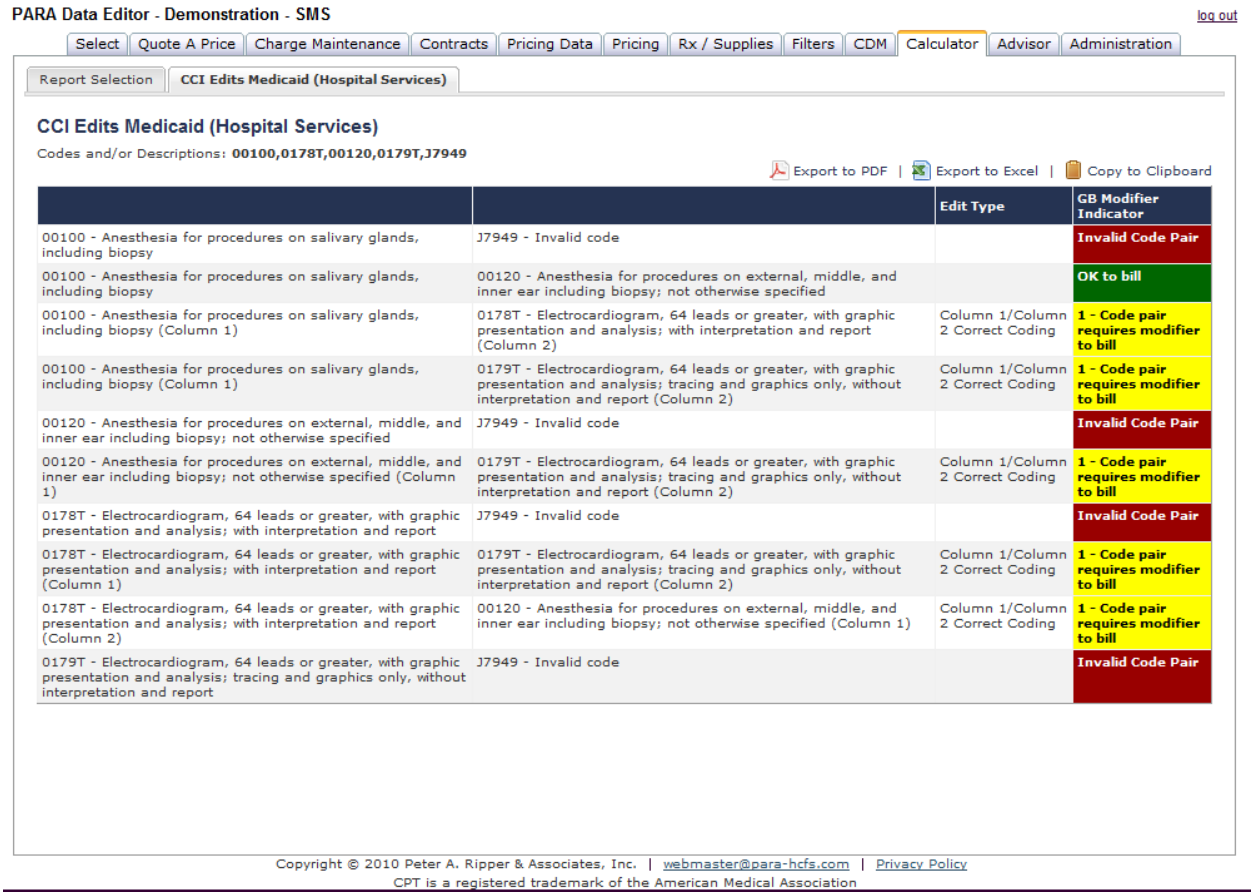
The query can be a single code or wildcard for all edits tied to the code, or a comma separated series of codes which will make comparisons against all combinations of the code pairs.

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.



		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

National Coverage Determination

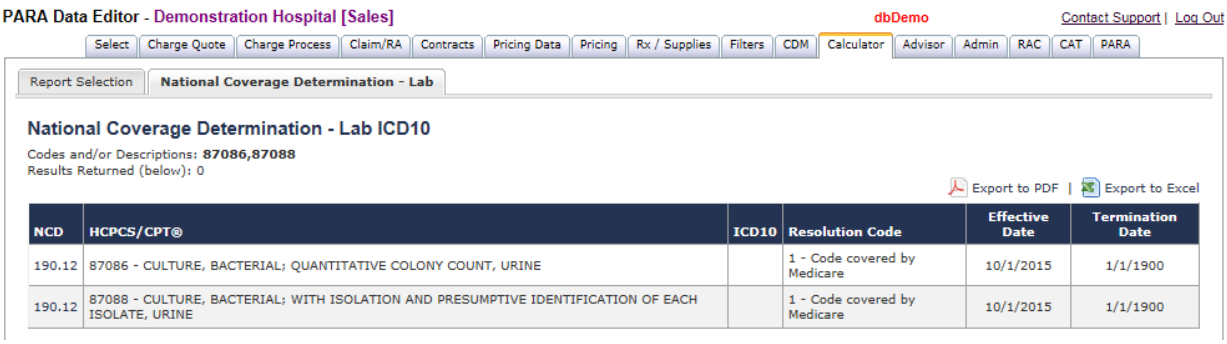
The query checks against the CMS Coverage data tables.

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:



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

Local Coverage Determination

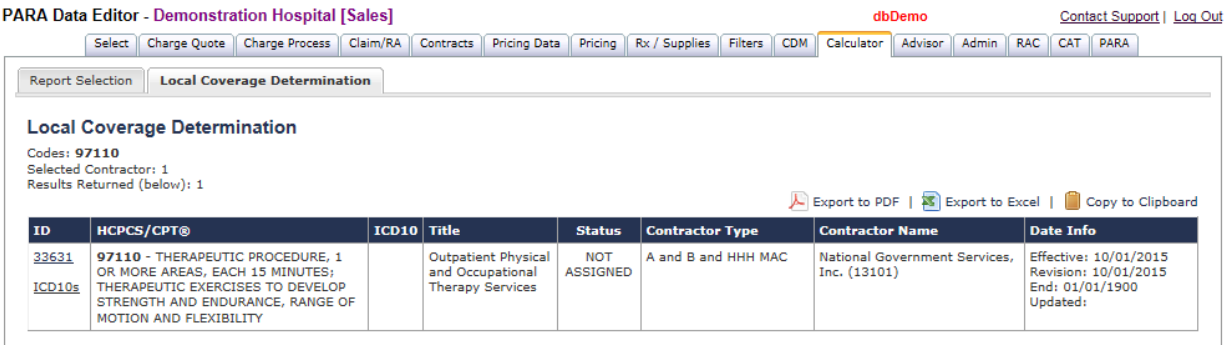
The query checks against the CMS Local Coverage data tables as defined by the Contractor chosen in the report selection tab. When using the "Select Contractor" drop-down be sure to save your default selections.

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:



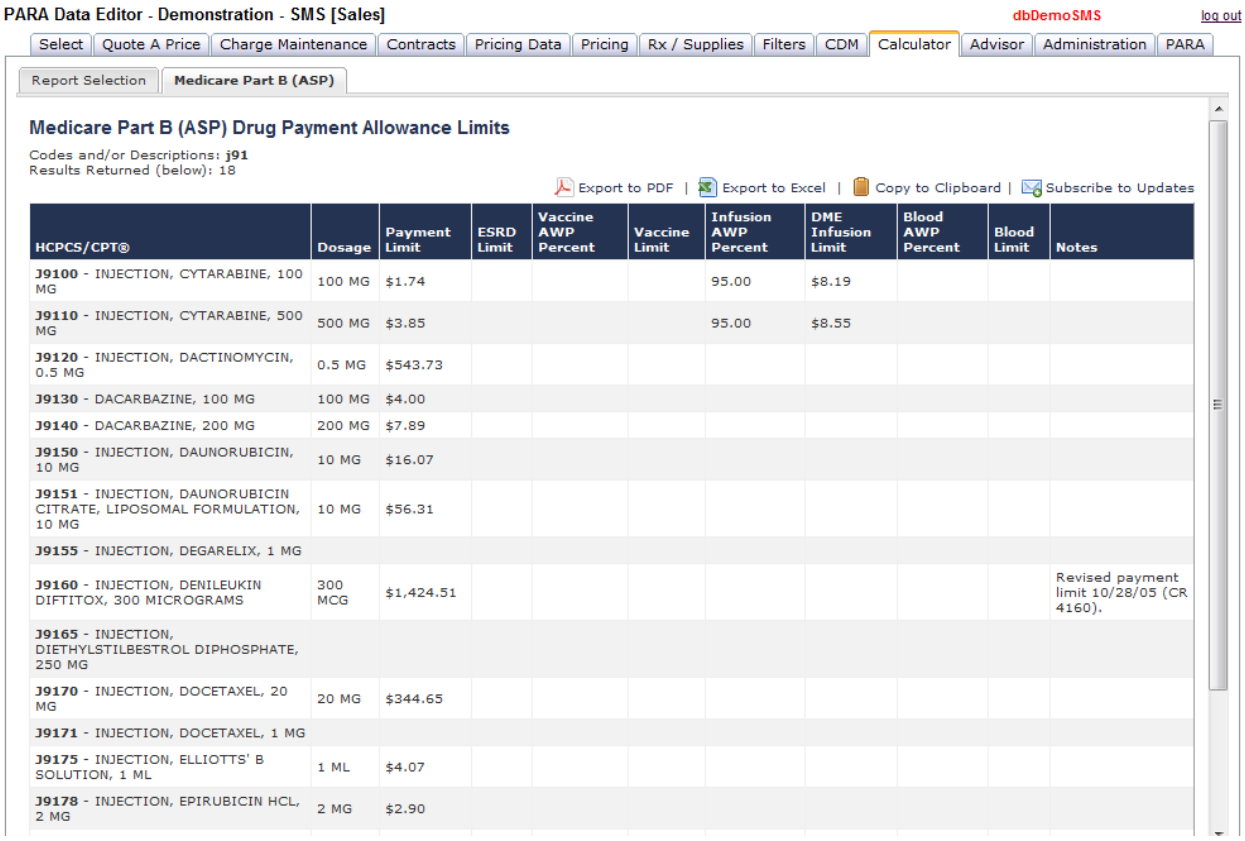
Medicare Part B ASP Drug Payments

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



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, ELLIOTTS' B SOLUTION, 1 ML	1 ML	$4.07								
J9178 - INJECTION, EPIRUBICIN HCL, 2 MG	2 MG	$2.90								

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

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

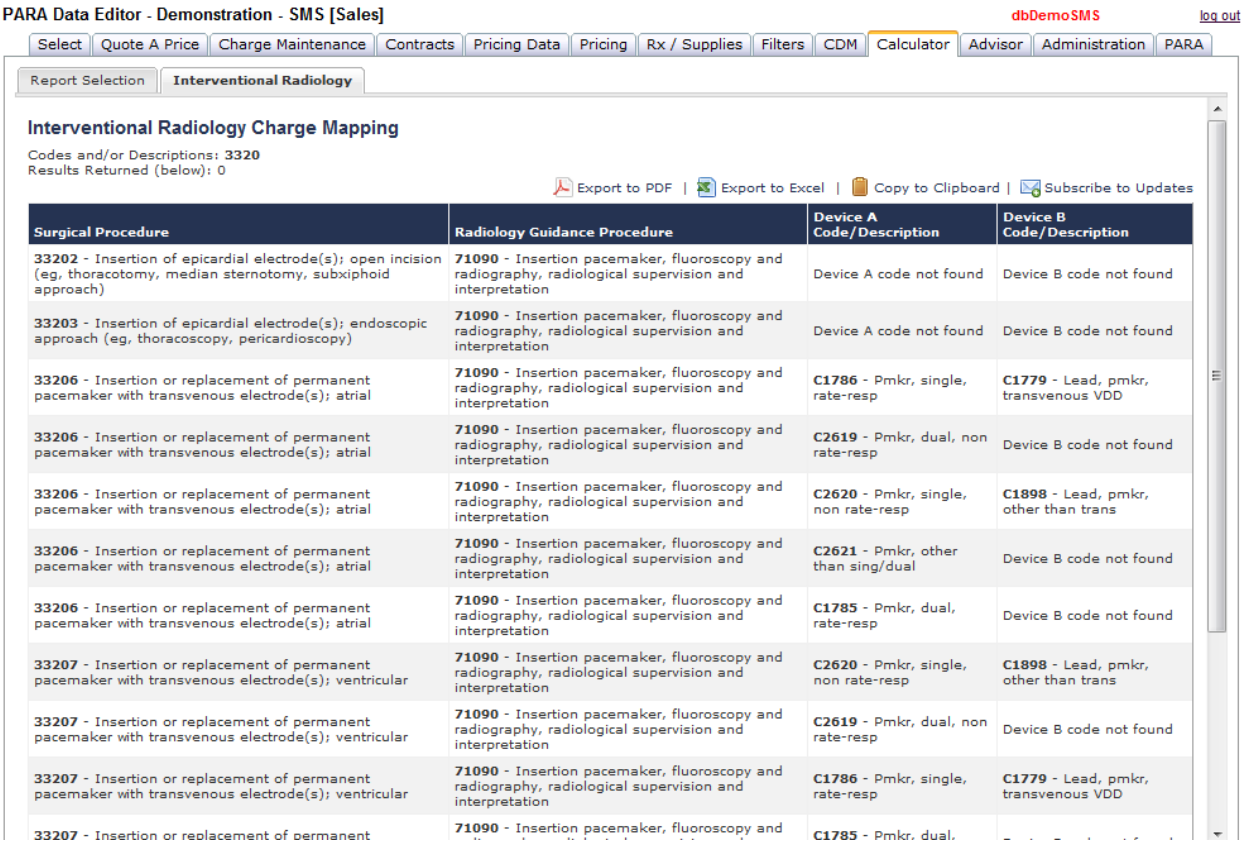
Interventional Radiology Charge Mapping

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



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,	

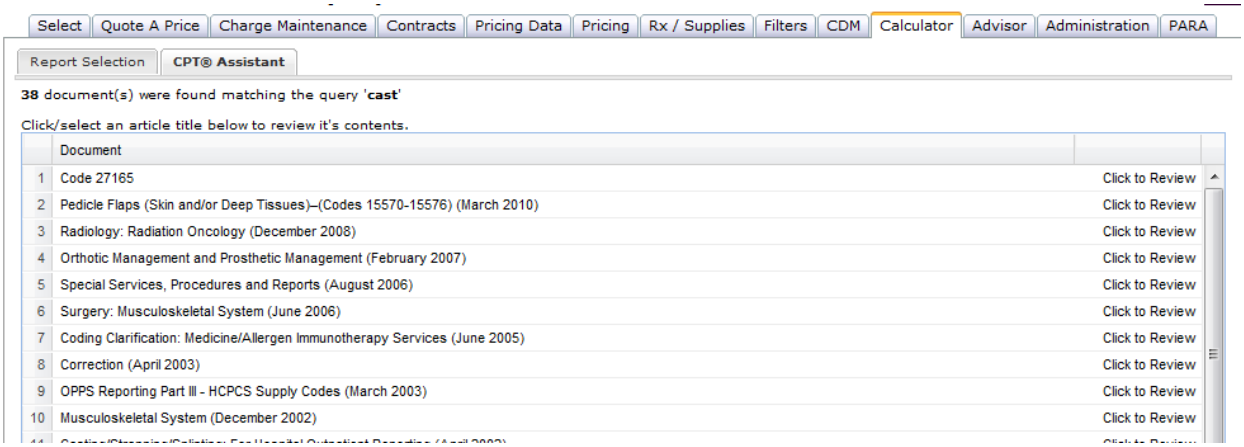
CPT® Assistant – 1990 to Present

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

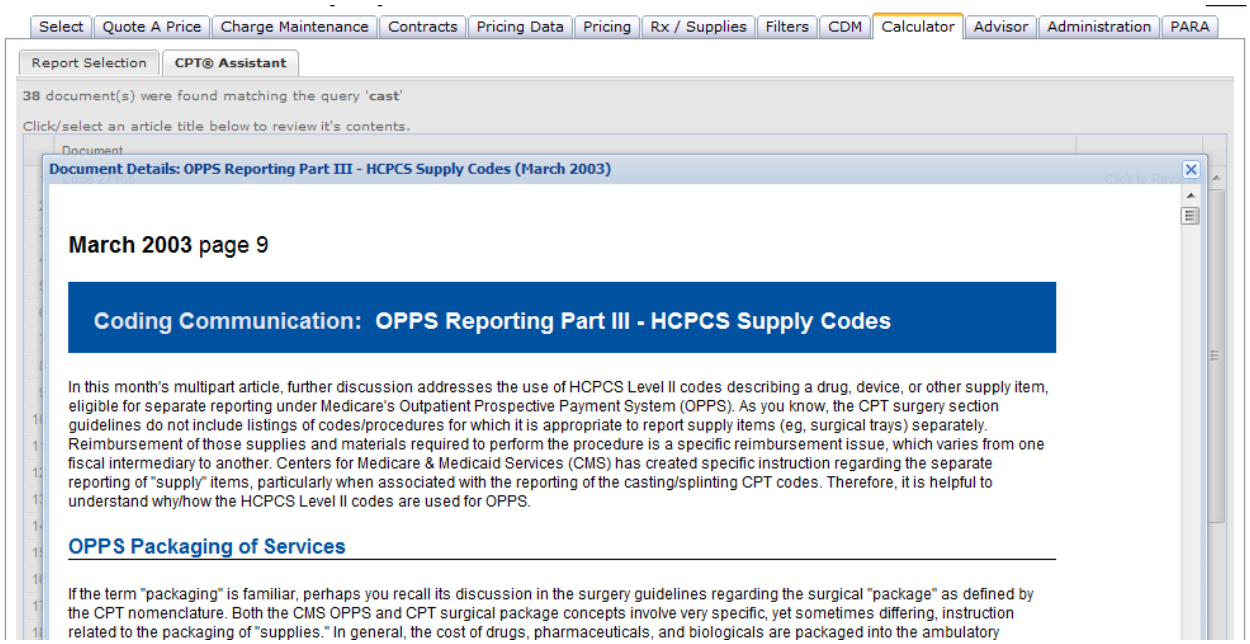
The query format is comma separated code, wildcard and text.

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:



Selection of specific article:



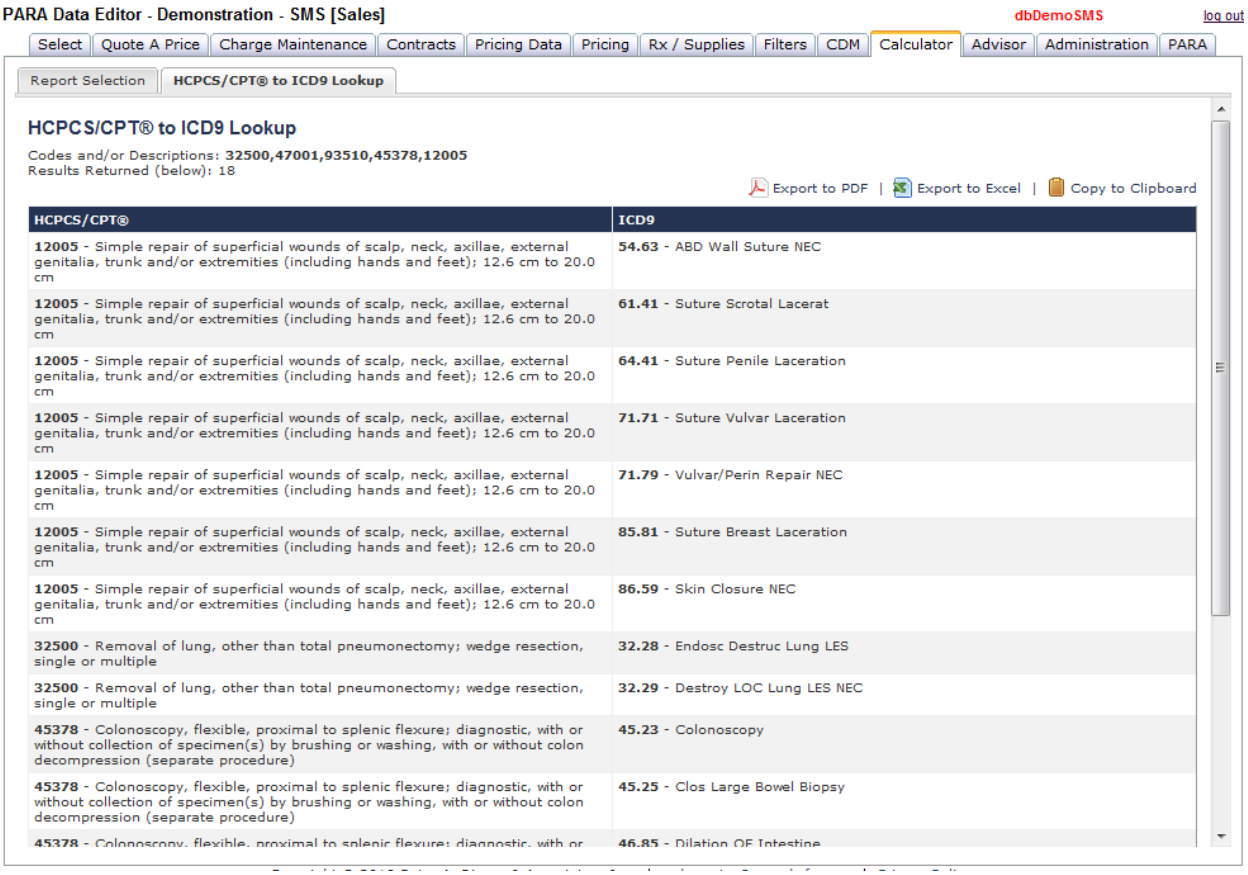
HCPCS/CPT® to ICD-9 Crosswalk

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:

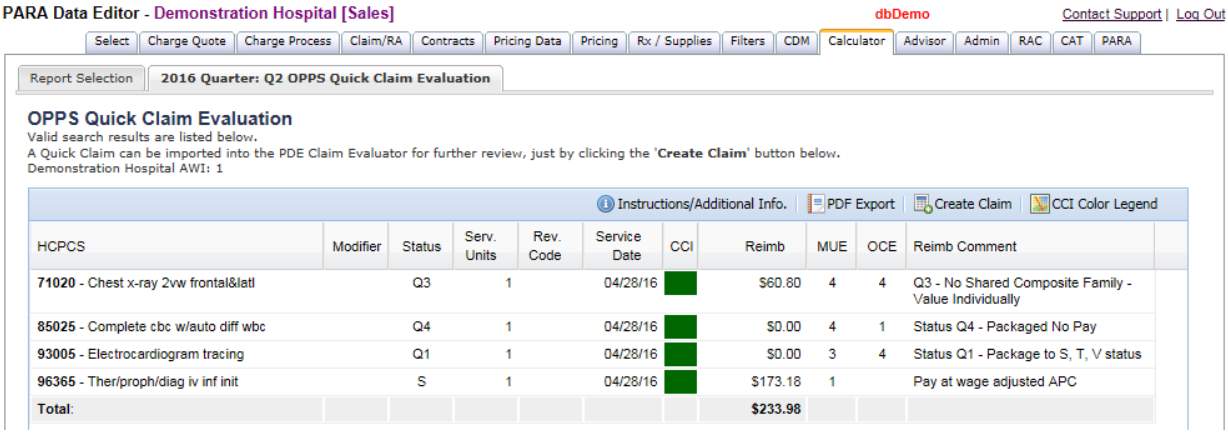
1. CPT®/HCPCS Code
2. CPT®/HCPCS Code Description
3. ICD-9 Code
4. ICD-9 Code Description



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

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:



HCPCS	Modifier	Status	Serv. Units	Rev. Code	Service Date	CCI	Reimb	MUE	OCE	Reimb Comment
71020 - Chest x-ray 2vw frontal&latl		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

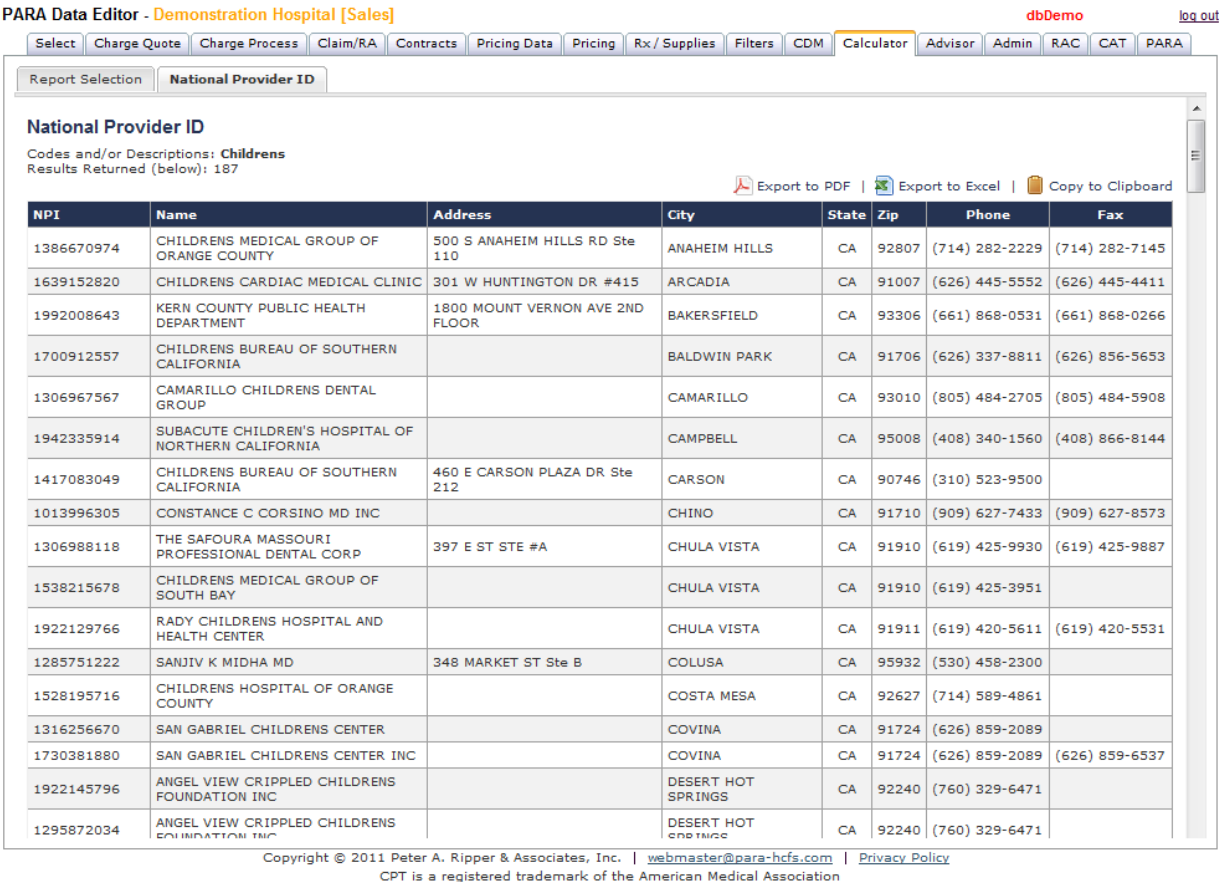
The results can be exported to a PDF formatted report, or the User can “create” a claim within the Claim Evaluator Module.

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:

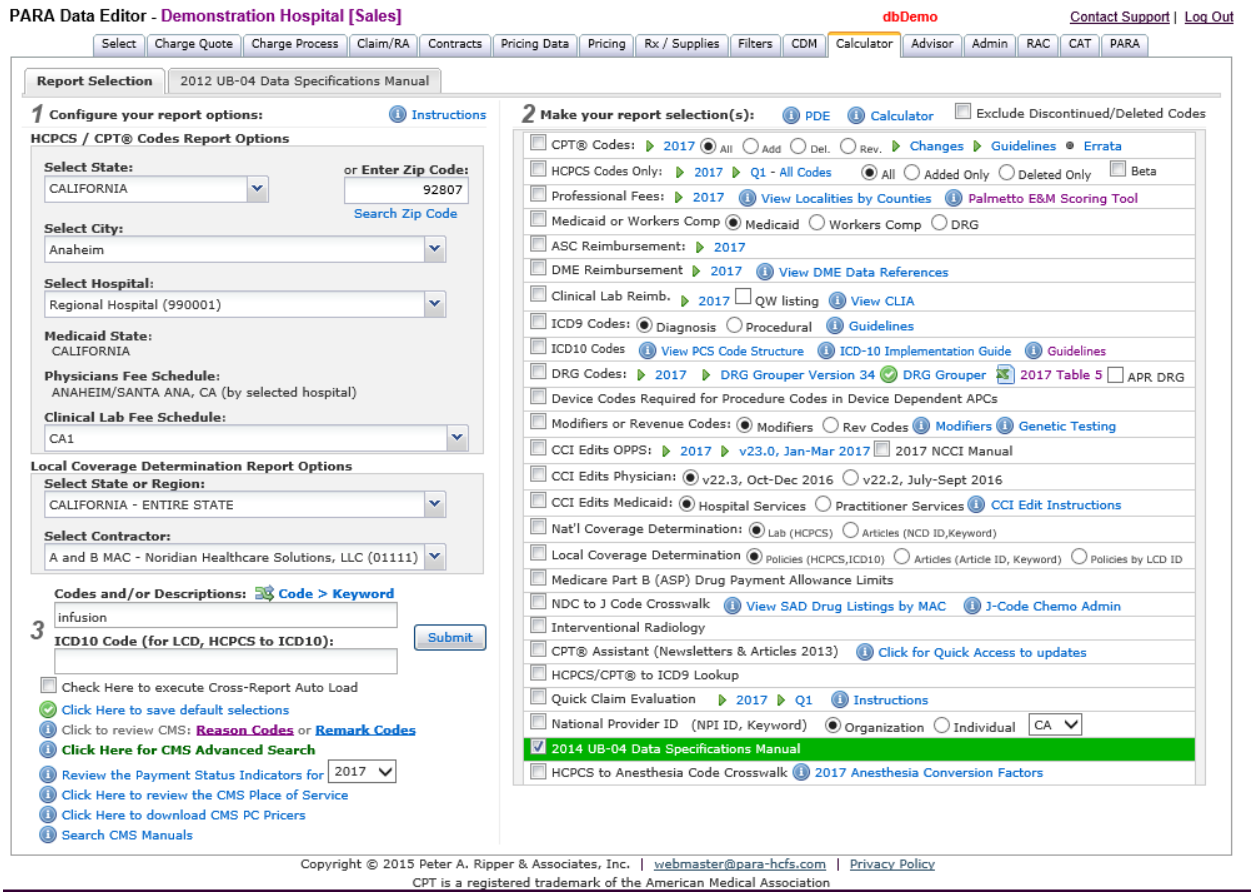
1. NPI Number
2. Name (of individual or organization)
3. Address
4. City
5. State
6. Zip Code
7. Phone Number
8. Fax Number

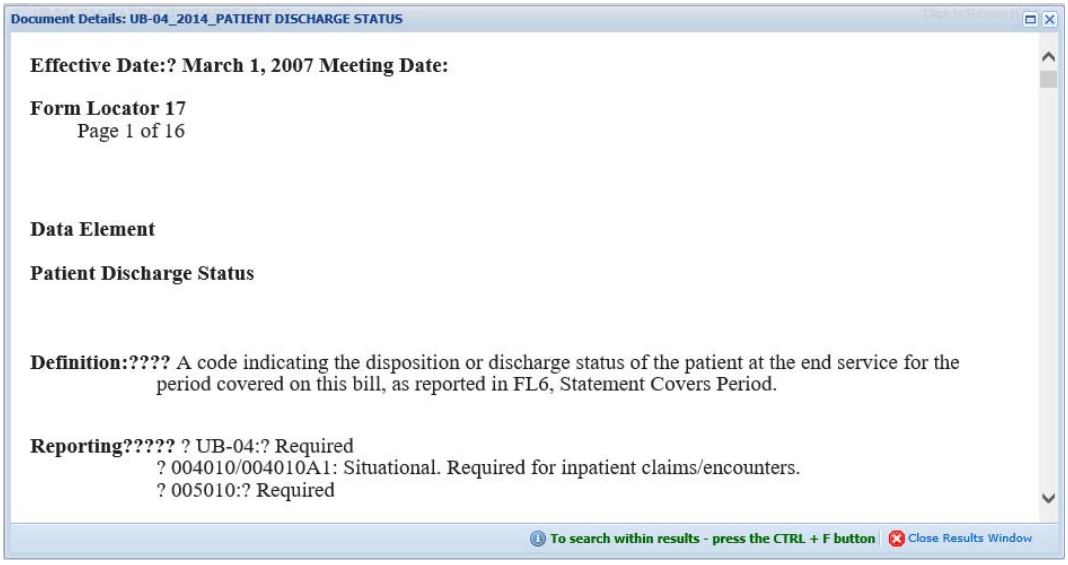


NPI	Name	Address	City	State	Zip	Phone	Fax
1386670974	CHILDRENS MEDICAL GROUP OF ORANGE COUNTY	500 S ANAHEIM HILLS RD Ste 110	ANAHEIM HILLS	CA	92807	(714) 282-2229	(714) 282-7145
1639152820	CHILDRENS CARDIAC MEDICAL CLINIC	301 W HUNTINGTON DR #415	ARCADIA	CA	91007	(626) 445-5552	(626) 445-4411
1992008643	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	

UB-04 Data Specifications Manual

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





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: