PARA Weekly Update – February 6, 2015

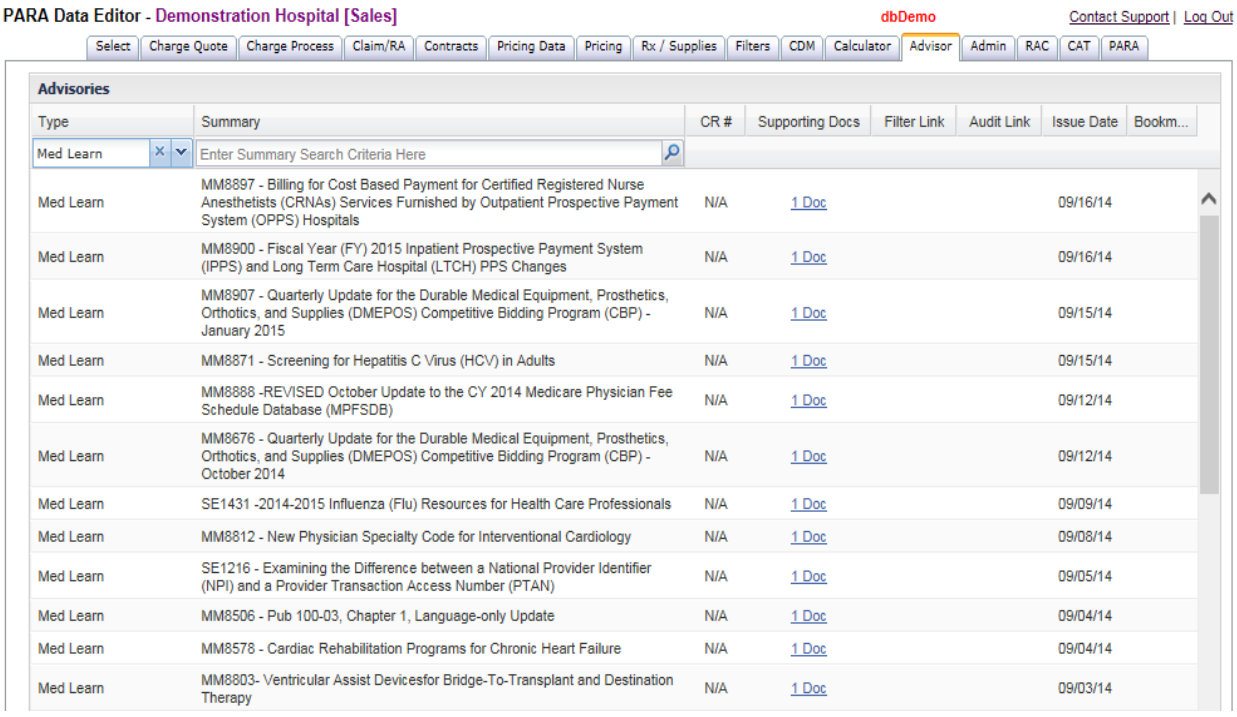
The following Departments are impacted by the contents of this week's update:

- Patient Financial Services – see pages 1-22
- Hospital Administration - see page 22
- Pharmacy Departments – see pages 3, 13
- Laboratory Departments – see pages 5, 14
- Radiology Departments – see pages 6, 15
- Surgery Departments – see pages 6, 15
- Home Health Providers – see pages 9, 10, 14
- Hospice Providers – see pages 7, 17
- Skilled Nursing Facilities (SNFs) – see page 9
- Inpatient Rehabilitation Facilities – see page 9
- FCHIP Facilities – see page 15
- Facility Fee Coders/Billers – see pages 18-21

Med Learns:

There were ten new or revised Med Learn articles released this week. There were no coding changes contained within the articles, so there are no links to your charge master.

All new and previous Med Learn Articles can be viewed under the type "Med Learn" in the Advisor tab:



Links to the Med Learns are also on the following pages.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8583.pdf

MLN Matters® Number: MM8583 Revised	**Related Change Request (CR) #: CR 8583**
Related CR Release Date: February 4, 2015	**Effective Date: April 1, 2015**
Related CR Transmittal #: R567PI	**Implementation Date: April 6, 2015**

New Timeframe for Response to Additional Documentation Requests

Note: This article was revised on February 9, 2015, to reflect the revised CR8583 issued on February 4. In the article, the CR release date, transmittal number, and the Web address for accessing the CR are revised. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment (DME) MACs, for services to Medicare beneficiaries.

What You Need to Know

This article is based on Change Request (CR) 8583, which instructs MACs and Zone Program Integrity Contractors (ZPICs) to produce pre-payment review Additional Documentation Requests (ADRs) that state that providers and suppliers have 45 days to respond to an ADR issued by a MAC or a ZPIC. Failure to respond within 45 days of a pre-payment review ADR will result in denial of the claim(s) related to the ADR. Make sure your billing staffs are aware of these changes.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9084.pdf

MLN Matters® Number: MM9084	**Related Change Request (CR) #: CR 9084**
Related CR Release Date: January 30, 2015	**Effective Date: April 1, 2015**
Related CR Transmittal #: R3180CP	**Implementation Date: April 6, 2015**

April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

Provider Types Affected

This MLN Matters® Article is intended for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Home Health & Hospice MACs and Durable Medical Equipment MACs for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9084 informs Medicare MACs to download and implement the April 2015 ASP drug pricing files and, if released by the Centers for Medicare & Medicaid Services (CMS), the January 2015, October 2014, July 2014, and April 2014, ASP drug pricing files for Medicare Part B drugs.

Medicare will use these files to determine the payment limit for claims for separately payable Medicare Part B drugs processed or reprocessed on or after April 6, 2015, with dates of service April 1, 2015, through June 30, 2015. MACs will not search and adjust claims that have already been processed unless you bring such claims to their attention. Make sure that your billing staffs are aware of these changes.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8961.pdf

MLN Matters® Number: MM8961	**Related Change Request (CR) #: CR 8961**
Related CR Release Date: January 30, 2015	**Effective Date: For claims received on or after July 1, 2015**
Related CR Transmittal #: R3181CP	**Implementation Date: July 6, 2015**

Implementation of New National Uniform Billing Committee (NUBC) Condition Code "53" - "Initial placement of a medical device provided as part of a clinical trial or a free sample"

Provider Types Affected

This MLN Matters® Article is for hospitals submitting outpatient claims to Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8961 implements Condition Code "53" (Initial placement of a medical device provided as part of a clinical trial or a free sample) for reporting on the outpatient hospital claim. Make sure your billing staffs are aware of the new Condition Code of 53.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9035.pdf

MLN Matters® Number: MM9035	**Related Change Request (CR) #: CR 9035**
Related CR Release Date: January 30, 2015	**Effective Date: January 1, 2015**
Related CR Transmittal #: R3182CP	**Implementation Date: April 6, 2015**

Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

Provider Types Affected

This MLN Matters® Article is intended for clinical diagnostic laboratories submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9035 informs MACs about the HCPCS codes for 2015 that are both subject to and excluded from CLIA edits. CR 9035 also includes the HCPCS codes discontinued as of December 31, 2014.

Make sure that your billing staffs are aware of these CLIA-related changes for 2015 and that you remain current with CLIA certification requirements.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8954.pdf

MLN Matters® Number: MM8954	**Related Change Request (CR) #: CR 8954**
Related CR Release Date: January 30, 2015	**Effective Date: January 1, 2015**
Related CR Transmittal #: R3175CP	**Implementation Date: March 2, for local system edits; July 6, 2015 for Medicare Shared System edits**

Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)

Provider Types Affected

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

What You Need to Know

Change Request (CR) 8954 is a follow-up to CR8757, Transmittal 2959 and Transmittal 167 (Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)). CR8757 was effective on January 9, 2014, and provided for percutaneous image-guided decompression (PILD) when provided in a clinical study through Coverage with Evidence Development (CED) for beneficiaries with LSS.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9042.pdf

MLN Matters® Number: MM9042	**Related Change Request (CR) #: CR 9042**
Related CR Release Date: January 30, 2015	**Effective Date: January 1, 2014**
Related CR Transmittal #: R1455OTN	**Implementation Date: July 6, 2015**

Corrections to Processing Service Facility Information on Hospice Claims

Provider Types Affected

This MLN Matters® Article is intended for hospice agencies submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9042 informs providers that MACs have reported that the Medicare system is incorrectly replacing the billing facility ZIP code with the service facility location ZIP code, resulting in inaccurate billing provider information and incorrect payments. The hospice benefit does not make payment based on the service facility location and CR9042 will require the Medicare system to correctly use the billing facility location and not to replace the billing facility location with the service facility location.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9031.pdf

MLN Matters® Number: MM9031	**Related Change Request (CR) #: CR 9031**
Related CR Release Date: January 30, 2015	**Effective Date: July 1, 2015**
Related CR Transmittal #: R1457OTN	**Implementation Date: July 6, 2015**

Renaming PPS-FLX6- PAYMENT Field in the Inpatient Prospective Payment System (IPPS) Pricer Output

Provider Types Affected

This MLN Matters® Article is intended for providers and suppliers submitting institutional claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9031 informs MACs about the changes to the PPS-FLX6-PAYMENT field in the IPPS PRICER output record, created in CR8546. The field will be renamed to identify the field as the Hospital Acquired Condition (HAC) Reduction Amount. Make sure that your billing staffs are aware of these changes.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9016.pdf

MLN Matters® Number: MM9016	**Related Change Request (CR) #: CR 9016**
Related CR Release Date: January 30, 2015	**Effective Date: July 1, 2015**
Related CR Transmittal #: R1459OTN	**Implementation Date: July 6, 2015**

Continuation of Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments

Provider Types Affected

This MLN Matters® Article is intended for Skilled Nursing Facilities (SNFs), Home Health Agencies (HHAs) and Inpatient Rehabilitation Facilities (IRFs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9016 informs MACs about the changes needed to implement the Fiscal Intermediary Standard System (FISS) changes required to refine the interface between FISS and the Quality Improvement and Evaluation Service. These changes include new fields to house an Assessment Identification Number (AIN) for each Health Insurance Prospective Payment System (HIPPS) Revenue Code line on submitted claims. Make sure your billing staffs are aware of these changes.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9027.pdf

MLN Matters® Number: MM 9027	**Related Change Request (CR) #: CR 9027**
Related CR Release Date: January 30, 2015	**Effective Date: July 1, 2015**
Related CR Transmittal #: R3176CP	**Implementation Date: July 6, 2015**

Preventing Inappropriate Payments on Home Health Low Utilization Payment Adjustment (LUPA) Claims

Provider Types Affected

This MLN Matters® Article is intended for providers and Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries in a Home Health period of coverage.

Provider Action Needed

The Centers for Medicare & Medicaid Services (CMS) issued Change Request (CR) 9027 to notify providers of new edits in Original Medicare systems to ensure Low Utilization Payment Adjustment (LUPA) payments under the Home Health Prospective Payment System (HH PPS) are made appropriately. CR9027 clarifies billing instructions for HH PPS claims. No new policy is created by CR9027; these new requirements improve the enforcement of existing Original Medicare payment policies. Make sure your billing staffs are aware of these changes.

Med Learns (continued):

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8961.pdf

MLN Matters® Number: MM8961	**Related Change Request (CR) #: CR 8961**
Related CR Release Date: January 30, 2015	**Effective Date: For claims received on or after July 1, 2015**
Related CR Transmittal #: R3181CP	**Implementation Date: July 6, 2015**

Implementation of New National Uniform Billing Committee (NUBC) Condition Code "53" - "Initial placement of a medical device provided as part of a clinical trial or a free sample"

Provider Types Affected

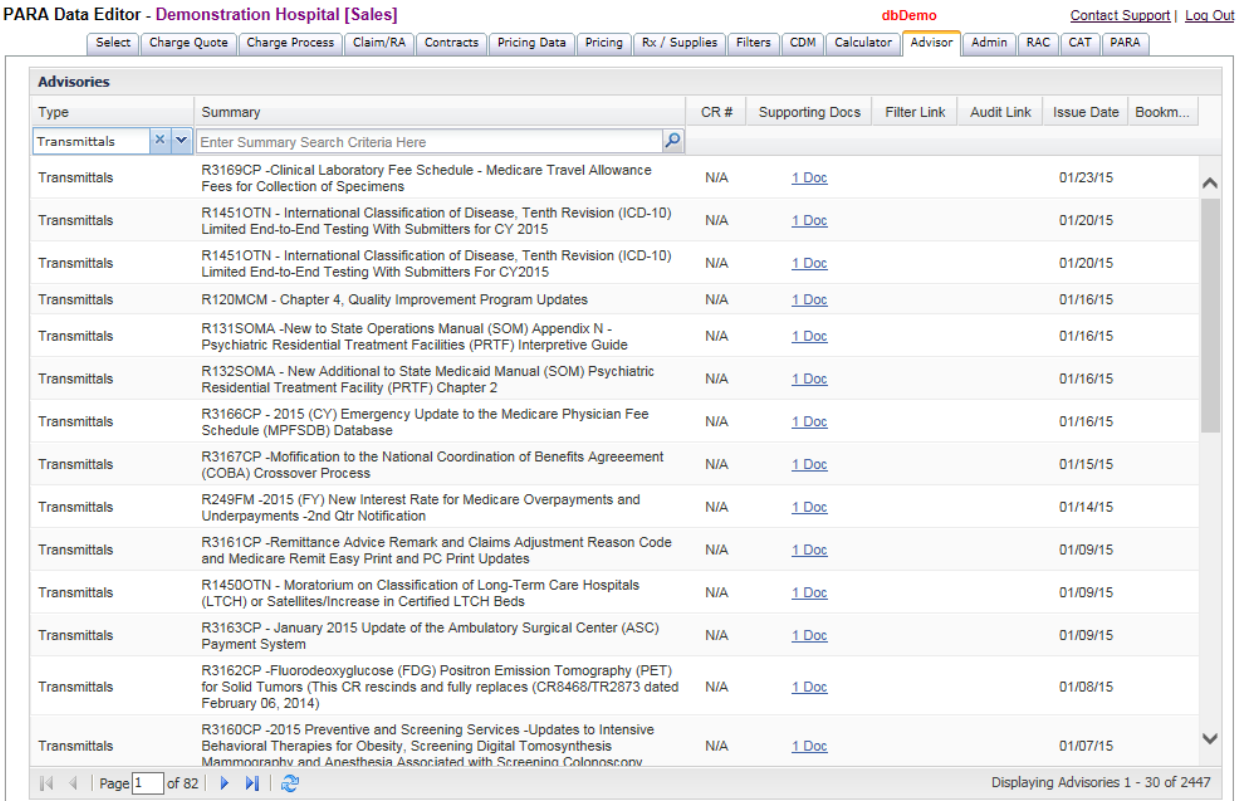
This MLN Matters® Article is for hospitals submitting outpatient claims to Medicare Administrative Contractors (MAC) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 8961 implements Condition Code "53" (Initial placement of a medical device provided as part of a clinical trial or a free sample) for reporting on the outpatient hospital claim. Make sure your billing staffs are aware of the new Condition Code of 53.

Transmittals:

There were fifteen new or revised Transmittals released by CMS this week. None of the Transmittals contained coding changes, so there are no links to you charge master. All new and previous Transmittals can be viewed in the Advisor tab:



Links to the Transmittals are also pasted below:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1459OTN.pdf

SUBJECT: Continuation of Systematic Validation of Payment Group Codes for Prospective Payment Systems (PPS) Based on Patient Assessments

I. SUMMARY OF CHANGES: The Fiscal Intermediary Shared System (FISS) does not have access to the assessment databases. This inability to validate the submitted HIPPS code against the associated assessment creates significant payment vulnerability for the Medicare program. This CR continues to implement the FISS changes required to refine the interface between FISS and QIES.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

Transmittals (continued):

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R567PI.pdf

Transmittal 566 for CR 8583, issued January 7, 2015, is being rescinded and replaced by Transmittal 567, to correct the transmittal number that was erroneously duplicated. All other information remains the same.

SUBJECT: New Timeframe for Response to Additional Documentation Requests

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update section 3.2.3.2 of Chapter 3 of the Program Integrity Manual to address the new prepayment review timeframe for Additional Documentation Requests (ADRs) submission and to also instruct the Shared Systems Maintainers to produce ADRs to reflect the new change.

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R568PI.pdf

Transmittal 566, dated January 23, 2015, is being rescinded and replaced by Transmittal 568 to correct the transmittal number, which was inadvertently duplicated for CR 8443. Additionally, information from CR 8802, section 3.2.3 that was erroneously overwritten has been included. All other information remains the same.

SUBJECT: Review Timeliness Requirements for Prepay Review

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to change the number of days MACs have to conduct complex review from 60 days to 30 days.

EFFECTIVE DATE: March 1, 2015
**The effective date is based on the claim receipt date.*
IMPLEMENTATION DATE: March 1, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3180CP.pdf

SUBJECT: April 2015 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

I. SUMMARY OF CHANGES: The ASP methodology is based on quarterly data submitted to CMS by manufacturers. CMS will supply contractors with the ASP and not otherwise classified (NOC) drug pricing files for Medicare Part B drugs on a quarterly basis. Payment allowance limits under the OPPS are incorporated into the Outpatient Code Editor (OCE) through separate instructions that can be located in Chapter 4, section 50 of the IOM.

EFFECTIVE DATE: April 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

Transmittals (continued):

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3181CP.pdf

SUBJECT: Implementation of New NUBC Condition Code "53" "Initial placement of a medical device provided as part of a clinical trial or a free sample"

I. SUMMARY OF CHANGES: This instruction implements Condition Code "53" for reporting on the outpatient hosptial claim.

EFFECTIVE DATE: July 1, 2015 - for claims received on or after
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3182CP.pdf

SUBJECT: Healthcare Common Procedure Coding System (HCPCS) Codes Subject to and Excluded from Clinical Laboratory Improvement Amendments (CLIA) Edits

I. SUMMARY OF CHANGES: This change request informs contractors about the new HCPCS codes for 2015 that are subject to and excluded from CLIA edits. This Recurring Update Notification applies to Chapter 16, section 70.9.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R115DEMO.pdf

SUBJECT: Implementation of the Intravenous Immune Globulin (IVIG) demonstration - Processing for home health service overlap editing

I. SUMMARY OF CHANGES: Change Request (CR) 8599 (Issued February 7, 2014) specified the implementation requirements for the Intravenous Immune Globulin (IVIG) Demonstration. Under this demonstration, demonstration claims are not payable if the beneficiary is receiving home health services under a home health episode of care on the same date of service. In such situations, services related to the administration of IVIG in the home should be provided by the home health provider and covered under the home health payment system.

During the testing of CR 8599, a problem was identified in how the date editing was done to identify when beneficiaries enrolled in the demonstration were also receiving home health services. The purpose of this CR is to correct the editing in the standard systems to accurately identify when services to administer IVIG in the home should be covered under the home health benefit and not the demonstration.

EFFECTIVE DATE: October 1, 2014 - retroactive to original demonstration start date
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

Transmittals (continued):

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R116DEMO.pdf

SUBJECT: Implementing Home Health Travel Reimbursement Payment Changes for FCHIP (Frontier Community Health Integration Project) Mandated by section 123 of MIPPA 2008 and as amended by section 3126 of the ACA 2010

I. SUMMARY OF CHANGES: Section 123 of the Medicare Improvements for Providers and Patients Act of 2008 authorizes a Demonstration project on community health integration models in certain rural counties to develop and test new models for the delivery of healthcare in order to better integrate the delivery of acute care, extended care, and other healthcare, thereby improving access to care for Medicare and Medicaid beneficiaries located in very sparsely populated areas. CMS will be modifying payment rules for Medicare payment for providers in no more than four States, among Alaska, Montana, Nevada, North Dakota, and Wyoming. Medicare payment changes will occur forhome health agencies from no more than four of these States.

A previous change request has been submitted for the other affected service areas.

EFFECTIVE DATE: July 15, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3175CP.pdf

SUBJECT: Percutaneous Image-guided Lumbar Decompression (PILD) for Lumbar Spinal Stenosis (LSS)-Blinded Clinical Trial – Follow-Up CR to Implement a Second Claims Processing Procedure Code

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide direction as a follow-up to CR8757, Transmittal 2959, dated May 16, 2014. This CR provides additional direction specifically for a new PILD, procedure code when performed in a randomized, blinded clinical trial ONLY, for claims with dates of service on or after January 1, 2015.

EFFECTIVE DATE: January 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 2, 2015 - For Local System edits; July 6, 2015 - For Shared Shared Systems edits

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1456OTN.pdf

SUBJECT: Phase Two: Changing Fiscal Intermediary Shared System (FISS) Action on Informational Unsolicited Responses (IURs) From Canceled Claims to Adjustments

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to ensure that FISS processes all IURs as adjustments.

EFFECTIVE DATE: July 1, 2015 - For IURs created on or after July 6, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

Transmittals (continued):

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1460OTN.pdf

SUBJECT: Health Insurance Portability and Accountability Act (HIPAA) EDI Front End Updates for July 2015

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide the July 2015 Common Edits and Enhancements Module (CEM) edits for the Part A and Part B Medicare Administrative Contractors (A/B MACs) and the Common Electronic Data Interchange (CEDI) contractor. Additionally, this CR directs Shared Systems to appropriately update the CEM.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1458OTN.pdf

SUBJECT: Fee for Service Beneficiary Data Streamlining (FFS BDS) Phase II Beneficiary Address Analysis and Design

I. SUMMARY OF CHANGES: This Change Request (CR) is a request for the Shared System Maintainers (SSMs) to perform detail analysis and design, to consolidate and access the beneficiary's temporary address information at the Common Working File (CWF).

Cross reference CRs 7548, 7611, 7712, 7895, 8091, 8285, 8603, 8677, 8681 and 8915.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3177CP.pdf

SUBJECT: Updating CMS IOM 100-04, Chapter 26 with Specialty Code B1

I. SUMMARY OF CHANGES: The purpose of this CR is to update the Claims Processing Manual to include Specialty Code B1, which is already in use.

EFFECTIVE DATE: March 2, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: March 2, 2015

Transmittals (continued):

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1455OTN.pdf

SUBJECT: Corrections to Processing Service Facility Information on Hospice Claims

I. SUMMARY OF CHANGES: Medicare Administrative Contractors (MACs) have reported that the standard system is incorrectly replacing the billing facility ZIP code with the service facility location ZIP code, resulting in inaccurate billing provider information and incorrect payments. The hospice benefit does not make payment based on the service facility location, and this instruction will require the standard system to correctly use the billing facility location and not to replace the billing facility location with the service facility location.

EFFECTIVE DATE: January 1, 2014
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1457OTN.pdf

SUBJECT: Renaming PPS-FLX6- PAYMENT Field in the Inpatient Prospective Payment System (IPPS) Pricer Output

I. SUMMARY OF CHANGES: The PPS-FLX6- PAYMENT field in the IPPS PRICER output record, created in CR8546, will be renamed to identify this field for the HAC Reduction Amount.

EFFECTIVE DATE: July 1, 2015
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2015

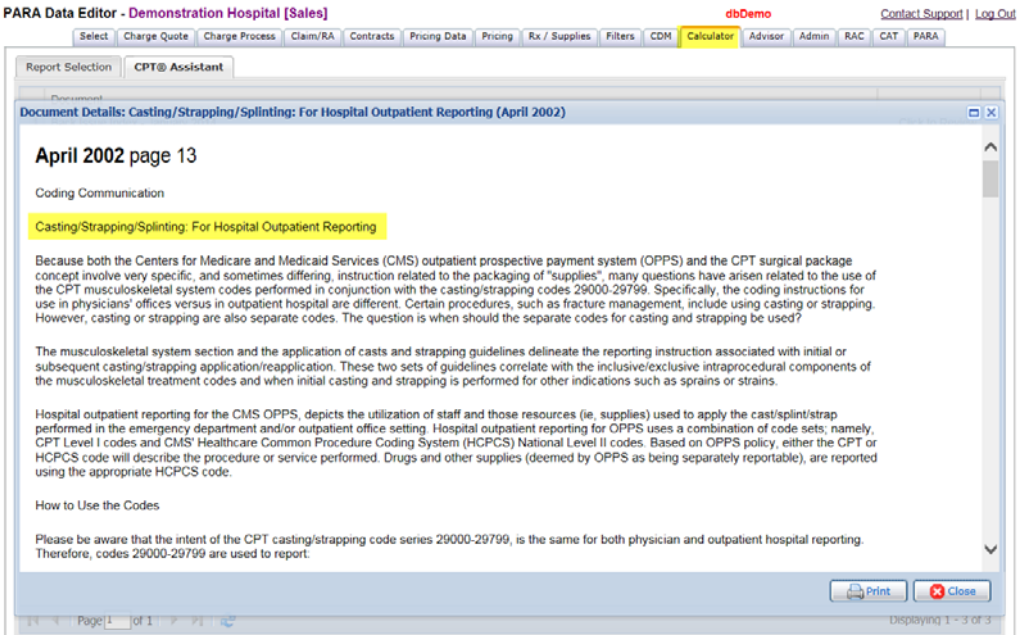
1. When the ED applies a shoulder sling, is 29240 the correct code for this service?

Answer: The description associated with 29240 is: Strapping; shoulder (e.g., Velpeau), therefore we agree that 29240 is the correct code to charge for providing and applying a sling, provided that no other code with a procedure which would include strapping as an integral component is charged.

The following excerpt from a CPT® Assistant April 2002 article entitled "Casting/Strapping/Splinting For Hospital Outpatient Reporting" is helpful:

> "Please be aware that the intent of the CPT® casting/strapping code series 29000-29799, is the same for both physician and outpatient hospital reporting. Therefore, codes 29000-29799 are used to report:
>
> - a replacement cast/strapping procedure, during or after the period of normal follow-up care;
> - an initial service performed without restorative treatment or procedures to stabilize or protect a fracture, injury or dislocation, and/or to afford pain relief to a patient;
> - an initial cast/strapping service when no other treatment or procedure (specific to that injury) is performed or expected to be performed by the same physician (e.g., when placed by the ED physician).
>
> "Codes 20900-29799 are <u>not</u> used to report:
>
> - an initial cast/strapping service when the restorative treatment is performed (e.g., surgical repair, closed or open reduction of a fracture or joint dislocation)…"

CPT® Assistant articles are available to authorized users on the **PARA Data Editor** Calculator tab:



2. What is the difference between strapping vs. sling?

Answer: Per CPT® Assistant, May 2009:

> "Strapping is the creating of the mechanism that performs the immobilization, not the use, fitting, or training for the application of durable medical equipment. Splint application requires creation of the splint…customized reinforcement and support for ligament structures through restriction of movement for increased stabilization. It requires specialized knowledge not only of the anatomical structures being strapped, but also of the method of applying the strap for the best support of these structures…."

A sling may be used for immobilization, particularly when strapped to the torso as in the Velpeau position, or it may simply provide support and elevation of an injured arm. For the purpose of ensuring accurate billing of 29240, the significant factor is in whether the strapping is integral to another procedure, or should be separately charged.

3. Does ace wrapping to the knee or ankle qualify for a strapping procedure code?

Answer: The application of elastic bandages (Ace), slings, and post-op boots are not sufficiently complex to qualify as separately coded services. The nursing resources used for these services should be considered only as a component of the Evaluation and Management level charge on the facility fee. These items may be billed as supplies.

The following link and excerpt from the AHIMA article "The Casting Conundrum - Correct Coding for Casts, Splints, and Strapping" may be helpful:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_043991.hcsp?dDocName=bok1_043991

> "Per AHA Coding Clinic for HCPCS ace bandages and slings are often used with casts and splints and are not separately reportable. However, the supply may be billed separately. Without specific guidance, the best practice is to consider these supplies as part of the E/M service.
>
> Some supplies such as splints and post-op shoes applied after surgery, used only to augment wound repair, are considered part of the operative procedure. Best practice guidance is to charge only the supply for these items. Otherwise, and in the absence of specific guidance, if the OCE edits allow billing for the application of splints with wound repair, then it is appropriate to assign these codes together…"

4. ***Can hospitals bill for the supply of crutches, and can hospitals bill for nurse time in training the patient to use crutches? (i.e., bump up the E/M code for the training, provided the training is medically necessary)***

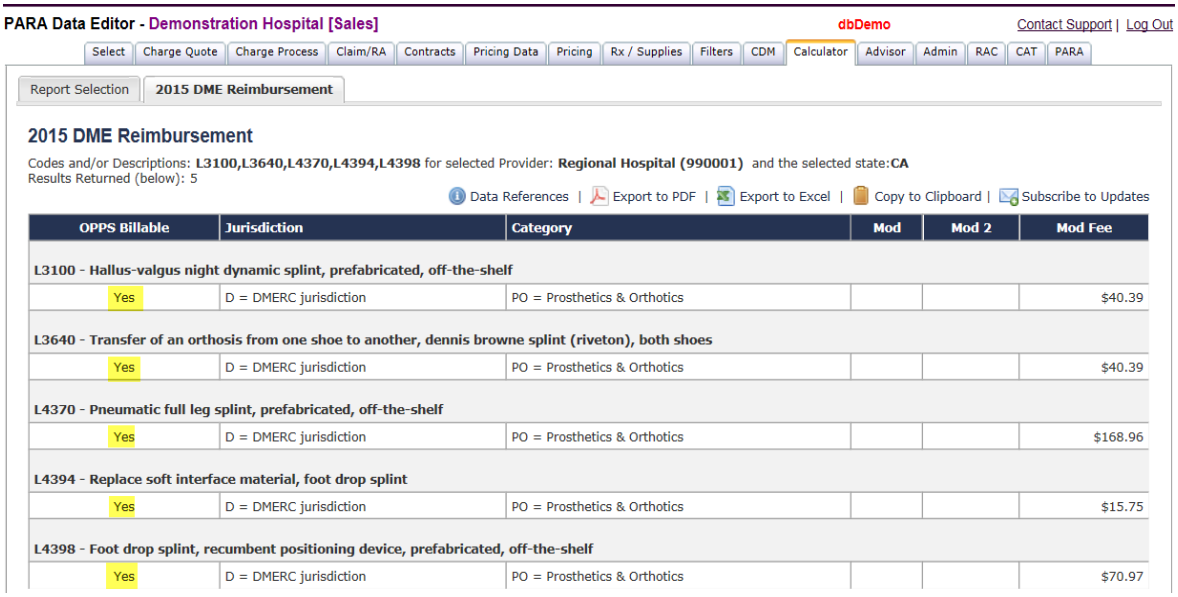
   Answer: The DME codes for crutches may not be billed for reimbursement under Medicare's hospital reimbursement OPPS system; reimbursement under Medicare for crutches is limited to enrolled Durable Medical Equipment suppliers.

   If crutches are supplied to the patient as a convenience and a practical necessity, the hospital should charge for the crutches as a general supply item (revenue code 0270) without a HCPCS assignment on the claim.

   Training the patient in the use of crutches is acceptable as a contributing factor toward the assignment of an appropriate E/M level, as the service requires face-to-face patient care and education which is not separately billable.

5. ***What are the coding differences for pre-manufactured stock DME splints vs. custom casting using supplies?***

   Answer: There are dozens of DME L-Codes for orthotics and splints which can be billed by a hospital without enrollment as a DME supplier. The **PARA Data Editor** Calculator feature allows users to search for DME by keywords; the following L-Codes were returned on the keyword search of "splint" and are APC Status A with a DME fee indicated. This constitutes a partial list of prefabricated splint codes for which Medicare will reimburse a hospital:



OPPS Billable	Jurisdiction	Category	Mod	Mod 2	Mod Fee
L3100 - Hallus-valgus night dynamic splint, prefabricated, off-the-shelf					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics			$40.39
L3640 - Transfer of an orthosis from one shoe to another, dennis browne splint (riveton), both shoes					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics			$40.39
L4370 - Pneumatic full leg splint, prefabricated, off-the-shelf					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics			$168.96
L4394 - Replace soft interface material, foot drop splint					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics			$15.75
L4398 - Foot drop splint, recumbent positioning device, prefabricated, off-the-shelf					
Yes	D = DMERC jurisdiction	PO = Prosthetics & Orthotics			$70.97

Application of custom casts using the 290xx codes may be reported only when the cast is not "integral to" another procedure, such as closed fracture treatment. Once more, we suggest the AHIMA article "The Casting Conundrum - Correct Coding for Casts, Splints, and Strapping" as a reference:

http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_043991.hcsp?dDocName=bok1_043991

6. ***How should a hospital report the facility fee for revisits during the global period, including:***
   a) ***Suture removal***
   b) ***Dressing changes (i.e., patient returns frequently because they prefer that the clinic nurses re-pack an I&D site)***
   c) ***Bronchitis patient, I&D, follow up with a revision I&D, injection of antibiotic with eval of bronchitis***

Answer: In general, professional fees for related services during the global period are not separately reimbursed. However, facility fees for an Evaluation and Management level procedure (typically 99211 or 99212, or 99281 for the ED), for the administration of an injection, pharmacy charges, and associated supplies are reportable for return visits in the emergency department or a provider-based clinic.

At the outset of OPPS reimbursement, CMS explained their view of follow-up visits during the global period in the Federal Register:

> Federal Register / Vol. 65, No. 68 / Friday, April 7, 2000 / Rules and Regulations, page 18448
>
> "The packaging that we proposed as the basis for determining APC payment rates and that we will implement under the hospital outpatient PPS is generally consistent with MedPAC's recommendation. However, we did not propose to include ''limited follow-up services'' in our packaged groups under the hospital outpatient PPS because of the difficulty of matching in our database the costs of these services with their associated primary encounter. For now, hospitals are to bill follow-up care, such as suture removal, using an appropriate medical visit code. We did not propose, nor have we included in this final rule with comment period, provision for a global period for hospital outpatient services analogous to the global period affecting payments for professional services made under the Medicare physician fee schedule."

REVENUE CYCLE MANAGEMENT

The PARA Revenue Integrity Program

The goal of program is to audit and enhance each aspect of the revenue cycle process to ensure that all appropriate revenue is created, captured, coded and priced correctly.

The program components are:

Claim audit: charge capture, coding and compliance

Pricing: market based pricing with a relationship to fee schedules or cost

Charge Master: code review and maintenance

Compliance: HIM / Business Office assigned codes and modifiers

Revenue Management Committee: oversight, governance and guidance

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PARA Healthcare Financial Services

Peter A. Ripper, President
(800) 999-3332 x 211
pripper@para-hcfs.com

4801 E. Copa De Oro Drive
Anaheim, CA 92807
www.para-hcfs.com

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According to the February issue of Becker's Hospital Review (dated 2/2/2015), the need for updated Revenue Cycle Management (RCM) systems is clear in order to stay in business, but what options are available for struggling hospitals? One vital option is to outsource your RCM needs. This has become a growing trend.

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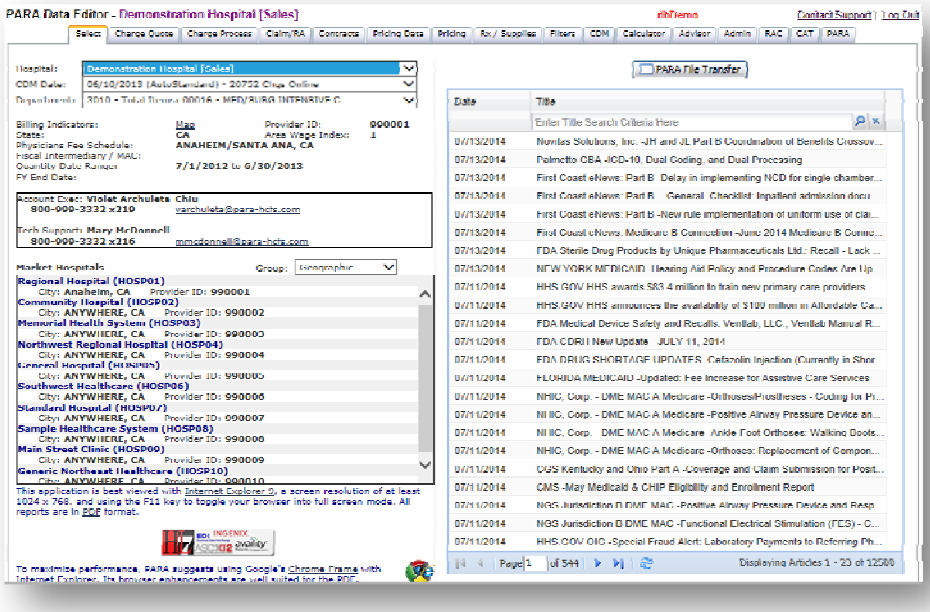
- RAC Analysis
- Physician Billing
- Accounts Receivable Follow-up
- Emergency Charge Process
- PARA Data Editor (PDE)



Contact your PARA Account Representative or one of our partners to learn more.

Violet Archuleta-Chiu varchuleta@para-hcfs.com (800) 999-3332 x 219
Randi Brantner rbrantner@para-hcfs.com (800) 999-3332 x 215
Sandra LaPlace slaplace@para-hcfs.com (800) 999-3332 x 225

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