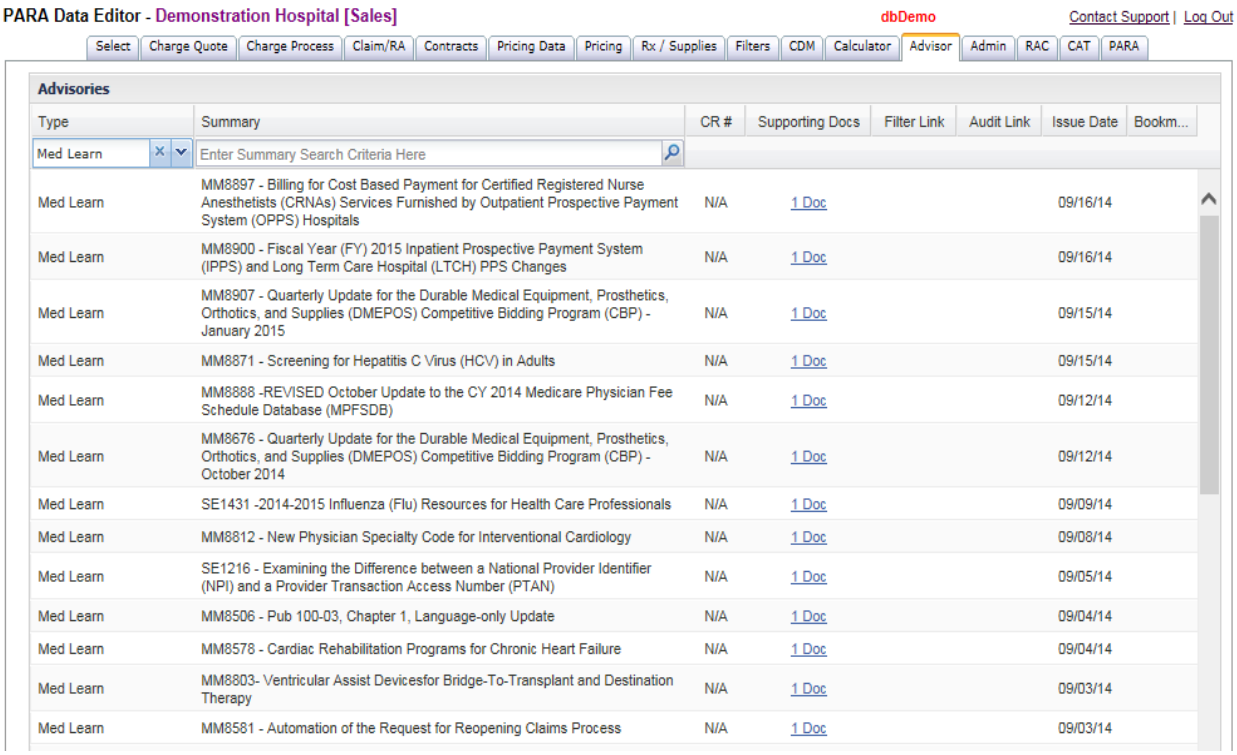
PARA Weekly Update – March 31, 2017

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

- **Patient Financial Services – see pages 1-32**
- **Hospital Administration - see page 32**
- **PDE Users – see pages 6, 7-9, 13**
- **HIM/Coding Staff – see pages 14, 15-17, 18-24, 25-31**
- **Laboratory Departments – see pages 2, 2**
- **OPPS Hospitals – see pages 10-12**
- **Wound Care Departments – see page 14**
- **Surgery Departments – see page 14**
- **Chemotherapy Providers – see pages 15-17**
- **Physicians – see pages 18-24, 25-31**
- **Chronic Care Management Providers – see pages 18-24**
- **Palliative Care Providers – see pages 25-31**

Med Learns:

There was one new or revised Med Learn article released this week. All new and previous Med Learn Articles can be viewed under the type "Med Learn" in the Advisor tab:



Type	Summary	CR #	Supporting Docs	Filter Link	Audit Link	Issue Date	Bookm...
Med Learn	Enter Summary Search Criteria Here						
Med Learn	MM8897 - Billing for Cost Based Payment for Certified Registered Nurse Anesthetists (CRNAs) Services Furnished by Outpatient Prospective Payment System (OPPS) Hospitals	N/A	1 Doc			09/16/14	
Med Learn	MM8900 - Fiscal Year (FY) 2015 Inpatient Prospective Payment System (IPPS) and Long Term Care Hospital (LTCH) PPS Changes	N/A	1 Doc			09/16/14	
Med Learn	MM8907 - Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2015	N/A	1 Doc			09/15/14	
Med Learn	MM8871 - Screening for Hepatitis C Virus (HCV) in Adults	N/A	1 Doc			09/15/14	
Med Learn	MM8888 -REVISED October Update to the CY 2014 Medicare Physician Fee Schedule Database (MPFSDB)	N/A	1 Doc			09/12/14	
Med Learn	MM8676 - Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - October 2014	N/A	1 Doc			09/12/14	
Med Learn	SE1431 -2014-2015 Influenza (Flu) Resources for Health Care Professionals	N/A	1 Doc			09/09/14	
Med Learn	MM8812 - New Physician Specialty Code for Interventional Cardiology	N/A	1 Doc			09/08/14	
Med Learn	SE1216 - Examining the Difference between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)	N/A	1 Doc			09/05/14	
Med Learn	MM8506 - Pub 100-03, Chapter 1, Language-only Update	N/A	1 Doc			09/04/14	
Med Learn	MM8578 - Cardiac Rehabilitation Programs for Chronic Heart Failure	N/A	1 Doc			09/04/14	
Med Learn	MM8803- Ventricular Assist Devicesfor Bridge-To-Transplant and Destination Therapy	N/A	1 Doc			09/03/14	
Med Learn	MM8581 - Automation of the Request for Reopening Claims Process	N/A	1 Doc			09/03/14	

A link to the Med Learn is also on the following page.

Med Learns (continued)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9956.pdf

MLN Matters® Number: MM9956 Revised	**Related Change Request (CR) #: CR 9956**
Related CR Release Date: March 30, 2017	**Effective Date: April 1, 2017**
Related CR Transmittal #: R3741CP	**Implementation Date: April 3, 2017**

New Waived Tests

Note: This article was revised on April 3, 2017, to reflect the revised CR9956 issued on March 30, 2017. In the article, the CR release date, transmittal number, and the Web address for CR9956 are revised. All other information remains the same. The CR was revised to correct CPT drug test code from 80305 to 80305QW in the attachment to CR9956.

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) 9956 informs MACs of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration (FDA). Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify MACs of the new tests so that they can accurately process claims. Make sure that your billing staffs are aware of these CLIA-related changes.

Background

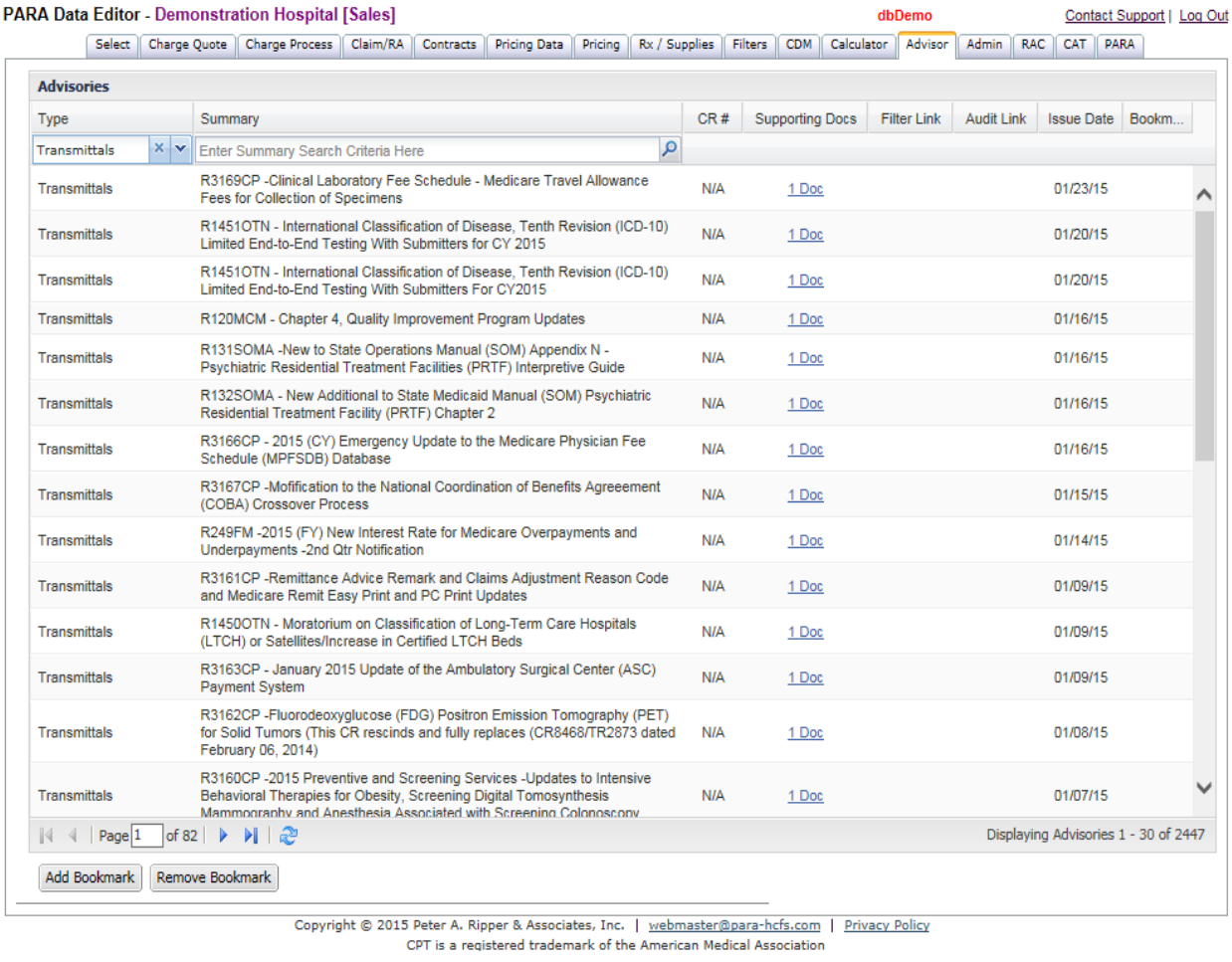
The CLIA regulations require a facility to be appropriately certified for each test performed. To ensure that Medicare & Medicaid only pay for laboratory tests categorized as waived complexity under CLIA in facilities with CLIA certificate of waiver, laboratory claims are currently edited at the CLIA certificate level.

Listed below are the latest tests approved by the FDA as waived tests under CLIA. The Current Procedural Terminology (CPT) codes for the following new tests must have the modifier QW to be recognized as a waived test. However, the tests mentioned on the first page of the list attached to CR9956 (CPT codes: 81002, 81025, 82270, 82272, 82962, 83026, 84830, 85013, and 85651) do not require a QW modifier to be recognized as a waived test.

Transmittals:

There were five new or revised Transmittals released by CMS this week. None of the Transmittals contained coding changes, so there are no links to your charge master.

All new and previous Transmittals can be viewed in the Advisor tab:



Links to the Transmittals are also on the following pages.

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1812OTN.pdf

SUBJECT: HIGLAS Connectivity Updates and Testing

I. SUMMARY OF CHANGES: CMS has awarded the Healthcare Integrated General Ledger Accounting System (HIGLAS) contract for Hosting Operations and Maintenance (HOM) to CSRA. Currently IBM supports the Hosting and Operations of the HIGLAS, as part of the contract transition, entities that perform file transmissions wth HIGLAS will be required to update thier systems connectivity rules and settings. Updates and testing are required to ensure a continuity of operations for these entities and HIGLAS.

EFFECTIVE DATE: March 31, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 30, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1813OTN.pdf

SUBJECT: Shared System Enhancement 2015: Identify Inactive Medicare Demonstration Projects Within the Common Working File (CWF)

I. SUMMARY OF CHANGES: Since some Medicare demonstration projects no longer serve a business need and claims processing for the demonstration is complete, CMS believes archiving obsolete Medicare demonstration projects/code will reduce system complexity and make future maintenance efforts more efficient. This change request is subsequent to CR9325, CR9802 and CR9890.

EFFECTIVE DATE: July 1, 2017; October 1, 2017; January 1, 2018
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 3, 2017 - Design with the July, 2017 Release; October 2, 2017 - Coding with the October, 2017 Release; January 2, 2018 - Implementation with the January, 2018 Release

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1811OTN.pdf

Transmittal 1736, dated October 27, 2016, is being rescinded and replaced by Transmittal 1811, dated March 29, 2017, to remove the July 2017 implementation date. All other information remains the same.

SUBJECT: Shared System Enhancement 2014 – Identification of Fiscal Intermediary Shared System (FISS) Obsolete On-Request Jobs - Analysis Only

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to identify any FISS produced obsolete on-request jobs (i.e., on-request jobs that no longer meet the needs of the business owner).

EFFECTIVE DATE: April 1, 2017 - List of jobs to be reviewed for each release will be identified by FISS as the analysis is performed; October 1, 2017 - List of jobs to be reviewed for each release will be identified by FISS as the analysis is performed
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017; October 2, 2017

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R1814OTN.pdf

Transmittal 1774, dated January 13, 2017, is being rescinded and replaced by Transmittal 1814, dated, March 30, 2017 to remove the July 2017 implementation date. All other information remains the same.

SUBJECT: Shared System Enhancement 2014 – Identification of Fiscal Intermediary Standard System (FISS) Obsolete Reports - Analysis Only

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to identify any FISS produced obsolete reports (i.e., reports that no longer meet the needs of the business owner).

EFFECTIVE DATE: October 1, 2016 - Analysis of Core Reports; October 1, 2017 - Analysis of Core Reports; January 1, 2018 - Analysis of Financial / ECPS Reports
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016 - Analysis of Core Reports; October 2, 2017 - Analysis of Core Reports; January 2, 2018 - Analysis of Financial / ECPS Reports

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3741CP.pdf

Transmittal 3696, dated January 20, 2017, is being rescinded and replaced by Transmittal 3741, dated, March 30, 2017 to change the incorrect CPT drug test code from 80305 to 80305QW in the attachment. All other information remains the same.

SUBJECT: New Waived Tests

I. SUMMARY OF CHANGES: This Change Request (CR) will inform contractors of new Clinical Laboratory Improvement Amendments of 1988 (CLIA) waived tests approved by the Food and Drug Administration. Since these tests are marketed immediately after approval, the Centers for Medicare & Medicaid Services (CMS) must notify its contractors of the new tests so that the contractors can accurately process claims. There are 22 newly added waived complexity tests. The initial release of this Recurring Update Notification applies to Chapter 16, section 70.8 of the IOM.

EFFECTIVE DATE: April 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: April 3, 2017

PDE Update – Select Tab – Bulletin Board Updates

The following table lists the articles that were added to the Bulletin Board in the past week:

Date	Description
4/3/2017	Center for Medicaid and CHIP Services (CMCS) The Affordable Care Act Federal Upper Limits Have Been Updated
4/3/2017	Center for Medicaid and CHIP Services (CMCS) -Final Rule: Medicaid Disproportionate Share Hospital (DSH) Payments: Treatment
3/28/2017	AHRQ News Now: electronic trigger system, new patient safety research, cancer patient survey
3/28/2017	PARA Weekly Update 3/24/2017

PARA Data Editor (PDE) Data Table Updates

Below is a list of the Data Tables utilized throughout the **PDE**, and the frequency of their issued updates. **PARA** is continually updating these tables as their new data becomes available.

Item Name	Update Frequency
AL Medicaid	Annually
Ambulance Fee Schedule	Annually
AR Medicaid	Annually
ASC payment rates	Annually
ASP Drug Pricing Files	Quarterly
AZ Medicaid	Annually
CA Medi - Cal	Monthly
Calculator link "review Payment Status Indicator"-Addendum D1	Annually
Clinical Laboratory Fee Schedule	Annually
CO Medicaid	Annually
CPT Data Files	Annually
DE Medicaid	Annually
Device, Radiolabeled Product, and Procedure Edits	Quarterly
DRG Table 5	Annually
Durable Medical Equipment, Prosthetics/Orthotics & Supplies Fee Schedules	Annually
Final Rule Hospital Wage Index	Annually
FL Medicaid	Annually
HCPCS File	Quarterly
HI Medicaid	Annually
IA Medicaid	Annually
ICD-9 Diagnosis and Procedure Codes and Their Abbreviated Titles	Annually
ICD-9-CM Codes	Annually
ICD9 to ICD10 Crosswalk	Annually
ICD-10 Codes	Annually
ID Medicaid	Monthly
IL Medicaid	Annually
IL Medicaid DME	Annually
IN Medicaid	Annually
Integrated Outpatient Code Editor (I/OCE) Specifications Version	Quarterly
Interventional Radiology	Annually
J-Code Chemo Admin List	Annually
J-Code Chemo Admin List	Annually
J-Code Chemo Admin List	Annually

PARA Data Editor (PDE) Data Table Updates (continued)

Item Name	Update Frequency
KS Medicaid	Annually
KY Medicaid	Annually
LA Medicaid	Annually
LCD - LMRP	Weekly
ME Medicaid	Annually
Medicaid NCCI Edits	Quarterly
Medically Unlikely Edits	Quarterly
Medicare Preventative Services Quick Reference Chart	Annually
MEDPAR Limited Data Set	Annually
MI Medicaid	Quarterly
MN Medicaid	Monthly
MO Medicaid	Annually
MS Medicaid	Annually
MS-DRGs	Annually
MT Medicaid	Annually
NC Medicaid	Annually
NCCI Edit Manual	Annually
NCCI Edits - Hospital Outpatient PPS	Quarterly
NCCI Edits - Physicians	Quarterly
NCD Lab	Quarterly
ND Medicaid	Annually
NDC - First Data Bank Data	Weekly
NDC/HCPCS Crosswalk	Quarterly
NE Medicaid	Annually
NH Medicaid	Annually
NJ Medicaid	Annually
NM Medicaid	Annually
NPI	Quarterly
NV Medicaid	Annually
NY Medicaid	Annually
OH Medicaid	Annually
OK Medicaid	Annually
OPPS Addenda	Annually
OR Medicaid	Monthly

PARA Data Editor (PDE) Data Table Updates (continued)

Item Name	Update Frequency
Outpatient Limited Data Set (limited)	Annually
Outpatient Standard Analytical File (expanded)	Annually
Physicians fee schedule	Quarterly
Physicians RVU	Quarterly
Provider Compliance Newsletter	Quarterly
RI Medicaid	Annually
SD Medicaid	Annually
Self Administered Drug Quarterly Update- FI/MAC	Annually
SNF MEDPAR Limited Data Set	Annually
Supplier Data- Phys/Supplier Procedure Summary Master File	Annually
Tricare No-Pay List	Quarterly
Tricare ProcCodeNumberofService Limits	Quarterly
TriCare Questionable Covered Services	Quarterly
TX Medicaid	Annually
Updates of Addendum A and B	Quarterly
VT Medicaid	Annually
WA Medicaid	Quarterly
Wage indexes for each provider ID	Annually
WI Medicaid	Annually
WV Medicaid	Annually
WY Medicaid	Weekly
ZIP code to Carrier Locality File	Annually

CMS April 2017 OPPS Quarterly Update

CMS published the quarterly update to OPPS, effective April 1, 2017, at the following link:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3728CP.pdf

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3728	Date: March 3, 2017
	Change Request 10005

During the week of March 20, PARA will provide its charge master clients with a spreadsheet listing any CDM line items which correspond to HCPCS codes affected by the Medicare update. Please look for instructions in the PARA Weekly Update to be released on March 22 for further information.

The CMS update includes the following points:

- **3 new proprietary lab codes** will be covered by Medicare effective 4/1/17; The three new tests are:

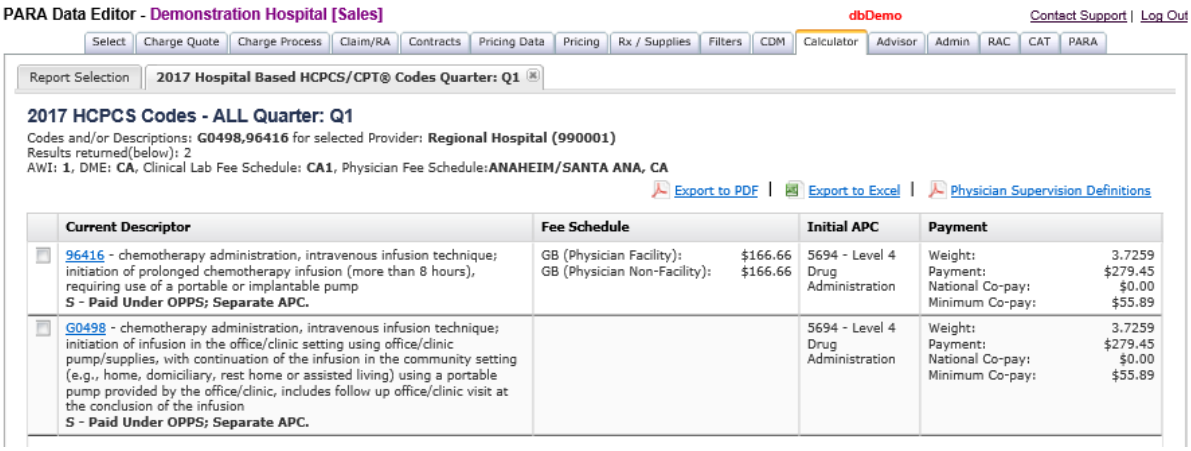
Code	Long Descriptor	OPPS Status
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported	A
0002U	Oncology (colorectal), quantitative assessment of three urine metabolites (ascorbic acid, succinic acid and carnitine) by liquid chromatography with tandem mass spectrometry (LC-MS/MS) using multiple reaction monitoring acquisition, algorithm reported as likelihood of adenomatous polyps	Q4
0003U	Oncology (ovarian) biochemical assays of five proteins (apolipoprotein A-1, CA 125 II, follicle stimulating hormone, human epididymis protein 4, transferrin), utilizing serum, algorithm reported as a likelihood score	Q4

- **Drug Screen HCPCS G0477-G0479** are officially deleted in favor of CPT's 80305-80307; the new 2017 CPT's 80305, 80306, and 80307 are nearly identical to the G-codes, therefore Medicare has discontinued the G-codes. PARA clients were advised of this change at year-end 2016 within the 2017 Coding Update documents at: https://apps.para-hcfs.com/para/Documents/2017_Drug_Testing_Code_Update_Rev_12272016_edited.pdf

- **Reporting prolonged chemotherapy with new HCPSC G0498 is clarified**. In mid-2016, Medicare created G0498 (chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion.)

G0498 - continued

Previously, chemotherapy providers may have billed 96416 for this service.



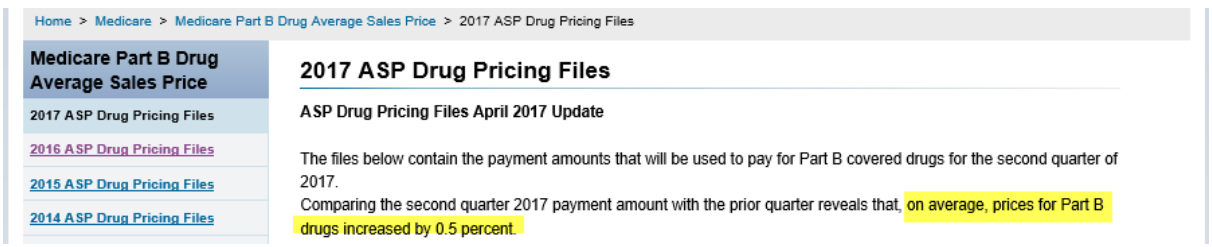
The new HCPCS G0498 differs from CPT 96416 for prolonged chemotherapy in that it specifies:

1) the portable infusion pumps are supplied by the clinic or outpatient department;
2) the infusion service is continued in the "community setting"; and
3) No minimum number of hours for the prolonged infusion is defined; and
4) The outpatient visit at the conclusion of the infusion is not separately billable, as it is included within the G0498 code description.

PARA recommends billing G0498 for prolonged chemotherapy which is initiated in the outpatient hospital setting, but continued in the community setting. Hospitals are cautioned that the subsequent visit for the disconnection/discontinuation of the infusion is included in G0498 (not separately billable.) If the hospital does not supply the portable pump, modifier 52 for reduced services is appropriate for this HCPCS.

- **Providers are advised that implant code C1842 for the Argus Retinal Prosthesis is appropriate for ASC reporting only**, and should not be used for hospital outpatient claim reporting.

- **The Average Sales Price database will update drug reimbursement by an average increase by 0.5%** through the usual quarterly update of reimbursement rates for separately payable drugs under OPPS. The ASP files are available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2017ASPFiles.html



- **Seven drugs were added to the list of separately payable drugs** with pass-through status G; five of the seven have newly assigned C-codes. These will become separately payable as of 4/1/17:

HCPCS Code	Long Descriptor	APC	Status Indicator
C9484	Injection, eteplirsen, 10 mg	9484	G
C9485	Injection, olaratumab, 10 mg	9485	G
C9486	Injection, granisetron extended release, 0.1 mg	9486	G
C9487	Ustekinumab, for intravenous injection, 1 mg	9487	G
C9488	Injection, conivaptan hydrochloride, 1 mg	9488	G
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	1862	G
Q5102	Injection, infliximab, biosimilar, 10 mg	1847	G

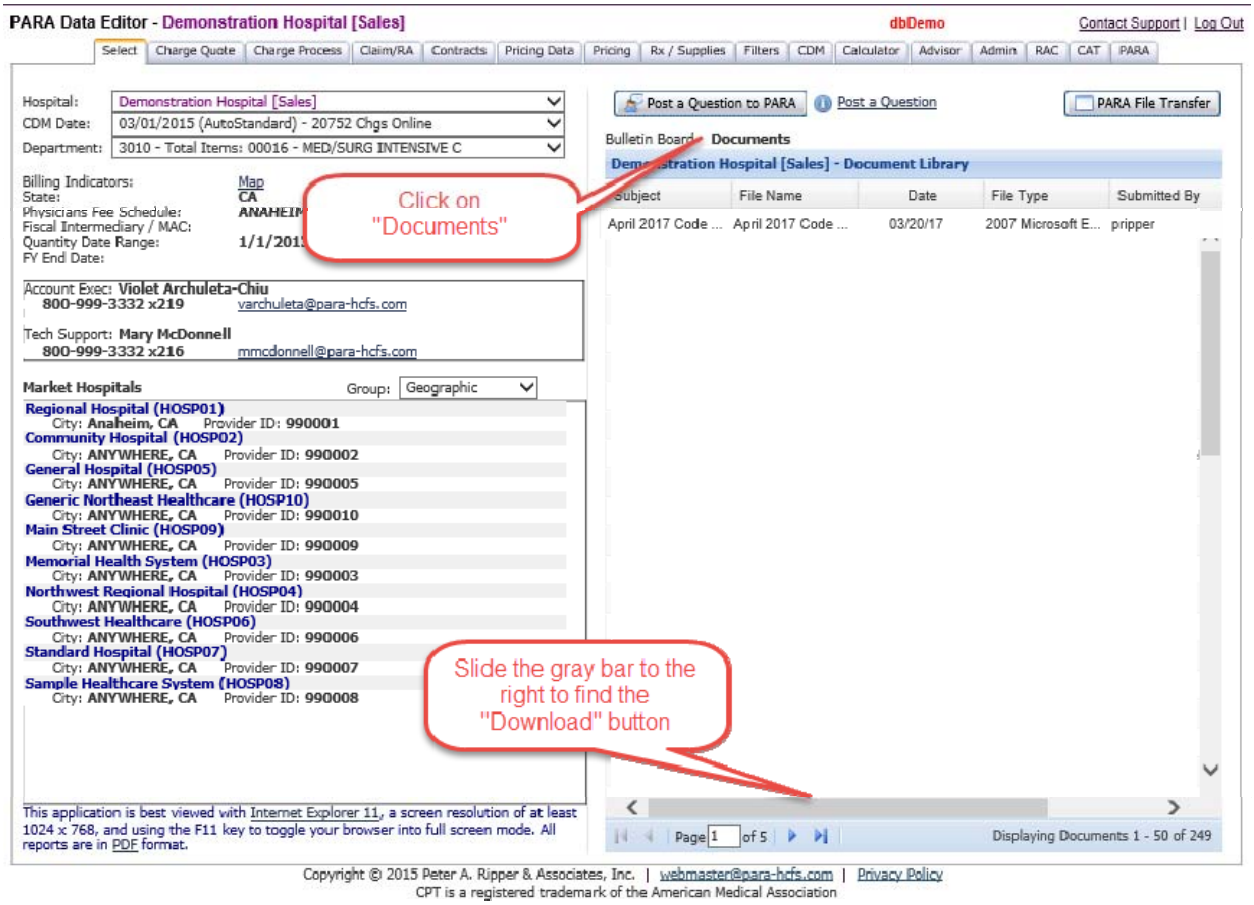
- **The OPPS status for J1130 (injection, diclofenac sodium, 0.5 mg) was changed** from E2 (excluded) to K (separately payable) retroactive to 1/1/17. CMS had temporarily discontinued coverage of this drug while it reassessed the reimbursement rate. Now that pricing data has been evaluated successfully, CMS is covering the drug retroactive to 1/1/17.

- **Four skin substitute HCPCs were reassigned** from the low-cost to the high-cost category; specifically:

HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
Q4161	Bio-Connekt per square cm	N	High
Q4169	Artacent wound, per square cm	N	High
Q4173	Palingen or palingen xplus, per sq cm	N	High
Q4175	Miroderm, per square cm	N	High

- CMS corrected a prior error by removing from the skin substitute list HCPCS Q4171 Interfyl, 1 mg, which should not have been listed as a skin substitute at all.

PARA clients will find a list of charge master line items which are potentially affected by the April 2017 OPPS update in the **PARA Data Editor**. The spreadsheet can be downloaded by logging into the **PDE**, toggling the bulletin board on the right hand side to "Documents", and locating the item at or near the top of the list entitled "April 2017 Code Map Update":



Note that some smaller facilities may not have any charges affected by the update.

PARA suggests a careful review of pharmacy line items to verify that the drug in the CDM precisely matches the new HCPCS code. For example, the drug granisetron (aka Kytril) may be coded J1626 currently; this J-code would continue to be accurate even after 4/1/17 if the granisetron drug is not the "extended release" formulation identified in the new HCPCS C9486.

Please contact **PARA** with any questions or concerns by using the "Post a Question" feature on the home page of the **PARA Data Editor**.

Q & A – ICD-10 PCS Debridement

Question: What is the appropriate ICD-10 PCS code for Debridement?

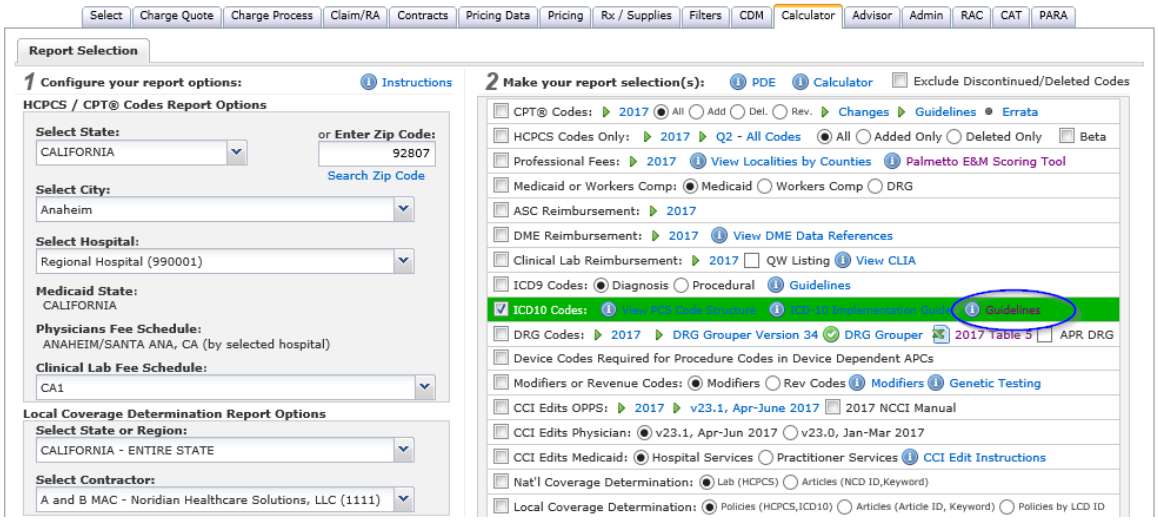
Procedure: General anesthetic was inducted. The patient's right lower extremity was prepared. The leg was elevated and the tourniquet inflated to 300 mmHg. The wound was identified. The necrotic tissue was sharply debrided down through the fascia to the bone. A dry dressing was applied. The patient was then brought out of anesthesia and taken to the recovery room.

Answer: Report ICD-10 PCS code 0JDN0ZZ, Extraction of right lower leg, subcutaneous tissue and fascia, open approach. The documentation supports a non-excisional debridement. The objective of the procedure is strip off a portion of a body part by force. The objective supports "Extraction". Although the documentation states sharply debrided, additional documentation is needed to support an excisional debridement. The Body System is reported to subcutaneous tissue and fascia. The debridement was through the fascia and stopped at the bone. The bone was not debrided. The body part is also reported to subcutaneous tissue/fascia and additionally identifies the right lower leg. The approach meets the criteria of open. Please refer to the **PARA Data Editor** code description and 2017 Official Coding Guidelines for Coding and Reporting located in the **PARA Data Editor** Calculator tab.

2017 ICD-10-PCS Official Coding Guidelines for Coding and Reporting

Overlapping body layers

If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded. Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.



New Prolonged Chemo Infusion HCPCS G0498

Medicare created HCPCS G0498 in 2016 to represent the typical prolonged chemotherapy infusion that is initiated in a physician clinic. Effective 1/1/2017, G0498 also valid for reporting prolonged infusions started in a hospital outpatient department and "continued in the community setting."

> **G0498** - Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/clinic, includes follow up office/clinic visit at the conclusion of the infusion

In an undated MLN Article, CMS clarified that when the infusion is initiated in a provider setting, and continued in the "community setting", the external infusion pump supplied for patient use is a component of the prolonged chemotherapy administration service, and may not be billed as DME to the DME MAC.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1609.pdf

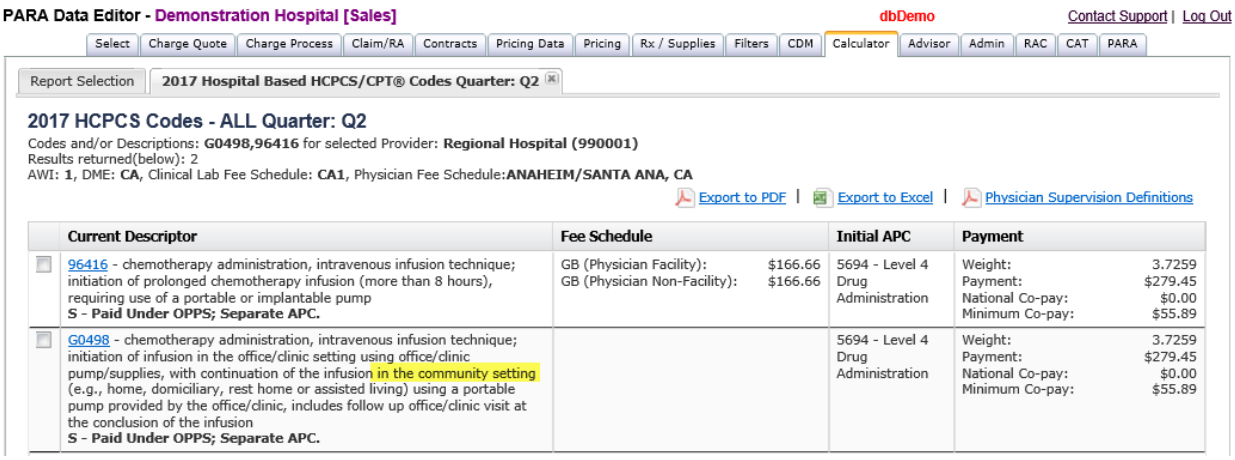
What You Need to Know

Medicare pays for drugs and biologicals which are not usually self-administered by the patient and furnished "incident to" physicians' services rendered to patients while in the physician's office or the hospital outpatient department. In some situations, a hospital outpatient department or physician office may:

- purchase a drug for a medically reasonable and necessary prolonged drug infusion,
- begin the drug infusion in the care setting using an external pump,
- send the patient home for a portion of the infusion, and
- have the patient return at the end of the infusion period.

In this case, the drug or biological, the administration, and the external infusion pump is billed to your MAC. **However, because prolonged drug and biological infusions started incident to a physician's service using an external pump should be treated as an incident to service, it cannot be billed on suppliers' claims to DME MACs.**

Under Medicare OPPS reimbursement, both the traditional prolonged chemotherapy CPT®, 96416, and G0498 are reimbursed at the same rate:



A number of Medicare Durable Medical Equipment MACs have issued a Local Coverage Determination which prohibits DME suppliers from billing portable infusion pumps that are used for chemotherapy initiated in the physician office or outpatient hospital setting.

Below is a link and an excerpt from the LCD issued by Novitas applicable to DME Suppliers in Colorado, Arkansas, Colorado, Delaware, District of Columbia, Louisiana, Maryland, Mississippi, New Jersey, New Mexico, Oklahoma, Pennsylvania, and Texas:

https://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=55134&ContrTypeId=12&ContrId=334&ContrVer=1&CntrctrSelected=334*1&ver=22&ContrNum=4411&SearchType=Advanced&CoverageSelection=Local&ArticleType=Ed%7cKey%7cSAD%7cFAQ&PolicyType=Both&s=---&Cntrctr=334&ICD=&CptHcpcsCodepump&&kq=true&bc=IAAAACAAAAAA

"Under section 1861(s)(2)(A) of the Social Security Act (the Act), Medicare will pay for drugs and biologicals which are not usually self-administered by the patient furnished as "incident to" physicians' services rendered to outpatients. In order for Medicare to pay for a drug or biological under section 1861(s)(2)(A) or (B) of the Act, the physician or hospital (respectively) must incur a cost for the drug or biological. Generally, the administration of drugs or biologicals covered by Medicare under the "incident to" benefit (1861(s)(2)(A) and (B)) will start and end while the patient is in the physician's office or the hospital outpatient department under the supervision of a physician. Medicare's payment for the administration of the drug or biological billed to the MAC will also include payment for equipment used in furnishing the service. Equipment, such as an external infusion pump used to begin administration of the drug or biological that the patient takes home to complete the infusion, is not separately billable as durable medical equipment for a drug or biological paid under the section 1861(s)(2)(A) and (B) incident to benefit.

…

"Part A and Part B: Administration of Chemotherapy Drug Infusions

"For complete information, please see MLN Matters® MM9749 Revised.

"HCPCS code G0498 is to be used when billing prolonged drug and biological infusions for chemotherapy administration started incident to a physician's service using an external pump. It is not necessary to include the word "PUMP" in block 19 or the equivalent section for electronic claims."

Several other DME MACs, including CGS and Noridian, have adopted similar LCD policies.

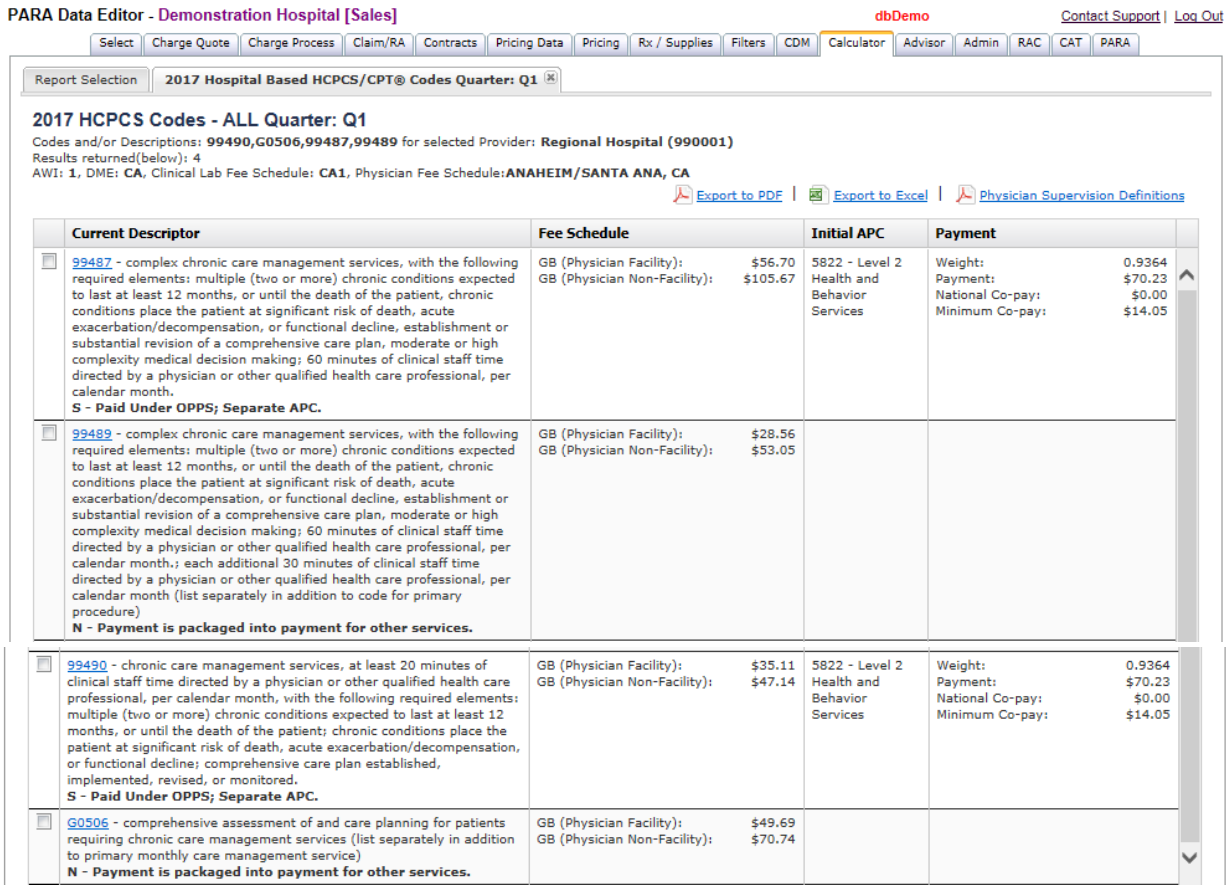
Since DME suppliers cannot be reimbursed for the infusion pumps directly by Medicare, the outpatient hospital or physician clinic is expected to absorb the cost of the pump, either by purchasing pumps for patient use or by paying the DME supplier directly for a rental.

Medicare created HCPCS G0498 in 2016 for physician clinic billing, and made that HCPCS appropriate for hospital outpatient chemotherapy billing effective 1/1/2017. This code also includes the visit for disconnection of the equipment at the conclusion of the infusion.

Chronic Care Management Services Program

Medicare began reimbursing providers for chronic care management (CCM) services as of January 01, 2015 using CPT® code 99490. In November 2016, CMS expanded the program to add 3 new codes G0506, 99487 and 99489. The requirements are numerous but with a complete program implemented and monitored it could provide a significant impact to a practice's bottom line. CCM is defined as:

1. **non-face-to-face services provided to Medicare patients who meet the chronic condition code requirements of the program**
2. **In addition to office visits and other face-to-face encounters (billed separately)**
3. **"Other services" defined as communication directly with the patient and other treating health professionals for care coordination, and**
4. **being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff)**
5. **The creation and revision of electronic care plans are the key component to the CCM program**



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

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

Report Selection | 2017 Hospital Based HCPCS/CPT® Codes Quarter: Q1

2017 HCPCS Codes - ALL Quarter: Q1

Codes and/or Descriptions: **99490,G0506,99487,99489** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 4
AWI: **1**, DME: **CA**, Clinical Lab Fee Schedule: **CA1**, Physician Fee Schedule:**ANAHEIM/SANTA ANA, CA**

Export to PDF | Export to Excel | Physician Supervision Definitions

Current Descriptor	Fee Schedule	Initial APC	Payment
99487 - complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month. **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): $56.70 GB (Physician Non-Facility): $105.67	5822 - Level 2 Health and Behavior Services	Weight: 0.9364 Payment: $70.23 National Co-pay: $0.00 Minimum Co-pay: $14.05
99489 - complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure) **N - Payment is packaged into payment for other services.**	GB (Physician Facility): $28.56 GB (Physician Non-Facility): $53.05		
99490 - chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored. **S - Paid Under OPPS; Separate APC.**	GB (Physician Facility): $35.11 GB (Physician Non-Facility): $47.14	5822 - Level 2 Health and Behavior Services	Weight: 0.9364 Payment: $70.23 National Co-pay: $0.00 Minimum Co-pay: $14.05
G0506 - comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service) **N - Payment is packaged into payment for other services.**	GB (Physician Facility): $49.69 GB (Physician Non-Facility): $70.74		

For reimbursement success, the Centers for Medicare and Medicaid (CMS) decided that CCM is targeted for patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until death of the patient, that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline. CMS has not specified or otherwise limited the eligible chronic conditions that meet this definition. CMS is expecting physicians to focus particularly on eligible patients with higher acuity and higher risk levels (e.g., patients with four or more chronic conditions) when deciding to furnish CCM services because the benefits are likely to be greater.

What are examples of Chronic Conditions for patient eligibility components to the program? CMS requires the billing practitioner to furnish a comprehensive evaluation and management (E&M) visit, Annual Wellness Visit (AWV) or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM services, and to initiate the CCM service as a component of this visit or exam. The listing inserted below is just a sample of diseases that can be included within the CCM program:

1. Alzheimer's disease and related dementia
2. Arthritis (osteoarthritis and rheumatoid)
3. Asthma
4. Atrial fibrillation
5. Autism spectrum disorders
6. Cancer
7. Chronic Obstructive Pulmonary Disease (COPD)
8. Depression
9. Diabetes
10. Heart failure
11. Hypertension
12. Ischemic heart disease
13. Osteoporosis

Practitioner eligibility: The following is a listing of practitioners CMS has determined to be eligible to submit claims and get reimbursed for rendering CCM services:

Only one (1) practitioner may be paid for the CCM service for a given calendar month

1. Certified Nurse Midwives (CNM)
2. Clinical Nurse Specialists (CNS)
3. Nurse Practitioners (NP)
4. Physician Assistants (PA)
5. **Beginning January 01, 2016, CMS finalized the payment methodology for CCM services that will now include separate reimbursement for CCM services rendered in an Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) setting**

CMS is advising with this eligible practitioners listing, they must also be acting within their State licensure, scope of practice, and Medicare statutory benefit.

CMS is expecting to see CCM services billed most frequently by primary care physicians, however specialty physicians that meet all the requirements for the program may also submit claims for reimbursement.

CMS is indicating CCM services at this time are not within the scope of practice for limited license physicians (LLP) and other practitioners (e.g., clinical psychologists, podiatrists or dentists) therefore they cannot bill for CCM services, if rendered. They are eligible to "refer to" or "consult with" such physicians and practitioners by the billing practitioner to coordinate and manage the patient care.

Components of the CCM Program: The CCM program model consists of 6 distinct concepts that are designed to assist in the healthcare delivery of the program. They are:

1. Organizational support: This concept addresses the culture of the practice as well as the system leadership. In a practice that has adopted and implemented a CCM model chronic illness and practice improvement are demonstrated as key values. In addition, leadership is committed and visibly involved, supports change and quality improvements, and creates incentives for providers and patients to improve care and adhere to evidence-based practice.
2. Clinical information systems: Practice improvement cannot be accomplished without data on trends in individual patients and the health of the practice population. Most current Clinical Information systems (CIS) are structured to organize patient, population and provider data to describe the health of the population and to facilitate efficient and effective care.
3. Delivery system design: This component addresses the composition and function of the practice team, the organization of visits, and the management of follow-up care. The delivery is effective, efficient clinical care through appropriate use of all team members, planned patient interactions, regular follow-up, and case management are all important parts of this program component.
4. Decision support: This includes mechanisms for increasing provider access to evidence-based practice guidelines and to specialists for collaboration (e.g.; system prompts and reminders). Evidence-based practice guidelines provide standards for care and should be made readily available in daily practice, as should the integration of clinical expertise from specialists and generalists. Practice improvement programs that optimize team members need to ensure that all the team members are visible to the patient. Patients should know who all the team members are and what they do as it relates to the patient's condition.
5. Self-management support: This is a critical component of the CCM model, and emphasizes the need for the patient-centered interventions. These interventions can be identified with educational resources tailored to the specific patient. Skills training, psychosocial support and collaboration between provider and patient to define problems, set priorities, establish goals, identify barriers, create treatment plans and solve problems. The goal CMS has intended for this program component is to empower and prepare CCM patients to manage their health and healthcare. Research has indicated being given the skill set to self-manage has a positive effect on the health outcomes of CCM populations.

CMS has identified and included six self-management skills that form the core of the self-management component. They are:

1. Problem solving – Instead of solving the problem for the patient or coming up with suggestions to resolve the problem, an NP that is assisting in self-management teaches the patient the problem solving process; problem identification and definition, solution options that include implementation and evaluation.
2. Decision making –Patients that suffer from CCM conditions must make dozens of decisions daily and these decisions could affect their health. Not only could these decisions affect the daily outcomes for the patient but could also affect the confidence in their ability to successfully manage the disease process. Tools that are provided to assist in this decision making can include skills such as how to read a food label or when to slow down in a prescribed exercise program.
3. Resource utilization –There are many resources available to help patients with self-management of their chronic illness. These resources can be defined as social support, access to fitness facilities and the Internet.
4. Patient-provider relationship – It is important for the patient to believe the channels of communication with the healthcare provider are open, that they can inform their provider of any changes in their health or life situations that influence their health. They can make decisions related to their health in a collaborative manner.
5. Taking action – All of the above previous skills are of no value if patients cannot take action to improve their health on a regular basis. Taking action involves readiness to change, having access to sufficient information, setting goals and having ongoing support for change.
6. Community resources: This is the final component of the CCM program. This component is intended to implement links to the community for peer support, care coordination, and community-based interventions. Community-practice partnerships are important among the elder, low-income and underserved populations.

Patient Agreement Requirements Summary: The provider must inform eligible patients of the availability of CCM services and obtain a written and signed consent form before furnishing or billing for service. A portion of the patient agreement provisions require the use of certified Electronic Record (EHR) technology.

Patient consent requirements need to include:

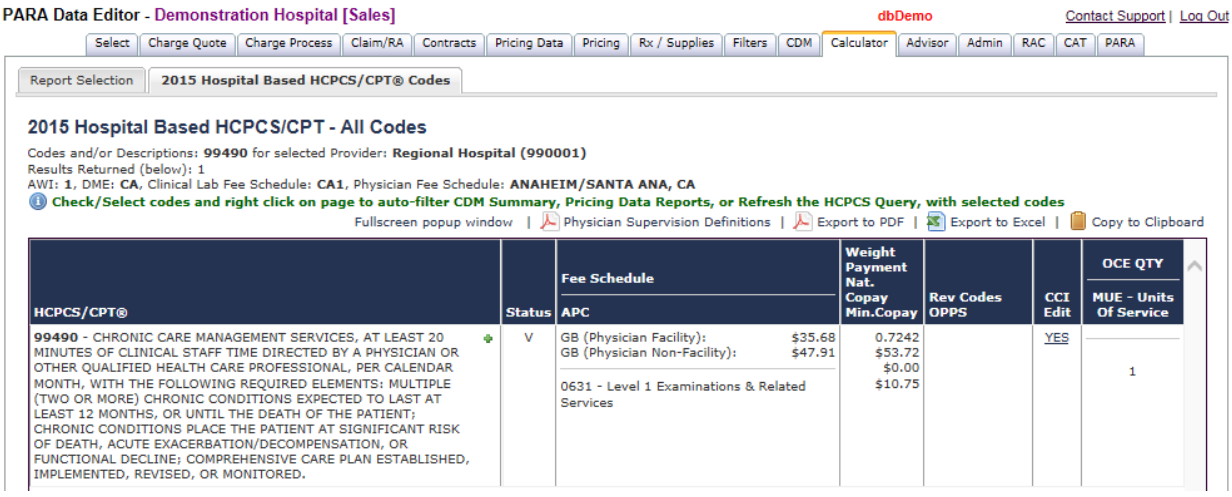
1. Advising the patient that CCM services are available and obtain a written agreement to engage in the services, including authorization for the electronic communication of medical information with other treating practitioners and providers.
2. Explain the details of the program being offered to the patient. The medical records should reflect documentation of this conversation with the patient and if the patient decision was to accept or decline at this time.
3. Explain the revocation of CCM services process to the patient.
4. Informing the patient that only one practitioner can furnish and be reimbursed for the service within one calendar month.

Furthermore, the agreement process should include a complete discussion with the patient/caregiver (when applicable) about:

1. The definition of CCM service
2. The process of accessing the various elements of the service
3. How the patient's information will be shared among the CCM team (practitioners and providers)
4. How cost-sharing is applied to the services (co-insurance and deductibles)
5. How to revoke the service

The informed patient consent is only required to be completed once prior to the start of the CCM services, or if the patient chooses to change the practitioner who will furnish and bill for the services.

Billing for CCM Services: CPT® code 99490 has been established to capture chronic care management (CCM) services. Payment for the code is estimated to be on the average of $42.60 for 20 minutes of staffing time. **This can be billed once per patient, per calendar month.**



1. Co-payments (coinsurance and deductibles) DO apply
2. The following codes cannot be billed during the same month as the CCM (99490) are reported:

    - Transition Care Management (TCM) (99495 and 99496) services
    - Home Healthcare Supervision (HHA) (G0181) visit
    - Hospice Care Supervision (G9182) visit
    - Certain ESRD services (90951-90970)

References for this article:

https://www.acponline.org/fcgi/search?q=Chronic+Care+Management&site=default_collection&as_filetype=html&x=35&y=10

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

CHRONIC CARE MANAGEMENT TOOL KIT
What Practices Need to Do to Implement and Bill CCM Codes

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Open a Text-Only Version

Medicare Learning Network®

Chronic Care Management Services

The Centers for Medicare & Medicaid Services (CMS) recognizes Chronic Care Management (CCM) as a critical component of primary care that contributes to better health and care for individuals.

In 2015, Medicare began paying separately under the Medicare Physician Fee Schedule (PFS) for CCM services furnished to Medicare patients with multiple chronic conditions.

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This fact sheet provides background on payable CCM service codes, identifies eligible practitioners and patients, and details the Medicare PFS billing requirements. Beginning January 1, 2017, the CCM codes are:

CCM	
CPT 99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient • Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline • Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month	

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2015-Transmittals-Items/SE1516.html?DLPage=2&DLEntries=10&DLSort=1&DLSortDir=ascending

MLN Matters® Number: SE1516	**Related Change Request (CR) #: N/A**
Related CR Release Date: N/A	**Effective Date: N/A**
Related CR Transmittal #: N/A	**Implementation Date: N/A**

Chronic Care Management (CCM) Services Frequently Asked Questions (FAQs)

Provider Types Affected

This MLN Matters® Special Edition is intended for physicians and non-physician practitioners such as Certified Nurse Midwives (CNMs), Clinical Nurse Specialists (CNSs), Nurse Practitioners (NPs) and Physician Assistants (PAs) who bill the Medicare Fee-For-Service Program (Original Medicare) for the new Chronic Care Management (CCM) services provided to Medicare beneficiaries.

Provider Action Needed

This article alerts providers that the Centers for Medicare & Medicaid Services (CMS) revised the Medicare Learning Network® Fact Sheet on CCM services (ICN 909188, released in March 2015) to clarify Medicare's requirement for 24/7 access by individuals furnishing CCM services to the electronic care plan rather than the entire medical record. Also, CMS released a set of Frequently Asked Questions (FAQs) and answers to address requests received from practitioners and providers for additional guidance in specific areas such as claims submission, intersection with transitional care management services, and the provision of CCM services in facility settings. Those FAQs appear later in this article.

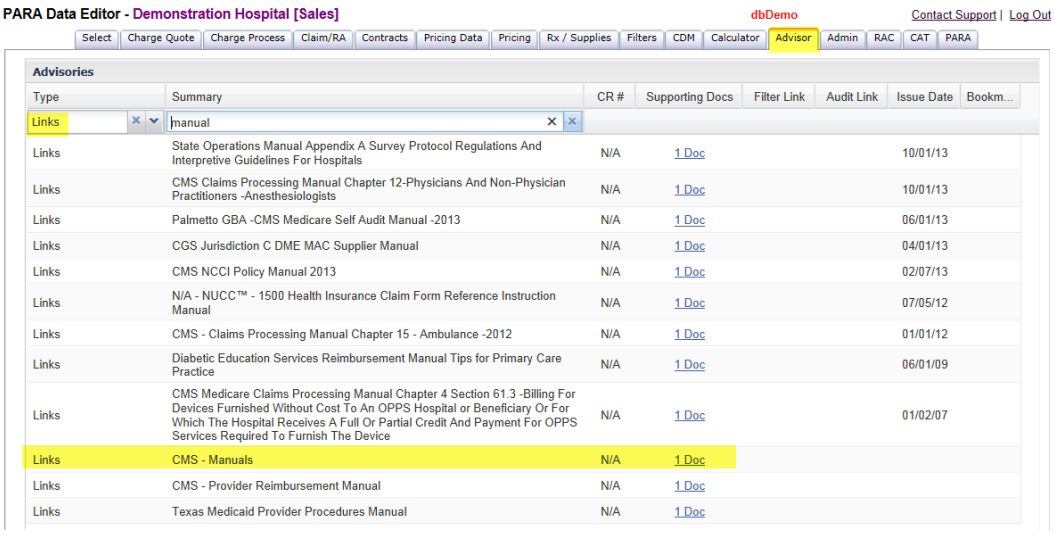
Chronic Care Management (CCM) Revocation

The CMS Medicare Learning Network Matter Fact Sheet - Chronic Care Management Services - ICN 909188 provides information on the CCM process. A physician's office must provide the patient with instructions on how to revoke the CCM authorization. CMS has not published any requirements for the patient notification of revocation. If a patient revokes the CCM authorization, the physician may submit and receive that calendar month's payment for the CCM if the documentation supports the CCM service with at least 20 minutes of clinical staff time. If less than 20 minutes, the CCM is not payable.

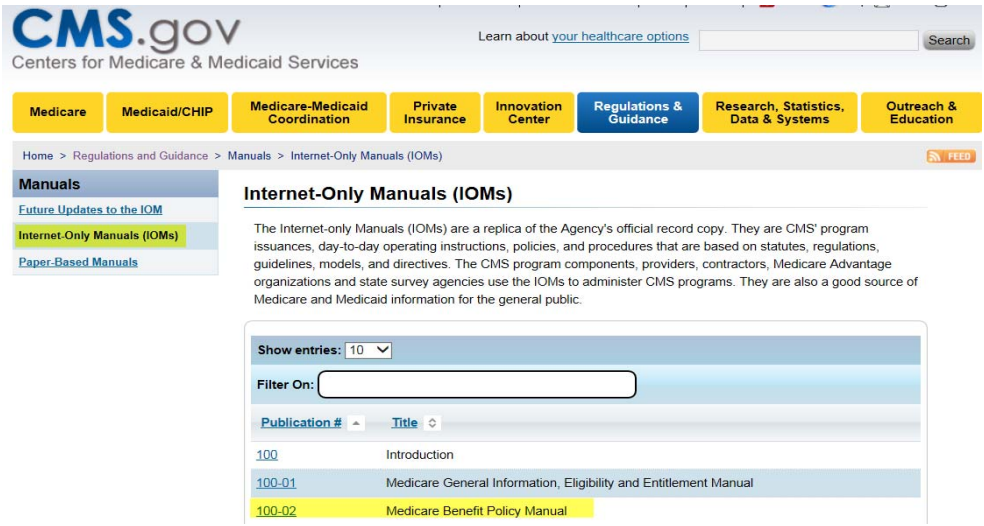
Many insurance companies offer palliative benefits. Medicare restricts its coverage to end-of-life care for patients with a prognosis of six months or less who have decided against curative treatment. There are no Medicare regulations or reimbursements for palliative medicine.

Regardless of the reimbursement issues, many hospitals are responding to the needs of their patients by offering palliative care programs. Typically, a Nurse Practitioner is employed to provide services which ease the condition of patients and their families enduring distressing, painful medical conditions.

Medicare offers a detailed guide to coverage and benefits in the Medicare Benefit Policy Manual. A link to the Medicare internet-only manuals, including the Benefits Policy Manual, is available on the Advisor tab of the **PARA Data Editor**; search for "Links" with the word "Manual" in the summary line:



The Benefits Policy Manual is available under Publication 100-02:



Coverage for Nurse Practitioners is found in the Medicare Benefit Policy Manual, Chapter 15 – Covered Medical and Other Health Services. A link and an excerpt are provided below:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

"Coverage is limited to the services an NP is legally authorized to perform in accordance with State law (or State regulatory mechanism established by State law).

1. **General**

The services of an NP may be covered under Part B if all of the following conditions are met:

- They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets the definition of an NP (see subsection A);
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with an MD/DO (see subsection D); and
- They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)

2. **Incident To**

If covered NP services are furnished, services and supplies furnished incident to the services of the NP may also be covered if they would have been covered when furnished incident to the services of an MD/DO as described in §60.

"C. Application of Coverage Rules

1. **Types of NP Services That May Be Covered**

State law or regulation governing an NP's scope of practice in the State in which the services are performed applies…

See §60.2 for coverage of services performed by NPs incident to the services of physicians.

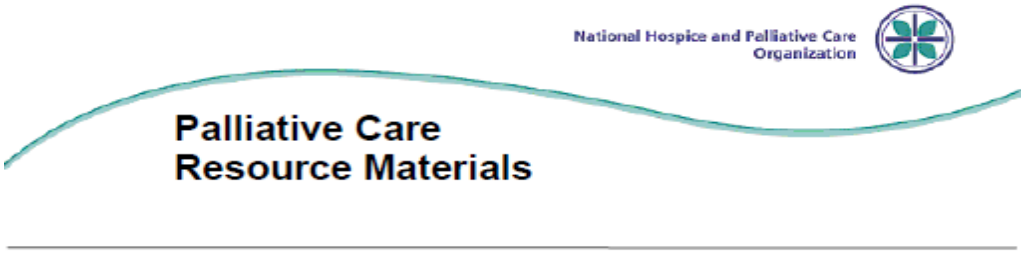
2. **Services Otherwise Excluded From Coverage**

The NP services may not be covered if they are otherwise excluded from coverage even though an NP may be authorized by State law to perform them. For example, the Medicare law excludes from coverage routine foot care, routine physical checkups, and

services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Therefore, these services are precluded from coverage even though they may be within an NP's scope of practice under State law."

The National Hospice and Palliative Care Organization offers resource materials to help organizations considering a palliative care program. The paper below discusses compliance issues when an organization which owns and operates a Hospice also embarks on a palliative care program:

http://www.nhpco.org/sites/default/files/public/palliativecare/pcchecklist.pdf



PALLIATIVE CARE CHECKLIST: SELECTED REGULATORY AND RISK MANAGEMENT CONSIDERATIONS[1]

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Before initiating a palliative care program[2], hospices are encouraged to consider the following and visit the NHPCO website at www.nhpco.org for forms, sample documents and sample additional palliative care resources:

- **The services the hospice wishes to offer are clearly defined.**

  Some hospices wish to offer the full IDT model of care. Others contemplate a physician (and perhaps nurse practitioner) providing direct care consultation visits in the hospital, nursing facility, home or clinic. Still others conduct one-time assessments upon the order of an attending physician. When reviewing regulatory issues, it is critical to review the precise model of non-hospice palliative care being considered.

[1] These considerations are not legal advice and should not be relied on in lieu of legal advice. Development of a palliative care program is complex and should include a careful analysis of all of the unique facts and circumstances.
[2] Palliative care programs based solely on volunteer support may be treated differently.

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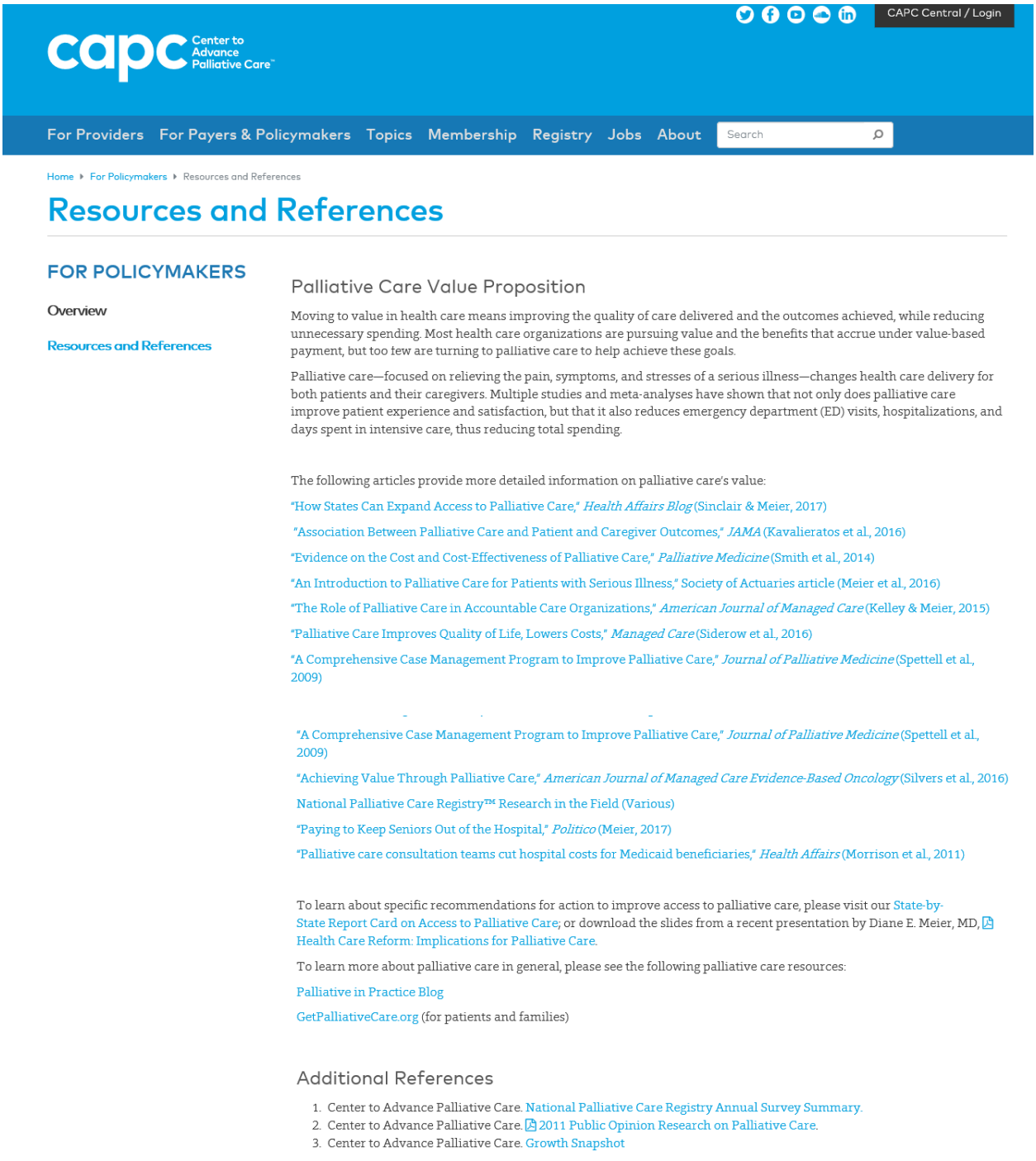
The Center to Advance Palliative Care offers references on building a palliative care program:

https://www.capc.org/policymakers/resources-and-references/



capc Center to Advance Palliative Care

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Resources and References

FOR POLICYMAKERS

Overview

Resources and References

Palliative Care Value Proposition

Moving to value in health care means improving the quality of care delivered and the outcomes achieved, while reducing unnecessary spending. Most health care organizations are pursuing value and the benefits that accrue under value-based payment, but too few are turning to palliative care to help achieve these goals.

Palliative care—focused on relieving the pain, symptoms, and stresses of a serious illness—changes health care delivery for both patients and their caregivers. Multiple studies and meta-analyses have shown that not only does palliative care improve patient experience and satisfaction, but that it also reduces emergency department (ED) visits, hospitalizations, and days spent in intensive care, thus reducing total spending.

The following articles provide more detailed information on palliative care's value:

"How States Can Expand Access to Palliative Care," *Health Affairs Blog* (Sinclair & Meier, 2017)

"Association Between Palliative Care and Patient and Caregiver Outcomes," *JAMA* (Kavalieratos et al., 2016)

"Evidence on the Cost and Cost-Effectiveness of Palliative Care," *Palliative Medicine* (Smith et al., 2014)

"An Introduction to Palliative Care for Patients with Serious Illness," Society of Actuaries article (Meier et al., 2016)

"The Role of Palliative Care in Accountable Care Organizations," *American Journal of Managed Care* (Kelley & Meier, 2015)

"Palliative Care Improves Quality of Life, Lowers Costs," *Managed Care* (Siderow et al., 2016)

"A Comprehensive Case Management Program to Improve Palliative Care," *Journal of Palliative Medicine* (Spettell et al., 2009)

"A Comprehensive Case Management Program to Improve Palliative Care," *Journal of Palliative Medicine* (Spettell et al., 2009)

"Achieving Value Through Palliative Care," *American Journal of Managed Care Evidence-Based Oncology* (Silvers et al., 2016)

National Palliative Care Registry™ Research in the Field (Various)

"Paying to Keep Seniors Out of the Hospital," *Politico* (Meier, 2017)

"Palliative care consultation teams cut hospital costs for Medicaid beneficiaries," *Health Affairs* (Morrison et al., 2011)

To learn about specific recommendations for action to improve access to palliative care, please visit our State-by-State Report Card on Access to Palliative Care; or download the slides from a recent presentation by Diane E. Meier, MD, Health Care Reform: Implications for Palliative Care.

To learn more about palliative care in general, please see the following palliative care resources:

Palliative in Practice Blog

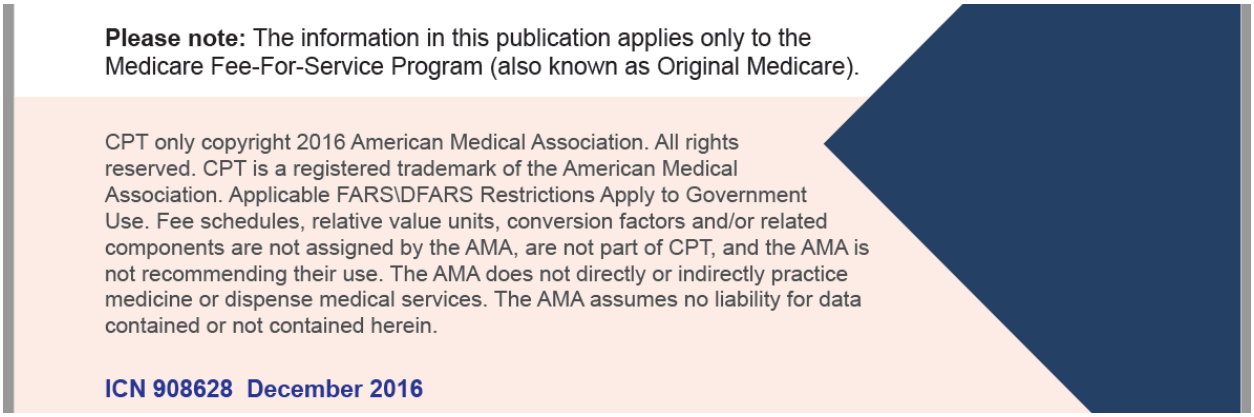
GetPalliativeCare.org (for patients and families)

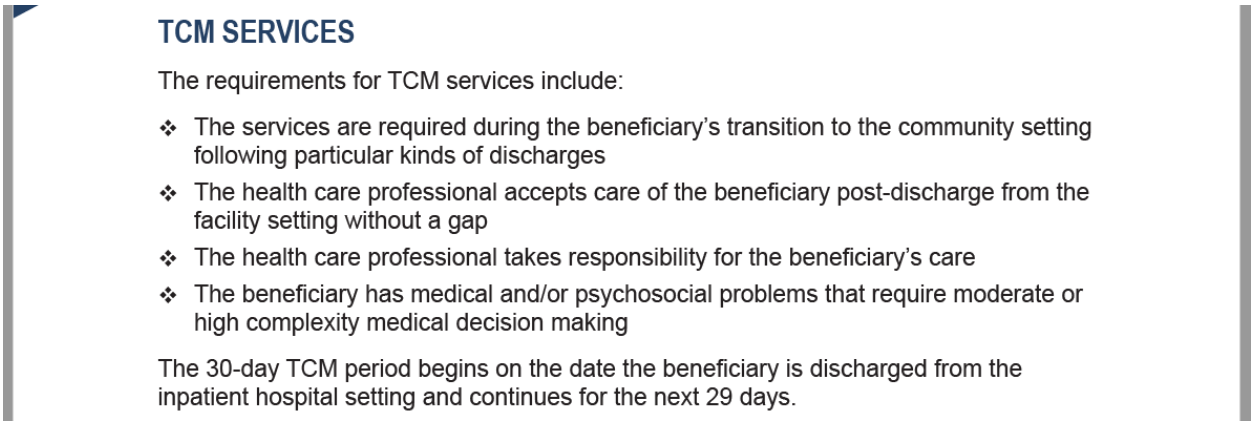
Additional References

1. Center to Advance Palliative Care. National Palliative Care Registry Annual Survey Summary.
2. Center to Advance Palliative Care. 2011 Public Opinion Research on Palliative Care.
3. Center to Advance Palliative Care. Growth Snapshot

Programs which assist patient transitioning from the inpatient to outpatient settings (Transitional Care) were granted coverage by Medicare effective January 1, 2013. A link and an excerpt from Medicare's publication on this topic are provided below:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf





The Medicare Administrative Contractor for Jurisdiction 5, WPS, provides "Questions and Answers" regarding Transitional Care Management at the following link:

http://wpsmedicare.com/j5macpartb/training/on_demand/2013-0925-transitional-care-mngmnt-qanda.shtml

…

8. **If the patient is being discharged under Home Health or Hospice, can the patient also receive TCM services?**

   Yes. The patient can receive TCM services by someone other than the physician who is providing Care Plan Oversight (CPO), procedure codes G0181 - supervision for home health or G0182 - supervision for hospice care. Medicare would not allow the 99495 or 99495 and the G0181 or G0182 within the same 30 day period billed by the same practitioner.

PARA responses to frequently asked questions relating to Palliative Care follow:

1. **The person hired to do the Palliative Care is a Nurse Practitioner. Is that is a billable service?**

   Answer: Services of a Nurse Practitioner are billable as professional fees, provided of course that the services billed are medically necessary.

2. **Our Nurse Practitioner will be seeing both inpatients and outpatients in the hospital. She may also be seeing patients in their homes.**

   Enroll the NP with Medicare under your medical group NPI with an 855B form (or on PECOS) no more than 30 days prior to the date on which the NP will begin seeing patients. The NP must also update the NP's individual Medicare enrollment (855I/PECOS) to add locations of service which include the facility and patient home visits. NP services billed as professional fees will be reimbursed at 85% of the Medicare physician fee schedule. (CAH Method II note: nurse practitioner services must be billed with modifier -GF appended to the CPT® code on the UB/837i).

3. Are there any guidelines for Palliative Care that you are aware of?

Answer: The National Consensus Project for Quality Palliative Care offers a guideline entitled "Clinical Practice Guidelines for Quality Palliative Care"; a link and an excerpt are provided below:

http://www.nationalconsensusproject.org/guideline.pdf

There are several clinical models that have demonstrated quality care for patients and families. They include a variety of disciplines that collaborate to provide quality care. These include:

1. **Hospice Care** – a well-established program to provide patients with a prognosis of six months or less. As delineated within the Medicare Hospice Benefit, these services can be provided in the home, nursing home, residential facility, or on an inpatient unit.
2. **Palliative Care Programs** – institutional based programs in the hospital or nursing home to serve patients with life-threatening or life-limiting illnesses. Occur in hospital settings (academic, community, rehabilitation) and skilled nursing facilities. Provide services to patients anywhere along the disease continuum between initial diagnosis and death. Can include a consultation team, a fixed-bed unit, or a swing-bed unit.
3. **Outpatient Palliative Care Programs** – occur in ambulatory care settings to provide continuity of care for patients with serious or life-threatening illnesses.
4. **Community Palliative Care Programs** – occur in communities as consultative teams who collaborate with hospices or home health agencies to support seriously ill patients who have not yet accessed hospice.

The continued success of this project is evidenced by how the *Clinical Practice Guidelines for Quality Palliative Care* encourage new programs. Accomplished either as the expansion of existing palliative and hospice programs to allow greater access to care, *The Clinical Practice Guidelines for Quality Palliative Care* will: continue the development and evaluation of new and existing services, ensure consistent and high quality palliative care as measured by the National Quality Forum Preferred Practices, provide certification initiatives for specialty status in palliative care, and provide recognition of specialty status for certification initiatives in palliative care. Most importantly the *Guidelines* will serve as the basis for all palliative care settings.

CLINICAL PRACTICE GUIDELINES FOR QUALITY PALLIATIVE CARE 11

PARA's Market Comparative Pricing Data Reports

PARA's Pricing Data Reports are always up to date with the most current public data available. The data source is:

- Inpatient Medicare MEDPAR – Federal Fiscal Year 2014
- Outpatient Medicare Complete Data Set – Calendar Year 2014
- Supplier Detailed Data - 2014

The data is parsed into 17 user-friendly reports making it easy for Hospital's to find service lines that are out of line compared to their peers and identify areas of opportunities.

PARA Data Editor Trial

PARA's web based tool the **PARA Data Editor (PDE)** is used to manage and improve your revenue cycle process.

Test drive the PDE for a complimentary 14 day trial. You can use it to help reduce cost and improve net revenue.

The trial period is at no cost or obligation and can be used to determine if it is a good fit for your hospital.

PARA Healthcare Financial Services

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PARA Healthcare Financial Services

Real-time Eligibility Verification and Benefits Inquiry

Determining eligibility prior to the patient arriving *(during scheduling and/or pre-registration)* is often problematic for providers. Eligibility is one of the driving factors towards ultimate payment. It is important that hospitals have the best tools in place to verify eligibility prior to the services being performed.

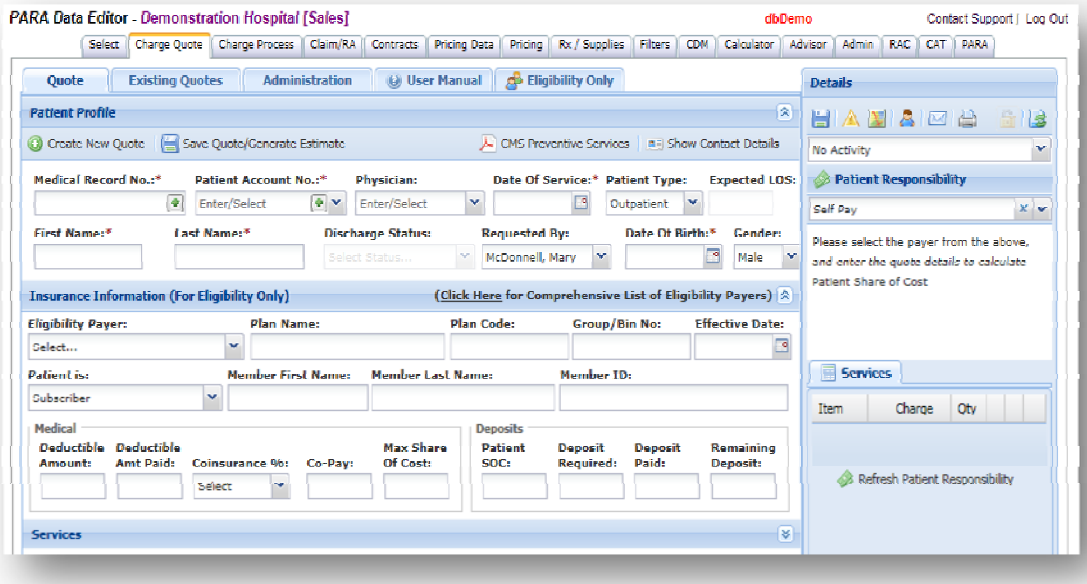
Providers are more successful with the eligibility process when using tools that capture REAL time eligibility. *(AKA 270/271 transactions under HIPAA)*

- 270 – Eligibility, Coverage or Benefit Inquiry
- 271 – Eligibility, Coverage or Benefit Information

Advantages of determining eligibility prior to date of service:

- Provides additional time to react if the patient is not eligible for coverage/payment
- Patients have a better understanding of their financial obligations
- Allows patients to be smarter consumers in the delivery of their healthcare
- Providers can determine if a "pre-certification" is required

PARA's Eligibility Check within our **Charge Quote** tool is one of the features built into the **PARA Data Editor (PDE)**. It is a real-time eligibility and benefits verification solution.



Contact your PARA Account Representative to learn more about PARA's Eligibility Checker.

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