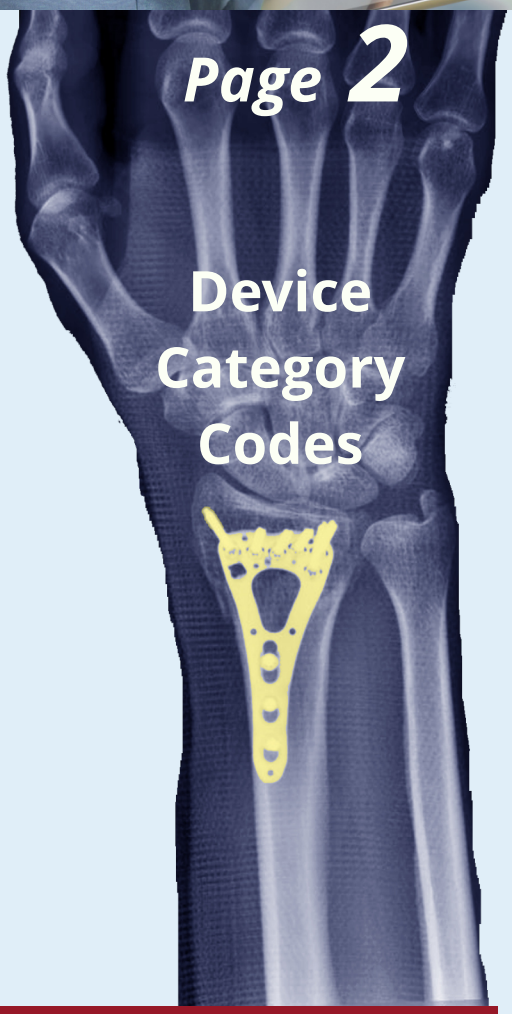
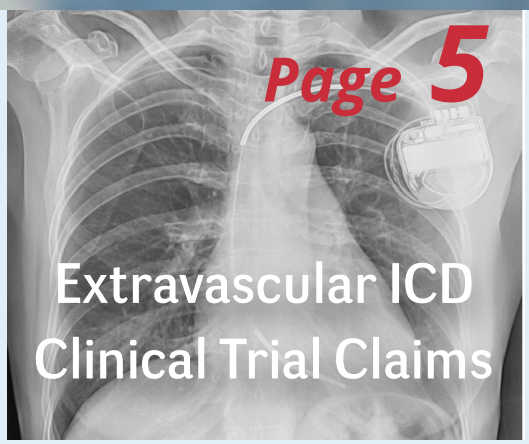
PARA HealthCare Analytics
HEALTHCARE FINANCIAL RESOURCES

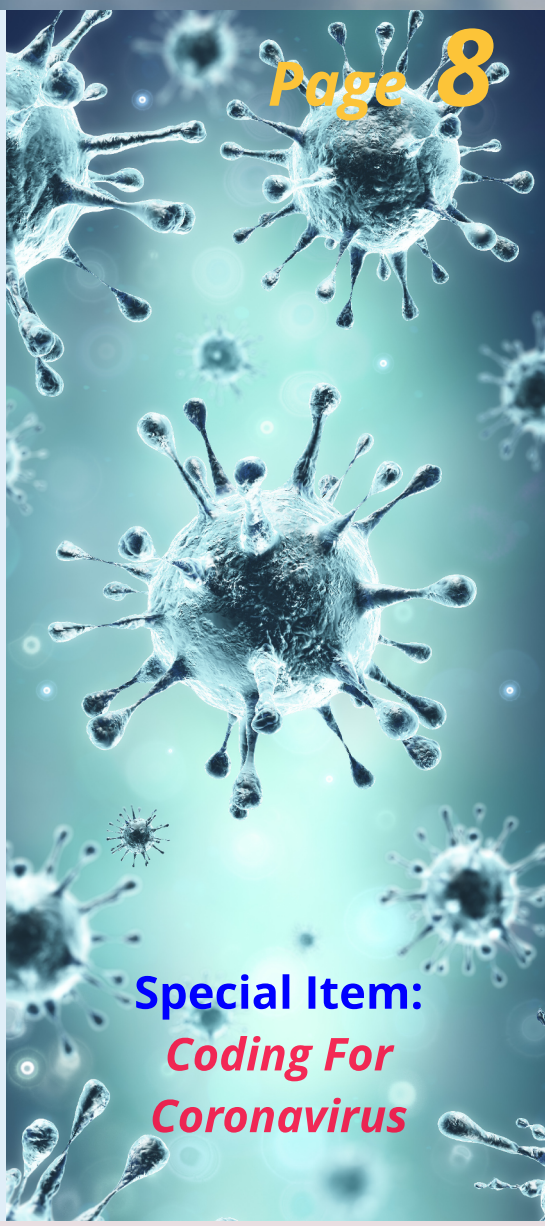
February 12, 2020

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS



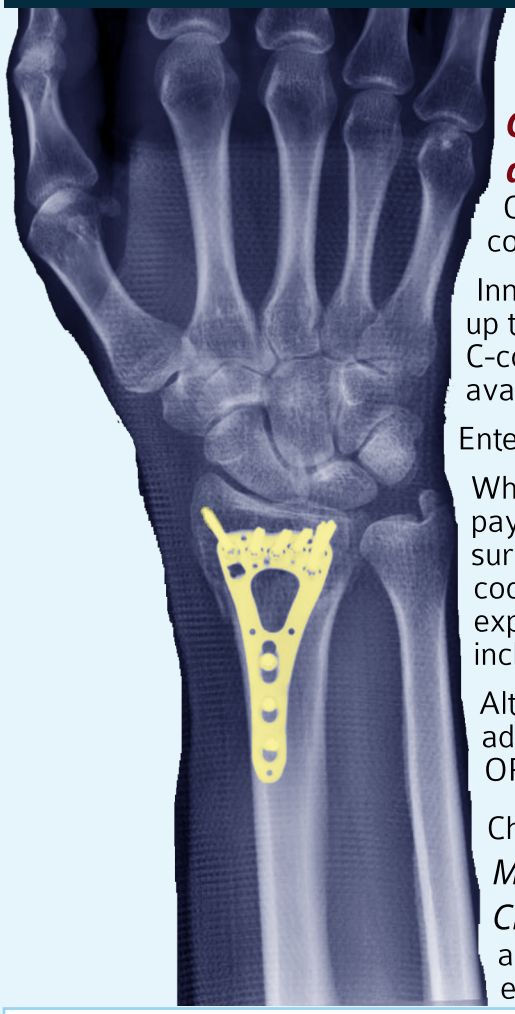




PARA

FAST LINKS

DEVICE CATEGORY CODES FOR PASS-THROUGH PAYMENTS



CMS has published its 2020 list of HCPCS codes for devices which are, or have been, separately reimbursed under OPPS with pass-through payment. This year, there are five new codes, which are described later in this document.

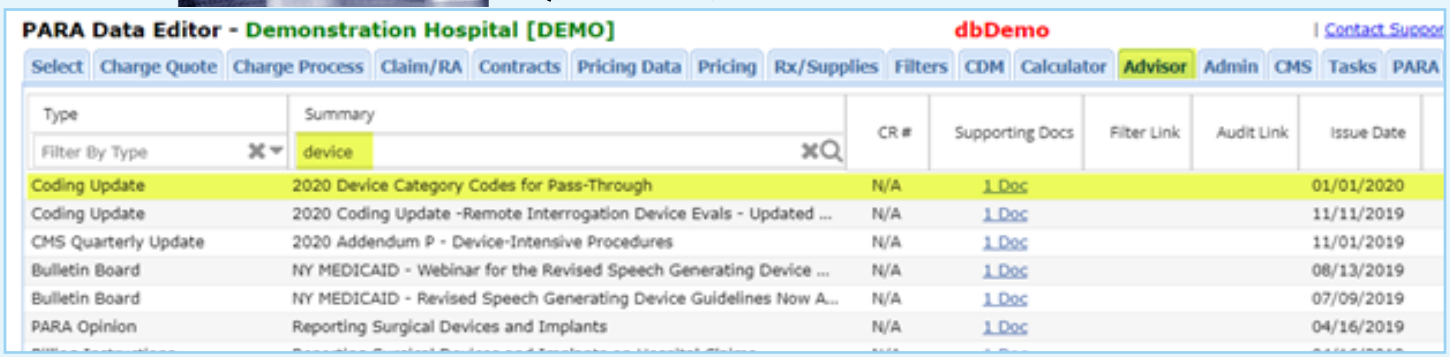
Innovative devices may be granted a pass-through payment status for up to 3 years while allowing CMS to collect cost data. The list of C-codes, which includes their definitions and expiration dates, is available on the **PARA Data Editor Advisor** tab.

Enter "device" in the Summary field. (see below)

When a claim includes a pass-through device (status G or H) a payment for the device is made in addition to the payment for the surgical procedure. OPPS hospitals are required to report the device codes with the procedures even when the pass-through status has expired. Once a device category expires, the cost of the device is included in the APC rate for the procedure.

Although the CMS HCPCS list appears to be complete, CMS has added a disclaimer that the device category list does not include all OPPS reportable device HCPCS codes.

Chapter 4, Section 61.1 of the *Medicare Claims Processing Manual, Requirement that Hospitals Report Device Codes on Claims on Which They Report Specific Procedures* provides additional information to OPPS hospitals on reporting and satisfying edits on devices.



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

61.1 - Requirement that Hospitals Report Device Codes on Claims on Which They Report Specified Procedures
(Rev. 1702, Issued: 03-13-09, Effective: 04-01-09, Implementation: 04-06-09)

DEVICE CATEGORY CODES FOR PASS-THROUGH PAYMENTS

The CMS file also provides more expansive definitions of some device category codes.For example, CMS provides an updated description on one of the most commonly reported C-Codes, C1713 implantable anchor/screw for opposing bone-to-bone, or soft tissue to bone:

Anchor for opposing bone-to-bone or soft tissue-to-bone (C1713) - Implantable pins and/or screws that are used to oppose soft tissue-to-bone, tendon-to-bone, or bone-to-bone. Screws oppose tissues via drilling as follows: soft tissue-to-bone, tendon-to-bone, or bone-to-bone fixation. Pins are inserted or drilled into bone, principally with the intent to facilitate stabilization or oppose bone-to-bone. This may include orthopedic plates with accompanying washers and nuts. This category also applies to synthetic bone substitutes that may be used to fill bony void or gaps (i.e., bone substitute implanted into a bony defect created from trauma or surgery).

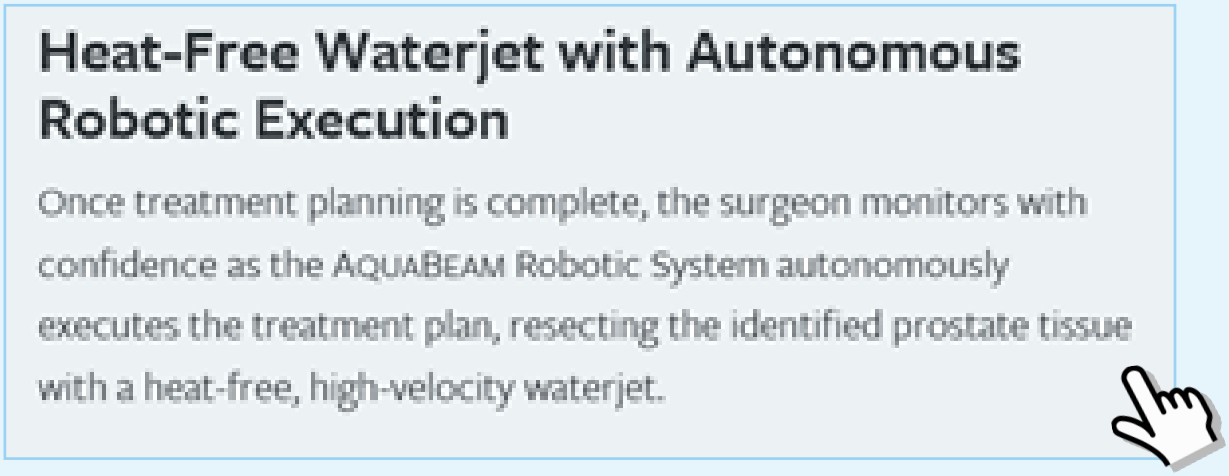
The five codes added in 2020, along with the product each of the codes represent, are provided below:

C1734-Orthopedic/device/drug matrix for opposing bone-to-bone or soft tissue-to bone (implantable) **AUGMENT® Bone Graft**, an alternative to autograft in arthrodesis of the ankle and/or hindfoot where the need for supplemental graft material is required. The applicant stated that the product has two components: human platelet-derived growth factor and Beta-tricalcium phosphate granules. The two components are combined at the point of use and applied to the surgical site.

https://www.wrightemedia.com/ProductFiles/Files/PDFs/LBS104_EN_LR_LE.pdf

C2596 – Probe, image-guided, robotic, waterjet ablation AquaBeam® Robotic System (CPT® 0421T),system resects the prostate to relieve symptoms of urethral compression. The resection is performed robotically using a high velocity, non-heated sterile saline water jet (in a procedure called Aquablation).

https://www.procept-biorobotics.com/aquabeam-surgical-robotic-system/#section-aquablation-procedure



DEVICE CATEGORY CODES FOR PASS-THROUGH PAYMENTS

C1982 - Catheter, pressure-generating, one-way valve, intermittently occlusive

Surefire® Spark Infusion System, a flexible, ultra-thin microcatheter with a self-expanding, nonocclusive one-way microvalve at the distal end. The technology improves distribution and penetration of therapy during Transcatheter Arterial Chemoembolization (TACE) procedures.

https://surefireinfusion.com

C1824 - Generator, cardiac contractility modulation (implantable)

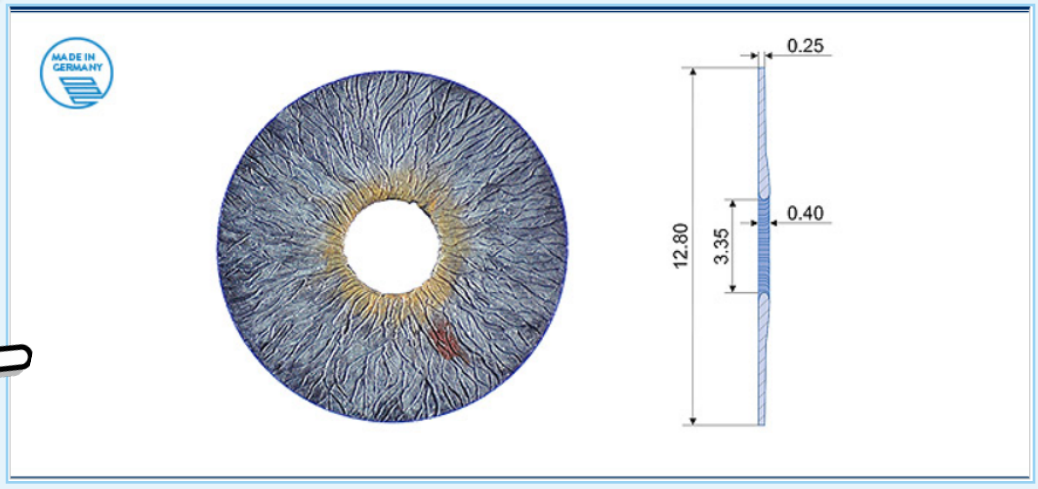
Optimizer® Smart System, an implantable device that delivers Cardiac Contractility Modulation (CCM) therapy for the treatment of patients with moderate to severe chronic heart failure.

https://www.impulse-dynamics.com/us/?cr=1

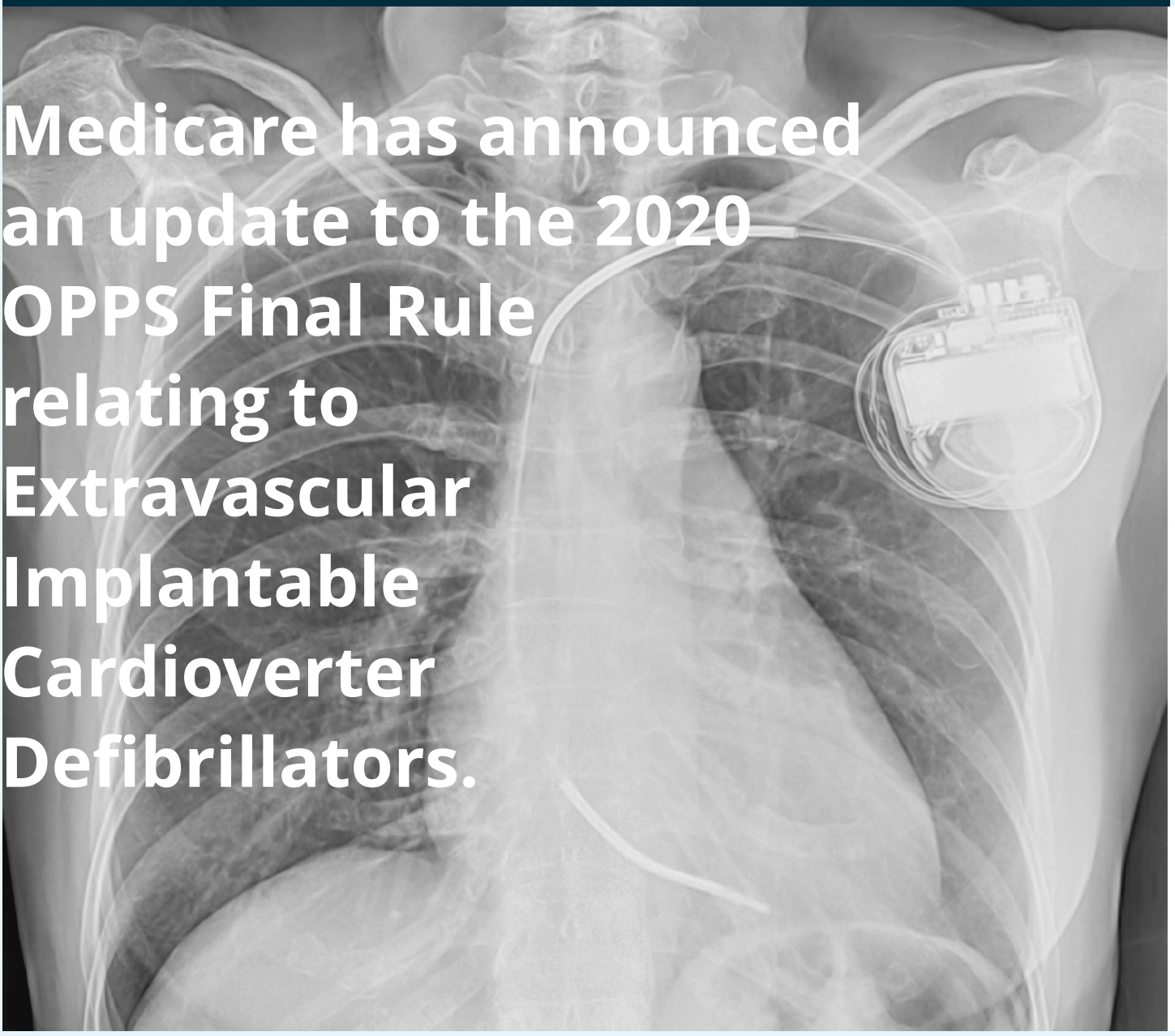
C1839 – Iris Prosthesis

CustomFlex® Artificial Iris, an iris prosthesis for the treatment of iris defects.

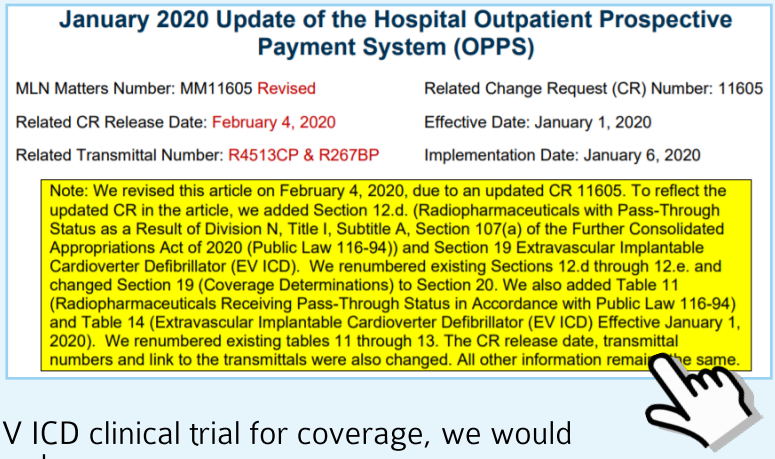
https://www.humanoptics.com/en/physicians/artificialiris/



2020 COVERAGE FOR EXTRAVASCULAR ICD CLINICAL TRIAL CLAIMS



https://www.cms.gov/files/document/mm11605.pdf



January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS)

MLN Matters Number: MM11605 Revised | Related Change Request (CR) Number: 11605

Related CR Release Date: February 4, 2020 | Effective Date: January 1, 2020

Related Transmittal Number: R4513CP & R267BP | Implementation Date: January 6, 2020

Note: We revised this article on February 4, 2020, due to an updated CR 11605. To reflect the updated CR in the article, we added Section 12.d. (Radiopharmaceuticals with Pass-Through Status as a Result of Division N, Title I, Subtitle A, Section 107(a) of the Further Consolidated Appropriations Act of 2020 (Public Law 116-94)) and Section 19 Extravascular Implantable Cardioverter Defibrillator (EV ICD). We renumbered existing Sections 12.d through 12.e. and changed Section 19 (Coverage Determinations) to Section 20. We also added Table 11 (Radiopharmaceuticals Receiving Pass-Through Status in Accordance with Public Law 116-94) and Table 14 (Extravascular Implantable Cardioverter Defibrillator (EV ICD) Effective January 1, 2020). We renumbered existing tables 11 through 13. The CR release date, transmittal numbers and link to the transmittals were also changed. All other information remai[illegible]e same.

19. Extravascular Implantable Cardioverter Defibrillator (EV ICD)In the CY 2020 OPPS/ASC final rule that was published in the Federal Register on November 12, 2019, we stated that CPT codes 0571T through 0580T, which were effective January 1, 2020, would be assigned to OPPS status indicator "E1" to indicate that the codes are not payable by Medicare because the clinical trial associated with the codes has not met Medicare's standards for coverage. We further stated that if Medicare approved the EV ICD clinical trial for coverage, we would reassess the SI and APC assignments for the codes.

2020 COVERAGE FOR EXTRAVASCULAR ICD CLINICAL TRIAL CLAIMS

Since the publication of the CY 2020 OPPS/ASC final rule, theEV ICD clinical study was approved by CMS for Medicare coverage on December 4, 2019 as a Category B IDE study. Therefore, we have revised the OPPS status indicator and APC assignments for the codes for the January 2020 update.

Table 14 shows the status indicator and APC assignments for CPT® codes 0571T through 0580T. The payment rates for CPT® codes 0571T through 0580T can be found in Addendum B of the January 2020 OPPS Update that is posted on the CMS website.

Table 14 -- Extravascular Implantable Cardioverter Defibrillator (EV ICD) Effective January 1, 2020

CPT Code	Long Descriptor	CY 2020 OPPS SI	CY 2020 OPPS APC
0571T	Insertion or replacement of implantable cardioverter defibrillator system, with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	J1	5232
0572T	Insertion of substernal implantable defibrillator electrode	J1	5222
0573T	Removal of substernal implantable defibrillator electrode	Q2	5221
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	Q2	5221
0575T	Programming device evaluation (in person) of implantable cardioverter defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	Q1	5741
0576T	Interrogation device evaluation (in person) of implantable cardioverter defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	Q1	5741
0577T	Electrophysiological evaluation of implantable cardioverter defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	J1	5211

2020 COVERAGE FOR EXTRAVASCULAR ICD CLINICAL TRIAL CLAIMS

CPT Code	Long Descriptor	CY 2020 OPPS SI	CY 2020 OPPS APC
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	M	N/A
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Q1	5741
0580T	Removal of substernal implantable defibrillator pulse generator only	Q2	5221

Links and excerpts to other CMS publications regarding Investigation Device Exemption Category B studies appear below.

The rules relating to IDE Category B studies are discussed at the following link (excerpt provided.)

https://www.cms.gov/Medicare/Coverage/IDE

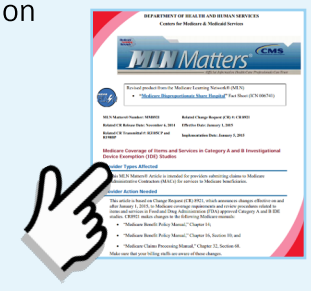
Medicare Coverage Related to Investigational Device Exemption (IDE) Studies

Instructions: Medicare Coverage Related to Investigational Device Exemption (IDE) Studies

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed Medicare payment of the routine costs of care furnished to Medicare beneficiaries in certain categories of Investigational Device Exemption (IDE) studies. Covering the costs in these IDE studies removes a financial barrier that could otherwise discourage beneficiaries from participating.

CMS finalized changes to the IDE regulations (42 CFR § 405 Subpart B), effective January 1, 2015. CMS added criteria for coverage of IDE studies and changed from local Medicare Administrative Contractor (MAC) review and approval of IDE studies to a centralized review and approval of IDE studies. An approval for a Category A (Experimental) IDE study will allow coverage of routine care items and services furnished in the study, but not of the Category A device, which is statutorily excluded from coverage.An approval for a Category B (Nonexperimental/investigational) IDE study will allow coverage of the Category B device and the routine care items and services in the trial.

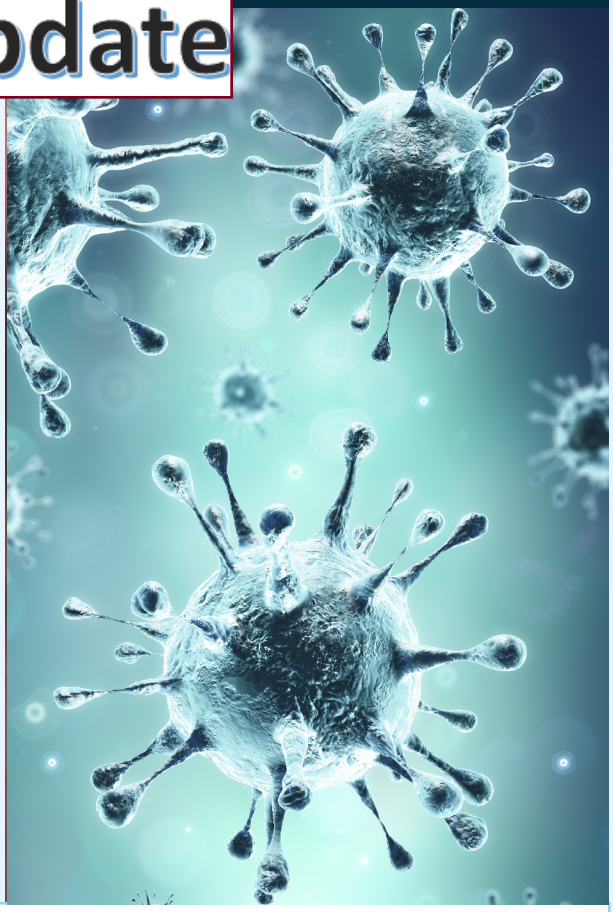
IDE studies approved by MACs prior to January 1, 2015 will continue to be administered by the MAC.Study sponsors do not have to submit the protocol to CMS if the participating study investigator sites have already received approval from their MAC. Study sponsors should continue to follow the process established by the MAC for any site additions or protocol changes.Click on this link to find a list of MACs:
https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/MACJurisdictions



Further details about billing requirements are available in the MLN Matters article here:
https://www.cms.gov/Medicare/Coverage/IDE/Downloads/MM8921pdf.pdf

CODING FOR CORONAVIRUS

Special Update



Coronaviruses are classified as a large family of viruses that cause infection in the sinuses, nose and upper throat. Some coronaviruses cause illness in people and others circulate among animals, including camels, cats and bats.

The 2019 Novel Coronavirus (2019-nCoV) is a new form of coronavirus first identified in Wuhan, Hubei Province, China.

The 2019-nCoV continues to expand with growing numbers of illness in people in multiple countries, including recent confirmation in the United States.The CDC is currently closely monitoring the outbreak of the 2019-nCoV respiratory illness.

Clinical indications of the virus include early symptoms of fever, cough and shortness of breath. The CDC reported, "Symptoms may appear in as few as 2 days or as long as 14 after exposure ".

When coding for the coronavirus, report ICD-10 CM code B34.2, Coronavirus infection, unspecified. Refer to the **PARA Data Editor** code description:

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ICD10 Codes

ICD10 Code	Description
B342	Coronavirus infection, unspecified

Diagnosis codes B97.21 and B97.29 would not be appropriate for the 2019-nCoV.The B97.2- ICD-10 CM category is classified as a "viral agent as the cause of other diseases" and only identifies the organism not the virus. Refer to the Official Coding Guidelines Section I.C.1.b found in the **PARA Data Editor Calculator** which discusses category B97.- and the **PARA Data Editor** code descriptions.

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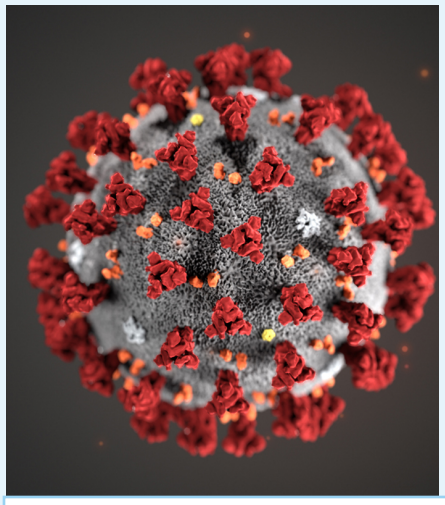
ICD10 Codes

ICD10 Code	Description
B9721	SARS-associated coronavirus as the cause of diseases classified elsewhere
B9729	Other coronavirus as the cause of diseases classified elsewhere

CODING FOR CORONAVIRUS



2020 Official Coding Guidelines - Section I.C.1.b

...B97, Viral agents as the cause of diseases classified to other chapters, is to be used as an additional code to identify the organism. An instructional note will be found at the infection code advising that an additional organism code is required.ICD-10 CM code J12.81 would not be appropriate for 2019-nCoV even if the patient develops pneumonia.ICD-10 CM defines J12.81 as Pneumonia due to SARS-associated coronavirus. The 2019-nCoV has not been confirmed as SARS (Severe Acute Respiratory Syndrome) associated coronavirus.

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ICD10 Codes

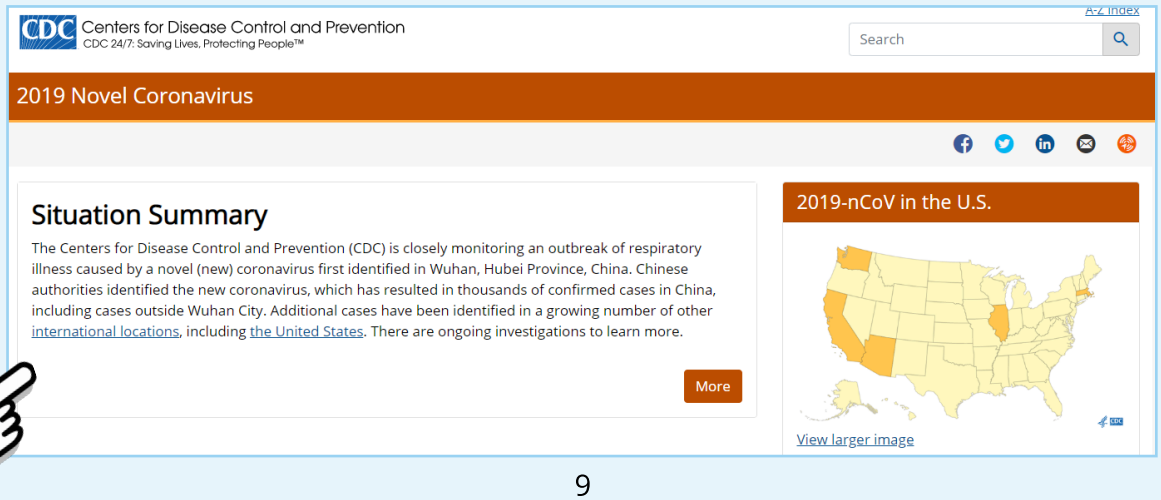
ICD10 Code	Description
J1281	Pneumonia due to SARS-associated coronavirus

The CDC reported that the 2019-nCoV is likely spread person to person via respiratory droplets when the infected person coughs or sneezes.There is much more to learn about the transmissibility, severity, and other features associated with 2019-nCoV and investigations are ongoing.

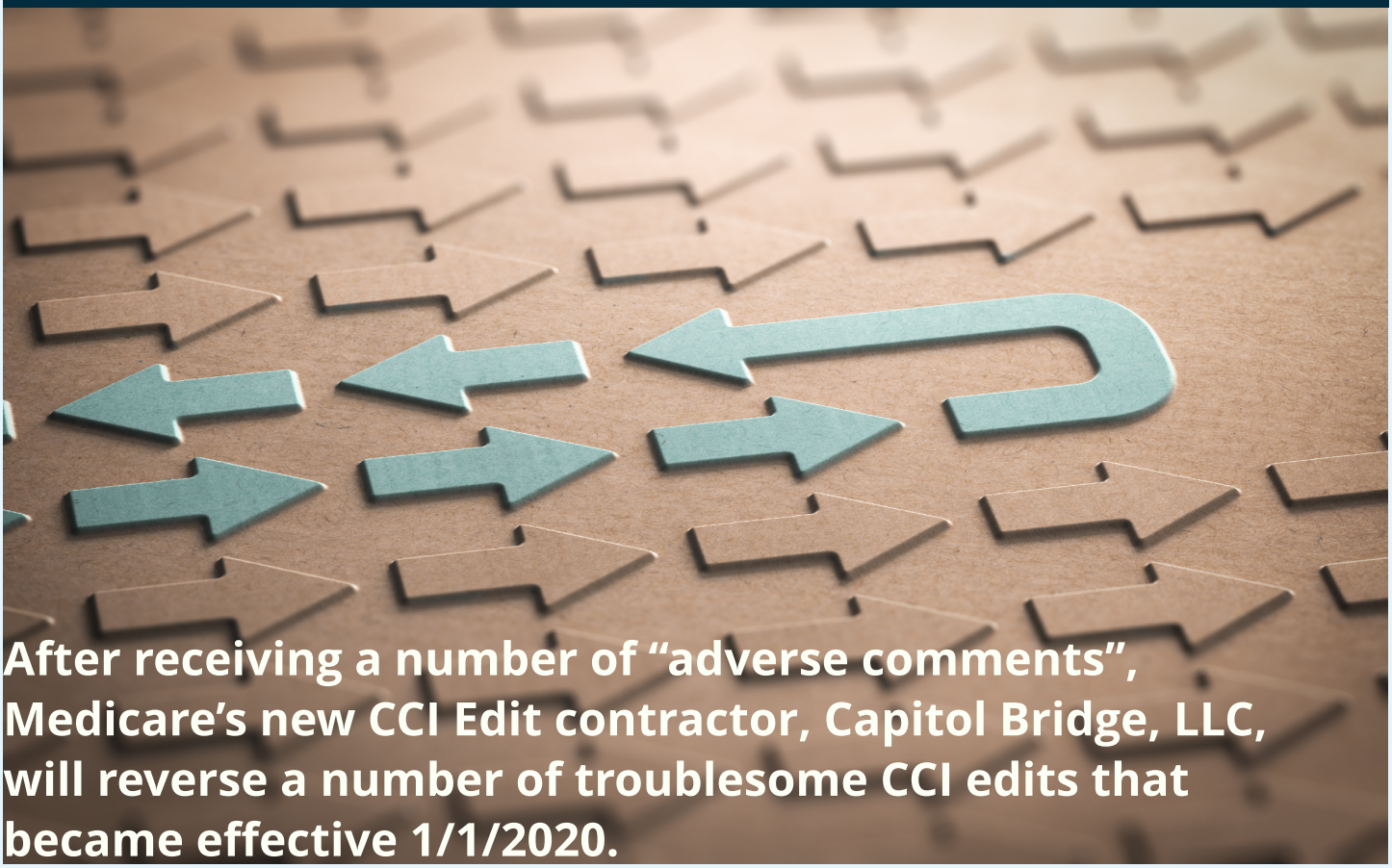
https://www.cdc.gov/coronavirus/2019-ncov/index.html

There is currently no vaccine to prevent 2019-nCoV infection. The best way to prevent infection is to avoid being exposed to this virus. However, as a reminder, CDC always recommends everyday preventive actions to help prevent the spread of respiratory viruses, including:

- Wash your hands often with soap and water for at least 20 seconds.
- Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people who are sick.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.Clean and disinfect frequently touched objects and surfaces.



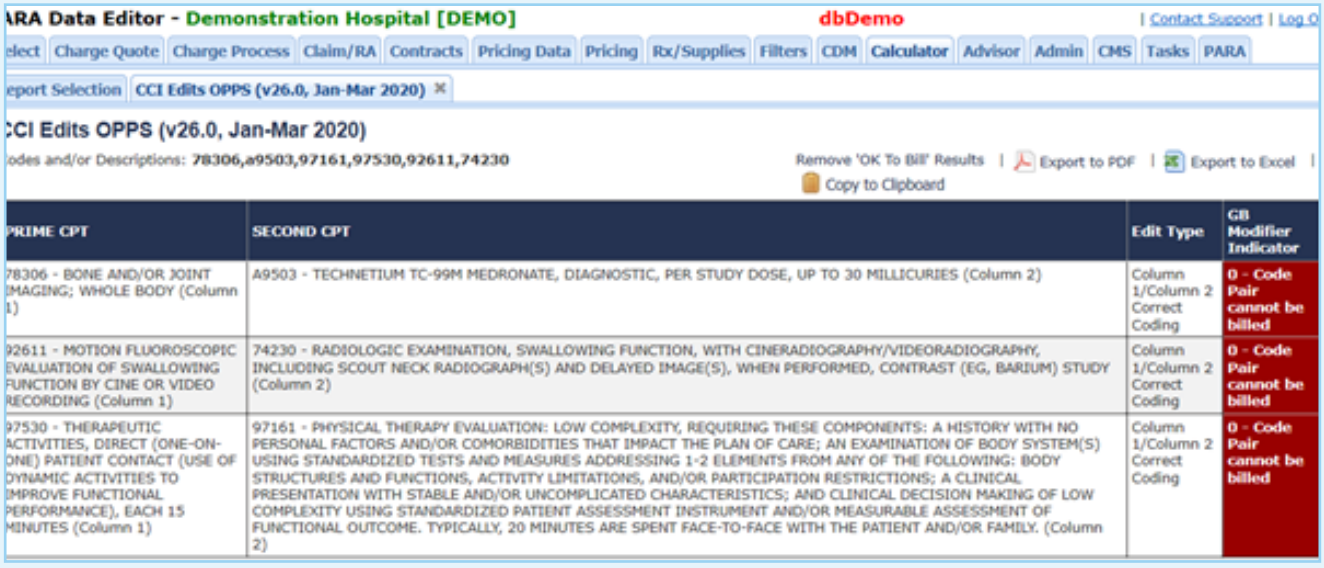
NEW 2020 CCI EDITS TO BE REVERSED



After receiving a number of "adverse comments", Medicare's new CCI Edit contractor, Capitol Bridge, LLC, will reverse a number of troublesome CCI edits that became effective 1/1/2020.

The contractor intends to remove the edits retroactive to 1/1/2020, although as a practical matter the edits will still cause claims to reject until the claims processing files used by MACs can be corrected.The relaxed edits will include:

- Nuclear medicine tests billed together with a radiopharmaceutical, (i.e. 78306 with A9503)
- Barium swallow testing (92611 with 74230);
- And PT/OT evaluations (97161-97163 and 97165-97168) billed on the same DOS as therapeutic activities (97530) (as reported by the American Physical Therapy Association and the American Occupational Therapy Association in late January.) The Medicare Outpatient Code Editor, which includes NCCI edits and MUE values, is updated on a quarterly basis.The next scheduled update is 4/1/2020.



ARA Data Editor - Demonstration Hospital [DEMO] dbDemo | Contact Support | Log O

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

eport Selection | CCI Edits OPPS (v26.0, Jan-Mar 2020)

CCI Edits OPPS (v26.0, Jan-Mar 2020)

odes and/or Descriptions: 78306,a9503,97161,97530,92611,74230

Remove 'OK To Bill' Results | Export to PDF | Export to Excel | Copy to Clipboard

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
78306 - BONE AND/OR JOINT IMAGING; WHOLE BODY (Column 1)	A9503 - TECHNETIUM TC-99M MEDRONATE, DIAGNOSTIC, PER STUDY DOSE, UP TO 30 MILLICURIES (Column 2)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed
92611 - MOTION FLUOROSCOPIC EVALUATION OF SWALLOWING FUNCTION BY CINE OR VIDEO RECORDING (Column 1)	74230 - RADIOLOGIC EXAMINATION, SWALLOWING FUNCTION, WITH CINERADIOGRAPHY/VIDEORADIOGRAPHY, INCLUDING SCOUT NECK RADIOGRAPH(S) AND DELAYED IMAGE(S), WHEN PERFORMED, CONTRAST (EG, BARIUM) STUDY (Column 2)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed
97530 - THERAPEUTIC ACTIVITIES, DIRECT (ONE-ON-ONE) PATIENT CONTACT (USE OF DYNAMIC ACTIVITIES TO IMPROVE FUNCTIONAL PERFORMANCE), EACH 15 MINUTES (Column 1)	97161 - PHYSICAL THERAPY EVALUATION: LOW COMPLEXITY, REQUIRING THESE COMPONENTS: A HISTORY WITH NO PERSONAL FACTORS AND/OR COMORBIDITIES THAT IMPACT THE PLAN OF CARE; AN EXAMINATION OF BODY SYSTEM(S) USING STANDARDIZED TESTS AND MEASURES ADDRESSING 1-2 ELEMENTS FROM ANY OF THE FOLLOWING: BODY STRUCTURES AND FUNCTIONS, ACTIVITY LIMITATIONS, AND/OR PARTICIPATION RESTRICTIONS; A CLINICAL PRESENTATION WITH STABLE AND/OR UNCOMPLICATED CHARACTERISTICS; AND CLINICAL DECISION MAKING OF LOW COMPLEXITY USING STANDARDIZED PATIENT ASSESSMENT INSTRUMENT AND/OR MEASURABLE ASSESSMENT OF FUNCTIONAL OUTCOME. TYPICALLY, 20 MINUTES ARE SPENT FACE-TO-FACE WITH THE PATIENT AND/OR FAMILY. (Column 2)	Column 1/Column 2 Correct Coding	0 - Code Pair cannot be billed

NEW 2020 CCI EDITS TO BE REVERSED

Nuclear Medicine & Barium Swallow Edits

PARA received an email from Capitol Bridge, LLC on Friday, January 31, 2020 acknowledging the nuclear medicine and barium swallow CCI edit changes. The text of that email is provided below:

From: NCCI <NCCIMailbox@capitolbridgellc.com>
Sent: Friday, January 31, 2020 1:02 PM
Subject: RE: New CCI Edits for Nuc Med Procedures

Thank you for your inquiry regarding the National Correct Coding Initiative (NCCI) program. The Centers for Medicare & Medicaid Services (CMS) owns the NCCI program and is responsible for all decisions regarding its contents.

In your correspondence, you inquired about the recent implementation of certain Procedure-to-Procedure (PTP) edits related to Nuclear Medicine and Diagnostic Radiology.After reviewing this issue more closely, CMS has made the decision to delete the following January 1, 2020 PTP edits:

Column 1	Column 2
78300	A9503
78300	A9561
78305	A9503
78305	A9561
78306	A9503
78306	A9542
78306	A9561
78315	A9503
78315	A9561
78315	A9528
78803	A9582

CMS will change the Practitioner (PRA) and Outpatient Hospital (OPH) Modifier indicator for the following January 1, 2020 PTP edit:

Column 1	Column 2	PRA Modifier Indicator	OPH Modifier Indicator
92611	74230	1	1

NEW 2020 CCI EDITS TO BE REVERSED

Both of these changes will be retroactive to January 1, 2020 and will be implemented as soon as technically possible in a future edit update. The update will be available at the following websites:

Medicare:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html

Medicaid:
https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html

Providers may choose to delay submission of claims for deleted edits until after the implementation of the replacement edit file with retroactive date of January 1, 2020. Providers may also choose to appeal claims denied due to the PTP edits to the appropriate MAC including supporting documentation or resubmit claims denied due to the PTP edits after the implementation of the replacement edit file with January 1, 2020 retroactive date, as permitted by the MAC.CMS and the NCCI Program appreciate your time in making this inquiry.

Sincerely,

Capitol Bridge, LLC
National Correct Coding Initiative Contractor
Email:NCCIPTPMUE@cms.hhs.gov
P.O. Box 368
Pittsboro, IN 46167
SBA Certified 8(a) Small Disadvantaged Business

Therapy Evaluation with Therapeutic Activities –In late January, both the American Occupational Therapy Association and the American Physical Therapy Association announced that Medicare will roll back the CCI edit between the therapy evaluation codes (97161-97163, 97165-97168) and therapeutic activities, 97530.

PARA was not a party to the correspondence from Medicare that indicated this change.See **PARA's** paper on this topic at:

https://apps.para-hcfs.com/para/Documents/CMS%20May%20Reverse%202020%20CCI%20Edits%20for%20PT%20OT%20Services.pdf

CMS May Reverse 2020 CCI Edits for PT OT Services

Both the American Occupational Therapy Association (AOTA) and the American Physical Therapy Association (APTA) have announced that Medicare's new CCI edit contractor, Capitol Bridge, LLC, has agreed to relax CCI edits between an evaluation code and therapeutic procedures. CMS has not confirmed the information conveyed by APTA and AOTA, and consequently we do not yet have details. Links and excerpts from the organization websites are provided below:

https://www.aota.org/Advocacy-Policy/Federal-Reg-Affairs/News/2017/Correcting-NCCI-Edits-to-OT-Evaluation-Codes.aspx

National Correct Coding Initiative (NCCI) Edits Reversal

ADVOCACY SUCCESS!

http://www.apta.org/PTinMotion/News/2020/01/24/NCCIDecision/

PTinMotion News

Payment Win: CMS Reverses Most of Its Damaging Coding Edits, More Details to Come

BILLING DEVICE-INTENSIVE HCPCS WITHOUT A DEVICE

Medicare repeated little-known news about modifier CG that was quietly introduced in the October, 2019 Integrated Outpatient Code Editor update file.The guidance instructs hospitals to append modifier CG – "Policy criteria applied" – when reporting a device-dependent outpatient procedure which did not require a device.

The OPPS guidance is retroactive to January 1, 2019, although it was first included in the October 2019 update of the Integrated Outpatient Code Editor.

Many hospitals were advised by their MAC to report a device code at a nominal value to resolve the edit preventing claim submission without the device reported.Hospitals which may have reported a device-intensive procedure in 2019 which did not require a device should consider submitting a corrected claim with modifier CG, rather than device codes with a nominal value.

Here's an excerpt from Medicare's January 2020 Update of the Hospital Outpatient Prospective Payment System (OPPS):

https://apps.para-hcfs.com/PDE_V2/CDMEditor_New.aspx

3. Billing for Devices Under the OPPS

Effective for dates of service beginning on or after January 1, 2019, providers may bypass the claims processing edit that requires a device HCPCS for the procedure. For certain device-intensive procedures that describe situations in which a device may not be required, providers may bypass the claims processing edits that require a device by reporting modifier "CG". In light of this policy change, we are modifying section 61.2 of chapter 4 of the Medical Claims Processing Manual, publicatioin100-04. The modified manual section is part of CR11605.

The edit to be bypassed is IOCE edit 92:

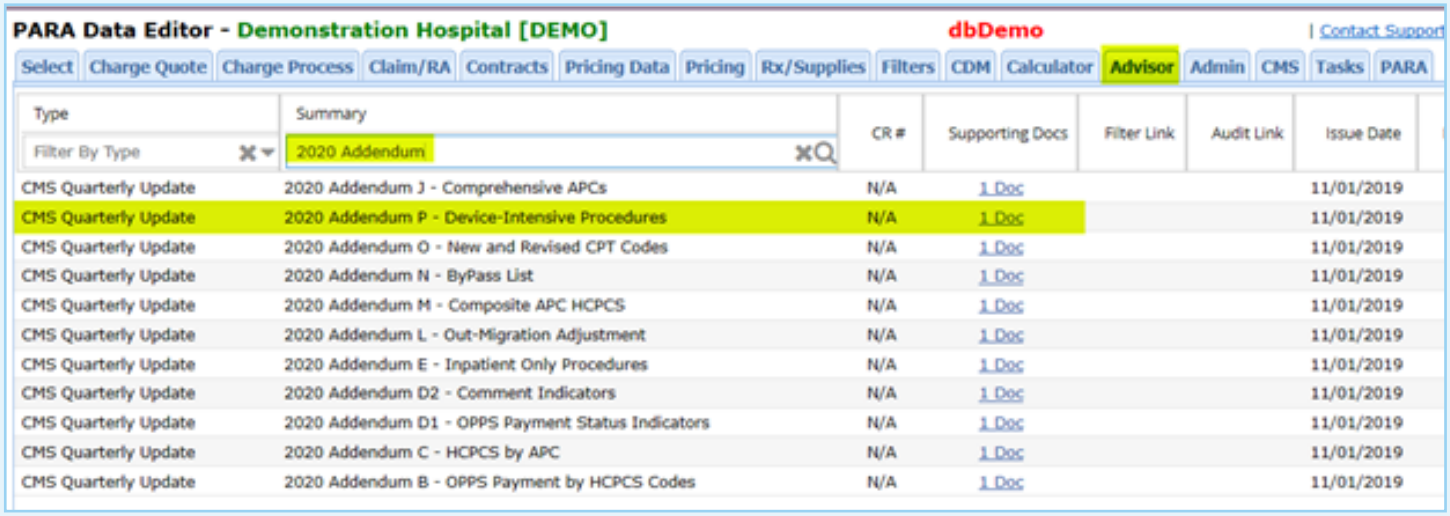
Edit	Edit Description	Reason for Edit Generation	Version Implemented	Dates Effective	Non OPPS	Disposition
92	Device-dependent procedure reported without device code	A device-dependent procedure is reported without a device code. See Device-Dependent Procedure Editing and Processing for more information.	16.0 – present	1/1/15 – present	No	RTP

BILLING DEVICE-INTENSIVE HCPCS WITHOUT A DEVICE

Background

In the January 2019 OPPS update, Medicare nearly doubled the number of HCPCS on OPPS Addendum P – "Device Intensive Procedures" -- procedures for which CMS has determined at least 30% of the APC payment is attributed to a packaged device code. Addendum P lists the percentage by which CMS will reduce payment -- an "offset percentage" – to the OPPS hospital if the hospital does not incur the expected cost of an implant.

While CMS has long provided instructions for reporting a reduced-cost implant, it had not provided instructions for situations in which no implant at all was needed. Billers were unable to resolve edit 92 without including an implant on the claim, even if no implant at all was used for the procedure.
OPPS Addendum P, which is available on the **PARA Data Editor Advisor** tab – bear in mind that CMS may publish changes to this addendum quarterly:



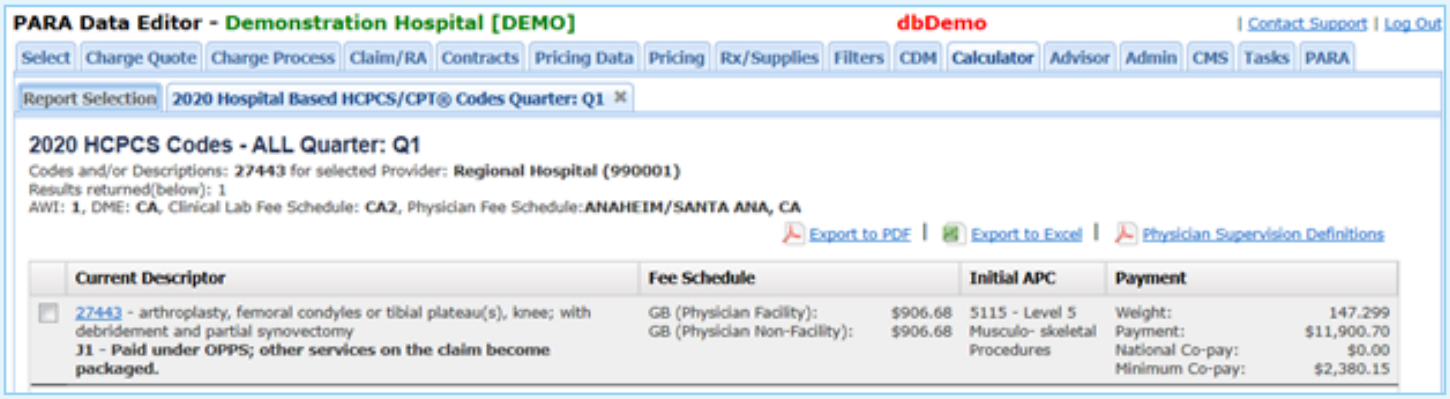
Since some of the HCPCS listed on the OPPS Addendum P "Device-Intensive Procedures" do not always require a device, hospitals previously had no appropriate mechanism to report such procedures. Some hospitals were verbally advised by their MAC to report a device anyway, at a very nominal price (e.g., $1.00.) However, this billing method could result in full payment of the APC, when reduced payment should have been paid.

Modifier CG is not a new modifier. It is also used by dialysis providers and Rural Health Clinics for completely different purposes. Now, modifier CG has a third application. It may also be reported by OPPS hospitals when billing certain device-dependent procedures (which required no device) on an outpatient claim.

For example, HCPCS 27443 (ARTHROPLASTY, FEMORAL CONDYLES OR TIBIAL PLATEAU(S), KNEE; WITH DEBRIDEMENT AND PARTIAL SYNOVECTOMY) may involve either realigning the joint or replacing it with a prosthetic one.

Therefore, this HCPCS may be reported either a procedure which requires an implant or one which does not.Since 27443 appears on the OPPS list of "device-dependent procedures in Addendum P, claims in 2019 were not accepted unless a device was also reported on the claim.

BILLING DEVICE-INTENSIVE HCPCS WITHOUT A DEVICE



If the hospital used no implant, or a significantly reduced cost implant, a lower APC reimbursement rate should be paid, according to the "Device Offset Amount" indicated in Addendum P. Here is an excerpt from Addendum P which indicates that the APC reimbursement for HCPCS 27443 will be reduced by $4,972.76 (unadjusted national average) when reported with modifier CG appended, or when the implant is reported at a significantly reduced cost to the hospital.

File Description:
*List of HCPCS codes payable under the OPPS that are final to be designated as device-intensive procedures. *The final CY 2020 portion of the APC payment amounts uniquely associated with the cost of devices. The device offset percentage for each HCPCS code will be used to evaluate whether the procedure is designated as device-intensive, which is final to require a device offset greater than 30 percent.

*The implanted device offset amount is the product of the APC payment rate multiplied by HCPCS device offset percent.

*Implanted device cost statistics reflect the data from CY 2018 used for ratesetting in this CY 2020 OPPS/ASC final rule. Device cost statistics for HCPCS codes established in CY 2019 or CY 2020 do not appear in this file.

HCPC	Short Descriptor	SI	APC	Final CY 2020 APC Payment Rate	Device Offset Percentage	Device Offset Amount
27400	Revise thigh muscles/tendons	J1	5114	$5,981.28	30.47%	$1,822.50
27403	Repair of knee cartilage	J1	5114	$5,981.28	31.80%	$1,902.05
27415	Osteochondral knee allograft	J1	5115	$11,899.39	61.39%	$7,305.04
27427	Reconstruction knee	J1	5114	$5,981.28	34.29%	$2,050.98
27428	Reconstruction knee	J1	5115	$11,899.39	34.23%	$4,073.16
27429	Reconstruction knee	J1	5115	$11,899.39	43.82%	$5,214.31
27438	Revise kneecap with implant	J1	5115	$11,899.39	37.31%	$4,439.66
27440	Revision of knee joint	J1	5115	$11,899.39	46.75%	$5,562.96
27442	Revision of knee joint	J1	5115	$11,899.39	47.06%	$5,599.85
27443	Revision of knee joint	J1	5115	$11,899.39	41.79%	$4,972.76
27446	Revision of knee joint	J1	5115	$11,899.39	46.44%	$5,526.08
27447	Total knee arthroplasty	J1	5115	$11,899.39	48.67%	$5,791.43
27477	Surgery to stop leg growth	J1	5114	$5,981.28	49.53%	$2,962.53
27485	Surgery to stop leg growth	J1	5114	$5,981.28	60.03%	$3,590.56
33274	Tcat insj/rpl perm ldls pm	J1	5194	$15,938.20	65.06%	$10,369.39

For more information on claims submission requirements for reduced cost implants, see **PARA's** paper at https://apps.para-hcfs.com/para/Documents/Reporting_Manufacturer_Credit_for_Devices_edited.pdf

MEDI-CAL CHILDHOOD SCREENINGS

Effective for dates of service on or after January 1, 2020 there are multiple new benefits as well as re-instated benefits for Medi-Cal beneficiaries.

Adverse Childhood Experiences:

Beginning January 1, 2020 Medi-Cal will begin reimbursing screenings for Adverse Childhood Experiences (ACEs) for both children and adults up to 65 years of age with Proposition 56 funds, except for those who are dually eligible for Medi-Cal and Medicare Part B. Federally Qualified Health Centers, Rural Health Clinics and Indian Health Services will also be eligible for reimbursement under Proposition 56 in addition to their Prospective Payment System and all inclusive per visit reimbursement.

Beneficiaries under 21 years of age may receive periodic screening per medical necessity but screenings will only be paid once per year, per provider. Beneficiaries 21 years of age and older may receive periodic screenings per medical necessity but will only be paid once in their lifetime, per provider.

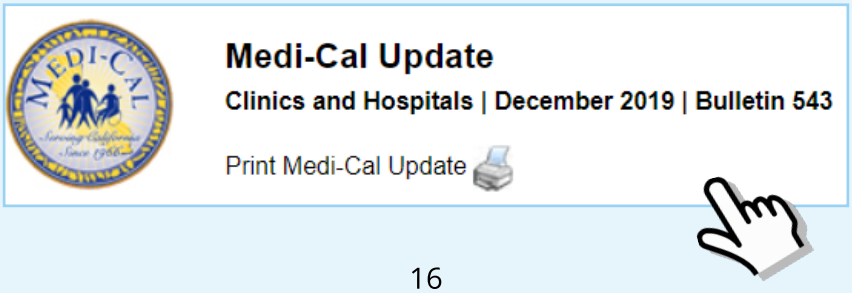
ACEs screenings will be reimbursed in both the fee-for-service and managed care delivery systems when billed with the following HCPCS codes:

- G9919 – High-risk, patient score of 4 or greater
- G9920 – Lower-risk, patient score of 0 – 3

Under the fee-for-service payment system, providers will be reimbursed at the Medi-Cal rate up to $29. Under the Managed Care payment system, plans will reimburse network providers no less than $29 for each qualifying ACEs screening.

Documentation requirements include that the completed screen was reviewed, appropriate screening tool was used, results documented and interpreted, results discussed with beneficiary and/or family and any clinically appropriate actions were taken. Documentation should remain in the beneficiary's medical record and made available upon request.It is important to note that for providers to continue to be eligible for trauma payment after July 1, 2020, providers need to complete the DHCS training for ACEs screening and trauma-informed care.

http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/cah201912.asp



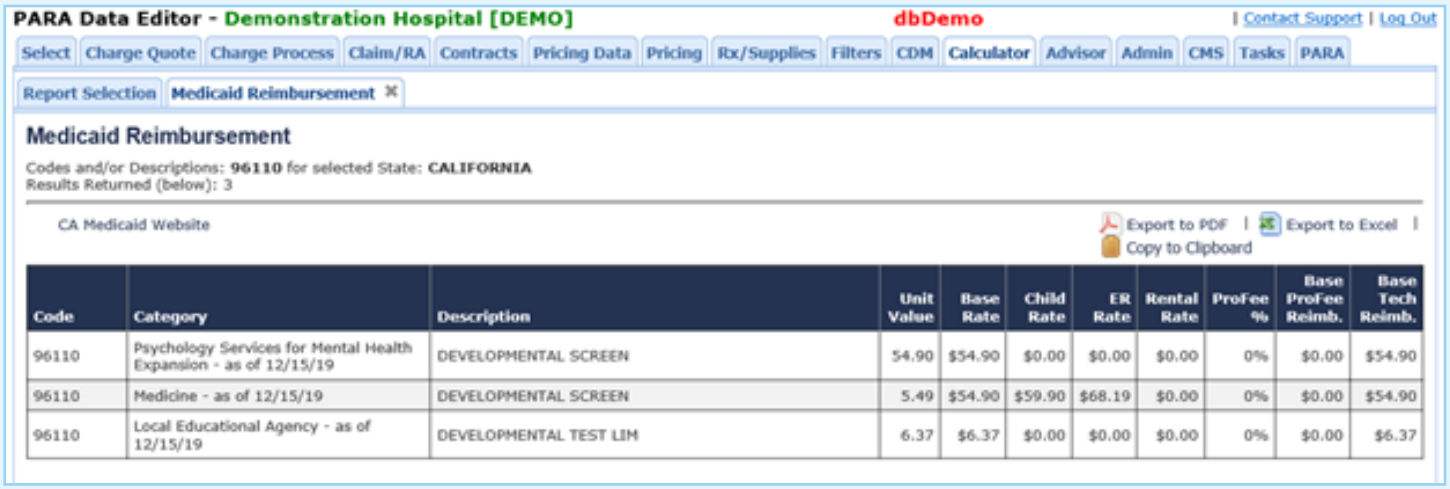
MEDI-CAL CHILDHOOD SCREENINGS

Childhood Developmental Screening:

Effective January 1, 2020 through December 31, 2021, Medi-Cal will reimburse providers for developmental screenings with funds from Proposition 56. Developmental screenings are performed at well-child visits during the first year of life and when medically necessary based on developmental surveillance.

A standardized screening tool must be used by providers that meets the criteria set forth by the American Academy of Pediatrics and CMS. In order to bill for these services, documentation must include that the completed screen was reviewed, the appropriate tool was used, results were documented and interpreted, results were discussed with the child's family and/or caregiver, and any clinically appropriate actions were documented. The documentation should stay in the beneficiary's medical record and be available upon request.

Developmental screenings should be billed with CPT® Code 96110 and the KX modifier should not be appended.



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

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

Report Selection | Medicaid Reimbursement

Medicaid Reimbursement

Codes and/or Descriptions: **96110** for selected State: **CALIFORNIA**
Results Returned (below): 3

CA Medicaid Website | Export to PDF | Export to Excel | Copy to Clipboard

Code	Category	Description	Unit Value	Base Rate	Child Rate	ER Rate	Rental Rate	ProFee %	Base ProFee Reimb.	Base Tech Reimb.
96110	Psychology Services for Mental Health Expansion - as of 12/15/19	DEVELOPMENTAL SCREEN	54.90	$54.90	$0.00	$0.00	$0.00	0%	$0.00	$54.90
96110	Medicine - as of 12/15/19	DEVELOPMENTAL SCREEN	5.49	$54.90	$59.90	$68.19	$0.00	0%	$0.00	$54.90
96110	Local Educational Agency - as of 12/15/19	DEVELOPMENTAL TEST LIM	6.37	$6.37	$0.00	$0.00	$0.00	0%	$0.00	$6.37

http://files.medi-cal.ca.gov/pubsdoco/bulletins/artfull/cah201912.asp

Podiatry Services:

Effective January 1, 2020, podiatry services that had been previously eliminated as part of the optional benefits exclusion are reinstated as full Medi-Cal benefits.

In addition to benefits being reinstated, the two-visit limit has also been removed. All TAR requirements remain the same.

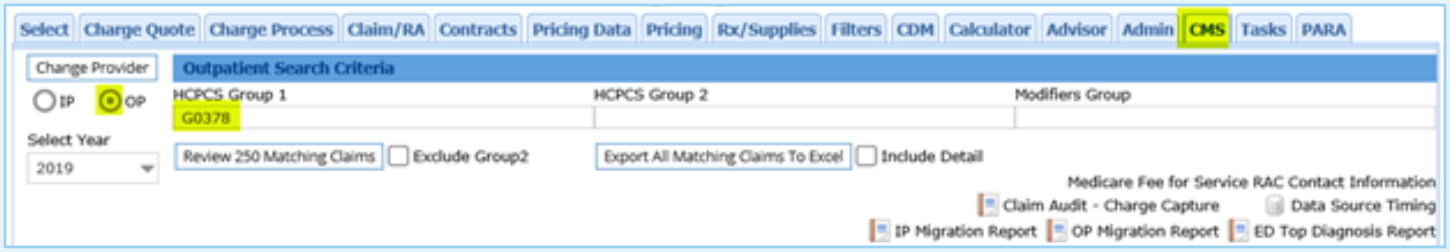
Audiology and Speech Therapy:

Effective January 1, 2020 Audiology and Speech Therapy benefits that had been previously eliminated have been reinstated with full benefits. Medi-Cal covers audiological services only when ordered by a physician. Audiological treatment services for full-scope Medi-Cal recipients under 21 years of age are available through Early and Periodic Screening, Diagnostic and Treatment Supplemental Services, subject to authorization when medically necessary.

REPORTING ALL OBSERVATION HOURS ON ONLY ONE CLAIM FORM

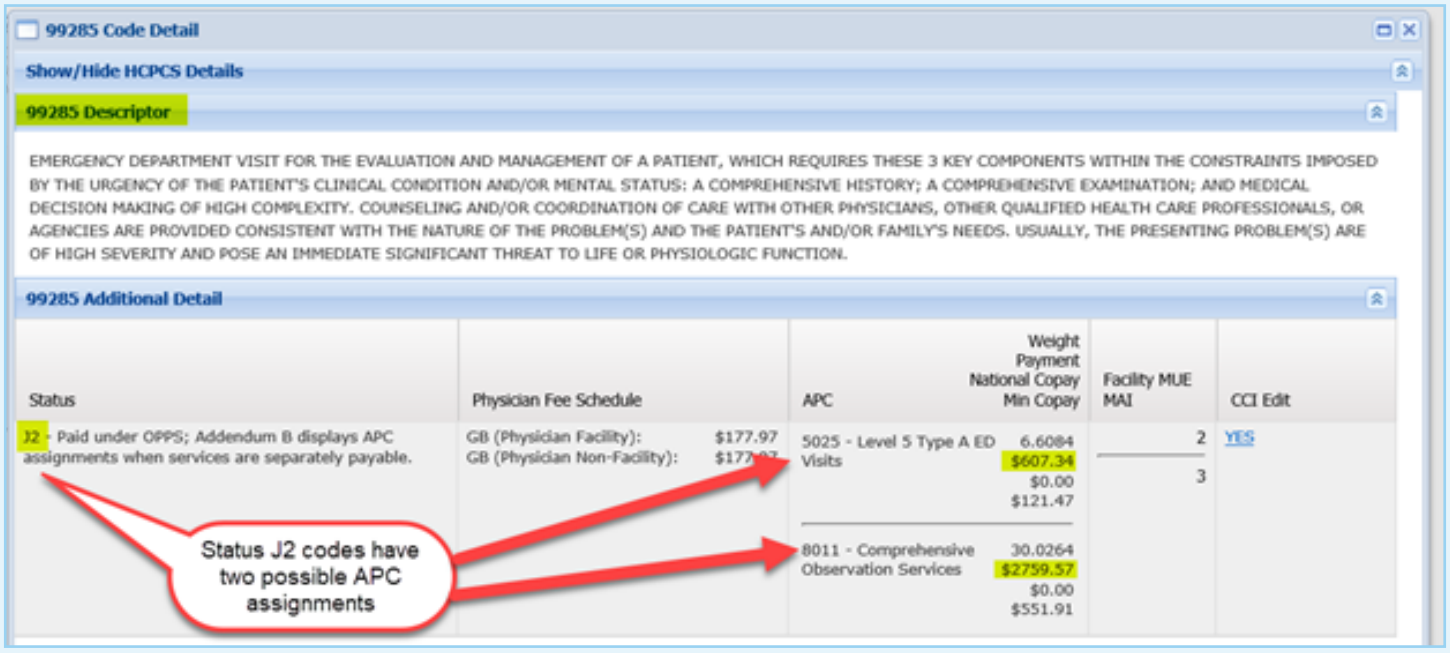
Chapter 4 of the Medicare Claims Processing Manual instructs hospitals to report all hours of observation on only one line of the claim, indicating the date on which observation care begins.If the hours are split on multiple lines, the claim may not be processed correctly, and reimbursement could be incorrectly reduced. **PARA** clients are encouraged to verify their own billing practices to ensure full reimbursement.

PARA Data Editor users can view their facility's observation billing practices by using the **PARA Data Editor's** CMS tab to view actual outpatient claims (scrubbed of Protected Health Information) submitted to Medicare in a prior period.Here's the tab settings to review claims reporting HCPCS G0378:



Under Medicare's OPPS reimbursement methodology, a higher-paying APC rate is paid on the evaluation and management (E/M) code if three criteria are met on the outpatient claim:

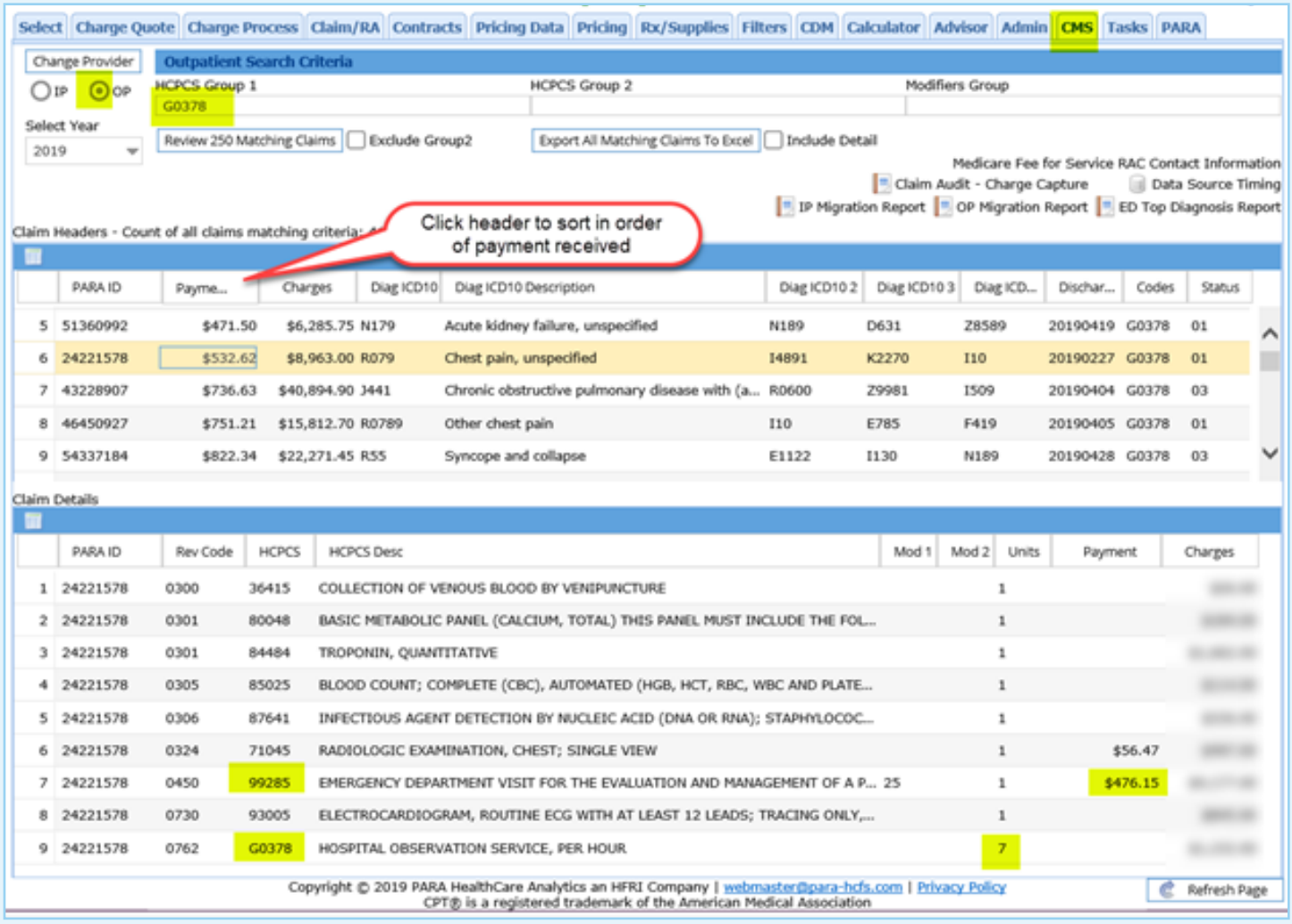
- At least 8 hours of observation care is reported (8 or more units of G0378)
- No status T or J1 surgical procedure was performed on the same day or day prior to observation care; and
- A hospital evaluation and management code is reported, such as an ED visit (99281-99285, 99291), an outpatient clinic visit (G0463), "direct referral to observation care" (G0379), or a "type b" emergency department visit (G0380-G0384). (These codes are all status J2 under OPPS.)



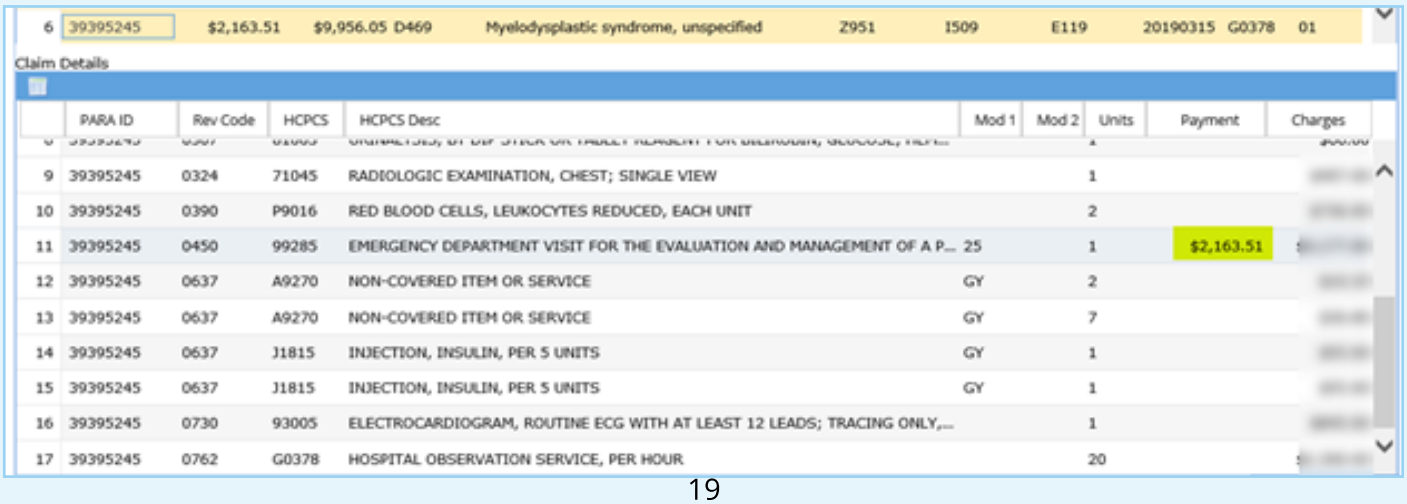
Medicare's claims processing software relies on the quantity reported on each line to determine the correct APC. It will not sum up two or more lines of G0378 to determine if the 8-unit minimum was met to pay the higher "comprehensive" observation care APC.

REPORTING ALL OBSERVATION HOURS ON ONLY ONE CLAIM FORM

Here's a 2019 claim on which 99285 was paid at the standard OPPS rate (rate shown is reduced by patient liability). Only seven hours of observation care were reported.

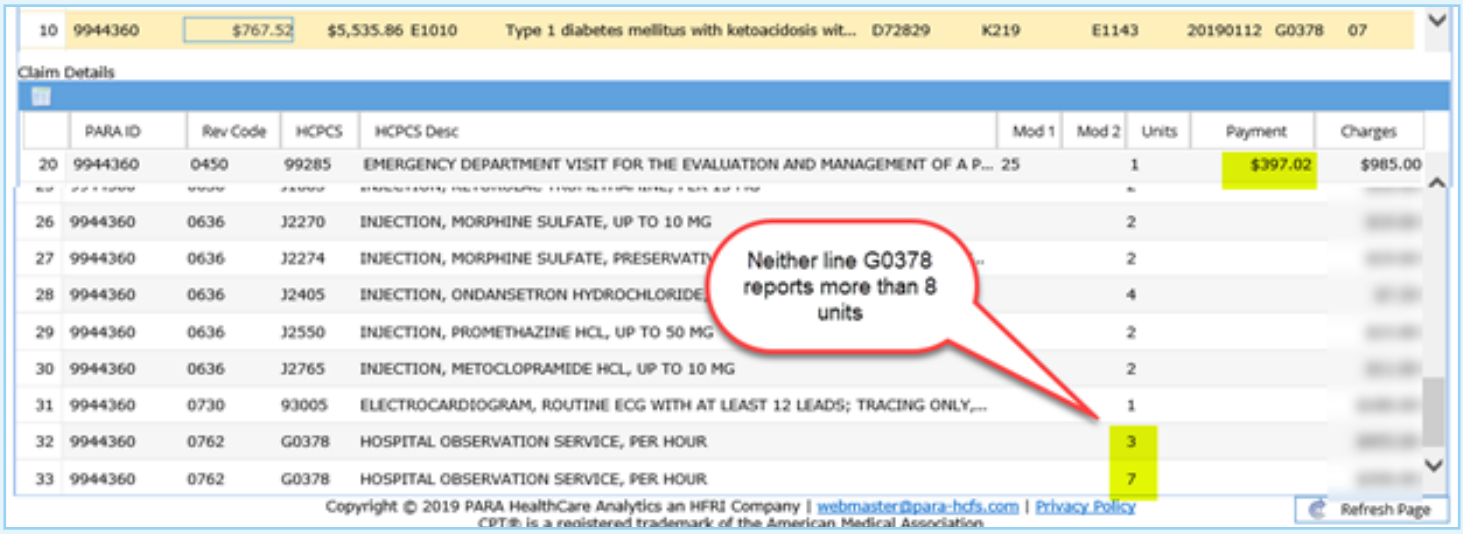


Here's a claim from the same facility reporting an ED visit, no surgical procedure, and 20 hours of observation care (G0378).Note that 99285 was paid at the higher "comprehensive observation" APC rate of $2,163 (which does not include that portion assigned to patient liability):



REPORTING ALL OBSERVATION HOURS ON ONLY ONE CLAIM FORM

The following claim from a different facility demonstrates the importance of reporting observation on one line only-–since two lines were reported, and neither line was more than 8 units (although together the two lines amounted to 11 units), the higher comprehensive observation APC was **not** paid on 99285:



The Medicare Claims Processing Manual instructs providers to report all hours of observation care on one line, using the date observation care began as the date of service on the claim:

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

290.2.2 - Reporting Hours of Observation

(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began

receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

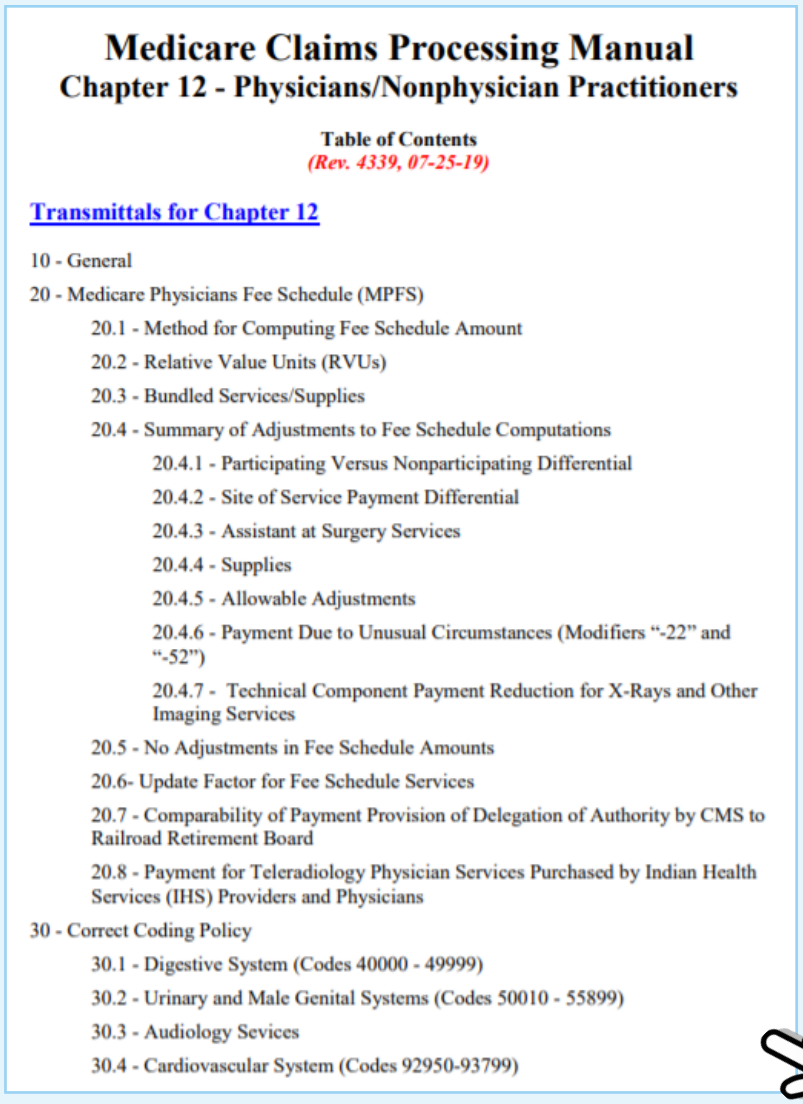
General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378.

REPORTING ALL OBSERVATION HOURS ON ONLY ONE CLAIM FORM

290.2.2 - Reporting Hours of Observation

(Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Observation time ends when all medically necessary services related to observation care are completed. For example, this could be before discharge when the need for observation has ended, but other medically necessary services not meeting the definition of observation care are provided (in which case, the additional medically necessary services would be billed separately or included as part of the emergency department or clinic visit). Alternatively, the end time of observation services may coincide with the time the patient is actually discharged from the hospital or admitted as an inpatient. Observation time may include medically necessary services and follow-up care provided after the time that the physician writes the discharge order, but before the patient is discharged. However, reported observation time would not include the time patients remain in the hospital after treatment is finished for reasons such as waiting for transportation home.If a period of observation spans more than 1 calendar day, all of the hours for the entire period of observation must be included on a single line and the date of service for that line is the date that observation care begins.



Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 4339, 07-25-19)

Transmittals for Chapter 12

THERAPIST VISITS TO EVALUATE HOME ENVIRONMENT

Several Critical Access Hospitals (CAHs) have inquired whether they may claim reimbursement for a physical therapist or occupational therapist's services in travelling to a patient's home to conduct a "Home Safety Visit" or a "home environment evaluation."

Typically, this visit follows discharge from an inpatient stay; in some instances, the therapist plans to visit the home prior to the patient's discharge.

Acute care hospitals (including CAHs) are not reimbursed by Medicare or other commercial carriers for home safety or environment evaluations. If the hospital wishes to offer home environment evaluations, **PARA** recommends partnering with a home health agency as the vehicle to deliver the service, or offering the service on a private-pay basis. (Incidentally, Home Health agencies are not directly reimbursed by Medicare for each service rendered, but for each 60-day "episode" of care based on acuity.)

Nether Medicare nor commercial payors expect acute care hospitals to provide this service. In general, Medicare covers medically necessary services provided by hospitals when performed for the patient directly, rather than indirectly in assessing the patient's environment. Home Health agencies and Comprehensive Outpatient Rehab Facilities (CORFs), however, may be reimbursed by Medicare if the home environment evaluation service meets medical necessity requirements.

Although there are no details of reimbursement rates or HCPCS codes, the Medicare Benefits Policy Manual indicates that a "Home Environment Evaluation" may be covered when performed by a Comprehensive Outpatient Rehab Facility (CORF) as part of the overall treatment plan. The purpose of this assessment is to permit the rehabilitation plan of treatment to be tailored to take into account the patient's home environment. (Unfortunately, neither the Benefits Manual nor the Medicare Claims Processing Manual offer guidance on billing for home environment evaluations.)

To be become a CORF, organizations must enroll under Medicare as a Comprehensive Outpatient Rehab Facility. Here is a link and an excerpt to Medicare's CORF information website:

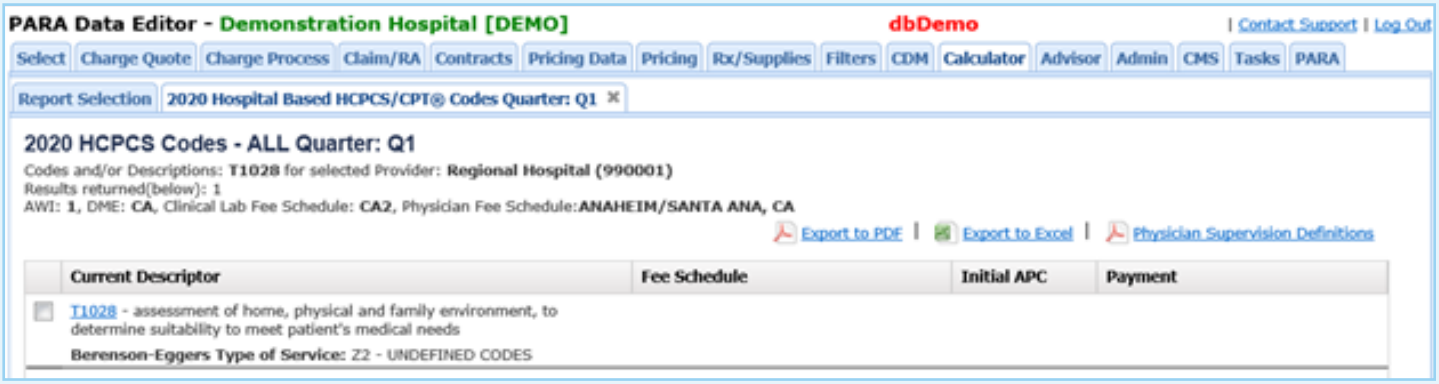
https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CORFs

Comprehensive Outpatient Rehabilitation Facilities

This page provides basic information about being certified as a Medicare and/or Medicaid Comprehensive Outpatient Rehabilitation Facility (CORF) provider and includes links to applicable laws, regulations, and compliance information.

THERAPIST VISITS TO EVALUATE HOME ENVIRONMENT

To report this service, we identified only HCPCS T1028 (Assessment of home, physical and family environment, to determine suitability to meet patient's medical needs), which is not covered by Medicare under OPPS or the Physician Fee Schedule:



Here's a link and an excerpt from the Medicare Benefits Policy Manual, Chapter 12 - Comprehensive Outpatient Rehabilitation Facility (CORF) Coverage:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c12.pdf

40.10 - Home Environment Evaluation
(Rev. 111, Issued: 09-25-09; Effective Date: 07-07-08; Implementation Date: 10-26-09)

One single, home environment evaluation visit is a covered CORF service if it is included in the physical therapy, occupational therapy or speech-language pathology plan of treatment. The single home environment evaluation visit allows the evaluation of the patient in the home environment and the assessment of the potential impact on the patient's rehabilitation goals. The purpose of the home environment evaluation is to permit the rehabilitation plan of treatment to be tailored to take into account the patient's home environment. However, Medicare does not pay for physical alterations to the home that facilitates the patient's rehabilitation. The patient must be present during the home environment evaluation visit, which must be performed by the physical therapist, occupational therapist or speech-language pathologist, as appropriate. The patient's presence is necessary to fully evaluate the potential impact of the home situation on the rehabilitation goals as specified in the plan of treatment.

The home environment evaluation visit is not covered as a routine service for all CORF patients. It is covered only if, in establishing or carrying out the physical therapy, occupational therapy, or speech-language pathology plan of treatment, there is a clear indication that the home environment might adversely affect the patient's rehabilitation. Coverage is limited to the services of one professional, either a physical therapist, occupational therapist, or a speech-language pathologist who provides the therapy services established in the corresponding plan of treatment that identifies the necessity for the home environment evaluation visit.

Unless the CAH is enrolled as a CORF, **PARA** recommends offering home safety or environment assessment services on a private-pay basis at a fixed rate plus travel reimbursement at a per-mile rate. The hospital should be sure to provide an Advanced Beneficiary Notice to Medicare beneficiaries prior to conducting the service.

Resolution | Recovery | Management

HFRI is altering the hospital AR landscape by delivering unparalleled speed, scalability and accuracy to the insurance AR management process. Through our proprietary, intelligent automation and powerful process engineering, we're able to resolve all claims, regardless of size or age. That means you're able to recover collections from insurance claims that otherwise would have been written off.

Our AR management services are easily integrated into your hospital's existing workflow to seamlessly function as an extension to your existing billing office. **HFRI** specialists collaborate with your team not only to assist with your denial management initiatives but to identify root causes that will help prevent denials from occurring in the first place.

Specialized Services to Improve AR Performance

HEALTHCARE FINANCIAL RESOURCES

HFRI's scalable, client-specific solutions allow hospitals to systematically address problem claims across the full AR spectrum, from government and commercial payers to managed care, worker's compensation and personal injury claims.

Our capabilities include:

- Primary AR recovery and resolution
  We pursue aging, small-balance claims identified by your staff as problematic. If a claim has previously been worked internally, referring it to **HFRI's** dedicated, specialized teams can help ensure quicker cash conversion and a reduction of bad debt reserves.

- Pre write-off AR recovery and resolution
  In addition to primary AR recovery and management services, **HFRI** also offers pre write-off (often known as secondary) insurance AR recovery to help you collect highly-aged claims and minimize write-offs.

- Legacy system conversions
  Transitioning to a new system can slow down the claims process and create problems for hospital personnel who must work between two billing platforms. **HFRI** can provide interim solutions to help you accelerate pre-conversion cash and assist with post-conversion AR resolution. AR recovery projects: **HFRI** is available to assist you on a temporary project basis to address AR backlogs that can't be worked by your existing staff.

SIX STEPS FOR DEPLOYING AI SOLUTIONS IN DENIAL MANAGEMENT

Hospitals' attempts to resolve denied insurance claims can be costly, time-consuming and frequently unsuccessful. As a result, many facilities choose to ignore high-volume, lower-value claims to concentrate their limited manpower and technology resources on only the most valuable, big-ticket denials.

Unfortunately, this triage process means facilities and health systems often end up leaving large amounts of insurance company money on the table. And that's something few providers can afford to do in today's challenging economic environment.

The good news is that intelligent automation and data mining capabilities are transforming accounts receivable (AR) recovery and resolution by reducing the human touches necessary to identify the root causes of payment delays, underpayments and denials.

Armed with knowledge about how and why denials are occurring, outsourced remediation specialists can work far more efficiently and effectively to resolve unpaid claims. Just as important, intelligent automation is able to remedy the simplest denials or delays with no human intervention whatsoever. Together, these breakthrough capabilities accelerate claims resolution, reduce write-offs and improve hospital cash flow.

Healthcare Financial Resources (HFRI) is an industry leader in utilizing intelligent automation to transform denial management and maximize collections. The company follows a systematic, 6-step process that produces optimal speed and success in addressing all denials, regardless of type, age or amount.

A growing problem

Healthcare AR follow-up traditionally has been highly dependent on manual intervention. Because the reasons for denying or delaying claims can vary greatly from carrier to carrier, trained personnel must analyze each unresolved payment and associated payer rules to determine the underlying cause and what, if any, action can be taken.

This process can be extremely time-consuming and usually involves multiple conversations with the insurance company representative. As payer contracts and reimbursement requirements have become more complex and the volume of denials has increased, the ability of staff to keep pace has diminished.

SIX STEPS FOR DEPLOYING AI SOLUTIONS IN DENIAL MANAGEMENT

The problem of timely resolution is compounded by the fact that denial management staffers often lack the knowledge required to address the full range of denial types once the underlying cause has been identified. This means that for most hospitals, the growing volume of increasingly complicated denials has led to a steadily rising backlog of aging, unresolved accounts.

Managers consequently are left with no recourse but to focus limited resources only on those claims that offer the greatest potential return. Generally, that means low-value, high-volume denials, or those that have aged beyond a certain date, are written off.

Healthcare AR follow-up traditionally has been highly dependent on manual intervention.

Recent analysis found that hospital claims totaling $262 billion were denied in 2016; an amount representing about 9% of all healthcare transactions.[1] The cost of remediating denials through appeal, meanwhile, averaged $118 per claim, or $8.6 billion for U.S. hospitals overall.[2]

Yet only about 65% of payer rejections are reworked and resubmitted.[3] The reality is that write-offs have increased dramatically for the average 350-bed hospital in recent years, up 79% from $3.9 million to $7 million between 2011 and 2017, according to the Advisory Board.[3]

HFRI's 6-step process for harnessing intelligent automation

HFRI has focused exclusively on the challenges associated with hospital payment delay and denial resolution for nearly 20 years. From this effort, we've perfected a system that utilizes a combination of robotic process automation (RPA), intelligent automation and staff specialization to streamline and accelerate the resolution process.

RPA software can be programmed to accomplish basic tasks across applications by replicating manual human activity. Intelligent automation takes this a step further by incorporating machine learning and decision-making logic into the process. The result is incrementally improved decisions as the number of cases or variances increase.

HFRI's intelligent automation process utilizes the following steps to help ensure your organization collects everything you're entitled to in a timely manner:

1. **Collecting information:** Proprietary bot applications scrape denied claims, hospital billing systems, EDI applications and other transactional data for all available intelligence related to a specific account. This information can include everything from denial codes and payment and service history to contractual information and filing deadlines

2. **Automating resolution:** From this aggregation, common, relatively simple barriers to account resolution, such as misallocated remittances, can be identified and addressed automatically through artificial intelligence applications. This automated functionality greatly decreases resolution cycle time for the simplest denials

3. **Categorizing by root cause:** The remaining denials are categorized by root cause into separate buckets or work queues. Root cause categories can range from contractual, registration and clinical issues to coding, coverage and utilization denial triggers. Succinct summaries of all relevant information are developed for each denied, delayed or underpaid claim

SIX STEPS FOR DEPLOYING AI SOLUTIONS IN DENIAL MANAGEMENT

4. **Organizing complex denial data:** Working from category-specific, prioritized work queues, HFRI remediation specialists access the summary screens for each claim. This detailed information, combined with the specialist's in-depth knowledge about how best to resolve a specific type of issue, allows them to expedite rework and secure resolution for both high- and low-value claims much more quickly

5. **Identifying all relevant payer deadlines:** Beyond categorizing and prioritizing claims by root cause, intelligent automation also identifies all relevant payer deadlines associated with each claim. Equipped with this knowledge, the resolution specialist is cognizant of the available window in which to work, resubmit and/or appeal the denial

6. **Recommending process improvements:** HFRI additionally provides clients with recommended process improvements that can help decrease aged and denied claims at the front end of the revenue cycle once root causes are identified. Comprehensive reporting likewise is generated to provide trends and other insights into the entire A/R portfolio.

A proven solution

HFRI's process sets the company apart from other third-party AR management recovery and resolution firms. While many vendors rely on standard denial management technologies, HFRI has combined proven intelligent automation with deep subject matter expertise in the areas of revenue cycle workflow, process management and claims resolution. The result is a comprehensive, hybrid approach that addresses every claim, regardless of size, to generate tangible results for clients.

For most hospitals, HFRI's AR management solution typically increases cash collections by 30% versus a non-automated approach, and some clients have seen collections jump by as much as 100%. In addition, the lifecycle for resolving a claim is generally reduced by 25% or more. And thanks to ongoing process improvement guidance provided by HFRI, the volume of denials, delays and underpayments is usually reduced by 20-25%.

No margin for error

In an earlier era, denials were frequently viewed as simply an annoyance by hospitals and the process for resolving them was straightforward. In any case, the amount of money at stake was usually modest when compared to an organization's overall revenue.

Today the landscape has changed substantially. Increasingly complex payer contracts, coupled with expanding payer rules and restrictions, have greatly increased the number of denials and the level of financial risk they present. Hospitals can no longer afford to write off high-volume, low-value claims simply because they lack the resources to pursue them.

HFRI combines advanced technology and staff specialization to rebalance the provider-payer dynamic and assist hospitals in finally overcoming the critical financial problem that denials represent. For more information about how HFRI can help your organization. Contact us today.

1. Philip Betbeze, "Claims Appeals Cost Hospitals Up to $8.6B Annually," HealthLeaders, June 26, 2017

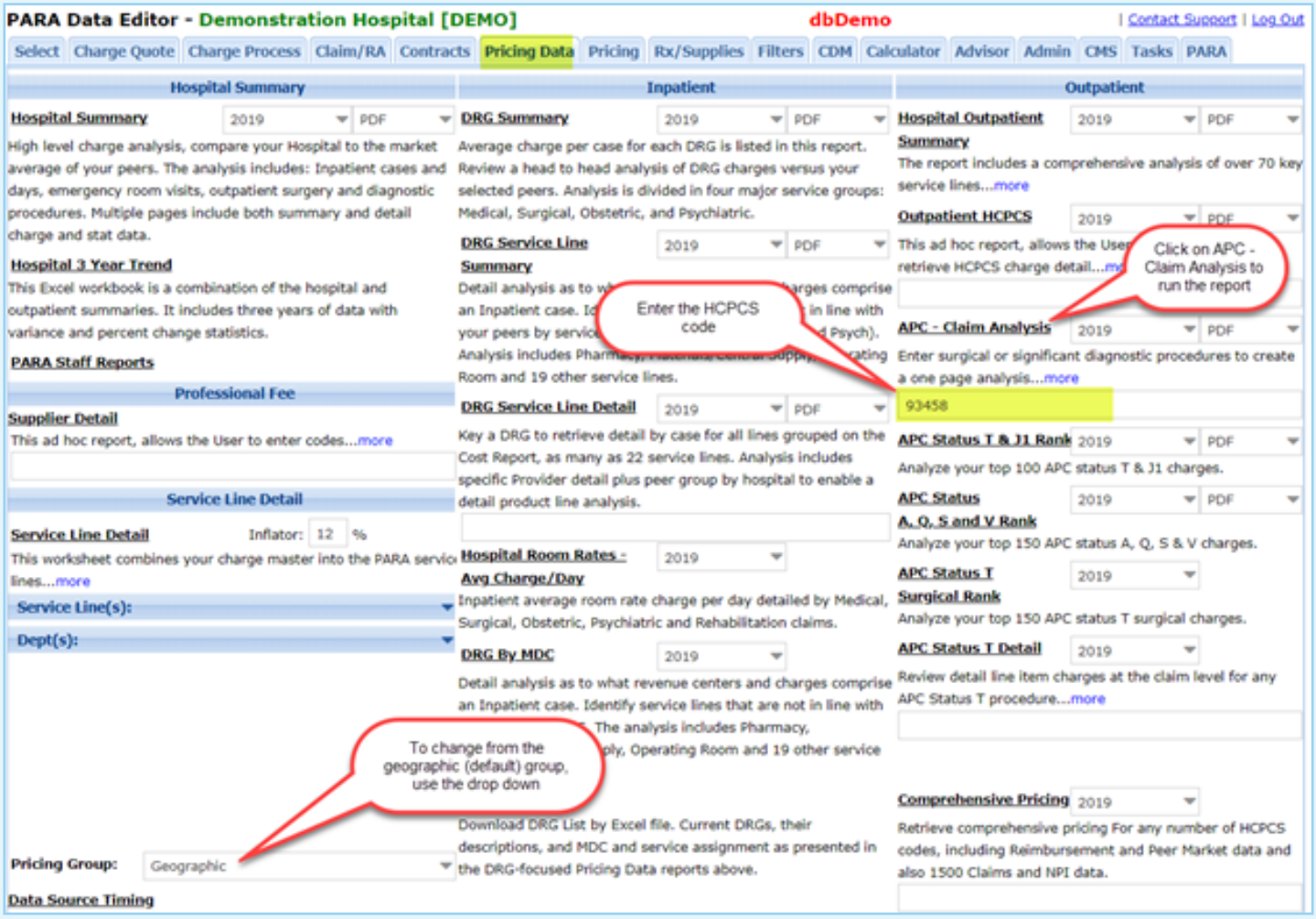
2. Ibid.

3. Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA, July 7, 2015

4. Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018

PDE PRICING DATA REPORT -- APC CLAIM ANALYSIS

Hospitals often express an interest in the billing practices of hospitals aligned with their geographic market group. The **APC Claim Analysis** ad hoc report provides CMS claims data on surgical or significant diagnostic procedures to create a comparative analysis of your hospital's data to the national norm.



The report lists the HCPCS code requested with its APC Reimbursement. The report then provides APC status and reimbursement for each of the procedures, drugs, and supplies found on other claims with that HCPCS code. The percentages listed in the Hospital Peer Group and the National columns indicate how often a procedure was billed with the HCPCS code that was requested.

Only separately payable OPPS codes will return results. These consist of status J1, J2 and T codes. Other codes such as status N (not separately paid under OPPS), or status Q1, Q2, Q3, or Q4 (paid or packaged under OPPS) and status A (paid on the Physician Fee Schedule, such as physical therapy services) will not return results.

As an example, please see the snippet of the report requesting information on HCPCS 93458 catheter placement in coronary artery(s) for coronary angiography, C1769 Guide Wire, was reported on 100% of the claims within the hospital's peer group and 77% nationally. Likewise, hospitals within the peer group reported J1644 Injection, Heparin Sodium, 1000 units on 100% and nationally hospitals reported the

PDE PRICING DATA REPORT -- APC CLAIM ANALYSIS

J1644 72.2% of the time. The report can be formatted in PDF or in Excel; a sample of the PDF version is provided below.

The report can be run with different market groups by using the drop-down in Pricing Group in the lower left corner of the **Pricing Data** tab.

Demonstration Hospital — **Claim Summary** — Outpatient Medicare Limited Data Set - Calendar Year 2019

Geographic Market Group — 2020 ADDB Query: 93458

HCPCS Code	Description	APC Status	Reimbursement		Hospital	Peer Group	National
93458	CATHETER PLACEMENT IN CORONARY ARTERY(S) FOR CORONARY ANGIOGRAPHY, INCLUDING INTRAPROCEDURAL INJECTION(S) FOR CORONARY ANGIOGRAPHY, IMAGING SUPERVISION AND INTERPRETATION; WITH LEFT HEART CATHETERIZATION INCLUDING INTRAPROCEDURAL INJECTION(S) FOR LEFT VENTRICULOGRAPHY, WHEN PERFORMED	J1	2,849.63	APC	143,808 Total Claims Peer Claims 4 Hospital Claims		
99153	MODERATE SEDATION SERVICES PROVIDED BY THE SAME PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL PERFORMING THE DIAGNOSTIC OR THERAPEUTIC SERVICE THAT THE SEDATION SUPPORTS, REQUIRING THE PRESENCE OF AN INDEPENDENT TRAINED OBSERVER TO ASSIST IN THE MONITORING OF THE PATIENT'S LEVEL OF CONSCIOUSNESS AND PHYSIOLOGICAL STATUS; EACH ADDITIONAL 15 MINUTES INTRASERVICE TIME (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY SERVICE)	N	12.57	PROFEE			25.6 %
99285	EMERGENCY DEPARTMENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES THESE 3 KEY COMPONENTS WITHIN THE CONSTRAINTS IMPOSED BY THE URGENCY OF THE PATIENT'S CLINICAL CONDITION AND/OR MENTAL STATUS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY. COUNSELING AND/OR COORDINATION OF CARE WITH OTHER PHYSICIANS, OTHER QUALIFIED HEALTH CARE PROFESSIONALS, OR AGENCIES ARE PROVIDED CONSISTENT WITH THE NATURE OF THE PROBLEM(S) AND THE PATIENT'S AND/OR FAMILY'S NEEDS. USUALLY, THE PRESENTING PROBLEM(S) ARE OF HIGH SEVERITY AND POSE AN IMMEDIATE SIGNIFICANT THREAT TO LIFE OR PHYSIOLOGIC FUNCTION.	J2	504.46	APC			7.8 %
A9270	NON-COVERED ITEM OR SERVICE	E1					26.3 %
C1725	CATHETER, TRANSLUMINAL ANGIOPLASTY, NON-LASER (MAY INCLUDE GUIDANCE, INFUSION/PERFUSION CAPABILITY)	N					24.2 %
C1760	CLOSURE DEVICE, VASCULAR (IMPLANTABLE/INSERTABLE)	N			50.0 %		26.0 %
C1769	GUIDE WIRE	N			100.0 %		77.0 %
C1874	STENT, COATED/COVERED, WITH DELIVERY SYSTEM	N					21.4 %
C1887	CATHETER, GUIDING (MAY INCLUDE INFUSION/PERFUSION CAPABILITY)	N					53.6 %
C1894	INTRODUCER/SHEATH, OTHER THAN GUIDING, OTHER THAN INTRACARDIAC ELECTROPHYSIOLOGICAL, NON-LASER	N			50.0 %		71.8 %
C9600	PERCUTANEOUS TRANSCATHETER PLACEMENT OF DRUG ELUTING INTRACORONARY STENT(S), WITH CORONARY ANGIOPLASTY WHEN PERFORMED; SINGLE MAJOR CORONARY ARTERY OR BRANCH	J1	9,907.37	APC			19.7 %
G0378	HOSPITAL OBSERVATION SERVICE, PER HOUR	N					13.0 %
J0153	INJECTION, ADENOSINE, 1 MG (NOT TO BE USED TO REPORT ANY ADENOSINE PHOSPHATE COMPOUNDS)	N			25.0 %		5.5 %
J0360	INJECTION, HYDRALAZINE HCL, UP TO 20 MG	N			25.0 %		5.0 %
J0583	INJECTION, BIVALIRUDIN, 1 MG	N					7.6 %
J1200	INJECTION, DIPHENHYDRAMINE HCL, UP TO 50 MG	N					7.5 %
J1644	INJECTION, HEPARIN SODIUM, PER 1000 UNITS	N			100.0 %		72.2 %
J2001	INJECTION, LIDOCAINE HCL FOR INTRAVENOUS INFUSION, 10 MG	N					14.9 %

Hospitals should exercise caution interpreting this data. This report provides information on billing practices that are common for hospitals outpatient claims submitted to Medicare – common billing practices are not necessarily compliant billing practices.

NEW YEAR'S RESOLUTION #1: GET PDE FIT

In an effort to streamline the **PARA Data Editor (PDE)** training process, **PARA** will begin hosting weekly Overviews of the **PDE**. These sessions will be open to any client or user who wishes to join, and will consist of a high-level review of the functionality available within the **PDE**. If you are new to the **PDE**, or would like a refresher on its capabilities, please join us at whichever session is most convenient for you.

Beginning January 8, 2020 Overview sessions will be held:

Wednesdays at 11:00 am Pacific time
(12:00 pm Mountain, 1:00 pm Central, 2:00 pm Eastern)

Fridays 8:00 am Pacific time
(9:00 am Mountain, 10:00 am Central, 11:00 am Eastern)

Please note, focused training for your staff on the modules of the **PDE** that you choose to utilize will still be available.

If you are interested in attending one of the sessions, please email Mary McDonnell, Director of PDE Training and Development at mmcdonnell@para-hcfs.com. An invitation to the session of your choice will be emailed to you. If you have any questions, please email us at the address above or call (800) 999-3332 ext. 216.

MLN CONNECTS

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

Thursday, February 6, 2020

News

·Open Payments Registration

·Promoting Interoperability Programs: Deadline to Submit 2019 Data is March 2

·Quality Payment Program: Updated Explore Measures Tool

·Quality Payment Program: MIPS 2020 Call for Measures and Activities

·Medicare Promoting Interoperability Program: Requirements for 2020

·SNF Quality Reporting Program: FY 2022 APU Table

·Reassignment of Medicare Benefits: Revised CMS-855R Required May 1

·February is American Heart Month

Compliance

·Outpatient Rehabilitation Therapy Services: Comply with Medicare Billing Requirements

Claims, Pricers & Codes

·ICD-10-CM: New Diagnosis Code for Vaping-related Disorders Effective April 1

Events

·Substance Use Disorders: Availability of Benefits Listening Session — February 18

·Ground Ambulance Organizations: Reporting Volunteer Labor Call — February 20

·Dementia Care: CMS Toolkits Call — March 3

·Part A Providers: QIC Appeals Demonstration Call — March 5

MLN Matters® Articles

·Provider Enrollment Appeals Procedure

·Quarterly Influenza Virus Vaccine Code Update - July 2020

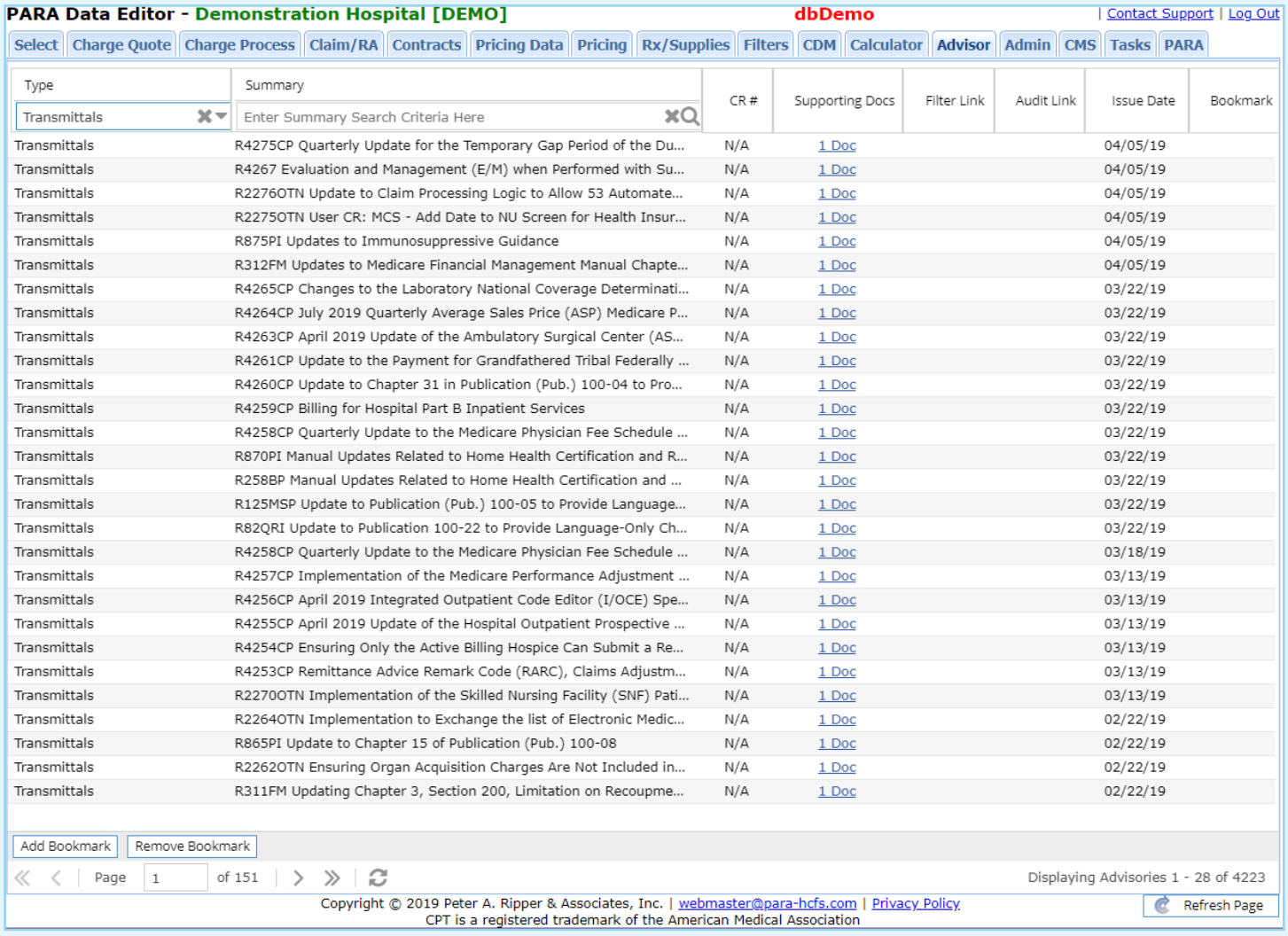
·2020 Annual Update to the Therapy Code List — Revised

·2020 Durable Medical Equipment Prosthetics, Orthotics, and Supplies Healthcare Common Procedure Coding System (HCPCS) Code Jurisdiction List — Revised

There were THREE new or revised MedLearns 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** 3



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

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The link to this MedLearn MM11632

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KNOWLEDGE • RESOURCES • TRAINING

Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

MLN Matters Number: MM11632 | Related Change Request (CR) Number: 11632

Related CR Release Date: February 7, 2020 | Effective Date: July 1, 2020

Related CR Transmittal Number: R2431OTN | Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Skilled Nursing Facilities (SNFs) and hospital swing bed providers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11632 alerts providers that CR11152 erroneously made modifications to edits and the Centers for Medicare & Medicaid Services (CMS) needs to omit and make corrections to allow for proper claims processing. (See the related MLN Matters article at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11152.pdf.) Make sure your billing staffs are aware of these changes.

BACKGROUND

CR11632 implements changes to the SNF Prospective Payment System (PPS), specifically changes required for the Patient Driven Payment Model (PDPM). SNFs billing on Type of Bill (TOB) 21X and hospital swing bed providers billing on TOB 18X (subject to SNF PPS) are subject to these requirements. No policy changes exist with CR11632.

The corrected edits allow proper adherence to Medicare's interrupted stay policy. That policy is as follows for SNF PDPM and should only apply to SNF PPS providers:

- If a resident is discharged from a SNF and returns to the same SNF by the end of the third day of the interruption window, the resident's stay is treated as a continuation of the previous stay for purposes of resident classification and the variable per diem adjustment schedule.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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KNOWLEDGE • RESOURCES • TRAINING

Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy

MLN Matters Number: MM11559

Related Change Request (CR) Number: 11559

Related CR Release Date: February 7, 2020

Effective Date: July 1, 2020

Related CR Transmittal Number: R2429OTN

Implementation Date: July 6, 2020

PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, hospitals, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR 11559 informs MACs about changes to Medicare Common Working File (CWF) edits to ensure the original 1-Day and 3-Day Payment Window edits' set and bypass conditions are consistent with current policy.

There are no policy changes. Current policy is in the Medicare Claims Processing Manual, Chapter 4, Section 10.12, "Payment Window for Outpatient Services Treated as Inpatient Services" and Chapter 3, Section 40.3, "Outpatient Services Treated as Inpatient Services".

ADDITIONAL INFORMATION

The official instruction, CR11559, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r2429otn.pdf.

Note: The business requirements of CR11559 are effective for all dates of service processed on or after January 6, 2020.

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

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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The link to this MedLearn MM11656

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KNOWLEDGE • RESOURCES • TRAINING

Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder

MLN Matters Number: MM11656 | Related Change Request (CR) Number: 11656

Related CR Release Date: February 7, 2020 | Effective Date: April 1, 2020

Related CR Transmittal Number: R2433OTN | Implementation Date: July 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Home Health Agencies (HHAs) billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11656 updates the version of the Home Health Grouper software used in Original Medicare claims processing. The new version includes the diagnosis code (U07.0) recently created for vaping related disorder. Make sure your billing staffs are aware of the update.

BACKGROUND

In response to recent occurrences of vaping related disorders, the Centers for Disease Control and Prevention's National Center for Health Statistics (CDC/NCHS) is implementing a new diagnosis code into the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) for reporting vaping-related disorder effective April 1, 2020.

The Grouper Contractor, 3M Health Information Systems (3M-HIS), developed the new HH Grouper, Version 01.1.20, software package to accommodate this new code, effective for claim From dates on or after April 1, 2020. The HH Grouper assigns each claim into a Home Health Resource Group (HHRG) based on the reported claim and patient assessment information.

The revised HH Grouper and related documentation will be available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.

There is no policy change. Current instructions regarding the HH Grouper are available in the Medicare Claims Processing Manual Publication, Chapter 10, Section 80.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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There were SEVEN new or revised Transmittals released this week.

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

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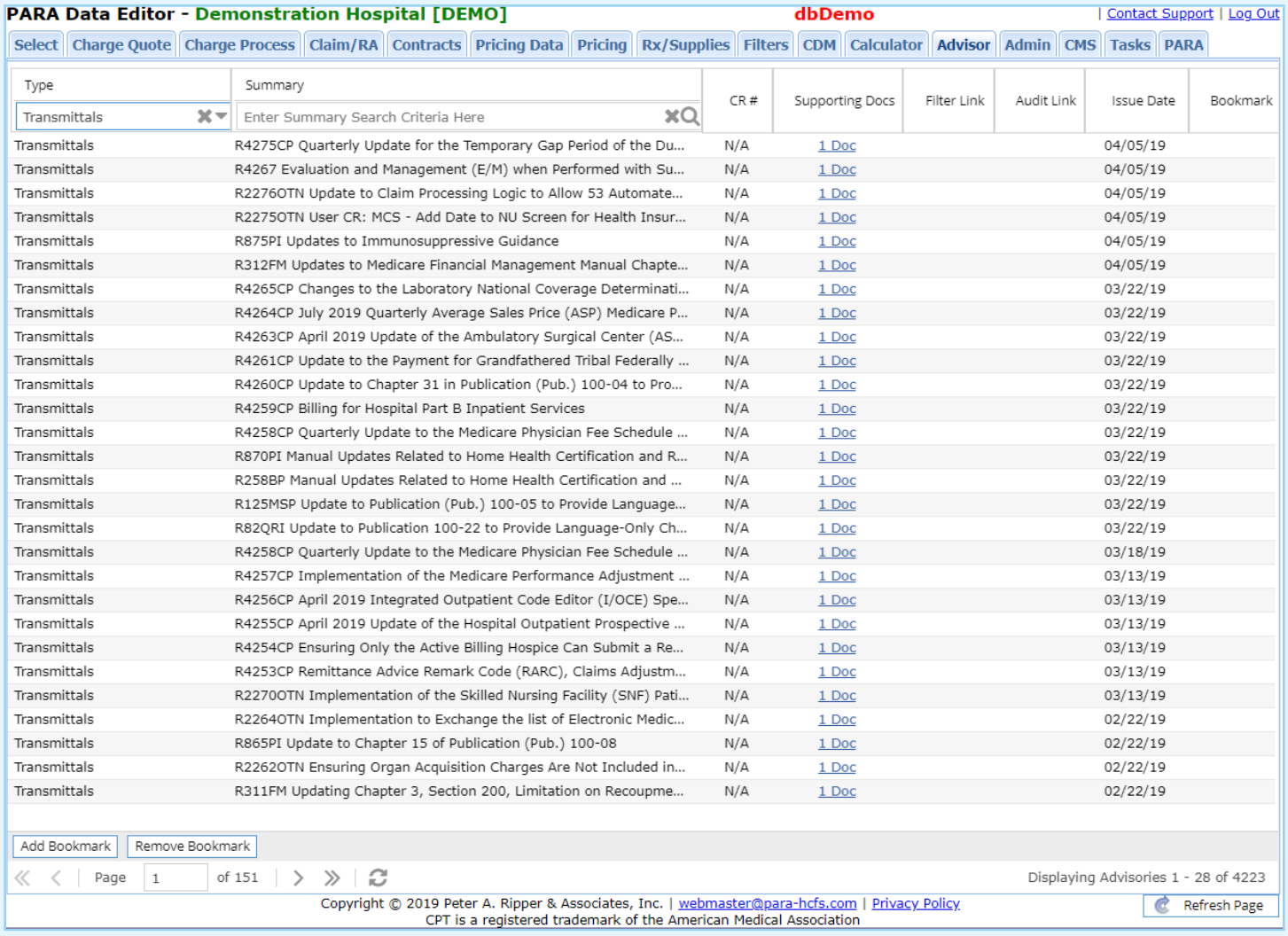

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The link to this Transmittal R336FM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 336	**Date: February 7, 2020**
	Change Request 11486

SUBJECT: Pub. 100-06, Chapter 4, Section 110 (Confirmed Identity Theft) Revision

I. SUMMARY OF CHANGES: The Change Request (CR) will revise Pub. 100-06, Chapter 4, section 110 (Confirmed Identity Theft). The revisions will include the new instruction for the contractor to adjust down all overpayments (debts) related to the confirmed identity theft of a provider or supplier.

EFFECTIVE DATE: May 8, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 8, 2020

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

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

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/110/Confirmed Identity Theft
D	4/110.1/IRS Form 1099 MISC

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

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

The link to this Transmittal R2431OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2431	**Date: February 7, 2020**
	Change Request 11632

SUBJECT: Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)

I. SUMMARY OF CHANGES: This Change Request (CR) contains updates/corrections to the SNF PDPM.

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

III. FUNDING:
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IV. ATTACHMENTS:
One Time Notification

The link to this Transmittal R2429OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2429	**Date: February 7, 2020**
	Change Request 11559

SUBJECT: Updates to Ensure the Original 1-Day and 3-Day Payment Window Edits are Consistent with Current Policy

I. SUMMARY OF CHANGES: The purpose of this change request is to ensure the original 1-Day and 3-Day Payment Window edits' set and bypass conditions, implemented in 1990, are consistent with current policy.

EFFECTIVE DATE: July 1, 2020 - The business requirements are effective for all dates of service processed on or after January 6, 2020.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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IV. ATTACHMENTS:

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The link to this Transmittal R2433OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2433	**Date: February 7, 2020**
	Change Request 11656

SUBJECT: Update to the Home Health Grouper for New Diagnosis Code for Vaping Related Disorder

I. SUMMARY OF CHANGES: This Change Request updates the version of the Home Health Grouper software used in Original Medicare claims processing. The new version includes the diagnosis code recently created for vaping related disorder.

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

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IV. ATTACHMENTS:
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The link to this Transmittal R4519CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4519	**Date: February 7, 2020**
	Change Request 11591

SUBJECT: File Conversions Related to the Spanish Translation of the Healthcare Common Procedure Coding System (HCPCS) Descriptions

I. SUMMARY OF CHANGES: This Change Request (CR) provides direction for the contractors to perform any necessary file conversions related to the Spanish translation of the HCPCS descriptions provided by First Coast Service Options (FCSO) on a quarterly basis. This recurring update notification applies to chapter 21, section 20. FCSO is providing these updates to the contractors because FCSO is the entity that translates the HCPCS descriptions into Spanish for the Centers for Medicare & Medicaid Services.

EFFECTIVE DATE: April 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2020 - or no later than 30 days after receipt of the quarterly HCPCS description updates sent by FCSO, or as soon as FISS and VMS are able to upload the file in a subsequent release.

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R2430OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2430	**Date: February 7, 2020**
	Change Request 11569

SUBJECT: Update to the Fiscal Intermediary Shared System (FISS) Integrated Outpatient Code Editor (IOCE) Claim Return Buffer

I. SUMMARY OF CHANGES: This Change Request (CR) will implement the usage of the full array of claims processed flags in the Claim Return Buffer Table.

EFFECTIVE DATE: July 1, 2020 - Claims received on or after the effective date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

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The link to this Transmittal R2428OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2428	**Date: February 7, 2020**
	Change Request 11522

SUBJECT: Multi-Carrier System (MCS) Financial Changes for Combining Pay Alone Payments in the Healthcare General Ledger Accounting System (HIGLAS) Payment Sets

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to enhance the MCS and HIGLAS Pay Alone process for Part B payment sets within each system and to discontinue the creation of separate "pay alone" incentive payments, with the exception of Health Professional Shortage Area (HPSA) bonus payments. This CR also instructs the contractors to generate a single consolidated payment, similar to the FISS Part A shared system, eligible for netting during the HIGLAS payment batch processing.

EFFECTIVE DATE: July 1, 2020 - Functional Design and Development; October 1, 2020 - Testing, Technical Design and Implementation
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020 - Functional Design and Development; October 5, 2020 - Testing, Technical Design and Implementation

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IV. ATTACHMENTS:

One Time Notification

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