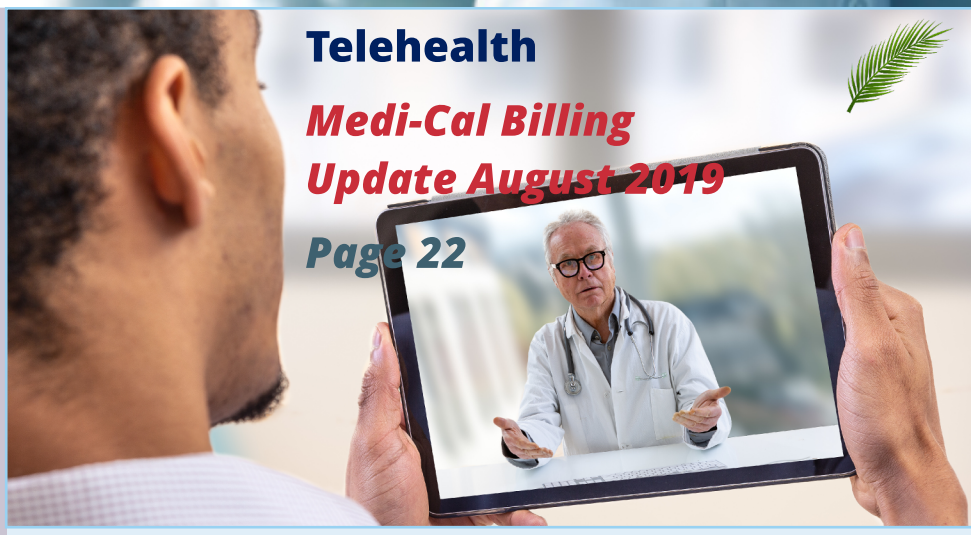
PARA
HealthCare Analytics
an HFRI Company
August 21, 2019

Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

IN THIS ISSUE

PARA



Telehealth

Medi-Cal Billing Update August 2019

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4 The number of new or revised Med Learn articles released this week.

11 The number of new or revised Transmittals released this week.

Price Transparency Guidelines

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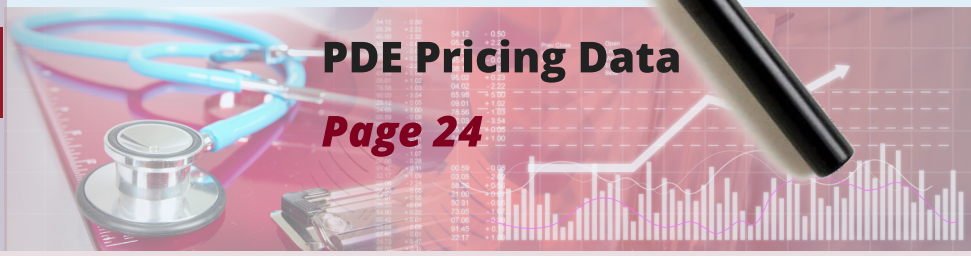

PDE Pricing Data

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FAST LINKS

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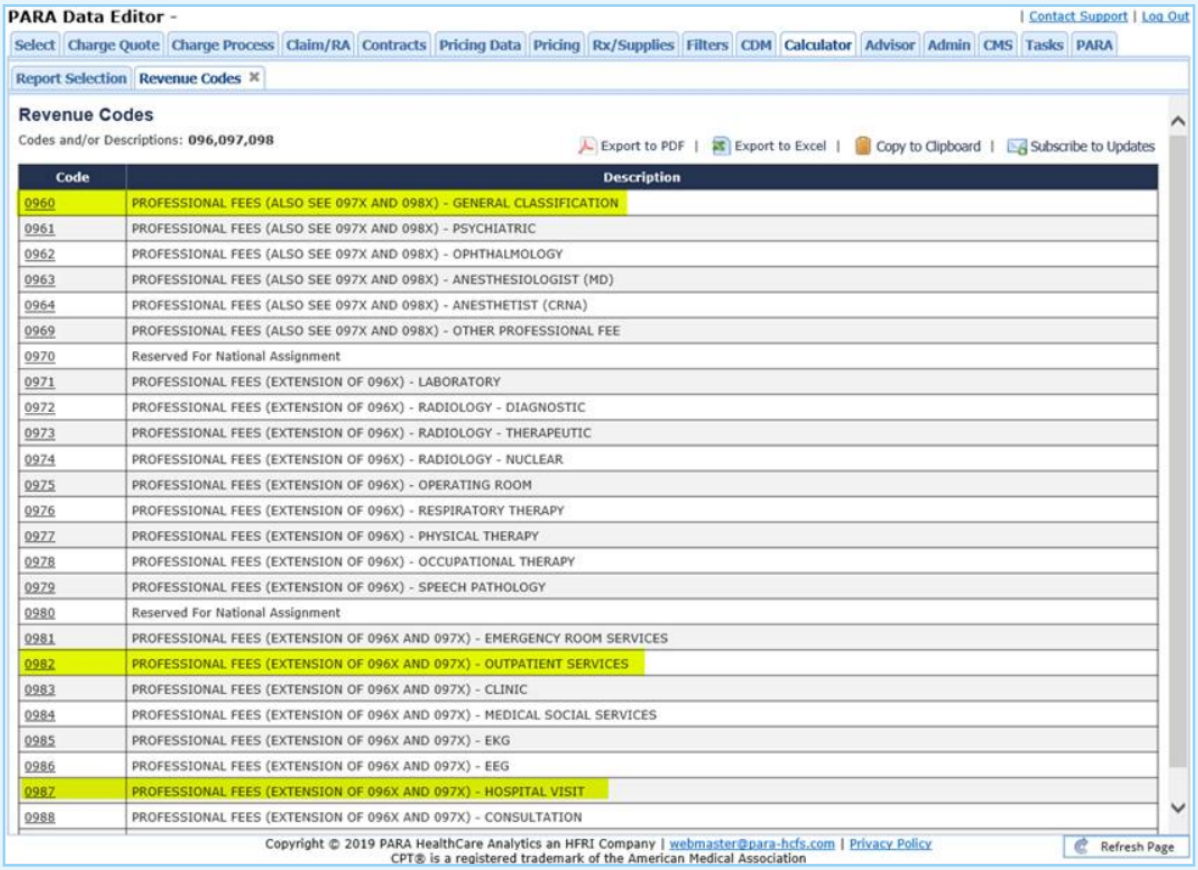
FACILITY AND PRO FEES REV CODES 99217 - 99220

Q. I have a concern regarding the revenue codes on the **PARA Data Editor** for CPT ® codes 99217, 99218, 99219 and 99220. Our CFO is creating a new department for our hospitalist and we are building the charges. She had 982 as the revenue code for the majority of the OBS and Inpatient initial and subsequent visits, and I wanted to make sure these were correct before we had them built. All other codes in the daily hospital visits are stating 987 or 657. Codes 99217, 99218, 99219 and 99220 are stating to use 762 as the revenue code. Is this correct??

A. **Answer:** We would suggest using rev code 0960 for the 992XX daily for pro fees and then 0762 (Method II) with G0378 for the hourly hospital. The revenue codes reported in the **PARA Data Editor** are derived from the HCPCS to Revenue Code crosswalk in the UB Editor. The UB Editor is primarily interested in facility fee billing, therefore no professional fee revenue codes are provided in the HCPCS to Rev Code crosswalk. Facility fees for patients in observation status are generally reported under revenue code 0762, that is why you will see that revenue code listed with the CPT®s 99217-99220. For facility fees, we recommend reporting HCPCS G0378 for hourly observation care.

A CAH Method II may report physician charges for outpatient services on a UB04/837i claim, of course. The professional fee revenue codes are in the ranges 096X, 097X, and 098X. Therefore, if reporting a professional fee, it is acceptable to report the services within those codes. While we prefer the most general professional fee revenue code 0960, it is also acceptable to report 0982 for physician outpatient services, such as observation – but it would not be appropriate to report 0982 for a physician's services in rendering inpatient care. Here are most of the professional fee revenue codes:



In order to avoid unnecessary edits due to a mismatch in the revenue code, we recommend sticking with the 0960 general classification professional fee revenue code for hospitalist services.

PA IV STARTS

Q. Is a Physician Assistant able to bill separately for starting IVs with ultrasound guidance in the outpatient and inpatient setting?

A. **Answer:** No, the PA should not generate a professional fee claim for starting an IV in the hospital setting, inpatient or outpatient. There is no HCPCS code for simply starting an IV. Even if the IV start resulted in an infusion or injection via IV, the Medicare NCCI Edit manual explains that Physicians and non-physician practitioners should not report IV therapy codes in the facility setting:

https://apps.para-hcfs.com/para/documents/CHAP11-CPTcodes90000-99999_final103118.pdf

CHAPTER XI MEDICINE / EVALUATION AND MANAGEMENT SERVICES

7. CPT® codes 96360-96379, 96401-96425, and 96521-96523 are reportable by physicians for services performed in physicians' offices. These drug administration services shall not be reported by physicians for services provided in a facility setting such as a hospital outpatient department or emergency department. Drug administration services performed in an Ambulatory Surgical Center (ASC) related to a Medicare approved ASC payable procedure are not separately reportable by physicians. Hospital outpatient facilities may separately report drug administration services when appropriate.

For purposes of this paragraph, the term "physician" refers to M.D.'s, D.O.'s, and other practitioners who bill Medicare claims processing contractors for services payable on the "Medicare Physician Fee Schedule".

If the IV start is successful and IV therapy is administered, which therapy is not part of a surgical procedure, the facility may report the appropriate HCPCS code (i.e. 96360-96379, 96401-96425) as a facility fee charge. The facility may also report 76937 - ULTRASOUND GUIDANCE FOR VASCULAR ACCESS REQUIRING ULTRASOUND EVALUATION OF POTENTIAL ACCESS SITES, DOCUMENTATION OF SELECTED VESSEL PATENCY, CONCURRENT REALTIME ULTRASOUND VISUALIZATION OF VASCULAR NEEDLE ENTRY, WITH PERMANENT RECORDING AND REPORTING (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) if a permanent record of the ultrasound is retained.

CHAP11-CPTcodes90000-99999_final10312018.doc
Revision Date: 1/1/2019

CHAPTER XI
MEDICINE
EVALUATION AND MANAGEMENT SERVICES
CPT CODES 90000 - 99999
FOR
NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL
FOR MEDICARE SERVICES

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PT EVALUATIONS WITHOUT AN ORDER

Q. Currently, our physical therapists tell us that it is within their scope of practice to perform a PT evaluation on a patient without a referral/physician order. If further services are needed, they obtain a referral and the doctor will sign off the Plan of Care.

Is it acceptable to bill for an evaluation on the facility side for a PT evaluation without a physician order? The other issue is that we do not have a physician name to place in the physician field. The PT clinic also informed us of SB 732 in Texas but we don't believe that has fully passed.

A. **Answer:** No, it is not acceptable to report a PT evaluation on a hospital patient without a referral for that evaluation from a referring provider, e.g., physician, nurse practitioner, etc. While it may be within the state scope of practice laws for a PT in private practice to perform an evaluation at the request of a private patient, without a referral, the hospital setting is a different matter. All services rendered in the hospital setting must be under the supervision/orders of a physician.

Here are the federal regulations from the Medicare Conditions of Participation for "Optional" Outpatient Services:

§ 482.54 Condition of participation: Outpatient services.

If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice.

(a)Standard: Organization. Outpatient services must be appropriately organized and integrated with inpatient services.

(b)Standard: Personnel. The hospital must –

(1) Assign one or more individuals to be responsible for outpatient services.

(2) Have appropriate professional and nonprofessional personnel available at each location where outpatient services are offered, based on the scope and complexity of outpatient services.

(c)Standard: Orders for outpatient services. Outpatient services must be ordered by a practitioner who meets the following conditions:

(1) Is responsible for the care of the patient.

(2) Is licensed in the State where he or she provides care to the patient.

(3) Is acting within his or her scope of practice under State law.

(4) Is authorized in accordance with State law and policies adopted by the medical staff, and approved by the governing body, to order the applicable outpatient services. This applies to the following:

(i) All practitioners who are appointed to the hospital's medical staff and who have been granted privileges to order the applicable outpatient services.

(ii) All practitioners not appointed to the medical staff, but who satisfy the above criteria for authorization by the medical staff and the hospital for ordering the applicable outpatient services for their patients.

[51 FR 22042, June 17, 1986, as amended at 77 FR 29075, May 16, 2012; 79 FR 27154, May 12, 2014]

36568 WITH C1751

Q. If a patient comes in for midline insertion (36568-Insertion of peripherally inserted central venous catheter, without subcutaneous port or pump, without imagine guidance; younger than 5 years of age), is the kit (C1751) (catheter power-midline 4 French) included in the CPT® code 36568? What if doctor performs? What if nurse performs? Is there a way on **PARA** that I can figure this kind of stuff out without having to submit a question? The CFO will ask me these kinds of questions and Google doesn't seem to give me the information I am needing.

A. **Answer:** Here are the definitions for the codes in question as displayed on the **PARA Data Editor:**

2019 HCPCS Codes - ALL Quarter: Q3

Codes and/or Descriptions: **36568,C1751** for selected Provider:
Results returned(below): 2
AWI: **1**, DME: **WI**, Clinical Lab Fee Schedule: **WI**, Physician Fee Schedule:**WISCONSIN**

Export to PDF | Export to Excel | Physician Supervision Definitions

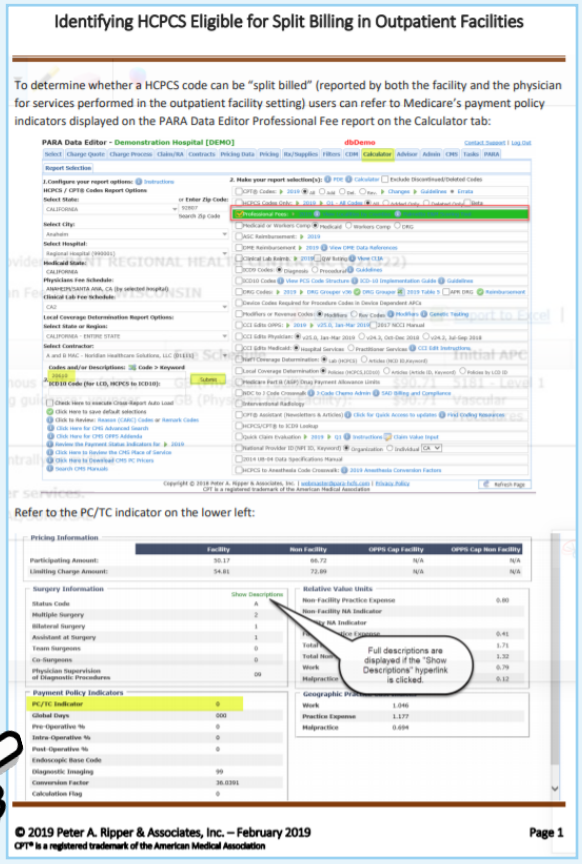
Current Descriptor	Fee Schedule		Initial APC	Payment	
36568 - insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age **T - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$90.71 $90.71	5181 - Level 1 Vascular Procedures	Weight: Payment: National Co-pay: Minimum Co-pay:	7.7999 $620.01 $0.00 $124.01
C1751 - catheter, infusion, inserted peripherally, centrally or midline (other than hemodialysis) **N - Payment is packaged into payment for other services.** **Berenson-Eggers Type of Service:** D1A - MEDICAL/SURGICAL SUPPLIES					

The charge for the supply C1751 should be separately reported in addition to the charge for 36568 on the facility fee. For an OPPS hospital paid under APC methodology, reimbursement for the kit is included in the payment for the supply, but for a Critical Access Hospital, every line on the claim is separately paid. Report the charge for the kit separately under revenue code 0278 for an implant.

The procedure 36568 may be performed by a physician or a specially trained nurse, so long as s/he is operating within state scope of practice laws according to his/her licensure. If performed by a nurse, the hospital can charge only the facility fee. If performed by a physician, the hospital may charge a separate professional fee and a facility fee.

When a procedure is performed in the hospital setting, the professional fee should never report supply charges, as supply charges are exclusively billed by hospitals.

Attached is our paper that explains how to determine if a procedure can be billed by both the facility UB04/837i and on a professional fee 1500/837p claim. Only professionals which are licensed to practice medicine independently (MD, DO, ARNP, PA, etc.) may report a professional fee. All nursing services are considered included in the facility fees of a hospital.



Simple solutions to complex problems.

The business of healthcare today is anything but simple. The challenges facing revenue cycle professionals are many, and the problems complex. That's why PARA HealthCare Analytics has joined HFRI.

We've got simple, practical solutions to everyday complex problems.

HEALTHCARE FINANCIAL RESOURCES | PARA HealthCare Analytics

Contact Us When	Contact Us When
Net days in AR is greater than 45	Reimbursement losses mount
10% of your AR is over 90 days	Coding errors are causing denials
Small balance accounts go untouched for 30 days	Price transparency and share of cost program is non-compliant
Your write-offs are over 2.5%	Your Chargemaster is out of date

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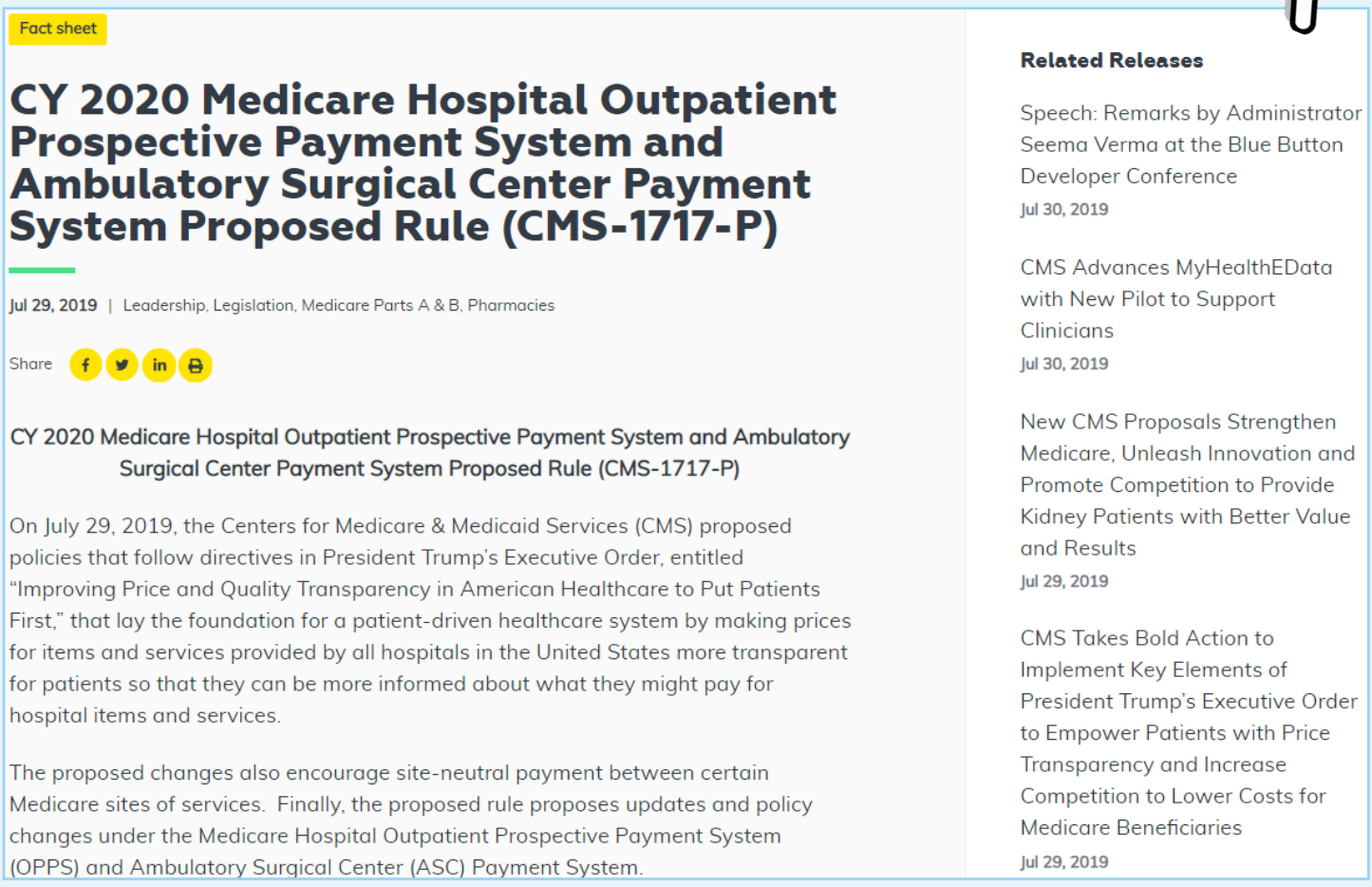
It's that simple.

PROPOSED 2020 OPPS AND ASC PROPOSED RULE: JUST RELEASED

On July 29, 2019, the Centers for Medicare (CMS) released the CY2020 proposed rule for review. The proposed policies are further advancing price transparency and encouraging site-neutral payment between certain Medicare sites of services.

This article is only a summary. The fact sheet related to this article can be reached at the following link

https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center



Fact sheet

CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1717-P)

Jul 29, 2019 | Leadership, Legislation, Medicare Parts A & B, Pharmacies

Share

CY 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1717-P)

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) proposed policies that follow directives in President Trump's Executive Order, entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First," that lay the foundation for a patient-driven healthcare system by making prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services.

The proposed changes also encourage site-neutral payment between certain Medicare sites of services. Finally, the proposed rule proposes updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System.

Related Releases

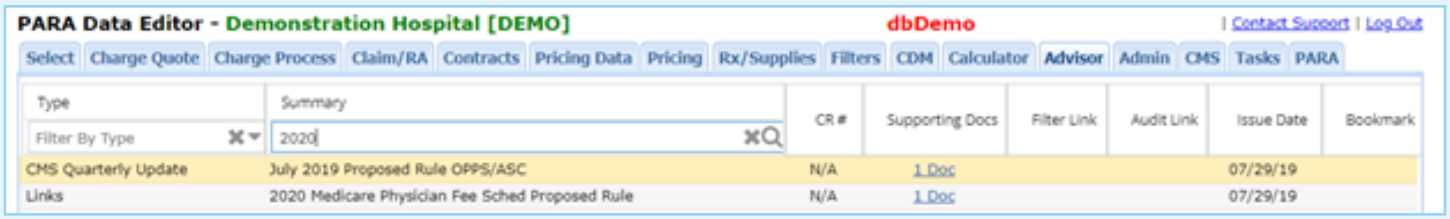
Speech: Remarks by Administrator Seema Verma at the Blue Button Developer Conference
Jul 30, 2019

CMS Advances MyHealthEData with New Pilot to Support Clinicians
Jul 30, 2019

New CMS Proposals Strengthen Medicare, Unleash Innovation and Promote Competition to Provide Kidney Patients with Better Value and Results
Jul 29, 2019

CMS Takes Bold Action to Implement Key Elements of President Trump's Executive Order to Empower Patients with Price Transparency and Increase Competition to Lower Costs for Medicare Beneficiaries
Jul 29, 2019

The full proposed rule is available for review on the CMS website. **PARA** has provided a link to the document on the **PDE Advisor** tab.



PROPOSED 2020 OPPS AND ASC PROPOSED RULE: JUST RELEASED

Key points within the proposal:

1. Increasing Price Transparency of Hospital Standard Charges:

In follow-up to a Presidential Executive Order on Improving Price and Quality Transparency in America, the proposed rule is seeking to implement Section 2719€ of the Public Health Service Act. This will improve on prior agency guidance that required hospitals to make public their standard charges. There are four components targeted in the rule pertaining to this key point:

- Definitions of "hospital", standard charges, and items and services
- Requirements for making public a machine-readable file online that includes all standard charges for all hospital items and services
- Requirements for making public payer-specific negotiated charges for a limited set of "shoppable" services that are displayed and packaged in a consumer-friendly manner
- Monitoring for hospital non-compliance and actions to address hospital non-compliance (including issuing a warning notice, requesting a corrective action plan and imposing civil monetary penalties) and a process for hospitals to appeal these penalties

2. Increasing Choices and Encouraging Site Neutrality:

Within this rule, there are a number of policies that reduce payment differences between outpatient sites of service so patients can benefit from high-quality care at lower costs. There are five (5) components targeted in the rule pertaining to this key point:

- Method to control for un-necessary increases in utilization of Outpatient Services – In following up with the Final Rule implementation regarding payments for clinic visits rendered in an off-campus setting, CMS is proposing changes that will result in lower co-payments for beneficiaries and savings for Medicare programs and taxpayers is estimated to be $810 million for CY2020
- Example given by CMS in proposed rule: "for a clinic visit furnished in an excepted off-campus provider-based department, average beneficiary cost sharing is currently $16.00 in CY2019, but would be $23.00 absent this policy. With the completion of the two (2) year phase-in, that cost-sharing would reduce to $9.00, saving beneficiaries an average of $14.00 each time they visit an off-campus department for a clinic visit in CY2020
- Changes to the Inpatient-Only List – CMS is proposing to remove Total Hip Arthroplasty from the Addendum C listing (Inpatient Only Listing). This would make the procedure reimbursable by Medicare in both the hospital inpatient and outpatient setting. A component of this change would include an additional one (1) year exemption from medical review activities for procedures removed from the IOP listing
- ASC Covered Procedures List – For CY2020, CMS is seeking to add Total Knee Arthroplasty (TKA), Knee Mosaicplasty and 3 additional coronary intervention procedures to the ASC CPL. CMS is currently seeking comments on any additional limitations on the provision of TKA or other procedures in an ASC setting. High-Cost/Low-Cost Threshold for Packaged Skin Substitutes – CMS is proposing to continue assigning skin substitutes to low-cost or high-cost group under the established policy of CY2018.

PROPOSED 2020 OPPS AND ASC PROPOSED RULE: JUST RELEASED

- Device Pass-through Applications – There were seven (7) applications reviewed by CMS for this proposed rule. Currently, there are no proposals to approve or deny, CMS is soliciting comments prior to making final determinations on the applications in the Final Rule. CMS is seeking public comment which is targeted to ensuring beneficiaries timely access to new therapies, removing access obstacles

3. Rethinking Rural Health:

There are two components targeted in this proposed rule pertaining to this key point:

- Addressing Wage Index Disparities – For CY 2020 CMS is proposing to use the FY2020 hospital Inpatient Prospective Payment System (IPPS) post-reclassified wage index for urban and rural areas as the wage index for OPPS to determine the wage adjustments for both the OPPS payment rate and the co-payment standardized amount. This change would be implemented as of January 01, 2020

- Changes in the Level of Supervision of Outpatient Therapeutic Services in Hospital and Critical Access Hospitals (CAH) – In this proposal, CMS is attempting to align the standard minimum level of supervision for each hospital service furnished incident to a physician service

4. Unleashing Innovation:

CMS is proposing an alternative pathway to qualifying for device-pass-through payment status, for which the substantial clinical improvement criteria would not apply.

5. Protecting Taxpayer Dollars:

CMS is proposing to initiate a prior authorization requirement for the following services, which are commonly cosmetic and are only billed when medically necessary:

- Blepharoplasty
- Botulinum-Toxin Injections
- Panniculectomy
- Rhinoplasty
- Vein Ablations

6. Meaningful Measures/Patients Over Paperwork:

CMS is seeking comment on utilizing a set of patient safety measures for both programs:

- Hospital Outpatient Quality Reporting (OQR) Program
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program

7. CY2020 OPPS Payment Methodology for 340B Purchased Drugs:

For CY2020, CMS is proposing to reimburse at the current adjusted amount of the ASP, minus 22.5% for certain separately payable drugs or biologicals that are acquired through the 340B program.

PROPOSED 2020 OPPS AND ASC PROPOSED RULE: JUST RELEASED

8. Proposed Updates to OPPS Payment Rates:

CMS is proposing to update OPPS payment rates by 2.7%. This increase is based on the projected hospital market basket increase to 3.2% minus a 0.5% point adjustment for multi-factor productivity (MFP). In addition, CMS is proposing to increase rates for:

- Partial Hospitalization Program (PHP) Rate Setting
- PHP Per Diem Rates

9. Proposed Updates to ASC Payment Rates:

To promote site-neutrality between hospitals and ASCs, as well at encourage the migration of services from the hospital setting to the lower cost ASC, CMS is proposing to update ASC rates for CY2020 by 2.7% for meeting quality reporting requirements.

10. Revision to the Organ Procurement Organization Conditions for Certification:

Under the current requirements OPOs are required to meet two out of three outcome measures. CMS is seeking to clarify the regulatory standard in place to enable proper enforcement of the second outcome measure, eliminate provider confusion, and to further support goals related to accurately measuring OPO performance.

11. Potential Changes to the Organ Procurement Organization and Transplant Center Regulations:

Request for Information: In this proposal, CMS is seeking public comment and assistance in making updates to the OPO Conditions of Coverage (CfCs), in addition to updating the Conditions of Participation (CoPs) for transplant centers.

CMS RELEASES 2020 PHYSICAN FEE SCHEDULE PROPOSED RULE

On July 29, 2019, Medicare released the 2020 Medicare Physician Fee Schedule Proposed Rule. The fact sheet relating the changes to the rule is available at the following link:

https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2

The full proposed rule is available for review on the Medicare website. A link is provided on the **PARA Data Editor Advisor** tab.

Enter the year 2020 in the Summary field:

Key proposals concerning physician reimbursement are summarized below (this is not an all-inclusive list):

- Set the CY 2020 PFS conversion factor at $36.09, a slight increase above the CY 2019 rate of $36.04
- Align with changes laid out by the CPT® Editorial Panel for office/outpatient E/M visits which:
  - Retain 5 levels of coding for established patient office/outpatient EM visits, and
  - Reduce the number of levels to 4 for new patient office/outpatient E/M visits, and
  - Revise the code definitions in regard to the times and medical decision-making process for all of the codes, and to require performance of history and exam only as medically appropriate
- Provide a Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

CMS RELEASES 2020 PHYSICAN FEE SCHEDULE PROPOSED RULE

- Allow PAs greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice; in the absence of State law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services
- Make broad modifications to the documentation policy so that physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives could review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team
- Increase payment for Transitional Care Management (TCM), which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays
- Provide a set of Medicare-developed HCPCS G-codes for certain Chronic Care Management (CCM) services. CCM is a service for providing care coordination and management services to beneficiaries with multiple chronic conditions over a calendar month service period
- Create new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single serious and high risk condition
- Implement a new Medicare Part B benefit for opioid use disorder treatment programs, including enrollment, bundled payment methodology for full and partial weeks, service delivery via two-way interactive video communication, and zero beneficiary copays for a limited duration
- Require the CO and CQ modifiers to identify services rendered by PT and OT Assistants

This paper serves as a summary of key provisions that will be of wide interest; it is not a complete list of all changes. Please refer to the full Medicare document for more complete information.

Comments on the proposed rule will be accepted until 5 p.m. on September 27, 2019; the final rule is typically announced in October of each year.

2020 INPATIENT PROSPECTIVE PAYMENT SYSTEM (IPPS) FINAL RULE

On August 2, 2019, CMS published the 2020 Inpatient Prospective Payment System (IPPS) Final rule. The release includes increases for acute care hospital Medicare payment rates as well as changes to the hospital wage index.

A link to the 2020 IPPS Final rule is available on the **PARA Data Editor Advisor** tab; enter "2020" in the Summary field:

Inpatient payment policy changes, combined with rate increases, are expected by CMS to increase hospital payments by an estimated $3.8 billion in 2020. Among these changes are:

- **Increase by 3.1 percent IPPS rates** for acute care hospitals that participate in meaningful EHR and submit quality data
- **$78 million increase over the 2019 rates for DSH payments** with over $8.3 billion distributed to disproportionate share hospitals
- **Addressing wage index disparities:**
  - **Change the "rural floor"** of the wage index calculation. Wage index values for rural hospitals in the same state will be no lower than urban hospitals
  - **Wage index increases for hospitals with a wage index value below the 25th percentile.** Adjustments will be made for all hospitals in order to remain budget neural with this policy change and will be in effect for a minimum of 4 years
  - **Removal of urban to rural hospital reclassifications** will address the wage index disparities from states who received higher wages for urban hospitals due to manipulating the calculations
  - **Cap the payment decreases to 5%** due to adjustments in the wage index calculations
- **Increase from 50% to 65% for add-on payments for technology** including CART-T cancer therapy. A 75% new technology add-on payment is finalized for certain antimicrobials.

CMS' final inpatient payment rule for 2020: 8 things to know

IRF: FY 2020 PAYMENT AND POLICY CHANGES

On July 31, CMS issued a final rule that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) and the IRF Quality Reporting Program for FY 2020.

CMS is continuing their efforts towards the eventual transition to a unified post-acute care system through updates to the data used for IRF payments, including revising the Case-Mix Groups (CMGs), updating the CMG relative weights and average length of stay values, and using concurrent inpatient prospective payment system wage index data for the IRF PPS to align wage index data across settings of care.

For FY 2020, CMS is finalizing updates to the IRF PPS payment rates using the most recent data to reflect an estimated 2.5 percent increase factor (reflecting an IRF-specific market basket increase factor of 2.9 percent, reduced by a 0.4 percentage point multifactor productivity adjustment). CMS projects that IRF payments will increase by 2.5 percent (or $210 million) for FY 2020, relative to payments in FY 2019.

This Rule Finalizes:

- Rebase and revise the IRF market basket
- Clarification of "rehabilitation physician"
- Two new quality measures

See the full text of this excerpted CMS Fact Sheet (Issued July 31).

Fact sheet

Fiscal Year 2020 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1710-F)

Jul 31, 2019 | Billing & payments, Legislation

Share

Fiscal Year 2020 Payment and Policy Changes for Medicare Inpatient Rehabilitation Facilities (CMS-1710-F)

On July 31, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) and the Inpatient Rehabilitation Quality Reporting Program (IRF QRP) for fiscal year (FY) 2020. This final rule moves the agency closer to unified post-acute care payment and updates IRF payment rates as required by statute.

Strengthening Medicare:

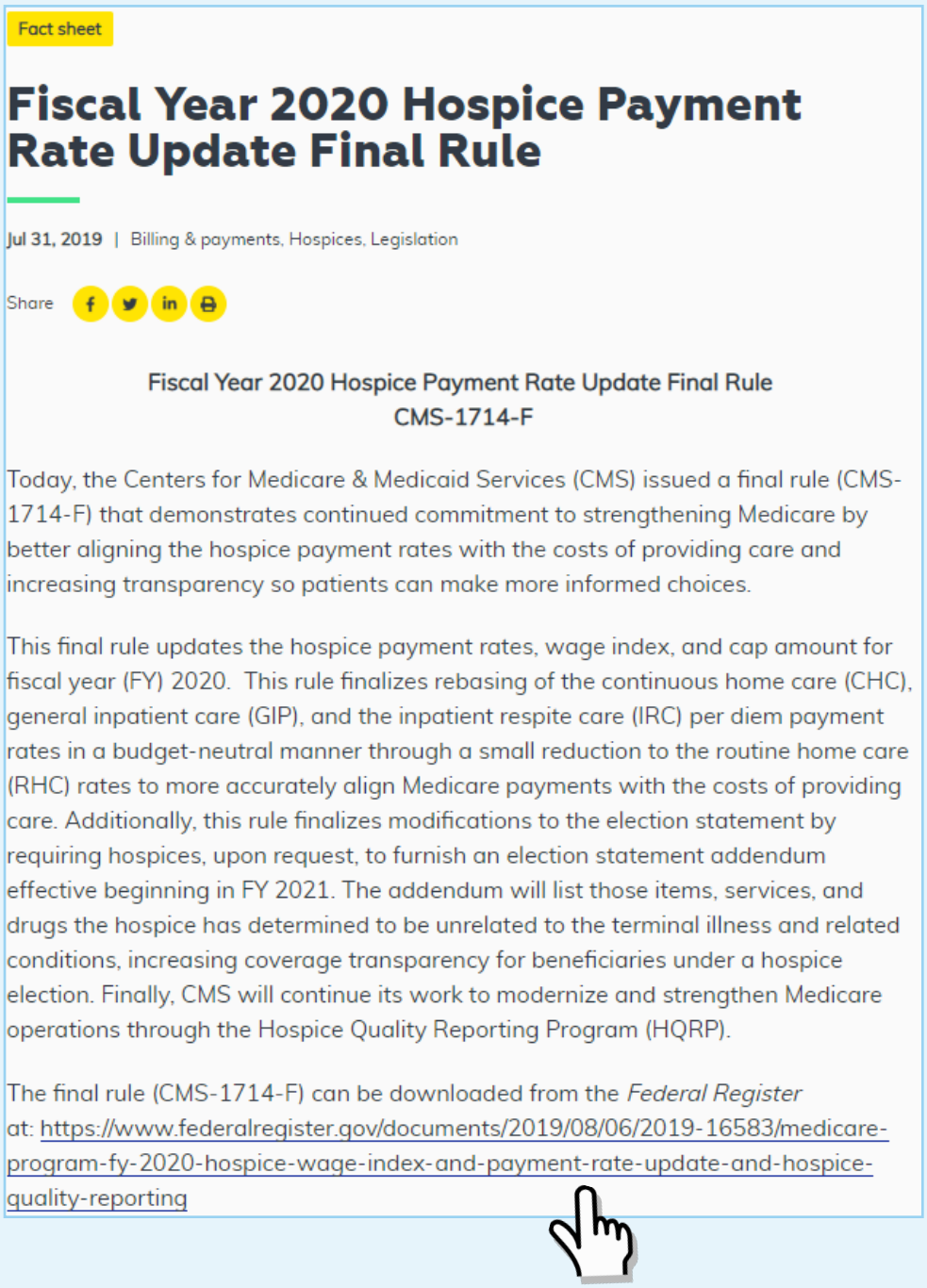
We are continuing our efforts towards the eventual transition to a unified post-acute care system, through updates to the data used for IRF payments, including revising the case-mix groups (CMGs), updating the CMG relative weights and average length of stay values, and using concurrent inpatient prospective payment system (IPPS) wage index data for the IRF PPS to align wage index data across settings of care.

This fact sheet discusses the major provisions of the final rule. The final rule can be downloaded from the *Federal Register* at: https://www.federalregister.gov/documents/2019/08/08/2019-16603/medicare-programs-inpatient-rehabilitation-facility-irf-prospective-payment-system-for-federal

IRF: FY 2020 HOSPICE PAYMENT RATE FINAL RULE

On July 31, CMS issued a final rule that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices.

For FY 2020, hospice payment rates are increased by 2.6 percent ($520 million increase in their payments). The final hospice cap amount for the FY 2020 cap year will be $29,964.78, which is equal to the FY 2019 cap amount ($29,205.44) updated by the final FY 2020 hospice payment update percentage of 2.6 percent. The aggregate cap limits the overall payments per patient made to a hospice annually.



Fact sheet

Fiscal Year 2020 Hospice Payment Rate Update Final Rule

Jul 31, 2019 | Billing & payments, Hospices, Legislation

Share

Fiscal Year 2020 Hospice Payment Rate Update Final Rule
CMS-1714-F

Today, the Centers for Medicare & Medicaid Services (CMS) issued a final rule (CMS-1714-F) that demonstrates continued commitment to strengthening Medicare by better aligning the hospice payment rates with the costs of providing care and increasing transparency so patients can make more informed choices.

This final rule updates the hospice payment rates, wage index, and cap amount for fiscal year (FY) 2020. This rule finalizes rebasing of the continuous home care (CHC), general inpatient care (GIP), and the inpatient respite care (IRC) per diem payment rates in a budget-neutral manner through a small reduction to the routine home care (RHC) rates to more accurately align Medicare payments with the costs of providing care. Additionally, this rule finalizes modifications to the election statement by requiring hospices, upon request, to furnish an election statement addendum effective beginning in FY 2021. The addendum will list those items, services, and drugs the hospice has determined to be unrelated to the terminal illness and related conditions, increasing coverage transparency for beneficiaries under a hospice election. Finally, CMS will continue its work to modernize and strengthen Medicare operations through the Hospice Quality Reporting Program (HQRP).

The final rule (CMS-1714-F) can be downloaded from the *Federal Register* at: https://www.federalregister.gov/documents/2019/08/06/2019-16583/medicare-program-fy-2020-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting

This Rule Finalizes:

- Rebasing to more accurately align Medicare payments with the costs of providing care
- Modifications to the election statement beginning in FY 2021, increasing coverage transparency for beneficiaries under a hospice election
- Hospice Quality Reporting Program updates, including developing a hospice assessment tool for real-time patient assessments

For More Information:

- Final Rule
- Hospice Center webpage
- Hospice Quality Reporting webpage See the full text of this excerpted CMS Fact Sheet (Issued July 31).

CMS 2020 PROPOSED RULE OFFERS TRANSPARENCY GUIDELINES

Within the 2020 OPPS/ASC Proposed Rule released on Monday, July 29, 2019, CMS provided long-awaited guidance on price transparency requirements in section XVI, Proposed Requirements for Hospitals to Make Public a List of Their Standard Charges.

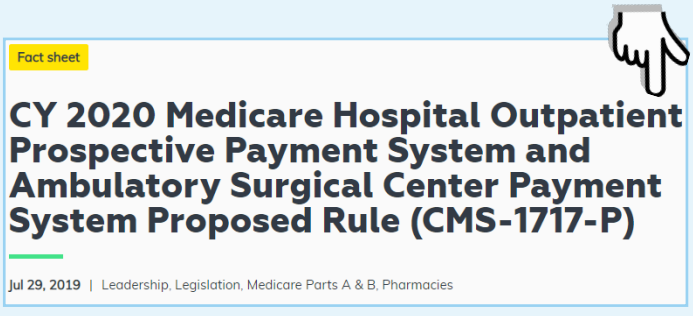
The Proposed Rule is available on the **Advisor** tab of the **PARA Data Editor**; enter "2020" in the Summary field:

Reaction to the guidance has been swift and somewhat negative. The American Hospital Association, America's Essential Hospitals, the Association of American Medical Colleges, the Children's Hospital Association, and the Federation of American Hospitals issued a joint statement on the proposed calendar year 2020 Outpatient Prospective Payment System rule:

> *"Hospitals and health systems want to ensure that patients have access to information they need to choose their health care, including their out-of-pocket obligations. This rule, however, is a misguided attempt to improve price transparency for patients because it fails to give them the information they need. Disclosing the negotiated rate between insurers and hospitals will not help patients make decisions about their care. Instead, this disclosure could harm patients by reducing patient access to care. This is the wrong approach to price transparency, and the administration should reverse course on this provision."*

The deadline for submitting comments on the proposed rule is September 27, 2019.

A link and excerpts from the CMS Fact Sheet pertinent to transparency guidance is provided below: https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center



CMS 2020 PROPOSED RULE OFFERS TRANSPARENCY GUIDELINES

Increasing Price Transparency of Hospital Standard Charges

On June 24, 2019, the President signed an Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First noting that it is the policy of the Federal Government to increase the availability of meaningful price and quality information for patients. The Executive Order directed the Secretary of Health and Human Services (HHS) to propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information[1]. We believe healthcare markets work more efficiently and provide consumers with higher-value healthcare if we promote policies that encourage choice and competition.[2] In short, as articulated by the CMS Administrator, we believe that transparency in health care pricing is "critical to enabling patients to become active consumers so that they can lead the drive towards value."[3]

This proposed rule implements Section 2718(e) of the Public Health Service Act and improves upon prior agency guidance that required hospitals to make public their standard charges upon request starting in 2015 (79 FR 50146) and subsequently online in a machine-readable format starting in 2019 (83 FR 41144).. Section 2718 is entitled "Bringing Down the Cost of Health Care Coverage." Section 2718(e) requires each hospital operating within the United States to establish (and update) and make public a yearly list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act. In the proposed rule, we propose the following: (1) definitions of "hospital", "standard charges", and "items and services"; (2) requirements for making public a machine-readable file online that includes all standard charges for all hospital items and services; (3) requirements for making public payer-specific negotiated charges for a limited set of 'shoppable' services that are displayed and packaged in a consumer-friendly manner; and (4) monitoring for hospital noncompliance and actions to address hospital noncompliance (including issuing a warning notice, requesting a corrective action plan, and imposing civil monetary penalties), and a process for hospitals to appeal these penalties.

...the Act improves upon prior agency guidance that requires hospitals to make public their standard charges...

Proposed Definition of 'Hospital'

We propose to define 'hospital' as an institution in any State in which State or applicable local law provides for the licensing of hospitals and which is licensed as a hospital pursuant to such law, or is approved by the agency of such State or locality responsible for licensing hospitals as meeting the standards established for such licensing. For purposes of this definition, a State would include each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. This proposal would include all Medicare-enrolled institutions that are licensed as hospitals (or approved as meeting licensing requirements) as well any non-Medicare enrolled institutions that are licensed as a hospital (or approved as meeting licensing requirements). We propose that federally owned or operated institutions (for example, hospitals operated by an Indian Health Program, the US Department of Veterans Affairs, or the US Defense Department) which are not accessible to the general public, except in emergency situations, and already make their charges publicly available be deemed to have the requirements of Section 2718(e).

CMS 2020 PROPOSED RULE OFFERS TRANSPARENCY GUIDELINES

Proposed Definition of 'Standard Charges'

We are proposing to define "standard charges" to mean the hospital's gross charge and payer-specific negotiated charge for an item or service. Hospitals would be required to make public all hospital standard charges for all items and services provided by the hospital in a digital and machine-readable file posted online. Additionally, we propose that hospitals make public the payer-specific negotiated charge for a limited set of 'shoppable' services that are displayed and packaged in a consumer-friendly manner.

Proposed Definition of Hospital 'Items and Services'

We propose to define hospital "items and services" to include all items and services (including individual items and services and service packages) provided by a hospital to a patient in connection with an inpatient admission or an outpatient department visit for which the hospital has established a charge. Examples of these items and services would be supplies, procedures, room and board, use of the facility and other items (generally described as facilities fees), services of employed practitioners (generally described as professional charges), and any other items or services for which the hospital has established a charge.

Proposed Requirements for Making Public All Standard Charges for All Items and Services

We are proposing that hospitals make public their standard changes (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format. We believe this information and format is most useful for developers who could use these data in consumer-friendly price transparency tools, or who may integrate the data into electronic medical records and shared decision making tools at the point of care.

Proposed Requirements for Making Public Consumer-Friendly Standard Charges for a Limited Set of 'Shoppable Services'

We are proposing requirements for hospitals to make public standard charge data for a limited set of "shoppable services" the hospital provides in a form and manner that is more consumer-friendly. We propose to define 'shoppable service' as a service that can be scheduled by a health care consumer in advance. We believe these proposed requirements will allow healthcare consumers to make apples-to-apples comparisons of payer-specific negotiated charges across healthcare settings. Specifically, we propose that hospitals would do the following:

- *Display payer-specific negotiated charges for at least 300 shoppable services, including 70 CMS-selected shoppable services and 230 hospital-selected shoppable services. If a hospital does not provide one or more of the 70 CMS selected shoppable services, the hospital must select additional shoppable services such that the total number of shoppable services is at least 300*
- *Include charges for services that the hospital customarily provides in conjunction with the primary service that is identified by a common billing code (e.g. Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS)/ Diagnosis-Related Group (DRG)*
- *Make sure that the charge information is displayed prominently on a publicly available webpage, clearly identifies the hospital (or hospital location), easily accessible and without barriers, and searchable*
- *Update the information at least annually*

CMS 2020 PROPOSED RULE OFFERS TRANSPARENCY GUIDELINES

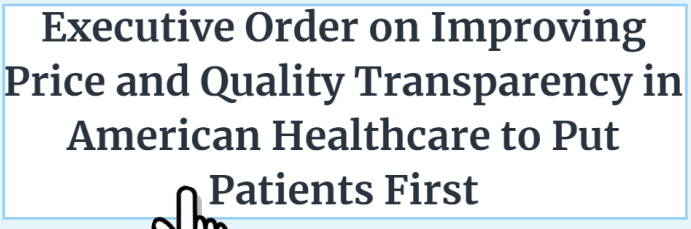
Proposals for Monitoring and Enforcement

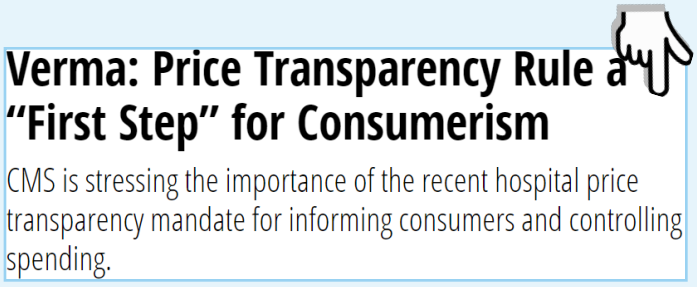
We are proposing regulations for monitoring and enforcement of hospitals' compliance with these requirements. CMS would have the authority to monitor hospital compliance with Section 2718(e) of the Public Health Service Act, by evaluating complaints made by individuals or entities to CMS, reviewing individuals' or entities' analysis of noncompliance, and auditing hospitals' websites. Should CMS conclude a hospital is noncompliant with one or more of the requirements to make public standard charges, CMS may assess a monetary penalty after providing a warning notice to the hospital, or after requesting a corrective action plan from the hospital if its noncompliance constitutes a material violation of one or more requirements. If the hospital fails to respond to CMS' request to submit a corrective action plan or comply with the requirements of a corrective action plan, CMS may impose a civil monetary penalty on the hospital not in excess of $300 per day, and publicize these penalties on a CMS website. We also propose to establish an appeals process for hospitals to request a hearing before an Administrative Law Judge (ALJ) of the civil monetary penalty. Under this process, the Administrator of CMS, at his or her discretion, may review in whole or in part the ALJ's decision.

[1] https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality-transparency-american-healthcare-put-patients-first/

[2]Azar, A. M., Mnuchin, S. T., and Acosta, A. "Reforming America's Healthcare System Through Choice and Competition." December 3, 2018. Available at: https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf

[3] Bresnick J. Verma: Price Transparency Rule a "First Step" for Consumerism. January 11, 2019. Available at: https://healthpayerintelligence.com/news/verma-price-transparency-rule-a-first-step-for-consumerism





AUTOMATED APPROACH TO DENIAL RESOLUTION

Clinical Labs Benefit From Comprehensive, Automated Approach To Denial Resolution.

Because clinical laboratory claims typically are low-dollar amounts generated in large volume, many hospitals have concluded it's simply not cost-effective to aggressively pursue laboratory denials when they occur, given the resources required to work them and the nominal returns resolution can produce. This results in an often-significant number of write-offs.

However, hospitals that shift their thinking and no longer view laboratories as simply cost centers can generate a substantial source of new or "found" revenue by taking a more aggressive and systematic approach to lab denials. Strong denial management programs are especially important for hospitals that seek to expand their outreach business and transform the lab into a profit center.

Comprehensive lab denial management includes intelligent automation processes that can resolve the simplest denials without human intervention while supporting detailed analysis and identification of denial root causes. Healthcare Financial Resources (HFRI) partners with hospitals to address denials and identify denial root causes for emergent, inpatient, outpatient, laboratory and other ancillary services.

From this experience, we've determined that the failure to obtain prior authorizations and medical necessity confirmations, as well as inaccurate or incomplete documentation, represent the most common reasons for laboratory denials.

Verifying prior authorizations

Because prior authorizations typically are the responsibility of either the referring physician practice, the emergency department or the hospital's pre-certification department, making sure authorizations are obtained is usually beyond the control of the pathology group and laboratory. But unless the testing is conducted during emergent care, it is probable that the test is pre-scheduled. Therefore, pre-authorization can and should take place when the lab work is scheduled.

It admittedly can be difficult for the laboratory or hospital staff to keep track of the many and varied insurance company pre-authorization guidelines. But most carriers provide links on their websites that identify the procedures or tests requiring pre-authorization, and hospitals should be able to consolidate these links for easy access or create their own documents for internal use.

In any case, laboratories should develop their own pre-authorization check systems to confirm decisions from the referring physicians. They should avoid simply relying on oral assurances from the referring doctors, particularly if the physician practice has been a significant source of denials in the past. Like the failure to secure prior authorizations for commercially insured patients, neglecting to document medical necessity or submitting claims without specific or appropriate diagnosis codes can have a major impact on reimbursement.

Clinical Labs Benefit From Comprehensive, Automated Approach To Denial Resolution.

Documentation

Toxicology tests are another category that continues to generate significant numbers of denials. According to the Centers for Medicare & Medicaid Services (CMS), the majority of the denials for the category of "Laboratory Tests – Other," which includes urine drug screenings, are due to insufficient documentation.[1]

Specifically, denials in this category are triggered by:

- Insufficient or no documentation to support the intent to order the test
- Insufficient or no documentation to support the medical necessity for the test of the individual patient
- Unsigned medical record documentation by the treating physician or non-physician practitioner

LCD, NCD criteria: A combination of local coverage determinations (LCDs) and national coverage determinations (NCDs) usually will enable staff to determine medical necessity criteria for specific diagnosis codes and tests. The most current information is available online and should be checked by referring staff before exams are ordered, especially for those tests that have historically high denial rates. In addition, providers should build rules into the EHR system to identify diagnoses and reduce manual follow-up.

Finally, providers should make sure all patients are provided with, and sign, an Advanced Beneficiary Notice of Non-Coverage (ABN) before treatment. This ensures that the pathology group or lab will be able to bill the patient directly if the service is not payable by Medicare.

Your denial specialists

HFRI specializes in AR recovery and resolution and serves as a virtual extension of your hospital central billing office to help you quickly resolve and collect more of your insurance accounts receivable. We'll help improve operating margins through a seamless and collaborative partnership with your internal team.

To expedite the capture of revenue for large-volume, low-dollar claim denials, we utilize intelligent automation technology that reduces the human touches necessary to isolate the root causes of payment delays, underpayments and denials. These systems also can resolve the simplest denials or payment delays with no human intervention whatsoever. The net effect of these breakthrough capabilities is that claims resolution is accelerated, write-offs are reduced and hospital cash flow is improved.

Contact HFRI today to learn more about how we can help you identify the source of your laboratory denials and develop a process to help prevent them from happening again.

[1] "Provider Compliance Tips for Laboratory Tests – Other-Urine Drug Screening," CMS Medicare Learning Network, September 2016.

MEDI-CAL BILLING FOR TELEHEALTH: AUGUST 2019

California Update

Telehealth and Telemedicine are covered Medi-Cal benefits. Health Care providers are not required to document a barrier to in-person visits for Medi-Cal coverage of telehealth visits. Patients must be informed by the provider at the originating site that the patient will be receiving services via telehealth and oral consent from the patient must be obtained.

A Telehealth Policy Update for Medi-Cal and Family PACT Programs was issued in August pursuant to Assembly Bill 415, known as the Telehealth Advancement Act of 2011.

Effective for dates of service on or after July 1, 2019,. benefits or services covered under the Medi-Cal and Family PACT programs, identified by CPT® or HCPCS codes and subject to all existing Medi-Cal and Family PACT coverage and reimbursement policies, including any Treatment Authorization Requests (TARs), may be provided via telehealth if the following requirements are met:

- The treating Health Care provider at the distant site believes that the benefits or services being provided are clinically appropriate based upon evidence-based medicine and/or best practices delivered via telehealth; and
- The benefits or services delivered via telehealth meet the procedural definition and components of the CPT® or HCPCS codes as defined by the American Medical Association, associated with the service or benefit covered under the Medi-Cal and Family PACT programs, as well as any extended guidelines as described I the Medi-Cal and Family PACT provider manuals; and
- The benefits or services provided via telehealth meet all laws regarding confidentiality of health care information and a patients right to her or her medical information

http://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_27966.asp

MEDI-CAL BILLING FOR TELEHEALTH: AUGUST 2019

Per the Medi-Cal Manual, originating and distant sites are defined as:

Transmission Sites	An "originating site" is where the patient is located at the time health care services are provided via a telecommunications system, or where the asynchronous store and forward service originates. A "distant site" is where the health care provider is located while providing services via a telecommunication system.

HealthCare providers are required to document Place of Service code 02 on CMS1500/837p claims submitted, which indicates that services were rendered via a telecommunications system.

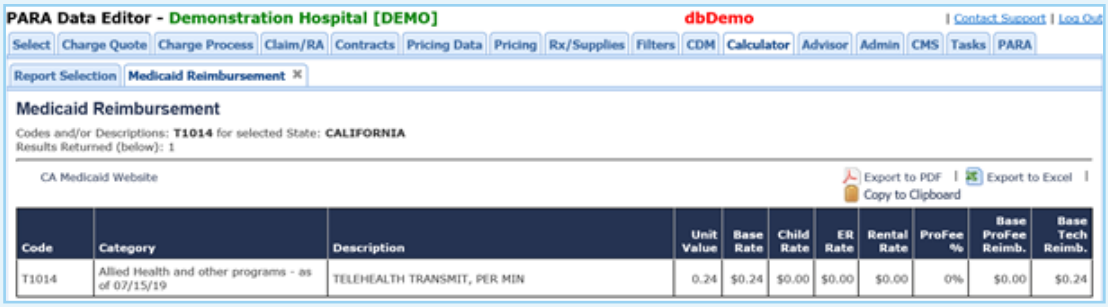
Effective July 1, 2019 HealthCare providers are no longer required to report Modifier GT. Covered benefits or services provided via a telehealth modality are reimbursable when billed in one of two ways:

1. For services or benefits provided via synchronous, interactive audio and telecommunications systems, the Health Care provider bills with Modifier 95

2. For Services or benefits provided via asynchronous store and forward telecommunications systems, the HealthCare provider bills with Modifier GQ. Providers may be bill for an originating site fee with HCPCS Code Q3014. An originating site is defined as where the patient is located at the time of health care services rendered via a telecommunications system or where the asynchronous store and forward service originates. Providers may bill HCPCS Code Q3014 once per day, same recipient and same provider

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
Q3014	Allied Health and other programs - as of 07/15/19	TELEHEALTH FACILITY FEE	22.94	$22.94	$0.00	$0.00	$0.00	0%	$0.00	$22.94

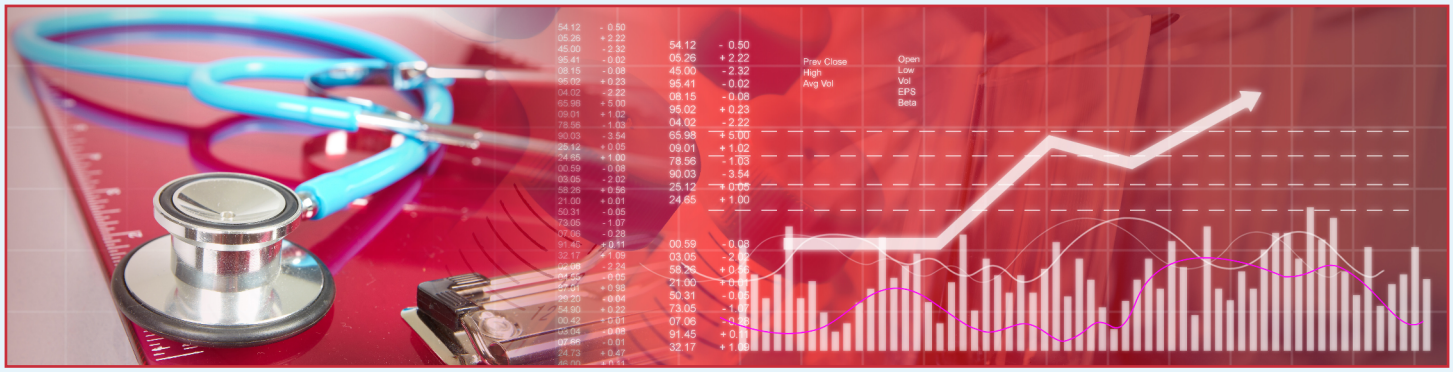
Both the originating site and the distant side providers may also claim a per-minute charge for transmission costs while providing telehealth services via audio/visual communication utilizing HCPCS Code T1014. HCPCS Code T1014 may be billed with a maximum of 90 minutes per day (1 unit=1 minute) for the same recipient and same provider. Documentation of the time charged must be in the record.



Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
T1014	Allied Health and other programs - as of 07/15/19	TELEHEALTH TRANSMIT, PER MIN	0.24	$0.24	$0.00	$0.00	$0.00	0%	$0.00	$0.24

Further instruction and guidance for Telehealth billing can be found within the Telehealth Manual on the Medi-Cal Website, keyword search Telehealth www.Medi-Cal.gov.

PARA DATA EDITOR: PRICING DATA



PARA HealthCare Analytics, Inc. prides itself at being a proven resource for contract management services, pricing data, charge master coding, compliance, billing, reimbursement, and web-based solutions.

Our mission is to provide a value-based solution that supports the revenue cycle process, to be recognized as an industry leader in delivering value and measurable results, and to lead the healthcare market in improving financial management in the delivery of care.

In order to do this, **PARA** collects data from a variety of sources and processes it so that it are useful for financial analysis and User interface. **PARA** knows every price for every CPT®/HCPCS Codes for every hospital in the US.

PARA gathers this information from the Medicare claims data files which includes the following data:

- Inpatient Room Rates and DRG Charges
- Outpatient Hospital Charges by CPT®/HCPCS
- Inpatient/Outpatient Migration Data by Patient County
- Diagnoses by Emergency Room Visit
- Skilled Nursing Facility/Long Term Care Hospital Claims Data
- Ambulatory Surgery Center Case Charges
- Independent Testing Facility Charges
- Freestanding Laboratory Charges
- Clinic Charges (Professional and Technical)
- Physician Charges by NPI

The following pages outline the various sources of pricing data, components of the data, timing of data availability, processing of data, and the reports available to **PARA Data Editor** (PDE) Users.
https://para-hcfs.com/dataEditor

PARA HealthCare Analytics
an HFRI COMPANY

IMPROVING THE BUSINESS OF HEALTHCARE SINCE 1985

PARA DATA EDITOR: PRICING DATA

PARA receives hospital charge data for every CPT®/HCPCS Code for every hospital in the Medicare claim file which includes inpatient, outpatient, ASC, physician, and independent testing facilities.

Medicare data is the most accurate and comprehensive source for comparing charges between hospitals, due to the fact that almost all US hospitals participate in Medicare and hospitals are required to charge the same price for the same service, regardless of the patient's insurance payer. Since Medicare publishes claims data, it is a readily available and accurate source of hospital peer group charge data.

PARA does not use the data compiled from clients to create a separate pricing database. It is **PARA's** position that using this data creates a narrowed focus of pricing data. The use of data like this creates an ongoing cycle of using limited data to price a client charges then using that proposed prices for the following year's review. This continued cycle means that there is no outside forces used to develop rational pricing methodologies.

Because of this, **PARA** prefers to maintain complete transparency in the data used to compare client pricing by using only the data provided to Medicare in the most recent available year. The Medicare data is more detailed and robust, which allows **PARA** to be a leader in the industry in terms of comparative pricing data.

COMPONENTS:

Each data source provides complete Medicare claims data for every hospital in the Medicare claim file.

The patient information has been removed from the file and replaced with a random account number for HIPAA Compliance purposes.

- Inpatient Medicare MEDPAR – Contains records for 100% of Medicare beneficiaries who use hospital inpatient services
- Outpatient Medicare Complete Data Set – Includes claims for services furnished on or after January through December that were received, processed, paid, and passed to the National Claims History file
- Physician Supplier Detail – 1500 Claims (By Carrier/Locality) – This file is a 100% summary of all Part B Carrier and Durable Medical Equipment Regional Carrier (DMERC) Claims processed through the Common Working File and stored in the National Claims History Repository

TIMING:

Current pricing data can be an invaluable tool in determining appropriate pricing for various procedures. Our data is released quarterly and can provide the user with information on the closest competitors in order to position the facility strategically within the chosen market.

PARA PRICING EDITOR: PRICING DATA

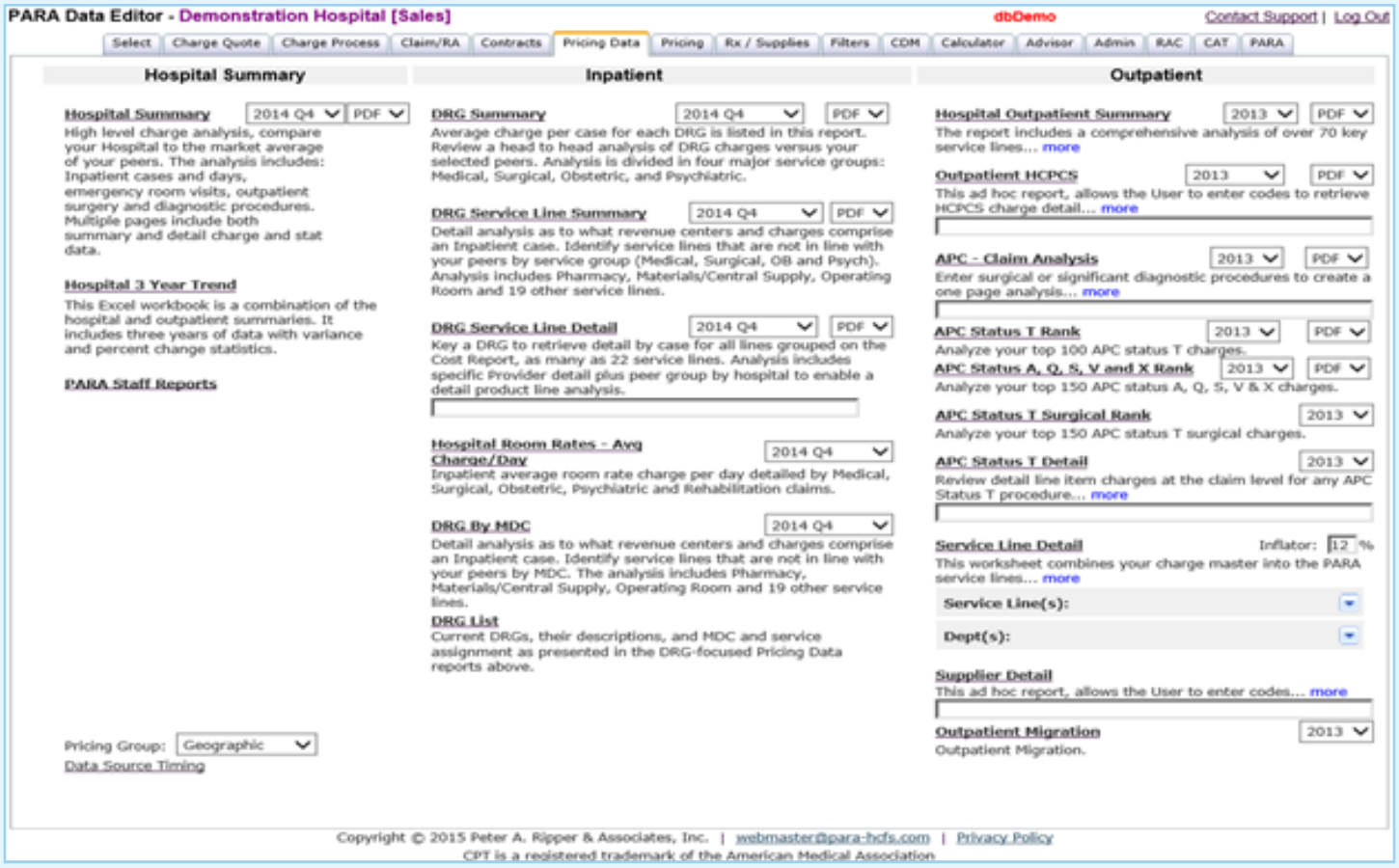
PROCESSING:

PARA collects the raw data files from Medicare sources then analyzes and processes the data in order to provide a variety of report options for users.

- Annually, the Inpatient Data Set includes approximately 15 million inpatient claims with detailed charge data
- Annually, the Outpatient Data Set includes over 150 million claims with over 1 billion detailed lines of charge data

REPORTING:

The **PDE Pricing Data** tab provides a User-friendly interface to the Medicare data collected by **PARA**. Data can be reviewed for both Inpatient DRGs and Outpatient CPT®/HCPCS codes. Many reports also allow the user to select either a year of data or isolate the fourth quarter to eliminate any anomalies associated with mid-year pricing changes in the data.



The **PDE** allows users to select specific hospitals to include in a designated market group. The organization's standard geographic market is created when the client's data is loaded into the **PDE**. Organizational and Service-related markets can also be created based on User needs to allow for review data for a variety of market peers.

PARA PRICING EDITOR: PRICING DATA

The following reports, for any of the available markets, can be accessed through the **Pricing Data** tab:

- **Hospital Summary Report** – Includes several Inpatient and Outpatient measures to provide overall view of how facility compares to peers
- **Hospital 3 Year Trend** – Compares the changes in the Inpatient and Outpatient Summary measures over a three year period
- **DRG Summary** – Compares the hospital to its peers on all reported DRGs and includes the number of cases and average case rates
- **DRG Service Line Summary** – examines the revenue centers that contribute to an Inpatient case
- **DRG Service Line Detail** – provides review of individual DRGs compared to peers
- **Hospital Room Rates-Average Charge/Day** – displays average charge per day for each room rate type
- **DRG by MDC** – provides additional view of Inpatient data grouped by Major Diagnostic Category
- **DRG List** – complete list of current DRGs, descriptions, and MDC for User reference
- **Hospital Outpatient Summary** – compares service lines that comprise an Outpatient case
- **Outpatient HCPCS** – provides CPT®/HCPCS code specific data including reimbursement rates, peer pricing data, state and national pricing data, packaged rates (where applicable), and data from non-hospital providers
- **APC Status T Claim Analysis** – examines claims nationwide for the APC Status T Procedures with all services included on the claim, number of claims, and percentile comparison
- **APC Status T Rank** - list of top 100 (by volume) Status T procedures including number of claims, client average charge, peer market average charge, and percent differences
- **APC Status A, Q, S, V, and X** – list of top 150 (by volume) Status A, Q, S, V, and X procedures including number of claims, client average charges, peer market average charge, and percent differences
- **APC Status T Surgical Rank** – list of top 150 (by volume) Surgical APC Status T claims including comparison of package charges, anesthesia charge, operating room charges, recovery charges, medical supply charges, and drug charges billed with the procedure
- **APC Status T Detail** – compares facilities on Outpatient Surgical Services by all line items that appear on a claim
- **Service Line Detail** – includes data for all procedures within a service line based on the CPT® code groups and shows market data for peers and non-hospital providers
- **Supplier Detail** – displays charge data from 1500 form file and Physician Fee Schedule reimbursement rates

For more assistance with the **Pricing Data** tab, or any other feature of the **PARA Data Editor**, please contact your **PARA** Account Executive for a demonstration or additional training.

ATTACKING THE ROOT CAUSES OF RADIOLOGY DENIALS

Radiologists face unique challenges when it comes to getting paid. Coding for imaging is complex and multi-faceted, and documentation must be thorough and precise.

In addition, unlike most other specialists, radiologists are usually dependent on the referring physician's office or emergency department to document medical necessity or ensure that any required prior authorizations are obtained.

Given these challenges, it is not unusual for a large portion of hospital denials to originate in the radiology department. That's why attacking the problem is essential for stabilizing cash flow and improving collections.

Ultimately, reducing radiology denials hinges on accurate demographic and insurance eligibility information, appropriate coding, complete documentation, and the creation of systems that can ensure prior authorizations and medical necessity confirmations are obtained before the imaging exam is conducted.

Root cause analysis

Reducing denials begins by developing a comprehensive understanding of the root causes of previously denied claims. This can be accomplished through a careful analysis of denial reports and should highlight where, when and why denials are occurring. Radiology denials generally fall into four categories:

- Patient eligibility problems
- Failure to obtain prior authorization for the procedure
- Failure to document medical necessity for the exam
- Inaccurate or incomplete coding and documentation

1. Eligibility

Patient eligibility is an issue that plagues not just radiology, but most physician practices to a greater or lesser extent. Given the financial risks associated with denials, it is important to ensure that accurate information about the patient's insurance coverage, or lack thereof, is obtained as quickly as possible. Ideally this should occur before the exam is performed and certainly before any claim is submitted.

Practices can implement edits in their billing systems to block claims from dropping if there is no active insurance. Staff likewise needs to be trained in the appropriate steps to take if patients present without active coverage. Too often, personnel submit claims to the insurance company on record, even if automated rejections in the radiology information or billing systems already have indicated the insurance is no longer in force.

Eligibility problems also can be triggered by listing the incorrect site of service or by inaccurate patient demographic information. For those reasons, systems should be established to double-check each detail relating to the patient's information, their coverage and the location and nature of the exam.

2. Prior authorization

An increasing number of commercial insurance companies in recent years have required prior authorization for imaging exams, particularly for more expensive procedures like MRI, CT and PET imaging.

Healthcare Financial Resources (HFRI) works with a range of provider clients to identify and mitigate denial root causes for emergent, inpatient, outpatient and ancillary services. From this experience, we've determined that failure to obtain prior authorizations represents the most common reason for radiology denials.

Because prior authorizations typically are the responsibility of either the referring physician practice or the hospital's pre-certification department, making sure they are obtained is usually beyond the control of the radiologist. But unless the exam is conducted during emergent care, it is probable the procedure is a pre-scheduled service. Therefore, the pre-authorization can and should take place when the exam is scheduled.

It admittedly can be difficult for physician or hospital staff to keep track of the many and varied insurance company pre-authorization guidelines.

It admittedly can be difficult for physician or hospital staff to keep track of the many and varied insurance company pre-authorization guidelines. But most carriers provide links on their websites regarding what requires pre-authorization, and hospitals should be able to consolidate these links for easy access or create their own documents for internal use.

To underscore the impact that failure to obtain pre-authorizations can have, radiology groups should list pre-authorization denials by type of procedure, carrier, referring physician and dollar value, and then convey this information to the physician practice, hospital pre-authorization office, and if necessary, hospital administrators. Educating those further upstream about the impact of their actions (or inactions) ultimately is the most effective way to reduce pre-authorization denials.

3. Medical necessity

Failure to prove and document medical necessity can have a major impact on radiology reimbursement when it comes to commercial payers as well as Medicare and Medicaid.

In addition to confirming medical necessity based on the initial diagnosis, groups should build rules engines that identify imaging services that Medicare will not reimburse. Frequently, these services can be identified through NCDs and LCDs. Similarly, many commercial payers publish experiential clinical policy bulletins that identify services they will not reimburse. Rules can also be created to flag these procedures to reduce unnecessary follow-up, balance bill the patient or write off the balance if no other option exists.

ATTACKING THE ROOT CAUSES OF RADIOLOGY DENIALS

4. Coding and documentation

Because coding and documentation requirements for many imaging procedures are becoming more complex, it is important that processes be established to help ensure both clinicians and coding staff remain current on the latest guidelines. For example, failure to add modifiers that reflect the appropriate chronology of the imaging studies often will lead to denials.

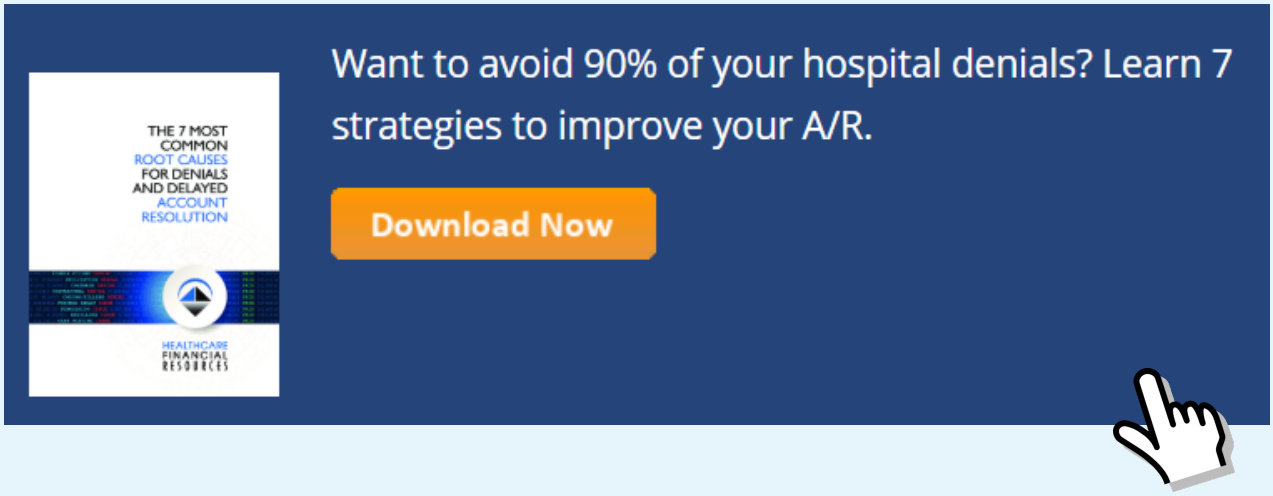
Omitting essential details in the imaging report can also prevent coders from submitting complete and accurate claims. According to the American College of Radiology, all imaging reports must have the following:

- Exam name
- Clinical indication
- Description of exam, sequences and/or technique
- Comparison studies if applicable
- Findings
- Conclusion and recommendations, if indicated
- Physician signature

Your denial specialists

HFRI specializes in AR recovery and resolution. We work as a virtual extension of your hospital central billing office to help you resolve and collect more of your insurance accounts receivable faster and improve operating margins through a seamless and collaborative partnership with your internal team.

In addition to our resolution capabilities, **HFRI** also can provide denial management assistance by conducting root cause analysis and recommending process improvements to help decrease aged and denied claims going forward. Contact HFRI today to learn more about how we can help you identify the source of your radiology denials and develop a process to help prevent them from happening again.



HFRI WEBINAR: EFFECTS OF INTELLIGENT AUTOMATION ON CASH FLOW

Robotic process automation and Intelligent Automation (IA) can help hospitals reverse negative reimbursement trends and improve accounts receivable processes. Experts from Healthcare Financial Resources (HFRI) explained how in a March 5, 2019 webinar hosted by *Becker's Hospital Review*.

WATCH THE *Webinar*

HEALTHCARE FINANCIAL RESOURCES

And coming soon, you can watch the webinar below!

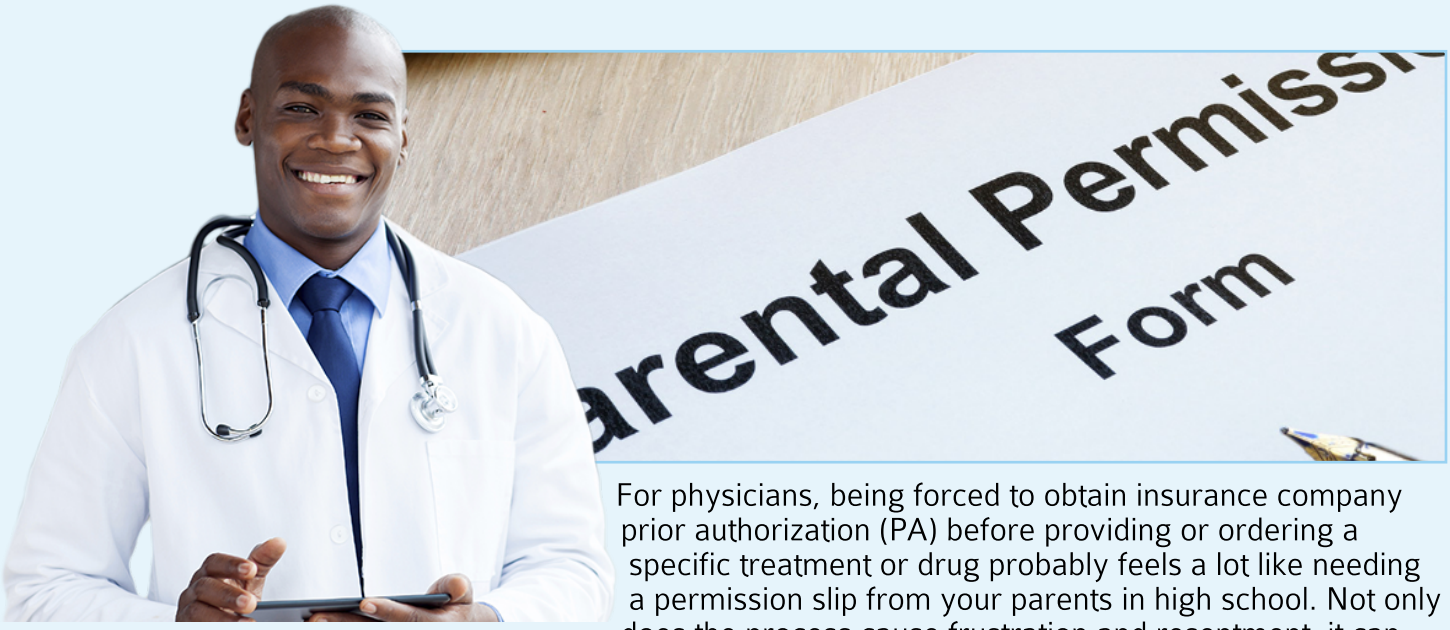
What You Don't Know CAN Hurt You: A Deep Dive Into How Using Intelligent Automation Can Revolutionize Your AR Recovery

Presenters

Jon Giuliani
Vice President, Operations
Healthcare Financial Resources (HFRI)

Daniel Low
Director of Operations
Healthcare Financial Resources (HFRI)

PHYSICIANS SEEK REPRIEVE FROM PRIOR AUTHORIZATION BURDEN



For physicians, being forced to obtain insurance company prior authorization (PA) before providing or ordering a specific treatment or drug probably feels a lot like needing a permission slip from your parents in high school. Not only does the process cause frustration and resentment, it can also lead to treatment delays and substandard care.

A 2018 physician survey by the American Medical Association (AMA) highlighted the negative impact PAs can have on the practice of medicine. According to the survey, 91 percent of responding physicians said PAs delayed access to necessary treatment, with 65 percent saying they waited, on average, one business day for PA approval and 26 percent reporting they waited at least three days.[1]

More critically, 28 percent of physicians said the PA process had led to a serious adverse event (e.g., death, hospitalization, disability/permanent bodily damage, or other life-threatening event) for a patient under their care.[2] More than 90 percent said PAs had a significantly negative or somewhat negative impact on clinical outcomes, and 75 percent said the PA process had resulted in patients abandoning their recommended course of treatment.[3]

According to the survey, practices are required to complete 31 PAs per physician, per week, on average, and nearly 40 percent of practices have staff working exclusively on authorizations.[4] Beyond adding to administrative overhead, PAs can have a significant impact on provider cash flow if a claim for a service requiring prior authorization is denied or delayed.

Legislative relief coming?

In releasing the survey results earlier this spring, the AMA decried insurers' "foot-dragging and opposition" around implementation of proposed PA process advances developed through a consensus effort involving the AMA and other national groups representing hospitals, medical groups, pharmacists and health plans.[5]

The good news is that the five areas of improvement identified and articulated in the groups' consensus statement have now formed the basis for newly proposed federal legislation that would streamline the PA process for Medicare Advantage (MA) plans.

HEALTHCARE FINANCIAL RESOURCES

Known as the Improving Seniors' Timely Access to Care Act (HR 3107), the bill was introduced in early June in the House of Representatives with sponsorship from two Democrats and two Republicans.[6]

Under the act, the Centers for Medicare and Medicaid Services (CMS) would foster greater transparency around the PA process by requiring MA plans to report to CMS a list of all items and services that are subject to PA, the percentage of PA requests approved during the previous plan year by service and/or prescription, and the average amount of time elapsed between the PA request and final determination.[7]

In addition, HR 3107 would reduce the administrative burden of PAs by requiring that plans accelerate the development of an electronic process to replace the primarily phone-and-fax-driven approach currently used in most instances.

Finally, the act would require that PAs adhere to evidence-based guidelines and are developed in consultation with physicians. MA plans would likewise be required to conduct annual reviews of items and services for which PAs are mandated. The reviews would reflect input from physicians as well as an analysis of past PA requests and current clinical criteria.[8]

CORE recommendations

The introduction of HR 3107 follows the release in May of parallel guidelines developed by the Council of Affordable Quality Healthcare (CAQH) CORE aimed at strengthening the accuracy and consistency of the PA process.

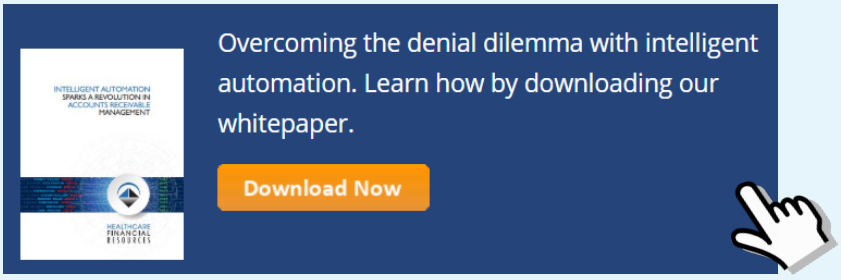
Noting that 88 percent of prior authorizations currently are conducted either by phone or fax, the CORE recommendations are designed to standardize data shared between plans and providers, eliminate unnecessary back-and-forth and accelerate adjudication timeframes. According to CAQH, full adoption of a standardized electronic prior authorization process could result in savings of 70 percent per transaction.[9]

CAQH CORE is an industry-led consortium that supports the creation and adoption of healthcare operating rules that support standards, accelerate interoperability and align administrative and clinical activities among providers, payers and consumers.

PA denial expertise

As new regulations are enacted to streamline the PA process, it will still be important to understand the reason behind PA denials. Healthcare Financial Resources (HFRI) works with a range of provider clients to identify and mitigate denial root causes for emergent, inpatient, outpatient and ancillary services. From this experience, we've determined that failure to obtain PAs represents one of the most common reason for denials. Overcoming PA denials requires that hospitals be well-versed in an insurance company's clinical policy bulletins, which describe what the carrier will and will not cover, what they consider to be medical necessity, and the treatments and drugs that require prior authorization.

[1] "2018 AMA Prior Authorization Physicians Survey," American Medical Association, 2019.
[2] Ibid.
[3] Ibid.
[4] Ibid.
[5] "Health insurance industry slow to adopt prior authorization reforms," American Medical Association press release, March 12, 2019.
[6] "Legislation introduced to streamline prior authorization in Medicare Advantage," Gastro.org, June 5, 2019.
[7] Ibid.
[8] Ibid.
[9] "CAQH CORE Releases Operating Rules to Promote Automation for Prior Authorization," CAQH press release, May 5, 2019



WEEKLY IT UPDATE

PARA HealthCare Analytics has provided a list of enhancements and updates that our Information Technology (IT) team has made to the **PARA Data Editor** this past week.

The following tables includes which version of the **PDE** was updated, the location within the **PDE**, and a description of the enhancement.

This Week's Updates

Week Ending	Platform	Tab	Sub-Tab	Enhancement	User Action
August 16, 2019	PARA Data Editor	Calculator		DRG Query on the PDE Calculator has been updated with the 2020 Inpatient Final Rule. DRG Table 5 is available there for downloaded.	Users can query the latest DRG information in the PDE Calculator
August 16, 2019	PARA Data Editor	Calculator		An issue with the code to text feature has been corrected. The function will now work for codes from the current year.	Users can enter a CPT/HCPCS code into the PDE Calculator search box, and then use the Code > Keyword tool to select words from the description to use as search criteria in the calculator.
August 16, 2019	PARA Data Editor	PARA	Operations	There is a new report for PARA Staff to quickly identify the current status of 835/837 data sent to us by clients. The report includes counts for each payer by month, and also includes the number of claims for which we have both 835 and 837.	No action required. The PARA team will use this new report to assist clients.
August 16, 2019	PARA Data Editor	Advisor		Update search functionality in Advisor for Summary field.	Users can search the Advisor by Summary without having to put in the exact word order. For example, a result that has the entry "Search Partial Entry" can be pulled by typing in "Search Entry" regardless of capital letters.

Previous Updates

Week Ending	Platform	Tab	Sub-Tab	Enhancement	User Action
August 9, 2019	PARA Data Editor	Pricing Data, CMS & Pricing		2019Q1 Inpatient and Outpatient Medicare Claims data is now available on the CMS, pricing and pricing data tabs.	Users can now query Medicare claims for 2019Q1 on the CMS tab. Reports throughout the PDE are now selectable for 2019.
August 9, 2019	PARA Data Editor	PARA	Operations	New 835/837 Report provides claim counts for a variety of bill types. It includes a tab that shows how many accounts we have received both an 837 and 835 for.	PARA Staff can use this report to more easily understand what data has been provided by the client.
August 9, 2019	PARA Data Editor	Pricing Data	PARA Staff Reports	Enhancements made to Market Pricing Summary. Two new tabs compare the hospital CPT/HCPCS charges and room rates to the selected peer market. The tabs also provide revenue impacts of setting prices to market average or 75th percentile.	No action required. This report is sent to clients at the beginning of PARA Pricing Reviews.

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!**

mlnconnects
Official CMS news from the Medicare Learning Network

Thursday, August 15, 2019

News

· New Medicare Card: Transition Period Ends in Less Than 5 Months

· CAR T-Cell Cancer Therapy Available to Medicare Beneficiaries Nationwide

· DMEPOS Competitive Bidding: Round 2021 Deadlines

· MACRA Patient Relationship Categories and Codes: Learn More

Compliance

· Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

MLN Matters® Articles

· Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services

· Display PARHM Claim Payment Amounts

· Inpatient Psychiatric Facilities Prospective Payment System (IPF PPS) Updates for Fiscal Year (FY) 2020

· International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) – January 2020 Update

Publications

· Chronic Care Management Services — Revised

· ICD-10-CM, ICD-10-PCS, CPT, and HCPCS Code Sets — Revised

Multimedia

· I&A Enrollment Webcast: Audio Recording and Transcript


mlnconnects
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- New Medicare Card: Transition Period Ends in Less Than 5 Months
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- DMEPOS Competitive Bidding: Round 2021 Deadlines
- MACRA Patient Relationship Categories and Codes: Learn More

Compliance
- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Events
- ESRD Quality Incentive Program: CY 2020 ESRD PPS Proposed Rule Call — August 20
- IPPS/LTCH PPS FY 2020 Final Rule Special Open Door Forum — August 20
- Home Health Patient-Driven Groupings Model: Operational Issues Call — August 21
- Self-Direction for Dually Eligible Individuals Utilizing LTSS Webinar — August 21
- Radiation Oncology Model Listening Session — August 22
- Understanding Your SNF VBP Program Performance Score Report Call — August 27
- Dementia Care: Supporting Comfort and Resident Preferences Call — September 10

MLN Matters® Articles
- Bypassing Payment Window Edits for Donor Post-Kidney Transplant Complication Services
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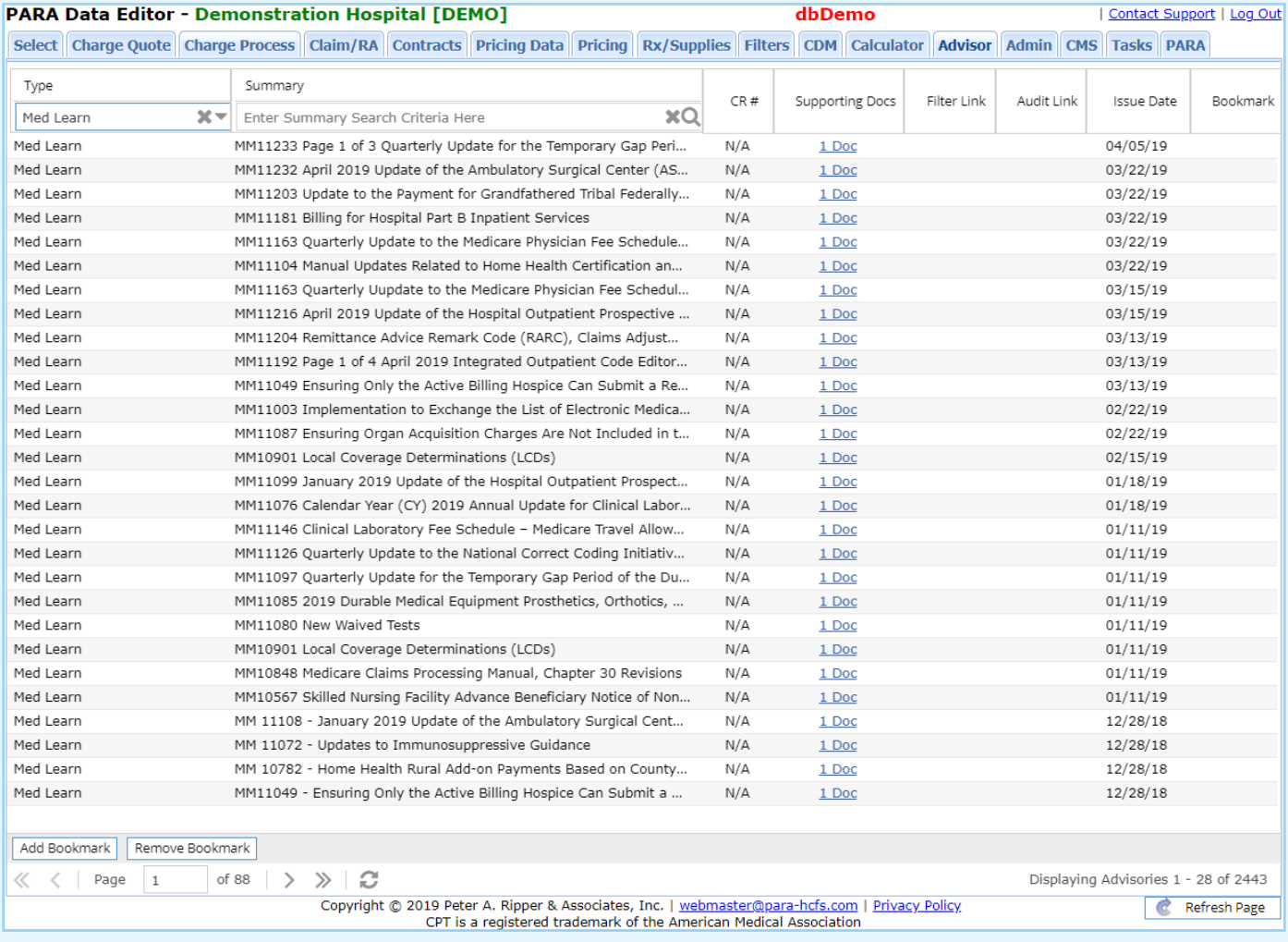
There were FOUR new or revised Med Learn (MLN Matters) article released this week.

To go to the full Med Learn document **simply click on the screen shot or the link.**

FIND ALL THESE MED LEARNS IN THE **ADVISOR** TAB OF THE **PDE** 4



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Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
Med Learn	Enter Summary Search Criteria Here						
Med Learn	MM11233 Page 1 of 3 Quarterly Update for the Temporary Gap Peri...	N/A	1 Doc			04/05/19	
Med Learn	MM11232 April 2019 Update of the Ambulatory Surgical Center (AS...	N/A	1 Doc			03/22/19	
Med Learn	MM11203 Update to the Payment for Grandfathered Tribal Federally...	N/A	1 Doc			03/22/19	
Med Learn	MM11181 Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
Med Learn	MM11163 Quarterly Update to the Medicare Physician Fee Schedule...	N/A	1 Doc			03/22/19	
Med Learn	MM11104 Manual Updates Related to Home Health Certification an...	N/A	1 Doc			03/22/19	
Med Learn	MM11163 Quarterly Uupdate to the Medicare Physician Fee Schedul...	N/A	1 Doc			03/15/19	
Med Learn	MM11216 April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/15/19	
Med Learn	MM11204 Remittance Advice Remark Code (RARC), Claims Adjust...	N/A	1 Doc			03/13/19	
Med Learn	MM11192 Page 1 of 4 April 2019 Integrated Outpatient Code Editor...	N/A	1 Doc			03/13/19	
Med Learn	MM11049 Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Med Learn	MM11003 Implementation to Exchange the List of Electronic Medica...	N/A	1 Doc			02/22/19	
Med Learn	MM11087 Ensuring Organ Acquisition Charges Are Not Included in t...	N/A	1 Doc			02/22/19	
Med Learn	MM10901 Local Coverage Determinations (LCDs)	N/A	1 Doc			02/15/19	
Med Learn	MM11099 January 2019 Update of the Hospital Outpatient Prospect...	N/A	1 Doc			01/18/19	
Med Learn	MM11076 Calendar Year (CY) 2019 Annual Update for Clinical Labor...	N/A	1 Doc			01/18/19	
Med Learn	MM11146 Clinical Laboratory Fee Schedule – Medicare Travel Allow...	N/A	1 Doc			01/11/19	
Med Learn	MM11126 Quarterly Update to the National Correct Coding Initiativ...	N/A	1 Doc			01/11/19	
Med Learn	MM11097 Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			01/11/19	
Med Learn	MM11085 2019 Durable Medical Equipment Prosthetics, Orthotics, ...	N/A	1 Doc			01/11/19	
Med Learn	MM11080 New Waived Tests	N/A	1 Doc			01/11/19	
Med Learn	MM10901 Local Coverage Determinations (LCDs)	N/A	1 Doc			01/11/19	
Med Learn	MM10848 Medicare Claims Processing Manual, Chapter 30 Revisions	N/A	1 Doc			01/11/19	
Med Learn	MM10567 Skilled Nursing Facility Advance Beneficiary Notice of Non...	N/A	1 Doc			01/11/19	
Med Learn	MM 11108 - January 2019 Update of the Ambulatory Surgical Cent...	N/A	1 Doc			12/28/18	
Med Learn	MM 11072 - Updates to Immunosuppressive Guidance	N/A	1 Doc			12/28/18	
Med Learn	MM 10782 - Home Health Rural Add-on Payments Based on County...	N/A	1 Doc			12/28/18	
Med Learn	MM11049 - Ensuring Only the Active Billing Hospice Can Submit a ...	N/A	1 Doc			12/28/18	

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The link to this Med Learn MM11403

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KNOWLEDGE • RESOURCES • TRAINING

Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual

MLN Matters Number: MM11403	Related Change Request (CR) Number: 11403
Related CR Release Date: August 16, 2019	Effective Date: November 18, 2019
Related CR Transmittal Number: R4364CP	Implementation Date: November 18, 2019

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11403 updates the language in sections 1.2 and 10.2.1 in Chapter 18 of the Medicare Claims Processing Manual to add a link to the current influenza codes and payment rates. Make sure your billing staffs are aware of these updates. For the Medicare-covered codes for the influenza vaccines approved by Food and Drug Administration (FDA) for the current influenza vaccine season, visit https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html.

ADDITIONAL INFORMATION

The official instruction, CR11403, issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4364CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

CMS Medicare Learning Network

The link to this Med Learn MM11402

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KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) – October 2019 Update

MLN Matters Number: MM11402 | Related Change Request (CR) Number: 11402

Related CR Release Date: August 16, 2019 | Effective Date: January 1, 2019

Related CR Transmittal Number: R4362CP | Implementation Date: October 7, 2019

PROVIDER TYPES AFFECTED

This MLN Matters article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11402 informs providers that the Centers for Medicare & Medicaid Services (CMS) issued payment files to the MACs based on the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. CR 11402 amends those payment files. Please make sure your billing staffs are aware of these changes.

BACKGROUND

The updated payment files are effective for services you deliver from January 1, 2019, through December 31, 2019.

Section 1848(c)(4) of the Social Security Act authorizes the Secretary of the Department of Health and Human Services (HHS) to establish ancillary policies necessary to implement relative values for physicians' services.

Summary of Changes for October 2019

1. Codes 96931 and 96934 (the global components) are changing their Relative Value Units (RVUs) as indicated in Table 1. The rationale behind this change is that the global codes (96931/96934) need to sum to the values of the professional and technical component codes (96932 and 96933 for 96931, respectively; and 96935 and 96936 for 96934, respectively). These changes apply to services as of January 1, 2019.

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The link to this Med Learn MM11422

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KNOWLEDGE • RESOURCES • TRAINING

Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

MLN Matters Number: MM11422 | Related Change Request (CR) Number: 11422

Related CR Release Date: August 16, 2019 | Effective Date: October 1, 2019

Related CR Transmittal Number: R4367CP | Implementation Date: October 7, 2019

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, providers, and suppliers billing Medicare Administrative Contractors (MACs) for drug and biological services.

PROVIDER ACTION NEEDED

CR 11422 updates the HCPCS code set for codes related to drugs and biologicals. Make sure your billing staffs are aware of these updates.

BACKGROUND

The HCPCS code set is updated quarterly. CR 11422 informs MACs and providers of the latest updates to specific drug/biological HCPCS codes. The October 2019 quarterly HCPCS file includes forty-four (44) new HCPCS codes. Effective for claims with dates of service on or after October 1, 2019, you may use, as appropriate, the following HCPCS codes on claims for Medicare:

1) **J0121**
   a. Short Descriptor: Inj., omadacycline, 1 mg
   b. Long Descriptor: Injection, omadacycline, 1 mg
   c. Type of Service (TOS): 1,P
2) **J0122**
   a. Short Descriptor: Inj., eravacycline, 1 mg
   b. Long Descriptor: Injection, eravacycline, 1 mg
   c. TOS: 1,P

CMS Medicare Learning Network

The link to this Med Learn MM11345

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KNOWLEDGE • RESOURCES • TRAINING

Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020

MLN Matters Number: MM11345 Revised | Related Change Request (CR) Number: 11345

Related CR Release Date: August 15, 2019 | Effective Date: October 1, 2019

Related CR Transmittal Number: R4368CP | Implementation Date: October 7, 2019

Note: We revised this article on August 16, 2019, to reflect a revised CR11345 issued on August 15. CMS revised the CR to replace the Health Insurance Prospective Payment System (HIPPS) Case Mix Group (CMG) Codes spreadsheet with a corrected version. In this article, we revised the CR release date, transmittal number and the web address of the CR. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Inpatient Rehabilitation Facilities (IRFs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11345 notifies MACs that a new IRF Pricer software package will be released prior to October 1, 2019, which will contain the updated rates that are effective for claims with discharges that fall within October 1, 2019, through September 30, 2020. MACs will install and pay IRF claims with the FY 2020 IRF PPS Pricer for discharges on or after October 1, 2019. Make sure your billing staffs are aware of these changes.

BACKGROUND

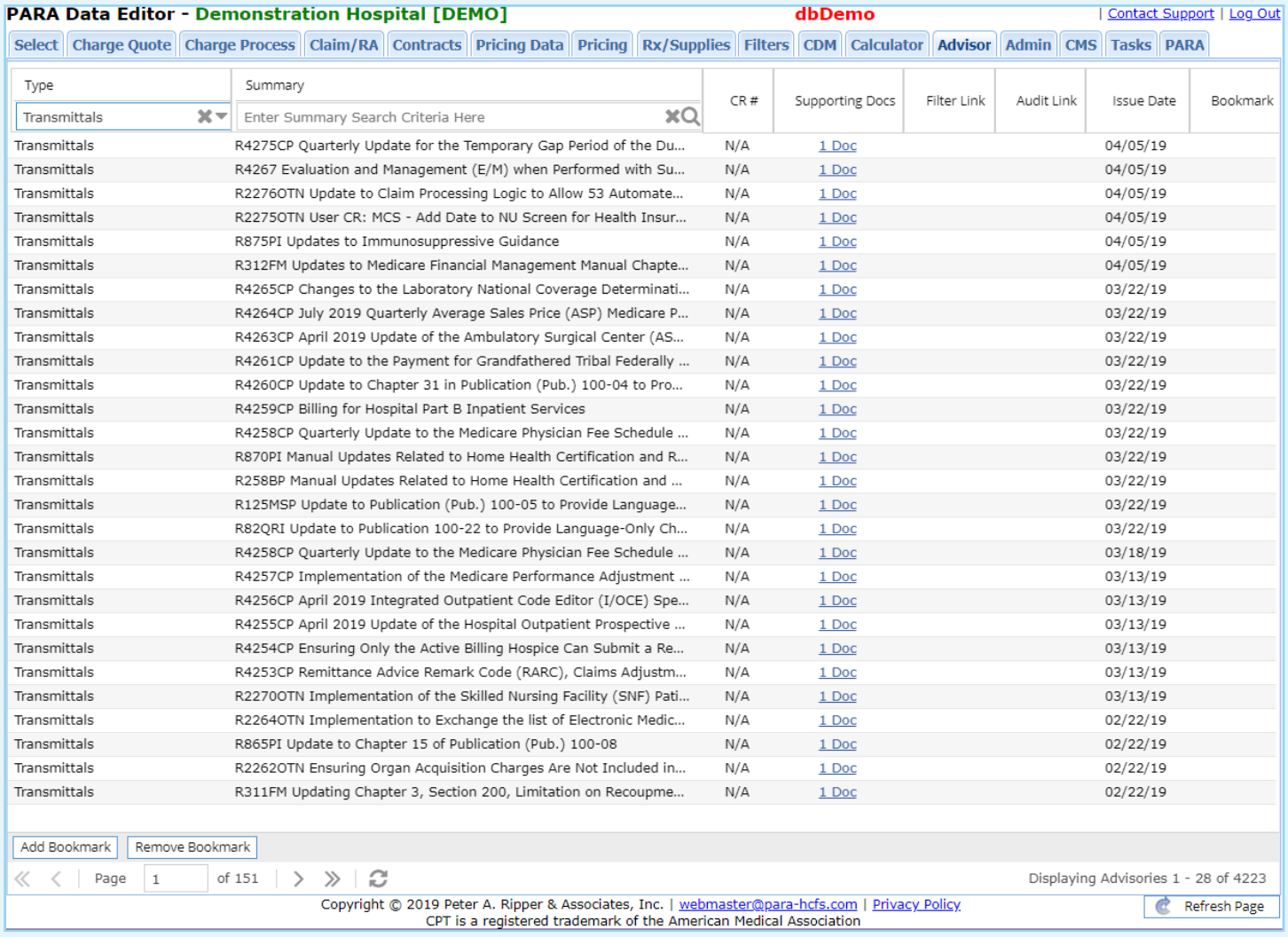
On August 7, 2001, the Centers for Medicare & Medicaid Services (CMS) published in the Federal Register a final rule that established the PPS for IRFs, as authorized under Section 1886(j) of the Social Security Act (the Act). In that final rule, CMS set forth per discharge Federal rates for Federal fiscal year (FY) 2002. These IRF PPS payment rates became effective for cost reporting periods beginning on or after January 1, 2002. Annual updates to the IRF PPS rates are required by Section 1886(j)(3)(C) of the Act.

CMS Medicare Learning Network

There were ELEVEN new or revised Transmittals released this week.

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

FIND ALL THESE TRANSMITTALS IN THE **ADVISOR** TAB OF THE **PDE** 11



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Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookmark
Transmittals	Enter Summary Search Criteria Here						
Transmittals	R4275CP Quarterly Update for the Temporary Gap Period of the Du...	N/A	1 Doc			04/05/19	
Transmittals	R4267 Evaluation and Management (E/M) when Performed with Su...	N/A	1 Doc			04/05/19	
Transmittals	R2276OTN Update to Claim Processing Logic to Allow 53 Automate...	N/A	1 Doc			04/05/19	
Transmittals	R2275OTN User CR: MCS - Add Date to NU Screen for Health Insur...	N/A	1 Doc			04/05/19	
Transmittals	R875PI Updates to Immunosuppressive Guidance	N/A	1 Doc			04/05/19	
Transmittals	R312FM Updates to Medicare Financial Management Manual Chapte...	N/A	1 Doc			04/05/19	
Transmittals	R4265CP Changes to the Laboratory National Coverage Determinati...	N/A	1 Doc			03/22/19	
Transmittals	R4264CP July 2019 Quarterly Average Sales Price (ASP) Medicare P...	N/A	1 Doc			03/22/19	
Transmittals	R4263CP April 2019 Update of the Ambulatory Surgical Center (AS...	N/A	1 Doc			03/22/19	
Transmittals	R4261CP Update to the Payment for Grandfathered Tribal Federally ...	N/A	1 Doc			03/22/19	
Transmittals	R4260CP Update to Chapter 31 in Publication (Pub.) 100-04 to Pro...	N/A	1 Doc			03/22/19	
Transmittals	R4259CP Billing for Hospital Part B Inpatient Services	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/22/19	
Transmittals	R870PI Manual Updates Related to Home Health Certification and R...	N/A	1 Doc			03/22/19	
Transmittals	R258BP Manual Updates Related to Home Health Certification and ...	N/A	1 Doc			03/22/19	
Transmittals	R125MSP Update to Publication (Pub.) 100-05 to Provide Language...	N/A	1 Doc			03/22/19	
Transmittals	R82QRI Update to Publication 100-22 to Provide Language-Only Ch...	N/A	1 Doc			03/22/19	
Transmittals	R4258CP Quarterly Update to the Medicare Physician Fee Schedule ...	N/A	1 Doc			03/18/19	
Transmittals	R4257CP Implementation of the Medicare Performance Adjustment ...	N/A	1 Doc			03/13/19	
Transmittals	R4256CP April 2019 Integrated Outpatient Code Editor (I/OCE) Spe...	N/A	1 Doc			03/13/19	
Transmittals	R4255CP April 2019 Update of the Hospital Outpatient Prospective ...	N/A	1 Doc			03/13/19	
Transmittals	R4254CP Ensuring Only the Active Billing Hospice Can Submit a Re...	N/A	1 Doc			03/13/19	
Transmittals	R4253CP Remittance Advice Remark Code (RARC), Claims Adjustm...	N/A	1 Doc			03/13/19	
Transmittals	R2270OTN Implementation of the Skilled Nursing Facility (SNF) Pati...	N/A	1 Doc			03/13/19	
Transmittals	R2264OTN Implementation to Exchange the list of Electronic Medic...	N/A	1 Doc			02/22/19	
Transmittals	R865PI Update to Chapter 15 of Publication (Pub.) 100-08	N/A	1 Doc			02/22/19	
Transmittals	R2262OTN Ensuring Organ Acquisition Charges Are Not Included in...	N/A	1 Doc			02/22/19	
Transmittals	R311FM Updating Chapter 3, Section 200, Limitation on Recoupme...	N/A	1 Doc			02/22/19	

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The link to this Transmittal R229DEMO

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-19 Demonstrations	Centers for Medicare & Medicaid Services (CMS)
Transmittal 229	**Date: August 16, 2019**
	Change Request 11350

SUBJECT: Next Generation and Vermont ACO Model - AIPBP Reduction File and BE Modifications

I. SUMMARY OF CHANGES: A correction to CRs 10339 and 10588 is necessary to revise one of the requirements to ensure the beneficiary's HICN is no longer transmitted to the ACOs after this year (2019).

We are also revising a requirement for the SNF 3-days Rule Waiver and Post-Discharge Home Visits Benefit Enhancements.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

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II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
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IV. ATTACHMENTS:

Demonstrations

The link to this Transmittal R4364CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4364	**Date: August 16, 2019**
	Change Request 11403

SUBJECT: Manual Update to Sections 1.2 and 10.2.1 in Chapter 18 of Publication (Pub.) 100-04

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the language in sections 1.2 and 10.2.1 in chapter 18 of Pub.100-04 to add a link to the current flu codes and payment rates.

EFFECTIVE DATE: November 18, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: November 18, 2019

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	Chapter 18/1/1.2/Table of Preventive and Screening Services
R	Chapter 18/10/10.2.1/Healthcare Common Procedure Coding System (HCPCS) and Diagnosis Codes

III. FUNDING:
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IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R4363CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4363	**Date: August 16, 2019**
	Change Request 11411

SUBJECT: Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and Hospice Pricer for FY 2020

I. SUMMARY OF CHANGES: This Change Request (CR) updates the hospice payment rates, hospice wage index, and Pricer for FY 2020. The CR also updates the FY 2020 hospice aggregate cap amount. These updates apply to Pub 100-04, Chapter 11, section 30.2.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R4362CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4362	**Date: August 16, 2019**
	Change Request 11402

SUBJECT: Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - October 2019 Update

I. SUMMARY OF CHANGES: Payment files were issued to contractors based upon the 2019 Medicare Physician Fee Schedule (MPFS) Final Rule. This Change Request (CR) amends those payment files. This recurring update notification applies to Publication (Pub.) 100-04, Medicare Claims Processing Manual, chapter 23, section 30.1.

EFFECTIVE DATE: January 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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IV. ATTACHMENTS:

The link to this Transmittal R2351OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2351	Date: August 16, 2019
	Change Request 10759

SUBJECT: User Change Request: Fiscal Intermediary Standard System (FISS) - Wage Index for End Stage Renal Disease (ESRD) Providers Incorrect on MAP1C15

I. SUMMARY OF CHANGES: When CMS implemented End Stage Renal Disease (ESRD), Home Health (HH) and Hospice Prospective Payment Systems (PPS), provider reimbursement was calculated using a blended rate during the transition to full PPS payment. The blended rate did not solely use the wage index and therefore did not accurately represent how payment was calculated. Because the wage index information was not valid during the transition period, FISS did not make modifications to the Outpatient Provider Specific file (OPSF) to display the correct wage index information for these PPS providers when the payment systems implemented. The purpose of this change request (CR) is to ensure ESRD providers display the wage index specific for ESRD PPS in FISS. Hospice and Home Health claims are priced using the wage index associated with the site where services are rendered which is billed in claim value codes. There is not a single wage index for Hospice or Home Health PPS providers. This CR will modify the displayed information in the FISS OPSF to only display wage index information that is valid for claims pricing so that MAC provider customer service representatives will have the correct information when reviewing the pricing of these claims.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

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The link to this Transmittal R2350OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2350	**Date: August 16, 2019**
	Change Request 11382

SUBJECT: User Change Request: Fiscal Intermediary Standard System (FISS) - Autopopulate the Line Item User Action Code for Hard Coded 59XXX Reason Codes

I. SUMMARY OF CHANGES: When hard coded Fiscal Intermediary Shared System (FISS) National Coverage Determination (NCD) line level reason codes are set to automatically deny, the claims suspend for reason code 31995 because a line level user action code (LUAC) and med-tech indicator are required for line item denials. The purpose of this Change Request (CR) is to modify FISS to assign the LUAC and med-tech indicator when the line level FISS NCD reason codes are auto-denied.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R2352OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2352	**Date: August 16, 2019**
	Change Request 10755

SUBJECT: User Change Request: Fiscal Intermediary Standard System - Online PARM 6L Line Numbers

I. SUMMARY OF CHANGES: When a user inquires in the Fiscal Intermediary Shared System (FISS) online parm screen, MAP1171, it is difficult to find and correct entries because the online parm members do not number the lines when more than one entry is allowed. The purpose of this Change Request (CR) is to modify FISS to add line numbers to the online parm display.

EFFECTIVE DATE: January 1, 2020
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IMPLEMENTATION DATE: January 6, 2020

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IV. ATTACHMENTS:
One Time Notification

The link to this Transmittal R4367CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4367	**Date: August 16, 2019**
	Change Request 11422

SUBJECT: Quarterly Healthcare Common Procedure Coding System (HCPCS) Drug/Biological Code Changes - October 2019 Update

I. SUMMARY OF CHANGES: The HCPCS code set is updated on a quarterly basis. This instruction informs contractors of updates to drug and biological HCPCS codes. This recurring update notification applies to chapter 17, section 10 of the Claims Processing manual.

EFFECTIVE DATE: October 1, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 7, 2019

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R8pr233

Medicare
Provider Reimbursement Manual
Part 2, Provider Cost Reporting Form and Instructions, Chapter 33, Form CMS-216-94

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

Transmittal 8 **Date: August 16, 2019**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents - 3300	33-1 - 33-2 (2 pp.)	33-1 - 33-2 (2 pp.)
3300 - 3303.2	33-3 - 33-6 (6 pp.)	33-3 - 33-6 (6 pp.)
3304 (Cont.) - 3305 (Cont.)	33-10.1 - 33-12 (4pp.)	33-10.1 - 33-12 (4 pp.)
3309 (Cont.) - 3309 (Cont.)	33-15 - 33-16 (2 pp.)	33-15 - 33-16 (2 pp.)
3319	33-25 - 33-26 (2 pp.)	
3390 (Cont.) - 3390 (Cont.)	33-301 - 33-302 (2 pp.)	33-301 - 33-302 (2 pp.)
	33-304.1 - 33-306 (4 pp.)	33-304.1 - 33-306 (4 pp.)
3395 - 3395 (Cont.)	33-501 - 33-504 (4 pp.)	33-501 - 33-504 (4 pp.)
	33-505 - 33-506 (2 pp.)	33-505 - 33-506 (2 pp.)
	33-509 - 33-510 (2 pp.)	33-509 - 33-510 (2 pp.)
	33-514.1 - 33-514.2 (2 pp.)	33-514.1 - 33-514.2 (2 pp.)
	33-521 - 33-522 (2 pp.)	33-521 - 33-522 (2 pp.)
	33-525 - 33-526 (2 pp.)	33-525 - 33-526 (2 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE:* Cost reporting periods that end on or after June 30, 2019.

This transmittal updates Chapter 33, Organ Procurement Organization and Tissue Typing Laboratory Cost Reports, Form CMS-216-94 to incorporate data previously reported on OMB No. 0938-0301, the Provider Cost Report Reimbursement Questionnaire, Form CMS-339. This transmittal also updates the electronic specifications adding the CMS-approved portal as a medium for transmitting electronic cost report files to contractors, and clarifies instructions.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged.

Revisions include:

- Worksheet S-2:
  - Created worksheet S-2 to incorporate data previously reported on the Form CMS-339.
- Worksheet A:
  - Clarified instructions for lines 4, 13, 14, and 15 through 20.
- Worksheet A-1:
  - Clarified instruction for line 20.

The link to this Transmittal R4368CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4368	**Date: August 15, 2019**
	Change Request 11345

Transmittal 4353, dated August 2, 2019, is being rescinded and replaced by Transmittal 4368, dated, August 15, 2019 to replace the Health Insurance Prospective Payment System (HIPPS) Case Mix Group (CMG) Codes spreadsheet with a corrected version. All other information remains the same.

SUBJECT: Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2020

I. SUMMARY OF CHANGES: A new IRF PRICER software package will be released prior to October 1, 2019, that will contain the updated rates that are effective for claims with discharges that fall within October 1, 2019, through September 30, 2020. Chapter 3 Section 140.2 of the Pub 100-04 Medicare Claims Processing Manual is being updated accordingly.

EFFECTIVE DATE: October 1, 2019
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IMPLEMENTATION DATE: October 7, 2019

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	3/ 140.2/ Payment Provisions Under IRF PPS

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IV. ATTACHMENTS:
Recurring Update Notification

The link to this Transmittal R2353OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2353	**Date: August 16, 2019**
	Change Request 10660

SUBJECT: User CR: MCS - Updates to Beneficiary Deliverable Logic for Internal/Clerk Duplicate Medicare Summary Notices (MSNs) and Temporary Addresses

I. SUMMARY OF CHANGES: Currently, when the beneficiary address is undeliverable, duplicate MSNs are suppressed. This includes internal/clerk duplicate requests. The purpose of this change request is to allow internal/clerk duplicate MSN requests when the beneficiary address is undeliverable.

Additionally, this Change Request (CR) will correct an issue when a beneficiary address is undeliverable, but has a valid temporary address or temporary legal address in the system. MCS will be updated to set the DLV flag to Y when a temporary address is received. This will allow the mailing of MSNs to the temporary address.

EFFECTIVE DATE: January 1, 2020
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IV. ATTACHMENTS:

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