APRIL 20, 2022

eJOURNAL

PARAREV

Revenue Cycle Leakage

An End-To-End Reset RCM Practices

Colonoscopy Screening

Guidance For RHC Billable Services

RARC Update

Codes Related To No Surprises Act

MEDICARE RULE REGARDING COLONOSCOPIES

Q. We have been holding bills at our Rural Health Clinic for pre-operative clearance visit for Medicare patients scheduled for a colonoscopy. I have been asked to look into whether these encounters are billable.

We have heard that E/Ms "before/prior to" a screening C-scope were not to be billed. However, for the 16 years I have been in clinic billing we have always billed them if they weren't the "day before or day of" of procedure, as those would get bundled. We've gotten paid just fine and in all those years to my knowledge, none of our MC audits resulted in any take backs or fines regarding our billing them.

We researched coding forums on line as well, and any data I could find from or regarding MC and screening C-scopes and opinion, is divided. Many stated that the "before/prior to" means within 24 hours of the procedure; and that they have billed for them as a rule and always been paid (as we did). Others said they felt that the "before/prior to" meant any time, even weeks before, and they didn't bill for them.

Is the "consulting/decision for surgery" visit to a specialist for a screening colonoscopy billable? We understand that a pre-operative clearance/H&P after the decision for surgery is made, is not billable as it is not deemed medically necessary. But can we bill for the visit in which the patient meets the specialist and a decision is made as to whether or a colonoscopy should be done or not?

Also, if the consult/decision for surgery is indeed billable, does it fall into the "day before/day of" rule where it's not billable even with modifier 57, due to being a minor procedure, or is that rule only regarding pre-ops? Typically, our consults are done days to weeks prior to the scope, but sometimes it is more of a list-minute decision.

A. Medicare and most other insurers cover only medically necessary services. A patient is eligible for a screening colonoscopy if there are no signs or symptoms of GI trouble. It stands to reason that a pre-op clearance exam that finds no health care condition to support the medical necessity of the visit is not medically necessary, and therefore should not be billed, regardless of the timing (same day or not.) Medicare may have paid claims for such visits at the RHC in the past, but that doesn't necessarily mean the visits have truly met the general test of medical necessity.

MEDICARE RULE REGARDING COLONOSCOPIES

However, if there is a medically necessary reason for the visit, such as any other complicating condition that would be pertinent to the safety of the patient while undergoing the procedure (high blood pressure, diabetes, etc.), then the visit might be considered medically necessary. Medical necessity will be determined by the documentation and diagnosis coding provided in addition to the ICD10 Z01.81x (Encounter for preprocedural examinations.)

Medicare defines an RHC visit as "medically necessary":

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c09.pdf#

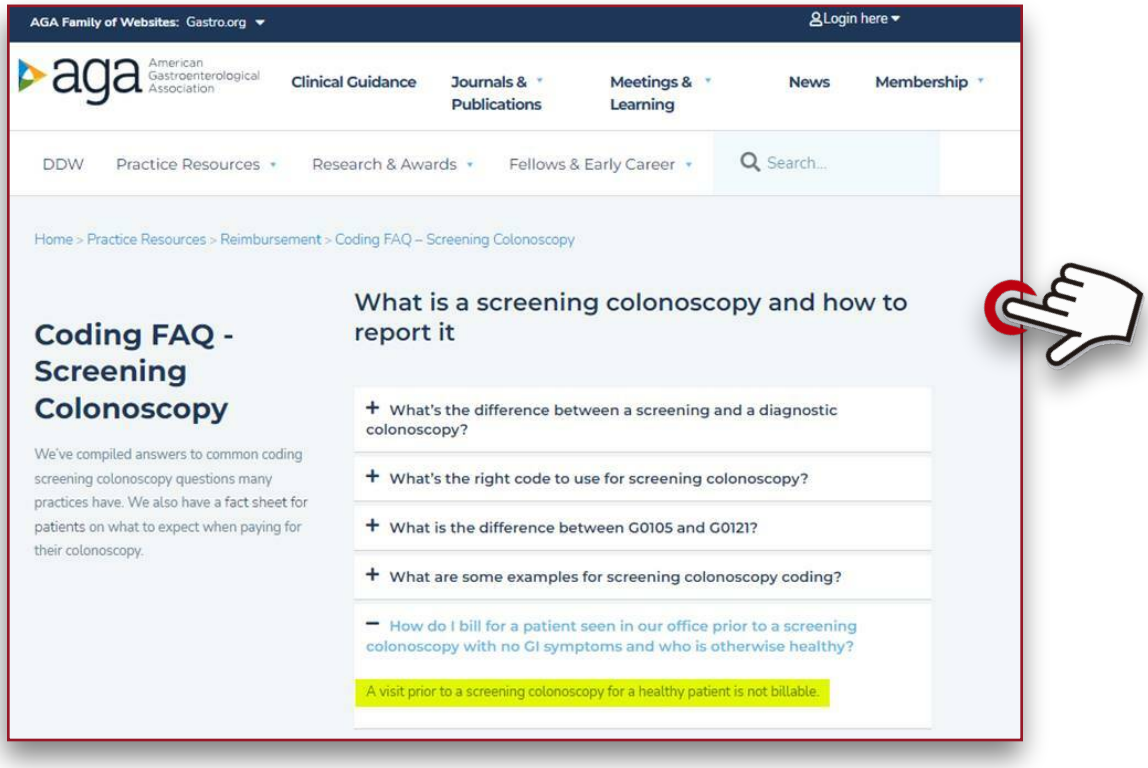
10.1 - RHC General Information
(Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs are facilities that provide services that are typically furnished in an outpatient clinic setting. The statutory requirements that RHCs must meet to qualify for the Medicare benefit are in §1861(aa) (2) of the Social Security Act (the Act).

A RHC visit is defined as a medically-necessary, face-to-face (one-on-one) medical or mental health visit, or a qualified preventive health visit, with a RHC practitioner during which time one or more RHC services are rendered. A RHC practitioner is a physician, nurse practitioner (NP), physician assistant (PA), certified nurse midwife (CNM), clinical psychologist (CP), and clinical social worker (CSW). A Transitional Care Management (TCM) service can also be a RHC visit. A RHC visit can also be a visit between a home-bound patient and an RN or LPN under certain conditions.

Here's a link and an excerpt from the American Gastroenterological Association website mentioning this problem:

https://gastro.org/practice-resources/reimbursement/coding-faq-screening-colonoscopy/



MEDICARE RULE REGARDING COLONOSCOPIES

If the service is not a screening colonoscopy, then several other factors influence whether a pre-operative H&P visit should be separately reported and/or reimbursed:

- Whether the E/M is performed by the same physician/same group practice who will perform the surgical procedure, and
- Whether the decision for surgery has already been made at the time of the H&P; and
- Whether the E/M is performed on the same day or the day prior to the surgical procedure, and
- Whether the global period for the surgical procedure 10 days or less
- Whether the service was medically necessary, in other words, were there conditions that required assessment before the patient could safely have surgery;

As you may already be aware, Medicare assigns a "global" period indicator of 000 to most colonoscopy codes -- "000 - Endoscopic or minor procedure with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure generally not payable."

Surgeons may bill for a visit prior to surgery, as they need to evaluate the problem and determine the best surgical approach – but:

- If the global surgical period is greater than 10 days -- A preoperative examination by the same physician that will perform the surgery to clear the patient for surgery on the same day, or the day prior to surgery, is part of the global surgical package, and should not be reported separately

- If the procedure has a global period of 10 days or less, and the surgeon makes the decision to perform surgery during a visit which occurs within a day before the surgery, the surgeon may bill for an E/M with modifier 57 (decision for surgery), in addition to the surgery

- If the procedure is preventive in nature, and there is no "problem" to report on a problem-focused visit, then the visit does not meet medical necessity

Another physician (not the surgeon) can bill for an H&P after the surgeon makes the decision to perform surgery, and refers the patient to a second physician (often a primary care physician) for a preoperative H&P.

This service is reportable, but if the visit is not deemed to be medically necessary, a payor may deny payment. Medical necessity will be determined by the documentation and diagnosis coding provided in addition to the ICD10 Z01.81x:

MEDICARE RULE REGARDING COLONOSCOPIES

ICD10 Codes

Codes and/or Descriptions: **z0181**

ICD10 Code	Description
Z0181	Encounter for preprocedural examinations
Z01810	Encounter for preprocedural cardiovascular examination
Z01811	Encounter for preprocedural respiratory examination
Z01812	Encounter for preprocedural laboratory examination
Z01818	Encounter for other preprocedural examination

We put together the following matrix in an attempt to simplify the various scenarios when a *medically necessary* pre-op exam would be billable:

	Date of Pre-Op E/M		
	More than one day prior to surgery	Within one day of a surgery with a Global Period of >=10 days	Within one day of a surgery with a Global Period of <10 days
E/M performed by the same physician who will perform the surgery	Billable	Not billable	Billable only if Decision for Surgery made (modifier 57)
E/M performed by another (non-surgeon) provider	Billable	Billable	Billable

Below are the references I used to develop this information:

The 2020 CPT® manual says that the H&P is included in the global surgical package only if it is performed by the same surgeon, and not within a day of the date of surgery:

CPT® Surgical Package Definition

By their very nature, the services to any patient are variable. The CPT® codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT® surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation per se:

- Evaluation and Management (E/M) service(s) subsequent to the decision for surgery on the day before and/or day of surgery (including history and physical)
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals

MEDICARE RULE REGARDING COLONOSCOPIES

- Writing orders
- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

In February 2009, CPT® Assistant published the following Q&A:

Surgery Guidelines

Question: Are preoperative visits billable? If so, what code should be used and what is the time frame before surgery to submit this code?

Answer: Only the preoperative E/M service related to the procedure performed on the day immediately before the date of the procedure (including the history and physical) is stated as inclusive of the CPT® surgical package definition.

CPT® Assistant published the following article in its March 2015 edition:

For the CPT® 2015, the definition of global surgical package was changed. As indicated in the Surgery Guidelines (page 62 of the CPT® Professional 2015), the CPT® surgical package is defined as follows:

CPT Surgical Package Definition

By their very nature, the services to any patient are variable. The CPT® codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. In defining the specific services "included" in a given CPT® surgical code, the following services related to the surgery when furnished by the physician or other qualified health care professional who performs the surgery are included in addition to the operation per se:

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- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians or other qualified health care professionals
- Writing orders

- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

To reiterate, the concept of a "surgical package" refers to a combination of services provided by the physician once the decision for surgery is reached. The elements of the surgical package vary widely but are considered inherent in a readily identifiable CPT® procedure code. Therefore, it is important to understand which components of a procedure may or may not be reported individually. The reporting exception(s) include additional services performed at the time of or subsequent to the definitive surgical procedure(s) due to complications, exacerbations, recurrence, or the presence of other disease(s) or injury(ies).

Reporting Evaluation and Management (E/M) Services

The physician or other qualified health care professional work of performing and preparing the history and physical (H&P) is reported differently, when it is part of the surgical package. The following three clinical examples illustrate the following two scenarios.

Scenario 1

When the decision for surgery occurs the day of or the day before a major procedure and includes the preoperative E/M services, this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate that this is the decision-making service, not the H&P alone.

Example

A patient is seen in the emergency room with acute appendicitis. The surgeon sees the patient, makes a diagnosis, and reaches a decision to perform surgery. The patient then promptly undergoes a laparoscopic appendectomy.

How to Code

Report CPT®code 99222 (or similar initial emergency department code) with modifier 57, along with the appropriate appendectomy code: 99222-57 and 44970.

Scenario 2 (Examples 1 and 2)

When the surgeon sees a patient and makes a decision for surgery, and the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (e.g., 1 day, 3 days, or 2 weeks), the visit is not separately reported because it is included in the surgical package.

MEDICARE RULE REGARDING COLONOSCOPIES

Example 1

The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and any needed clarification.

How to Code

The E/M services on March 1 are reported with modifier 57, Decision for Surgery. The visit on March 27 is not reported because it is the preoperative H&P visit and is included in the surgical package.

Example 2

A patient is seen in the physician's office for evaluation of perirectal fluctuance. Evaluation suggests the rectal abscess will need to be drained. The patient is taken to the operating room for the procedure.

How to Code

The appropriate office or other outpatient E/M level visit is reported with modifier 57 appended. However, if the patient is admitted or observed in the hospital, then the appropriate E/M code would be 99218. Modifier 57 would be appended, and the operative procedure would be reported as well.

The Medicare Claims Processing Manual offers the following guidance:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf#

> **30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery**
>
> (Rev. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06)
>
> **A. CPT® Modifier "-24" - Unrelated Evaluation and Management Service by Same Physician During Postoperative Period**
>
> A/B MACs (B) pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT® codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT® modifier "-24," and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure.

MEDICARE RULE REGARDING COLONOSCOPIES

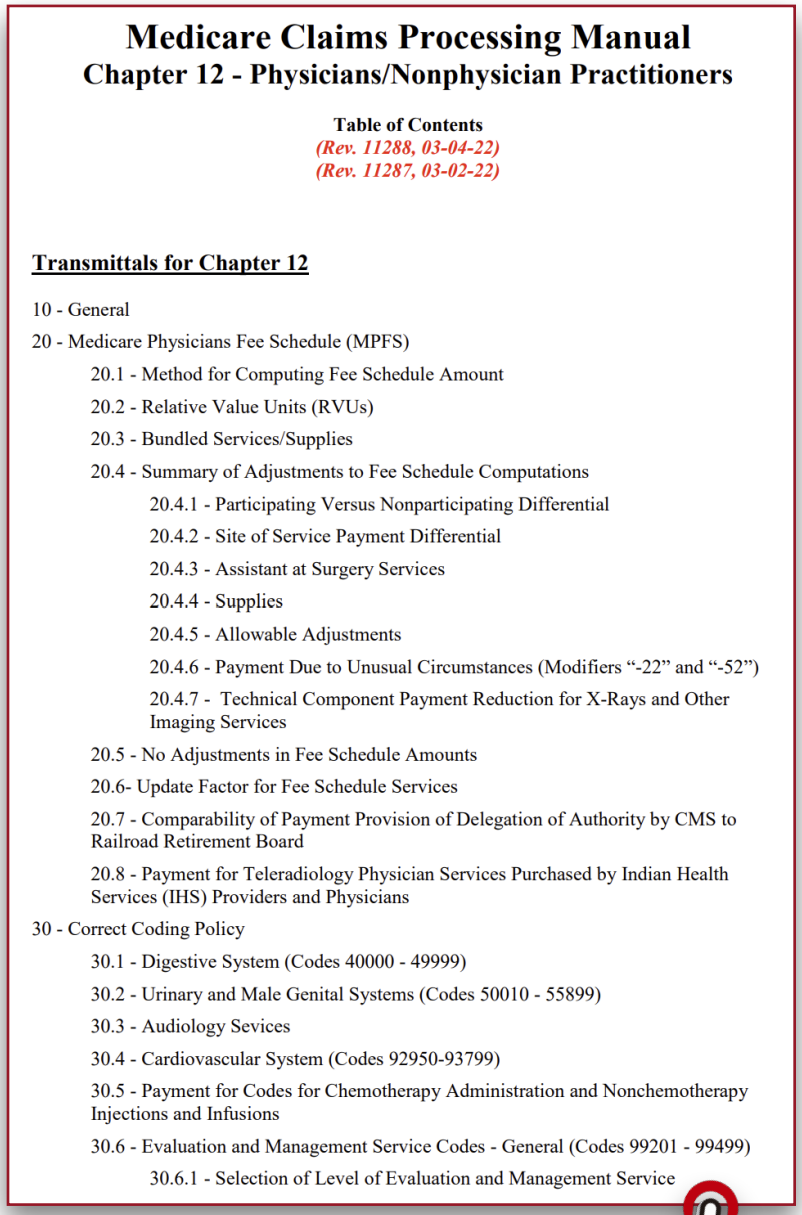
They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

B. CPT Modifier "-25" - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified non physician practitioner) to the same patient on the same day as another procedure or other service.

A/B MACs (B) pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure.

Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.



Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 11288, 03-04-22)
(Rev. 11287, 03-02-22)

Transmittals for Chapter 12

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified nonphysician practitioner in the patient's medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

MEDICARE RULE REGARDING COLONOSCOPIES

If the physician bills the service with the CPT® modifier "-25," A/B MACs (B) pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

- When inpatient dialysis services are billed (CPT® codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;

- When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure; or

- When an A/B MAC (B) has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of modifier "-25" compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. When a A/B MAC (B) has completed a review and determined that a high usage rate of modifier "-57," the A/B MAC (B) must complete a case-by-case review of the records. Based upon this review, the A/B MAC (B) will educate providers regarding the appropriate use of modifier "-57." If high usage rates continue, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. A/B MACs (B) may not permit the use of CPT® modifier "-25" to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT® definition of the modifier.

C. CPT® Modifier "-57" - Decision for Surgery Made Within Global Surgical Period

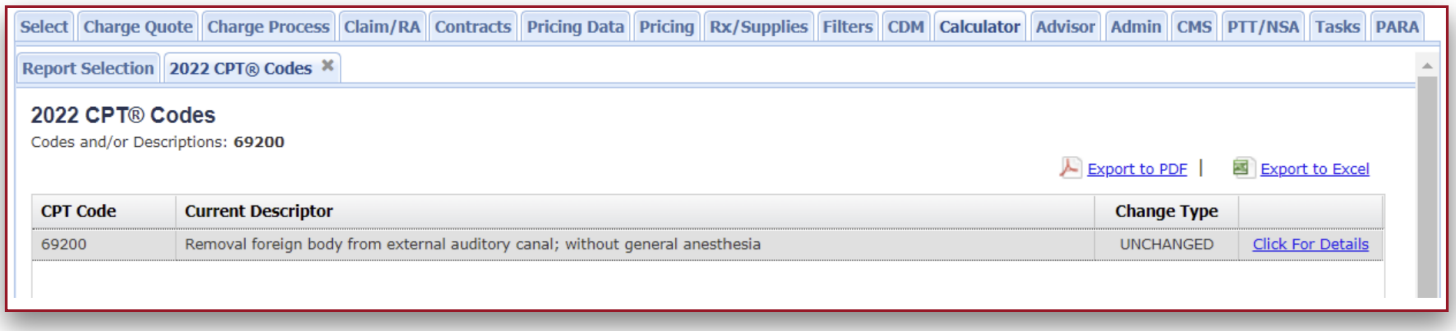
A/B MACs (B) pay for an evaluation and management service on the day of or on the day before a procedure with a 90-day global surgical period if the physician uses CPT® modifier "-57" to indicate that the service resulted in the decision to perform the procedure. A/B MACs (B)vmay not pay for an evaluation and management service billed with the CPT® modifier "-57" if it was provided on the day of or the day before a procedure with a 0 or 10-day global surgical period.

DISCONTINUED VERSUS UNSUCCESSFUL PROCEDURES

Q. What CPT® code(s) and/or modifier(s) should be reported for an attempted Foreign Body (FB) removal of the ear? Should modifier 52 or 74 be appended?

> **Procedure Note:** Patient has a plastic lego piece in left ear canal. Patient is sedated with ketamine IM. Provider was able to visualize the plastic Lego piece but had difficulty in removing the object. The piece seemed to be stuck In the ear canal, and after several attempts, the physician was unsuccessful at removing it. Unfortunately, the provider did not have access to alligator clips or right-angle hooks, so attempt was made with forceps and a needle nose hemostat. Patient was noted to have some mild bleeding/oozing from ear canal and was uncomfortable throughout the procedure.
>
> After some time, the provider decided to abort the procedure as patient was uncomfortable and unable to tolerate it. An ENT was consulted, who advised that it would be okay to send patient home and follow up in AM.

A. Report CPT® code 69200-LT. The documentation stated the removal was fully attempted but unsuccessful, therefore a modifier 52 or 74 is not needed. Please refer to the **PARA Data Editor** CPT® code description.



If this procedure was discontinued rather than unsuccessful, then a modifier 52 would be appended since anesthesia was not planned as advised in Coding Clinic for HCPCS® - First Quarter 2016 Page: 12-14. Coding Clinic for HCPCS® - Third Quarter 2007 Page: 10 explains the difference between discontinued vs unsuccessful procedures. It states that even though a procedure might be described as "failed" and the expected result is not achieved, in actuality the procedure was performed and should be coded.

DISCONTINUED VERSUS UNSUCCESSFUL PROCEDURES

Modifier 52 is only used for facility reporting purposes when no anesthesia is used/planned for the procedure. AHA Coding Clinic® for HCPCS - First Quarter 2012 Page: 10,11 explains that CMS has this statement regarding the use of modifier 52:

"Modifier 52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. In the instance where a planned service or procedure in the hospital outpatient setting is reduced, canceled, or discontinued and anesthesia is planned but not administered, Modifier 73 would be appended to the CPT® code; and if anesthesia is administered then Modifier 74 would be appended to the CPT® code."

The following is from CMS's Internet-Only Manual Publication 100-04, Chapter 4, and section 20.6.

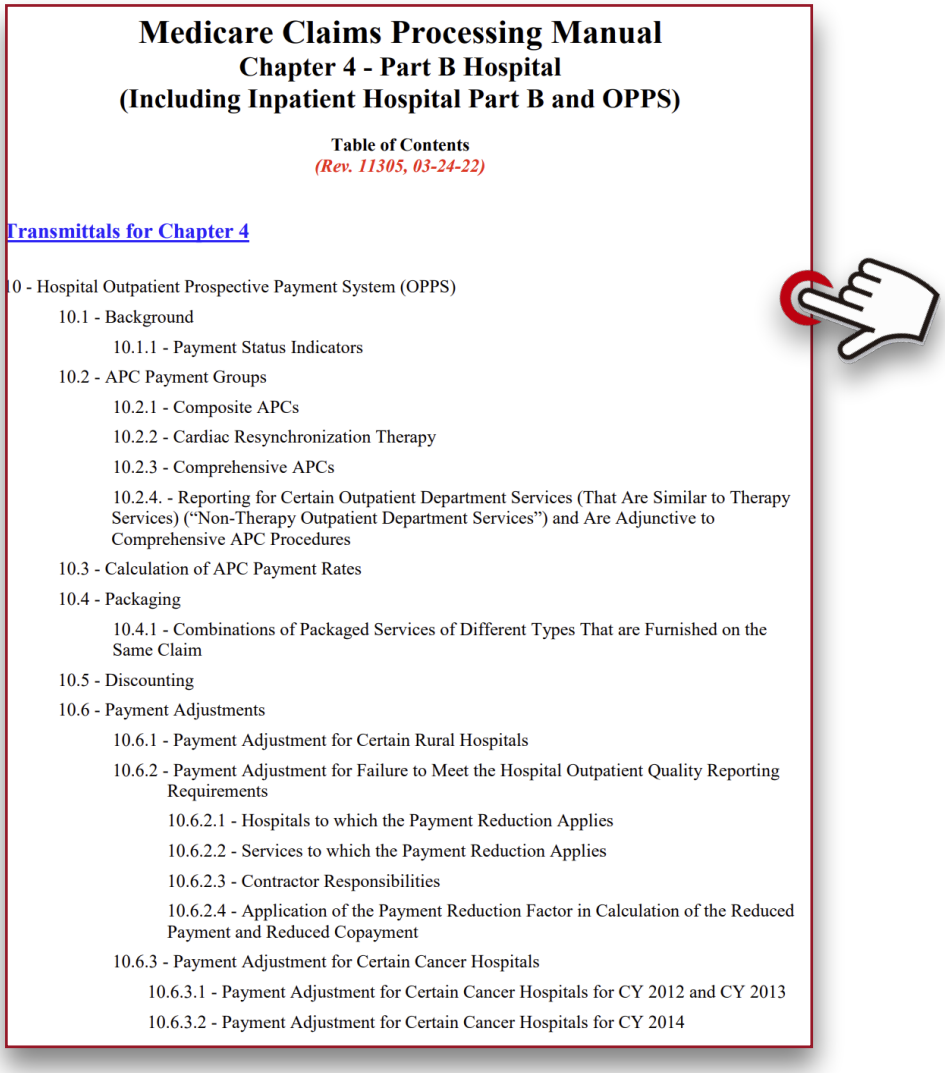
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads//clm104c04.pdf

> 20.6.4 - Use of Modifiers for Discontinued Services Modifier -73 is used by the facility to indicate that a procedure requiring anesthesia was terminated due to extenuating circumstances or to circumstances that threatened the well being of the patient after the patient had been prepared for the procedure (including procedural pre-medication when provided), and been taken to the room where the procedure was to be performed, but prior to administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia.
>
> This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resource s expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued. Modifier -74 is used by the facility to indicate that a procedure requiring anesthesia was terminated after the induction of anesthesia or after the procedure was started (e.g., incision made, intubation started, scope inserted) due to extenuating circumstances or circumstances that threatened the well being of the patient.

DISCONTINUED VERSUS UNSUCCESSFUL PROCEDURES

This modifier may also be used to indicate that a planned surgical or diagnostic procedure was discontinued, partially reduced or cancelled at the physician's discretion after the administration of anesthesia. For purposes of billing for services furnished in the hospital outpatient department, anesthesia is defined to include local, regional block(s), moderate sedation/analgesia ("conscious sedation"), deep sedation/analgesia, or general anesthesia.

This modifier code was created so that the costs incurred by the hospital to prepare the patient for the procedure and the resources expended in the procedure room and recovery room (if needed) could be recognized for payment even though the procedure was discontinued. Coinciding with the addition of the modifiers -73 and -74, modifiers -52 and -53 were revised. Modifier - 52 is used to indicate partial reduction, cancellation, or discontinuation of services for which anesthesia is not planned. The modifier provides a means for reporting reduced services without disturbing the identification.

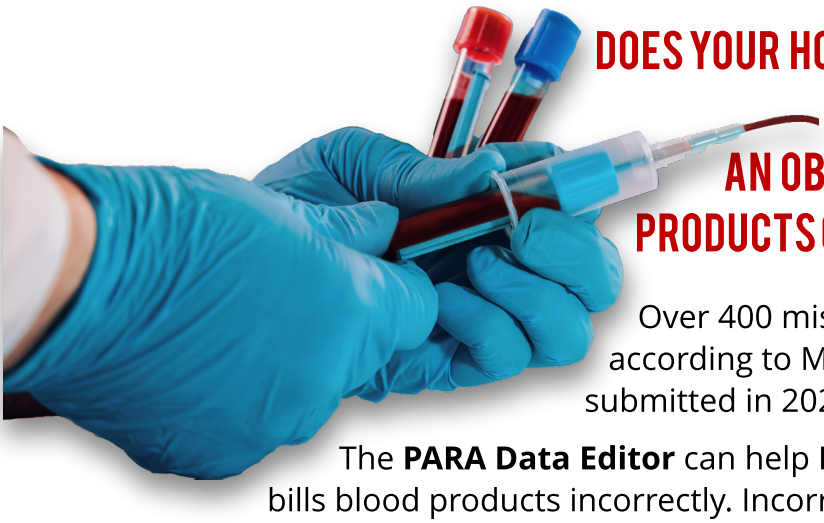


Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 11305, 03-24-22)

Transmittals for Chapter 4

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING



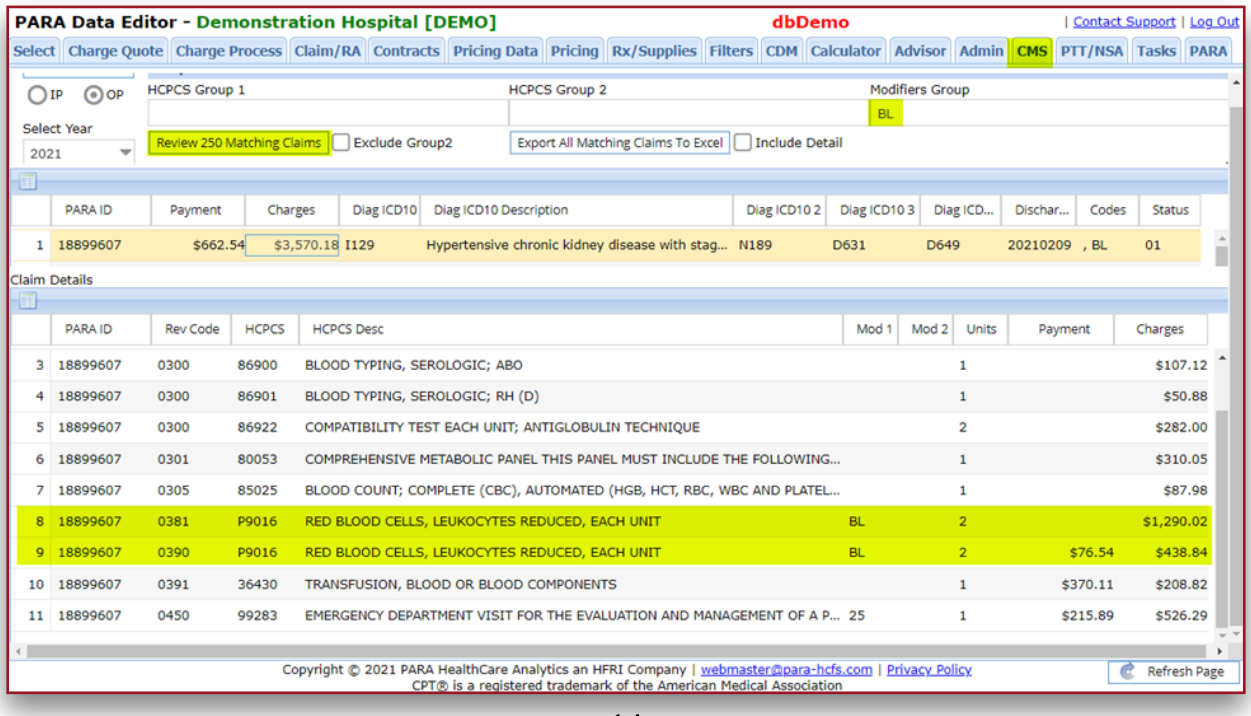
DOES YOUR HOSPITAL INCORRECTLY PENALIZE MEDICARE BENEFICIARIES BY USING AN OBSOLETE METHOD TO BILL BLOOD PRODUCTS ON OUTPATIENT CLAIMS?

Over 400 misguided hospitals in America do so, according to Medicare data on outpatient claims submitted in 2021.

The **PARA Data Editor** can help **ParaRev** clients check whether a hospital bills blood products incorrectly. Incorrect billing charges two lines for the same unit of blood -- one each in revenue codes 038x and 039x, with the BL modifier appended to the HCPCS.

The **PARA Data Editor** "CMS" tab allows the user to review claims from a prior period which were submitted to Medicare, as reported by Medicare itself. All protected health information is concealed, but the line item details including revenue codes, HCPCS, charges, and payments processed, are displayed instantly on the **PARA Data Editor**.

To check whether a facility is billing blood products correctly, enter "BL" in the modifier field, and click "Review 250 Matching Claims." A list of the claims matching the criteria will appear in the upper box, and detail from each claim appears in the lower box as the user highlights an individual claim – here's an example of a claim that reports two lines for the same units of blood product with modifier BL:



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

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

IP OP | HCPCS Group 1 | HCPCS Group 2 | Modifiers Group: BL

Select Year: 2021 | Review 250 Matching Claims | Exclude Group2 | Export All Matching Claims To Excel | Include Detail

	PARA ID	Payment	Charges	Diag ICD10	Diag ICD10 Description	Diag ICD10 2	Diag ICD10 3	Diag ICD...	Dischar...	Codes	Status
1	18899607	$662.54	$3,570.18	I129	Hypertensive chronic kidney disease with stag...	N189	D631	D649	20210209	, BL	01

Claim Details

	PARA ID	Rev Code	HCPCS	HCPCS Desc	Mod 1	Mod 2	Units	Payment	Charges
3	18899607	0300	86900	BLOOD TYPING, SEROLOGIC; ABO			1		$107.12
4	18899607	0300	86901	BLOOD TYPING, SEROLOGIC; RH (D)			1		$50.88
5	18899607	0300	86922	COMPATIBILITY TEST EACH UNIT; ANTIGLOBULIN TECHNIQUE			2		$282.00
6	18899607	0301	80053	COMPREHENSIVE METABOLIC PANEL THIS PANEL MUST INCLUDE THE FOLLOWING...			1		$310.05
7	18899607	0305	85025	BLOOD COUNT; COMPLETE (CBC), AUTOMATED (HGB, HCT, RBC, WBC AND PLATEL...			1		$87.98
8	18899607	0381	P9016	RED BLOOD CELLS, LEUKOCYTES REDUCED, EACH UNIT	BL		2		$1,290.02
9	18899607	0390	P9016	RED BLOOD CELLS, LEUKOCYTES REDUCED, EACH UNIT	BL		2	$76.54	$438.84
10	18899607	0391	36430	TRANSFUSION, BLOOD OR BLOOD COMPONENTS			1	$370.11	$208.82
11	18899607	0450	99283	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A P...	25		1	$215.89	$526.29

Refresh Page

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

In the claim above, both lines 8 and 9 report the same two units of blood – the revenue codes report a separate the charge for a blood product itself (rev code 0380), and the second charge for the processing and storage of the blood (revenue code 0390.)

This billing process became obsolete after blood banks no longer paid donors for blood used in transfusions, which eliminated the cost hospitals incurred for the blood product itself. Using revenue code 0380 is inaccurate and increases the patient liability for blood products by triggering a hefty annual "Blood Deductible."

The Blood Deductible falls to patient liability, and reduces the portion that Medicare-pays.

Rev Code	HCPCS	HCPCS Description	Mod	Units	Charges	MCare Allowed	Pt Liability Blood Deductible	Patient Coins.	MCare Provider Payment
0381	P9016	RED BLOOD CELLS, (LR) EACH UNIT	BL	2	1,290.02	281.32	281.32	0.00	0.00
0390	P9016	RED BLOOD CELLS, (LR) , EACH UNIT	BL	2	438.84	95.68	0.00	19.14	76.54
				Total:	**1,728.86**	**376.02**	**281.32**	**19.14**	**76.54**

The second line reported under revenue code 039X with the BL modifier represents only the processing and storage of the blood product, the allowable is covered at 80% by Medicare, with 20% assigned to patient coinsurance. This line should be the only line conveying the full charge for these units of blood.Had the hospital billed these 2 units of blood correctly, with the full charge on only one line under revenue code 0390, without the BL modifier, the reimbursement would have been higher from Medicare, and a much lower amount would have been assigned to patient liability:

Rev Code	HCPCS	HCPCS Description	Mod	Units	Charges	MCare Allowed	Pt Liability Blood Deductible	Patient Coins.	MCare Provider Payment
0390	P9016	RED BLOOD CELLS, (LR), EACH UNIT		2	1,728.86	**$376.02**	**0.00**	**75.42**	**301.60**

For Medicare beneficiaries, the application of a blood deductible is a hefty penalty that harkens back to the days when friends and family would make a dedicated donation to replace the units of blood used by a particular patient. The blood deductible was waived if individuals in the community volunteered to replace the blood consumed through donations.

The facility would indicate the receipt of offsetting units of blood by reporting value codes on the claim, which in turn eliminated the blood deductible. Medicare then applied a modest coinsurance for processing and storage costs only.

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

Prior to the AIDS epidemic in the late 1980s, it was not uncommon for commercial blood banks to pay donors for each pint of blood. Since marginalized individuals and IV drug users may have been driven to sell their blood for cash, these payments may have contributed to the global HIV/AIDS crisis in transfusion. Thousands of blood recipients were infected through receiving blood from an infected donor, and thousands died. In addition, thousands were infected with hepatitis C (HCV).

When the tragedy of HIV infection through blood donation was fully understood, blood banks began diligently screening donors, and they stopped paying donors in order to remove any financial incentive for the donor to conceal potential exposure to infectious disease.

Today, blood from paid donors must be labeled as such, by law. Under the Federal Code of Regulations (21 CFR 606.121(c)(8)(v)), if a donor receives monetary payment for a blood donation, all blood and blood components that are intended for transfusion and collected during the donation at which the donor received the monetary payment must be labeled with the “paid donor” classification statement.

Unless the blood purchased by the hospital bears that label, the cost of the blood itself is not a component of the charge assessed by the blood bank. Hospitals will not use blood obtained from a paid donor due to safety concerns. Plasma is the only component for which donors are sometimes paid, and it’s taken by the apheresis method.

Plasma can be treated for safety in ways that blood cells cannot. Hospitals should not report the cost of the blood itself under revenue code 038X, because the blood itself was free-–only the processing and storage represents an expense to the blood bank and the hospital.

Today, community blood banks rely wholly upon “voluntary non-remunerated blood donations” (VNRBD.) Since the donor is not compensated for the blood donation, the cost applied to the patient account is exclusively for the processing and storage of the blood product, not the blood itself.

The American Red Cross and virtually all other community blood banks collect the actual blood itself from unpaid donors.There is no cost for the blood itself. The money hospitals pay to the Red Cross or other blood banks for each unit of blood is not, therefore, for the blood itself, but for the processing and storage of the blood only.

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

Here's a screen shot from an American Red Cross slide deck making this point:

https://www.redcrossblood.org/content/dam/redcrossblood/forms-and-certificates/2018_arc_reimbursement_seminar_02202018.pdf

When billing only for blood processing, hospitals should report charges for blood units using revenue code 0390.

- The Red Cross does not charge hospitals for blood itself; rather, it charges only for processing and handling.
- CMS has clarified that this is true of most U.S. blood suppliers (not just the Red Cross):
  - "Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself."[1]
- Under Medicare, the appropriate revenue code for blood carrying only a processing fee is 0390 (Blood and Blood Component Administration, Processing, and Storage; General Classification).
  - Revenue code series 038X should not be used by hospitals reporting only blood processing charges.

There are still some blood banks that pay for plasma, however, and this is not illegal. Plasma collected with payment to the donor is not used for direct transfusions into another person; it is processed to remove or kill any infectious diseases, and broken into many different protein products that are used in pharmaceuticals. Whole red blood cells are too fragile to undergo the same kind of processing as plasma.

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

Here are a some of the 038X revenue codes that represent the cost of the blood product itself, and the 039X revenue codes which represent only the processing and storage of the blood product:

Revenue Codes

Code	Description
0380	BLOOD AND BLOOD COMPONENTS - GENERAL CLASSIFICATION
0381	BLOOD AND BLOOD COMPONENTS - PACKED RED CELLS
0382	BLOOD AND BLOOD COMPONENTS - WHOLE BLOOD
0383	BLOOD AND BLOOD COMPONENTS- PLASMA
0390	ADMINISTRATION, PROCESSING, AND STORAGE FOR BLOOD AND BLOOD COMPONENTS - GENERAL CLASSIFICATION
0391	ADMINISTRATION, PROCESSING, AND STORAGE FOR BLOOD AND BLOOD COMPONENTS - ADMINISTRATION (E.G. TRANSFUSIONS)
0392	ADMINISTRATION, PROCESSING, AND STORAGE FOR BLOOD AND BLOOD COMPONENTS - PROCESSING AND STORAGE
0399	ADMINISTRATION, PROCESSING, AND STORAGE FOR BLOOD AND BLOOD COMPONENTS - OTHER BLOOD HANDLING

For assistance in determining whether your facility is billing blood products correctly on outpatient claims, please contact your **PARA** Account Executive.

The following excerpts from the Medicare Claims Processing Manual provides additional guidance:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf

Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

231.1 - When a Provider Paid Under the OPPS Does Not Purchase the Blood or Blood Products That It Procures from a Community Blood Bank, or When a Provider Paid Under the OPPS Does Not Assess a Charge for Blood or Blood Products Supplied by the Provider's Own Blood Bank Other Than Blood Processing and Storage

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

When an OPPS provider furnishes blood or a blood product collected by its own blood bank for which only processing and storage costs are assessed, or when an OPPS provider procures blood or a blood product from a community blood bank for which it is charged only the processing and storage costs incurred by the community blood bank, the OPPS provider bills the processing and storage charges using Revenue Code 0390 (Blood Processing/Storage), 0392 (Blood Processing/Storage; Processing and Storage),or 0399 (Blood Processing /Storage; Other Processing and Storage), along with the appropriate blood HCPCS code, the number of units transfused, and the line item date of service (LIDOS).

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

Processing and storage costs may include blood product collection, safety testing, retyping, pooling, irradiating, leukocyte-reducing, freezing, and thawing blood products, along with the costs of blood delivery, monitoring, and storage. In general, such categories of processing costs are not patient-specific. There are specific blood HCPCS codes for blood products that have been processed in varying ways, and these codes are intended to make payment for the variable resource costs of blood products that have been processed differently.

Most OPPS providers obtain blood or blood products from community blood banks that charge only for processing and storage, and not for the blood itself. These hospitals should follow the instructions outlined in this section. Those OPPS providers that incur a charge for the blood product itself, in addition to the charge for processing and storage, should follow the coding requirements outlined in §231.2.

231.2 - When a Provider Paid Under the OPPS Purchases Blood or Blood Products from a Community Blood Bank or When a Provider Paid Under the OPPS Assesses a Charge for Blood or Blood Products Collected By Its Own Blood Bank That Reflects More Than Blood Processing and Storage

(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

If an OPPS provider pays for the actual blood or blood product itself, in addition to paying for processing and storage costs when blood or blood products are supplied by either a community blood bank or the OPPS provider's own blood bank, the OPPS provider must separate the charge for the unit(s) of blood or blood product(s) from the charge for processing and storage services.

The OPPS provider reports charges for the blood or blood product itself using Revenue Code series 038X (excluding 0380, which is not a valid revenue code for Medicare billing) with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The OPPS provider reports charges for processing and storage services on a separate line using Revenue Code 0390, 0392, or 0399 with the LIDOS, the number of units transfused, and the appropriate blood product HCPCS code and HCPCS modifier BL. The same LIDOS, the same number of units, the same HCPCS code, and HCPCS modifier BL must be reported on both lines.This requirement applies to all OPPS providers that transfuse blood and incur charges for both the blood itself and processing and storage.

Effective for services furnished on or after July 1, 2005, the I/OCE will return to providers any claim that reports a charge for blood or blood products using Revenue Code 038X without a separate line for processing and storage services using Revenue Code 0390, 0392, or 0399.

CHECK CLAIMS FOR INAPPROPRIATE BLOOD PRODUCT BILLING

Moreover, in order to process to payment, both lines must report the same line item date of service, the same number of units, and the same HCPCS code accompanied by modifier BL.Payment for blood and blood products is based on the Ambulatory Payment Classification (APC) Group to which its HCPCS code is assigned, multiplied by the number of units transfused.

Units of whole blood or packed red cells for which only processing and storage charges are reported are not subject to the blood deductible. The Medicare blood deductible is applicable only if the OPPS provider purchases whole blood or packed red cells from a community blood blank or if the OPPS provider assesses a charge that reflects more than blood processing and storage for whole blood or packed red cells collected by its owns blood bank. If the beneficiary has not already fulfilled the annual blood deductible or replaced the blood, OPPS payment will be made for processing and storage costs only.

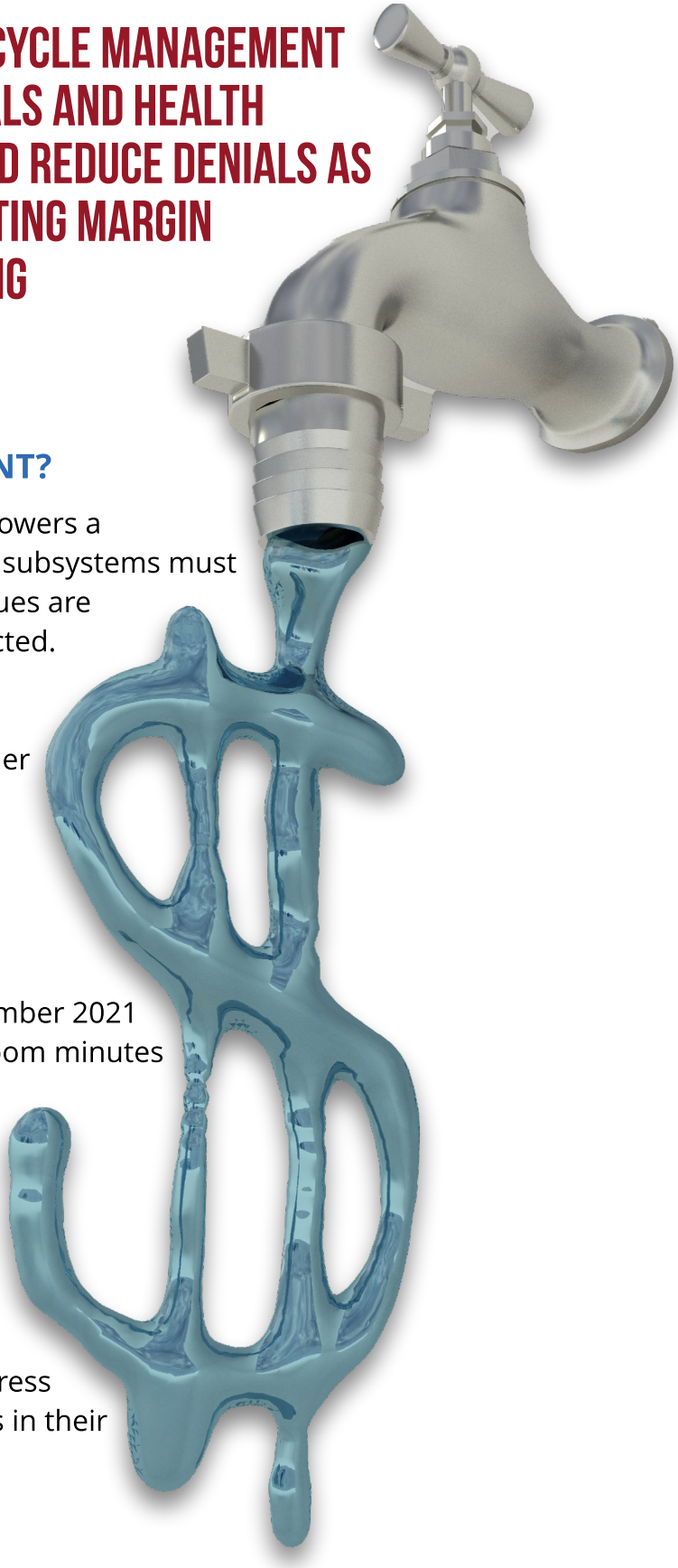
The beneficiary is liable for the blood portion of the payment as the blood deductible. In order to ensure correct application of the Medicare blood deductible, providers should report charges for whole units of packed red cells using Revenue Code 381 (Packed red cells), and should report charges for whole units of whole blood using Revenue Code 382 (Whole blood). Revenue Codes 381 and 382 should be used only to report charges for packed red cells and whole blood, respectively.

Please note that most hospitals obtain blood or blood products from community blood banks that charge only for processing and storage, rather than for the blood itself. The blood coding requirements discussed in this section do not apply to blood and blood products carrying only a processing and storage fee; when billing only for blood processing and storage, OPPS providers should follow the coding requirements outlined in §231.1.

> **EXAMPLE:** An OPPS provider purchases 2 units of leukocyte-reduced red blood cells from a community blood bank and incurs a charge for the red cells themselves, and a charge for the blood bank's processing and storage of the red blood cell unit. The OPPS provider further incurs costs related to additional processing and storage of the red blood cell units after the OPPS provider has received the 2 units.
>
> A Medicare beneficiary is transfused the two units of leukocyte-reduced red blood cells. The OPPS provider should report the charges for 2 units of P9016 by separately billing the red blood cell charges and the total processing and storage charges incurred. The charges for the red blood cell units are to be reported on one line with the date the blood was transfused, Revenue Code series 038X (excluding 380), 2 units, HCPCS code P9016, and modifier BL.
>
> The total charges for processing and storage are to be reported on the same claim, on a separate line, showing the date the blood was transfused, Revenue Code 390, 0392, or 399, 2 units, HCPCS code P9016, and modifier BL. Note that HCPCS modifier BL is reported on both lines.

HOW TO STOP LEAKAGE ALONG THE REVENUE CYCLE JOURNEY

AN END-TO-END RESET OF REVENUE CYCLE MANAGEMENT (RCM) PRACTICES CAN HELP HOSPITALS AND HEALTH SYSTEMS OPTIMIZE COLLECTIONS AND REDUCE DENIALS AS THEY WORK TO OVERCOME UNRELENTING MARGIN PRESSURE IN TODAY'S FAST-CHANGING OPERATIONAL ENVIRONMENT.



WHAT IS REVENUE CYCLE MANAGEMENT?

The revenue cycle is the financial engine that powers a healthcare organization. Complex, interlocking subsystems must mesh perfectly to ensure patient service revenues are consistently and accurately captured and collected. Shortcomings in any one of several key areas—clinical coding, claims submission and payment processing—can result in chronic under performance and lost revenue.

HOW HAVE HOSPITALS BEEN DOING?

According to a report by Kaufman Hall, median hospital operating margins fell 71% from December 2021 to January 2022 to a minus-3.68%; operating room minutes fell by 16%, length-of-stay increased by 9%, and labor cost per adjusted discharge jumped by 15%.[1]

These impacts further undermined organizations that had already been struggling to improve cash flow and margins before 2020-2021. Facing rising costs and declining revenue, organizations are now starting to address fundamental but often-overlooked weaknesses in their traditional RCM practices.

These problems can include:

- Mismatched or inappropriate pricing
- Registration inaccuracies and inefficiencies
- Porous charge capture
- Cumbersome pre-certification and case management
- Coding errors
- Ineffective claims editing
- Inadequate denial management and growing write-offs
- Deficient patient collections and limited or non-existent bad debt review

HOW CAN HOSPITALS STRENGTHEN THEIR RCM?

To stop revenue leakage, hospital must adopt a systematic approach that focuses on optimizing each phase of the revenue cycle.

The following eight areas are critical to improved RCM performance:

1. PRICING INTEGRITY

Facing new requirements to provide greater pricing transparency to consumers, hospitals have been pushing to develop and implement solutions that collect, organize and post enterprise pricing.

But before this information can be shared publicly, healthcare organizations must be sure their prices make economic sense and are justifiable and competitive when compared to their peers. To accomplish this, providers need to create rational pricing models assembled around cost, reimbursement and peer pricing data.

The process starts with a review of existing pricing information across all hospital revenue streams, including emergency visits, room rates, diagnostic and therapeutic procedures, operating room, anesthesia, PACU, pharmacy and medical supplies. With this baseline established, comparisons can be made to a designated group of peer entities.

These comparisons allow hospitals to see exactly how their pricing stacks up against specific competitors and also against averages for the entire group. Quantifying the extent to which prices may deviate from group averages enables hospitals to quickly spot opportunities for increasing prices while still remaining competitive. Conversely, pricing models also enable the correction of higher prices that represent over-market outliers.

HOW TO STOP LEAKAGE ALONG THE REVENUE CYCLE JOURNEY

Equipped with solid pricing, hospitals now have the data required to comply with federal transparency rules. Making the hospital's array of standard charges and prices for 300 specific shoppable healthcare services easily accessible online is a vital step toward improved patient engagement and satisfaction. It can also provide a competitive advantage, providing the numbers have been optimized before posting.

2. PRE-REGISTRATION

Providers are critically dependent on front-end registration staff for insurance coverage verification. Most registration personnel have access to real-time insurance eligibility software that uses the patient's insurance number to confirm whether coverage is in place. But even though these systems are from 75-90% accurate, staff frequently fail to use the applications properly or even bother to use them at all.

Reasons vary: They may not trust the system's results; they may face productivity quotas and time pressure, or they may assume verification will be done later.

It's true that the daily flow of patients can be relentless and registration personnel are frequently pushed to the limit. But that's all the more reason for hospitals and physician offices to implement comprehensive processes that systematically flag coverage rejections and provide staff with an opportunity to resolve them, either before the patient arrives or before service is provided. They simply can't afford not to: Unresolved claims due to insurance coverage issues can make up as much as one-quarter of all claim denials.[2]

3. CHARGE CAPTURE

Charge capture involves accurately documenting medical services provided to patients so medical coders can attach the appropriate code to the service. Coders, as well as coding software, should be able to determine if the clinical documentation is complete. If it is not, an automated request system should be in place to quickly and accurately obtain the information required.

Incomplete or inaccurate documentation puts medical practices and hospitals at risk for both under-coding and over-coding. Under-coding results in money legitimately owned to the provider being left on the table. Over-coding can trigger expensive claw-backs, non-compliance penalties and even potential fraud charges. Unfortunately, because codes continue to expand in number and also change frequently, under-coding and over-coding remain common problems.

Capturing the correct information is therefore essential for correct claims processing. Having a system that can easily identify which staff members are consistently having documentation problems enables RCM managers to point these issues out and provide assistance to strengthen the charge capture process.

4. PRE-CERTIFICATION AND CASE MANAGEMENT

Pre-certification is the review and approval process that payers, including commercial insurers, Medicare and Medicaid, mandate for some treatments and procedures.

Beyond potentially disrupting or preventing required medical care, pre-authorizations can have a major impact on collections. An estimated 25% of claim denials result from utilization issues, which can include medical necessity, pre-authorization, DRG downgrades and experimental treatments.[3]

Mitigating utilization denials requires that hospitals be fully versed in payers' clinical policy bulletins. These frequently changing documents describe what the payer will and won't cover, how they define medical necessity and the treatments they consider to be experimental. Hospitals also must be ready to construct cogent and detailed appeal narratives that can make a strong medical case for the treatment provided.

Denials relating to authorizations can also be triggered by something as simple as a missing or misplaced authorization code. By reviewing claims information using intelligent automation capabilities, these kinds of mistakes can be quickly identified and addressed before submission.

5. CODING

Medical coding is how medical services are documented for billing purposes. Coding and billing mistakes are responsible for about 15% of all denied charges. One of the most common problems is the failure to implement automated solutions and edits that can provide safeguards against a range of coding errors. These capabilities can greatly reduce errors triggered by inappropriate CPT® and HCPCS code usage, payment bundling and crosswalk mistakes, registration and demographic omissions or mistakes, as well as filing errors, including the failure to designate the patient responsibility portion of the claim. Regular charge master reviews can identify invalid HCPCS/CPT® codes, help ensure line-item charge compliance and modifiers, confirm valid coding assignment, and match pricing alignment with fee schedules. These safeguards provide a critical baseline for coding accuracy and revenue cycle optimization.

6. CLAIM SUBMISSION

Claim submission entails the preparation and transmission of patient service claims to clearinghouses and on to payers for reimbursement. This phase of the revenue cycle represents providers' final line of defense to ensure claim accuracy and resultant prompt payment. Critical to submission success are appropriate edits, or automated rules, that can flag deficient claims.

Failure to develop a robust and flexible editing system can create a domino effect of costly problems. These can include increasing denials and rising error rates, non-compliance penalties, and fraud and litigation expense.[4]

An estimated 9% of $3 trillion in hospital charges were initially denied in 2016, with the administrative cost of rework to overturn denials estimated at $118 per claim, or $8.6 billion nationwide.[5]

It is therefore important to incorporate into the revenue cycle automated, intelligent claims review edits that will quickly flag charge capture issues, coding and compliance errors, billing mistakes and documentation omissions or errors.

7. INSURANCE FOLLOW-UP AND ROOT CAUSE IDENTIFICATION

Insurance follow-up (commercial, Medicare and Medicaid) includes any payer-provider communications or interactions aimed at resolving unpaid, delayed or denial claims. Root cause identification is part of a denial management process focused on working back from the denial to identify and rectify the underlying reason for the unpaid claim.

While some providers continue to task internal billing staff with working all denial follow-ups, others increasingly are opting for a hybrid approach that incorporates external resources and organizes claims by size and age. This strategy is particularly important in the face of growing shortages of qualified billing personnel. A recent survey of healthcare leaders found that 92% of respondents were facing challenges attracting and retaining support staff.[6]

A hybrid denial remediation approach typically incorporates three phases:

1. Internal staff works commercial accounts up to 60 days from billing date
2. A primary AR vendor works accounts for the next 120 days from day 60 to 180
3. A pre write-off vendor, also known as a secondary AR management firm, focuses on highly aged claims of 180 billing days or greater

This triage strategy helps ensure all partial, late, or denied payments are systematically worked to resolution, regardless of size or age. As part of the process, rule-based denial mapping can be applied to identify how, why, and where denials are occurring. Typically, causes fall into one of seven categories: utilization, coverage, contractual, coding and billing, submission/re-billing, cash posting and process delays. From detailed root-cause reports, providers can isolate and eliminate denial origins.

8. PATIENT COLLECTIONS AND BAD DEBT/ZERO BALANCE REVIEW

One of the most effective ways to stabilize the revenue cycle is to develop comprehensive methods for improving patient collections before or at the time of service. A patient payment process should include providing accurate estimates through price transparency and multiple payment platforms. By taking lessons from the retail industry, providers can enhance the digital patient experience to maximize collections.

At the other end of the revenue cycle spectrum, specialized, forensic audits of written-off or zero balance claims provide an opportunity to ensure all available dollars are collected from payers. Zero-balance recoveries involve comparing payments received to anticipated revenue based on episode-of-care specifics, coding best-practices and payer-provider contractual terms. Any underpaid claims identified are resubmitted, per the payer's terms, for reimbursement.

Recovered underpayments from zero-balance reviews can total 1% of write-off net placements, an amount that may be significant for large hospitals and health systems that typically write off tens of millions of dollars annually.

DEVELOPING A HEALTHY REVENUE CYCLE

Now more than ever, providers can ill-afford to continue relying on outdated and inefficient RCM practices. Even though the pandemic is receding, organizations undoubtedly will face rising costs and downward pricing pressure in the years ahead. It is therefore critical that they assess and re-engineer each phase of the revenue cycle to achieve incremental performance gains. Taken together, these improvements will accumulate to produce significant found revenue.

HOW TO STOP LEAKAGE ALONG THE REVENUE CYCLE JOURNEY

PARAREV CAN HELP

ParaRev, a leader in healthcare revenue cycle management, works side-by-side with you as a virtual extension of your hospital central billing office. We help you improve operating margins and collect more of your revenue through a seamless and collaborative partnership with your internal team.

Let **ParaRev** help your organization supplement any staffing shortages, stay on top of accounts receivable inventory, identify where and how to maximize revenue and, if not completed yet, implement a price transparency program.

Contact us today to learn how you can begin the process of transforming your revenue cycle.

1. *National Hospital Flash Report: February 2022*, Kaufman Hall, Feb. 28, 2022.
2. **ParaRev** internal data.
3. Ibid
4. *Six Best Practices for Claims Editing*, Optum Insight, 2012.
5. Philip Betbeze, *Claims Appeals Cost Hospitals Up to $8.6B Annually*, HealthLeaders, June 26, 2017.
6. Jacqueline LaPointe, *Hospital Revenue Cycle Transformation Needed to Boost Performance*, Rev Cycle Intelligence, Oct. 19, 2021.

NEW UPDATE

RARC CODES RELATED TO THE NO SURPRISES ACT

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

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

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

RARC CODES RELATED TO THE NO SURPRISES ACT

N872	Alert: This final payment was calculated based on a specified state law, in accordance with the No Surprises Act.
N873	Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act.
N874	Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act.
N875	Alert: This final payment equals the amount selected as the out-ofnetwork rate by a Federal Independent Dispute Resolution Entity, in accordance with the No Surprises Act.
Denial of Payment	
RARC #	RARC Text
N876	Alert: This item or service is covered under the plan. This is a notice of denial of payment provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost sharing.
Notice and Consent	
RARC #	RARC Text
N878	Alert: The provider or facility specified that notice was provided and consent to balance bill obtained, but notice and consent was not provided and obtained in a manner consistent with applicable Federal law. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.
N879	Alert: The notice and consent to balance bill, and to be charged out-ofnetwork cost sharing, that was obtained from the patient with regard to the billed services, is not permitted for these services. Thus, cost sharing and the total amount paid have been calculated based on the requirements under the No Surprises Act, and balance billing is prohibited.
Miscellaneous	
RARC #	RARC Text
N830	Alert: The charge[s] for this service was processed in accordance with Federal/ State, Balance Billing/ No Surprise Billing regulations. As such, any amount identified with OA, CO, or PI cannot be collected from the member and may be considered provider liability or be billable to a subsequent payer. Any amount the provider collected over the identified PR amount must be refunded to the patient within applicable Federal/State timeframes. Payment amounts are eligible for dispute pursuant to any Federal/State documented appeal/grievance process(es).
N859	Alert: The Federal No Surprise Billing Act was applied to the processing of this claim. Payment amounts are eligible for dispute pursuant to any Federal documented appeal/ grievance/ dispute resolution process(es).

CATCHING UP ON AGED ACCOUNTS

A CRITICAL BACKSTOP FOR AR MANAGEMENT STRATEGIES

As payer rules and coding have become more complex and internal pressures mount to keep accounts receivable (AR) days low, denial rates and resulting write-offs have continued to climb for most hospitals. Between 2011 and 2017, denial volume soared by nearly 80 percent for the average hospital.[1] The financial impact of these late or foregone collections is significant. Even though 90 percent of denials are preventable, and two-thirds are recoverable, 65 percent of claim denials are never corrected and resubmitted for reimbursement.[2] A recent survey of hospital executives found that 30 percent of facilities had bad debt of between $10 million and $50 million.[3]

AR STRATEGIES FOR AGED ACCOUNTS

Today, in the wake of often-severe cash flow problems triggered by the COVID-19 pandemic and other operational and regulatory challenges, a growing number of hospitals are partnering with third parties to implement comprehensive AR management strategies that can help reduce denials and ensure facilities collect every dollar they're entitled to. These integrated approaches typically incorporate both internal and external elements: Hospital billing staff focus exclusively on the newest claims, then turn over unpaid balances to specialists at specific aging intervals.

Relying on external experts to pursue low-dollar, high-volume claims is often the most cost-effective way to optimize collections and minimize write-offs, since it frees up staff to concentrate on fresher, higher-dollar claims. Pre-write-off insurance collection experts well-versed in health plan policies can provide an additional safeguard to help prevent legitimate claims, regardless of age or size, from going uncollected. A comprehensive approach will help organizations obtain hard collectible dollars from the full spectrum of aged accounts, including pre-write off claims and even from closed balance accounts.

BOOSTING CASH FLOW WITH ZERO-BALANCE REVIEWS OF CLOSED BALANCE ACCOUNTS

One critical element in a comprehensive AR management strategy is a zero-balance claims review. Zero-balance reviews are essentially forensic audits of written-off claims. Thorough, closed-balance reviews can validate claims integrity and maximize contractual revenue for all payers. They are designed to assess whether the factors that initially caused a payer's denial can be mitigated to secure retroactive reimbursement.

While some may assume that pursuing old write-offs isn't likely to be productive, experts skilled at identifying common mistakes that frequently result in denials can recover up to one percent of a hospitals total net patient revenue. For large hospitals and health systems that may generate hundreds of millions of dollars annually, this can translate into a significant amount of found revenue.

FOUR STEPS TO IMPROVING COLLECTIONS THROUGH AN EXTERNAL ZERO-BALANCE REVIEW

Most healthcare systems or organizations typically don't have the time, resources or expertise to conduct in-depth reviews of denied or unpaid aged claims. External reviews consequently can provide the extra scrutiny needed to potentially capture revenue from denied, underpaid and unpaid claims. Zero-balance reviews of closed balance accounts performed by an experienced partner represent a final safety net at the end of the revenue cycle management process, again freeing up staff to concentrate on fresher, higher-dollar claims.

Here are the four primary steps that should be included in a zero-balance review:

1. Scrutinize contracts

Specialists review all payer contractual agreements to identify areas of underpayment risk. This process is conducted in conjunction with hospital contracting staff and attorneys to help clarify the facility's expectations or intent with respect to specific contract provisions. Not infrequently, specialists identify ambiguous language that leaves the facility vulnerable to underpayments or common reimbursement methodologies that can be exploited by payers to reduce reimbursement.

Contract problems sometimes can be as simple as a grammatical error or word choice: A clause that should have included 'and' instead of 'or,' or vice versa, depending on the anticipated scenario, can lead to reoccurring underpayments. Language like this may be causing significant underpaid revenue unbeknownst to revenue cycle staff. Experts also flag any coding changes that may have occurred since the contract was executed to ensure updates have been made and reimbursements continue to be paid at appropriate levels.

2. Evaluate discharge files

After the contract review is completed, zero-balance specialists download a full set of discharge files for a specific time frame, usually two full years of data for all payers, including Medicare, Medicare Advantage, Medicaid, Medicaid HMO, and commercial carriers.

ParaRev processes the data files through a proprietary application that has been custom-programmed with each payer's contract specifications. This process produces an independent payment analysis that isn't reliant on the hospital's contractual expected amounts to identify both underpayments and areas where the hospital's model may be deficient or inaccurate.

Given the inherent limitations of existing billing platforms in calculating complex reimbursements—such as payments due from a secondary payer or more accurate outpatient coding—greater accuracy is usually achieved.'

3. Perform an in-depth, 360-degree review

Once the subset of closed accounts is identified for potential additional revenue, an in-depth review is performed to pressure-test the integrity of the claim and the subsequent reimbursement. This step relies on the external team's collective experience to research each claim and maximize the revenue potential unique to that claim and payer, focusing on industry changes, coding best practices, and the contractual intent for each hospital. When accounts are verified through this review as underpaid, **ParaRev's** experts work with the payers to deliver the additional revenue to the hospital's bottom line.

4. Recommend improvements

From this extensive review process and subsequent trend analysis, recommendations can be made about how hospitals can optimize collections through implementation of coding best practices for specific procedures or drugs. One example: a hospital may not be billing properly for expensive new drugs that are FDA-approved but do not have an HCPCS code assigned.

Medicare and most commercial payers have specific, often complex requirements for reimbursing for unclassified drugs, and external experts can help in resubmitting claims with this correct coding to achieve proper reimbursement.

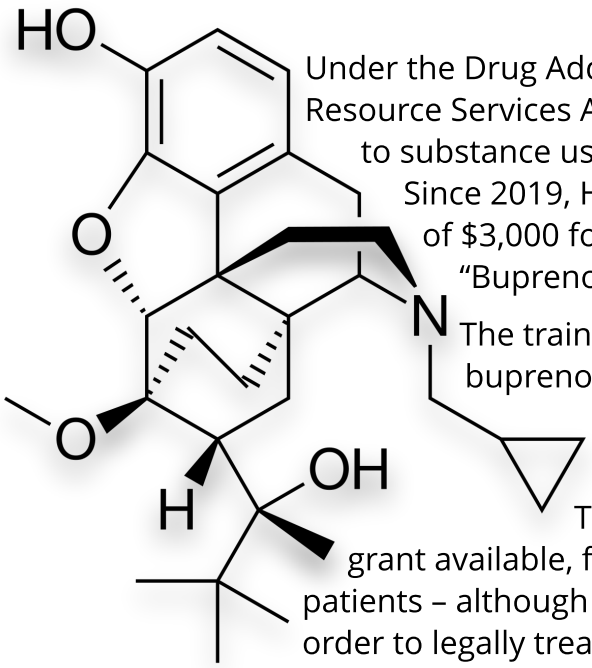
In addition to flagging coding mistakes, the zero-balance claims analysis also identifies payer deficiencies, whether they're one-off events or reoccurring, systemic issues. Working withing appropriate contractual claim and appeal submission time frames, **ParaRev** will work with the hospital staff to resubmit corrected claims to the payer, and, in instances when the payer is at fault, bring the problem to the attention of provider relations and help prepare for arbitration if necessary.

A SECOND SET OF EYES

The zero-balance review can produce immediate benefits, in terms of recovered reimbursement on written-off claims, as well as longer-term reductions in inaccurate coding, denials and write-offs. Working in partnership with hospital staff, experts identify process improvements and help implement staff training to reduce and eliminate denial root causes. Ultimately, zero-balance reviews provide expert oversight to scrutinize the all-important denial arena. This can help produce lasting solutions that improve collections while ensuring optimal compliance. Amid the current challenges in healthcare, this capability helps hospitals not only collect every dollar they are owed, but also allows them to focus on other, equally pressing areas of operations.

1 Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018
2 Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA, July 7, 2015
3 "Bad Debt Exceeds $10M at a Third of Organizations, But Lack of Confidence Exists in How Much is Recoverable," Cision PR Newswire. June 19, 2018.

HRSA FUNDS FOR RHC/FQHC BUPRENORPHINE TRAINING



Under the Drug Addiction Treatment Act of 2000 (DATA 2000), the Health Resource Services Administration (HRSA) seeks to promote greater access to substance use disorder treatment in rural and underserved areas. Since 2019, HRSA has offered RHC and FQHC organizations a grant of $3,000 for each qualified provider who completes training as a "Buprenorphine Waivered Practitioner."

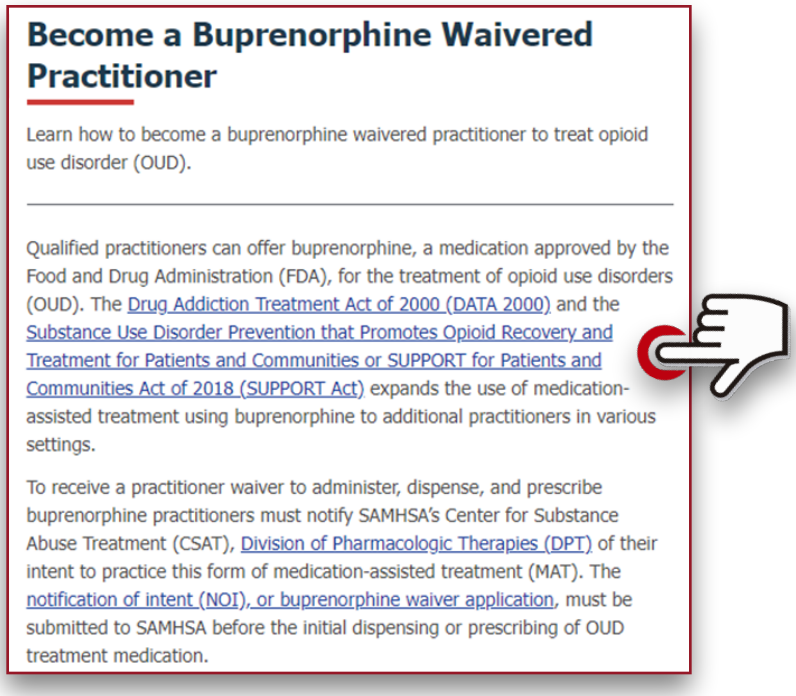
The training allows qualified practitioners to offer buprenorphine, a medication approved by the FDA for the treatment of opioid use disorders (OUD), for up to 100 patients per year.

Training is not required, nor is the $3,000 per practitioner grant available, for qualified practitioners who seek to treat up to 30 patients – although the practitioner must apply for a waiver, regardless, in order to legally treat OUD with buprenorphine.

Before treating patients with buprenorphine for opioid use disorder, practitioners are required to obtain a waiver under the CSA by submitting a Notice of Intent to the Substance Abuse Mental Health Services Administration (SAMHSA.) (To check eligibility for a waiver, visit https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php.)

Information about becoming a Buprenorphine Waivered Practitioner is available on the Substance Abuse and Mental Health Services Administration (SAMSA) webpage:

https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner



Become a Buprenorphine Waivered Practitioner

Learn how to become a buprenorphine waivered practitioner to treat opioid use disorder (OUD).

Qualified practitioners can offer buprenorphine, a medication approved by the Food and Drug Administration (FDA), for the treatment of opioid use disorders (OUD). The Drug Addiction Treatment Act of 2000 (DATA 2000) and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities or SUPPORT for Patients and Communities Act of 2018 (SUPPORT Act) expands the use of medication-assisted treatment using buprenorphine to additional practitioners in various settings.

To receive a practitioner waiver to administer, dispense, and prescribe buprenorphine practitioners must notify SAMHSA's Center for Substance Abuse Treatment (CSAT), Division of Pharmacologic Therapies (DPT) of their intent to practice this form of medication-assisted treatment (MAT). The notification of intent (NOI), or buprenorphine waiver application, must be submitted to SAMHSA before the initial dispensing or prescribing of OUD treatment medication.

HRSA FUNDS FOR RHC/FQHC BUPRENORPHINE TRAINING

HRSA grants reward RHC's and FQHC's for training eligible providers which:

- Are a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical nurse specialist, or certified registered nurse anesthetist;
- First obtained a DATA 2000 waiver on or after January 1, 2019; and
- Are employed by or working under contract for the applying FQHC or RHC; and
- Complete a course of training; 8 hours for physicians, and a total of 24 hours for nurse Advance Practice Registered Nurses and Physician Assistants.
    - Waiver training for Physicians – see https://pcssnow.org/medications-for-opioid-use-disorder/waiver-training-for-physicians/
    - Waiver Training for PAs – see https://pcssnow.org/medications-for-opioid-use-disorder/waiver-training-for-pas/
    - Waiver training for Advanced Practice Registered Nurses -- see https://pcssnow.org/medications-for-opioid-use-disorder/waiver-training-for-nurses/

In addition, one of the following two conditions must be satisfied for qualified practitioners to qualify for a waiver to treat more than 30 and up to 100 patients in their first year:

- The physician holds a board certification in addiction medicine or addiction psychiatry by the American Board of Preventive Medicine or the American Board of Psychiatry and Neurology
- The practitioner provides medication-assisted treatment (MAT) in a "qualified practice setting." A qualified practice setting is a practice setting that:
    - Provides professional coverage for patient medical emergencies during hours when the practitioner's practice is closed;
    - Provides access to case-management services for patients including referral and follow-up services for programs that provide, or financially support, the provision of services such as medical, behavioral, social, housing, employment, educational, or other related services;
    - Uses health information technology systems such as electronic health records;
    - Is registered for their State prescription drug monitoring program (PDMP) where operational and in accordance with Federal and State law; and
    - Accepts third-party payment for costs in providing health services, including written billing, credit, and collection policies and procedures, or federal health benefits.

HRSA FUNDS FOR RHC/FQHC BUPRENORPHINE TRAINING

There is an upcoming 8-hour remote training for both physicians and physician assistants available onApril 27, 2022 8:00 am – 5:00 pm EST (Philadelphia, PA).For more information, visit

https://education.sudtraining.org/Public/Catalog/Details.aspx?id=a%2bLB3KlMW%2bskm85uOD5%2fcg%3d%3d.

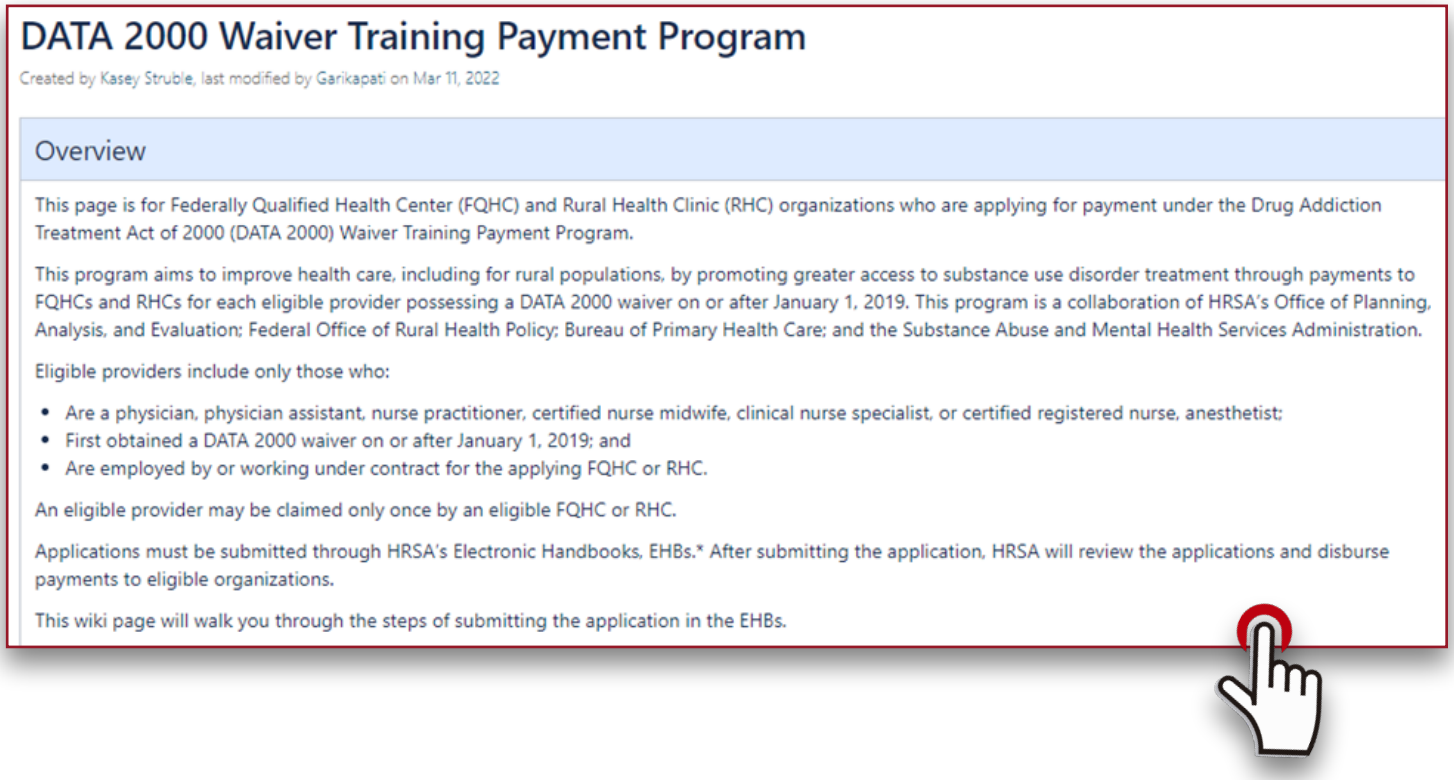
For those seeking to treat 30 or less patients at one time for OUD with buprenorphine, the HHS federal *Practice Guidelines for the Administration of Buprenorphine for Treating Opioid Use Disorder* allows practitioners to apply for a buprenorphine waiver without undergoing additional training.

Exempt eligible physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists and certified nurse midwives are not required to obtain federal certification related to training, counseling, and other ancillary services that are part of the process for obtaining a waiver to treat up to 30 patients with buprenorphine.

However, they must qualify for a waiver, even though no training is required.

A link to the HRSA website providing instructions to apply for the $3,000 per-practitioner grant:

https://www.ruralhealthinfo.org/funding/5304



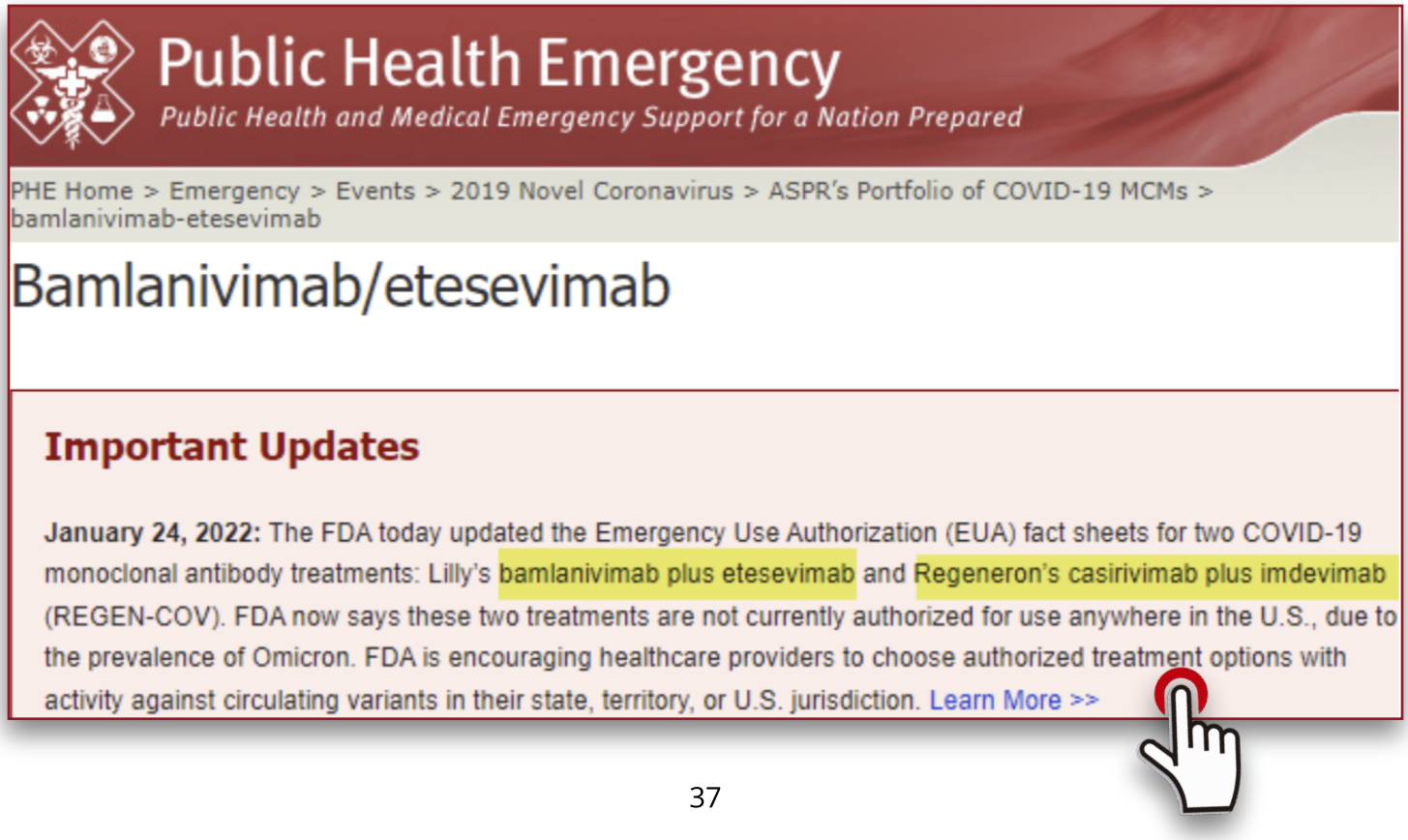
NEW UPDATE

FDA PAUSES CERTAIN COVID-19 MONOCLONAL THERAPIES

On April 5, 2022, the FDA updated the Emergency Use Authorization (EUA) to add Sotrovimab to the list of monoclonal antibody therapies paused for the treatment of COVID-19. https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-sotrovimab-emergency-useauthorization?utm_campaign=FDA+Roundup%3A+April+5%2C+2022&utm_medium=email&utm_sou rce=govdelivery

On January 24, 2022, the FDA revised the EUA for the Regeneron drug combination (casirivamab and imdevimab and the Eli Lilly drug combination (bamlanivimab and etesevimab). Because studies indicate these therapies are less effective in targeting the most prevalent COVID-19 variant, Omicron, the FDA limits the use of these monoclonals to patients infected with or exposed to COVID-19 variants receptive to these therapies.

https://www.phe.gov/emergency/events/COVID19/investigation-MCM/Bamlanivimabetesevimab/Pages/default.aspx



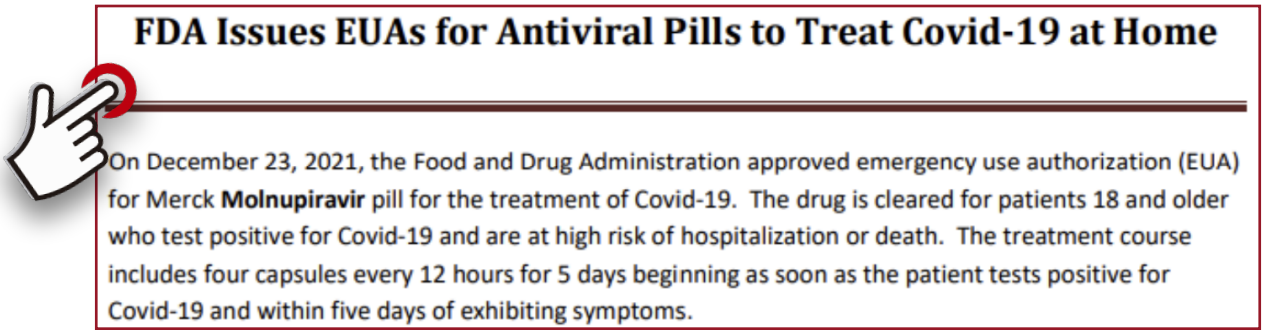
NEW UPDATE

FDA PAUSES CERTAIN COVID-19 MONOCLONAL THERAPIES

Other FDA-approved therapies to treat patients with mild to moderate COVID-19 and are at high risk for hospitalization, severe disease, or death include:

- Infusions of Veklury (remdesivir) or bebtelovimab (both deemed effective against Omicron, which currently accounts for most COVID-19 infections in the United States.)
- Convalescent plasma (blood product transfusion)
- Antiviral oral medications Pfizer's Paxlovid (12 and older) and Merck's molnupiravir (18 and older)

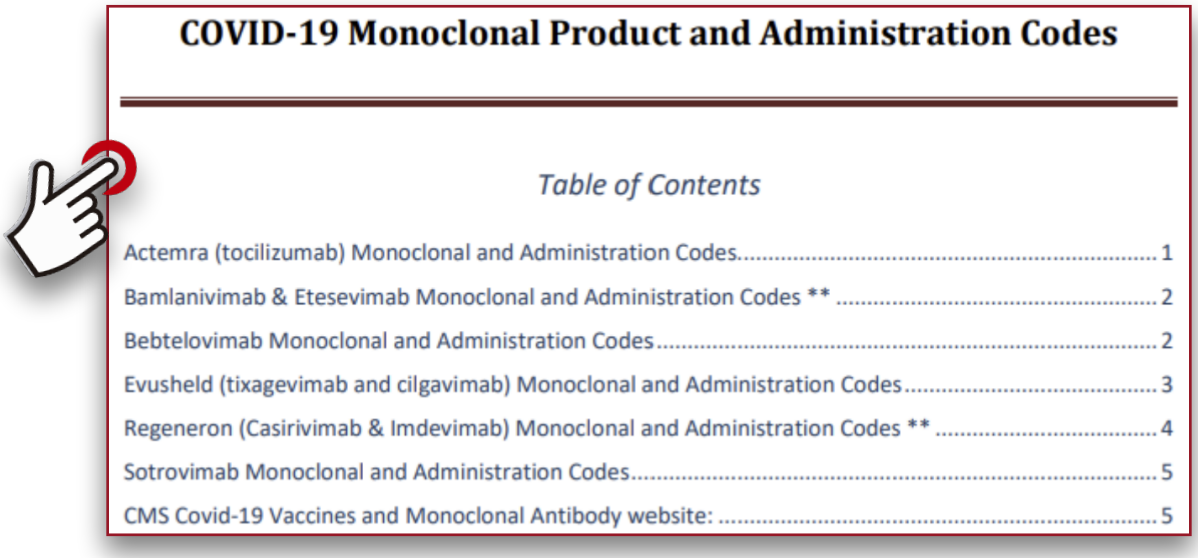
ParaRev offers papers with detailed information at the following links:
https://apps.parahcfs.com/para/Documents/EUA%20Issued%20for%20Antiviral%20Pills%20to%20Treat%20Covid.pdf



FDA Issues EUAs for Antiviral Pills to Treat Covid-19 at Home

On December 23, 2021, the Food and Drug Administration approved emergency use authorization (EUA) for Merck **Molnupiravir** pill for the treatment of Covid-19. The drug is cleared for patients 18 and older who test positive for Covid-19 and are at high risk of hospitalization or death. The treatment course includes four capsules every 12 hours for 5 days beginning as soon as the patient tests positive for Covid-19 and within five days of exhibiting symptoms.

https://apps.para-hcfs.com/para/Documents/COVID19%20Monoclonal%20Product%20and%20Administration%20Codes.pdf



COVID-19 Monoclonal Product and Administration Codes

Table of Contents

PROPOSAL TO DELAY RADIATION ONCOLOGY (RO) MODEL INDEFINITELY

On April 8, 2022, CMS released a proposed rule to delay the implementation of the Radiation Oncology (RO) Model to a date yet to be determined. Congress has delayed the RO Model twice during the Covid pandemic which has created substantial costs to continue funding preparation for implementation of the RO Model.

CMS feels that delaying the RO Model indefinitely will give RO participants the ability to pause their efforts to better utilize their resources and it will allow CMS to focus on development of other alternative payment models.

Should there be no objections to the proposed rule during the 60 day comment period, CMS plans to propose a new start date through rulemaking no less than 6 months prior to that proposed start date.

The document can be read in its entirety on the Federal Register:

2022-07525.pdf (federalregister.gov)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 512

[CMS-5527-P2]

RIN 0938-AT89

Radiation Oncology (RO) Model

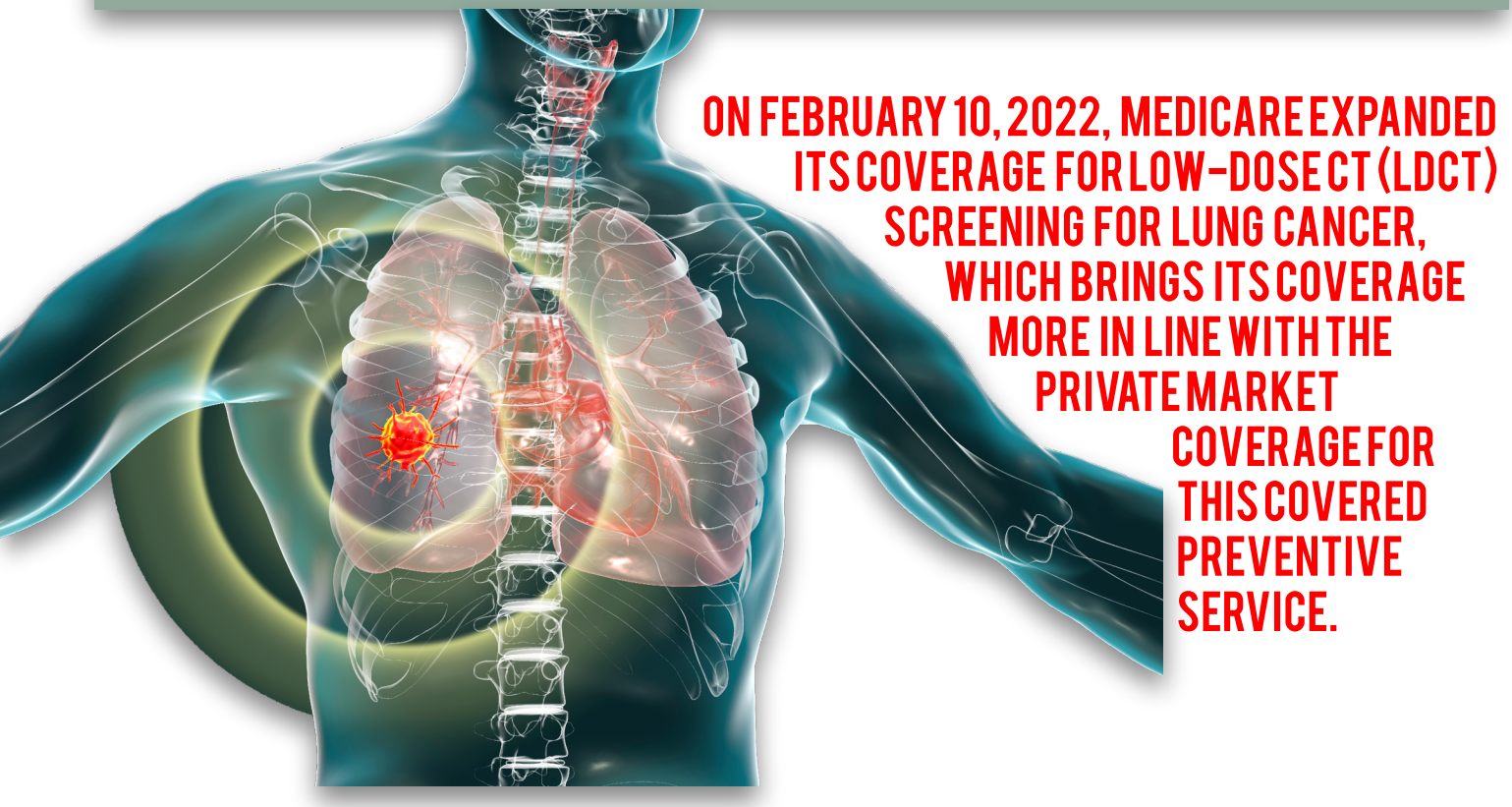
AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, (HHS).

ACTION: Proposed rule.

SUMMARY: We are proposing to delay the current start date of the RO Model to a date to be determined through future rulemaking, and to modify the definition of the model performance period to provide that the start and end dates of the model performance period for the RO Model will be established in future rulemaking.

ParaRev will continue to monitor the status of the proposed rule.

CMS EXPANDS, SIMPLIFIES LUNG CANCER SCREENING COVERAGE



Among other changes, the updated National Coverage Determination (210.14) expands the eligibility for screening to ages 50 to 70 (from 55 to 70 previously) and reduces the pack-years of tobacco smoking history from 30 pack years to 20. The full Decision Memo is available at the following link:

https://www.cms.gov/medicare-coverage-database/view/ncacal-decisionmemo.aspx?proposed=N&ncaid=304

National Coverage Analysis (NCA) | Decision Memo

Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

CAG-00439R | Expand All | Collapse All

Beneficiary eligibility criteria:

- Age 50 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receive an order for lung cancer screening with LDCT.

CMS EXPANDS, SIMPLIFIES LUNG CANCER SCREENING COVERAGE

The final National Coverage Decision Memo also simplifies requirements for the counseling and shared decision-making visit, relaxes certain professional requirements for the reading radiologist, and added back the requirement for radiology imaging facilities to use a standardized lung nodule identification, classification and reporting system.

However, the performing facility is no longer required to participate in the registry operated by the American College of Radiology. The new LDCT beneficiary eligibility criteria include:

- Age 50 – 77 years
- Asymptomatic (no signs or symptoms of lung cancer)
- Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes)
- Current smoker or one who has quit smoking within the last 15 years; and,
- Receive an order for lung cancer screening with LDCT

The final decision simplifies requirements for the counseling and shared decision-making visit by removing the restriction that it must be furnished by a physician or non-physician practitioner, allowing the visit to be conducted by "health educators and others beyond physicians or non-physician practitioners."

The beneficiary must receive this counseling and shared decision-making visit before the first LDCT and is appropriately documented in the beneficiary's medical records. The visit must meet all the following criteria:

- Determination of beneficiary eligibility
- Shared decision-making, including the use of one or more decision aids
- Counseling on the importance of adherence to annual lung cancer LDCT screening, impact of comorbidities and ability or willingness to undergo diagnosis and treatment; and
- Counseling on the importance of maintaining cigarette smoking abstinence if former smoker; or the importance of smoking cessation if current smoker and, if appropriate, furnishing of information about tobacco cessation interventions

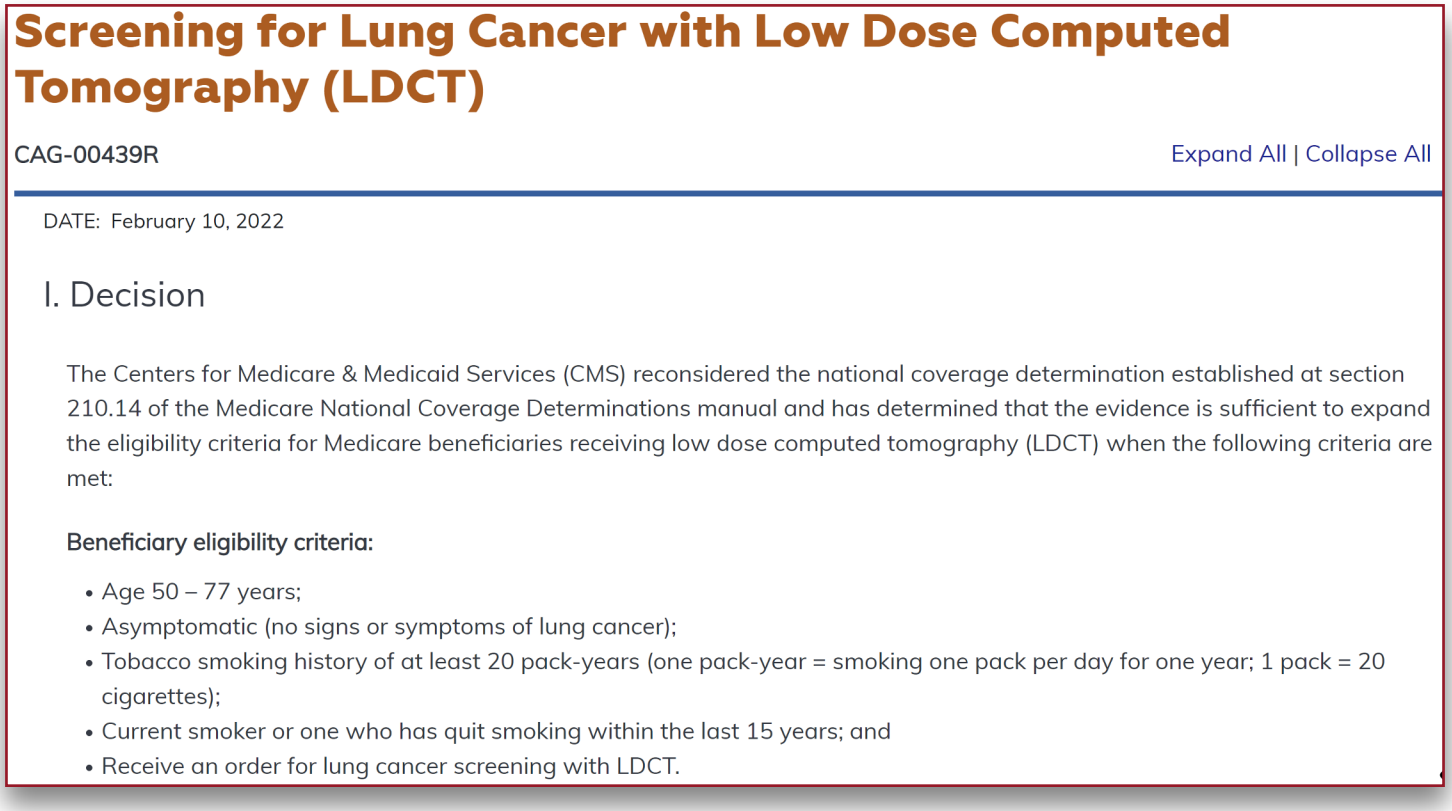
CMS EXPANDS, SIMPLIFIES LUNG CANCER SCREENING COVERAGE

The reading radiologist must be eligible for, or have earned board certification with the American Board of Radiology or equivalent organization. CMS removed the requirement that interpreting radiologists have reviewed 300 chest CT acquisitions within 3 years, as well as the requirement that the radiologist maintain documented participation in continuing medical education.

The LDCT must be furnished in a radiology imaging facility that utilizes a standardized lung nodule identification, classification and reporting system.

After considering comments and reviewing published studies, CMS decided to remove the criteria for imaging facilities to participate in a CMS-approved low dose CT lung cancer screening registry. The National Coverage Analysis *NCA - Screening for Lung Cancer with Low Dose Computed Tomography (LDCT) (CAG-00439R) - Decision Memo (cms.gov)* states:

> *"Given that three published studies use the Lung Cancer Screening Registry administered by the American College of Radiology fulfilled the purpose as outlined in the previous NCD and that the most recent 2021 USPSTF recommendation statement has changed to having no comment on the need for a lung cancer registry, we will remove the radiology imaging facility eligibility criteria for collecting and submitting data to a CMS-approved low dose CT lung cancer screening registry which is likely to reduce the burden of administrative paperwork on providers and institutions."*



Screening for Lung Cancer with Low Dose Computed Tomography (LDCT)

CAG-00439R

Expand All | Collapse All

DATE: February 10, 2022

I. Decision

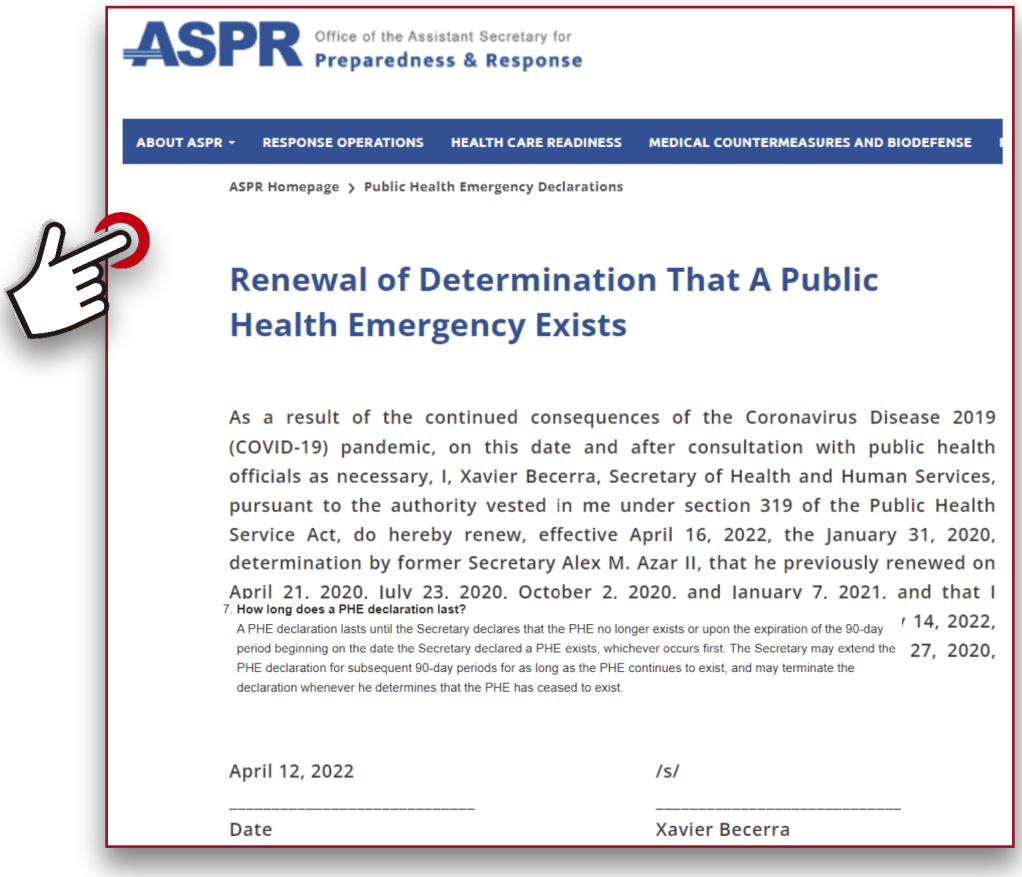
The Centers for Medicare & Medicaid Services (CMS) reconsidered the national coverage determination established at section 210.14 of the Medicare National Coverage Determinations manual and has determined that the evidence is sufficient to expand the eligibility criteria for Medicare beneficiaries receiving low dose computed tomography (LDCT) when the following criteria are met:

Beneficiary eligibility criteria:

- Age 50 – 77 years;
- Asymptomatic (no signs or symptoms of lung cancer);
- Tobacco smoking history of at least 20 pack-years (one pack-year = smoking one pack per day for one year; 1 pack = 20 cigarettes);
- Current smoker or one who has quit smoking within the last 15 years; and
- Receive an order for lung cancer screening with LDCT.

PUBLIC HEALTH EMERGENCY (PHE) EXTENDS THROUGH JULY 15, 2022

On April 12, 2022, Xavier Becerra, the Secretary of Health and Human Services, renewed the national Public Health Emergency (PHE) for up to an additional 90-day period. https://aspr.hhs.gov/legal/PHE/Pages/COVID19-12Apr2022.aspx



ASPR Office of the Assistant Secretary for Preparedness & Response

ABOUT ASPR | RESPONSE OPERATIONS | HEALTH CARE READINESS | MEDICAL COUNTERMEASURES AND BIODEFENSE

ASPR Homepage › Public Health Emergency Declarations

Renewal of Determination That A Public Health Emergency Exists

As a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic, on this date and after consultation with public health officials as necessary, I, Xavier Becerra, Secretary of Health and Human Services, pursuant to the authority vested in me under section 319 of the Public Health Service Act, do hereby renew, effective April 16, 2022, the January 31, 2020, determination by former Secretary Alex M. Azar II, that he previously renewed on April 21, 2020, July 23, 2020, October 2, 2020, and January 7, 2021, and that I

7. How long does a PHE declaration last?
A PHE declaration lasts until the Secretary declares that the PHE no longer exists or upon the expiration of the 90-day period beginning on the date the Secretary declared a PHE exists, whichever occurs first. The Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist, and may terminate the declaration whenever he determines that the PHE has ceased to exist.

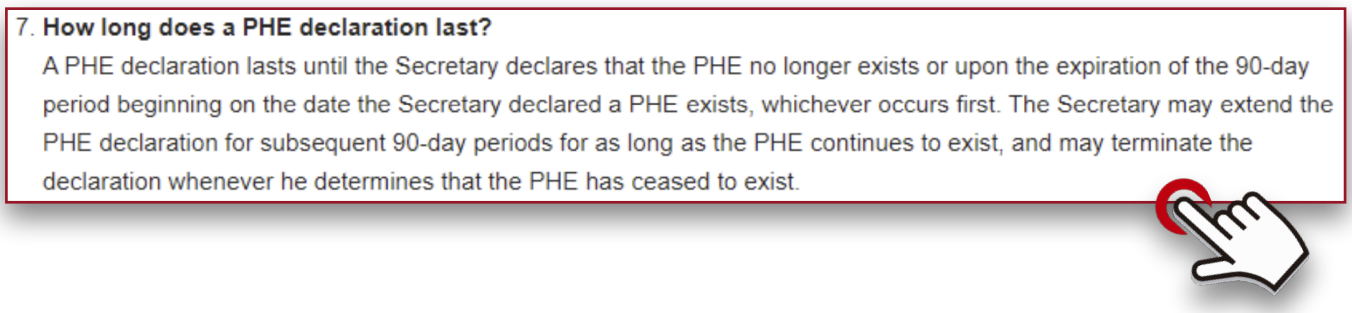
14, 2022,
27, 2020,

April 12, 2022 — Date

/s/ — Xavier Becerra

This latest extension will expire on July 15, 2022, unless the HHS Secretary determines the PHE is over or extends the PHE.

The PHE Declaration Questions and Answers webpage states that the PHE may be terminated either at the end of the 90-day extension or until the HHS Secretary declares the PHE no longer exists: https://www.phe.gov/Preparedness/legal/Pages/phe-qa.aspx#faq7

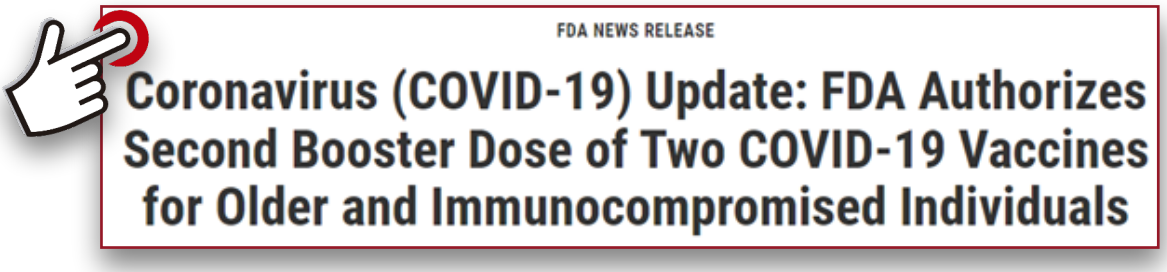


7. **How long does a PHE declaration last?**
A PHE declaration lasts until the Secretary declares that the PHE no longer exists or upon the expiration of the 90-day period beginning on the date the Secretary declared a PHE exists, whichever occurs first. The Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist, and may terminate the declaration whenever he determines that the PHE has ceased to exist.

FDA AUTHORIZES SECOND COVID-19 BOOSTER

In a statement released on March 29, 2022, the FDA authorized a second Covid-19 vaccine booster for immunocompromised individuals and people aged 50 and older.

https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-authorizes-second-booster-dose-two-covid-19-vaccines-older-and

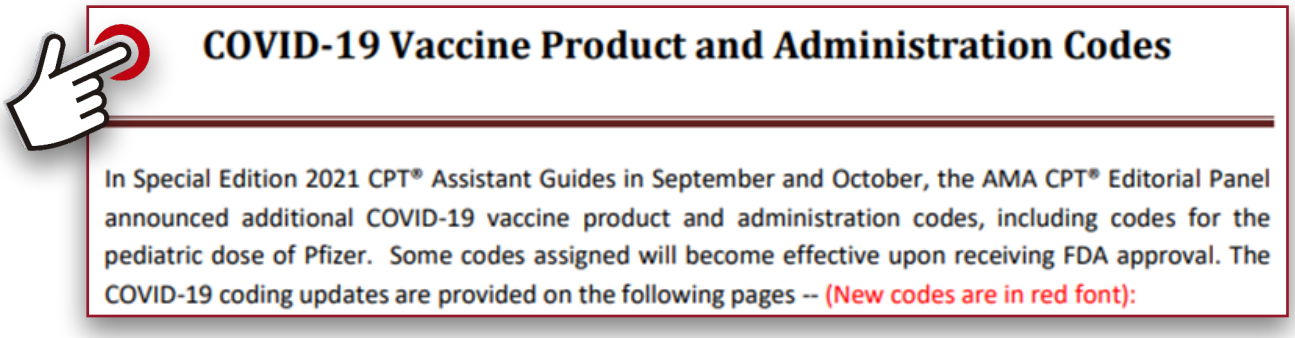


The emergency use authorization (EUA) revision includes second Covid-19 booster doses for both Pfizer and Moderna vaccines:

- Administration of **Pfizer** or **Moderna** COVID-19 booster dose to individuals 50 years of age and older at least 4 months after receipt of a first booster dose of any authorized or approved COVID-19 vaccine
- Administration of a second booster dose of **Pfizer** COVID-19 vaccine to individuals 12 years of age and older with certain kinds of immunocompromised conditions. The administration is authorized at least 4 months after the receipt of a first booster dose of any authorized or approved COVID-19 vaccine
- Administration of a second booster dose of the **Moderna** COVID-19 Vaccine at least four months after the first booster dose of any authorized or approved COVID-19 vaccine to individuals 18 years of age and older with the same certain kinds of immunocompromised conditions

COVID-19 vaccine products and administration codes may be found through the following link:

https://apps.para-hcfs.com/para/Documents/COVID-19%20Vaccine%20Product%20and%20Administration%20Codes%20(02-17-2022).pdf



HRSA COVID-19 UNINSURED PROGRAM TO STOP ACCEPTING CLAIMS

Due to a lack of funds, on **March 22, 2022**, HRSA Covid-19 Uninsured Program (UIP) will stop accepting claims for testing and treatment.

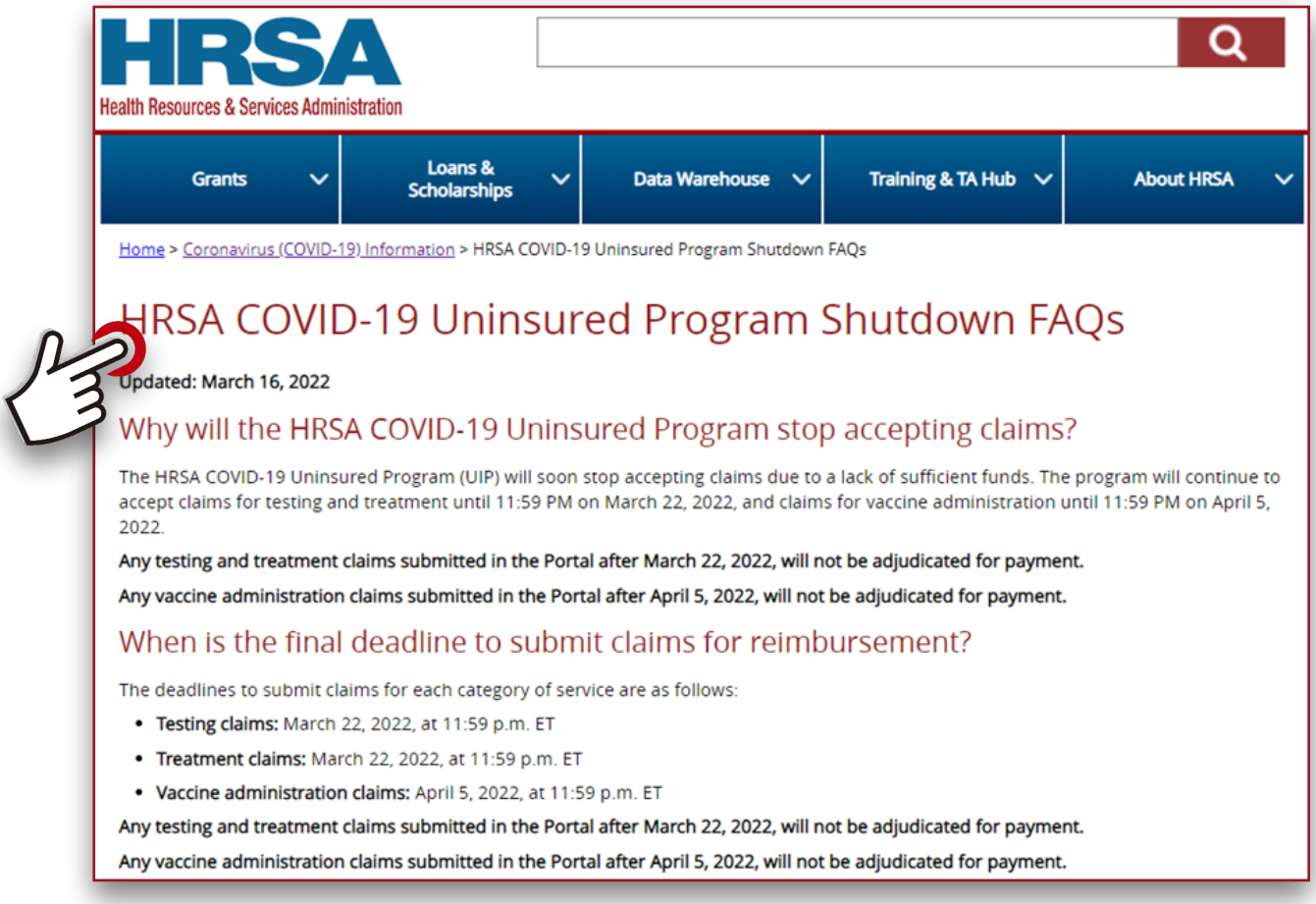
Beginning **April 5, 2022**, the program will no longer accept vaccination claims submitted for the Uninsured Program. HRSA will continue to adjudicate and pay claims submitted based on the availability of remaining funds.

We remind all providers participating in the CDC COVID-19 Vaccine Program of the following requirements:

- Providers must administer the vaccine at no cost to the individual (may also not balance bill)
- Providers cannot charge an office visit (or other fees or services) if the individual received only the vaccine
- Providers may not deny vaccines based on insurance coverage or out-of-network status

HRSA provides a webpage for additional information and alternate resources for uninsured patients seeking Covid-19 treatment or services:

https://www.hrsa.gov/coviduninsuredclaim/submission-deadline



CMS ADDS HCPCS FOR NEW PNEUMOCOCCAL, HEP B VACCINES

FOLLOWING THE MEDICARE CLAIMS PROCESSING SYSTEM UPDATE ON APRIL 4, 2022, MEDICARE ADMINISTRATIVE CONTRACTORS WILL PROCESS CLAIMS FOR TWO NEW PNEUMOCOCCAL CONJUGATE VACCINE CODES:

90677- Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use)

90671- Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use)

Additionally, a new hepatitis B vaccine will be covered, but the claims processing system will not be updated (and therefore claims for this code will not be processed) until July 5, 2022:

90759- Hepatitis B vaccine (HepB), 3-antigen (S, Pre-S1, Pre-S2), 10 mcg dosage, 3-dose schedule, for intramuscular use

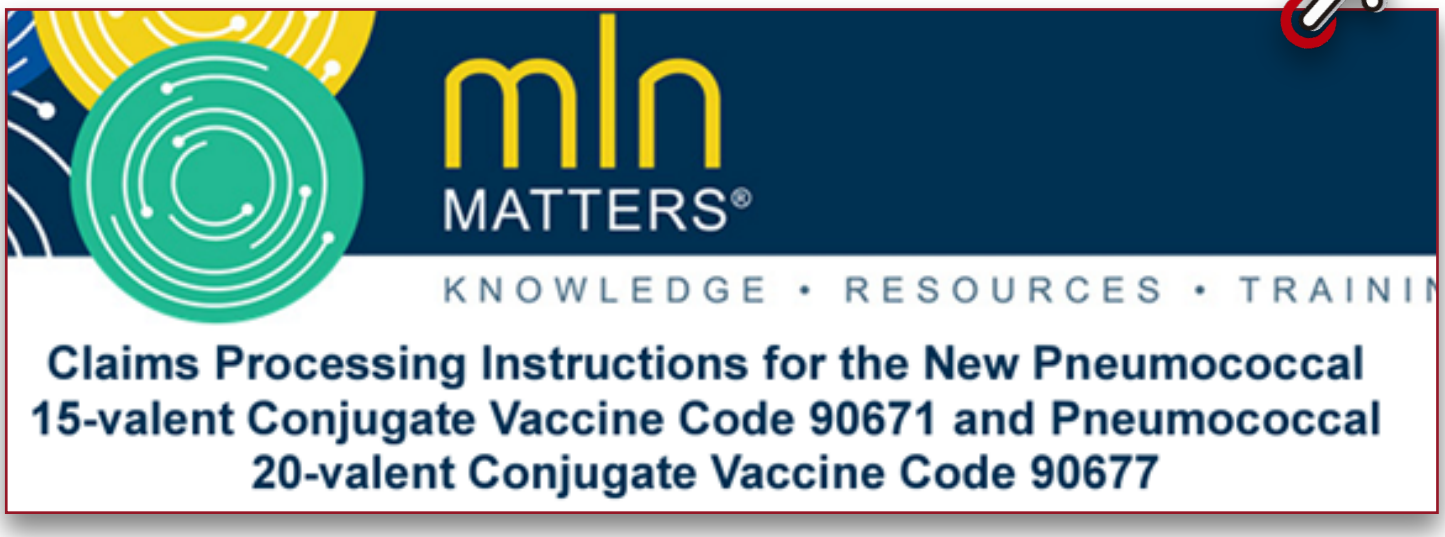
Reimbursement will be set at reasonable cost, using the Average Sales Price methodology. These vaccines are covered in full for Medicare beneficiaries (no coinsurance or deductible applies to these preventive vaccines.) MAC will hold claims received prior to April 1, 2022, but will reprocess claims received as follows:

- 90759 with DOS after January 11, 2022 (even though the HCPCS was effective 1/1/2022)
- 90677 with DOS on and after July 1, 2021
- 90671 with DOS on or after July 16, 2021

CMS ADDS HCPCS FOR NEW PNEUMOCOCCAL, HEP B VACCINES

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

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



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

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

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

NON-ESRD DIALYSIS FACILITY BILLING AND CODING

Medicare provides special coverage for persons with end-stage renal disease (ESRD.) Eligibility for Medicare benefits based on ESRD works differently than other types of Medicare eligibility – individuals who meet other eligibility requirements can sign up when diagnosed with ESRD, regardless of age.

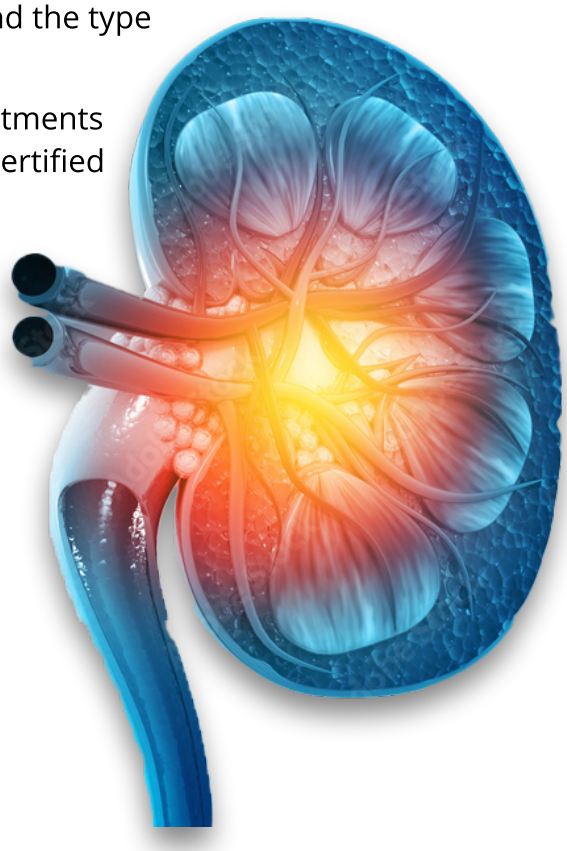
There is a coordination of benefits period of 30 months for beneficiaries who qualify for Medicare based on ESRD and who also have group health coverage – the group health coverage is primary during the 30-month waiting period. After 30 months, Medicare ESRD coverage becomes primary. Consequently, many patients with ESRD are Medicare beneficiaries.

One of the most common services that ESRD beneficiaries may require is dialysis.The two most common types of dialysis are hemodialysis and peritoneal dialysis:

- **Hemodialysis**– ongoing dialysis (3 to 5 times a week) that cleans the blood, usually provided at an outpatient ESRD dialysis center. Hemodialysis patients typically have an access port in the arm

- **Peritoneal dialysis**-- ongoing daily dialysis that collects waste from the blood by washing the empty space in the abdomen (peritoneal cavity). It can be done in the home setting, or within a facility in the outpatient or inpatient setting. The peritoneal dialysis access port is in the abdomen

Coding for outpatient dialysis at a non-ESRD facility differs depending on the beneficiary's coverage (ESRD or non-ESRD), eligibility for Part A or Part B Only, and the type of dialysis service provided.



ESRD Beneficiaries: Medicare covers routine dialysis treatments for an ESRD beneficiary only when furnished in an ESRD-certified facility. However, Medicare will cover emergency dialysis treatments in an outpatient department of a hospital, and dialysis services performed for ESRD beneficiaries during an acute inpatient hospital stay.

Non-ESRD beneficiaries are not ESRD patients, but may require dialysis to treat a non-ESRD condition. Medicare covers outpatient dialysis performed for a non-ESRD beneficiary at a non-ESRD facility.

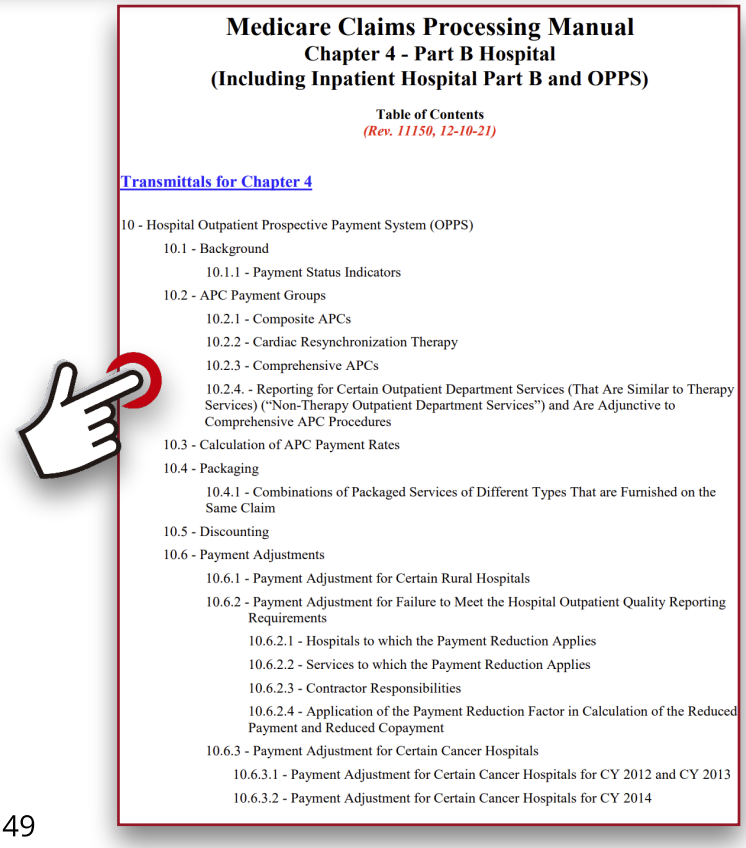
NON-ESRD DIALYSIS FACILITY BILLING AND CODING

The following table illustrates the three HCPCS codes which represent dialysis procedures performed in a non-ESRD outpatient hospital facility setting:

Beneficiary Coverage	Hospital Status / Type of Bill	Type of Dialysis Service	HCPCS/CPT®
ESRD	Outpatient 13X CAH 85X	Hemodialysis	**G0257** - Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility
Part B-Only (Non-ESRD)	Inpatient 12X	Hemodialysis	**90935** - hemodialysis procedure with single evaluation by a physician or other qualified health care professional
Non ESRD Outpatient	Outpatient 13X CAH 85X		
Part B Only (Non-ESRD)	Outpatient 13X CAH 85x Inpatient 12X	Dialysis *other than hemodialysis* (e.g., peritoneal dialysis, hemofiltration, etc.)	**90945** - Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional

Links and excerpts from the Medicare Claims Processing manual are provided below:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c04.pdf



Medicare Claims Processing Manual
Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents
(Rev. 11150, 12-10-21)

Transmittals for Chapter 4

200.2 - Hospital Dialysis Services For Patients With and Without End Stage Renal Disease (ESRD)

(Rev. 2455, Issued: 04-26-12, Effective: 10-01-12, Implementation; 10-01-12)

Effective with claims with dates of service on or after August 1, 2000, hospital-based End Stage Renal Disease (ESRD) facilities must submit services covered under the ESRD benefit in 42 CFR 413.174 (maintenance dialysis and those items and services directly related to dialysis such as drugs, supplies) on a separate claim from services not covered under the ESRD benefit. Items and services not covered under the ESRD benefit must be billed by the hospital using the hospital bill type and be paid under the Outpatient Prospective Payment System (OPPS) (or to a CAH at reasonable cost). Services covered under the ESRD benefit in 42 CFR 413.174 must be billed on the ESRD bill type and must be paid under the ESRD PPS. This requirement is necessary to properly pay only unrelated ESRD services (those not covered under the ESRD benefit) under OPPS (or to a CAH at reasonable cost).

Medicare does not allow payment for routine or related dialysis treatments, which are covered and paid under the ESRD PPS, when furnished to ESRD patients in the outpatient department of a hospital. However, in certain medical situations in which the ESRD outpatient cannot obtain her or his regularly scheduled dialysis treatment at a certified ESRD facility, the OPPS rule for 2003 allows payment for non-routine dialysis treatments (which are not covered under the ESRD benefit) furnished to ESRD outpatients in the outpatient department of a hospital. Payment for unscheduled dialysis furnished to ESRD outpatients and paid under the OPPS is limited to the following circumstances:

- Dialysis performed following or in connection with a dialysis-related procedure such as vascular access procedure or blood transfusions;
- Dialysis performed following treatment for an unrelated medical emergency; e.g., if a patient goes to the emergency room for chest pains and misses a regularly scheduled dialysis treatment that cannot be rescheduled, CMS allows the hospital to provide and bill Medicare for the dialysis treatment; or
- Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment.

In these situations, non-ESRD certified hospital outpatient facilities are to bill Medicare using the Healthcare Common Procedure Coding System (HCPCS) code G0257 (Unscheduled or emergency dialysis treatment for an ESRD patient in a hospital outpatient department that is not certified as an ESRD facility).

HCPCS code G0257 may only be reported on type of bill 13X (hospital outpatient service) or type of bill 85X (critical access hospital) because HCPCS code G0257 only reports services for hospital outpatients with ESRD and only these bill types are used to report services to hospital outpatients. Effective for services on and after October 1, 2012, claims containing HCPCS code G0257 will be returned to the provider for correction if G0257 is reported with a type of bill other than 13X or 85X (such as a 12x inpatient claim).

HCPCS code 90935 (Hemodialysis procedure with single physician evaluation) may be reported and paid only if one of the following two conditions is met:

NON-ESRD DIALYSIS FACILITY BILLING AND CODING

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c08.pdf#

10.5 - Hospital Services

(Rev. 10640, Issued:08-06-21, Effective:09-07-21, Implementation:09-07-21)

Outpatient dialysis services for a patient with acute kidney failure or chronic kidney failure but not eligible for Medicare under the ESRD provisions at the time services are rendered must be billed by the hospital and cannot be billed by a Medicare certified renal dialysis facility on bill type 72x.

Hospitals with a Medicare certified renal dialysis facility should have outpatient ESRD related services billed by the hospital-based renal dialysis facility on bill type 72x. Hospitals that do not have a Medicare certified renal dialysis facility may bill for outpatient emergency or unscheduled dialysis services. The *Prospective Payment System (PPS) base rate* is not paid. For more information regarding the outpatient hospital billing policy for ESRD related services, see chapter 4 section 210 of this manual.

When an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital due to renal failure - within 24 hours for non PPS hospitals and within 72 hours for PPS hospitals - the outpatient hospital services furnished are treated as inpatient services unless the patient does not have Part A coverage. Charges are reported on the ASC X12 837 institutional claim format or on Form CMS-1450. The day on which the patient is formally admitted as an inpatient is counted as the first inpatient day. The *PPS base rate* is not paid.

Medicare Claims Processing Manual

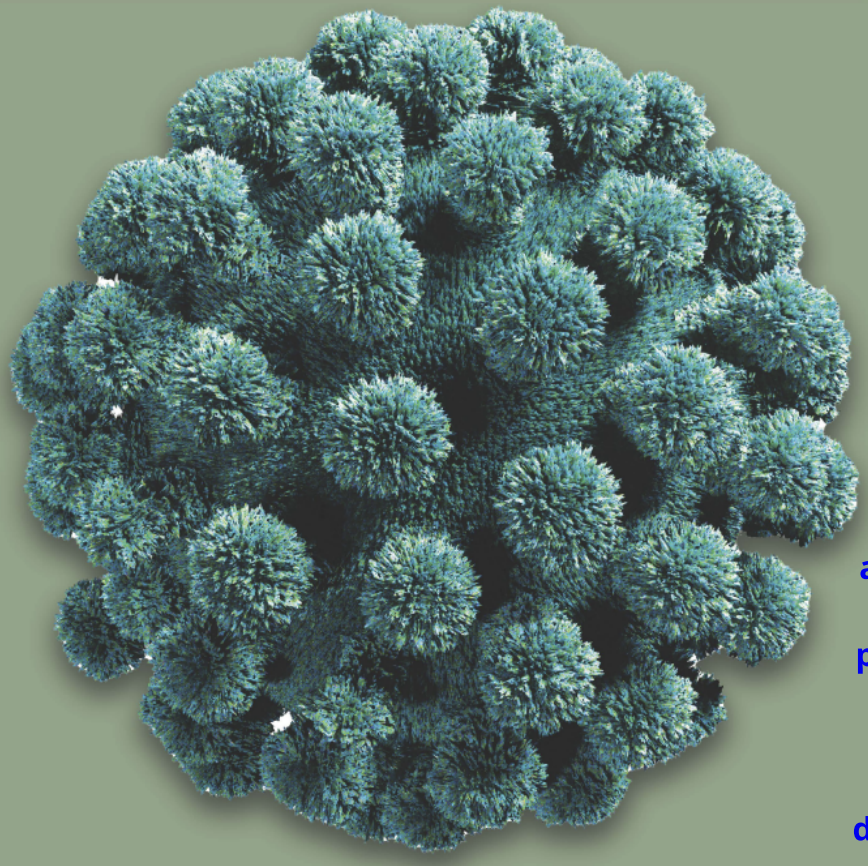
Chapter 8 - Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims

Table of Contents
(Rev. 10640, 08-06-21)

Transmittals for Chapter 8

UPDATED 3/15/22

2022 COMPREHENSIVE COVID-19 Guide



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

PARAREV

TUESDAY WEBINARS: COMPLYING WITH THE NO SURPRISES ACT

PARA experts are providing a free webinar each Tuesday designed to help hospitals understand and comply with the requirements under the No Surprises Act.

Every Tuesday

11:30 am PST

Sign Up By Clicking HERE,

Or Scan The QR Code

MLN CONNECTS

PARA invites you to check out the mlnconnects page available from the Centers For Medicare and Medicaid (CMS). It's chock full of news and information, training opportunities, events and more! Each week PARA will bring you the latest news and links to available resources. Click each link for the PDF!

Thursday, April 14, 2022

News

- Launch of the Cross-Cutting Initiatives
- Value-Based Insurance Design Model: Medicare Advantage Organizations Pay for Hospice Care

Compliance

- Collaborative Patient Care is a Provider Partnership

Claims, Pricers, & Codes

- COVID-19: New Codes for Moderna Vaccine Booster Doses

Events

- Medicare Cost Report E-Filing System: Interim Rate & Settlement Documentation Webinar — April 26

Date 2022-04-14

Subject COVID-19: New Codes for Moderna Vaccine Booster Doses

mlnconnects
Official CMS news from the Medicare Learning Network®

Thursday, April 14, 2022

News
- Launch of the Cross-Cutting Initiatives
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SPECIAL EDITION Monday, April 18, 2022

CMS Proposes Policies to Advance Health Equity & Maternal Health, Support Hospitals

On April 18, CMS issued a proposed rule for inpatient and long-term hospitals that builds on the Biden-Harris Administration's key priorities to advance health equity and improve maternal health outcomes. In addition to annual policies that promote Medicare payment accuracy and hospital stability, the fiscal year (FY) 2023 Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) rule includes measures that will encourage hospitals to build health equity into their core functions, thereby improving care for people and communities who are disadvantaged and/or underserved by the health care system. The rule includes 3 health equity-focused measures in hospital quality programs, seeks stakeholder input related to documenting social determinants of health in inpatient claims data, and proposes a "Birthing-Friendly" hospital designation.

For acute care hospitals paid under the IPPS that successfully participate in the Hospital Inpatient Quality Reporting Program and are meaningful electronic health record users, the proposed increase in operating payment rates is projected to be 3.2%. This reflects a FY 2023 projected hospital market basket update of 3.1% reduced by a projected 0.4 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by statute. Under the LTCH PPS, CMS expects payments to increase by approximately 0.8% or $25 million.

Additional items in the proposed rule related to payment stability for hospitals include a policy that smooths out significant year-to-year changes in hospitals' wage indexes and a solicitation for comments on payment adjustments for purchasing domestically made surgical N95 respirators. Specifically, CMS is proposing to apply a 5% cap on any decrease to a hospital's wage index from its wage index in the prior FY; and is considering the appropriateness of payment adjustments accounting for additional costs of purchasing surgical N95 respirators made in the U.S.

More Information*:*

- Complete press release
- Proposed payment rule fact sheet
- Maternal health & health equity measures fact sheet
- White House statement on Reducing Maternal Mortality and Morbidity
- Proposed rule: Comment by June 17

TRANSMITTALS

1

There was ONE new or revised Transmittal released this week.

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

TRANSMITTAL R11349FM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11349	**Date: April 12, 2022**
	Change Request 12729

SUBJECT: Notice of New Interest Rate for Medicare Overpayments and Underpayments -3rd Qtr Notification for FY 2022

I. SUMMARY OF CHANGES: Medicare Regulation 42 CFR Section 405.378 provides for the charging and payment of interest on overpayments and underpayments to Medicare providers. The Secretary of Treasury certifies an interest rate quarterly. Treasury utilizes the most comprehensive data available on consumer interest rates to determine the certified rate. Interest is assessed on delinquent debts in order to protect the Medicare Trust Funds. The attached Recurring Update Notification applies to Chapter 3, Section 10.

EFFECTIVE DATE: April 18, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 18, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

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

IV. ATTACHMENTS:

Recurring Update Notification

MEDLEARNS

0

There were 0 new or revised MedLearn released this week.

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