March 31, 2021

PARA Weekly eJOURNAL

NEWS FOR HEALTHCARE DECISION MAKERS

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

PARA Points The Way Through The Lab Payment Reporting Maze.

New Compliance Guide
Page 10

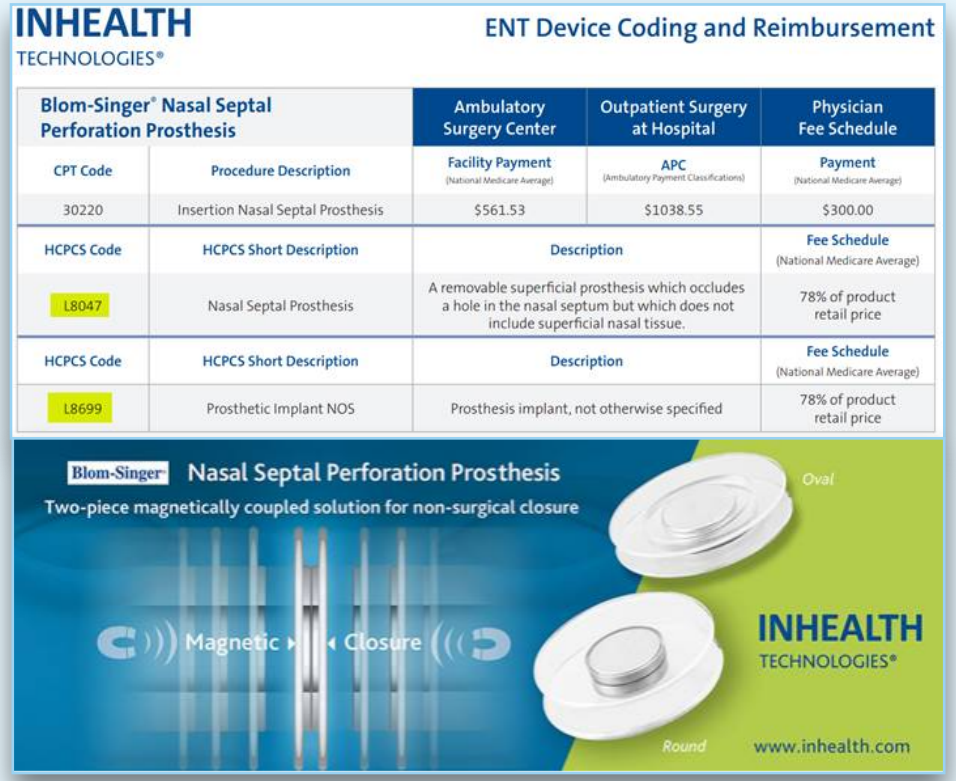
FAST LINKS

NASAL SEPTAL "BUTTON"

Q. Our ENT will be using a septal button for an upcoming procedure. The button will be sewn into the septum for three to four weeks, and then removed once the septum is healed. When creating the supply charge, would it be considered an implant (278 revenue code), or an item (272 revenue code)?

A. **Answer:** It is acceptable to report any implant that remains in the body after the patient is discharged as an implant under revenue code 0278. Although a HCPCS code is not required for charges under revenue code 0278, we are not sure that the following product is the one your ENT will use. The coding advice, however, should be useful. See our attached paper on this topic.

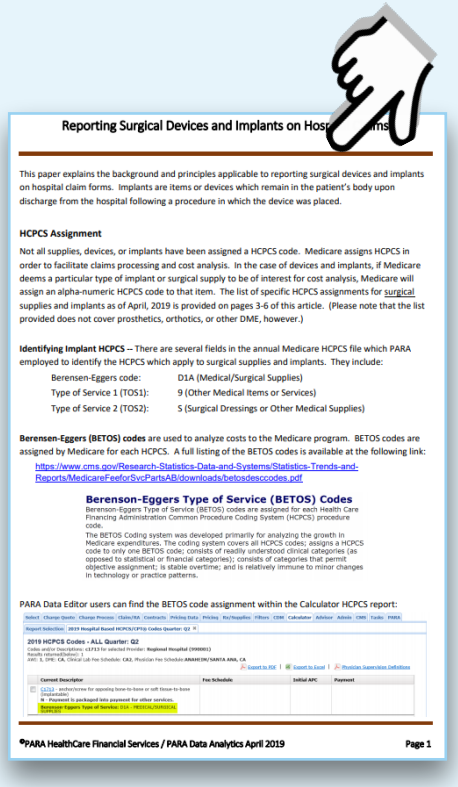
https://katzextractor.com/wp-content/uploads/2020/06/Katz-Coding.pdf



INHEALTH TECHNOLOGIES®

ENT Device Coding and Reimbursement

Blom-Singer® Nasal Septal Perforation Prosthesis		Ambulatory Surgery Center	Outpatient Surgery at Hospital	Physician Fee Schedule
CPT Code	Procedure Description	Facility Payment (National Medicare Average)	APC (Ambulatory Payment Classifications)	Payment (National Medicare Average)
30220	Insertion Nasal Septal Prosthesis	$561.53	$1038.55	$300.00
HCPCS Code	HCPCS Short Description	Description		Fee Schedule (National Medicare Average)
L8047	Nasal Septal Prosthesis	A removable superficial prosthesis which occludes a hole in the nasal septum but which does not include superficial nasal tissue.		78% of product retail price
HCPCS Code	HCPCS Short Description	Description		Fee Schedule (National Medicare Average)
L8699	Prosthetic Implant NOS	Prosthesis implant, not otherwise specified		78% of product retail price



Reporting Surgical Devices and Implants on Hosp...

This paper explains the background and principles applicable to reporting surgical devices and implants on hospital claim forms. Implants are items or devices which remain in the patient's body upon discharge from the hospital following a procedure in which the device was placed.

HCPCS Assignment

Not all supplies, devices, or implants have been assigned a HCPCS code. Medicare assigns HCPCS in order to facilitate claims processing and cost analysis. In the case of devices and implants, if Medicare deems a particular type of implant or surgical supply to be of interest for cost analysis, Medicare will assign an alpha-numeric HCPCS code to that item. The list of specific HCPCS assignments for surgical supplies and implants as of April, 2019 is provided on pages 3-6 of this article. (Please note that the list provided does not cover prosthetics, orthotics, or other DME, however.)

Identifying Implant HCPCS -- There are several fields in the annual Medicare HCPCS file which PARA employed to identify the HCPCS which apply to surgical supplies and implants. They include:

Berensen-Eggers code: D1A (Medical/Surgical Supplies)
Type of Service 1 (TOS1): 9 (Other Medical Items or Services)
Type of Service 2 (TOS2): S (Surgical Dressings or Other Medical Supplies)

Berensen-Eggers (BETOS) codes are used to analyze costs to the Medicare program. BETOS codes are assigned by Medicare for each HCPCS. A full listing of the BETOS codes is available at the following link:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareFeeforSvcPartsAB/downloads/betosdesccodes.pdf

Berenson-Eggers Type of Service (BETOS) Codes

Berenson-Eggers Type of Service (BETOS) codes are assigned for each Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure code.

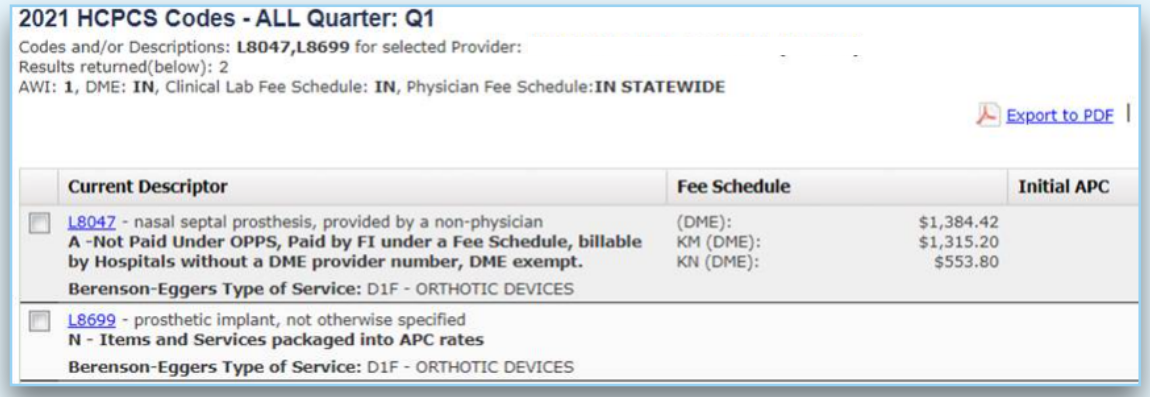
The BETOS Coding system was developed primarily for analyzing the growth in Medicare expenditures. The coding system covers all HCPCS codes; assigns a HCPCS code to only one BETOS code; consists of readily understood clinical categories (as opposed to statistical or financial categories); consists of categories that permit objective assignment; is stable overtime; and is relatively immune to minor changes in technology or practice patterns.

PARA Data Editor users can find the BETOS code assignment within the Calculator HCPCS report:

2019 HCPCS Codes - ALL Quarter: Q2

©PARA HealthCare Financial Services / PARA Data Analytics April 2019 Page 1

Under OPPS, the CMS Addendum B indicates that both L8047 and L8699 are reportable on facility fee claims.



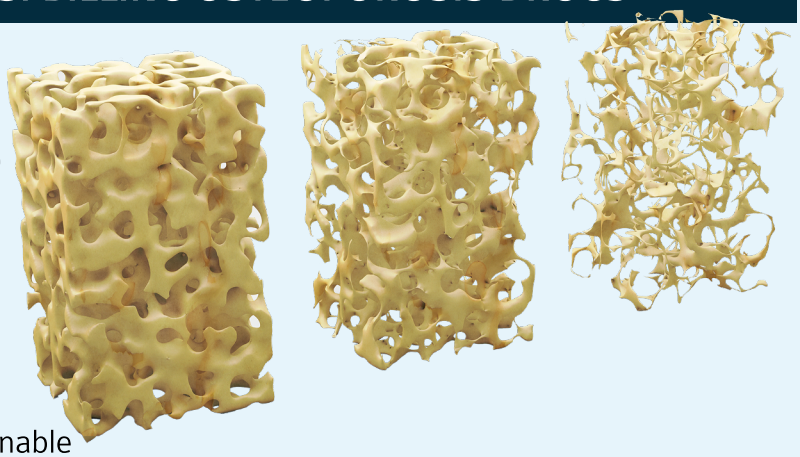
2021 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **L8047,L8699** for selected Provider:
Results returned(below): 2
AWI: **1**, DME: **IN**, Clinical Lab Fee Schedule: **IN**, Physician Fee Schedule:**IN STATEWIDE**

Export to PDF

Current Descriptor	Fee Schedule	Initial APC
L8047 - nasal septal prosthesis, provided by a non-physician **A -Not Paid Under OPPS, Paid by FI under a Fee Schedule, billable by Hospitals without a DME provider number, DME exempt.** **Berenson-Eggers Type of Service:** D1F - ORTHOTIC DEVICES	(DME): $1,384.42 KM (DME): $1,315.20 KN (DME): $553.80	
L8699 - prosthetic implant, not otherwise specified **N - Items and Services packaged into APC rates** **Berenson-Eggers Type of Service:** D1F - ORTHOTIC DEVICES		

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS



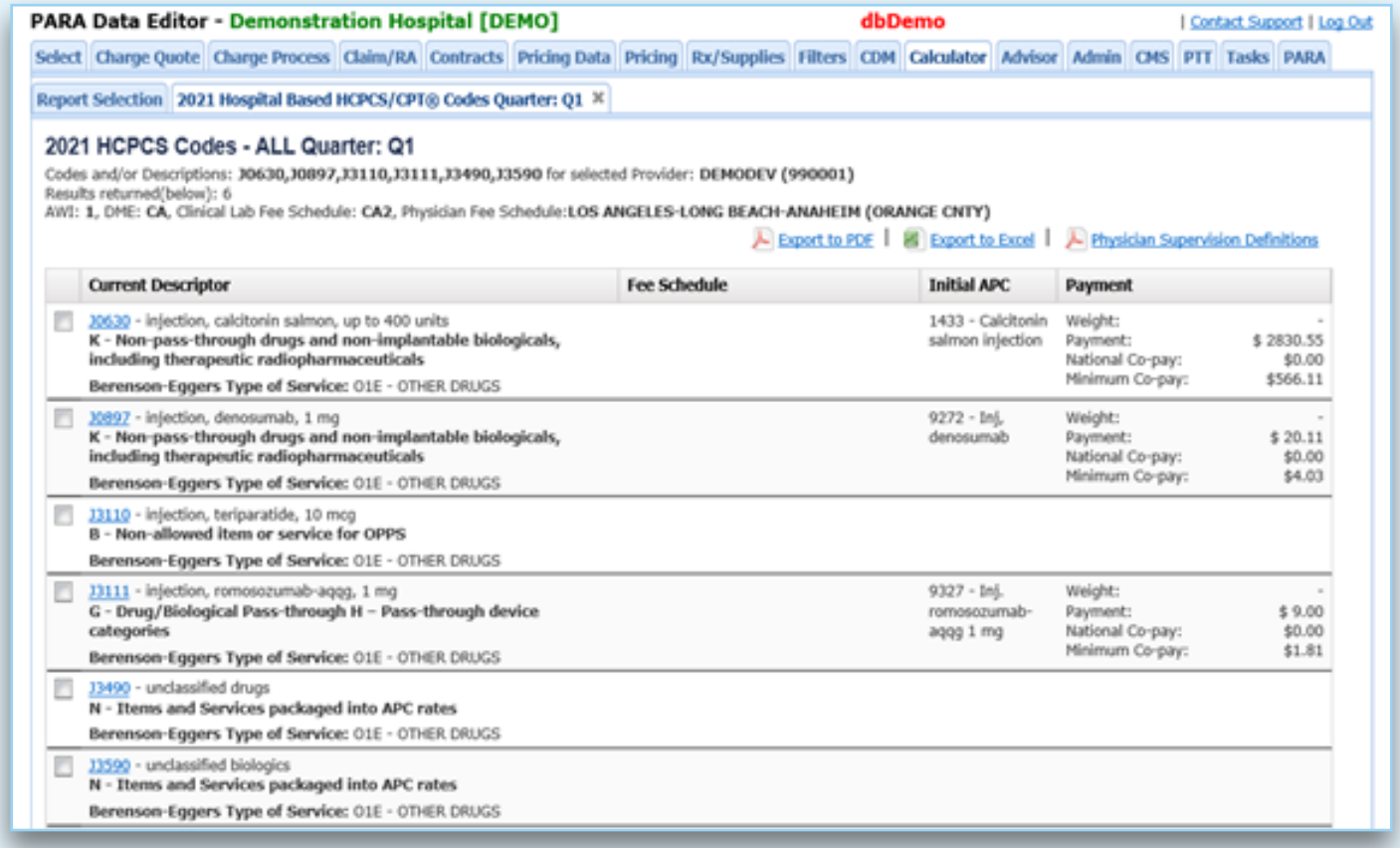
In Home Health, consolidated billing rules require the primary home health agency (HHA) to bill osteoporosis drugs for beneficiaries meeting the coverage requirements for these drugs, if the patient is under a certified HHA-PPS episode.

The actual Osteoporosis drug (s) are excluded from reimbursement under the Home Health Prospective Payment System (HHA-PPS) and are instead reimbursed to providers on a reasonable cost basis.

Reimbursement for administering the drug is included in the HH-PPS episode payment. The primary HHA should submit these charges with other skilled nursing visits on the HH-PPS claim using type of bill (TOB) 329, along with all other applicable home health related services provided by the HHA during the episode.

Providers seeking reimbursement for this service should:

- Ensure the beneficiary is entitled to Medicare Part B
- The date of service for the covered osteoporosis drug(s) must fall within the start and end-dates of an existing HHA PPS episode
- The provider number on the claim for osteoporosis drug(s) must also match the provider number that established the home health episode during which the drug(s) were administered
- Of note: HHAs should be aware if Medicare denies the skilled nursing visit during which the osteoporosis drug was administered, the charges for the drug will not be paid as well by Medicare.



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

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

Report Selection | 2021 Hospital Based HCPCS/CPT® Codes Quarter: Q1

2021 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: J0630,J0897,J3110,J3111,J3490,J3590 for selected Provider: DEMODEV (990001)
Results returned(below): 6
AWI: 1, DME: CA, Clinical Lab Fee Schedule: CA2, Physician Fee Schedule:LOS ANGELES-LONG BEACH-ANAHEIM (ORANGE CNTY)

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule	Initial APC	Payment
J0630 - injection, calcitonin salmon, up to 400 units K - Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals Berenson-Eggers Type of Service: 01E - OTHER DRUGS		1433 - Calcitonin salmon injection	Weight: - Payment: $ 2830.55 National Co-pay: $0.00 Minimum Co-pay: $566.11
J0897 - injection, denosumab, 1 mg K - Non-pass-through drugs and non-implantable biologicals, including therapeutic radiopharmaceuticals Berenson-Eggers Type of Service: 01E - OTHER DRUGS		9272 - Inj. denosumab	Weight: - Payment: $ 20.11 National Co-pay: $0.00 Minimum Co-pay: $4.03
J3110 - injection, teriparatide, 10 mcg B - Non-allowed item or service for OPPS Berenson-Eggers Type of Service: 01E - OTHER DRUGS			
J3111 - injection, romosozumab-aqqg, 1 mg G - Drug/Biological Pass-through H - Pass-through device categories Berenson-Eggers Type of Service: 01E - OTHER DRUGS		9327 - Inj. romosozumab-aqqg 1 mg	Weight: - Payment: $ 9.00 National Co-pay: $0.00 Minimum Co-pay: $1.81
J3490 - unclassified drugs N - Items and Services packaged into APC rates Berenson-Eggers Type of Service: 01E - OTHER DRUGS			
J3590 - unclassified biologics N - Items and Services packaged into APC rates Berenson-Eggers Type of Service: 01E - OTHER DRUGS			

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

In addition to the usual information that is required on an HHA -PPS Medicare claim, the following table will identify the specific data that is required for osteoporosis drug(s) reporting:

Field Name	Description
Type of bill (TOB)	34X – HHA visit(s) provided on an outpatient basis
Statement dates from/To	Enter the dates of service for the billing period. NOTE: these dates should fall within the "FROM" and "TO" dates for the HH-PPS episode of care being provided by the primary HHA
Revenue Code	Enter the revenue code 0636 - Pharmacy
HCPCS	Enter the appropriate HCPCS code: J0630 – Drugs containing calcitonin J3110 – Drugs containing teriparatide (Forteo) J0897 - Drugs containing denosumab (Xgeva, Prolia) J3111 - Drugs containing romosozumab-aqqg (Evenity) J3490 – Drugs that are FDA approved and awaiting a specific HCPCS assignment J3590 - Drugs that are FDA approved and awaiting a specific HCPCS assignment (Tymlos)
Total Unit/Covered Unit	Enter units as defined by HCPCS code: **J0630** – 1 unit for every 100-400 units furnished during billing period 2 units for every 401-800 units furnished during billing period 3 units for every 801 -1200 units furnished during billing period 4 units for every 1201 -1600 units furnished during billing period 5 units for every 1601 -2000 units furnished during billing period 6 units for every 2001- 2400 units furnished during billing period **J3110** – Report 1 units for every 10mcg furnished during billing period J0897 - Report 1 unit for each 1mg dose provided during the billing period J3111 – Report 1 unit for each 1mg does provided during the billing period **J3490** – Report units as defined by the HCPCS code
Total Charges	Enter the charge per revenue code for the osteoporosis drug
Service date	Enter the line item **date of service** the drug was provided
Diagnosis Codes	Enter the ICD-9 code 733.01 (for DOS on or before October 01, 2015), or the ICD-10 code M810 (for DOS on or after October 01, 2015)

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

References for this article:

https://www.cms.gov/files/document/r10670otn.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10670	**Date: March 12, 2021**
	Change Request 12016

Transmittal 10552, dated January 5, 2021, is being rescinded and replaced by Transmittal 10670, dated, March 12, 2021 to update the effective date from date of service to receipt date. All other information remains the same.

SUBJECT: Modification to Existing Common Working File (CWF) Edits for Osteoporosis Drug Codes Billable on Home Health Claims

I. SUMMARY OF CHANGES: This change request adds instructions to modify the existing CWF edits '5384' and '7283' for billing and paying additional codes for osteoporosis drugs under the home health benefit.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c07.pdf

Chapter 7, Section 50.4.3

50.4.3 – Covered Osteoporosis Drugs

(Rev. 10438, Issued: 11-06-20, Effective: 03-01-20, Implementation: 01- 11-21)

Sections 1861(m) and 1861(kk) of the Act provide for coverage of FDA approved injectable drugs for the treatment of osteoporosis. These drugs are expected to be provided by an HHA to female beneficiaries who are currently receiving services under an open home health plan of care, who meet existing coverage criteria for the home health benefit and who meet the criteria listed below. These drugs are covered on a cost basis when provided by an HHA under the circumstances listed below.

The home health visit (i.e., the skilled nurse's visit) to administer the drug is covered under all fee-for-service Medicare (Part A or Part B) home health coverage rules (see section 30 above). Coverage of the drug is limited to female beneficiaries who meet each of the following criteria:

HOME HEALTH PROVIDERS: BILLING OSTEOPOROSIS DRUGS

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c10.pdf
Chapter 10 Sections: 10, 20 and 90.1

Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

Table of Contents
(Rev. 10254, 07-31-20)
(Rev. 10274, 08-07-20)

https://www.cms.gov/files/document/r10274cp.pdf

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10274	**Date: August 7, 2020**
	Change Request 11846

SUBJECT: Update to Osteoporosis Drug Codes Billable on Home Health Claims

I. SUMMARY OF CHANGES: This change request adds instructions for billing and payment of additional codes for osteoporosis drugs under the home health benefit.

EFFECTIVE DATE: January 1, 2021 - Claims received on and after this date.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021

BIOFIRE® RESPIRATORY PANEL CODING AND COVERAGE UPDATE

Effective April 1, 2021, three proprietary CPT® codes for Biofire® respiratory panel lab tests will be deleted – 0098U, 0099U, and 0100U. The change was listed in the November 2020 CPT® Panel meeting agenda:

https://www.ama-assn.org/system/files/2021-01/cpt-pla-codes-short.pdf

AMA AMERICAN MEDICAL ASSOCIATION

CPT® Proprietary Laboratory Analyses (PLA) Codes: Short Descriptors

It is important to note that further CPT Editorial Panel (Panel) or Executive Committee actions may affect these codes and/or descriptors. For this reason, code numbers and/or descriptor language in the CPT code set may differ at the time of publication. In addition, further Panel actions may result in gaps in code number sequencing.

Most recent changes to the CPT® Proprietary Laboratory Analyses (PLA) Short Descriptor document

- Addition of 6 PLA codes (0242U-0247U) and deletion of 3 PLA codes (0098U-0100U) accepted by the CPT Editorial Panel.
- Deleted codes in this document appear with a ~~strikethrough~~.

Some have speculated that since COVID-19 was not among the targets tested in these three CPT®s, Biofire® withdrew the codes from active use.

0202U Deemed Non-Covered. Meanwhile, hospitals and laboratories across the US have found that the 22-target Biofire® respiratory panel HCPCS 0202U is non-covered by most MAC's through Local Coverage Determinations. This has confounded some purchasers of the test since the national Clinical Lab Fee Schedule rate was hefty $416.78.

In its response to comments received in the course of adopting LCD L37764, WPS offers the following rationale to a commenter who attempted to persuade the MAC that multiplex testing for more than five targets should be covered:

Local Coverage Article for Response to Comments: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (DL37764) (cms.gov)

BIOFIRE® BY BIOMÉRIEUX

BIOFIRE® RESPIRATORY PANEL CODING AND COVERAGE UPDATE

"The commenter makes a hypothetical argument pointing out that there potentially exists a clinical application for a respiratory viral panel in some patients so as to lead to a better outcome.

However, the commenter does not provide evidence that any particular panel (where a panel is a specified group of tests which must be ordered together) or any group of panels has clinical utility for a particular population or for beneficiaries with well identified indications. For coverage purposes Palmetto GBA must make coverage decisions regarding specific panels or specific selections of pathogens for specific indications. As such, while we agree that it is conceivable that there exists a patient population who might benefit from a particular group of multiple respiratory viral tests, at this point no evidence has been brought to our attention regarding how a clinician is to identify such a population for any specific available test. Moreover, the only virus group in the core set of pathogens for which treatment is widely (but still not universally) appropriate is influenza.

For those cases in which more than one causative virus could be related to the observed signs or symptoms (either due to overlap of typical symptoms or the presence of atypical symptoms), and diagnosis of a specific causative agent is expected to alter treatment in a way that improves the outcome, the clinician could order individual viral tests for which a result would be expected to lead to clinically actionable information.

If new evidence develops demonstrating that a particular panel or the use of a particular set of respiratory viral tests, which match the components of a panel, leads to enhanced patient outcomes we would be willing to reconsider this coverage determination. Draft LCDs and established LCDs limiting coverage of multiplex testing have been adopted by most MACs. Multiplex PCR respiratory viral panels of 6 or more pathogens are deemed not medically necessary and therefore non-covered.

Here are links to a few LCDs from MACs across the country

Novita

Proposed Local Coverage Determination for Respiratory Pathogen Panel Testing (DL38916) (cms.gov)

WPS

Local Coverage Determination for MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (L37764) (cms.gov)

Noridian

Local Coverage Determination for MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (L37315) (cms.gov)

CGS

Local Coverage Determination for MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (L37348) (cms.gov)

Palmetto

Local Coverage Article for Billing and Coding: MolDX: Multiplex Nucleic Acid Amplified Tests for Respiratory Viral Panels (cms.gov)

First Coast

Proposed Local Coverage Determination for Respiratory Pathogen Panel Testing (DL38918) (cms.gov)

BIOFIRE® RESPIRATORY PANEL CODING AND COVERAGE UPDATE

PARA inquired of CMS whether hospitals which had purchased the 0202U test could report a lower target-count CPT®, such as 87631, in lieu of 0202U in order to receive some reimbursement for the spent expense of the 22-target respiratory panel.CMS responded by referring the question to local MACs for guidance.

MACs tend to limit interaction to identified provider representatives within each jurisdiction; therefore, PARA recommends that hospitals and laboratories reach out to its regional MAC for this coding guidance.

A copy of the email from CMS appears here.

Tue 3/16/2021 3:18 AM

CMS MCD Feedback <MCDFeedback@cms.hhs.gov>

RE: 0202U vs 87631

To [redacted]

Thank you for your question. While we aren't able to provide you with guidance regarding the possible coding scenario you describe below we do recommend reaching out directly to each MAC representing the geographic area of your clients. At least some of the MACs may have previously encountered similar situations.

From: Monica Lelevich <mlelevich@para-hcfs.com>
Sent: Thursday, March 11, 2021 1:32 PM
To: CMS MCD Feedback <MCDFeedback@cms.hhs.gov>
Subject: 0202U vs 87631 - JOANNA

Greetings,

I represent a revenue cycle consulting firm with hospital clients across the US. Several of our clients have purchased Biofire laboratory equipment in order to perform multiplex testing, such as HCPCS 0202U, which tests a single specimen for 22 target organisms which may have caused a respiratory infection.

Most MAC's have adopted an LCD which does not deem multiplex testing for more than 5 targets to be supported by Medical Necessity, so our clients cannot be paid for testing done on the new equipment.

Since our clients have already invested in the technology to report 22 targets in one test, and since the test methodology is the same as that described by the HCPCS 87631, would it be acceptable for hospitals to report 87631 if the hospital agrees to accept that code as payment in full, even though more than 5 targets were evaluated?

HCPCS/CPT®	OPPS Status	Clinical Lab Fee Schedule
0202U - INFECTIOUS DISEASE (BACTERIAL OR VIRAL RESPIRATORY TRACT INFECTION), PATHOGEN-SPECIFIC NUCLEIC ACID (DNA OR RNA), 22 TARGETS INCLUDING SEVERE ACUTE RESPIRATORY SYNDROME CORONAVIRUS 2 (SARS-COV-2), QUALITATIVE RT-PCR, NASOPHARYNGEAL SWAB, EACH PATHOGEN REPORTED AS DETECTED OR NOT DETECTED	A	$416.78
87631 - INFECTIOUS AGENT DETECTION BY NUCLEIC ACID (DNA OR RNA); RESPIRATORY VIRUS (EG, ADENOVIRUS, INFLUENZA VIRUS, CORONAVIRUS, METAPNEUMOVIRUS, PARAINFLUENZA VIRUS, RESPIRATORY SYNCYTIAL VIRUS, RHINOVIRUS), INCLUDES MULTIPLEX REVERSE TRANSCRIPTION, WHEN PERFORMED, AND MULTIPLEX AMPLIFIED PROBE TECHNIQUE, MULTIPLE TYPES OR SUBTYPES, 3-5 TARGETS	Q4	$142.63

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

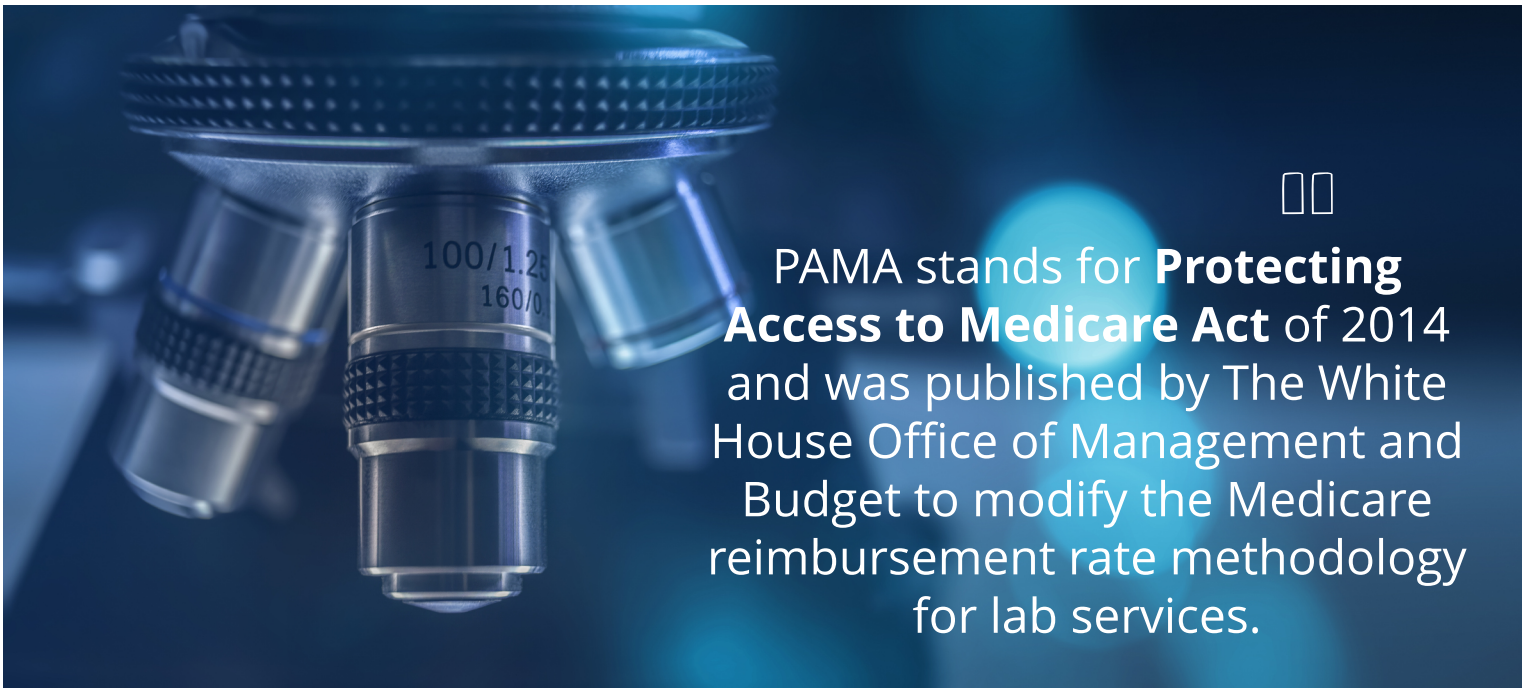
A COMPLIANCE GUIDE FOR LABORATORIES & HOSPITALS

Protecting Access To Medicare Act

Laboratory Private Payer Rate Reporting Requirements

Pricing | Coding | Reimbursement | Compliance

BACKGROUND



Introduction

CMS created the CLFS to guarantee the new fee schedule continues to ensure adequate access to lab services for Medicare beneficiaries. But, the pre-PAMA Medicare Clinical Lab Fee Schedule (CLFS) payments were based on 1984 cost data and sometimes updated for inflation.

A limited reconsideration process was in place for new tests.The hope for the new CLFS was that by performing a market-based pricing exercise, pricing could be brought up to date and in-line with current practices.

THE DETAILS

PAMA reporting requirements apply to any "applicable laboratory." An applicable laboratory is a laboratory that receives a majority of its Medicare revenue under the CLFS, the Physician Fee Schedule ("PFS"), or the new section 1834A of the Social Security Act, as added by PAMA.

What's An Applicable Lab?

Hospital Labs Serving:

- Inpatients
- Outpatients
- Non-Patients ("Outreach")

Physician Office Labs Performing:

- Point of Care/Traditional Tests
- Provider-Performed Microscopy
- Pathologists' Practices

Independent Labs Performing:

- Standard Tests
- Drug Abuse Testing
- Molecular Diagnostics

- A laboratory, as defined in CLIA, that bills Medicare Part B under its own NPI
- And receives the majority of its Medicare revenue from the PFS or CLFS
- And receives more than $12,500 Medicare revenue from the CLFS in a year
- The $12,500 threshold does not apply to a single laboratory that furnishes an ADLT (but does apply to any CDLTs that the laboratory performs)

THE COST OF NON-COMPLIANCE

CMPs

WHAT LEADERS NEED TO KNOW

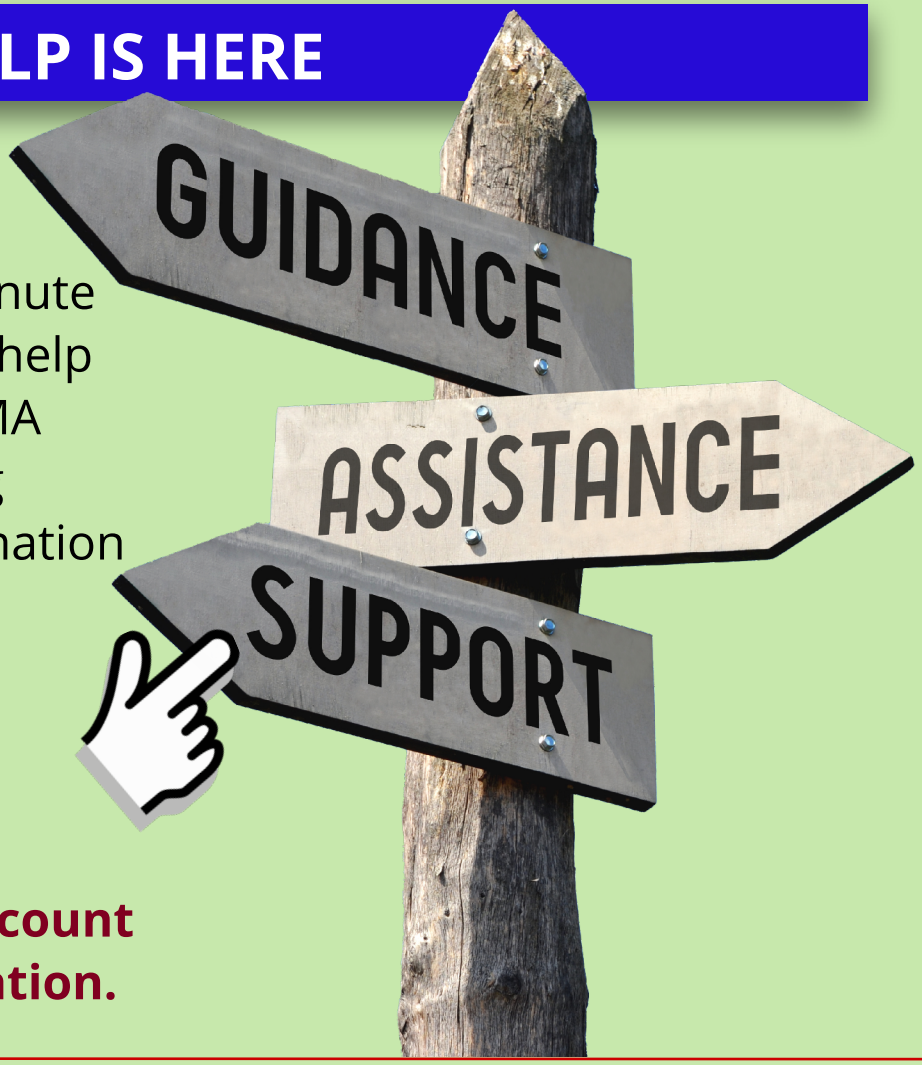
"We are revising the certification and CMP (Civil Monetary Penalties) policies in the final rule to require that the accuracy of the data be certified by the President, CEO, or CFO of the reporting entity, or an individual who has been designated to sign for, and who reports directly to such an officer.

Similarly, the reporting entity will be subject to CMPs for the failure to report or the misrepresentation or omission in reporting applicable information."

Current CMP Rate: $10,017 Per Day.

REQUIREMENTS CAN BE CONFUSING

HELP IS HERE



PARA has developed a 30-minute online presentation that can help keep you compliant with PAMA laboratory rate and reporting requirements. It's vital information for all clinical laboratories.

Click the signs to watch.

Then contact your PARA Account Executive for more information.

Our amazing guides.

Randi Brantner
Vice President of Analytics
rbrantner@hfri.net
719.308.0883

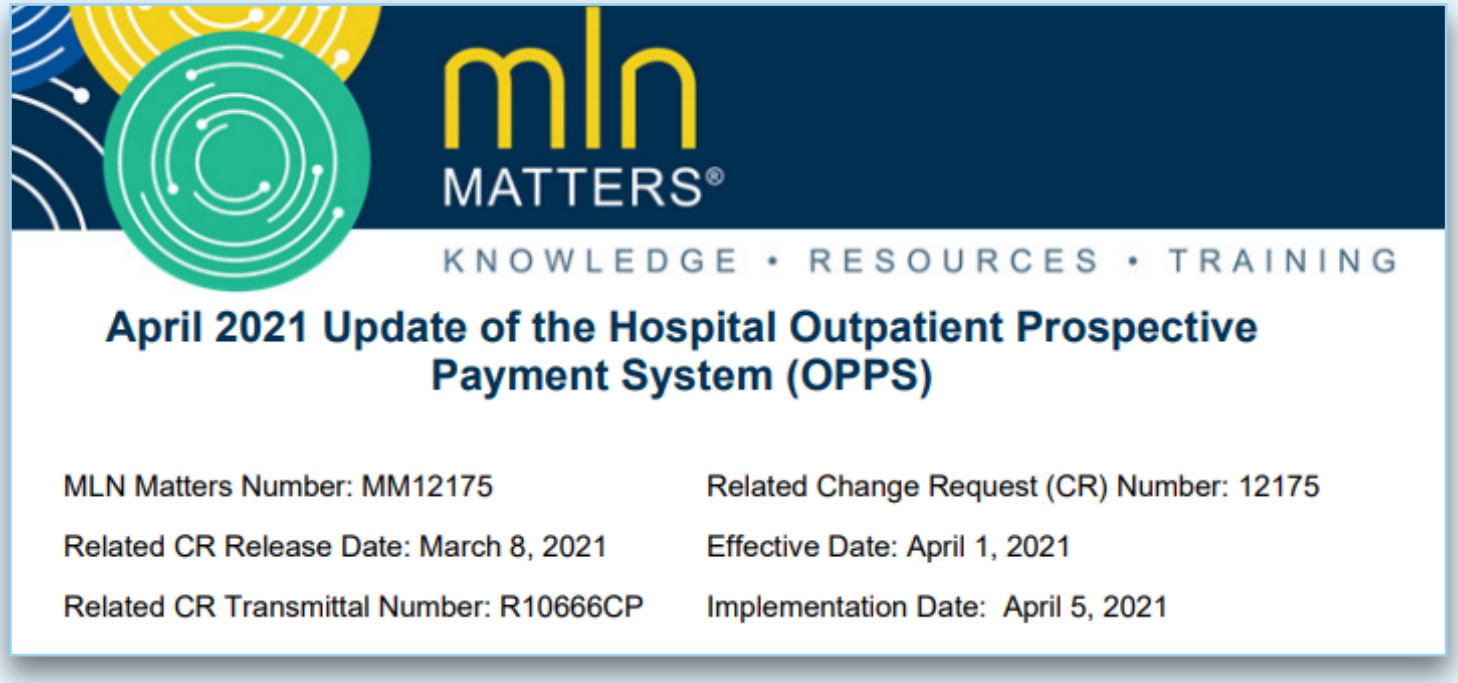
Sandra LaPlace
Account Executive
splace@para-hcfs.com
800.999.3332 x 225

Violet Archulet-Chiu
Senior Account Executive
varchuleta@para-hcfs.com
800.999.3332 x219

APRIL 1, 2021 OPPS UPDATES

CMS issued Transmittal R1066CP with an MLN article "April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)" on March 8, 2021.Eighteen HCPCS were deleted effective 4/1/2021, some of the deleted codes have been replaced with new HCPCS codes.Most of the newly added HCPCS were for proprietary laboratory testing and new pharmaceuticals.

https://www.cms.gov/files/document/mm12175.pdf



PARA will advise chargemaster clients by email of any line items in the hospital CDM require update as a result of a deleted HCPCS code; we will also provide a replacement HCPCS where available.(To take full advantage of **PARA** chargemaster support, clients are encouraged to upload a current CDM at least quarterly.)

The following summarizes the OPPS updates effective April 1, 2021.

- **Revised APC assignment:** Effective April 1, 2021, CMS reassigned OPPS APCs to Pfizer and Moderna COVID-19 administration codes. (The HCPCS are unchanged, only the payment APC changed.)

Old APC	APC Desciption	New APC	APC Description
1492	New Technology – Level 1B ($11-$20)	**9397**	Covid-19 Vaccine Administration Dose 1 of 2
1493	New Technology – Level 1C ($21-$30)	**9398**	Covid-19 Vaccine Administration Dose 2 of 2 or Single Dose Product

APRIL 1, 2021 OPPS UPDATES

Administration codes assigned rates from Addendum B will be available at the following webpage:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

*Note:At time of print, the Addendum A and B updates were not yet published on the CMS.gov website

Addendum A and Addendum B Updates

Updates of Addendum A and B are posted quarterly to the OPPS website. These addenda are a "snapshot" of HCPCS codes and their status indicators, APC groups, and OPPS payment rates, that are in effect at the beginning of each quarter. The quarterly updates of Addendum A and Addendum B reflect the OPPS Pricer changes that are part of the quarterly OPPS recurring update notification transmittals.

The COVID vaccine codes with updated APC assignments are below:

Labeler	HCPCS	Type	Long Description
Pfizer	91300	Vaccine Product	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted, for intramuscular use
Pfizer	0001A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **first dose**
Pfizer	0002A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; **second dose**
Moderna	91301	Vaccine Product	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage, for intramuscular use
Moderna	0011A	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **first dose**
Moderna	0012B	Administration Code	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS- CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; **second dose**

APRIL 1, 2021 OPPS UPDATES

- **Johnson & Johnson COVID-19 Vaccine:** Effective February 27, 2021, under the FDA Emergency Use Authorization (EUA) of the Johnson & Johnson (Janssen) COVID-19 vaccine, providers may report HCPCS91303 for the vaccine product and 0031A for its single-dose administration. The payment rates will be published in the April Addendum B

- **Monoclonal AB Therapy for COVID-19:** CMS establish new HCPCS codes for Monoclonal Antibody Therapy treatments for COVID-19 effective on the date the FDA provided an EUA for each. Medicare covers these treatments during the Public Health Emergency (PHE) in accordance with Section 3713 of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). Medicare covers and pays for the monoclonal therapy through the COVID-19 vaccine program. Medicare expects that, at least initially, providers will receive the drug products free of charge.When the provider receives the product at no cost, Medicare will reimburse the administration of the monoclonal antibody drugs when reported with the unique M-code, it is not necessary to report the drug itself on claims to Medicare.

The following chart lists the effective dates and payment rates for each monoclonal antibody therapy code.

Monoclonal Drug	Effective Date	HCPCS	Description	Payment
Bamlanivimab	11/9/2020	M0239	Intravenous infusion, bamlanivimab-xxxx, includes infusion and post administration monitoring	$309.60
		Q0239	Injection, bamlanivimab-xxxx, 700 mg	$ 0.01
Casirivimab / Imdevimab	11/21/2020	M0243	intravenous infusion, casirivimab and imdevimab includes infusion and post administration monitoring	$309.60
		Q0243	Injection, casirivimab and imdevimab, 2400 mg	$ 0.01
Bamlanivimab / Etesevimab	02/09/2021	M0245	Bamlan and etesev infusion	$309.60
		Q0245	Injection, bamlanivimab and etesevimab, 2100 mg	$ 0.01

- New PLA Codes:Effective April 1, 2021, the AMA established the six following Proprietory Lab Analyses (PLA) codes; these have been assigned OPPS status A (paid under fee schedule) or Q4 (conditionally packaged laboratory services): (See following page.)

APRIL 1, 2021 OPPS UPDATES

CPT®	Description	OPPS SI
0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements	A
0243U	Obstetrics (preeclampsia), biochemical assay of placental-growth factor, time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia	Q4
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffinembedded tumor tissue	A
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage	A
0246U	Red blood cell antigen typing, DNA, genotyping of at least 16 blood groups with phenotype prediction of at least 51 red blood cell antigens	A
0247U	Obstetrics (preterm birth), insulin-like growth factor–binding protein 4 (IBP4), sex hormone–binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth	Q4

- **New HCPCS Code C9776:** Effective April 1, 2021, report add-on code HCPCSC9776for intra-operative near-infrared fluorescence imaging of major extra hepatic bile duct(s) with intravenous administration of indocyanine green. This laser technique, which uses indocyanine (ICG) green, provides enhanced real-time visualization of cystic, common bile, or common hepatic ducts during open or laparoscopic cholecystectomy procedures.

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC
C9776	Fluo bile duct imaging w/icg	Intraoperative near-infrared fluorescence imaging of major extra-hepatic bile duct(s) (e.g., cystic duct, common bile duct and common hepatic duct) with intravenous administration of indocyanine green (icg) (list separately in addition to code for primary procedure)	N	N/A

APRIL 1, 2021 OPPS UPDATES

- **New HCPCS Code C9777:** Effective April 1, 2021, report C9777 for Esophageal Mucosal Integrity Testing by Electrical Impedance.This procedure is used to detect esophageal mucosal changes that result from chronic Gastroesophageal Reflux Disease (GERD) or Eosinophilc Esophagitis (EoE.)

HCPCS Code	Short Descriptor	Long Descriptor	OPPS SI	OPPS APC
C9777	Esophag mucosal integ add-on	Esophageal mucosal integrity testing by electrical impedance, transoral (list separately in addition to code for primary procedure)	N	N/A

- **Change of Long Descriptor for HCPCS C9761:** Effective October 1, 2020, the long descriptor for HCPCS code C9761 as shown below

HCPCS Code	Old Long Descriptor	New Long Descriptor	OPPS SI	OPPS APC
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy (ureteral catheterization is included) and vacuum aspiration of the kidney, collecting system and urethra if applicable	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable.	J1	5375

- **Change of Long Descriptor for HCPCS C9761:** Effective October 1, 2020, the long descriptor for HCPCS code C9761 as shown below

HCPCS Code	Old Long Descriptor	New Long Descriptor	OPPS SI	OPPS APC
C9761	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy (ureteral catheterization is included) and vacuum aspiration of the kidney, collecting system and urethra if applicable	Cystourethroscopy, with ureteroscopy and/or pyeloscopy, with lithotripsy, and ureteral catheterization for steerable vacuum aspiration of the kidney, collecting system, ureter, bladder, and urethra if applicable.	J1	5375

APRIL 1, 2021 OPPS UPDATES

- **Status Indicator Corrections:** In the January 1, 2021 Addendum B, CMS incorrectly listed G2061, G2062 and G2063 with a status indicator of A (paid by MACs under a fee schedule or payment system other than OPPS.) These codes were deleted effective December 31, 2020 and were replaced with CPT® codes 98970, 98971 and 97972 which CMS incorrectly assigned to status indicator B (Not paid under OPPS.) To correct these errors, CMS made the following changes with a retroactive effective date of January 1, 2021.

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2061	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes	D	N/A
G2062	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes	D	N/A
G2063	Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes	D	N/A
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	A	N/A
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	A	N/A
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	A	N/A

- **Additional Status Indicator Changes:** In the January 2021 OPPS, CMS incorrectly assigned G2010 and G2012 with status indicator of A (Paid by MACs under a fee schedule or payment system other than OPPS.)G2211 was incorrectly assigned status indicator of N (payment is packaged into payment for other services.) To correct these errors, each of these codes are assigned status indicator B (Not paid under OPPS) with an effective date of January 1, 2021.

APRIL 1, 2021 OPPS UPDATES

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	B	N/A

Status Indicator Corrections: In the January 1, 2021 Addendum B, CMS incorrectly listed G2061, G2062 and G2063 with a status indicator of A (paid by MACs under a fee schedule or payment system other than OPPS.) These codes were deleted effective December 31, 2020 and were replaced with CPT® codes 98970, 98971 and 97972 which CMS incorrectly assigned to status indicator B (Not paid under OPPS.) To correct these errors, CMS made the following changes with a retroactive effective date of January 1, 2021.

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
G2011	Brief communication technologybased service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	B	N/A
G2211	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established	B	N/A

APRIL 1, 2021 OPPS UPDATES

- **Change of HCPCS for DecisionDx-Melanoma test:** When DecisionDx-Melanoma test was approved as an ADLT on May 17, 2019, there was no CPT® code assigned to the test .In the October 2019 Update to OPPS labs were instructed to report this test with an unlisted code,81599(unlisted multianalyte assay with algorithmic analysis) with identifier ZB1D4.

  Effective January 1, 2021,DecisionDx-Melanomatest was assigned CPT® code81529(Oncology (cutaneous melanoma), mrna, gene expression profiling by real-time rt-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis).CPT® code 81529 was assignedstatus indicator A (Paid by MACs under a fee schedule or payment system other than OPPS.)

  Also, effective January 1, 2021, the status indicator for the unlisted code81599was returned to E1 (Not paid by Medicare when submitted on outpatient claims - any outpatient bill type.)

- **TIVUS™:** A treatment for pulmonary arterial hypertension (PAH),Therapeutic Intravascular Ultrasound (TIVUS) employs a catheter in an intravascular technology that interrupts nerve conduction surrounding blood vessels and other structures.The ultrasound waves heat the nerves to necrosis which interrupts nerve conduction.This ablation results in decreasing sympathetic hormones from the nerves, which, in turn, relaxes and reduces resistance and pressure in the vessels.

  Effective April 1, 2021, the OPPS status of the TIVUS procedure HCPCS code0632T(percutaneous transcatheter ultrasound ablation of nerves innervating thepulmonary arteries, including right heart catheterization, pulmonary artery angiography, and all imagingguidance) from E1 (excluded from coverage) to toJ1(hospital Part B services paid through a comprehensive APC.)-

  Additional information on TIVUS is available through the following webpage: https://sonivie.com/tivus

- **Drugs, Biologicals and Radiopharmaceuticals**
  - **New Pass-through Status:** The following HCPCS codes will be assigned Pass-Through Status indicator G effective April 1, 2021:

HCPCS Code	Long Descriptor	OPPS SI	OPPS APC
C9704	Injection, lumasiran, 0.5 mg	G	9407
J7212	Factor viia (antihemophilic factor, recombinant)-jncw (sevenfact), 1 microgram	G	9395
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	G	9406

APRIL 1, 2021 OPPS UPDATES

- **Expiring Pass-through Status:** Effective April 1, 2021, pass-through status on the following HCPCS codes will change from a status indicator G to K (Paid under OPPS by APC.)

HCPCS Code	Long Descriptor	Jan 2021 OPPS SI	Apr 2021 OPPS SI	Apr 2021 APC
C9462	Injection, delafloxacin, 1 mg	G	K	9462
J0185	Injection, aprepitant, 1 mg	G	K	9463
J0517	Injection, benralizumab, 1 mg	G	K	9466
J3304	Injection, triamcinolone acetonide, preservative-free, extended-release, microsphere formulation, 1 mg	G	K	9469
J7203	Injection factor ix, (antihemophilic factor, recombinant), glycopegylated, (rebinyn), 1 iu	G	K	9468
J7318	Hyaluronan or derivative, durolane, for intra-articular injection, 1 mg	G	K	9174
J9311	Injection, rituximab 10 mg and hyaluronidase	G	K	9467
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	K	9035
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	K	9194
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	G	K	9036

APRIL 1, 2021 OPPS UPDATES

- **Newly Established HCPCS Codes for Drugs, Biologicals and Radiopharmaceuticals:** The following seven new codes will replace current HCPCS codes beginning April 1, 2021

New HCPCS	Old HCPCS	Long Descriptor	OPPS SI	APC
A9592	C9068	Copper cu-64, dotatate, diagnostic, 1 millicurie	G	9383
J1427	C9071	Injection, viltolarsen, 10 mg	G	9386
J1554	C9072c	Injection, immune globulin (asceniv), 500 mg	G	9392
J7402	C9122	Mometasone furoate sinus implant, (sinuva), 10 micrograms	G	9346
J9037	C9069	Injection, belantamab mafodontin-blmf, 0.5 mg	G	9384
J9349	C9070	Injection, tafasitamab-cxix, 2 mg	G	9385
Q2053	C9073	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9391

- **Two HCPCS are deleted effective April 1, 2021:**

New HCPCS	Long Descriptor	OPPS SI	APC
J7333	Hyaluronan or derivative, visco-3, for intra-articular injection, per dose	N	N/A
J7401	Mometasone furoate sinus implant, 10 micrograms	N	N/A

- **Retroactive Status Indicator Changes:** The following drug status indicator change is retroactive from January 1, 2021, through March 31, 2021:

HCPCS Code	Long Descriptor	Old OPPS SI	New OPPS SI	APC
Q5122	Injection, pegfilgrastim-apgf, biosimilar, (nyvepria), 0.5 mg	E2	K	9406

APRIL 1, 2021 OPPS UPDATES

- **Updates on Drugs and Biologicals with payments based on Average Sales Price (ASP):**

  - Most nonpass-through, Non 340B Program = ASP +6 percent of reference product for biosimilars)
  - Nonpass-through, acquired through 340B Program = ASP – 22.5 percent of 340B acquired biosimilar
  - Single payment of ASP + 6 percent for pass-through to provide payment for the acquisition cost and pharmacy overhead
  - Based on OPPS/ASC final rule comments, values for many drugs and biologicals changed based on sales price from third quarter CY 2020.The full updated list will be available at the April 2021 update of OPPS Addendum A and B :

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS

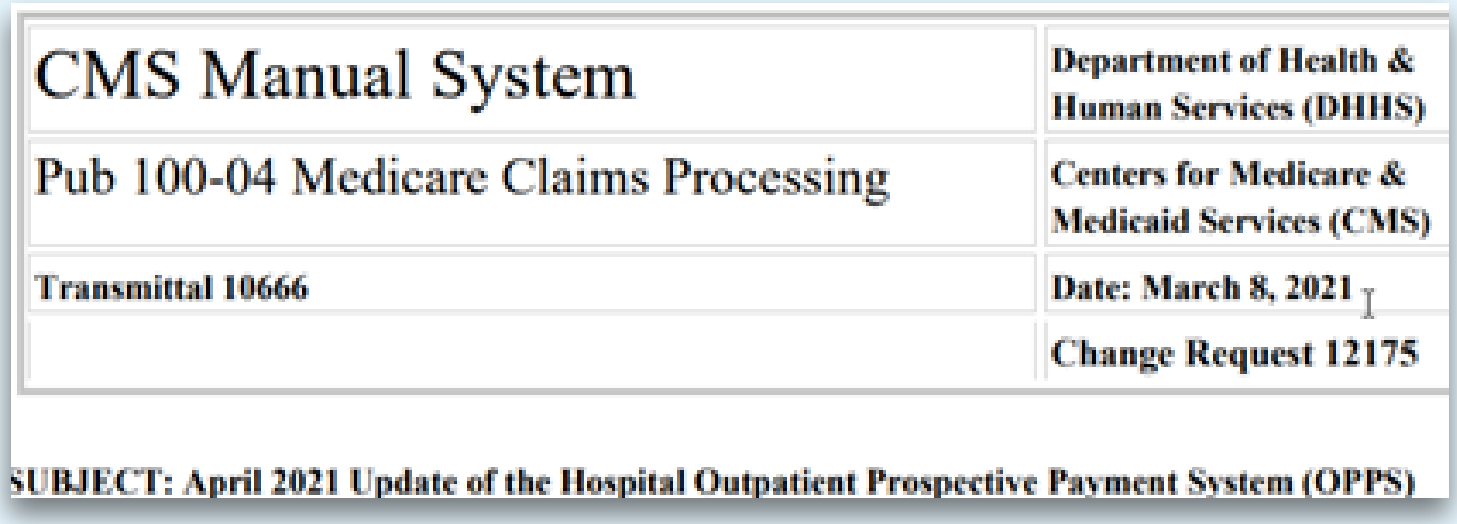
- **Restated ASP Methodology Payment Rates:** quarterly retroactive correction to some drugs and biological payment rates will be available on the first date of the quarter at the following CMS website:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/OPPS-Restated-Payment-Rates

- **Coverage Determination:** CMS reminds us that HCPCS codes and payment rates demonstrate how services, products, or procedures may pay if covered by Medicare.To determine coverage, consult the local MAC for HCPCS code coverage limitations.

CMS References:

- Change Request (CR) 12175/ Medicare Claim Processing Transmittal 10666:https://www.cms.gov/files/document/r10666cp.pdf



CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10666	Date: March 8, 2021
	Change Request 12175

SUBJECT: April 2021 Update of the Hospital Outpatient Prospective Payment System (OPPS)

Addendum A and Addendum B Updates:*

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

***Not available at time of this print (3/15/2021)**

MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

Medi-Cal has announced that the new Janssen COVID-19 vaccine recently released by Johnson & Johnson will be a payable benefit effective for dates of service on or after February 27, 2021. This vaccine can only be administered to patients 18 years of age and older.

When billed appropriately, the vaccine will be reimbursed at $28.39 for a 0.5mL dose.

It is important to note that providers shouldnotreport CPT Code 91303(severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] [coronavirus disease (COVID-19)] vaccine, DNA, spike protein, adenovirus type 26 [Ad26] vector, preservative free, 5x1010viral particles/0.5 mL dosage, for intramuscular use)for the Janssen vaccine; this CPT Code is not currently a Medi-Cal benefit and providers are reminded that at this time, only the administration of the vaccine is reimbursable, not the vaccine itself.

The billing guidelines listed below must be followed for claims to be reimbursed:
https://files.medi-cal.ca.gov/pubsdoco/Janssen_COVID19_Vaccine.aspx

Pharmacy Claims:

- Use NDC 59676058005
- Claim quantity dispensed must be submitted as 0.5mL per administered vaccine
- Use Submission Clarification Code (SCC) 2 (Other Override) to indicate that a COVID-19 vaccine is being administered and billed
    - Since the Janssen COVID-19 vaccine is a one-dose vaccine, providers do not need to submit SCC 6 (Starter Dose)

Electronic Submissions:

Electronic claims should also adhere to the updated Medi-CalNCPDP Payer Sheet. Notable NCPDP D.0 submission details providers should be aware of include:

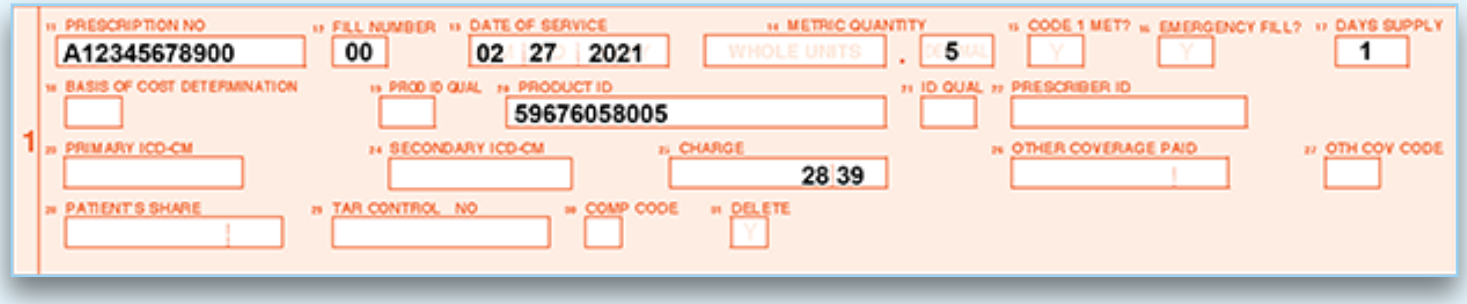
- Use of the value "MA" (Medication Administered) in the Professional Service Code (440-E5) field is not supported in Medi-Cal and submission of that code may result in a claim denial
- Use of the value "PH" (Preventive Health Care) in the Reason for Service Code (439-E4) field is not supportedin Medi-Cal and submission of that code may result in a claim denial
- Use of the value "3N" (Medication Administered) in the Result of Service Code (441-E6) field is not supported in Medi-Cal and submission of that code may result in a claim denial
- Use of the value "15" in the Basis of Cost Determination (423-DN) field is not supported in Medi-Cal and submission of that code may result in a claim denial. Providers are instructed to submit the value "01" instead.

- The Quantity Dispensed (field 442-E7) should be submitted with the value that represents the quantity of drug product administered.Submission Clarification Code (field 420-DK) should be submitted with a SCC code value of 2

MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

The examples below are included for reference only. Providers should note that these are merely an example, and should adjust to their billing situation as would be appropriate.

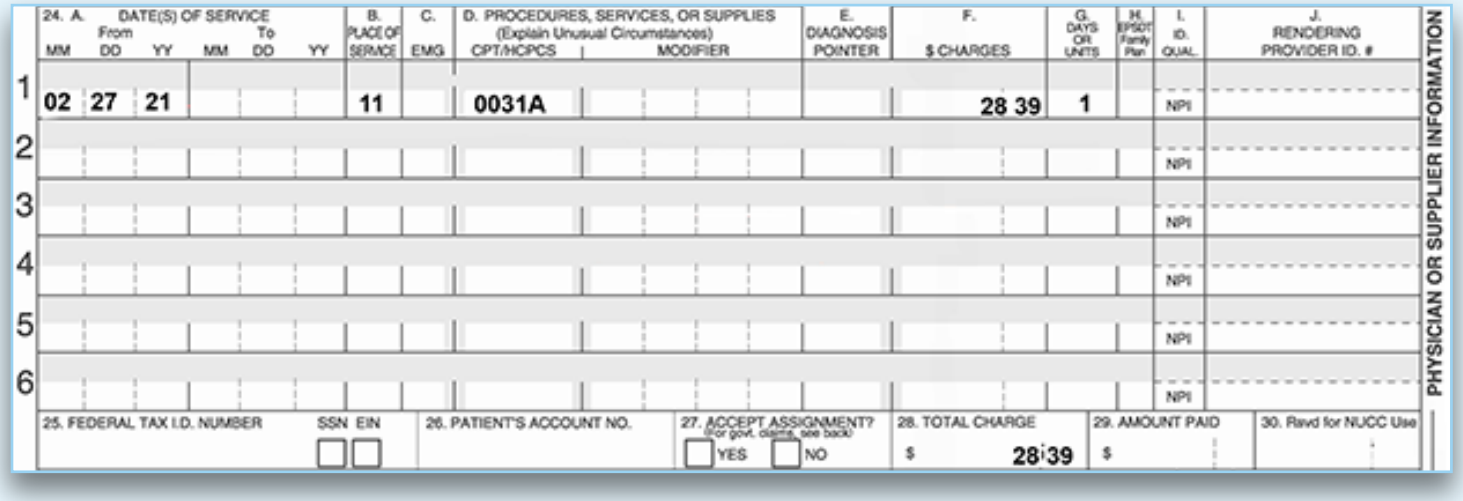
Hard Copy Submissions:



Medical and Outpatient Claims:

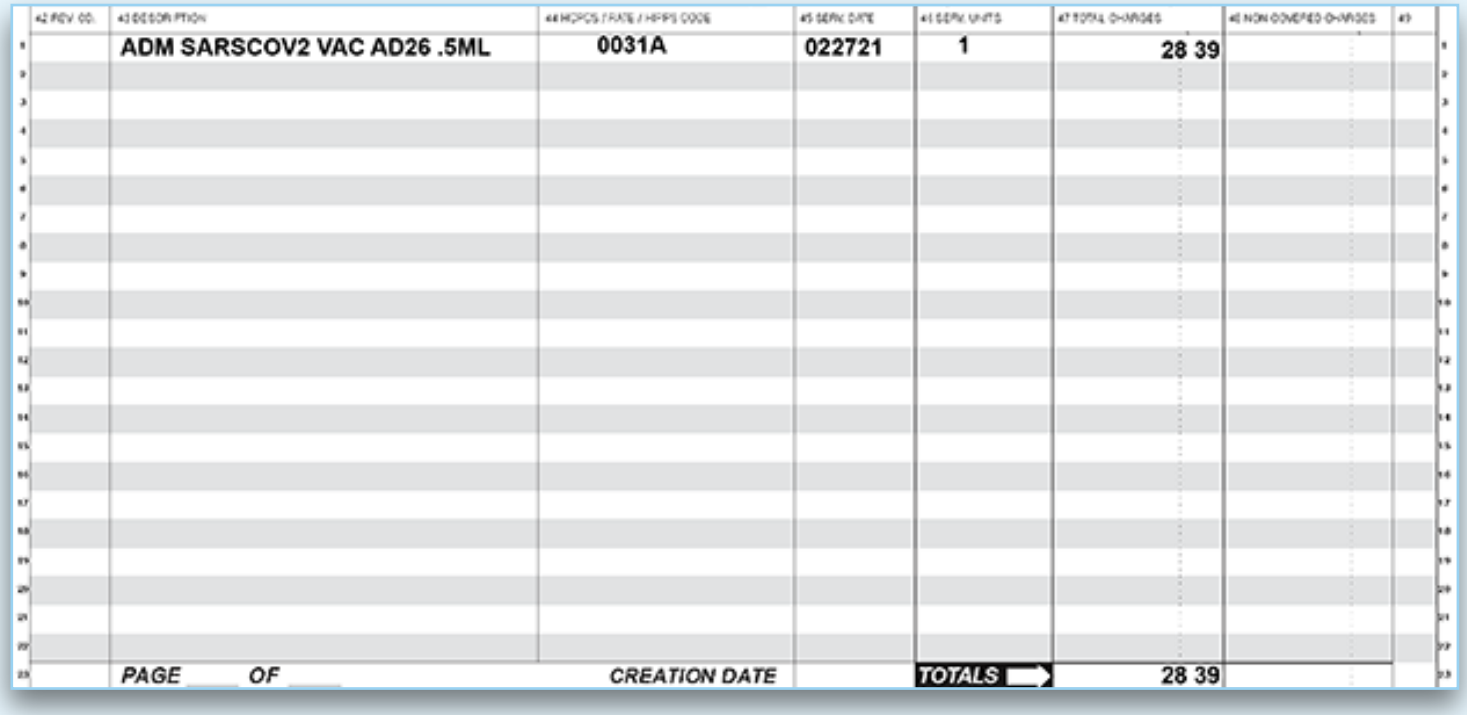
- Bill using Administration Code 0031A
- There are no special instructions for hard copy or electronic Medical or Outpatient submissions

1) Janssen vaccine administration on a CMS-1500



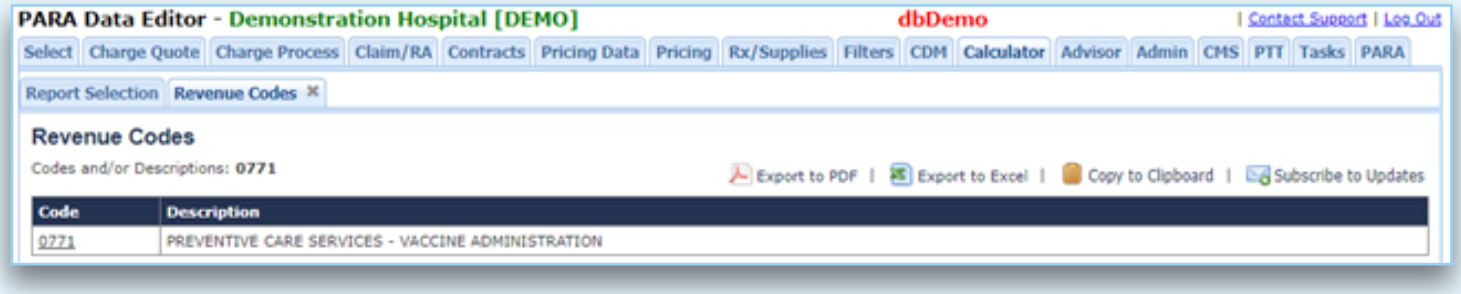
MARCH MEDI-CAL UPDATE: NEW COVID VACCINE BENEFIT

2) Janssen vaccine administration on a UB-04:



42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
	ADM SARSCOV2 VAC AD26 .5ML	0031A	022721	1	28 39		
	PAGE ___ OF ___	CREATION DATE		TOTALS	28 39		

Medi-Cal has not made a revenue code recommendation at this time. However, Medicare is requiring 0771.



MEDI-CAL COVID VACCINE CLAIM SUBMISSION

The Department of Health Care Service (DHCS) submitted a federal waiver request in December to the Centers for Medicare and Medicaid Services (CMS) seeking federal approval to cover the cost of vaccine administration for beneficiaries that have restricted scope coverage. The waiver includes vaccine coverage for beneficiaries who are enrolled in the Family Planning, Access, Care and Treatment (Family PACT) program as well as the Uninsured Group Program for COVID-19.

DHCS has also submitted a State Plan Amendment to request approval from CMS to reimburse Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) a fee-for-service rate for vaccine administration when the encounter does not meet all of the requirements of a billable visit (i.e. vaccine-only administration).

Providers who have administered the COVID-19 vaccines to Medi-Cal beneficiaries who are included in:

- The Family PACT program
- The COVID-19 Uninsured Group program

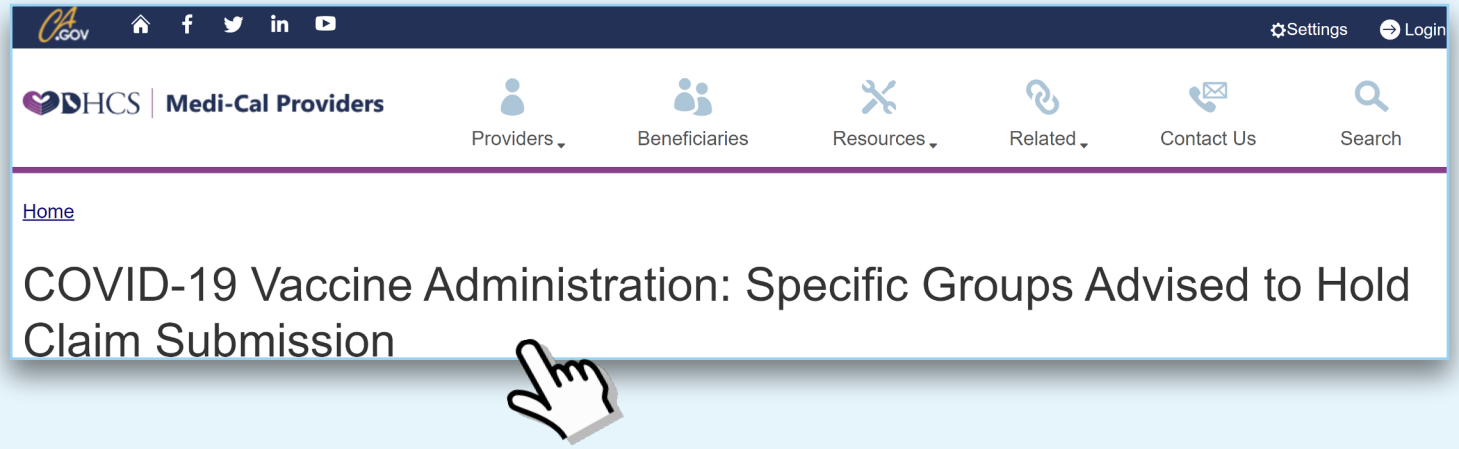
are advised to hold submission of claims pending further guidance from DHCS.

Similarly, FQHCs and RHCs should hold claims for vaccine-only administration to the extent the encounter does not meet the requirements of a billable visit or the beneficiary being served is in one of the identified populations above. Policy and reimbursement guidance will be updated upon additional CMS guidance and/or approvals of the requested waiver/State Plan Amendment.

Updates regarding IHS-MOA 638 clinics are forthcoming.

Providers with questions should contact the Telephone Service Center (TSC) at1-800-541-5555. The TSC is available 8 a.m. to 5 p.m., Monday through Friday, except holidays. Border providers and Out-of-State billers billing for in-state providers should call(916) 636-1200.

https://files.medi-cal.ca.gov/pubsdoco/newsroom/newsroom_30717_71.aspx?_cldee=bW1jbWlsbGFuQHBhcmEtaGNmcy5jb20%3d&recipientid=contact-9212cfb6eaf5ea11a815000d3a5bf119-ad7e1d690b2442a98883aeee6869497e&esid=6fabf100-4888-eb11-a812-00224809d41c



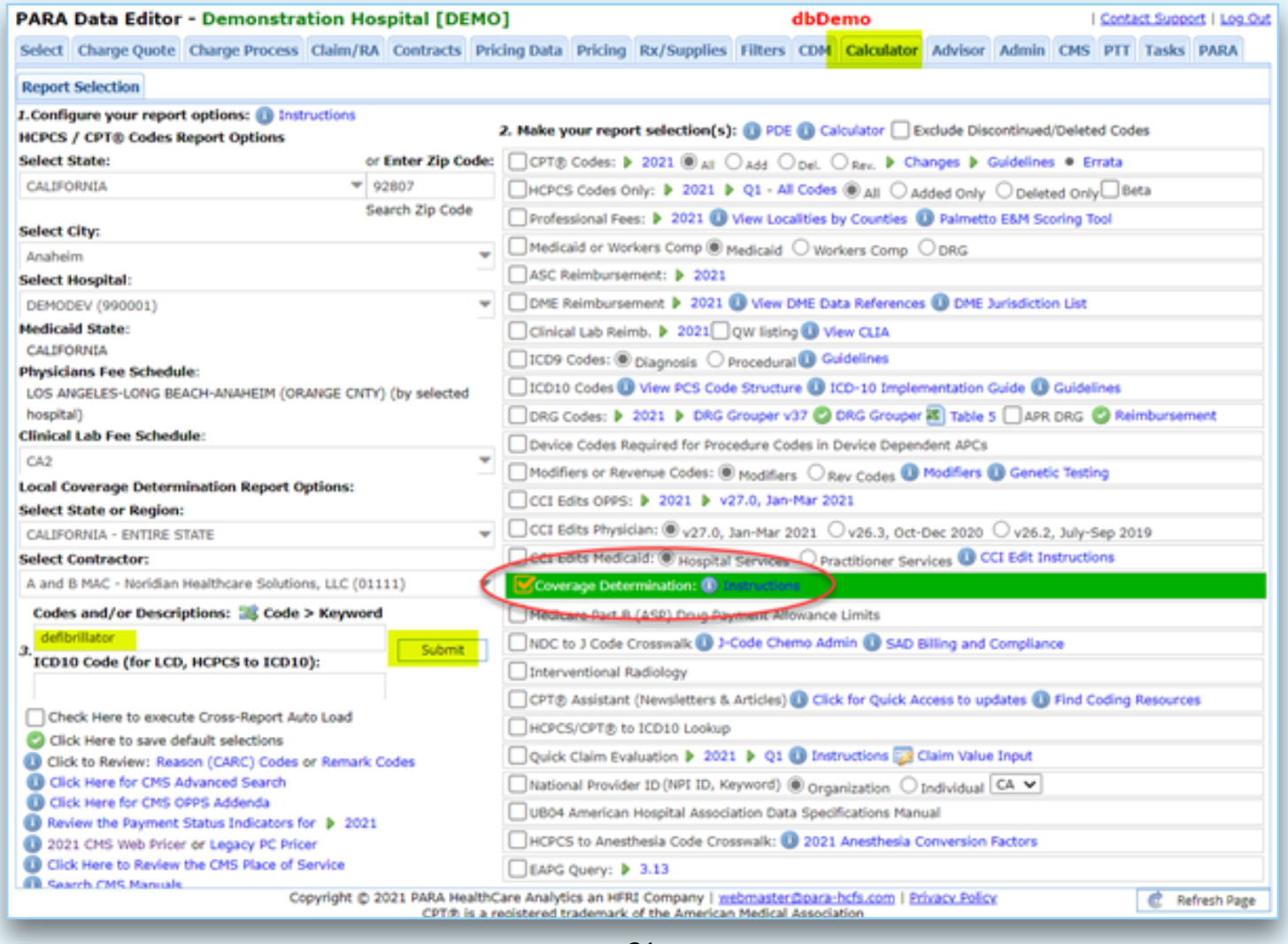
CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

Medicare's National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) began as a fairly straightforward matching game.

A particular service must report one of the covered diagnoses to support medical necessity. The most common medical necessity requirements apply to lab tests--most major EHR systems offer a built-in medical necessity evaluator to determine if the referring physician provided a covered ICD10 diagnosis code and assist in generating an ABN if the diagnosis is insufficient.

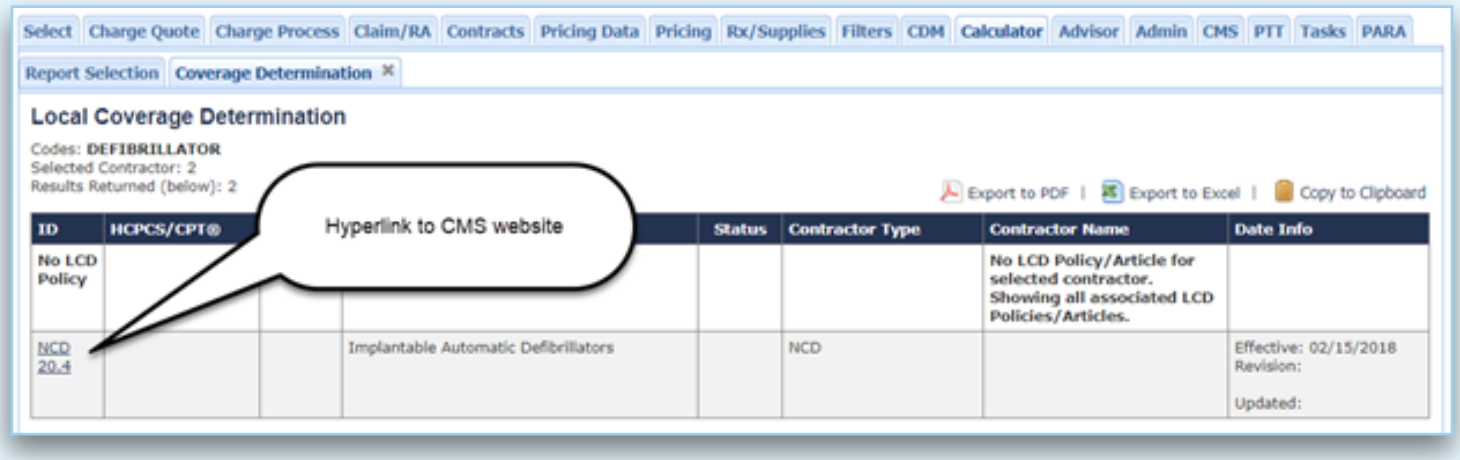
However, over the years, medical necessity requirements have become more complex, particularly for high-dollar procedures such as Implantable Cardiac Defibrillators and PET scans.

Many hospitals have no effective process to check more complex medical necessity requirements. **PARA recommends adopting processes that add documentation to support medical necessity to the hospital medical record prior to billing Medicare for services subject to an NCD or LCD.** This may be accomplished through documenting an attestation from the performing or ordering provider as a precondition of providing expensive surgical services.We provide a few examples on the last two pages of this paper. Medicare coverage information (NCDs and LCDs) is available on the **PARA Data Editor Calculator** feature – enter a HCPCS or a keyword into the "Codes and/or Descriptions" field, and select the report "Medicare Coverage" on the right, as illustrated:



CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

The resulting report will offer a hyperlink to the NCD or LCD or Local Coverage Article with details on the requirements to establish medical necessity (screenshot on the following page.)



Since October 2020, Medicare's Recovery Audit Contractors (RAC's) have been auditing whether hospital medical records support the medical necessity requirements for automatic implantable cardio defibrillators (AICD's.) Here's a link to Medicare's Approved Recovery Audit Contractor Issues List:

[0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements | CMS]

Issue Name	0195-Implantable Automatic Defibrillator- Inpatient Procedure: Medical Necessity and Documentation Requirements
Date	2020-10-06
Review Type	Complex
Provider Type	Inpatient Hospital
MAC Jurisdiction	All A/B MACs

Description

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating. Medical documentation will be reviewed for medical necessity to validate that implantable automatic cardiac defibrillators are used only for covered indications.

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

The requirements of NCD 20.4, which apply to most AICD patients, include evidence of the physician's *"formal shared decision making visit"* with the patient before undergoing an AICD procedure. In most cases, the hospital medical record will not contain information on a physician visit performed outside the hospital. The RACs have seized upon this weakness in documentation – and have identified an easy and rewarding target for high-dollar RAC recoveries.

Within a few minutes of receiving the hospital medical records for an AICD case, RAC auditors can determine whether the hospital's AICD procedure documentation includes evidence of the"formal shared decision making visit." Claims without the documentation are identified as non-covered, and the RAC promptly sends a recoupment request.The recoupment of an inpatient AICD case is generally between $30,000 and $80,000 – a big payday for light work at the expense of hapless hospitals which didn't comprehend the need to obtain evidence of the shared decision making visit for the hospital record.

While it may seem unfair to hold hospitals responsible for physician activities, the Medicare Program Integrity Manual explains that when an entity responds to an additional documentation request, the entity audited is responsible for submitting documentation that meets medical necessity requirements, even if that documentation exists in the records of another entity:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

Medicare Program Integrity Manual, Chapter 3 - Verifying Potential Errors and Taking Corrective Actions

3.2.3.3 - Third-party Additional Documentation Request

(Rev. 10228; Issued: 07-27-20; Effective: 08-27-20; Implementation: 08-27-20)

...

Unless otherwise specified, the MAC, RAC and UPIC shall request information from the billing provider/supplier. The treating physician, another clinician, provider, or supplier should submit the requested documentation. However, because the provider selected for review is the one whose payment is at risk, it is this provider who is ultimately responsible for submitting, within the established timelines, the documentation requested by the MAC, CERT, RAC and UPIC.

Hospitals should carefully evaluate whether complex medical necessity requirements have been met before performing expensive procedures, rather than finding out at a later date that payments will be recouped due to a RAC audit.

PARA advises hospitals to prepare brief physician attestations such as those found on the following pages and incorporate this documentation into the hospital medical record prior to performing services subjected to complex medical necessity standards.

Please note that the attestations must offer both medically necessary rationale and the opportunity to report a non-qualifying rationale – hospitals should not "drive" physicians to select only the options that support medical necessity.

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

However, suppose a physician's response indicates that a Medicare beneficiary service does not meet Medicare medical necessity standards. In that case, the hospital should decline to schedule or perform the procedure unless and until the patient has signed an Advance Beneficiary Notice indicating that the patient accepts full financial liability.

Additional information about Medicare's Advance Beneficiary Notice can be found at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

Pre-Scheduling Information from Ordering Physician

(Medicare beneficiary AICD Implant Procedures)

Patient Name/MRN: _____

I, the ordering provider, attest that on (date) _____

☐ **A formal "Shared Decision Making Visit" with the patient occurred prior to implantation of the AICD as detailed below:**

a. **Utilizing an "Evidence Based decision tool" obtained from:**

☐ **Colorado Program for Patient Centered Decisions (https://patientdecisionaid.org/wp-content/uploads/2016/06/ICD-tool-shortened-V1-3-20-2019.pdf)**

☐ **Other Source (identify):** _____

☐ **A shared decision making visit with the patient occurred, without the use of an evidence-based decision tool.**

☐ **No shared decision making visit occurred because the patient:**

☐ **Has a personal history of sustained VT which episode was either spontaneous or induced by an electrophysiology (EP) study, was not associated with an acute myocardial infarction (MI), and was not due to a transient or reversible cause; or**

☐ **Had an episode of cardiac arrest due to VF, not due to a transient or reversible cause; or**

☐ **Is scheduled to receive an ICD replacement due to the end of battery life, elective replacement indicator, or device/lead malfunction.**

☐ **Other:** _____

I attest that medical documentation supporting the attestation above will be made available from our practice in response to an "Additional Documentation Request" from the hospital or CMS.

Signed: _____

Date: _____

Physicians:Your attestation will add required documentation to the hospital medical record to ensure that Medicare's medical necessity requirements have been met.For more information, review the requirements at
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10865.pdf

CAPTURING UPSTREAM MEDICAL NECESSITY DOCUMENTATION

Supporting Information from Ordering Physician

(Required for Medicare beneficiary FDG PET imaging orders)

I, the ordering provider, attest that this order for an FDG PET study is reasonable and necessary for the following reasons (check all that apply.)

The study will:

- ☐ **Inform an initial treatment strategy**
- ☐ **Inform Subsequent treatment strategy**
- ☐ **Avoid an invasive diagnostic procedure that may be unnecessary**
- ☐ **Determine the optimal location to perform an invasive procedure that is necessary**
- ☐ **Guide clinical management of the patient depending on the staging of the cancer identified**
- ☐ **Identify the stage of cancer after a standard diagnostic workup been completed, but the stage of cancer remains in doubt**
- ☐ **Confirm the stage of cancer following a conventional imaging study which was deemed insufficient for clinical management of the patient**
- ☐ **Other (explain):** _____

_____

I attest that I have provided, and will provide upon request, medical documentation supporting the rationale provided above in support of this PET study order.

Signed: _____

Date: _____

Physicians: Your attestation will inform the hospital which modifier to report, and will serve to document the hospital medical record that Medicare's medical necessity requirements have been met.

The modifiers required by Medicare are:

PI - PET or PET/Computed Tomography (CT) to inform the initial treatment strategy of tumors that are biopsy proven or strongly suspected of being cancerous based on other diagnostic testing.

PS - PET or PET/CT to inform the subsequent treatment strategy of cancerous tumors when the beneficiary's treatment physician determines that the PET study is needed to inform subsequent anti-tumor strategy.

RCM IN 2021: ROADMAP TO A STRONG FINANCIAL COMEBACK

Throughout 2020, the COVID-19 pandemic threw hospitals an array of unprecedented challenges, but 2021 is the ultimate opportunity for your organization to bounce back.

The changing environments, staffing shortages and new regulations weren't easy for any organization, but you can ensure the best possible financial outcomes in 2021 by:

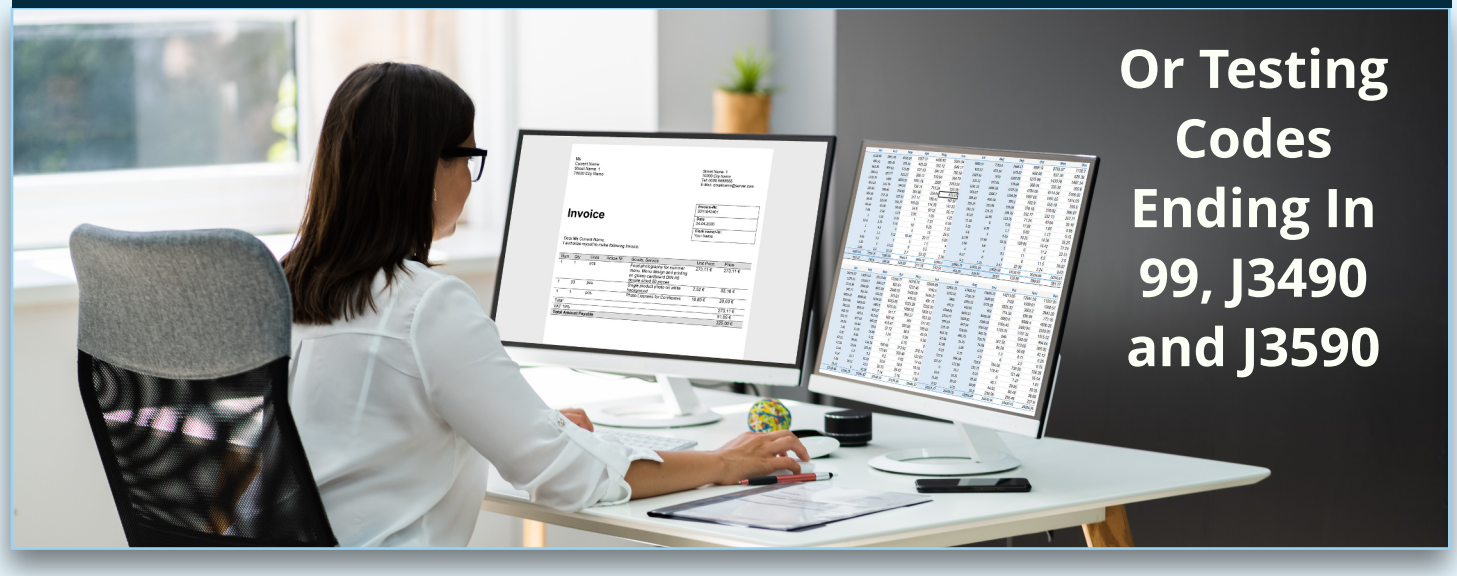
- Optimizing staff efficiency
- Staying on top of current inventory changes
- Identifying where and how to maximize revenue

How prepared is your organization to bounce back from the COVID-19 financial challenges?

Download this recorded webinar and listen to Daniel Low, Director of Operations at Healthcare Financial Resources, detail how to implement an action plan that will help your organization improve its bottom line.

Click here: https://www.hfri.net/resources/download-our-webinar-rcm-in-2021-roadmap-to-a-strong-financial-comeback/

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS



All medical billers and AR follow-up teams have experienced billing or claim denials because there is a "miscellaneous" HCPCS on a claim. The reason is because miscellaneous codes do not provide adequate information for the item being billed.

Unlike established HCPCS for standard procedures and testing, most payers will manually calculate the reimbursement for the claim line reporting the miscellaneous item or testing. To do this process, however, the provider is expected to supply the additional information on the claim upon submission.

The type of information required however, varies on the type of miscellaneous service or item that is being reported on the claim. For example:

- If the service is a surgery, an operative report will be required to be submitted with the claim submission. This allows the payer to review the procedure and adjudicate the claim correctly
- If the service is a diagnostic test, clinical notes should be included. The clinical notes should clearly and precisely describe the patient's diagnosis, the full name of the test performed and the results of the test
- If the item is a DME item, the name of the item, a full description of the item, the name of the manufacturer, the product code/number and a copy of the invoice should be included with the claim submission
- If the miscellaneous item is a drug, the claim should contain the full name of the drug, the manufacturer, strength and dosage, NDC code for the drug and route of administration. This would apply to anesthesia agents
- **Special note for 80299: The name of the drug being tested must be indicated in Box 19 of the CMS 1500 claim form (remarks field) or in Box 80 of the UB04 claim

In the tables on the follow pages of this article, are examples of various procedures and items for which this article is applicable.

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Anesthesia	
Code	**Description**
01999	Unlisted anesthesia procedure(s)
Surgery	
15999	Unlisted procedure, excision pressure ulcer
17999	Skin, mucous membrane and subcutaneous tissue
19499	Breast
20999	Musculoskeletal system, general
21089	Unlisted maxillofacial prosthetic procedure
21299	Unlisted craniofacial and maxillofacial procedure
21499	Unlisted musculoskeletal procedure, head
21899	Unlisted procedure, neck or thorax
22899	Spine
22999	Abdomen, musculoskeletal system
23929	Shoulder
24999	Humerus or Elbow
25999	Forearm or Wrist
26989	Hands or Fingers
27299	Pelvis or Hip Joint
27599	Femur or Knee
27899	Leg or Ankle
28899	Foot or Toes
29799	Casting or Strapping
29999	Arthroscopy
30999	Nose
31299	Accessory Sinuses
31599	Larynx
31899	Trachea, Bronchi
32999	Cardiac Surgery
36299	Vascular Injection

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Surgery, continued	
Code	**Description**
37501	Unlisted vascular endoscopy procedure
37799	Unlisted procedure, vascular surgery
38129	Unlisted laparoscopy procedure, spleen
38589	Lymphatic System
38999	Unlisted procedure, hemic or lymphatic system
39499	Mediastinum
39599	Diaphragm
40799	Lips
40899	Vestibule of Mouth
41599	Tongue, floor of mouth
41899	Dentoalveolar structures
42299	Palate, uvula
42699	Salivary glands or ducts
43289	Unlisted Laparoscopy procedure, esophagus
43499	Unlisted procedure, esophagus
43659	Unlisted Laparoscopy procedure, stomach
43999	Unlisted procedure, stomach
44238	Unlisted Laparoscopy procedure, intestine, except rectum
44799	Unlisted procedure, intestine
44899	Merckel's diverticulum and the mesentery
44979	Unlisted laparoscopy procedure, appendix
45499	rectum
45999	Unlisted procedure, rectum
46999	anus
47379	Unlisted laparoscopy procedure, liver
47399	Unlisted procedure, liver
47579	Unlisted laparoscopy procedure, biliary tract
47999	Unlisted procedure, biliary tract
48999	Pancreas
49329	Unlisted laparoscopy procedure, abdomen, peritoneum and omentum
49659	Hernioplasty, herniorrhaphy, herniotomy
49999	Unlisted procedure, abdomen, peritoneum and omentum
50549	Unlisted laparoscopy procedure, renal
50949	ureter
51999	bladder
53899	Urinary system
54699	testis
55559	Spermatic cord
55899	Unlisted procedure, male genital system
58578	Unlisted Laparoscopy procedure, uterus

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Surgery, Continued	
Code	**Description**
58579	Unlisted hysteroscopy procedure, uterus
58679	Unlisted Laparoscopy Procedure, oviduct, ovary
58999	Unlisted procedure, female genital system (non-obstetrical)
59897	Unlisted fetal invasive procedure, including ultrasound guidance
59898	Unlisted laparoscopy procedure, maternity care and delivery
59899	Unlisted procedure, maternity care and delivery
60659	Unlisted laparoscopy procedure, endocrine system
60699	Unlisted procedure, endocrine system
64999	Nervous system
66999	Anterior segment of eye
67299	Posterior segment
67399	Ocular muscle
67599	Orbit
67999	Eyelids
68399	Conjunctiva
68899	Lacrimal system
69399	External ear
69799	Middle ear
69949	Inner ear
69979	Temporal bone, middle fossa approach
Radiology	
76496	Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
76497	Unlisted computed tomography procedure (e.g., diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76999	Unlisted ultrasound procedure (e.g., diagnostic, interventional)
77299	Unlisted procedure, therapeutic radiology clinical treatment planning
77399	Medical radiation physics, dosimetry and treatment devices, and special services
77499	Therapeutic radiology treatment management
77799	Clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78599	Unlisted respiratory procedure, diagnostic nuclear medicine
78699	Unlisted nervous system procedure, diagnostic nuclear medicine
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79999	Radiopharmaceutical therapy, unlisted procedure

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Pathology – Laboratory	
Code	**Description**
80299	Quantitation of drug, not elsewhere classified
81099	Unlisted urinalysis procedure
84999	Unlisted chemistry procedure
85999	Unlisted hematology and coagulation procedure
86849	Unlisted immunology procedure
86999	Unlisted transfusion medicine procedure
87999	Unlisted microbiology procedure
88099	Unlisted necropsy (autopsy) procedure
88199	Unlisted cytopathology procedure
88299	Unlisted cytogenetic study
88399	Unlisted surgical pathology procedure
89240	Unlisted miscellaneous pathology test
89398	Unlisted reproductive medicine laboratory procedure
Medicine	
Code	**Description**
90399	Unlisted immune globulin
90749	Unlisted vaccine/toxoid
90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion
90899	Unlisted psychiatric service or procedure
90999	Unlisted dialysis procedure, inpatient or outpatient
91299	Unlisted diagnostic gastroenterology procedure
92499	Unlisted ophthalmological service or procedure
92700	Unlisted otorhinolaryngological service or procedure
93799	Unlisted cardiovascular service or procedure
94799	Unlisted pulmonary service or procedure
95199	Unlisted allergy/clinical immunologic service or procedure
95999	Unlisted neurological or neuromuscular service or procedure
96549	Unlisted chemotherapy service or procedure
96999	Unlisted special dermatological service or procedure
97039	Unlisted modality service or procedure (specify type and time if constant attendance)
97139	Unlisted therapeutic service or procedure (specify)
97799	Unlisted physical medicine/rehabilitation service or procedure
99199	Unlisted special service, procedure, or report
99600	Unlisted home visit service or procedure
Evaluation and Management	
Code	**Description**
99429	Unlisted preventive medicine service
99499	Unlisted evaluations and management service

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Miscellaneous A Codes	
Code	**Description**
A4335	Incontinence supply, miscellaneous
A4421	Ostomy supply, miscellaneous
A4913	Miscellaneous dialysis supplies, NOS
A9698	Non-radioactive contrast imaging material, not otherwise classified, per study
A9699	Radiopharmaceutical, therapeutic, not otherwise classified
A9900	Miscellaneous DME supply, accessory, and/or service component of another HCPCS code
A9999	Miscellaneous DME supply or accessory, not otherwise specified
Miscellaneous E Codes	
Code	**Description**
E1399	Durable Medical Equipment, miscellaneous
Miscellaneous G Codes	
Code	**Description**
G0235	PET Imaging, any site NOS
Miscellaneous J Codes	
Code	**Description**
J3490	Unclassified drugs
J3590	Unclassified biologics
J7599	Immunosuppressive drug, NOC
J7699	NOC drugs, inhalation solutions, administered through DME
J7799	NOC drugs, other than inhalation drugs, administered through DME
J8498	Antiemetic drug, rectal suppository, NEC
J8499	Prescription drug, oral, non-chemotherapeutic, NOS
J8597	Antiemetic drug, oral, NOS
J8999	Prescription drug, oral, chemotherapeutic, NOS
J9999	NOC, antineoplastic drug
Miscellaneous L Codes	
Code	**Description**
L8499	Unlisted procedure for miscellaneous prosthetic services
L8699	Unlisted procedure for miscellaneous implant services
Miscellaneous Q Codes	
Code	**Description**
Q4050	Cast supplies for unlisted types and material of casts
Q4051	Splint supplies, misc. (includes thermoplastics, strapping, fasteners, padding and other supplies
Q4082	Drug or biological NEC, Part B drug competitive acquisition program

CLAIM TIPS FOR BILLING MISCELLANEOUS ITEMS

Miscellaneous S Codes	
Code	**Description**
S8189	Tracheostomy supply NOS
S3870	Comparative Genomic Hybrization (CGH)
Miscellaneous V Codes	
Code	**Description**
V2199	Not otherwise classified – single vision lens
V2797	Vision supply, accessory or component of another HCPCS vision code
V2799	Vision service, miscellaneous
V5299	Hearing service, miscellaneous

COVID-19 UPDATE

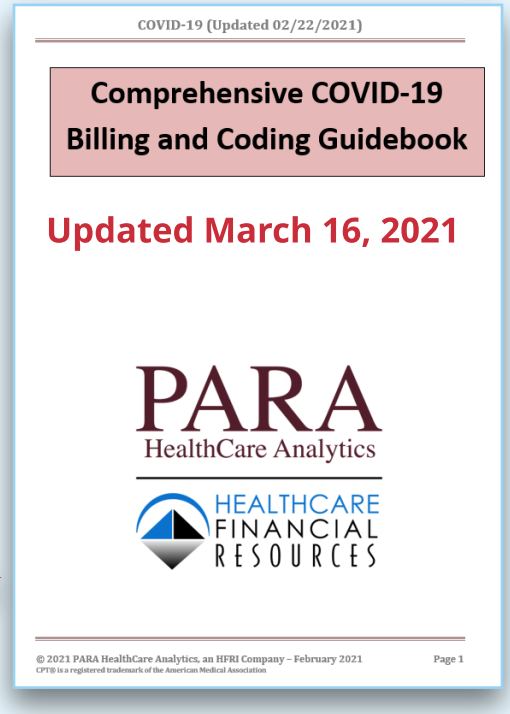
PARA HealthCare Analytics *continues to update COVID-19 coding and billing information based on frequently changing guidelines and regulations from CMS and payers. All coding must be supported by medical documentation.*

What you will find in this important update:

- New link to the CDC ICD-10 tool
- Updated information on Remdesivir, the FDA-approved COVID-19 treatment for most adults
- New MAC payment link and table for pricing of COVID-19 lab tests
- Updated language for RHCs and FQHCs regarding billing of MABs and vaccines
- Easier to read sections for Condition Codes and Modifiers
- New information on the CR/DR

https://apps.para-hcfs.com/para/Documents/COVID-19%20(Updated%2003-16-2021).pdf

Download the updated Comprehensive COVID-19 Billing and Coding Guidebook by clicking the link above or the document to the right.


COVID-19 (Updated 02/22/2021)

Comprehensive COVID-19 Billing and Coding Guidebook

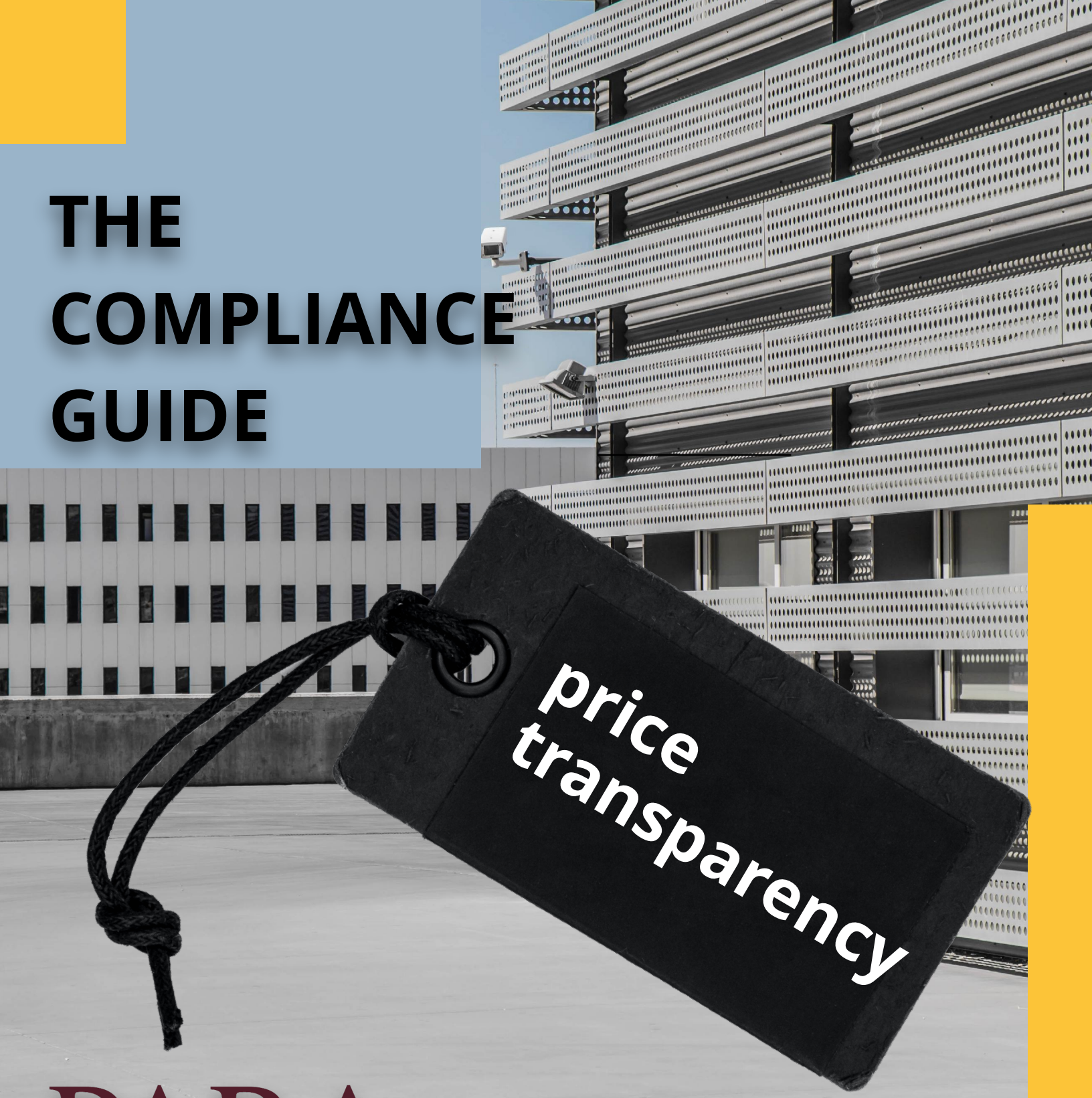
Updated March 16, 2021

PARA HealthCare Analytics

HEALTHCARE FINANCIAL RESOURCES

© 2021 PARA HealthCare Analytics, an HFRI Company – February 2021 Page 1
CPT® is a registered trademark of the American Medical Association

THE COMPLIANCE GUIDE



PARA
HealthCare Analytics

HEALTHCARE
FINANCIAL
RESOURCES

2021

There is still time to achieve readiness for the critical Price Transparency Rule.

PARA can help.

THE CLOCK IS TICKING

DATES, RULES & REGS

The CMS final rule (CMS-1717-F2) aims to make hospital price information readily available to patients, so they can compare costs and make more informed healthcare decisions. Meeting the deadline and maintaining compliance will be no small endeavor for providers. Complying with the mandate will be a large undertaking that requires multi-disciplinary coordination. ***PARA HealthCare Analytics and HFRI can help navigate the dates, the rules and the regulations****.*

REQUIREMENT #1

By January 1, 2021, hospitals are required to be in compliance with the Hospital Price Transparency requirements set forth in the CY 2020 Hospital Outpatient PPS Policy Changes (CMS-1717-FS).

REQUIREMENT #2

A comprehensive machine-readable file that includes the specific standard charges for all hospital items and services.

REQUIREMENT #3

A consumer-friendly display that includes the standard charges for at least 300 "shoppable" services that are grouped with charges for ancillary services that ar customarily provided by the hospital.

SOLUTIONS FOR HOSPITALS

THE PARA PTT

In speaking with hospital associations, clients, and business vendor groups, we are finding that we are one of the only vendors who can completely satisfy, to the letter of the law, both CMS requirements in a fully customizable manner.

Providers will need to publish both machine-readable format files and the patient facing price estimator is a value-add service for enhancing price transparency.

PARA will use the CMS Extract file embedded in the Price Transparency Tool tab via the **PARA Data Editor** to build the shoppable items/bundles. This can be done by the hospital, coupled with **PARA's** guidance to ensure all primary procedures are linked to its customarily paired ancillary services.

Turnaround time for the **Price Transparency Tool** is 60 days from submission of completed data.

There is no limit at this time on how many clients **PARA** can assist with the CMS' 2021 price transparency requirements as we are constantly monitoring workload and innovating our automation to support the data mining need for this initiative.

FROM <THIS, TO THIS>

TAKING CONSUMERS FROM THE STONE AGE TO THE DIGITAL AGE

MEET THE TEAM

Violet Archulet-Chiu

Senior Account Executive

varchuleta@para-hcfs.com

800.999.3332 x219

Sandra LaPlace

Account Executive

splace@para-hcfs.com

800.999.3332 x 225

Randi Brantner

Vice President of Analytics

rbrantner@hfri.net

719.308.0883

CAPABILITIES AND SERVICES

To ensure consumers will be able to browse for healthcare services in the same way they shop for other goods and services online, hospitals partner with **PARA HealthCare Analytics**, an HFRI company that has been providing hospitals and health systems with pricing, reimbursement, coding, and contract management services since 1985.

PARA works closely with clients to deploy robust and accurate pricing capabilities for area healthcare consumers. The **PARA** solution includes a patient-facing estimator engineered to deliver user-friendly, procedure-level estimates reflecting patients' specific coverage limits.

Providing consumers with the ability to effectively shop for healthcare services is essential as more employers transition to high-deductible health plans.

Peter Ripper, CEO of **PARA HealthCare Analytics**, has led his team to design a solution that will provide meaningful, easy-to-understand information for healthcare consumers.

With the healthcare providers facing a range of new financial pressures due to the COVID-19 pandemic, **PARA** has pushed to ensure that the critical but complex transparency rule can be implemented in a timely, cost-effective and consumer-friendly manner. We look forward to helping other systems who may be struggling to achieve price transparency.

WATCH YOUR HOSPITAL'S BRIGHT FUTURE UNFOLD

With The Help Of Our Price Transparency Tool

PRESS HERE

DEMO

REPORTING MANUFACTURER CREDITS FOR MEDICAL DEVICES

NOTE: This update removes advice regarding modifiers FB and FC, which are not required on outpatient claims for no-cost or reduced-cost implantable devices effective January 1, 2014.

The Health and Human Services Office of the Inspector General (OIG) released a new audit report in November of 2020 advising Medicare to recoup payments from hospitals that improperly claimed reimbursement for medical devices supplied at a reduced cost for specific patients.Both inpatient (IPPS) and outpatient (OPPS) claims with billing deficiencies related to credited medical devices were found.

Hospitals Did Not Comply With Medicare Requirements for Reporting Cardiac Device Credits A-01-18-00502 11-16-2020 (hhs.gov)

Hospitals Did Not Comply With Medicare Requirements for Reporting Cardiac Device Credits

11-16-2020 | A-01-18-00502 | Complete Report | Report in Brief

Why OIG Did This Audit

Prior OIG audits with audit periods ranging from 2005 through 2016 found that hospitals did not always comply with Medicare requirements for reporting credits received from manufacturers for medical devices that were replaced. Specifically, hospitals did not always report to CMS device manufacturer credits that they received. One prior review estimated that services related to the replacement of seven recalled and prematurely failed cardiac medical devices cost Medicare $1.5 billion during calendar years 2005 through 2014.

How OIG Did This Audit

We obtained a list of warranty credits from the device manufacturers and matched the device recipients to the Medicare enrollment database to determine which recipients were Medicare beneficiaries. Next, we matched the beneficiaries to the Medicare National Claims History to identify claims that had a cardiac device replacement procedure for which the date of service matched to the device replacement procedure date on the credit listing. We evaluated compliance with selected billing requirements.

When an implanted device is eligible for a free or discounted replacement due to a manufacturer’s defect or risk management policy, hospitals are required to report the discounts on their claims for the device's implantation. Under both Medicare reimbursement systems (Outpatient Prospective Payment System (OPPS) and Inpatient Prospective Payment System (IPPS)), facility reimbursement rates are calculated to compensate the hospital for both the cost of the surgical procedure and the cost of the device itself.

PRICE TRANSPARENCY: CLARIFYING THE UNKNOWN

Let us clarify the facts, the questions and uncertainties about Price Transparency.

Click on the video clip below and watch how **PARA HealthCare Analytics** and **HFRI** can ease the anxieties of hospital compliance executives.

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 25, 2021

News

- Medicare Shared Savings Program: Application Deadlines for January 1, 2022, Start Date
- Repetitive, Scheduled Non-Emergent Ambulance Transport: Documentation Requirements
- PT During COVID-19 & Response to Texas Storm

Compliance

- Non-Physician Outpatient Services Provided Before or During Inpatient Stays: Bill Correctly

Claims, Pricers, & Codes

- Home Health Payment Corrections

MLN Matters® Articles

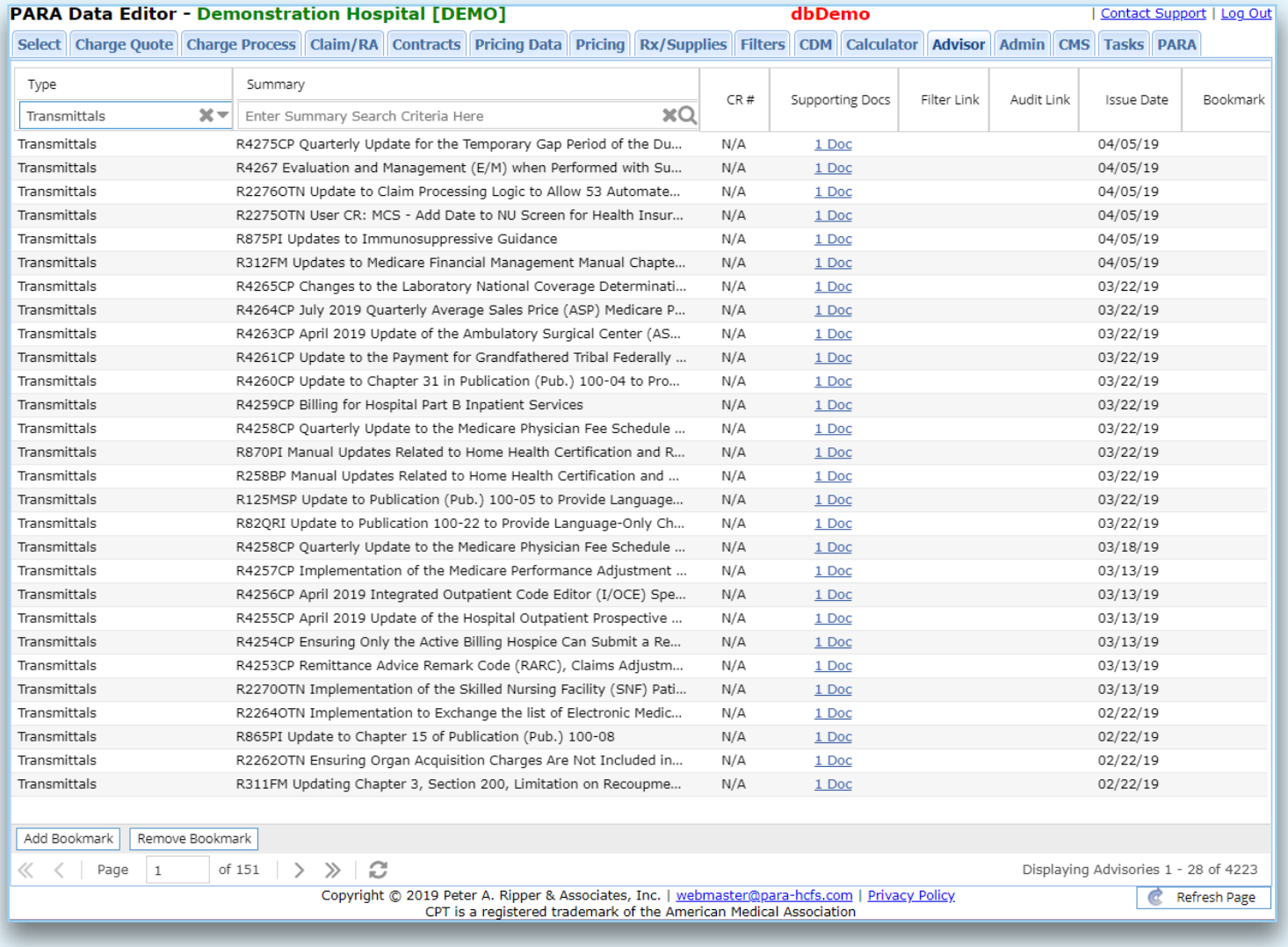
- Common Working File (CWF) Edits for Medicare Telehealth Services and Manual Update
- Correction to Period Sequence Edits on Home Health Claims
- Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2021
- Updated Billing Requirements for Home Infusion Therapy (HIT) Services on or After January 1, 2021
- Update to Rural Health Clinic (RHC) Payment Limits

View this edition as PDF (PDF)

There were 4 new or revised
MedLearns released this week.

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

FIND ALL THESE MEDLEARNS
IN THE **ADVISOR** TAB OF THE **PDE** 4



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

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

Add Bookmark | Remove Bookmark

Page 1 of 151 Displaying Advisories 1 - 28 of 4223

Copyright © 2019 Peter A. Ripper & Associates, Inc. | webmaster@para-hcfs.com | Privacy Policy
CPT is a registered trademark of the American Medical Association

Refresh Page

The link to this MedLearn MM12212

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

April 2021 Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

MLN Matters Number: MM12212 | Related Change Request (CR) Number: 12212

Related CR Release Date: March 25, 2021 | Effective Date: April 1, 2021

Related CR Transmittal Number: R10693CP | Implementation Date: April 5, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for Skilled Nursing Facilities (SNFs), physicians, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice (HH&H) MACs and Durable Medical Equipment (DME) MACs, for services they provide to Medicare patients in a Part A covered SNF stay.

PROVIDER ACTION NEEDED

This article tells you about updates to the lists of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS). Specifically, this quarterly update includes revisions to the Part B SNF CB files for 2021, 2020, 2019, and 2017.

These changes to HCPCS codes and Medicare Physician Fee Schedule designations will be used to revise Common Working File (CWF) edits to allow MACs to make appropriate payments in accordance with policy for SNF consolidated billing. This policy is contained in the Medicare Claims Processing Manual, Chapter 6, Section 20.6. Make sure your billing staffs are aware of these changes.

BACKGROUND

CMS periodically updates the lists of HCPCS codes that are excluded from the CB provision of the SNF Prospective Payment System (PPS). Services excluded from SNF PPS and CB may be paid to providers, other than SNFs, for beneficiaries, even when in a SNF stay.

Section 1888 of the Social Security Act codifies SNF PPS and CB. The new coding identified in each routine coding update describes the same services that are subject to SNF PPS payment by law, and do not add any additional services. Rather, we make new updates when there are changes to the coding system, not because the services subject to SNF CB are being redefined. We will note other regulatory changes beyond code list updates when and if they occur.

Services not appearing on the exclusion lists submitted on claims to MACs, including DME

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

The link to this MedLearn MM12104

mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)

MLN Matters Number: MM12104 | Related Change Request (CR) Number: 12104
Related CR Release Date: March 23, 2021 | Effective Date: February 15, 2018
Related CR Transmittal Number: R10635CP | Implementation Date: July 6, 2021

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians, hospitals, and providers billing Medicare Administrative Contractors (MACs) for Implantable Cardiac Defibrillator (ICD) services they provide to Medicare patients.

PROVIDER ACTION NEEDED

This article tells you about Medicare claims processing system changes for ICDs with dates of service on or after February 15, 2018. Make sure your billing staffs are aware of these instructions.

BACKGROUND

An ICD is an electronic device designed to diagnose and treat life-threatening Ventricular Tachyarrhythmias (VTs). The device consists of a pulse generator and electrodes for sensing and defibrillating. Trials show this therapy improves survival and reduces sudden cardiac death in patients with certain clinical characteristics.

Section 20.4 of the Medicare National Coverage Determinations (NCD) Manual establishes conditions of coverage for ICDs. In 1986, CMS first issued an NCD providing limited coverage of ICDs and we expanded the policy over the years. CMS last reconsidered this NCD in 2005.

CR 12104 provides that, effective for claims with dates of service on or after February 15, 2018, CMS will cover ICDs for the following patient indications: (Please see Section 20.4 of the NCD Manual for the full list of coverage criteria.)

1. Patients with a personal history of sustained VT or cardiac arrest due to Ventricular Fibrillation (VF)
2. Patients with a prior Myocardial Infarction (MI) and a measured Left Ventricular Ejection Fraction (LVEF) ≤ 0.30

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

The link to this MedLearn MM12171

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2021

MLN Matters Number: MM12171

Related Change Request (CR) Number: 12171

Related CR Release Date: March 23, 2021

Effective Date: July 1, 2021

Related CR Transmittal Number: R10658CP

Implementation Date: July 6, 2021

PROVIDER TYPES AFFECTED

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

PROVIDER ACTION NEEDED

This article announces the changes in the July 2021 quarterly release of the edit module for clinical diagnostic laboratory services. Please be sure your billing staffs are aware of these updates.

BACKGROUND

The laboratory negotiated rulemaking committee developed the National Coverage Determinations (NCDs) for clinical diagnostic laboratory services, and the final rule was published on November 23, 2001. Nationally uniform software was developed and incorporated in the Medicare shared systems, so they process laboratory claims subject to one of the 23 NCDs (see Medicare National Coverage Determination, Sections 190.12 - 190.34) uniformly throughout the nation, effective April 1, 2003.

In accordance with the Medicare Claims Processing Manual, Chapter 16, Section 120.2, the laboratory edit module is updated quarterly as necessary to reflect ministerial coding updates and substantive changes to the NCDs developed through the NCD process. The changes are a result of coding analysis decisions developed under the procedures for maintenance of codes in the negotiated NCDs and biannual updates of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

CR 12171 communicates requirements to Medicare's Shared System Maintainers (SSMs) and MACs, notifying them of changes to the laboratory edit module to update it for changes in laboratory NCD code lists for July 2021.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

The link to this MedLearn SE21003

mln MATTERS®

KNOWLEDGE • RESOURCES • TRAINING

New Provider Enrollment Administrative Action Authorities

MLN Matters Number: SE21003

Related Change Request (CR) Number: N/A

Article Release Date: March 24, 2021

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: N/A

PROVIDER TYPES AFFECTED

This MLN Matters Special Edition (SE) Article is for all physicians, providers, and suppliers in the Medicare program.

PROVIDER ACTION NEEDED

This article gives you important information about recently issued regulatory authorities. These authorities affect currently enrolled Medicare providers and suppliers, or prospective providers and suppliers. You and your staff should be aware of these new authorities.

BACKGROUND

CMS issued a Final Rule on September 10, 2019, to stop fraud before it happens by keeping problematic providers and suppliers out of our Federal health insurance programs. The Final Rule, "Program Integrity Enhancements to the Provider Enrollment Process," (CMS-6058-FC) created several new revocation and denial authorities, as well as other supporting authorities, to strengthen CMS' efforts to stop fraud, waste, and abuse. This article summarizes several key provisions in CMS-6058-FC.

Affiliation Disclosures

Overview

We believe these affiliation disclosure provisions will allow us to better track current and past relationships between and among different providers and suppliers. In addition, they will help us find and take action on affiliations among providers and suppliers posing an undue risk to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Based on authority in Section 1866(j)(5) of the Social Security Act (the Act), we initially proposed requiring affiliation disclosures from all providers and suppliers on all initial and revalidation Medicare enrollment applications. However, in light of commenter feedback, we decided to adopt a "phased-in" approach to the affiliation disclosure provisions.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

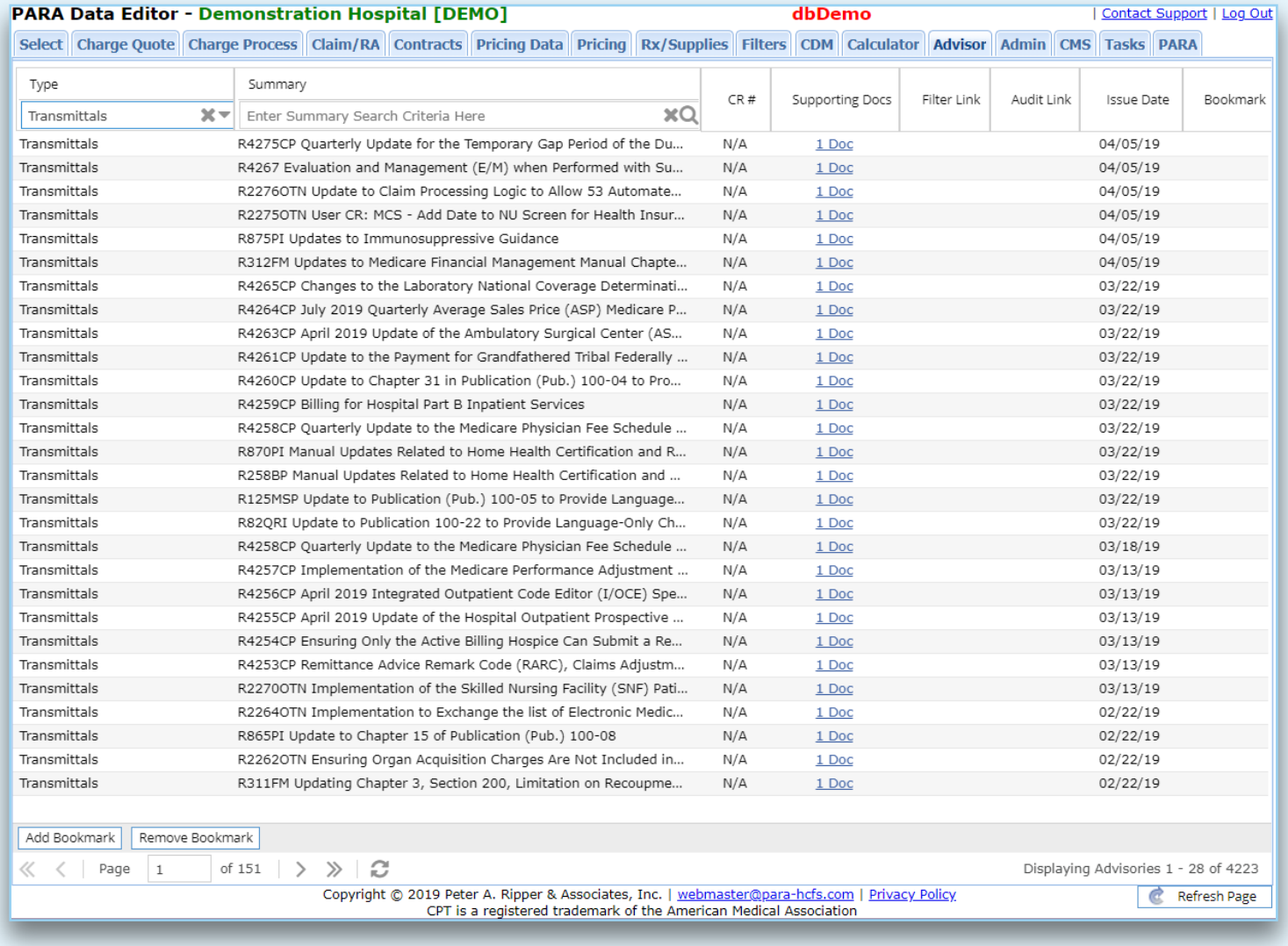
Medicare Learning Network®

There were 10 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**

10



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

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

Add Bookmark | Remove Bookmark

Page 1 of 151 Displaying Advisories 1 - 28 of 4223

Copyright © 2019 Peter A. Ripper & Associates, Inc. | webmaster@para-hcfs.com | Privacy Policy
CPT is a registered trademark of the American Medical Association

Refresh Page

The link to this Transmittal R10693CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10693	**Date: March 25, 2021**
	Change Request 12212

Transmittal 10678, dated March 16, 2021, is being rescinded and replaced by Transmittal 10693, dated, March 25, 2021 to remove business requirement 12212.2, to modify business requirement 12212.3 to remove the reference to any action being performed on the 2021 SNF Part B File #4, and any reference to these actions in the background section of the document. All other information remains the same.

SUBJECT: April 2021 Quarterly Update to HCPCS Codes Used for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Enforcement

I. SUMMARY OF CHANGES: This notification provides updates to the lists of HCPCS codes that are subject to the consolidated billing provision of the SNF Prospective Payment System (PPS).

Changes to Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes and Medicare Physician Fee Schedule designations will be used to revise CWF edits to allow MACs to make appropriate payments in accordance with policy for SNF consolidated billing in chapter 6, section 20.6.

EFFECTIVE DATE: April 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 5, 2021

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

The link to this Transmittal R10686OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10686	**Date: March 24, 2021**
	Change Request 11626

Transmittal 10291, dated August 6, 2020, is being rescinded and replaced by Transmittal 10686, dated, March 24, 2021 to revise the effective and implementation dates removing the CR off the April 2021 release and expanding it to the October 2021 release. All other information remains the same.

SUBJECT: Expand Retention of Claims History for Outpatient, Part B, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) to 5 years

I. SUMMARY OF CHANGES: The purpose of this CR is for the impacted system(s) to expand retaining Outpatient, Part B and DMEPOS claims history within Common Working File (CWF) up to five (5) years or 60 months.

EFFECTIVE DATE: October 4, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 5, 2020 - Development; July 6, 2021 - Testing; October 4, 2021 - Integration 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.

IV. ATTACHMENTS:

The link to this Transmittal R10573CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10573	**Date: March 24, 2021**
	Change Request 12115

SUBJECT: Update to Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Program Manual Sections

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make Medicare Contractors aware of updates to Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Program Manual Sections of the Medicare Claims Processing Manual and Benefit Policy Manual.

EFFECTIVE DATE: January 1, 2010
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 26, 2021
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	32/140/Cardiac Rehabilitation Programs, Intensive Cardiac Rehabilitation Programs, and Pulmonary Rehabilitation Programs
R	32/140/140.2/Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010
R	32/140/140.3/Intensive Cardiac Rehabilitation Program Services Furnished On or After January 1, 2010
R	32 /140/140.4/Pulmonary Rehabilitation Program Services Furnished On or After January 1, 2010

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 R10573BP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10573	**Date: March 24, 2021**
	Change Request 12115

SUBJECT: Update to Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Program Manual Sections

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to make Medicare Contractors aware of updates to Pulmonary Rehabilitation (PR), Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Program Manual Sections of the Medicare Claims Processing Manual and Benefit Policy Manual.

EFFECTIVE DATE: January 1, 2010
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 26, 2021

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	15/231/Pulmonary Rehabilitation (PR) Program Services Furnished On or After January 1, 2010
R	15/232/Cardiac Rehabilitation (CR) and Intensive Cardiac Rehabilitation (ICR) Services Furnished On or After January 1, 2010

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 R10658CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10658	**Date: March 23, 2021**
	Change Request 12171

SUBJECT: Changes to the Laboratory National Coverage Determination (NCD) Edit Software for July 2021

I. SUMMARY OF CHANGES: This Change Request (CR) announces the changes that will be included in the July 2021quarterly release of the edit module for clinical diagnostic laboratory services. This Recurring Update Notification applies to Chapter 16, Section 120.2, Publication 100-04.

EFFECTIVE DATE: July 1, 2021 - Unless noted differently in requirements.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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

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

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

III. FUNDING:

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

IV. ATTACHMENTS:

Recurring Update Notification

The link to this Transmittal R10601CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10601	**Date: March 23, 2021**
	Change Request 12091

SUBJECT: Modifications to the National Coordination of Benefits Agreement (COBA) Claims Crossover Process

I. SUMMARY OF CHANGES: Through this instruction, CMS is directing the Common Working File (CWF) maintainer to discontinue the practice of sending Beneficiary Other Insurance (BOI) auxiliary file data to the Next Generation Desktop (NGD) and the Medicare Beneficiary Database (MBD) **only** for COBA ID ranges 79000-79999 and for 89000-89999. Additionally, through this instruction, CMS is modifying one aspect of the CWF logic used as part of Recovery Audit Contractor (RAC)-initiated COBA crossover claims process, associated with COBA ID range 88000--88999.

EFFECTIVE DATE: July 1, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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	27/ 80.8- Inclusion and Exclusion of Specified Categories of Adjustment Claims for Coordination of Benefits Agreement (COBA) Crossover Purposes

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 R10629MSP

CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-05 Medicare Secondary Payer	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 10629	**Date: March 23, 2021**
	Change Request 11332

SUBJECT: Update Internet Only Manual (IOM) Chapter 7 Medicare Secondary Payer (MSP) Recovery Manual

I. SUMMARY OF CHANGES: Several years ago, Medicare Secondary Payer (MSP) Internet Only Manual (IOM) 100-05, Chapter 7 was removed from the IOM for MSP recovery processing revisions. The Centers for Medicare & Medicaid Services (CMS) has completed the updates to the manual and is sending the IOM out to the A/B MACs and DME MACs for review and comments. Certain references have been removed because either the law has been repealed, such as the Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match or the system no longer exists, such as the Recovery Management System (ReMAS). Overall, the IOM is smaller than previously due to the fact that many of the recoveries are now performed by the Coordination of Benefits & Recovery Contractors and are no longer required to be in the IOM.

EFFECTIVE DATE: April 19, 2021
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 19, 2021

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.*

The link to this Transmittal R10614FM

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-06 Medicare Financial Management	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10614	**Date: March 23, 2021**
	Change Request 12028

SUBJECT: The Fiscal Year 2021 Updates for the CMS Internet Only Manual (IOM) Publication (Pub.) 100-06, Medicare Financial Management Manual, Chapter 7 - Internal Control Requirements

I. SUMMARY OF CHANGES: This Change Request (CR) contains the upcoming Fiscal Year 2021 annual document updates, and provides clarification for the Office of Management & Budget (OMB) A-123 and Internal Controls over Financial Reporting (ICOFR).

EFFECTIVE DATE: October 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 22, 2021

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.*

The link to this Transmittal R10635CP

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10635	**Date: March 23, 2021**
	Change Request 12104

SUBJECT: Claims Processing Instructions for National Coverage Determination (NCD) 20.4 Implantable Cardiac Defibrillators (ICDs)

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform the MACs of the follow-on instructions incorporating shared system changes for claims processing for Implantable Cardiac Defibrillators with dates of service on or after February 15, 2018.

EFFECTIVE DATE: February 15, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2021

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	32/Table of Contents
R	32/270/Implantable Cardiac Defibrillators (ICDs)
R	32/270/270.1/Coding Requirements for ICDs
R	32/270/270.2/Special Editing for Inpatient Claims
N	32/270/270.3/Denial Messaging

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 R10694OTN

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10694	**Date: March 24, 2021**
	Change Request 11746

Transmittal 10278, dated August 7, 2020, is being rescinded and replaced by Transmittal 10694, dated, March 24, 2021 to revise Business Requirements (BRs) 11746.7 and 11746.8 and to add a note to BR 11746.2. All other information remains the same.

SUBJECT: Create a New Media Preference Indicator Custom Format and New eMedicare Correspondence Preference Indicator

I. SUMMARY OF CHANGES: The Centers for Medicare & Medicaid Services (CMS) has an obligation to provide the Medicare communications and notifications in accessible formats for beneficiaries who elect one of the formats as a preference. The purpose of this Change Request (CR) is for impacted shared systems to receive, process and transmit the new correspondence field to support the eMedicare initiative and the new media preference Custom Format.

EFFECTIVE DATE: January 1, 2021 - CWF shall develop and make available all copybooks as described in the BRs. FISS, MCS, VMS and CWF shall perform Analysis/Design; April 1, 2021 - FISS, MCS, VMS and CWF shall develop and implement; July 1, 2021 - BR 11746.1.11.1 only to implement and validate ECPS changes.
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 4, 2021 - CWF shall develop and make available all copybooks as described in the BRs. FISS, MCS, VMS and CWF shall perform Analysis/Design; April 5, 2021 - FISS, MCS, VMS and CWF shall develop and implement; July 6, 2021 - BR 11746.1.11.1 only to implement and validate ECPS changes.

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	

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

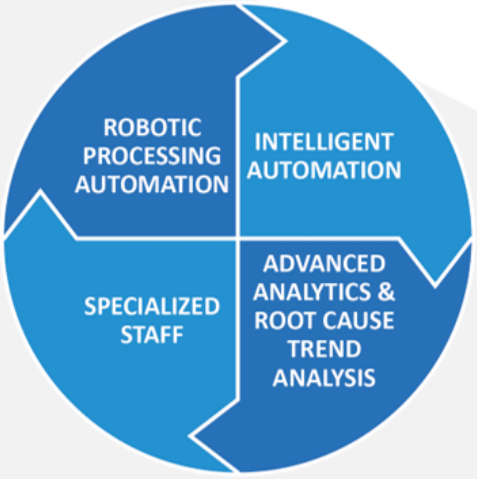
Creating results through our experience and automated processes.

30%+
INCREASE IN COLLECTIONS
IN SOME CASES UP TO 100% OR MORE

25%+
REDUCTION IN AN ACCOUNT'S LIFE CYCLE
LOWERING YOUR AR DAYS

20%+
DECREASE IN FUTURE DENIALS
INCREASING CASHFLOW & LOWERING WRITE-OFFS

Our Approach Uses:



HFRI Automation Process

- CATEGORIZE WORK INTO SIMILAR ISSUES
- IDENTIFY HIDDEN CAUSES OF DELAYED PAYMENTS
- TRAIN BOTS TO DO TEDIOUS FOLLOW-UP ACTIVITIES
- RESULT IN INCREASED PRODUCTION & COLLECTIONS

Additional Benefits Include:

AR FEES ARE CONTINGENCY BASED
PAY ONLY WHEN WE DELIVER CASH TO YOU

OUR SERVICE SITS ON THE BACKEND
AND DOESN'T DISRUPT ANY OTHER VENDOR OR INTERNAL EFFORTS ON AR

CANCEL AT ANY TIME FOR ANY REASON
WHETHER YOU WANT SHORT-TERM ASSISTANCE OR ARE EVER UNSATISFIED

PARA HealthCare Analytics | HEALTHCARE FINANCIAL RESOURCES

Randi Brantner
Vice President of Analytics
719.308.0883
rbrantner@hfri.net