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PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

July 17, 2019

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HEALTHCARE FINANCIAL RESOURCES

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

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

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FAST LINKS

BILLING CPT® 37195

Q. Should an outpatient Critical Access Hospital emergency department claim report CPT® 37195 for both the professional fee (revenue code 0981, PROFESSIONAL FEES - EMERGENCY ROOM SERVICES) and as a facility fee (we presume revenue code 0450 – EMERGENCY ROOM)? The claim is in "T" status in the Medicare system.

A. CPT® 37195 (Thrombolysis, cerebral, by intravenous infusion) is split-billable (both as a professional fee and as a facility fee) in the outpatient hospital setting. The professional reimbursement rate is "contractor priced", which simply means there is not an established fee schedule for the procedure at the national level. Noridian is authorized to set whatever professional fee reimbursement rate they decide is appropriate.

We investigated CPT® 37195 at the request of another client who questioned whether it was appropriate to report 37195 if the drug Activase was administered by IV injection, not infusion (which is gradual, an administration over at least 31 minutes.)

We posed that question to the AMA, and they responded that it would not be appropriate to report 37195 if the drug was injected; it is only appropriate if the drug is infused.

PARA offers guidance that if the start/stop time documentation for an infusion (96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour) does not support at least 31 minutes of administration, the facility may instead report 96374 - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug.)

Under OPPS, both an IV injection (96374) and an IV infusion (96365) are paid under the same APC 5693, Level 3 Drug Administration – so either code will yield the same reimbursement. However, 37195 is reimbursed under a higher-paying DRG, 5694, Level 4 Drug Administration. We are not in a position to recommend 37195 if the drug is administered by IV injection.

2019 HCPCS Codes - ALL Quarter: Q3

Codes and/or Descriptions: **96374,96365,37195** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 3
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA2**, Physician Fee Schedule:

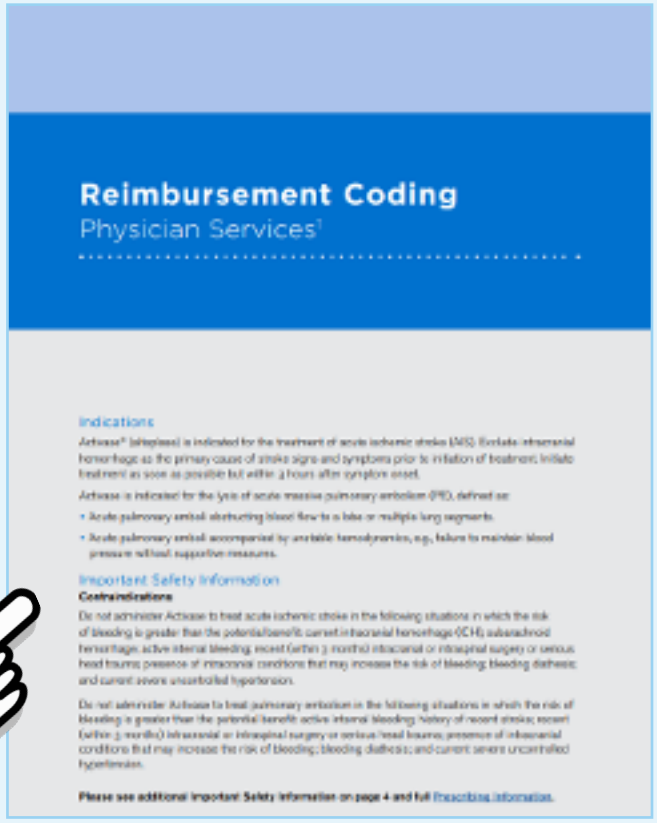
Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule		Initial APC	Payment	
37195 - thrombolysis, cerebral, by intravenous infusion **T - Paid Under OPPS; Separate APC.**	Contractor Priced		5694 - Level 4 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	3.6279 $288.38 $0.00 $57.68
96365 - Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$84.00 $84.00	5693 - Level 3 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	2.3547 $187.18 $0.00 $37.44
96374 - therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): GB (Physician Non-Facility):	$45.46 $45.46	5693 - Level 3 Drug Administration	Weight: Payment: National Co-pay: Minimum Co-pay:	2.3547 $187.18 $0.00 $37.44

BILLING CPT® 37195

Genentech, the pharmaceutical company that produces the thrombolytic drug most commonly used for cerebral occlusion, Activase, suggests reporting 37195 on its website – here's a link and an excerpt:

https://www.activase.com/content/dam/gene/activase/PDFs/Reimbursement-Return-and-Replacement/Reimbursement-Coding-Physician-Services.pdf



Reimbursement Coding

Physician Services[1]

Indications

Important Safety Information

Contraindications

Please see additional important Safety Information on page 4 and full Prescribing Information.

CPT[a] Codes

STROKE	
CPT 37195	Thrombolysis, cerebral, by intravenous infusion

[a]All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are Copyright 2010 American Medical Association. All rights reserved.

But there's a disclaimer at the end of the Genentech document:

> The submission and completion of reimbursement- or coverage-related documentation are the responsibility of the patient and healthcare provider. Genentech, Inc. and its affiliates make no representation or guarantees concerning reimbursement for any service or item.

SHUNT SERIES CHARGE CODE

Q. The radiology manager has posed the following question: Our current exam, "XR Shunt Series; Less than 4 Views", is set up with CPT® 70250 in the chargemaster. The actual exams being performed in this series are: - AP & LAT Skull (70250) - AP C-Spine (72020) - AP or PA Chest (71045) - KUB (Abdomen 1 view, AP) (74018) Should we be charging for all 4 CPT®s somehow? If so, how do you suggest we have all four CPT®s included in the charge? Also, should we drop the verbiage "Less than 4 Views" from the charge description?

A. **Answer:** The HCPCS you mentioned, 70250, 72020, 71045, and 74018, are all unique plain film studies, and should be reported separately if performed.

However, if there is a dye study to evaluate the shunt for patency or leakage, it may be appropriate to report 75809 - Shuntogram for investigation of previously placed indwelling nonvascular shunt (eg, leveen shunt, ventriculoperitoneal shunt, indwelling infusion pump), radiological supervision and interpretation.

If no contrast or dye is used, for instance if the purpose is to evaluate continuity of the shunt, the hospital should report each of the plain film codes to cover the entirety of the ventriculoperitoneal (VP) shunt from head to abdomen. There are no CCI edits that would be triggered by all four codes on the same claim:

CCI Edits OPPS (v25.2, July-Sept 2019)

Codes and/or Descriptions: **70250,72020,71045,74018**

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

PRIME CPT	SECOND CPT	Edit Type	GB Modifier Indicator
70250 - RADIOLOGIC EXAMINATION, SKULL; LESS THAN 4 VIEWS	71045 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW		OK to bill
70250 - RADIOLOGIC EXAMINATION, SKULL; LESS THAN 4 VIEWS	72020 - RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL		OK to bill
70250 - RADIOLOGIC EXAMINATION, SKULL; LESS THAN 4 VIEWS	74018 - RADIOLOGIC EXAMINATION, ABDOMEN; 1 VIEW		OK to bill
71045 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW	74018 - RADIOLOGIC EXAMINATION, ABDOMEN; 1 VIEW		OK to bill
72020 - RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL	71045 - RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW		OK to bill
72020 - RADIOLOGIC EXAMINATION, SPINE, SINGLE VIEW, SPECIFY LEVEL	74018 - RADIOLOGIC EXAMINATION, ABDOMEN; 1 VIEW		OK to bill

It is possible that the original intent was to set up an exploding charge, so that a physician could order all four tests at once, and when the radiology department completed the series all four HCPCS would be charged. The phrase "less than 4 views" is appropriate only for 70250:

2019 HCPCS Codes - ALL Quarter: Q3

Codes and/or Descriptions: **70250,72020,71045,74018** for selected Provider:
Results returned(below): 4
AWI: **0.0963**, DME: **NC**, Clinical Lab Fee Schedule: **NC**, Physician Fee Schedule:**NORTH CAROLINA**

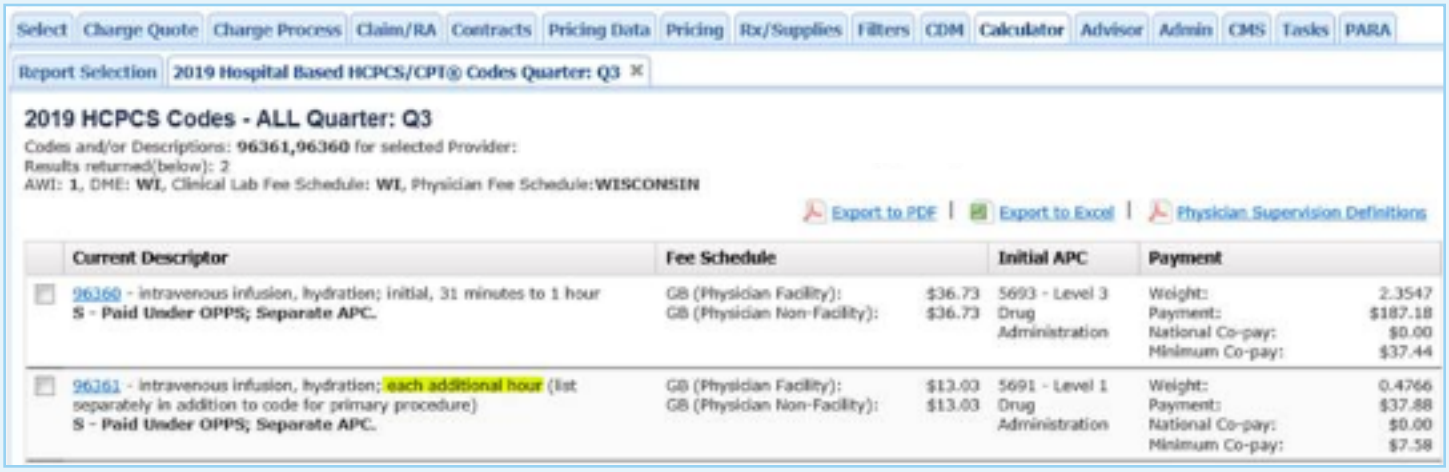
Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule		Initial APC	Payment	
70250 - radiologic examination, skull; less than 4 views **Q1 - Paid or pkgd w S, T, V**	GB (Physician Facility): GB (Physician Non-Facility): 26 (Physician Facility): 26 (Physician Non-Facility): TC (Physician Facility): TC (Physician Non-Facility):	$36.33 $36.33 $12.59 $12.59 $23.74 $23.74	5522 - Level 2 Imaging without Contrast	Weight: Payment: National Co-pay: Minimum Co-pay:	1.4154 $105.51 $0.00 $21.11
71045 - radiologic examination, chest; single view **Q3 - Paid or pkgd w J1 or J2**	GB (Physician Facility): GB (Physician Non-Facility): 26 (Physician Facility): 26 (Physician Non-Facility): TC (Physician Facility): TC (Physician Non-Facility):	$21.06 $21.06 $9.09 $9.09 $11.98 $11.98	5521 - Level 1 Imaging without Contrast Composite(s)	Weight: Payment: National Co-pay: Minimum Co-pay:	0.7838 $58.42 $0.00 $11.68
72020 - radiologic examination, spine, single view, specify level **Q1 - Paid or pkgd w S, T, V**	GB (Physician Facility): GB (Physician Non-Facility): 26 (Physician Facility): 26 (Physician Non-Facility): TC (Physician Facility): TC (Physician Non-Facility):	$22.01 $22.01 $7.67 $7.67 $14.34 $14.34	5521 - Level 1 Imaging without Contrast	Weight: Payment: National Co-pay: Minimum Co-pay:	0.7838 $58.42 $0.00 $11.68
74018 - radiologic examination, abdomen; 1 view **Q1 - Paid or pkgd w S, T, V**	GB (Physician Facility): GB (Physician Non-Facility): 26 (Physician Facility): 26 (Physician Non-Facility): TC (Physician Facility): TC (Physician Non-Facility):	$27.12 $27.12 $9.09 $9.09 $18.03 $18.03	5521 - Level 1 Imaging without Contrast	Weight: Payment: National Co-pay: Minimum Co-pay:	0.7838 $58.42 $0.00 $11.68

96361 MUE

Q. What is the Medically Unlikely Edit (MUE) for 96361? Where can I find this information to use as a reference to send to an insurance company for a denial?

A. **Answer:** 96361 is the add-on code for each hour of hydration provided after the initial hour.

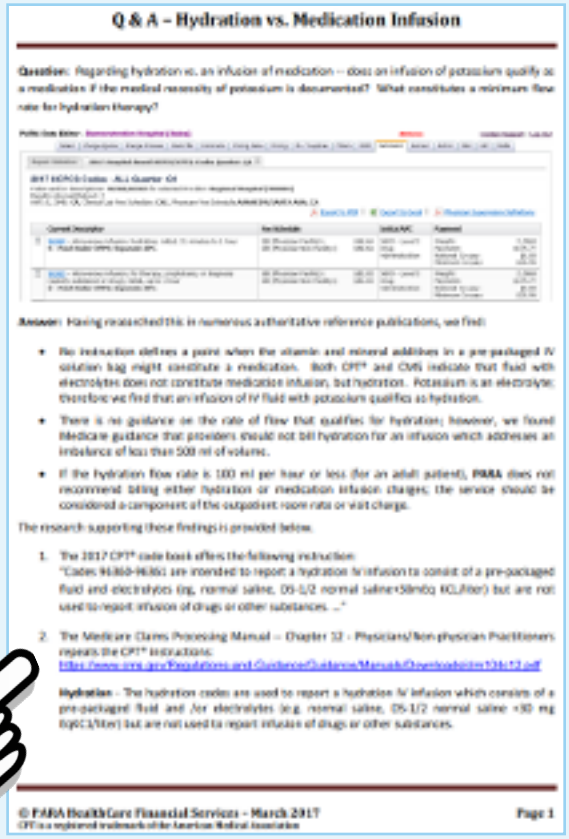


Attached is our paper on billing hydration vs. medication infusion in case it provides information that is useful.

Typically, an insurer will question whether hydration that lasts more than a few hours is truly hydration, or if it's a TKO (to keep open) line, which has no code to generate reimbursement.

PARA does not recommend billing for hydration unless the flow rate is a minimum of 100 ml per hour.

The MUE is available on the **PARA Data Editor HCPCS** report; first enter the HCPCS and run the report as follows, (see next page):


Q & A – Hydration vs. Medication Infusion

Question: Regarding hydration vs. an infusion of medication – does an infusion of potassium qualify as a medication if the medical necessity of potassium is documented? What constitutes a minimum flow rate for hydration therapy?

Answer: Having researched this in numerous authoritative reference publications, we find:

- No instruction defines a point when the vitamin and mineral additives in a pre-packaged IV solution bag might constitute a medication. Both CPT® and CMS indicate that fluid with electrolytes does not constitute medication infusion, but hydration. Potassium is an electrolyte; therefore we find that an infusion of IV fluid with potassium qualifies as hydration.
- There is no guidance on the rate of flow that qualifies for hydration; however, we found Medicare guidance that providers should not bill hydration for an infusion which addresses an imbalance of less than 500 ml of volume.
- If the hydration flow rate is 100 ml per hour or less (for an adult patient), **PARA** does not recommend billing either hydration or medication infusion charges; the service should be considered a component of the outpatient room rate or visit charge.

The research supporting these findings is provided below.

1. The 2017 CPT® code book offers the following instruction:
"Codes 96360-96361 are intended to report a hydration IV infusion to consist of a pre-packaged fluid and electrolytes (eg, normal saline, D5-1/2 normal saline+50mEq KCL/liter) but are not used to report infusion of drugs or other substances. ..."
2. The Medicare Claims Processing Manual – Chapter 12 - Physicians/Non-physician Practitioners repeats the CPT® instructions.
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Hydration - The hydration codes are used to report a hydration IV infusion which consists of a pre-packaged fluid and /or electrolytes (e.g. normal saline, D5-1/2 normal saline +50 mg KCl/liter) but are not used to report infusion of drugs or other substances.

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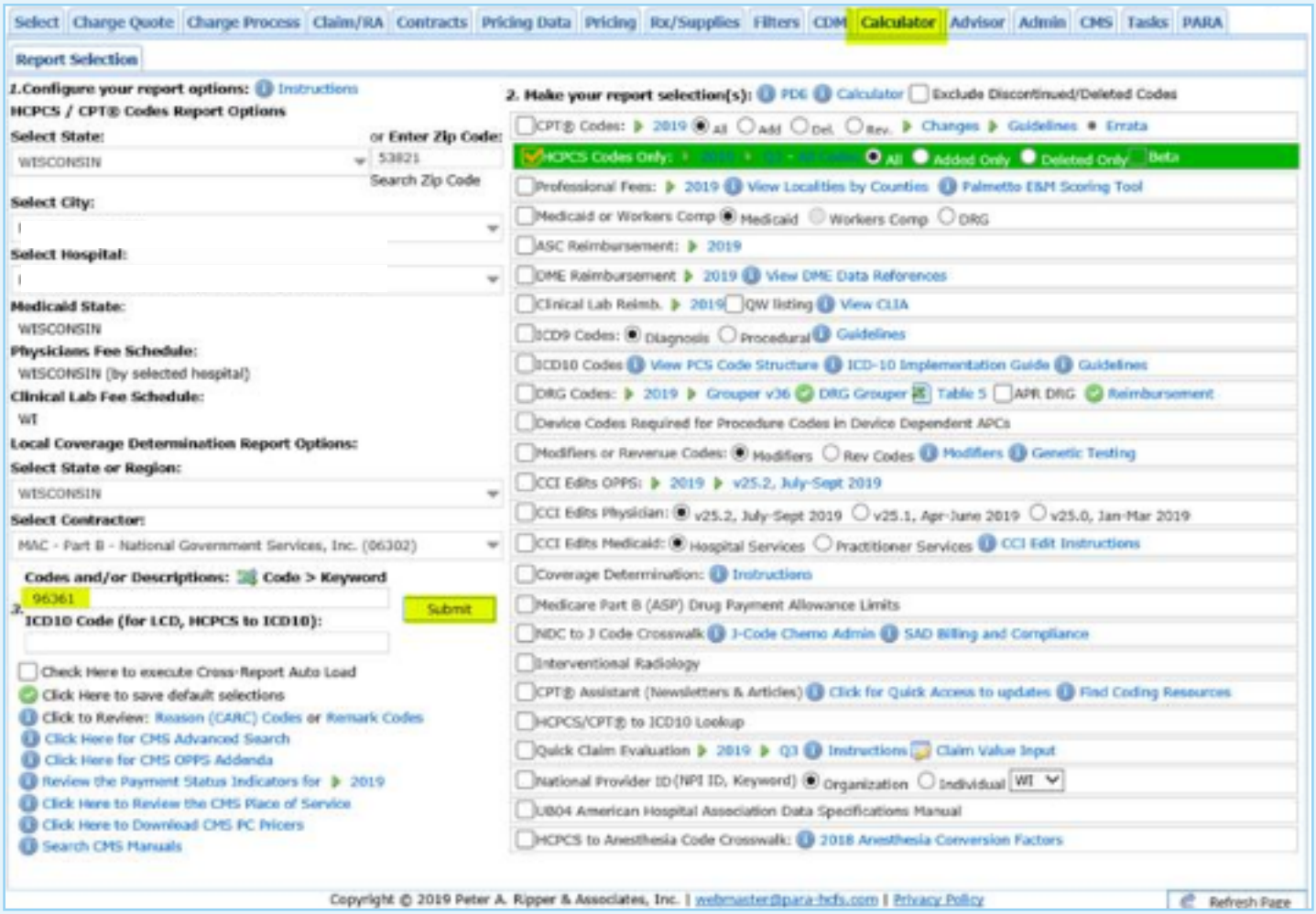
96361 MUE

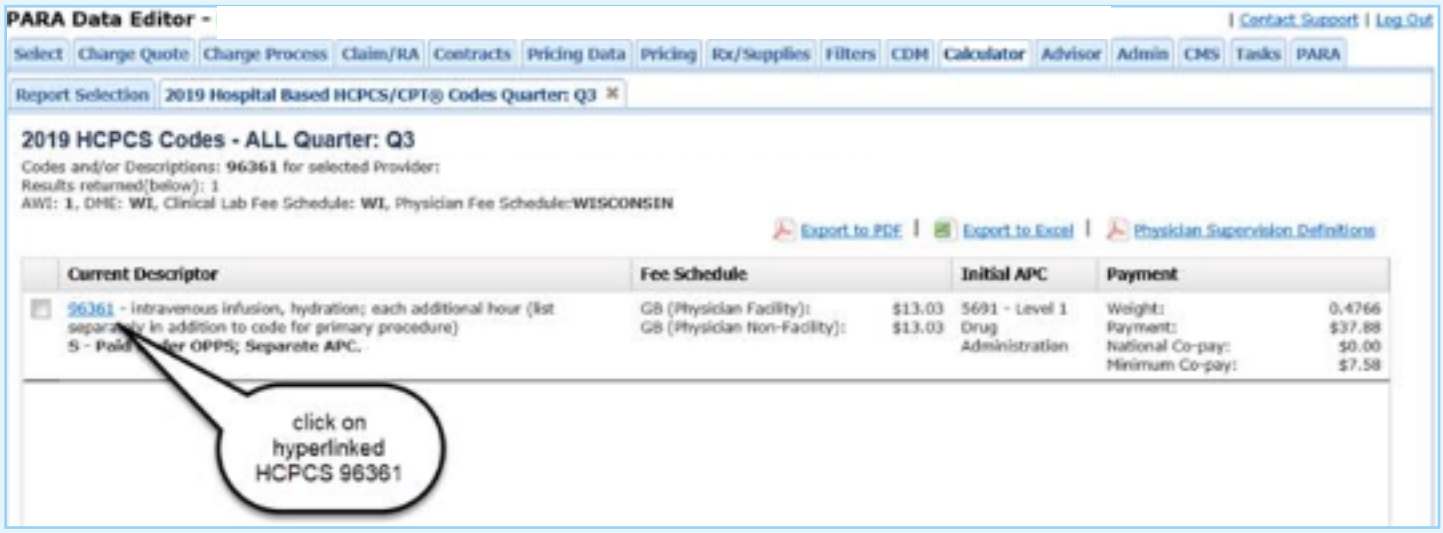


- **No instruction defines a point when the vitamin and mineral additives in a pre-packaged IV solution bag might constitute a medication. Both CPT® and CMS indicate that fluid with electrolytes does not constitute medication infusion, but hydration. Potassium is an electrolyte; therefore we find that an infusion of IV fluid with potassium qualifies as hydration.**

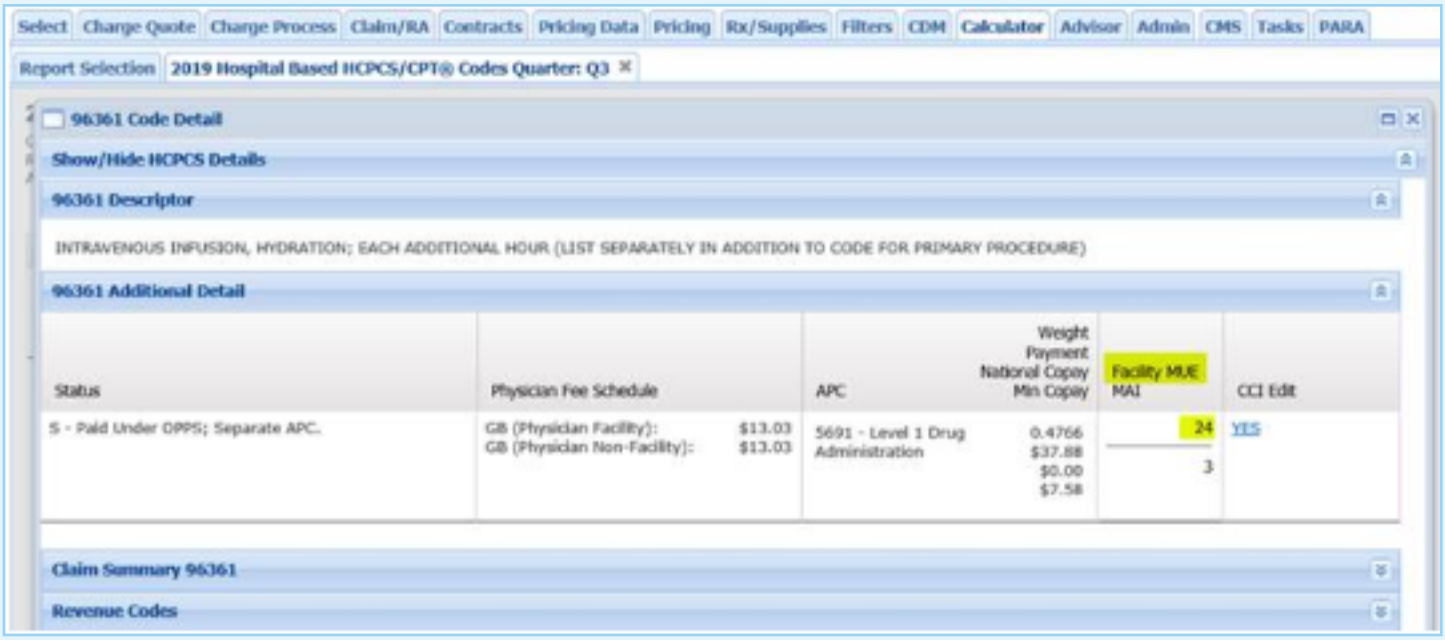
- **There is no guidance on the rate of flow that qualifies for hydration; however, we found Medicare guidance that providers should not bill hydration for an infusion which addresses an imbalance of less than 500 ml of volume.**

96361 MUE

Then, when the report pops up, click on the hyperlinked CPT®/HCPCS number:



The MUEs are displayed in the column on the right highlighted below:



NEWBORN KITS

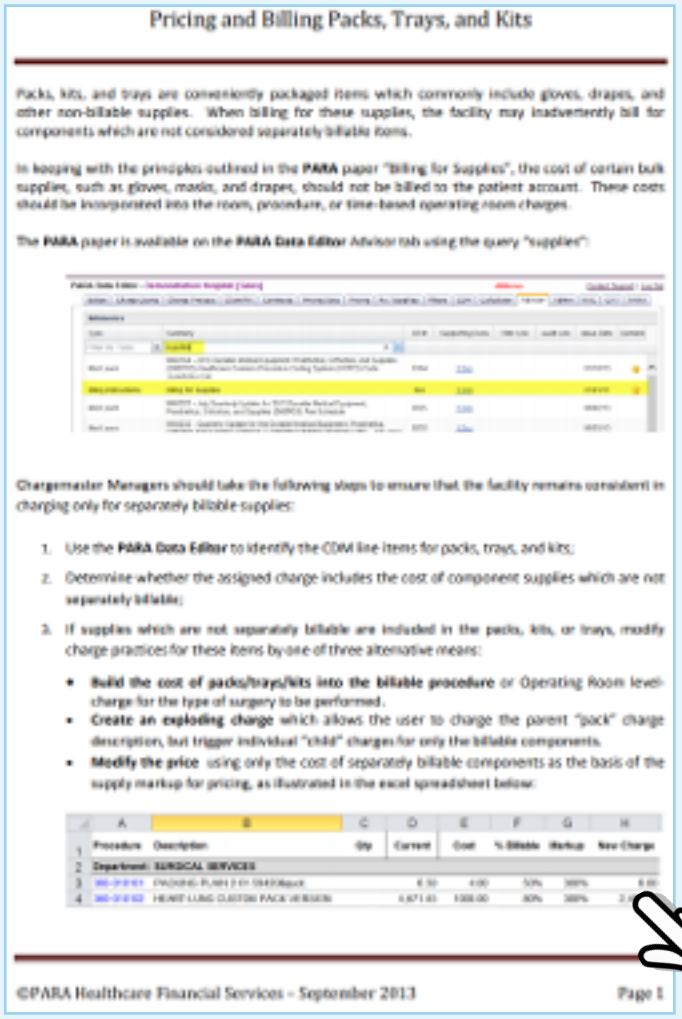
Q. MSD has contacted us about charging for a "newborn kit." The supply kit will be in every room. The kit contains a cannister, tubing for the cannister, 10fr suction delee, 1 roll of Coflex, oxisensory, cable for pulse ox, T-Piece Neonatal Patient Circuit kit, and O2 mask. According to MSD, there are only 3 separately chargeable items in this kit.

Based on what I was told, as it is now, each baby will have a kit in the room and we would only charge for the chargeable items actually used out of the kit and then the nurse would throw the rest of the unused kit in the trash.

The Medical Supply Department (MSD) is wanting to change the way these kits would be charged by proposing to charge one amount for the whole kit. Total cost of the items in this supply kit would be $18.31. How would you advise charging for this newborn supply kit?

A. **Answer:** We do not recommend charging every newborn for a newborn "kit." I have attached our paper on billing for packs, kits, and trays; if every newborn requires the same supply items, we would consider those to be a component of the room rate and not separately billable.

We are not sure which items within the kit are considered by MSD to be separately billable items. Separately billable items should meet the four question test on our paper **"Billing for Supplies"**, which is also attached.



Pricing and Billing Packs, Trays, and Kits

Packs, kits, and trays are conveniently packaged items which commonly include gloves, drapes, and other non-billable supplies. When billing for these supplies, the facility may inadvertently bill for components which are not considered separately billable items.

In keeping with the principles outlined in the **PARA** paper "Billing for Supplies", the cost of certain bulk supplies, such as gloves, masks, and drapes, should not be billed to the patient account. These costs should be incorporated into the room, procedure, or time-based operating room charges.

The **PARA** paper is available on the **PARA Data Editor** Advisor tab using the query "supplies":

Chargemaster Managers should take the following steps to ensure that the facility remains consistent in charging only for separately billable supplies:

1. Use the **PARA Data Editor** to identify the CDM line items for packs, trays, and kits;
2. Determine whether the assigned charge includes the cost of component supplies which are not separately billable;
3. If supplies which are not separately billable are included in the packs, kits, or trays, modify charge practices for these items by one of three alternative means:
   - **Build the cost of packs/trays/kits into the billable procedure** or Operating Room level charge for the type of surgery to be performed.
   - **Create an exploding charge** which allows the user to charge the parent "pack" charge description, but trigger individual "child" charges for only the billable components.
   - **Modify the price** using only the cost of separately billable components as the basis of the supply markup for pricing, as illustrated in the excel spreadsheet below:

	A	B	C	D	E	F	G	H
1	Procedure	Description	Qty	Current	Cost	% Billable	Markup	New Charge
2	Department: SURGICAL SERVICES							
3	[redacted]							
4	[redacted]							

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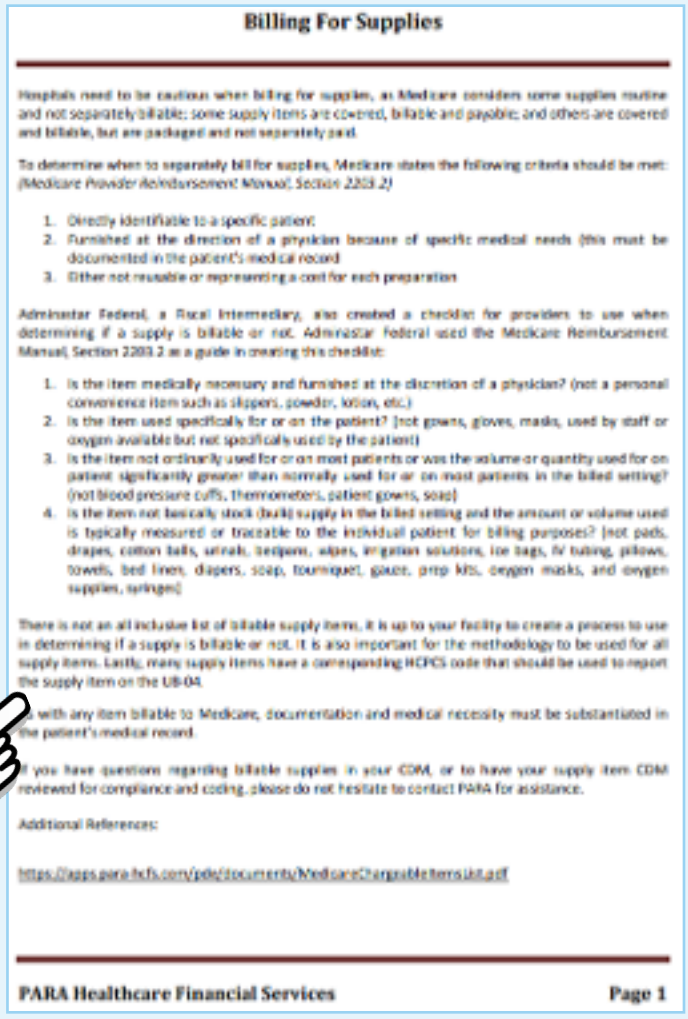


Billing For Supplies

Hospitals need to be cautious when billing for supplies, as Medicare considers some supplies routine and not separately billable; some supply items are covered, billable and payable; and others are covered and billable, but are packaged and not separately paid.

To determine when to separately bill for supplies, Medicare states the following criteria should be met: (*Medicare Provider Reimbursement Manual, Section 2203.2*)

1. Directly identifiable to a specific patient
2. Furnished at the direction of a physician because of specific medical needs (this must be documented in the patient's medical record
3. Either not reusable or representing a cost for each preparation

Administar Federal, a Fiscal Intermediary, also created a checklist for providers to use when determining if a supply is billable or not. Administar Federal used the Medicare Reimbursement Manual, Section 2203.2 as a guide in creating this checklist:

1. Is the item medically necessary and furnished at the discretion of a physician? (not a personal convenience item such as slippers, powder, lotion, etc.)
2. Is the item used specifically for or on the patient? (not gowns, gloves, masks, used by staff or oxygen available but not specifically used by the patient)
3. Is the item not ordinarily used for or on most patients or was the volume or quantity used for on patient significantly greater than normally used for or on most patients in the billed setting? (not blood pressure cuffs, thermometers, patient gowns, soap)
4. Is the item not basically stock (bulk) supply in the billed setting and the amount or volume used is typically measured or traceable to the individual patient for billing purposes? (not pads, drapes, cotton balls, urinals, bedpans, wipes, irrigation solutions, ice bags, IV tubing, pillows, towels, bed linen, diapers, soap, tourniquet, gauze, prep kits, oxygen masks, and oxygen supplies, syringes)

There is not an all inclusive list of billable supply items, it is up to your facility to create a process to use in determining if a supply is billable or not. It is also important for the methodology to be used for all supply items. Lastly, many supply items have a corresponding HCPCS code that should be used to report the supply item on the UB-04.

As with any item billable to Medicare, documentation and medical necessity must be substantiated in the patient's medical record.

If you have questions regarding billable supplies in your CDM, or to have your supply item CDM reviewed for compliance and coding, please do not hesitate to contact PARA for assistance.

Additional References:

https://apps.para-hcfs.com/pde/documents/MedicareChargeableItemsList.pdf

PARA Healthcare Financial Services Page 1

INCENTIVE SPIROMETRY

Q. Recently we have received several edits for CPT® 94010 - Spirometry against CPT® 94640 - Nebulizer Treatment. They were also getting edits for the multiple units of CPT® 94010 which has a MUE of only 1. When I checked the documentation, it shows that the department is doing incentive spirometry and not a true 94010 - Spirometry, including graphic record, total and timed vital capacity, etc.

We also checked if they were doing spirometry testing followed by the administration of a bronchodilator followed by another spirometry test. If they were doing that then they could charge CPT® 94060 instead of 94010 and 94640. The instruction for incentive spirometry is not included in the description of CPT® 94664 so I do not think they can use this CPT® code either. Since there is no graphic documentation for a spirometry test, we do not believe that they can charge CPT® 94010.

We found some documentation that states that incentive spirometry is separately billable. Can the pulmonary department charge for incentive spirometry? They are stating that they are instructing the patient on how to do the incentive spirometry (e.g., after surgery). We cannot find a CPT® code for incentive spirometry. Can they charge by time for the instructing? We checked the **Advisor** tab of the **PDE** and the **Admin Docs** tab and could not find any documents relating to incentive spirometry.

A. **Answer:** There is no HCPCS/CPT® code for incentive spirometry – while it is an important clinical service, it does not require a physician's expertise to perform, and HCPCS/CPT®s are created with the objective of characterizing clinical services which require advanced expertise. In some hospitals, incentive spirometry is performed by the regularly-assigned unit nursing staff rather than respiratory therapists.

Services performed at the bedside by regularly assigned unit nursing personnel are a component of the room rate and should not be separately charged. Attached is **PARA's** paper on billing for bedside procedures.

Furthermore, as you have already concluded, it is not appropriate to charge 94010, 94664, 94640, or 94060 for incentive spirometry. We have observed some hospitals reporting 94799 (unlisted pulmonary service) for incentive spirometry, but we do not recommend this practice.

We are not optimistic that a payer would find the documentation for incentive spirometry to be sufficient to support the code. Many payers will target "unlisted" codes for additional documentation requests. **PARA** does not recommend charging for incentive spirometry as a service. Instead, we recommend charging a marked-up fee for the supply item – the incentive spirometer itself -- to recapture the associated labor expense for the initial incentive spirometry service. Subsequent incentive spirometry services should be performed at no additional charge.

CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

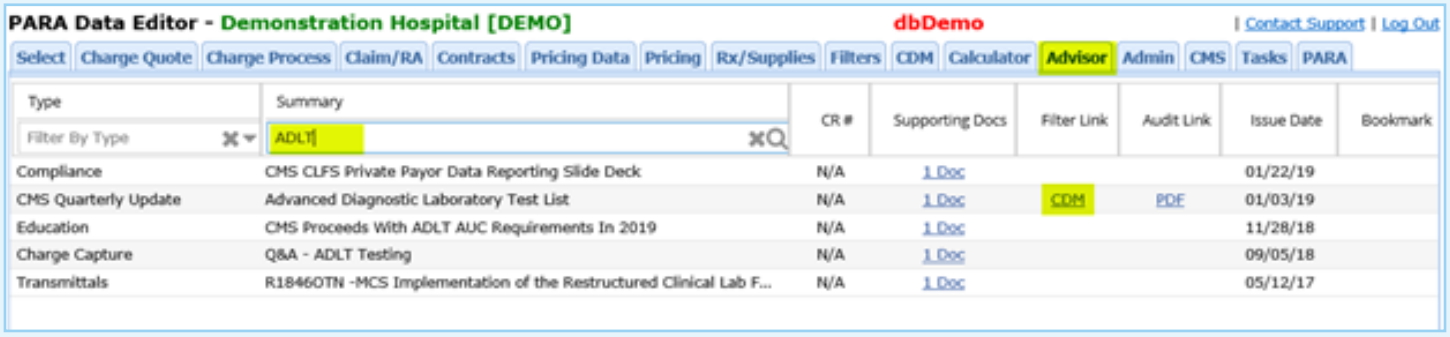
PREPARE NOW: DATE CHANGED TO JANUARY 1, 2020

CMS quietly posted a letter on their DOS Exception website on 6/28/2019 announcing that it has again delayed enforcement of the date of service (DOS) exception policy for Advanced Diagnostic Lab Tests.

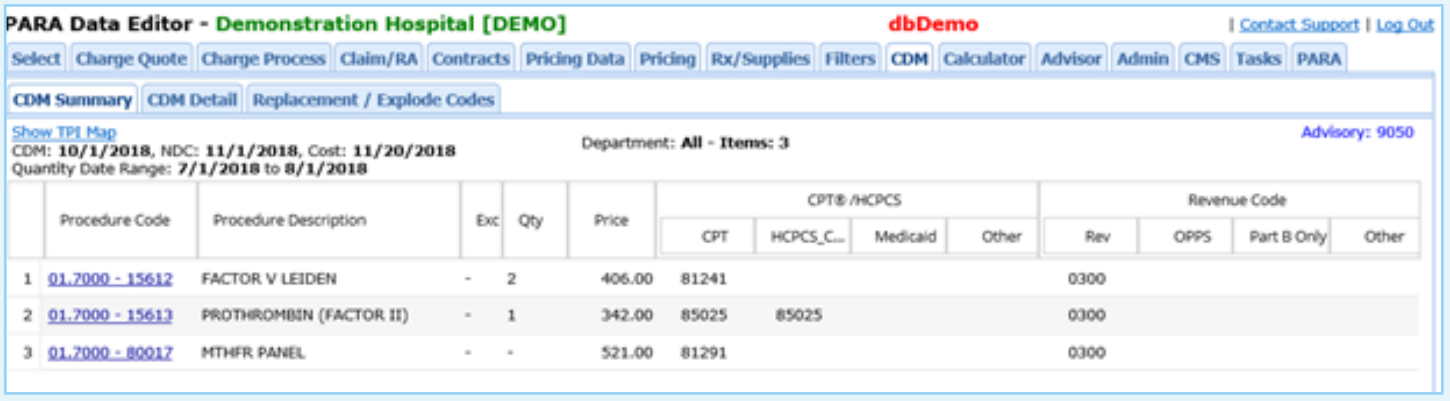
In the 2018 OPPS Final rule, Medicare required outpatient advanced diagnostic laboratory tests (ADLTs) to be billed by the performing lab rather than as send-out lab tests on an outpatient hospital claim.

Since many reference laboratories were unprepared to bill Medicare directly, Medicare first postponed compliance to July 1, 2018, then January 1, 2019, then July 1, 2019, and most recently to January 1, 2020. CMS reiterated in the latest letter that "CMS is committed to the successful implementation of the laboratory DOS exception policy at 42 CFR 414.510(b)(5) and will provide guidance as necessary."

PARA clients can review the list of the ADLT tests in the client chargemaster on the **PARA Data Editor** by finding the ADLT CDM report in the Advisor tab – enter "ADLT" in the summary line and click on the Filter Link labeled CDM:



Clicking the CDM link will deliver the user to the CDM tab with a list of CDM lines which are subject to the CMS ADLT policy.



CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

CMS states that performing laboratories need to make every effort to meet the billing requirements as quickly as they can. Performing laboratories that are capable of billing Medicare should do so now. Consequently, clients are advised to work with their performing laboratory vendors to bill Medicare directly for outpatient services now if they are capable, with the deadline for meeting this requirement now postponed to January 1, 2020.

The CMS letter and an updated Questions and Answers document are available at the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Lab-DOS-Policy.html

Subject: 6-Month Extension of Enforcement Discretion Period Announced for Date of Service Exception

CMS Announces Extension of Enforcement Discretion Period for Laboratory Date of Service Exception Policy Under the Medicare Clinical Laboratory Fee Schedule Until January 2, 2020

Today, the Centers for Medicare & Medicaid Services (CMS) announced that it will exercise enforcement discretion for an additional six (6) months, until January 2, 2020, with respect to the laboratory date of service (DOS) exception policy at 42 CFR 414.510(b)(5) under the Medicare Clinical Laboratory Fee Schedule (CLFS). During the enforcement discretion period, hospitals may continue to bill for advanced diagnostic laboratory tests (ADLTs) and molecular pathology tests that would otherwise be subject to the laboratory DOS exception. This enforcement discretion applies to providers and suppliers with regard to ADLTs and molecular pathology tests subject to the laboratory DOS exception policy as adopted in the CY 2018 Medicare Hospital Outpatient Prospective Payment System/Ambulatory Surgical Center final rule published on December 14, 2017 (82 FR 59393) and implemented by Change Request 10419, Transmittal 4000.

Medicare first postponed compliance to July 1, 2018, then January 1, 2019, then July 1, 2019, and most recently to January 1, 2020.

CMS ADDS ANOTHER 6-MONTH DELAY TO ADLT BILLING RULE

The complete list of over 300 HCPCS that may be billed by either the hospital or the performing laboratory (not both) until January 2, 2020 is available at the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Clinical-Lab-DOS-Policy.html

Medicare Clinical Laboratory Fee Schedule
Revised Laboratory Date of Service (DOS) Policy
Laboratory Tests For Which the DOS is the Date the Test is Performed
(Subject to the Conditions Specified in 42 CFR 414.510(b)(5))*

Revisions to Previous List Indicated By Red Font

HCPCS Code	OPPS Payment Status Indicator**	Short Descriptor	Effective Date
81105	A	Hpa-1 genotyping	1/1/2018
81106	A	Hpa-2 genotyping	1/1/2018
81107	A	Hpa-3 genotyping	1/1/2018
81108	A	Hpa-4 genotyping	1/1/2018
81109	A	Hpa-5 genotyping	1/1/2018
81110	A	Hpa-6 genotyping	1/1/2018
81111	A	Hpa-9 genotyping	1/1/2018
81112	A	Hpa-15 genotyping	1/1/2018
81120	A	Idh1 common variants	1/1/2018
81121	A	Idh2 common variants	1/1/2018
81161	A	Dmd dup/delet analysis	1/1/2018
81162	A	Brca1&2 seq & full dup/del	1/1/2018
81170	A	Abl1 gene	1/1/2018
81175	A	Asxl1 full gene sequence	1/1/2018
81176	A	Asxl1 gene target seq alys	1/1/2018
81200	A	Aspa gene	1/1/2018
81201	A	Apc gene full sequence	1/1/2018
81202	A	Apc gene known fam variants	1/1/2018
81203	A	Apc gene dup/delet variants	1/1/2018
81205	A	Bckdhb gene	1/1/2018
81206	A	Bcr/abl1 gene major bp	1/1/2018
81207	A	Bcr/abl1 gene minor bp	1/1/2018
81208	A	Bcr/abl1 gene other bp	1/1/2018
81209	A	Blm gene	1/1/2018

Downloads

Enforcement Discretion (Updated 06/28/2019) [ZIP, 57KB]
Enforcement Discretion (Updated 12/26/2018) [ZIP, 69KB]
Laboratory Test Codes Subject to Date of Service Exception (Updated, 6/24/2019) [ZIP, 198KB]
Enforcement Discretion (Updated 7/3/2018) [ZIP, 275KB]
Frequently Asked Questions (Updated 6/28/2018) [PDF, 204KB]

Related Links

R4000CP [PDF, 306KB]
CMS-1678-FC (PDF)

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

New Lab Reporting Requirements Could Put Your Hospital At Risk

The Center For Medicare and Medicaid (CMS) is now requiring hospital outreach laboratories to report private payer payment rates.

In the 2019 OPPS Final Rule, Medicare added a new reporting requirement to hospital "outreach" laboratories which submit claims for non-patient services, e.g., blood sample processing without patient contact, on the 14X type of bill (TOB.)

Hospitals are required to report private payer payment rates for the same tests that Medicare reimburses on the clinical laboratory fee schedule if they received at least $12,500 in Medicare revenues for claims billed on the 14X TOB for dates of service between January 1, 2019 and June 30, 2019, assuming the majority of the TOB 141 revenues were paid under the Clinical Lab Fee Schedule.

CMS will use the data reported by hospitals to develop its own payment rates under the Clinical Laboratory Fee Schedule (CLFS) in future years.

Medicare clarified reporting requirements in an MLN article published in late February, 2019.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

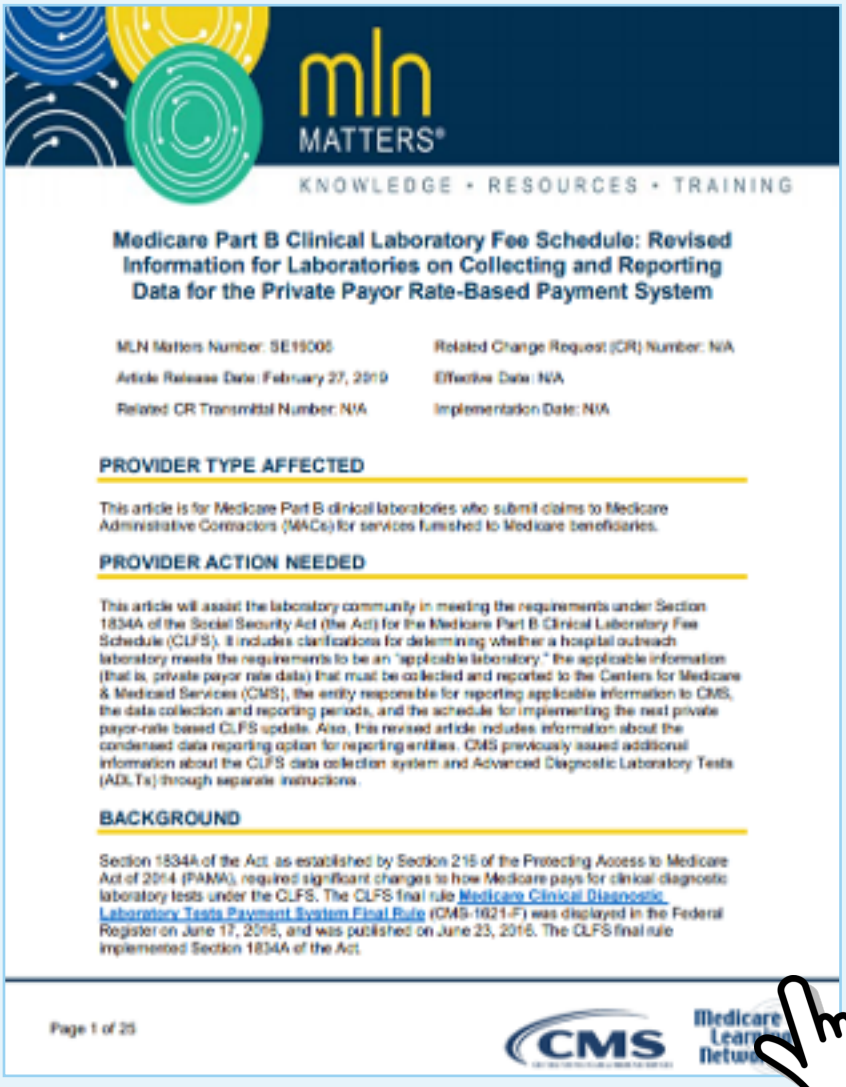
the Problem

Hospitals conducting "outreach" laboratory service should verify whether the 14X bill type was used to report "non-patient services" for lab testing. **PARA** has learned that contrary to its earlier understanding, even if the hospital lab reports under the same NPI as the hospital, the hospital must evaluate whether it meets the other two tests for required reporting.

Hospitals with labs billing on the 14X bill type are required to report payment data if:

- The hospital receives more than $12,500 in Medicare revenue for non-patient clinical lab services reported on bill type 14X in the period January 1 through June 30 2019, and
- the majority of revenues received from Medicare for services billed on the 14X bill type were paid under the Clinical Lab Fee Schedule (this is highly likely for TOB 141 claims.)

For hospitals that are subject to the requirement, private payer data must be collected for the period 1/1/19 through 6/30/19, analyzed, validated, and reported to Medicare in the next reporting period, 1/1/20 through 3/31/20.



mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Medicare Part B Clinical Laboratory Fee Schedule: Revised Information for Laboratories on Collecting and Reporting Data for the Private Payor Rate-Based Payment System

MLN Matters Number: SE19006 — Related Change Request (CR) Number: N/A

Article Release Date: February 27, 2019 — Effective Date: N/A

Related CR Transmittal Number: N/A — Implementation Date: N/A

PROVIDER TYPE AFFECTED

This article is for Medicare Part B clinical laboratories who submit claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

PROVIDER ACTION NEEDED

This article will assist the laboratory community in meeting the requirements under Section 1834A of the Social Security Act (the Act) for the Medicare Part B Clinical Laboratory Fee Schedule (CLFS). It includes clarifications for determining whether a hospital outreach laboratory meets the requirements to be an "applicable laboratory," the applicable information (that is, private payor rate data) that must be collected and reported to the Centers for Medicare & Medicaid Services (CMS), the entity responsible for reporting applicable information to CMS, the data collection and reporting periods, and the schedule for implementing the next private payor-rate based CLFS update. Also, this revised article includes information about the condensed data reporting option for reporting entities. CMS previously issued additional information about the CLFS data collection system and Advanced Diagnostic Laboratory Tests (ADLTs) through separate instructions.

BACKGROUND

Section 1834A of the Act, as established by Section 216 of the Protecting Access to Medicare Act of 2014 (PAMA), required significant changes to how Medicare pays for clinical diagnostic laboratory tests under the CLFS. The CLFS final rule Medicare Clinical Diagnostic Laboratory Tests Payment System Final Rule (CMS-1621-F) was displayed in the Federal Register on June 17, 2016, and was published on June 23, 2016. The CLFS final rule implemented Section 1834A of the Act.

Page 1 of 25

CMS

Medicare Learning Network

Presumably, this means that the deadline for reporting data from January through June 2019 is after January 1, 2020, but no later than March 31, 2020. Significant penalties apply if reporting is not submitted promptly and accurately.

Since the vast majority of services billable on the 14X bill type are paid under the Clinical Lab Fee Schedule, the central question is whether the hospital received $12,500 in allowable reimbursement from Medicare (not including managed Medicare) during the data collection period January through June 2019.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19006.pdf

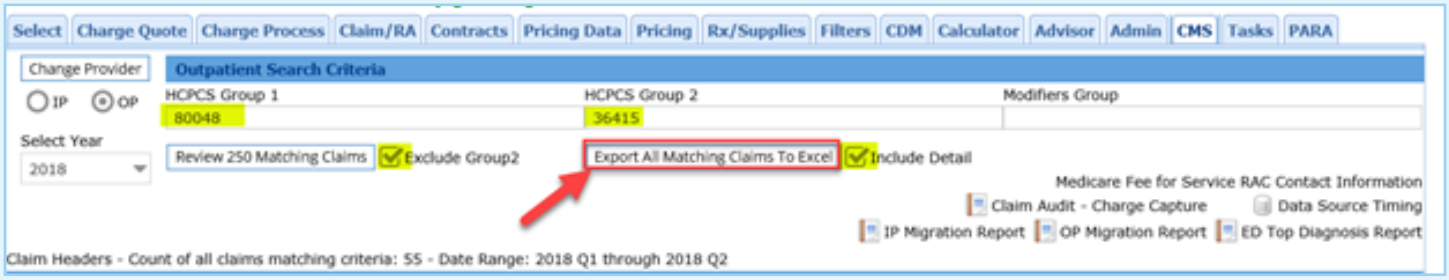
Significant penalties apply if reporting is not submitted promptly and accurately.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

thePARASolution FOR CLIENTS

To estimate whether a hospital has met the $12,500 threshold, **PARA Data Editor** clients may use the **PARA Data Editor CMS** tab to examine a few of the most common lab tests billed to Medicare for the six-month period January through June 2018. If the threshold was met in that period, it is likely to be met in 2019 as well.

To view revenues received from Medicare in 2018, navigate to the CMS tab on the **PARA Data Editor**. Enter a common lab test, such as 80048 (BMP), 80053 (CMP) or 85025 (CBC with auto diff.) In the second HCPCS field, enter the blood draw code 36415, and click the "Excludes Group 2" box below it, as well as the "Include Detail" box to the right of the Excel export field, as illustrated below:



This will generate an excel report which will yield the claims most likely to be billed on a 141 TOB. The resulting report will identify the bill type:

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**Community Hospital [PRIP]**													
2	**2018 Outpatient Claims with one or more of these HCPCS codes: 80048 and excluding one or more of these HCPCS codes: 36415**													
3	**Count of all claims matching criteria: 271 - Date Range: 18 Q1 through 18 Q2**													
5	**PARA ID**	**Prov ID**	**Payment**	**Charges**	**Group**	**Date**	**Bill Type**	**Reason Cd1**	**Reason Cd2**	**Reason Cd3**	**PartB Deduct**	**PartB Coins**	**Provider Payment**	**Diag ICD10 1**
6	74476	340042	10.23	151.11	80048	1/3/2018	141	N184			0.00	0.00	10.23	N184
7	74477	340042	14.98	213.21	80048	1/10/2018	141	N184			0.00	0.00	14.98	N184
8	106079	340042	18.33	222.53	80048	1/16/2018	141	I10			0.00	0.00	18.33	I10
9	504823	340042	65.38	663.45	80048	1/29/2018	131	N184			0.00	0.00	65.38	N184
10	647999	340042	34.53	383.99	80048	1/3/2018	141	E7800			0.00	0.00	34.53	E7800
11	1038496	340042	31.38	383.99	80048	1/3/2018	141	E870			0.00	0.00	31.38	E870
12	1038497	340042	10.23	151.11	80048	1/9/2018	141	E870			0.00	0.00	10.23	N049
13	1038498	340042	10.23	151.11	80048	1/15/2018	141	E870			0.00	0.00	10.23	E870
14	1074894	340042	29.75	447.13	80048	1/19/2018	141	I10			0.00	0.00	29.75	I2510
15	2318756	340042	54.52	515.44	80048	1/17/2018	141	I129			0.00	0.00	54.52	I129
16	2801453	340042	30.56	338.45	80048	1/15/2018	141	N189			0.00	0.00	30.56	E039

If the sum of payments on 14X TOB for several common lab tests gives the impression that the $12,500 threshold was met in 2018, then the hospital should begin planning to report data for the January-June 2019 data collection period.

This process identifies whether or not your hospital meets the qualifying threshold to report and ONLY counts existing Medicare data from bill type 14X during January 1 through June 20, 2019.

Clients will then need to report all private payer tests on all 14X types of bills. But how? This is where **PARA** can help existing clients.

The **PARA Data Editor** offers the ability to analyze electronic remittance files to quickly generate a spreadsheet of the allowable rate paid by CPT® codes on 14X bill types. This data will be configured into the required format for Medicare reporting. However, at this time **PARA** is not able to research payments submitted on paper remittances.

HELP WITH PRIVATE PAYER LAB REIMBURSEMENT REPORTING

the PARA Solution

The process is simple.

*For Existing **PARA** Clients*

Step 1

Initial Eligibility Assessment:

PARA takes existing Medicare bill type 141 data in the **PARA Data Editor** and determines if the client meets the $12,500 billing threshold. **PARA** issues qualified opinion to client.

Step 2

Complete Laboratory Claim Analysis

PARA takes all bill type data labeled as 14X in the **PARA Data Editor** and determines if the total amount to be reported.

Client receives a Data Worksheet and assistance with reporting to CMS.

start Here

Contact your account executive.

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800-999-3332, ext. 219

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Account Executive
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*For new **PARA** Clients*

Step 1

Initial Eligibility Assessment:

PARA takes claim Medicare bill type 141 data uploaded by the new client, and determines if the client meets the $12,500 billing threshold. **PARA** issues qualified opinion to client.

Step 2

Complete Laboratory Claim Analysis

Client uploads 837 electronic claim files for covered period. Client may limit data to 014X bill types or submit all claims within the period.

Client uploads 835 electronic remit files.

Step 3

Complete Laboratory Claim Analysis

PARA takes all bill type data labeled as 14X in the **PARA Data Editor** and determines if the total amount to be reported.

Client receives a Data Worksheet and assistance with reporting to CMS.

MAJOR CASH RECOVERY OPPORTUNITY

Special To PARA

Pre Write-Off Insurance Collections Can Lead To Major Cash Recovery

Denial write-offs are rising dramatically as hospitals wrestle with an ever-more complex reimbursement environment and mounting workloads for central billing office personnel. But despite studies showing denial volume increased by 79% for the average hospital between 2011 to 2017[1], many facilities have yet to develop effective or reliable strategies for resolving their oldest accounts receivable.

Too often, denial resolution efforts are abandoned by the hospital's internal billing staff or primary accounts receivable (AR) management firm once the claim reaches a specific age. An estimated 65% of claim denials are never corrected and re-submitted for reimbursement[2].

This poor follow-up rate reflects a widespread belief that chasing aged, low-value denials is not a cost-effective use of limited resources. Because no one either internally or externally is working these highly-aged claims – typically claims that exceed 300 days – they're frequently written off. Unfortunately, this can all but guarantee potentially-significant amounts of insurance dollars are left on the table.

A CHRONIC PROBLEM

Faced with shrinking margins, rising denial volume and limited billing staff capacity, hospitals and health systems must make cost-benefit decisions about pursuing claims that have aged beyond 90 days or more. Many organizations will instruct their primary AR resolution vendor to continue working claims that have aged beyond a specific days-in-AR threshold. However, if the vendor is unable to achieve resolution within an agreed-upon time frame, they will often recommend that the claim be written off.

A recent survey of hospital executives found that 30% of responding facilities had bad debt of between $10 million and $50 million[3], while 6% reported bad debt of greater than $50 million. Although insurance AR is just one component of bad debt, the survey results underscore the fact that viable and systematic strategies for insurance collection are few and far between, and denials and write-offs consequently represent a major, chronic problem for many hospitals.

NEW REVENUE OPPORTUNITIES

The good news is hospitals and health systems are starting to realize that pursuing highly-aged claims they previously would've written off presents a potentially major opportunity to recover "found" revenue. Just as hospitals depend on secondary collection firms to resolve patient bad debt, they're also turning to outsource firms that specialize in pre write-off AR recovery to work highly-aged insurance claims.

Also known as secondary assigned accounts or second placement AR services, pre write-off insurance collections provide a critical safeguard to ensure no insurance payments legitimately due the hospital go uncollected, regardless of age.

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

The benefits of enlisting this kind of outsource capability include:

- A reduction in write-offs, a commensurate increase in cash flow and a decrease in bad debt reserves caused by aging accounts
- The establishment of an AR management process that offers a systematic approach to obtaining 100% claims resolution
- The creation of incentives that push primary AR vendors to optimize their processes
- Greater transparency to enable hospitals to evaluate performance across the entire revenue cycle

As an example, a large health system in California with a 1,000-bed, multi-specialty academic health science center achieved the following results since implementing a pre write-off AR recovery process in 2012:

- Collected $50 million in revenue from highly-aged claims that otherwise would have been written off
- Achieved 100% resolution of all claims put through the process
- Rapidly identified self-pay accounts and enabled more efficient patient billing and collections

PURSUING A ZERO-PERCENT WRITE-OFF STRATEGY

An effective AR management strategy should incorporate processes to pursue claims at key aging intervals so no denials fall through the cracks. Typically, hospitals can enlist a primary AR management firm for claims that have aged from 30 to 90 days, depending on their policies, before sending older claims to the pre write-off insurance collection specialist. Alternatively, hospitals task internal staff with new claims, then turn any remaining inventory over to a pre write-off insurance collection vendor.

By enlisting a pre write-off insurance collections vendor as part of a zero-percent write-off strategy, hospitals are assured that either hard dollars are collected or verified uncollectable claims are removed from the balance sheet. In either case, the organization benefits by achieving 100% claims resolution.

However, during this process, it is critical to work the claim to the fullest extent possible to secure the maximum cash potential from the claim and avoid the practice of writing off small balances or challenging claims without due process.

Another key component in a robust accounts receivable strategy is determining the root cause of the delayed, underpaid or denied claims. Hospital personnel and many primary vendors often don't have the time or technology to determine the underlying reason for the denial.

However, vendors that utilize intelligent automation can systematically isolate denials by type, age and size before working all claims to 100% resolution. This process can also identify exactly where in the revenue cycle the issue occurred so that proactive measures can be established to help prevent the problem from happening again.

MAJOR CASH RECOVERY OPPORTUNITY

HOW DO YOU KNOW WHEN YOU COULD BENEFIT FROM PRE WRITE-OFF AR ASSISTANCE?

Developing answers to several key revenue cycle questions will help you determine how effectively your primary AR vendor is performing and whether you can benefit from incorporating pre write-off insurance collection services into your AR strategy.

Among these:

- Do you have aged claims in excess of 300 days?
- Do you have a systematic process for taking accounts back from your vendor?
- Is anyone internally or externally working accounts that are over 300 days?
- Do you have an established process for writing off claims with specific time parameters?

COMBINING HUMAN AND ADVANCED TECHNOLOGICAL RESOURCES

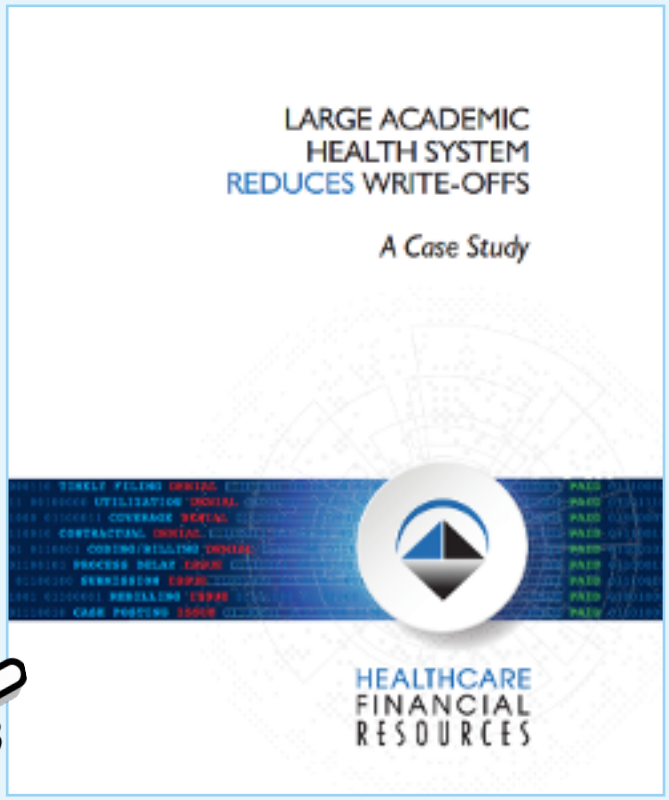
Healthcare Financial Resources (HFRI) offers pre write-off AR recovery to ensure that you collect every penny owed to you by insurance companies, even if claims are highly aged and have been worked for many months internally and by outsourced vendors.

Powered by proprietary intelligent automation and staff specialization, HFRI routinely delivers more than 70 percent cash from inventory that otherwise would have been written off as dead money, cutting precious basis points from increasingly thin operating margins. And HFRI guarantees its pre write-off results, charging no fees until significant cash has been delivered to you. As part of this process, HFRI's robust root cause analysis provides guidance on ways to improve the revenue cycle on the front-end to help prevent denials from happening in the future.

While it's obviously best to resolve and collect outstanding AR before they become highly aged, that isn't always practical in today's unforgiving reimbursement environment. By adopting a comprehensive accounts receivable strategy to ensure hospitals receive all the money they're due from payers, facilities can experience significant reductions in bad debt and write-offs and a corresponding increase in cash flow and margin.

Download the Case Study by clicking here.

Contact HFRI today to learn more about the many ways we can help you approach a goal of zero-percent write-offs through our pre write-off insurance collection service.



PRICE TRANSPARENCY EXECUTIVE ORDER

In PARA's continuing commitment to our clients and partners, we are posting the full text of the President Donald Trump's Executive Order on improving price transparency.

Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First

HEALTHCARE
Issued on: **June 24, 2019**

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered as follows:

Section 1. Purpose. My Administration seeks to enhance the ability of patients to choose the healthcare that is best for them. To make fully informed decisions about their healthcare, patients must know the price and quality of a good or service in advance. With the predominant role that third-party payers and Government programs play in the American healthcare system, however, patients open lack both access to useful price and quality information and the incentives to find low-cost, high-quality care. Opaque pricing structures may benefit powerful special interest groups, such as large hospital systems and insurance companies, but they generally leave patients and taxpayers worse o than would a more transparent system.

Pursuant to Executive Order 13813 of October 12, 2017 (Promoting Healthcare Choice and Competition Across the United States), my Administration issued a report entitled “Reforming America’s Healthcare System Through Choice and Competition.” The report recommends developing price and quality transparency initiatives to ensure that healthcare patients can make well-informed decisions about their care. In particular, the report describes the characteristics of the most effective price transparency efforts: they distinguish between the charges that providers bill and the rates negotiated between payers and providers; they give patients proper incentives to seek information about the price of healthcare services; and they provide useful price comparisons for “shoppable” services (common services offered by multiple providers through the market, which patients can research and compare before making informed choices based on price and quality).

PRICE TRANSPARENCY EXECUTIVE ORDER

Shoppable services make up a significant share of the healthcare market, which means that increasing transparency among these services will have a broad effect on increasing competition in the healthcare system as a whole. One study, cited by the Council of Economic Advisers in its 2019 Annual Report, examined a sample of the highest-spending categories of medical cases requiring inpatient and outpatient care. Of the categories of medical cases requiring inpatient care, 73 percent of the 100 highest-spending categories were shoppable. Among the categories of medical cases requiring outpatient care, 90 percent of the 300 highest-spending categories were shoppable. Another study demonstrated that the ability of patients to price-shop imaging services, a particularly fungible and shoppable set of healthcare services, was associated with a per-service savings of up to approximately 19 percent.

Improving transparency in healthcare will also further protect patients from harmful practices such as surprise billing, which occurs when patients receive unexpected bills at highly inflated prices from out-of-network providers they had no opportunity to select in advance. On May 9, 2019, I announced principles to guide efforts to address surprise billing. The principles outline how patients scheduling appointments to receive facility-based care should have access to pricing information related to the providers and services they may need, and the out-of-pocket costs they may incur. Having access to this type of information in advance of care can help patients avoid excessive charges.

Making meaningful price and quality information more broadly available to more Americans will protect patients and increase competition, innovation, and value in the healthcare system.

Sec. 2. Policy. It is the policy of the Federal Government to ensure that patients are engaged with their healthcare decisions and have the information requisite for choosing the healthcare they want and need. The Federal Government aims to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients' control over their own healthcare resources, including through tax preferred medical accounts; and to protect patients from surprise medical bills.

PRICE TRANSPARENCY EXECUTIVE ORDER

Sec. 3. Informing Patients About Actual Prices. (a) Within 60 days of the date of this order, the Secretary of Health and Human Services shall propose a regulation, consistent with applicable law, to require hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format using consensus-based data standards that will meaningfully inform patients' decision making and allow patients to compare prices across hospitals. The regulation should require the posting of standard charge information for services, supplies, or fees billed by the hospital or provided by employees of the hospital. The regulation should also require hospitals to regularly update the posted information and establish a monitoring mechanism for the Secretary to ensure compliance with the posting requirement, as needed.

(b) Within 90 days of the date of this order, the Secretaries of Health and Human Services, the Treasury, and Labor shall issue an advance notice of proposed rulemaking, consistent with applicable law, soliciting comment on a proposal to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

(c) Within 180 days of the date of this order, the Secretary of Health and Human Services, in consultation with the Attorney General and the Federal Trade Commission, shall issue a report describing the manners in which the Federal Government or the private sector are impeding healthcare price and quality transparency for patients, and providing recommendations for eliminating these impediments in a way that promotes competition. The report should describe why, under current conditions, lower-cost providers generally avoid healthcare advertising.

Sec. 4. Establishing a Health Quality Roadmap. Within 180 days of the date of this order, the Secretaries of Health and Human Services, Defense, and Veterans Affairs shall develop a Health Quality Roadmap (Roadmap) that aims to align and improve reporting on data and quality measures across Medicare, Medicaid, the Children's Health Insurance Program, the Health Insurance Marketplace, the Military Health System, and the Veterans Affairs Health System.

PRICE TRANSPARENCY EXECUTIVE ORDER

The Roadmap shall include a strategy for establishing, adopting, and publishing common quality measurements; aligning inpatient and outpatient measures; and eliminating low-value or counterproductive measures.

Sec. 5. Increasing Access to Data to Make Healthcare Information More Transparent and Useful to Patients. Within 180 days of the date of this order, the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury, Defense, Labor, and Veterans Aairs, and the Director of the Oiffce of Personnel Management, shall increase access to de-identified claims data from taxpayer-funded healthcare programs and group health plans for researchers, innovators, providers, and entrepreneurs, in a manner that is consistent with applicable law and that ensures patient privacy and security.

Providing access to this data will facilitate the development of tools that empower patients to be better informed as they make decisions related to healthcare goods and services. Access to this data will also enable researchers and entrepreneurs to locate inefficiencies and opportunities for improvement, such as patterns of performance of medical procedures that are outside the recommended standards of care.

Such data may be derived from the Transformed Medicaid Statistical Information System (T-MSIS) and other sources. As part of this process, the Secretary of Health and Human Services shall make a list of priority datasets that, if de-identified, could advance the policies set forth by this order, and shall report to the President on proposed plans for future release of these priority datasets and on any barriers to their release.

Sec. 6. Empowering Patients by Enhancing Control Over Their Healthcare Resources. (a) Within 120 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall issue guidance to expand the ability of patients to select high-deductible health plans that can be used alongside a health savings account, and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions.

PRICE TRANSPARENCY EXECUTIVE ORDER

(b) Within 180 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d) of title 26, United States Code.

(c) Within 180 days of the date of this order, the Secretary of the Treasury, to the extent consistent with law, shall issue guidance to increase the amount of funds that can carry over without penalty at the end of the year for flexible spending arrangements.

Sec. 7. Addressing Surprise Medical Billing. Within 180 days of the date of this order, the Secretary of Health and Human Services shall submit a report to the President on additional steps my Administration may take to implement the principles on surprise medical billing announced on May 9, 2019.

Sec. 8. General Provisions. (a) Nothing in this order shall be construed to impair or otherwise affect:

(i) the authority granted by law to an executive department or agency, or the head thereof; or

(ii) the functions of the Director of the Office of Management and Budget relating to budgetary, administrative, or legislative proposals.

(b) This order shall be implemented consistent with applicable law and subject to the availability of appropriations.

(c) This order is not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law or in equity by any party against the United States, its departments, agencies, or entities, its officers, employees, or agents, or any other person.

DONALD J. TRUMP

THE WHITE HOUSE,

June 24, 2019.

EPSDT SERVICES CPT® CODE CONVERSION

California Update

Historically, California has used local codes or HCPCS Level III codes for reimbursement of services and supplies. CPT® Category I codes and HCPCS Level II codes are more specific in nature and are considered HIPAA-Compliant National Codes. California Medi-Cal will be converting from HCPCS Level III codes to HIPAA-Compliant National Codes in order to meet the requirements set forth in the Health Insurance Accountability and Portability Act to meet the mandated billing requirements throughout 2019.

http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaacorrelations_home.asp

HIPAA: Code Conversions

The Health Insurance Portability and Accountability Act (HIPAA) mandates the standardization of internal (administrative) code sets and the use of standard service/procedure code sets for transactions. The Medi-Cal program is using a phased approach to convert its interim (local) codes to national values.

The links below provide additional information about Medi-Cal code conversions. Providers and submitters are encouraged to check this page periodically for new information.

General FAQs

Click to expand the sections below:

- Audiology/EPSDT Audiology/Speech Therapy
- CHDP
- Dialysis
- ECMO/ECLS Services
- EPSDT Services: Home Health New!
- EPSDT Services: Psychology, Mental and Behavioral Health New!
- EPSDT Services
- FQHC/RHC/IHS-MOA
- Home Health
- Hospice
- LTC
- Maternal Care Services and CPSP
- Medical Services Other
- Medical Transportation
- Miscellaneous Services
- MSSP
- NICU/PICU Services New!
- Organ Procurement New!
- Outpatient Services
- Physical and Occupational Therapy New!
- Psychological and Mental Health Services

Effective for dates of service on or after August 1st, 2019 DHCS will discontinue the use of HCPCS Level III codes for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) psychology, mental and behavioral health services. Providers that bill for EPSDT services will begin using HIPAA Compliant CPT® Codes for dates of service on or after August 1st, 2019.

Local Code – Description	National Revenue Code – Description	National Procedure Code – Description	Modifier – Description
Z5814 – EPSDT: marriage/family/child counsel **Z5816** – EPSDT: social worker	**0914** – Behavioral health treatment/services, individual therapy	**90837** – Psychotherapy, 60 minutes with patient	**EP** – Service provided as part of Medicaid early and periodic screening diagnostic and treatment (EPSDT)
Z5820 – EPSDT: case management	**0900** – Behavioral health treatment/services, general	**99366** – Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional Or **99368** – Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more, participation by nonphysician qualified health care professional	**EP** – Service provided as part of Medicaid EPSDT

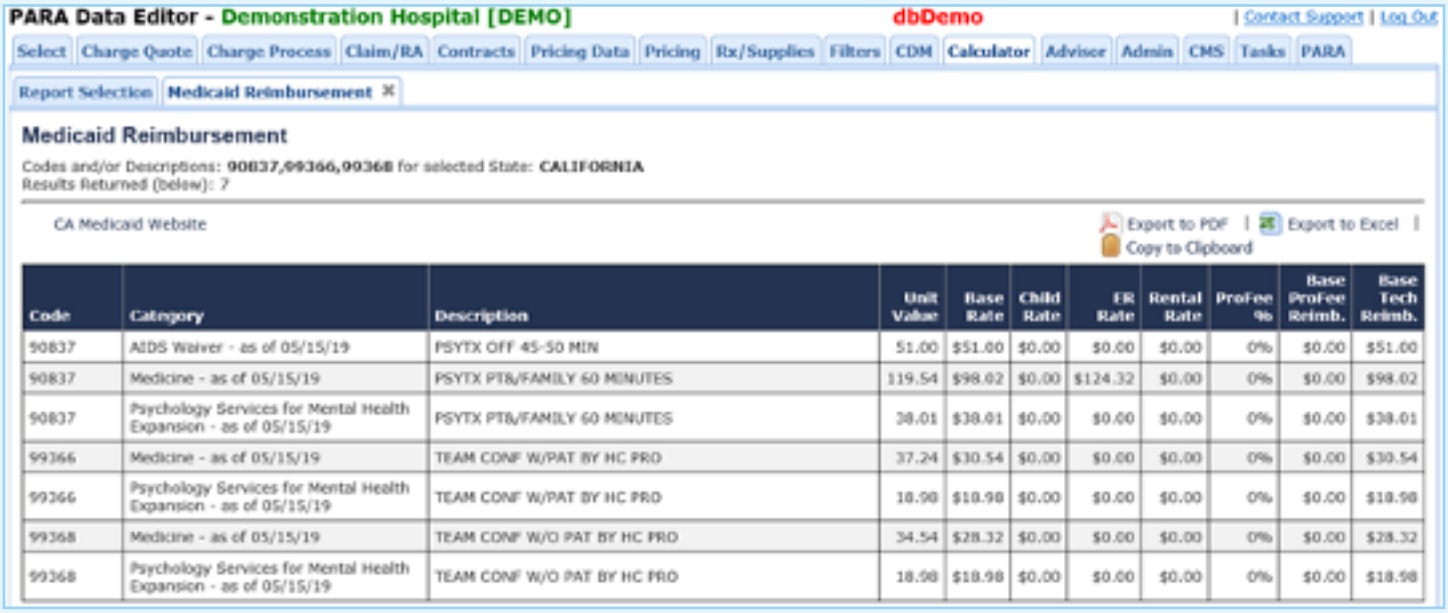
Local Code – Description	Action
Z5800 – EPSDT Supplemental Services: Research Psych	Code is terminated
Z5810 – EPSDT Supplemental Services: Nurse Practitioner	Code is terminated
Z5850 – EPSDT Services: Individual alcohol and other drug counseling ½ hour	Code is terminated

EPSDT SERVICES CPT® CODE CONVERSION

New Treatment Authorization Requests (TARS) for EPSDT services for dates of service on or after August 1st, must be submitted with the CPT® national codes. TARS submitted with service dates prior to August 1st should be submitted using the HCPCS Level III codes.

TARS that authorized through August 1st must be end dated and a new TAR submitted for dates of service after August 1st with the CPT® national codes. If TARS are resubmitted for the same, previously authorized services, per Medi-Cal they will not be reviewed for medical necessity.

Reimbursement for the HIPAA Compliant national codes is as follows:



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: **90837,99366,99368** for selected State: **CALIFORNIA**
Results Returned (below): 7

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.
90837	AIDS Waiver - as of 05/15/19	PSYTX OFF 45-50 MIN	51.00	$51.00	$0.00	$0.00	$0.00	0%	$0.00	$51.00
90837	Medicine - as of 05/15/19	PSYTX PT&/FAMILY 60 MINUTES	119.54	$98.02	$0.00	$124.32	$0.00	0%	$0.00	$98.02
90837	Psychology Services for Mental Health Expansion - as of 05/15/19	PSYTX PT&/FAMILY 60 MINUTES	38.01	$38.01	$0.00	$0.00	$0.00	0%	$0.00	$38.01
99366	Medicine - as of 05/15/19	TEAM CONF W/PAT BY HC PRO	37.24	$30.54	$0.00	$0.00	$0.00	0%	$0.00	$30.54
99366	Psychology Services for Mental Health Expansion - as of 05/15/19	TEAM CONF W/PAT BY HC PRO	18.98	$18.98	$0.00	$0.00	$0.00	0%	$0.00	$18.98
99368	Medicine - as of 05/15/19	TEAM CONF W/O PAT BY HC PRO	34.54	$28.32	$0.00	$0.00	$0.00	0%	$0.00	$28.32
99368	Psychology Services for Mental Health Expansion - as of 05/15/19	TEAM CONF W/O PAT BY HC PRO	18.98	$18.98	$0.00	$0.00	$0.00	0%	$0.00	$18.98

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, July 11, 2019

News

· New Medicare Card: Transition Period Ends in Less Than 6 Months
· HHS To Transform Care Delivery for Patients with Chronic Kidney Disease
· CMS Expands Coverage of Ambulatory Blood Pressure Monitoring
· Open Payments: Program Year 2018 Data
· SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

Events

· DMEPOS Competitive Bidding: Round 2021 Webcast Series
· Enrollment: Multi–Factor Authentication for I&A System Webcast — July 30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MLN Matters® Articles
- Medicare Plans to Modernize Payment Grouping and Code Editor Software
- Medicare Part A Skilled Nursing Facility (SNF) Prospective Payment System (PPS) Pricer Update FY 2020
- October 2019 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Medicare Summary Notice (MSN) Changes to Assist Beneficiaries Enrolled in the Qualified Medicare Beneficiary (QMB) Program — Revised
- July 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.2 — Revised
- July Quarterly Update for 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Fee Schedule — Revised
- Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

Publications
- Get Your New Medicare Card
- Medicare Documentation Job Aid for Doctors of Chiropractic
- Medicare Preventive Services — Revised

Multimedia
- CMS: Beyond the Policy Podcast: Throwback to HIMSS Conference

View this edition as a PDF [PDF, 259KB].

MLN Matters® Articles

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· Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment — Revised

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	Enhancement	User Action
July 12, 2019	PARA Data Editor	Calculator	EAPG Query has been added to the PDE Calculator	User can select EAPG version, and then query CPT/HCPCS codes and descriptions for any associated EAPGs. The query results list the national relative weight, EAPG type and category, and indicates whether it qaulifies as a Medical Visit or Ancillary Packagable EAPG.
July 12, 2019	PARA Data Editor	Calculator	2019 Q3 CPT PLA Updates have been added.	PLA codes are available in the PDE Calculator under the CPT and HCPCS queries.
July 5, 2019	PARA Data Editor	Calculator	July 2019 CLAB Fee Schedule has been loaded into the PDE Calculator.	Users can view current CLAB fee schedule information using the CLAB reimbursement query on the PDE Calculator.
July 5, 2019	PARA Data Editor	Calculator	July 2019 DME Fee Schedule has been loaded into the PDE Calculator.	Users can view current DME fee schedule information using the DME reimbursement query on the PDE Calculator.
July 5, 2019	PARA Data Editor	Calculator	July 2019 UB-04 Data Content has been loaded into the PDE Calculator.	Users can query all UB04 Revenue Codes using the Modifier/RevenueCode query on the PDE Calculator.

Previous Updates

Week Ending	Platform	Tab	Enhancement	User Action
June 28, 2019	PARA Data Editor	Calculator	May 2019 CPT Assistant added to Calculator	Users can query CPT Assistant documents and view 10+ years of PDF versions.
June 28, 2019	PARA Data Editor	Calculator	2019 National payment rate added to HCPCS Query for G0071	Fee schedule amount is published in a Medicare FAQ.

RURAL HOSPITAL PROGRAM GRANTS AVAILABLE

Rural hospitals and clinics face their own set of unique and burdensome challenges when it comes to program development, cash management and maintaining volume. That's why it's great when they can get some assistance from external funding sources.

At **PARA**, we've found an excellent source of funding opportunities for rural healthcare facilities. Here are some examples.

Tribal Opioid Response Grants

Short Title: TOR

Initial Announcement

Funding Opportunity Announcement (FOA) Information

FOA Number: TI-19-012

Posted on Grants.gov: Friday, June 7, 2019

Application Due Date: Tuesday, August 6, 2019

Catalog of Federal Domestic Assistance (CFDA) Number: 93.788

Tribal Opioid Response Grants

Provides up to $50,000 to develop a strategic plan to address opioid addiction in tribal nations.

Application Deadline: August 6, 2019

Service Area Competition Funding For Health Center Programs

Multi-year funding of up to $1.3 million dollars to provide comprehensive primary healthcare services to an underserved area or population. Areas with a March 1, 2020 project period start date are eligible to apply.

Application Deadline: August 26, 2019

Announcement Information

Announcement Number	HRSA-20-017
Announcement Code	SAC
CFDA Number	93.224
Provisional	No
Activity Code	H80
Competitive	Yes
Fiscal Year	2020

There were TWO 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** 2

The link to this Med Learn MM11295

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

MLN Matters Number: MM11295 | Related Change Request (CR) Number: 11295

Related CR Release Date: July 12, 2019 | Effective Date: August 13, 2019

Related CR Transmittal Number: R259BP | Implementation Date: August 13, 2019

PROVIDER TYPE AFFECTED

This MLN Matters® Article is for physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors for Intravenous Immune Globulin (IVIG) services for Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR11295 informs MACs about changes which update the list of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes for the coverage of IVIG for treatment of Primary Immune Deficiency Diseases (PIDD) in the home. Make sure that your billing staffs are aware of these changes.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provides coverage of IVIG for the treatment of PIDD in the home. The Act defines "intravenous immune globulin" as an approved pooled plasma derivative for the treatment of PIDD. IVIG is covered under this benefit when:

- The patient has a diagnosed PIDD
- The IVIG administration takes place in the home of a patient with a diagnosed PIDD
- The physician determines that administration of the derivative in the patient's home is medically appropriate.

Effective for dates of service on or after January 1, 2004, via CR3060, the appropriate ICD-9 codes were as follows: 279.04, 279.05, 279.06, 279.12, and 279.2.

Effective for dates of service on or after October 1, 2014, via CR8605, the appropriate ICD-9 codes were converted to the following ICD-10 codes: D80.0, D80.5, D81.0, D81.1, D81.2,

CMS Medicare Learning Network

The link to this Med Learn MM11357

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019

MLN Matters Number: MM11357 | Related Change Request (CR) Number: 11357

Related CR Release Date: July 12, 2019 | Effective Date: October 1, 2019

Related CR Transmittal Number: R4334CP | 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

CR11357 updates the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits, which relate to Chapter 23, Section 20.9 of the Medicare Claims Processing Manual. Please make sure your billing staffs are aware of these updates.

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Part B claims.

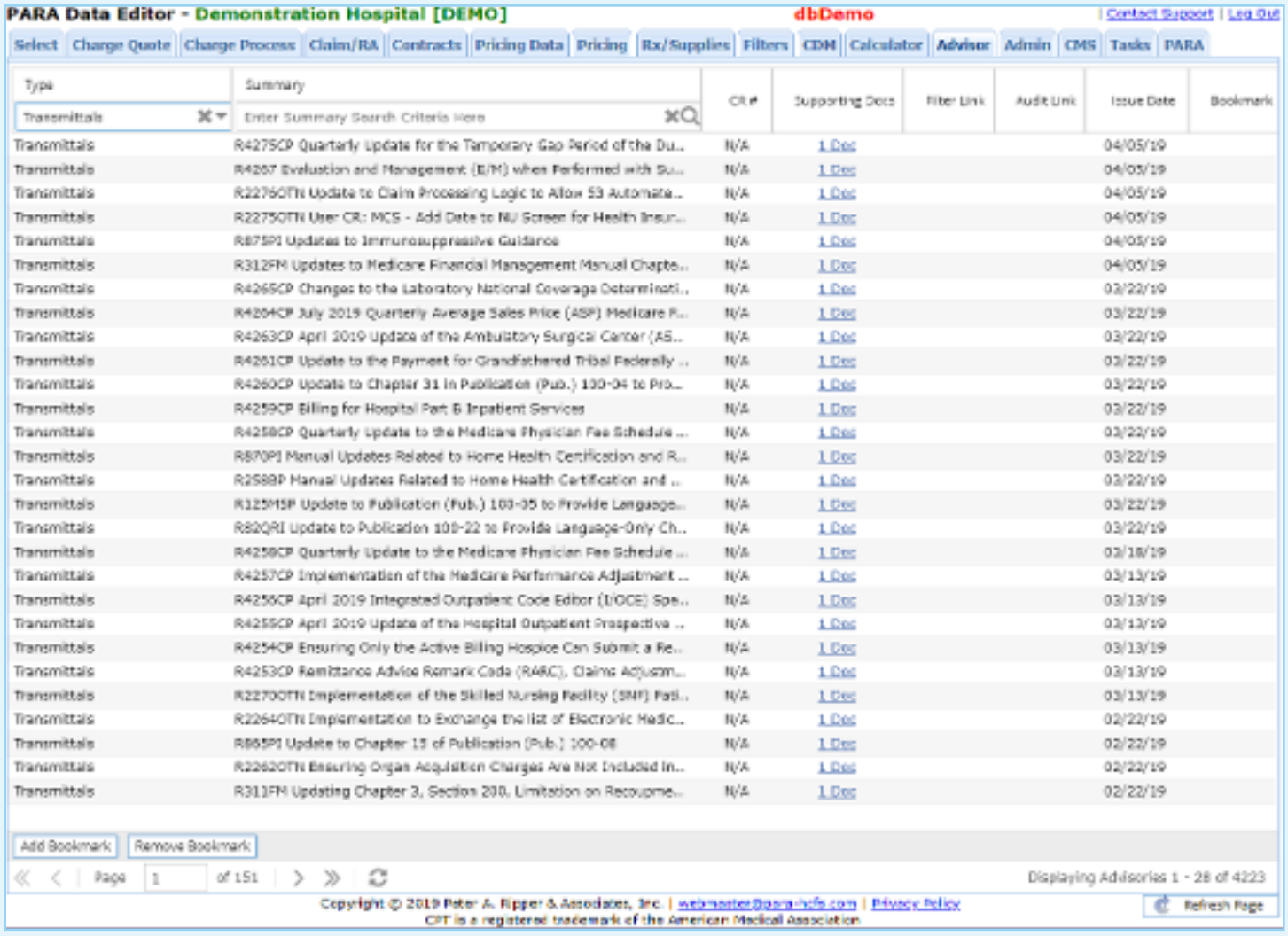
Version 25.3 includes all previous versions and updates from January 1, 1996 to the present. In the past, NCCI was organized in two tables: Column 1/Column 2 Correct Coding Edits and Mutually Exclusive Code (MEC) Edits. To simplify the use of NCCI edit files (two tables), on April 1, 2012, CMS consolidated these two edit files into the Column One/Column Two Correct Coding edit file. Separate consolidations occurred for the two practitioner NCCI edit files and the two NCCI edit files used for the Outpatient Code Editor (OCE). You only have to search the Column One/Column Two Correct Coding edit file for active or previously deleted edits. CMS no longer publishes a Mutually Exclusive edit file for either practitioner or outpatient hospital services, since all active and deleted edits will appear in the single Column One/Column Two Correct Coding edit file. The edits previously available in the Mutually Exclusive edit file are NOT deleted but are moved to the Column One/Column Two Correct Coding edit file.

CMS Medicare Learning Network

There were FIVE 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** 5



The link to this Transmittal R259BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 259	**Date: July 12, 2019**
	Change Request 11295

SUBJECT: Update to Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the list of ICD-10 codes to be included in the Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home.

EFFECTIVE DATE: August 13, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 13, 2019

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	15/50.6/Coverage of Intravenous Immune Globulin for Treatment of Primary Immune Deficiency Diseases in the Home

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 R2321OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2321	**Date: July 12, 2019**
	Change Request 11162

SUBJECT: Fee For Service (FFS) Applications Upgrade Customer Information Control System (CICS) to Transaction Server (TS) v5.4 and Liberty Profile Functionality

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for the FFS contractors to upgrade their Development (DEV) environments to CICS TS v5.4 and Liberty Profile Functionality, as the Virtual Data Centers (VDCs) will make the corresponding upgrade.

EFFECTIVE DATE: January 1, 2020 - Processing Date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020 - The VDCs will utilize a staged approach and ensure all UAT regions are upgraded in December 2019 and all Production regions will be upgraded by the end of January 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.

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

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IV. ATTACHMENTS:

One Time Notification

The link to this Transmittal R4334CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 4334	**Date: July 12, 2019**
	Change Request 11357

SUBJECT: Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.3 Effective October 1, 2019

I. SUMMARY OF CHANGES: This is the quarterly update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits. The attached recurring update notification applies to publication 100-04, chapter 23, section 20.9.

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

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.

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R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R318FM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 318	Date: July 12, 2019
	Change Request 11396

SUBJECT: Notice of New Interest Rate for Medicare Overpayments and Underpayments -4th Qtr Notification for FY 2019

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

EFFECTIVE DATE: July 17, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 17, 2019

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.

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IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R2320OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2320	**Date: July 8, 2019**
	Change Request 11183

Transmittal 2313, dated June 10, 2019, is being rescinded and replaced by Transmittal 2320, dated, July 8, 2019 to update the BR 11183.1 field name from "Error/Fatal Error Return Code" to match the IOCE attachment field name "Claim Return Code". All other information remains the same.

SUBJECT: FISS Integrated Outpatient Code Editor (IOCE) Claim Return Buffer Interface Changes Related to New Return Code Field Updates

I. SUMMARY OF CHANGES: This Change Request (CR) will implement a new return code field in the Claim Return Buffer Table.

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

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.

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IV. ATTACHMENTS:

One Time Notification

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Introducing, our new partner.

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