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eJOURNAL

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Monitoring Line Items

Miscellaneous Chargemaster Items

Zero-Balance Reviews

Catching Up On Aged Accounts

Medicare Therapy

Discounts Explained

ZERO-BALANCE CLAIM REVIEWS

A CRITICAL BACKSTOP FOR AR MANAGEMENT STRATEGIES

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

AR STRATEGIES FOR AGED ACCOUNTS

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

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

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

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

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

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

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

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

1. Scrutinize contracts

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

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

2. Evaluate discharge files

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

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

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

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

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

4. Recommend improvements

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

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

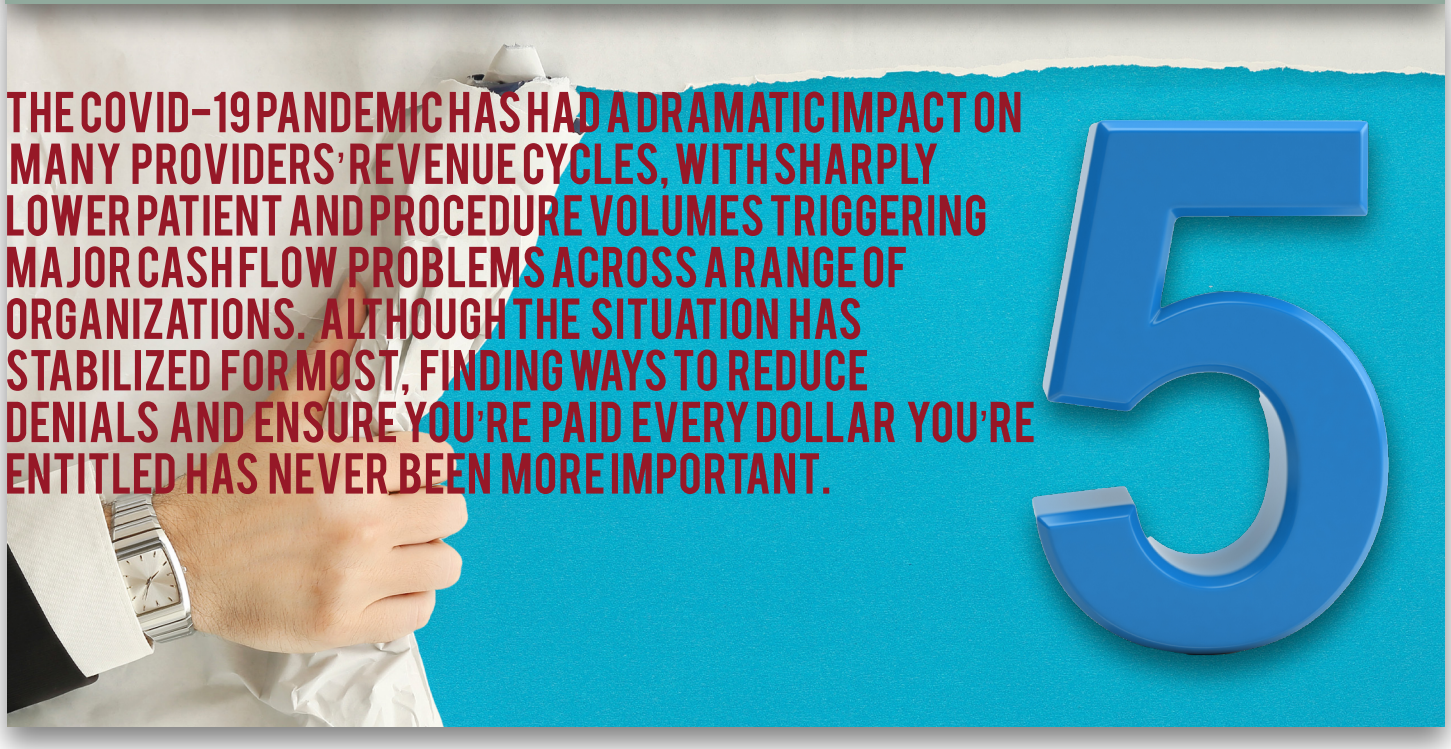
In addition to flagging coding mistakes, the zero-balance claims analysis also identifies payer deficiencies, whether they're one-off events or reoccurring, systemic issues. Working withing appropriate contractual claim and appeal submission time frames, **ParaRev** will work with the hospital staff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

A SECOND SET OF EYES

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

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

FIVE WAYS TO UNCOVER LOST REVENUE



DENIAL REALITY

Even before the pandemic, denials were a major and costly problem in healthcare.

Consider:

- Denial volume increased by 79% for the average hospital between 2011 to 2017 [1]
- A recent survey of hospital executives found that 30% of responding facilities had bad debt of between $10 million and $50 million, while 6% reported bad debt of greater than $50 million [2]
- 9% of $3 trillion in U.S. hospital claims ($270 billion) were initially denied in 2016 [3]
- Hospitals expend $9 billion annually in administrative costs for rework denials [4]
- It takes 5-12 minutes per claim to check status manually [5]
- The average cost of each claim status check by providers is $5.40 [6]

FIVE WAYS TO UNCOVER LOST REVENUE

Despite the growing prevalence of denials, the fact remains that 90% of claims are preventable and 66% are recoverable. Even so, 65% of claim denials are never corrected and resubmitted for reimbursement. [7]

Here are five ways to take control of your denial problem:

STEP 1: OPTIMIZE THE EFFECTIVENESS OF YOUR CURRENT AR PROCESS

While hospitals continue to face rising accounts receivable (AR) balances due to denied, unpaid and underpaid commercial insurance claims, adding staff to pursue denials can be costly and may still result in many low-dollar, high-volume claims going unworked.

A virtual extension of your central billing office's resources can help bolster your efforts with a dedicated, knowledgeable, and responsive team of experts who have specific experience with your payers. This additional capability, integrated seamlessly with your systems, can decrease cycle time, and help ensure all claims, no matter the age or balance, are effectively worked to 100% resolution.

STEP 2: DEVELOP A HARD DOLLARS COLLECTION 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 task their primary AR management firm with claims that have aged from 30 to 90 days before sending older claims to the pre-write-off insurance collection specialist. Alternatively, hospitals can task internal staff with new claims, then turn any remaining inventory over to a pre-write-off insurance collection vendor.

Ultimately, you want to develop a strategy to collect the extremely aged hard dollars or dollars already written off (zero balance) so that you can improve collections and verify that claims are truly un-collectable and may be removed from the balance sheet.

STEP 3: PURSUE PRE-WRITE-OFF INSURANCE COLLECTION

Secondary assigned accounts or second placement AR services for pre-write-off insurance collections provide a critical safeguard to ensure no insurance payments legitimately due to the hospital go uncollected, regardless of age. The benefits of enlisting this kind of outsource capability include:

- The establishment of an AR management process that offers a systematic approach to obtaining 100% claims resolution
- A reduction in write-offs, a commensurate increase in cash flow and a decrease in bad debt reserves caused by aging accounts
- 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

STEP 4: CONDUCT ZERO-BALANCE REVIEWS

Specialized, forensic audits of written-off (zero balance) claims compare payments received to anticipated revenue based on episode-of-care specifics, coding best-practices, and payer-provider contractual terms. Any underpaid claims are resubmitted, per the payer's terms, for reimbursement.

Recovered underpayments from zero-balance reviews can total up to 1% of a hospital's annual Net Patient Revenue, an amount that may be significant for large hospitals and health systems that generate hundreds of millions of revenue annually.

A zero-balance audit and recovery process should include training or education to help hospital staff mitigate systemic or reoccurring coding and process errors uncovered during the initial review.

STEP 5: DEVELOP A PROCESS TO IDENTIFY THE ROOT CAUSE OF ALL DENIALS

No matter where collections are pursued in the revenue cycle, one of the most important steps you can take in developing a robust accounts receivable strategy is determining the root cause of delayed, underpaid or denied claims.

Unfortunately, hospital personnel and many primary vendors frequently don't have the time or technology to determine the precise underlying reason for the denial.Partnering with a vendor that utilizes intelligent automation can help systematically isolate denials by type, age and size before all claims are worked to resolution.

This time-saving process also helps identify exactly where in the revenue cycle the initial problem occurred so proactive measures can be taken to prevent it from happening again.

While it's best to resolve and collect outstanding accounts receivable before they become highly aged, this isn't always practical in today's challenging reimbursement environment. By adopting a comprehensive and aggressive 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 margins.

Pararev can help you progress toward the goal of zero-percent write-offs through our comprehensive AR solutions. We're able to resolve all claims, regardless of size or age quickly, and conduct zero-balance reviews to ensure you're collecting every dollar you deserve.

Contact us today to learn more.

1. Kelly Gooch, "4 ways hospitals can lower claim denial rates," Becker's Hospital CFO Report, Jan. 5, 2018.
2. "Bad Debt Exceeds $10M at a Third of Organizations, But Lack of Confidence Exists in How Much is Recoverable," Cision PR Newswire. June 19, 2918.
3. Philip Betbeze, "Claims Appeals Cost Hospitals Up to $8.6B Annually" HealthAffairs, March 16, 2021.
4. ibid.
5. ibid.
6. ibid.
7. Chris Wyatt, "Optimizing the Revenue Cycle Requires a Financially Integrated Network," HFMA, July 7, 2015.

MONITOR "MISCELLANEOUS" CHARGEMASTER LINE ITEM USE

Some facility departments find it useful to use a “miscellaneous” chargemaster line item to use when an unusual drug or supply needs to be charged, but there is no established chargemaster line item that fits the item.A “miscellaneous” charge allows the user to enter the price, and even a HCPCS code, for each charge instance.This saves both time and work required to create a new chargemaster line for items that are unlikely to be charged again.Here are some examples of “miscellaneous” line items as displayed in the **PARA Data Editor:**

	Procedure Code	Procedure Description	Exc	Qty...	Price	CPT® /HCPCS				
						CPT_CODE	Medicare	Medicaid	ALT_CODE	REV_CODE
1	425.47100 - 2508...	Spec Admin Misc Drug Codes	-	1,245	-					0250
2	425.47100 - 2508...	Misc Drug Code	-	3,257	-					0250
3	4570 - 2700807	HC MISC. PLASTICS IMPLANT	-	569	-					0278
4	4570 - 2700812	HC MISC. GENERAL IMPLANT	-	377	-					0278

Certain drugs and implants may generate additional reimbursement on an outpatient claim when billed with the appropriate HCPCS and units.

- **Expensive drugs** are separately payable under Medicare’s OPPS reimbursement program, but the HCPCS and units billed must be appropriately reported in order to be paid. Even Critical Access Hospitals, which are paid by Medicare on a cost-reimbursement basis, risk losing reimbursement for expensive drugs and implants when submitting claims to non-Medicare payers which pay per unit according to the HCPCS

- **Supply charges** such as implants and off-the-shelf prosthetics and orthotics should be recorded with the appropriate HCPCS whenever possible; failure to report the HCPCS can result in lost reimbursement and billing issues for procedures which require a separate implant HCPCS to be reported on the same claim.

The use of “miscellaneous” charge lines should be carefully monitored in order to avoid lost reimbursement.Some department personnel may find it more convenient to use the miscellaneous charge code rather than to look up the appropriate chargemaster line item for the for pharmacy or supply to be charged.

MONITOR "MISCELLANEOUS" CHARGEMASTER LINE ITEM USE

In a recent audit of a “miscellaneous” pharmacy charge line, PARA found two expensive drugs were charged using the “miscellaneous drugs” charge line, although there were alternative established chargemaster procedure codes that would have reported the drug correctly.

This indicates that the staff inappropriately used the “misc” charge, perhaps because it was easier than looking up the correct charge code for those drugs.

Department managers which permit staff to use a “miscellaneous” charge line should regularly audit charges generated using that item no less frequently than once a week.

Managers have a responsibility to ensure that staff utilize “misc” line items appropriately, and to ensure the facility captures appropriate reimbursement for services that require HCPCS reporting on an outpatient claim.

HRSA COVID-19 UNINSURED PROGRAM TO STOP ACCEPTING CLAIMS

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

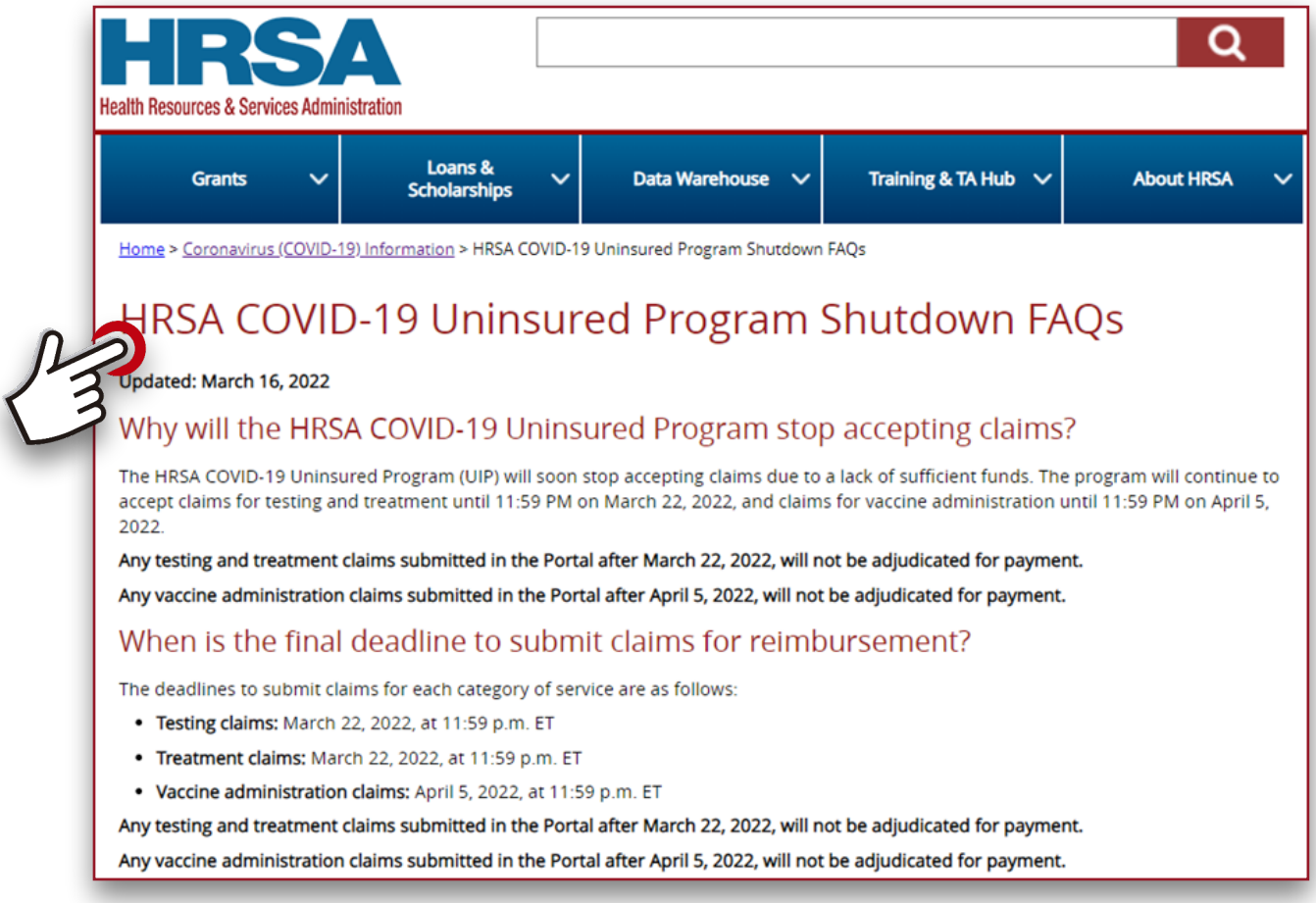
Beginning **April 5, 2022**, the program will no longer accept vaccination claims submitted for the Uninsured Program.HRSA will continue to adjudicate and pay claims submitted based on the availability of remaining funds.

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

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

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

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



FINDING CASH IN AN UNLIKELY REVENUE STREAM

A CASE STUDY: HOW A LARGE HEALTH SYSTEM REDUCED EXTREMELY-AGED ACCOUNT WRITE-OFFS.

OVERVIEW

A large California health system's fiscal year-end was fast approaching and was faced with a large subset of inventory at 386 days old.

It is well known that the longer a claim goes unresolved, the less money there is to collect and the general consensus for aged claims exceeding a year is to write it off. The system wasn't ready to accept the losses and was not in the position to add resources.

The system decided to partner with **ParaRev** to collect any amount that could be saved, and signed on for a one-time, fiscal year-end project.

BACKGROUND

The California health system's fiscal year-end was at the end of March, and upon agreement, **ParaRev** received the placements the first week of February with a four month agreement to boost their year-end collections. This left **ParaRev** with two months to collect as much of the $9 million in placements as possible before the year-end, plus an extra two months to collect anything else that could be reclaimed.

The age of the accounts and the denial mix were two major contributors to the challenge of resolving this inventory.

Thirty-one percent of the accounts were Managed Medicare and Medicaid with an average age of 409 days. The non-government payers consisted of 69% of the accounts and had an average age of 376 days.

Out of the total denial mix, 40% were inpatient contractual reviews and 33% were clinical based rejections.

FINDING CASH IN AN UNLIKELY REVENUE STREAM

EXECUTION

ParaRev utilized their process of combined robotic analytics and intelligent automation along with specialized representative experts to collect on the $9 million inventory that was over 386 days old. This process allowed **ParaRev** to quickly identify that out of the $9 million in inventory, $7 million had a chance of collectability while the remaining $2 million was labeled dead inventory. In order to accomplish the goal of making low collectible accounts collectible, strict oversight was required.

ParaRev then organized and distributed the collectible inventory to the remediation specialists whose skill set matched that of the inventory and had them challenge the carriers to the highest degree. The dead inventory was distributed to the analyst team to complete the proper adjustments and to identify exactly what went wrong.

After the analysts identified the actual root causes, the problems were compiled into a presentation for the health system, explaining the pain points and how the system could avoid these denials in the future. Following the set up of the structure of collecting on these accounts, experienced management constantly monitored and calibrated the staff to optimize for efficiency.

This strategy proved to be so successful that the health system requested an extension of the contract to have **ParaRev** continue to collect on the accounts.

RESULTS

The fiscal year-end project lead with $9 million in placements at 386 days and **ParaRev** was able to obtain a 34% net collection rate, with a 27% gross rate over a 9-month period.

In the four months **ParaRev** was originally given to work the accounts, a collection growth of $500k per month was achieved for totals of:

- $980k by the end of March
- $1.5 million by the end of April
- $2 million by the end of May

ParaRev Quickly identified $7 million in inventory as being collectible, collected $2 million within four months, and highlighted root-cause trending in the following areas:

- Clinical (37%)
- Contractual Underpayment (30%)
- Coding and Billing (27%)
- Coverage and Registration (6%)

At the end of the four months, **ParaRev** collected $2 million and identified that there was $2 million in opportunities remaining and continued to collect on them as the one-time service had grown into a true partnership.

After pushing back on the insurance carriers for lack of payment, **ParaRev** was able to collect $2.5 million for a net collection rate of 34%. In addition to bringing in the system's hard-earned cash, **ParaRev** also provided trending insights into the denials that impacted their bottom line and how to avoid these denials in the future.

This included detailed trending on top denial areas including: clinical (37%), contractual underpayments (30%), coding, billing, and rebilling (27%), and coverage and registration issues (6%). In the end, **ParaRev** successfully collected on a subset of inventory that is not typically highly collectible with a good turnaround. **ParaRev** can succeed where others have been unable to and areas that are not necessarily thought of as collectible.

CONCLUSION

ParaRev's scalable, client-specific accounts receivable resolution and recovery solutions allow hospitals to systematically address problem claims across the full AR spectrum- from long term to a project basis. With the addition of our proprietary intelligent automation working alongside our remediation specialists, we're able to resolve all claims, regardless of size or age- bringing in the cash and providing real-time trending presentations to provide insight into what is truly driving your delayed payments and offering solutions to prevent these occurrences from happening in the future.

Hospitals looking for a new AR recovery and resolution partner can look to **ParaRev.** Rates are contingency based, so there are no hidden nor cancellation fees.

"Some people call themselves vendors when they have no business calling themselves vendors, but ParaRev does," said Corporate Director of Patient Financial Services.

NON-ESRD DIALYSIS FACILITY BILLING AND CODING

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

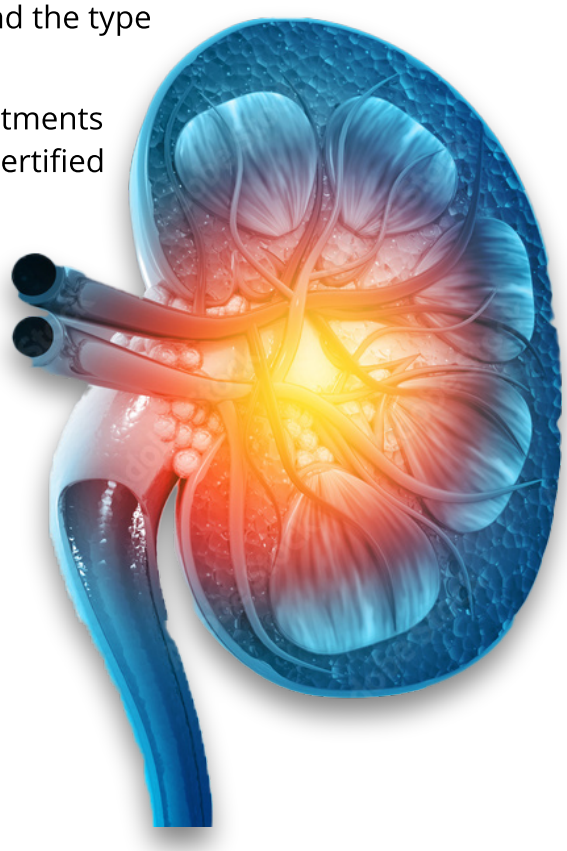
There is a coordination of benefits period of 30 months for beneficiaries who qualify for Medicare based on ESRD and who also have group health coverage – the group health coverage is primary during the 30-month waiting period. After 30 months, Medicare ESRD coverage becomes primary.Consequently, many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

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

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

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

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



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

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

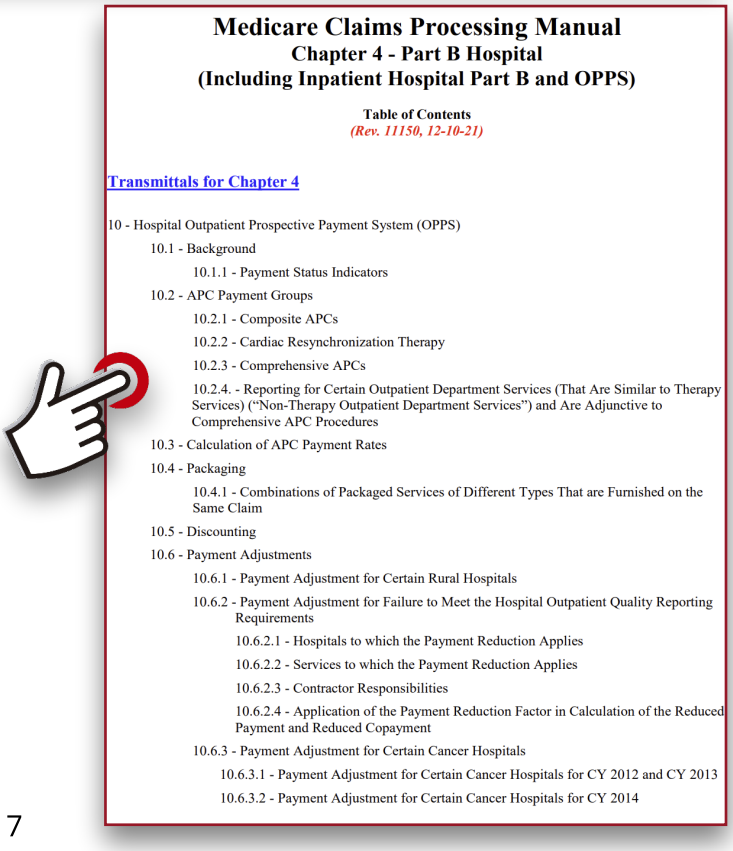
NON-ESRD DIALYSIS FACILITY BILLING AND CODING

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

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

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

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



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

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

Transmittals for Chapter 4

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

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

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

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

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

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

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

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

NON-ESRD DIALYSIS FACILITY BILLING AND CODING

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

10.5 - Hospital Services

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

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

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

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

Medicare Claims Processing Manual

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

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

Transmittals for Chapter 8

STAYING FINANCIALLY HEALTHY

As essential as these efforts are, it is also important that providers take steps to protect their revenue cycle operations and limit the economic fallout the pandemic is likely to produce. These actions can include adjusting financial projections to reflect the fast-changing operational environment and implementing alternative revenue cycle processes to help preserve cash flow. Hospitals with appropriate safeguards should allow revenue cycle staff to work from home.

They should also consider enlisting trusted third-parties to supplement key elements of the revenue cycle, including accounts receivable management, to avoid cash flow disruptions.

Before reviewing operational concerns and considering assistance, any initial effort to meet the anticipated financial impact of the COVID-19 pandemic must start with revising financial performance targets, cash flow projections, and operational plans to reflect the following:

- The extended suspension of higher-margin elective surgeries
- The impact of increased supply costs and potential supply chain disruptions
- The effect of rising labor costs due to extended operational demands
- The balance sheet implications of declining investment income due to equity losses
- The possibility of payer disruptions affecting prompt reimbursement

OPERATIONAL CONSIDERATIONS

In addition to making necessary adjustments in their financial projections, hospitals should be aware of operational issues related to the COVID-19 outbreak that could negatively impact cash flow and overall performance.

STAYING FINANCIALLY HEALTHY

Among them:

- Coders should be educated in the use of the new COVID-19-related CPT® and HCPCS codes for both private payer and government claims. And stemming from the National Emergency declaration, Medicare has expanded payments for professional services via telehealth, virtual check-ins, and e-visits. Failure to code COVID-19-related care correctly will likely result in denials and payment delays, which may be more difficult and time-consuming to resolve in the current environment

- It is important that hospitals monitor clearinghouse or bank electronic data interchange (EDI) capabilities to ensure 837 and 835 files containing claims and payment information continue to transit between payers and providers. Some hospitals have reported sporadic interruptions in their EDI services. Any substantial downtime that prevents timely claims submission or denial resolution could have a significant impact on collections

- Hospital payer mix may shift rapidly as a growing number of individuals suddenly find themselves out of work. Organizations should monitor claims frequently to determine if Medicare and Medicaid volume is increasing and/ or commercial reimbursement is falling. Significant changes could have a major impact on budget projections

- Payer hold times for hospital staff working denials in many instances have increased due to limited staff availability at insurance company call centers. As a result, any automation processes that allow claims to be resolved without direct payer-provider interaction should be brought to bear

- If they haven't done so already, hospitals should work with payers to enable the receipt of 266/267 claim status files from clearinghouses to ensure up-to-date information regarding the status of unpaid claims. Payer portals should also be used to monitor and track unpaid claims

WORKING REMOTELY

As hospitals reduce non-critical, on-site staff, ensuring that revenue cycle employees can continue coding, filing claims and handling accounts receivable follow-up from home is essential to keep cash coming in. Critical infrastructure elements needed to support secure, remote revenue cycle operations include:

- Robust work-at-home platforms
- Encryption both for data at rest and data in flight
- Multifactor authentication
- Secure operating environments

Internal encryption capabilities built into laptops and remote workstations are essential to reduce or eliminate breach risks surrounding the transfer of protected health information. Also important are virtual private networks and multi-factor logon authentication.

TRUSTED AND TIMELY THIRD-PARTY ASSISTANCE

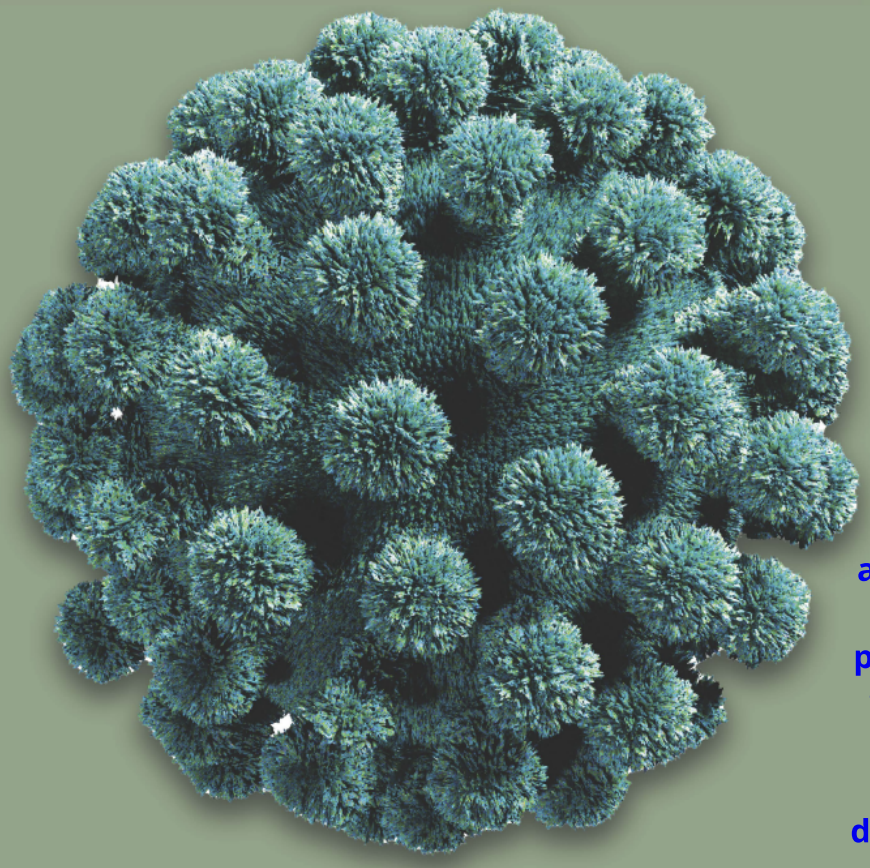
Whether hospitals and other providers elect to shift revenue cycle staff to the home setting or not, they should consider partnering with a trusted third-party capable of taking over elements of the revenue cycle for the duration of the crisis.

ParaRev provides a full range of outsourced AR follow-up services, including aging claims resolution, denial management and bad debt mitigation to help ensure claims are clean and paid the first time around to mitigate any delays. More than 98% of the company's workforce is now deployed remotely and all of **ParaRev's** remote work processes are HITRUST CSF®-certified. **ParaRev** additionally uses data analytics and intelligent automation to expedite claims resolution, often without human touchpoints.

And for clients using the **PARA Data Editor**, our services are built for remote access, so organizations can continue business as usual regardless of where personnel are working. Most importantly, **ParaRev** has the ability to scale up quickly to handle additional workflow. With assistance from the client, we can be up and running to manage aging AR and denials in a few days' time. Your organization can minimize or avoid cash flow disruptions while concentrating valuable employee resources in other areas.

UPDATED 3/15/22

2022 COMPREHENSIVE COVID-19 Guide



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

PARAREV

TUESDAY WEBINARS: COMPLYING WITH THE NO SURPRISES ACT

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

Every Tuesday

11:30 am PST

Sign Up By Clicking HERE,

Or Scan The QR Code

MEDICARE THERAPY DISCOUNTS EXPLAINED

EFFECTIVE JANUARY 1, 2022, MEDICARE BEGAN APPLYING A 15% DISCOUNT TO PAYMENTS FOR "ALWAYS THERAPY" SERVICES RENDERED BY A PT ASSISTANT OR AN OT ASSISTANT, AS INDICATED BY MODIFIERS CO OR CQ APPENDED TO THE THERAPY HCPCS ON A CLAIM.

- **CO**-Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

- **CQ**- Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

Providers may recognize the discount on therapy services billed with a CQ or CO modifier by examining the Medicare remittance advice for remark code N851; the actual discount due to the CO or CQ modifier will be reported with Remark Code CO45:

- **N851**– Payment reduced because services were furnished by a therapy assistant

- **CO 45**– Contractual Discount

Medicare pays both facility claims and professional fee claims for "always therapy" codes under the Medicare Physician Fee Schedule (MPFS), which calculates reimbursement using relative value units (RVUs.) The algebra of calculating the CO/CQ discount is tricky for two reasons -- not only is there a discount applied to the payments for services performed by a therapy assistant, but oftentimes another discount applies to multiple procedures performed on the same day

Here's an actual 2022 Medicare remittance from a facility in Indiana:

DOS	CPT®	Mod	Units	Charges	MCare Paid	Pt Liable PR1	Pt Liable PR2	Total Allowed
1/3/2022	97161	GP	1	298.00	71.78	6.74	17.95	96.47
1/3/2022	97110	GP	1	160.00	16.46	1.54	4.12	22.12
1/21/2022	97110	GP CQ	2	320.00	31.93	3.52	9.39	44.84
Claim Total:				**$ 800.00**	**$ 153.09**	**$ 14.88**	**$ 39.70**	**$ 163.43**

MEDICARE THERAPY DISCOUNTS EXPLAINED

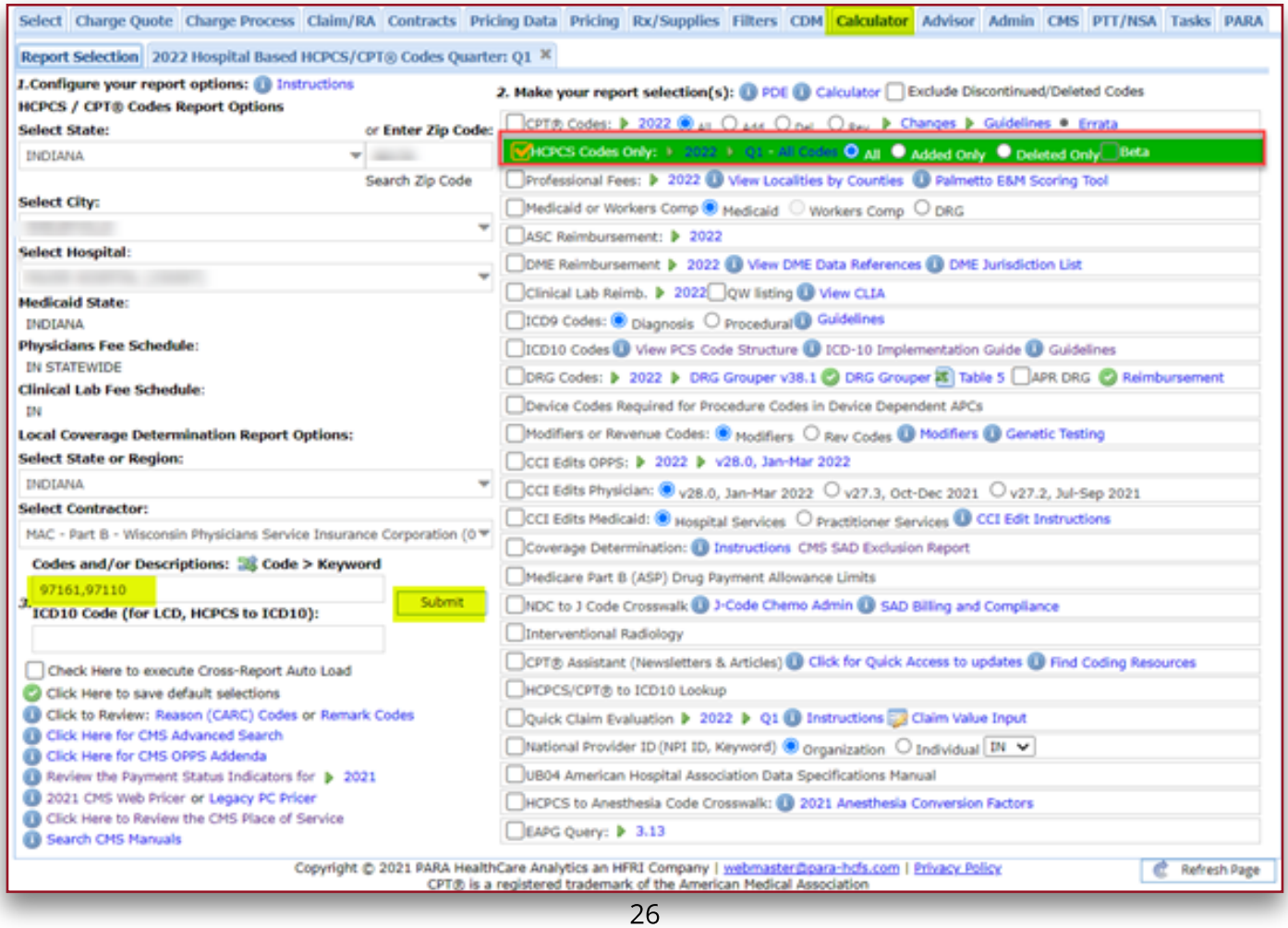
Here are the calculations in Medicare's adjudication, broken out by the multiple procedure discount and the CO/CQ discount:

DOS	CPT®	Mod	Units	First unit per DOS	Subsq Unit(s)	CQ Discount	Total Allowed
1/3/2022	97161	GP	1	96.47			96.47
1/3/2022	97110	GP	1		22.12		22.12
1/21/2022	97110	GP CQ	2	28.35	22.12	(5.63)	44.84
Claim Total:							**$163.43**

A detailed explanation of the two discounts that may be applied to therapy services is provided on the following pages.Medicare's list of "Always Therapy" for 2022 is on the Medicare website at:

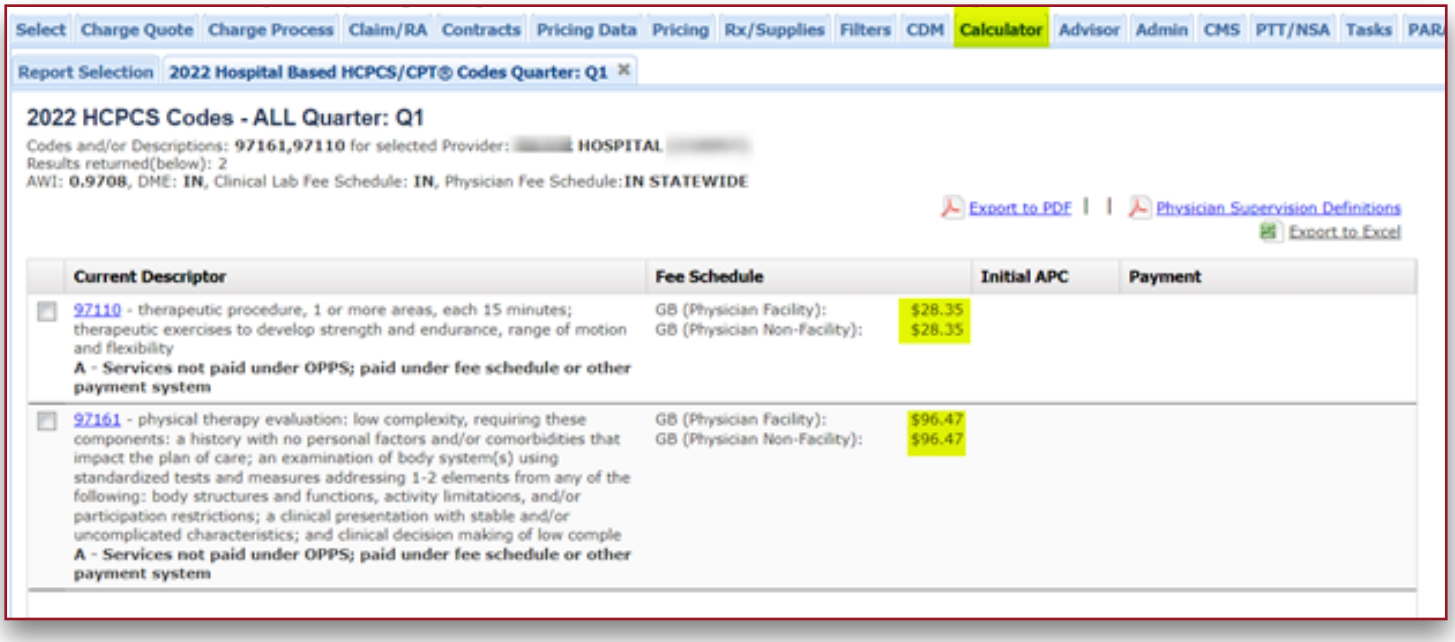
https://www.cms.gov/files/zip/2022-therapy-code-list-and-dispositions.zip

PARA Data Editor users can find the total allowed amount for the initial procedure (after Medicare GPCI adjustments appropriate to the client's locality) on the Calculator tab.Enter the code in the field on the left, and select the HCPCS report on the right:



MEDICARE THERAPY DISCOUNTS EXPLAINED

The report returns the payment rate that is adjusted for the locality, but **not adjusted** for multiple procedures, or for the CO/CQ modifier:



To calculate the multiple procedure discount:

- Start with the full value of the Medicare Physician Fee Schedule GPCI-adjusted allowable for the most highly valued therapy service on the same day

- Reduce the allowable for all “subsequent” therapy services provided on the same day.The full rate should be reduced by 50% of that portion which is attributed to the Practice Expense RVU for the specific CPT®(s.)

- If any therapy procedures were performed by an Assistant (CQ or CO modifier), reduce the portion of the allowable that Medicare paid for that line item by 15%. (In other words, the 15% reduction does not apply to that portion which is adjudicated to patient coinsurance or deductible.)

MEDICARE THERAPY DISCOUNTS EXPLAINED

Example– The unadjusted "national" rates for each therapy CPT® is calculated from the RVU values for each code.These values are summed and multiplied by the Medicare Physician Fee Schedule 2022 conversion factor of $34.6062. The three components of RVU (Practice Expense (PE), Work, and Malpractice Liability (MP)) are shown in the table below:

National Unadjusted RVUs (2022 MPFS rate @ $34.6062)						
HCPCS	**Description**	**Practice Expense**	**Work**	**Mal-Practice**	**Total RVU**	**2022 Allowable (RVU X $34.6062)**
97110	Ther Exercises	0.4	0.45	0.02	0.87	$ 30.11
97161	PT Eval - Low	1.35	1.54	0.07	2.96	$ 102.43

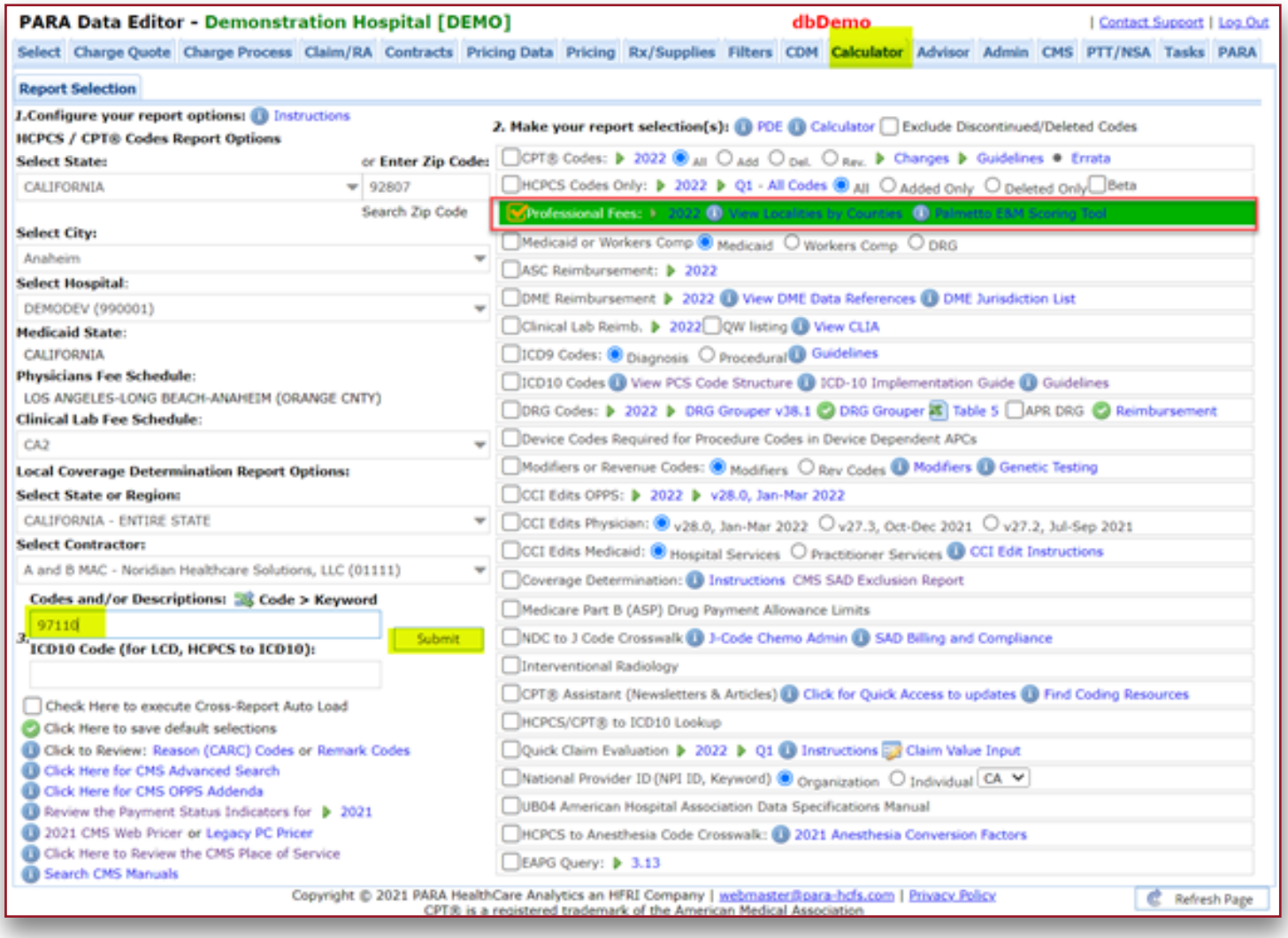
To adjust the total national RVUs for the Geographic Practice Cost Indices for a given locality, multiply the RVU category by the corresponding Geographic Practice Cost Index factors.

For example, to adjust the RVU values for 2022 in Indiana, Practice expense is adjusted to .9 x the national rate, and malpractice liability is adjusted to .465 x the national rate (work is not adjusted, valued at 1.0 times the national rate):

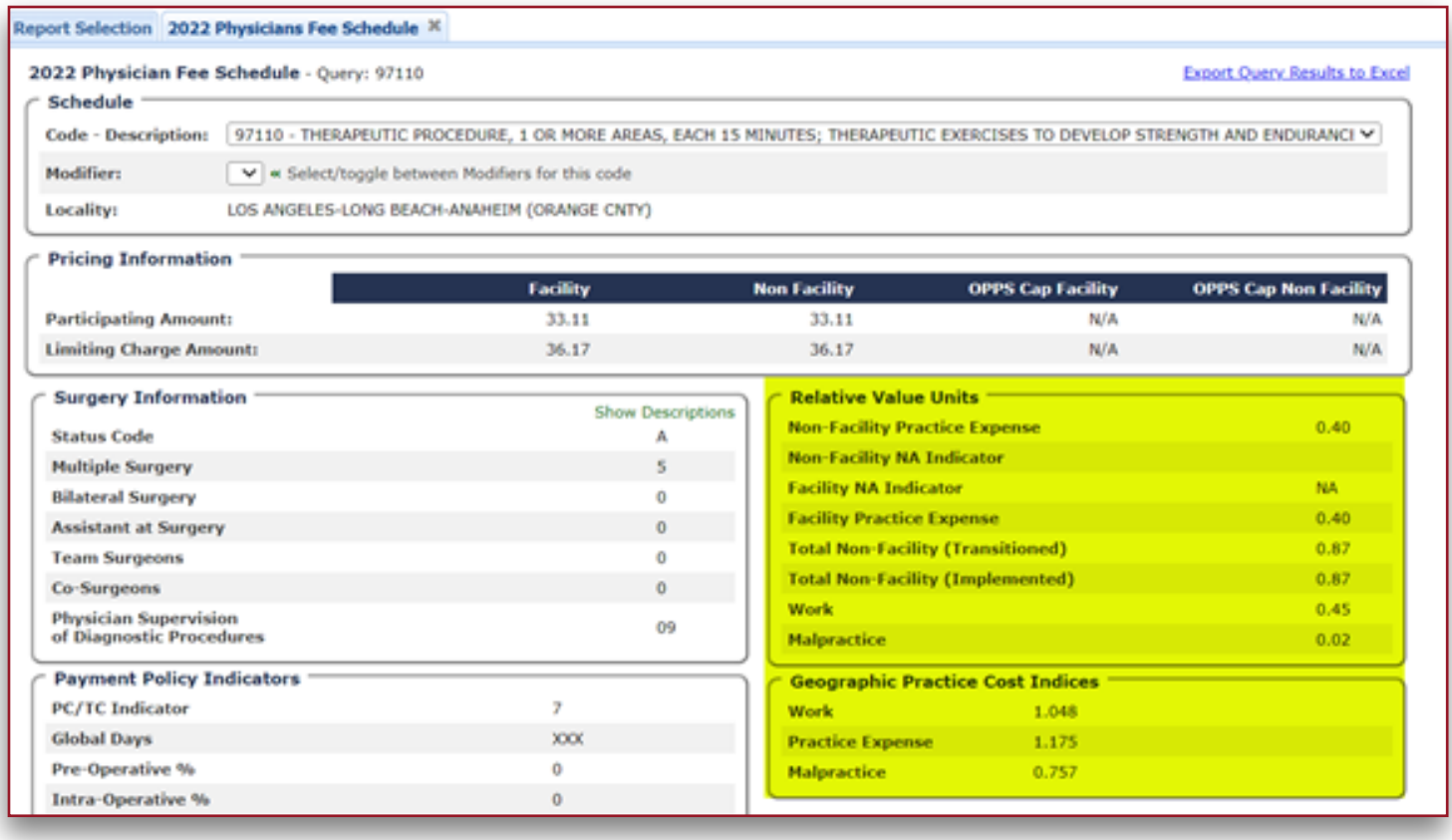
Indiana GPCI Adjusted RVUs (2022 MPFS rate @ $34.6062)						
HCPCS	**Description**	***Practice Expense @ 0.9x***	**Work @ 1x**	**Mal-Practice @ 0.465x**	**Total RVU**	**2022 Allowable (RVU X $34.6062)**
97110	Ther Exercise	.36	0.45	0.0093	0.8193	$ 28.35
97161	PT Eval - Low	1.215	1.54	0.03255	2.79	$ 96.47

MEDICARE THERAPY DISCOUNTS EXPLAINED

PARA Data Editor userscan find the national RVU rates and the GPCI adjustment factors for the client's locality by searching the CPT® code in the Calculator; select the "Professional Fees" report on the right:



MEDICARE THERAPY DISCOUNTS EXPLAINED



Report Selection | 2022 Physicians Fee Schedule

2022 Physician Fee Schedule - Query: 97110 — Export Query Results to Excel

Schedule

Code - Description:	97110 - THERAPEUTIC PROCEDURE, 1 OR MORE AREAS, EACH 15 MINUTES; THERAPEUTIC EXERCISES TO DEVELOP STRENGTH AND ENDURANCI
Modifier:	« Select/toggle between Modifiers for this code
Locality:	LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)

Pricing Information

	Facility	Non Facility	OPPS Cap Facility	OPPS Cap Non Facility
Participating Amount:	33.11	33.11	N/A	N/A
Limiting Charge Amount:	36.17	36.17	N/A	N/A

Surgery Information — Show Descriptions

Status Code	A
Multiple Surgery	5
Bilateral Surgery	0
Assistant at Surgery	0
Team Surgeons	0
Co-Surgeons	0
Physician Supervision of Diagnostic Procedures	09

Relative Value Units

Non-Facility Practice Expense	0.40
Non-Facility NA Indicator	
Facility NA Indicator	NA
Facility Practice Expense	0.40
Total Non-Facility (Transitioned)	0.87
Total Non-Facility (Implemented)	0.87
Work	0.45
Malpractice	0.02

Payment Policy Indicators

PC/TC Indicator	7
Global Days	XXX
Pre-Operative %	0
Intra-Operative %	0

Geographic Practice Cost Indices

Work	1.048
Practice Expense	1.175
Malpractice	0.757

To apply the Medicare discount for subsequent units of service on the same day, adjust the Practice Expense portion of the GPCI adjusted rates to 50% of the "initial" rate; the work and malpractice liability rates remain the same as the initial unit rate:

Indiana Subsequent Unit Medicare Allowable Rates – Practice Expense Discounted to .5

HCPCS	*Full Practice Expense*	Practice Expense @ .5	Work	MalPractice	Total
97110	*12.46*	$ 6.23	$ 15.57	$ 0.32	**$ 22.12**

MEDICARE THERAPY DISCOUNTS EXPLAINED

For example, if a physical therapist reported both an evaluation 97161 on the same DOS as one unit of 97110, Medicare would pay the full amount for the higher value service, 97161, and the discounted rate for the subsequent unit of service on the same day, 97110:

DOS	CPT®	Mod	Units	MCare Pays	Patient Liability (Deductible)	Patient Liability Coinsurance	Total Allowed
1/3/2022	97161	GP	1	71.78	6.74	17.95	**96.47**
1/3/2022	97110	GP	1	16.46	1.54	4.12	**22.12**

The CO/CQ Discount on Medicare Payment

To calculate payment for services performed by a Physical Therapy Assistant, the patient liability must be a known value.Since the discount for a therapy assistant does not affect patient liability, the portion of the allowable that is adjudicated to deductible and coinsurance remains unchanged.Medicare reduces only that portion of the allowable amount that Medicare pays by 15%.

In the table below, the allowable for CPT® 97161, which was performed by a physical therapist, is calculated at the full, GPCI-adjusted rate of $96.47.The Medicare-paid portion of the allowable for CPT® 97110, which reported the CQ modifier, is discounted from $16.46 to 85%, or $13.99.

Indiana Medicare Allowable Rates – PE discounted, MCare payment at 85%							
DOS	CPT®	Mods	Units	MCare Paid Portion	Patient Liability (Deductible)	Patient Liability Coinsurance	Total Allowed
1/3/2022	97161	GP	1	71.78	6.74	17.95	96.47
1/3/2022	97110	GP CQ	1	13.99*	1.54	4.12	19.65

**97110 subsequent rate of $22.12 less patient liability (1.54 + 4.12) xCQ discount of .85 = $13.99*

MEDICARE THERAPY DISCOUNTS EXPLAINED

The multiple procedure discount is explained in Chapter 5 - Part B Outpatient Rehabilitationand CORF/OPT Services of the Medicare Claims Processing Manual:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf#

> **10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services**
>
> (Rev. 3475, Issued: 03-04-16, Effective: 06-06-16, Implementation: 06-06-16)
>
> Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services.The reduction applies to the HCPCS codes contained on the list of "always therapy" services (see section 20), excluding A/B MAC (B)-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.
>
> Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures.Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure.The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.
>
> Full payment is made for the unit or procedure with the highest PE payment.
>
> **...**
>
> For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.
>
> ...

The same chapter of the Medicare Claims Processing Manual also explains the discount applied to the paid portion for services provided by a PT Assistant or OT Assistant:

> **20.1 - Discipline Specific Outpatient Rehabilitation Modifiers - All Claims**
>
> ...*For dates of service, on and after January 1, 2022, claims billed with a CQ or CO modifier to indicate the services were furnished in whole or in part by a PTA or OTA are paid at an amount equal to 85 percent of the otherwise applicable Part B payment that's based on the MPFS.The 15 percent reduction is taken last, e.g., after the MPPR (and other reductions where applicable) and right before sequestration. This reduction is taken from the paid amount, i.e., the actual amount paid not the MPFS allowed amount.*

APRIL 2022 HCPCS UPDATE RELEASED

MEDICARE RELEASED THE HCPCS CODE UPDATE FOR APRIL 1, 2022 IN EARLY MARCH.HOWEVER, AS OF MARCH 14, 2022, THE OPPS ADDENDUM B UPDATE FILE IS NOT AVAILABLE, THEREFORE WE ARE UNABLE TO REPORT WHETHER THE NEW HCPCS ARE PAYABLE UNDER OPPS AT THIS TIME.

PARA WILL PUBLISH UPDATES AS THE INFORMATION IS RELEASED.

Four HCPCS for drugs will change; the code pairs are provided in the table below:

ACTION	HCPC	SHORT DESCRIPTION	LONG DESCRIPTION
ADD	J0219	Inj aval alfa-nqpt 4mg	Injection, avalglucosidase alfa-ngpt, 4 mg
Deleted	~~C9085~~	~~Inj avalglucosid alfa-ngpt~~	~~Injection, avalglucosidase alfa-ngpt, 4 mg~~
ADD	J9071	Inj cyclophosphamd auromedic	Injection, cyclophosphamide, (auromedics), **5** mg
Deleted	~~C9087~~	~~Inj cyclophosphamd auromedic~~	~~Injection, cyclophosphamide, (auromedics), 10 mg~~
ADD	J9359	Inj lon tesirin-lpyl 0.075mg	Injection, loncastuximab tesirine-lpyl, **0.075 mg**
Deleted	~~C9084~~	~~Loncastuximab-lpyl, 0.1 mg~~	~~Injection, loncastuximab tesirine-lpyl, 0.1 mg~~
ADD	J0491	Inj anifrolumab-fnia 1mg	Injection, anifrolumab-fnia, 1 mg
Deleted	~~C9086~~	~~Inj, anifrolumab-fnia~~	~~Injection, anifrolumab-fnia, 1 mg~~

APRIL 2022 HCPCS UPDATE RELEASED

Seven new HCPCS were assigned to drugs and biologics which did not have a previous HCPCS assignment – including the HCPCS for Remdesivir, which was announced in January, 2022:

HCPCS	ACTION	SHORT DESCRIPTION	LONG DESCRIPTION
J0248	ADD	Inj. Remdesivir, 1 mg	Injection, remdesivir, 1 mg
J0879	ADD	Difelikefalin, ESRD on dialy	Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis)
C9093	ADD	Inj., susvimo, 0.1 mg	Injection, ranibizumab, via sustained release intravitreal implant (susvimo), 0.1 mg
C9092	ADD	Inj., xipere, 1 mg	Injection, triamcinolone acetonide, suprachoroidal (xipere), 1 mg
C9091	ADD	Sirolimus, protein-bound,1mg	Injection, sirolimus protein-bound particles, 1 mg
C9090	ADD	Plasminogen, human-tvmh 1 mg	Injection, plasminogen, human-tvmh, 1 mg
Q5124	ADD	Inj. byooviz, 0.1 mg	Injection, ranibizumab-nuna, biosimilar, (byooviz), 0.1 mg

Nine new HCPCS for skin substitutes were added – however, the classification of the new HCPCS as “high cost” or “low cost” skin substitutes is not yet published:

HCPC	ACTION	SHORT DESCRIPTION	LONG DESCRIPTION
Q4225	ADD	Amniobind, per sq cm	Amniobind, per square centimeter
Q4258	ADD	Enverse, per sq cm	Enverse, per square centimeter
Q4224	ADD	Hhf10-p per sq cm	Human health factor 10 amniotic patch (hhf10-p), per square centimeter
A2013	ADD	Innovamatrix fs, per sq cm	Innovamatrix fs, per square centimeter
Q4256	ADD	Mlg complet, per sq cm	Mlg-complete, per square centimeter
Q4257	ADD	Relese, per sq cm	Relese, per square centimeter
A4100	ADD	Skin sub fda clrd as dev nos	Skin substitute, fda cleared as a device, not otherwise specified
A2011	ADD	Supra sdrm, per sq cm	Supra SDRM, per square centimeter
A2012	ADD	Suprathel, per sq cm	Suprathel, per square centimeter

APRIL 2022 HCPCS UPDATE RELEASED

One HCPCS for an Appropriate Use Criteria Clinical Decision Support Mechanism was discontinued:

Category	HCPCS	SHORT DESCRIPTION	LONG DESCRIPTION
OPPS CDSM	~~G1009~~	~~Cdsm Sage Health~~	~~Clinical decision support mechanism sage health management solutions, as defined by the medicare appropriate use criteria program~~

A few new HCPCS were assigned to report miscellaneous new supplies/devices:

Type (PARA)	HCPCS	ACTION	SHORT DESCRIPTION	LONG DESCRIPTION
Ultrasound Contrast	A9574	ADD	Air Poly Intrauterine Foam	Air polymer-type a intrauterine foam, 0.1 ml
Opioid Tx	A9291	ADD	Pres Digital Behav Thera Fda	Prescription digital behavioral therapy, FDA cleared, per course of treatment
Optometry	V2525	ADD	Cl, Hydrophilic, Dual Focus	Contact lens, hydrophilic, dual focus, per lens

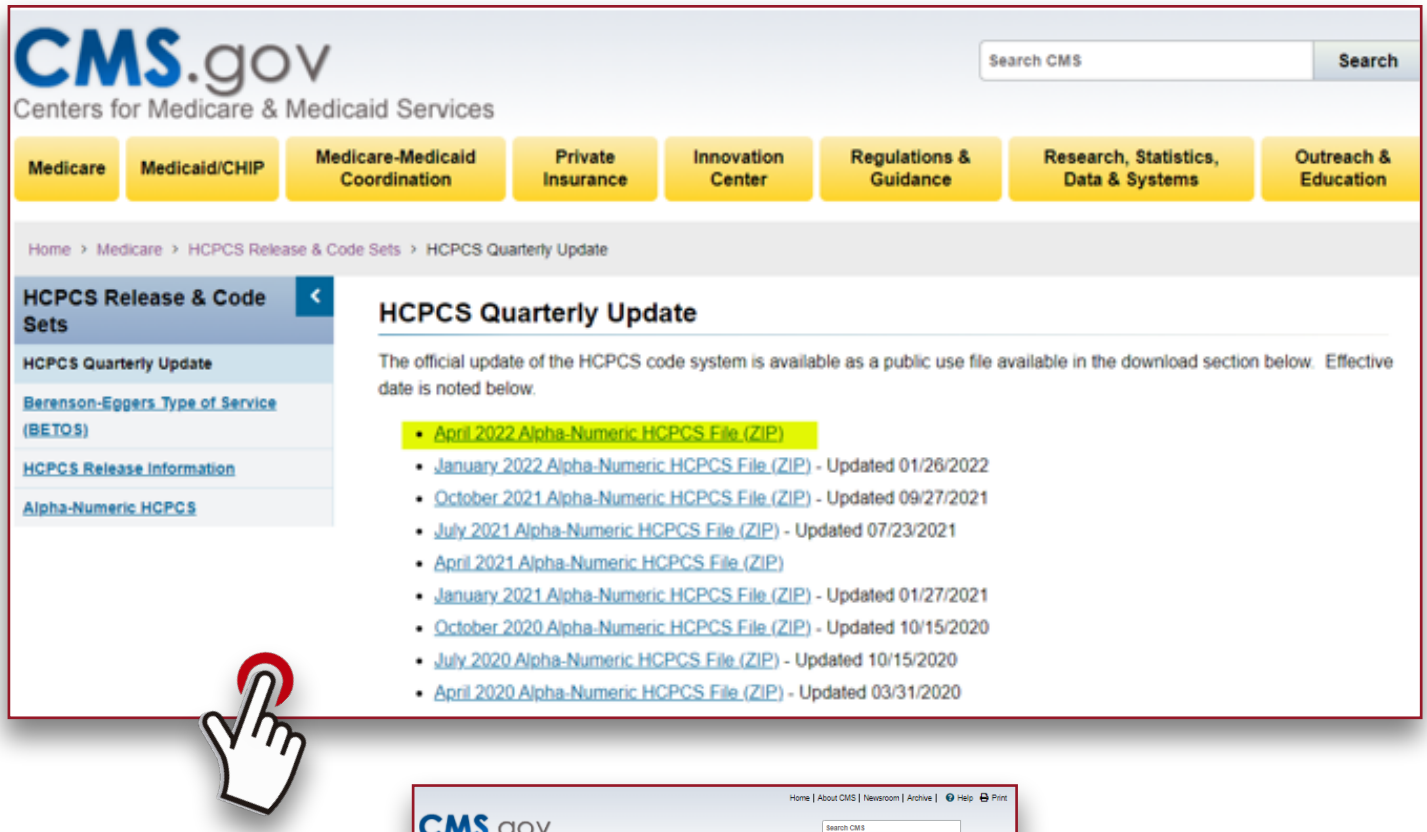
Three new HCPCS for reporting surgical procedures were added:

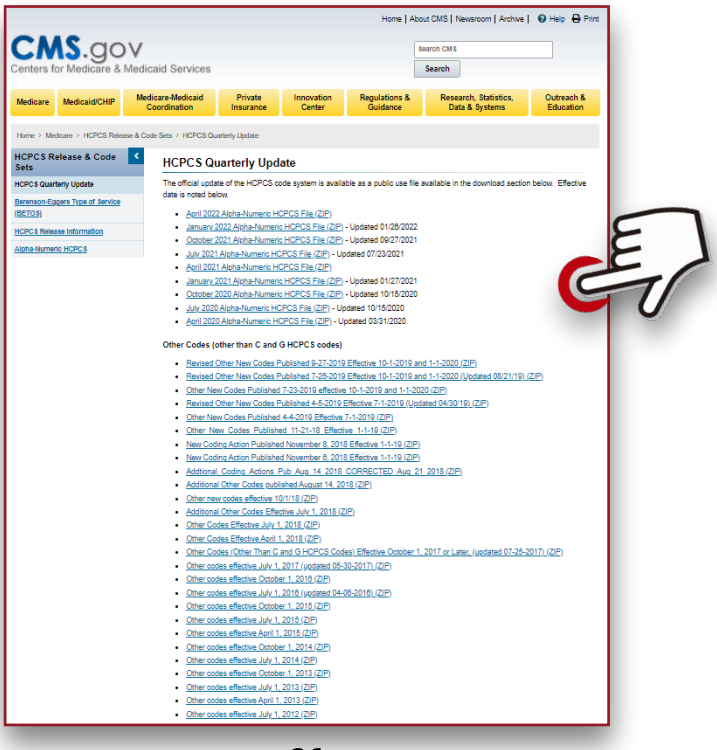
New HCPCS	SHORT DESCRIPTION	LONG DESCRIPTION
C9781	Arthro/shoul surg; w/spacer	Arthroscopy, shoulder, surgical; with implantation of subacromial spacer (e.g., balloon), includes debridement (e.g., limited or extensive), subacromial decompression, acromioplasty, and biceps tenodesis when performed
C9783	Blind cor sinus reducer impl	Blinded procedure for transcatheter implantation of coronary sinus reduction device or placebo control, including vascular access and closure, right heart catherization, venous and coronary sinus angiography, imaging guidance and supervision and interpretation when performed in an approved investigational device exemption (ide) study
C9782	Blind myocar trpl bon marrow	Blinded procedure for New York Heart Association (NYHA) class II or III heart failure, or Canadian Cardiovascular Society (CCS) class III or IV chronic refractory angina; transcatheter intramyocardial transplantation of autologous bone marrow cells (e.g., mononuclear) or placebo control, autologous bone marrow harvesting and preparation for transplantation, left heart catheterization including ventriculography, all laboratory services, and all imaging with or without guidance (e.g., transthoracic echocardiography, ultrasound, fluoroscopy), performed in an approved investigational device exemption (ide) study

APRIL 2022 HCPCS UPDATE RELEASED

The full April 2022 HCPCS file release is available at the following link:

https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update





FAQ: GOOD FAITH ESTIMATES IMPLEMENTATION

CMS HAS PUBLISHED A COMPREHENSIVE FREQUENTLY ASKED QUESTIONS DOCUMENT COVERING THE IMPLEMENTATION OF GOOD FAITH ESTIMATES FOR UNISURED AND SELF-PAY PATIENTS.

CLICK ON THE IMAGE BELOW TO VIEW THE ENTIRE, INFORMATIVE DOCUMENT.

Frequently Asked Questions (FAQs) about Consolidated Appropriations Act, 2021 Implementation- Good Faith Estimates

Good Faith Estimates (GFE) for Uninsured (or Self-pay) Individuals

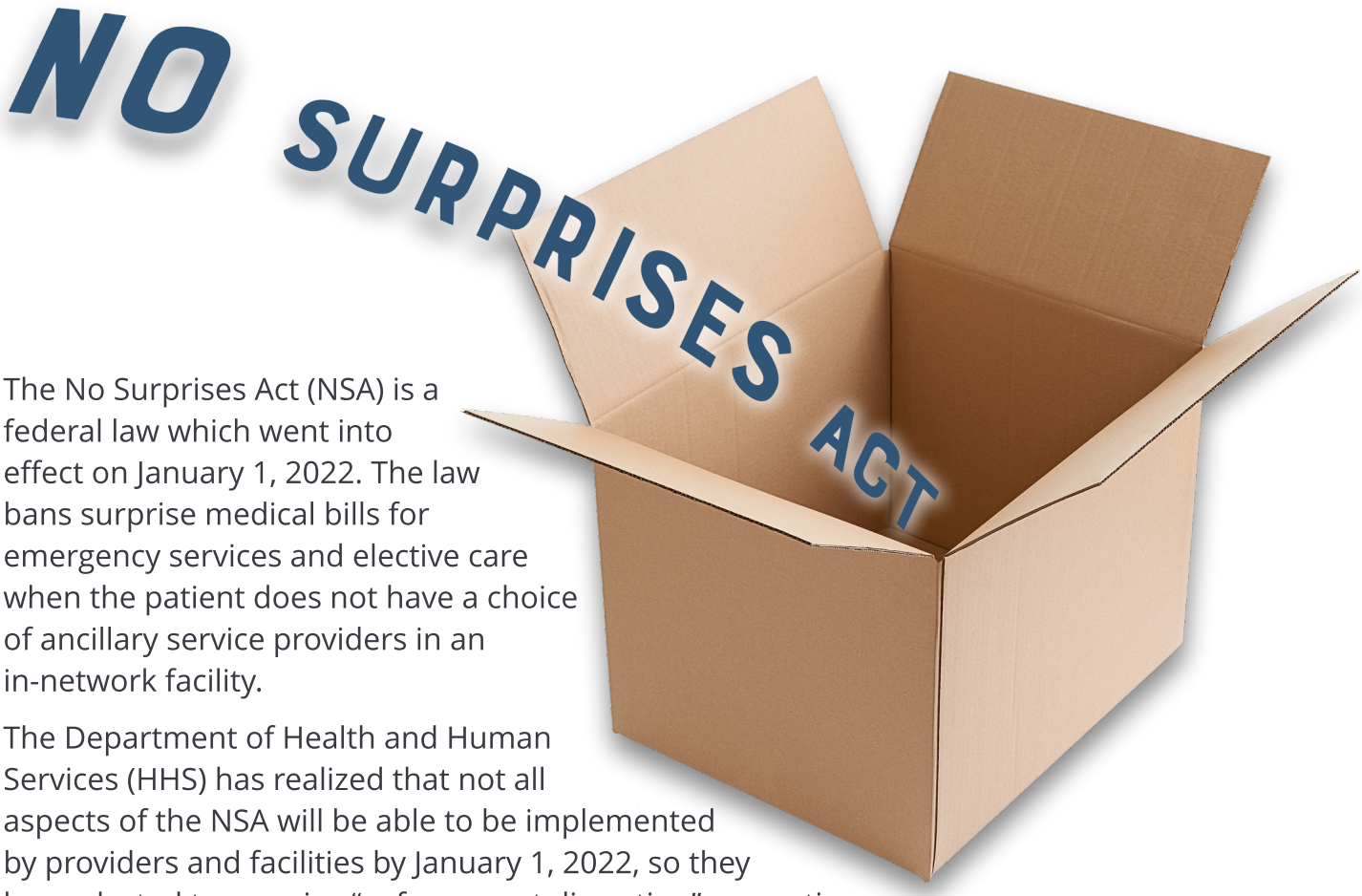
Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 112 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021 (CAA 2021), and implementing regulations published in the Federal Register on October 7, 2021 as part of interim final rules with comment period, entitled "Requirements Related to Surprise Billing; Part II."

These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

The information provided in this document is intended only to be a general informal summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance upon which it is based. This document summarizes current policy and operations as of the date it was presented. We encourage readers to refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

2022 REQUIREMENTS -- UPDATED

UNPACKING THE "NO SURPRISES ACT".



The No Surprises Act (NSA) is a federal law which went into effect on January 1, 2022. The law bans surprise medical bills for emergency services and elective care when the patient does not have a choice of ancillary service providers in an in-network facility.

The Department of Health and Human Services (HHS) has realized that not all aspects of the NSA will be able to be implemented by providers and facilities by January 1, 2022, so they have elected to exercise "enforcement discretion" on portions of the act in 2022. To be in compliance in 2022, healthcare providers and health care facilities must be prepared to:

1. Publicize and disseminate a "Disclosure Notice" which informs beneficiaries of group health plans of their rights under the No Surprises Act; and
2. Publicize and disseminate a "Right to Receive a Good Faith Estimate" to uninsured or self-pay patients; and
3. Provide uninsured or self-pay patients with a good faith estimate (within a $400 threshold) of services that will be billed by the "convening" provider or facility.
4. Present a Notice and Consent form, with an estimate of charges, to a beneficiary of a group health plan who chooses to receive services from an out-of-network facility or provider and submit a claim to the health plan.

2022 REQUIREMENTS -- UPDATED

DISCLOSURE NOTICE

As of January 1, 2022, the disclosure notice must be prominently displayed on websites, in public areas of an office or facility, and on a one-page (double-sided) notice provided in-person or through mail or e-mail, as chosen by the patient. The disclosure notice must be provided to all commercially insured patients after January 1, 2022, or before that date if the elective service will be provided after January 1, 2022. The notice must be provided before requesting a payment from the insured or before a claim is submitted on behalf insured.
[eCFR :: 45 CFR Part 149 — Surprise Billing and Transparency Requirements]

(d) ***Timing of disclosure to individuals.*** A health care provider or health care facility is required to provide the notice to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer no later than the date and time on which the provider or facility requests payment from the individual, or with respect to an individual from whom the provider or facility does not request payment, no later than the date on which the provider or facility submits a claim to the group health plan or health insurance issuer.

(e) ***Exceptions.*** A health care provider is not required to make the disclosures required under this section -

(1) If the provider does not furnish items or services at a health care facility, or in connection with visits at health care facilities; or

(2) To individuals to whom the provider furnishes items or services, if such items or services are not furnished at a health care facility, or in connection with a visit at a health care facility.

(c) ***Required methods for disclosing information.*** Health care providers and health care facilities must provide the disclosure required under this section as follows:

(1) With respect to the required disclosure to be posted on a public website, the information described in paragraph (b) of this section, or a link to such information, must appear on a searchable homepage of the provider's or facility's website. A provider or facility that does not have its own website is not required to make a disclosure under this paragraph (c)(1).

(2) With respect to the required disclosure to the public, a provider or facility must make public the information described in paragraph (b) of this section on a sign posted prominently at the location of the provider or facility. A provider that does not have a publicly accessible location is not required to make a disclosure under this paragraph (c)(2).

(3) With respect to the required disclosure to individuals who are participants, beneficiaries, or enrollees of a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a provider or facility must provide the information described in paragraph (b) of this section in a one-page (double-sided) notice, using print no smaller than 12-point font. The notice must be provided in-person or through mail or email, as selected by the participant, beneficiary, or enrollee.

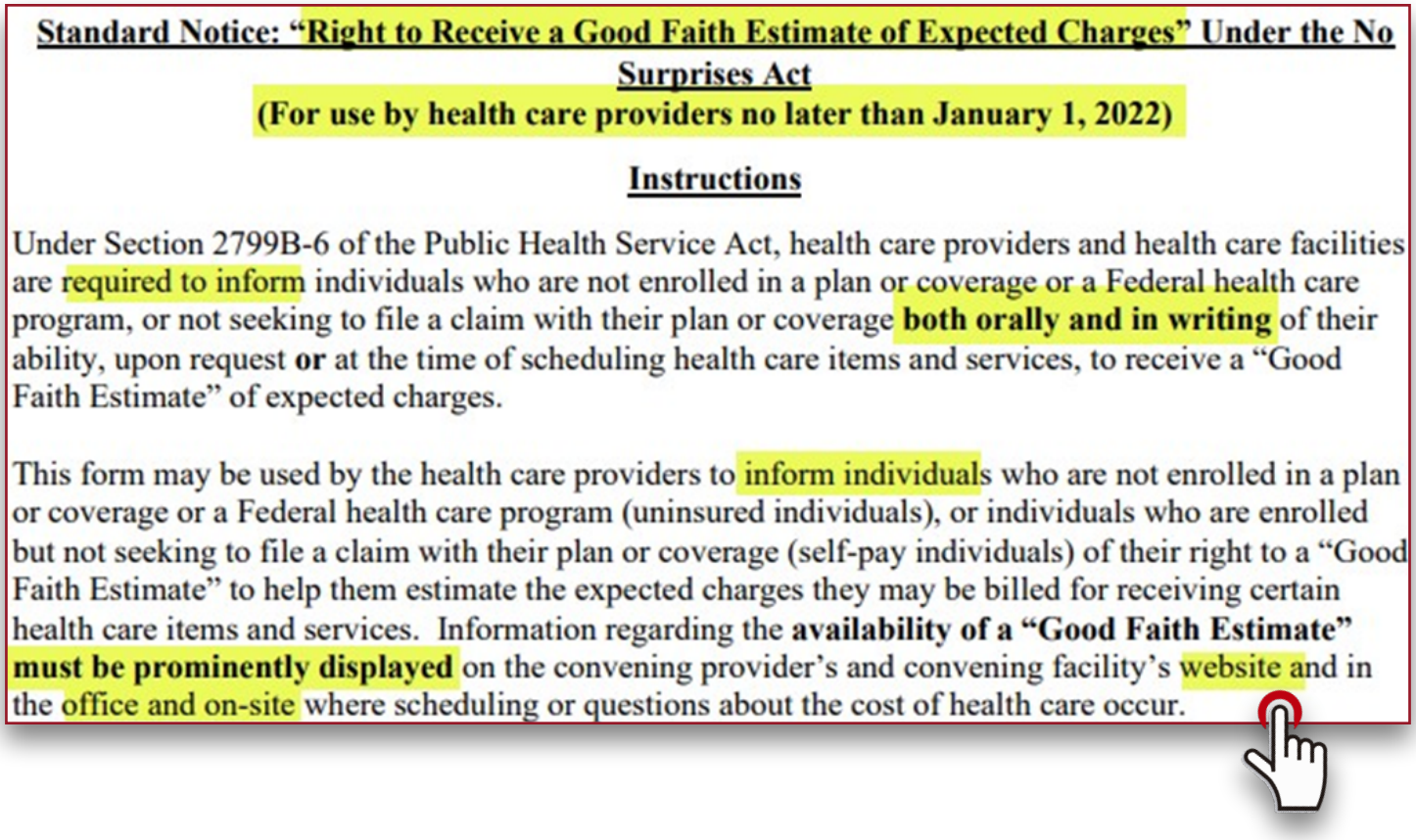
2022 REQUIREMENTS -- UPDATED

In states where there are state laws that protect patients against surprise billing, providers and facilities can use a state disclosure notice if it meets or exceeds the federal guidelines. If a provider or facility drafts their own disclosure notice it must include these three points:

1. Restrictions on providers and facilities regarding balance billing in certain circumstances
2. Any applicable state laws protecting against balance billing
3. Contact information for appropriate state and federal agencies if the individual believes their rights have been violated

RIGHT TO RECEIVE A GOOD FAITH ESTIMATE NOTICE

All uninsured or self-pay individuals must be made aware, both orally and in writing, of their right to receive a good faith estimate for any services that will be rendered beginning January 1, 2022. The form must be prominently displayed on websites, in offices, and where scheduling or questions about the cost of health care may occur.



Standard Notice: "Right to Receive a Good Faith Estimate of Expected Charges" Under the No Surprises Act

(For use by health care providers no later than January 1, 2022)

Instructions

Under Section 2799B-6 of the Public Health Service Act, health care providers and health care facilities are required to inform individuals who are not enrolled in a plan or coverage or a Federal health care program, or not seeking to file a claim with their plan or coverage **both orally and in writing** of their ability, upon request **or** at the time of scheduling health care items and services, to receive a "Good Faith Estimate" of expected charges.

This form may be used by the health care providers to inform individuals who are not enrolled in a plan or coverage or a Federal health care program (uninsured individuals), or individuals who are enrolled but not seeking to file a claim with their plan or coverage (self-pay individuals) of their right to a "Good Faith Estimate" to help them estimate the expected charges they may be billed for receiving certain health care items and services. Information regarding the **availability of a "Good Faith Estimate" must be prominently displayed** on the convening provider's and convening facility's website and in the office and on-site where scheduling or questions about the cost of health care occur.

GOOD FAITH ESTIMATES TO UNINSURED/SELF PAY

When discussing the good faith estimate it is important to know a few terms:

- A **health care provider (provider)** is defined as a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable State law.

- A **health care facility (facility)** is defined as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center that is licensed as an institution pursuant to State laws or is approved by the agency of such State or locality responsible for licensing such institution as meeting the standards established for such licensing.

- The **convening provider or facility** is the one who receives the initial request for a good faith estimate from an uninsured or self-pay individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service.

- A **co-provider or co-facility** furnishes items or services that are customarily provided in conjunction with the convening provider.

An uninsured patient is an individual who does not have benefits for an item or service under a group health plan; whereas a self-pay patient is an individual who has benefits under a group health plan but chooses not to have a claim submitted to their plan. The good faith estimate presented to an uninsured or self-pay patient must include services reasonably expected to be provided by the convening provider or facility.

At this time, estimates for services provided by co-providers and co-facilities do not have to be provided by the convening provider or facility.

The following list was provided in the interim final rule published in the Code of Federal Regulations. CMS followed up with a Fact Sheet that clarifies HHS will not be enforcing the requirement of including services provided by co-providers or co-facilities.

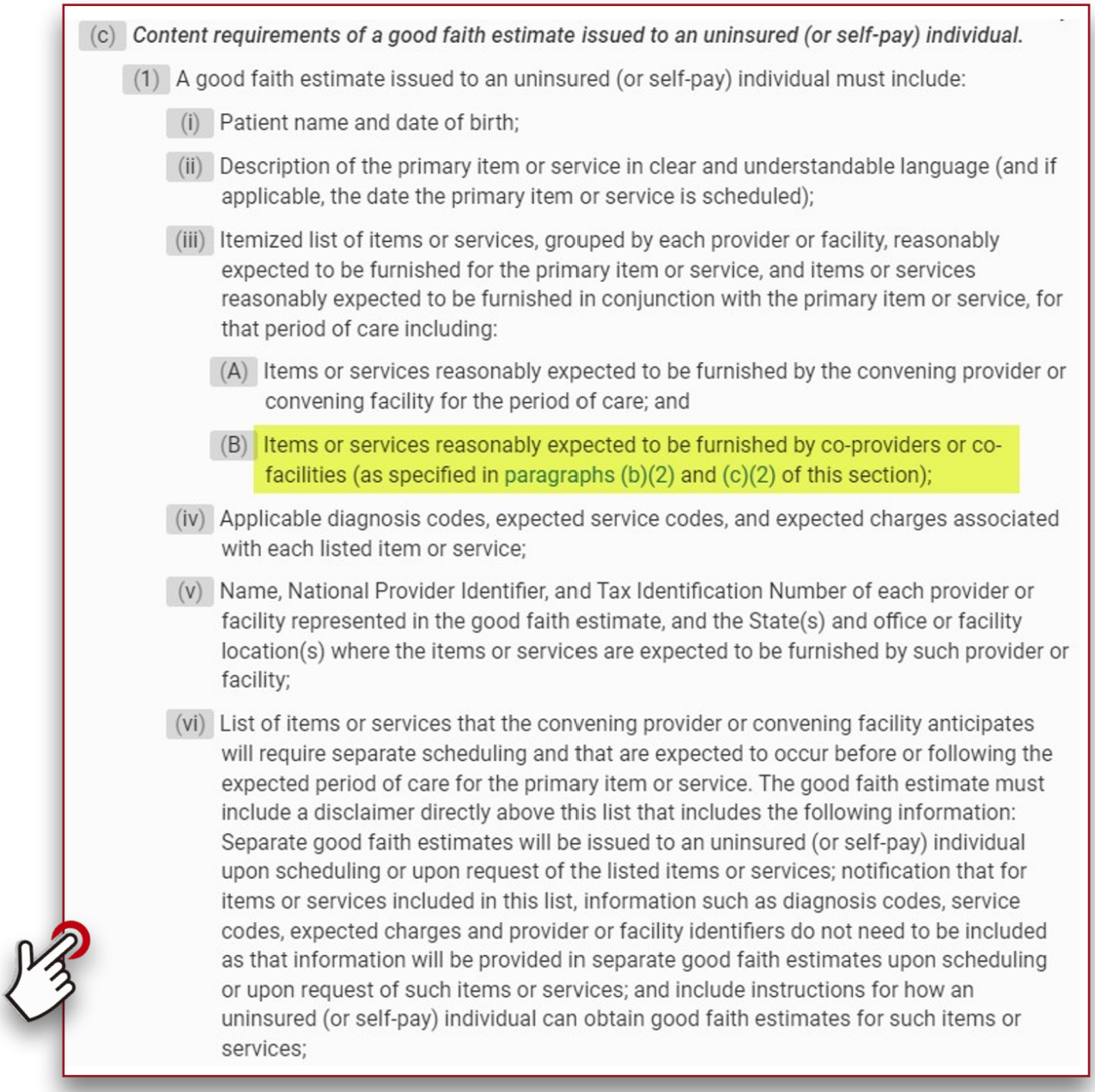
A good faith estimate must include:

- Patient name and date of birth
- Description of the primary item or service
- Itemized list of items or services reasonably expected to be furnished
    - Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and
    - Items or services reasonably expected to be furnished by co-providers or co-facilities

2022 REQUIREMENTS -- UPDATED

- Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service
- Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility
- List of items or services that the convening provider or convening facility anticipates will require separate scheduling

[eCFR :: 45 CFR Part 149 — Surprise Billing and Transparency Requirements]



(c) ***Content requirements of a good faith estimate issued to an uninsured (or self-pay) individual.***

(1) A good faith estimate issued to an uninsured (or self-pay) individual must include:

(i) Patient name and date of birth;

(ii) Description of the primary item or service in clear and understandable language (and if applicable, the date the primary item or service is scheduled);

(iii) Itemized list of items or services, grouped by each provider or facility, reasonably expected to be furnished for the primary item or service, and items or services reasonably expected to be furnished in conjunction with the primary item or service, for that period of care including:

(A) Items or services reasonably expected to be furnished by the convening provider or convening facility for the period of care; and

(B) Items or services reasonably expected to be furnished by co-providers or co-facilities (as specified in paragraphs (b)(2) and (c)(2) of this section);

(iv) Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service;

(v) Name, National Provider Identifier, and Tax Identification Number of each provider or facility represented in the good faith estimate, and the State(s) and office or facility location(s) where the items or services are expected to be furnished by such provider or facility;

(vi) List of items or services that the convening provider or convening facility anticipates will require separate scheduling and that are expected to occur before or following the expected period of care for the primary item or service. The good faith estimate must include a disclaimer directly above this list that includes the following information: Separate good faith estimates will be issued to an uninsured (or self-pay) individual upon scheduling or upon request of the listed items or services; notification that for items or services included in this list, information such as diagnosis codes, service codes, expected charges and provider or facility identifiers do not need to be included as that information will be provided in separate good faith estimates upon scheduling or upon request of such items or services; and include instructions for how an uninsured (or self-pay) individual can obtain good faith estimates for such items or services;

2022 REQUIREMENTS -- UPDATED

Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period | CMS

The Good Faith Estimate process that requires facilities and providers to transmit estimates to health plans, is still on hold.

NOTICE AND CONSENT

The Notice and Consent is being enforced for those rare instances when the patient has a choice of providers and chooses to receive services from an out-of-network facility or provider. Situations when a patient does not have a choice of providers and cannot be requested to sign a consent waiving their balance billing protections in an in-network facility are:

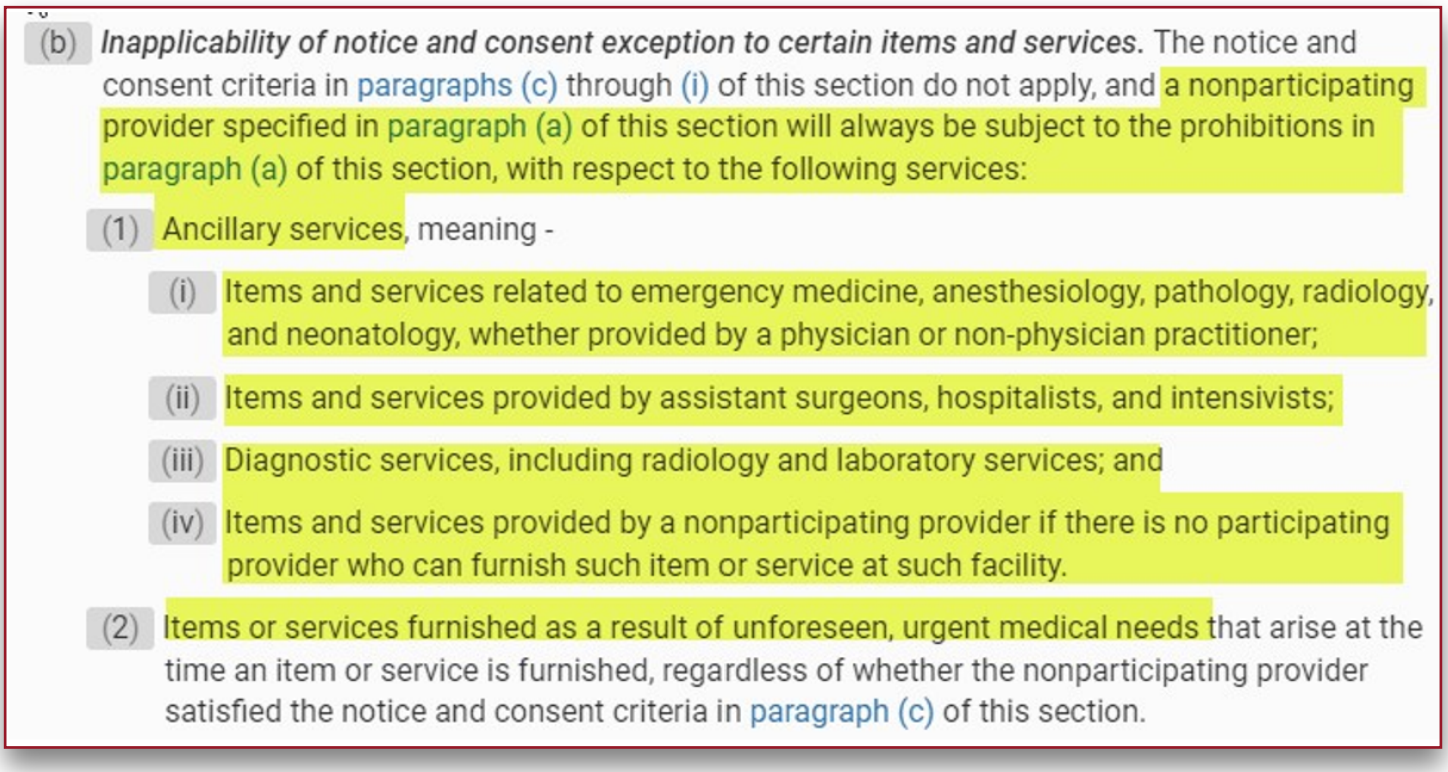
- When receiving services that are considered ancillary services:
  - Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
  - Items and services provided by assistant surgeons, hospitalists, and intensivists
  - Diagnostic services, including radiology and laboratory services
  - Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility

Balance billing is prohibited in all emergency situations, even those that arise during a service that is being provided under a written consent. Any charges related to that emergency cannot be balance billed until the patient is deemed stable, as defined in the NSA – able to transport to another facility by non-medical transportation.

In the event the patient requires a higher level of care that requires transport, the EMTALA guidelines take precedence. A patient admitted to an out-of-network facility from an emergency department who is then considered stable, must be presented with a notice and consent if they choose to continue treatment in the out-of- network facility. If the consent is signed, the out-of-network facility can balance bill for charges incurred after the provider documents that patient is stable, as defined in the NSA – able to transport to another facility by non-medical transportation. Ancillary services cannot balance bill even after the patient is considered stable.

2022 REQUIREMENTS -- UPDATED

[eCFR :: 45 CFR Part 149 Subpart E — Health Care Provider, Health Care Facility, and AirAmbulance Service Provider Requirements]



(b) ***Inapplicability of notice and consent exception to certain items and services.*** The notice and consent criteria in paragraphs (c) through (i) of this section do not apply, and a nonparticipating provider specified in paragraph (a) of this section will always be subject to the prohibitions in paragraph (a) of this section, with respect to the following services:

(1) Ancillary services, meaning -

(i) Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner;

(ii) Items and services provided by assistant surgeons, hospitalists, and intensivists;

(iii) Diagnostic services, including radiology and laboratory services; and

(iv) Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at such facility.

(2) Items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the nonparticipating provider satisfied the notice and consent criteria in paragraph (c) of this section.

The Notice and Consent form, with an estimate of all charges, must be presented to the patient for a signature.

- This form must be available in the 15 most common languages in the geographical area. If the individual's preferred language is not among those 15, a qualified interpreter must be made available to assist the patient with understanding their rights.

- The form must be provided at least 72 hours prior to scheduled services, when they are scheduled at least 72 hours out. When services are scheduled and performed on the same day, the document is required to be presented at least 3 hours before the services are rendered.

- The patient must be provided with a signed copy and a signed copy must be maintained in the medical record in the same manner as all other required documented.

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, March 17, 2022

News

- Medicare Shared Savings Program: Application Deadlines for January 1, 2023, Start Date
- Kidney Health: Help Address Disparities

Claims, Pricers, & Codes

- April 2022 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files
- Federally Qualified Health Centers: Retroactive Claims Adjustments
- Home Health Web Pricer

Events

- Medicare Ground Ambulance Data Collection System: Q&A Session — March 29

MLN Matters® Articles

- April 2022 Update to the Fiscal Year (FY) 2022 Inpatient Prospective Payment System (IPPS)

Publications

- Complying with Medicare Signature Requirements — Revised
- Medicare Preventive Services — RevisedSBIRT Services — Revised

TRANSMITTALS

1

There was ONE new or revised Transmittal released this week.

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

TRANSMITTAL R113120OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11312	**Date: March 22, 2022**
	Change Request 12346

Transmittal 11273, dated February 18, 2022, is being rescinded and replaced by Transmittal 11312, dated, March 22, 2022 to revise business requirement 12346.26. All other information remains the same.

SUBJECT: Send Electronic Funds Transfer (EFT) Information from Provider Enrollment Chain and Ownership System (PECOS) to Fiscal Intermediary Shared System (FISS) - Implementation CR, Consolidation of January 2022 and April 2022 Releases

I. SUMMARY OF CHANGES: This Implementation Change Request (CR) will use the requirements determined in a previously issued CR to incorporate the manually entered EFT fields in FISS into PECOS. It will update PECOS workflows, database, UI, business logic, extract logic, and fields for the PECOS FISS Extract file, the logic and fields for importing the PECOS FISS extract file into FISS, and FISS business logic and workflows.

EFFECTIVE DATE: January 1, 2022 - Analysis, Design, Coding, Testing, and Implementation; April 1, 2022 - Complete Coding, Testing, and Implementation
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022 - Analysis, Design, Coding, Testing, and Implementation; April 4, 2022 - Complete Coding, Testing, and Implementation

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

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

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

III. FUNDING:

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

MEDLEARNS

1

There was ONE new or revised MedLearn released this week.

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

MEDLEARN MM12583

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Quarterly Update to the End-Stage Renal Disease Prospective Payment System (ESRD PPS)

MLN Matters Number: MM12583 | Related Change Request (CR) Number: 12583

Related CR Release Date: March 15, 2022 | Effective Date: April 1, 2022

Related CR Transmittal Number: R11295CP | Implementation Date: April 4, 2022

Provider Types Affected

This MLN Matters Article is for ESRD facilities billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about:

- How to code for difelikefalin injection
- Modifier use for code J0879

Background

The Transitional Drug Add-on Payment Adjustment (TDAPA) is a payment adjustment under the ESRD PPS for certain new renal dialysis drugs and biological products.

For new renal dialysis drugs and biological products that fall into an existing ESRD PPS functional category, the TDAPA:

- Helps ESRD facilities to incorporate new drugs and biological products and make appropriate changes in their businesses to adopt such products
- Provides additional payments for such associated costs
- Promotes competition among the products within the ESRD PPS functional categories
- Focuses Medicare resources on products that are innovative[1]

The TDAPA payment for these products is applicable for a period of 2 years. Following payment of the TDAPA, the ESRD PPS base rate won't be modified. While the TDAPA applies to a new renal dialysis drug or biological product, the drug or biological product isn't considered an ESRD outlier service. The ESRD PPS includes Consolidated Billing (CB) requirements for limited Medicare Part B services included in the ESRD facility's bundled payment.

[1] 83 FR 56935 and 84 FR 60654

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®