# PARA Weekly Update – August 12, 2016

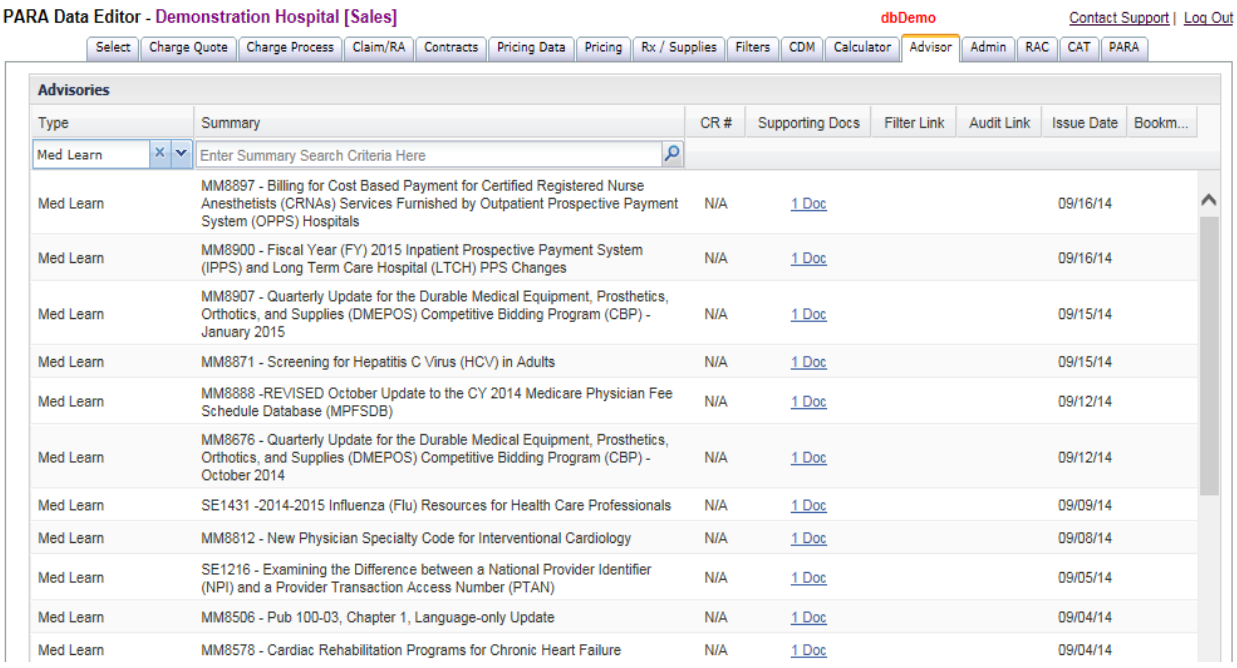
The following Departments are impacted by the contents of this week's update:

- **Patient Financial Services – see pages 1-21**
- **Hospital Administration - see page 21**
- **PDE Users – see pages 6, 7-9**
- **HIM/Coding Staff – see pages 10-12, 13, 14-15, 19-20**
- **Surgery Departments – see pages 10-12, 13**
- **Obstetric Departments – see pages 10-12**
- **Clinics – see pages 14-15, 16-18**
- **Respiratory Therapy Departments – see pages 16-18**
- **Materials Management Departments – see page 21**

## Med Learns:

There was one new or revised Med Learn article released this week. The article contained no coding changes, 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:




A link to the Med Learn appears on the following page.

**Med Learns (continued):**

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9754.pdf

| | |
|---|---|
| **MLN Matters® Number: MM9754** | **Related Change Request (CR) #: CR 9754** |
| **Related CR Release Date: August 12, 2016** | **Effective Date: October 1, 2016** |
| **Related CR Transmittal #: R3591CP** | **Implementation Date: October 3, 2016** |

## October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.3

### Provider Types Affected

This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs), including Home Health and Hospices (HH+H) MACs, for services provided to Medicare beneficiaries.

### What You Need to Know

Change Request (CR) 9754 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Integrated OCE that will be used under the Outpatient Prospective Payment System (OPPS) and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency (HHA) not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. Make sure that your billing staffs are aware of these changes.

The I/OCE specifications will be posted at **http://www.cms.gov/OutpatientCodeEdit/**. These specifications contain the appendices mentioned in the table below.

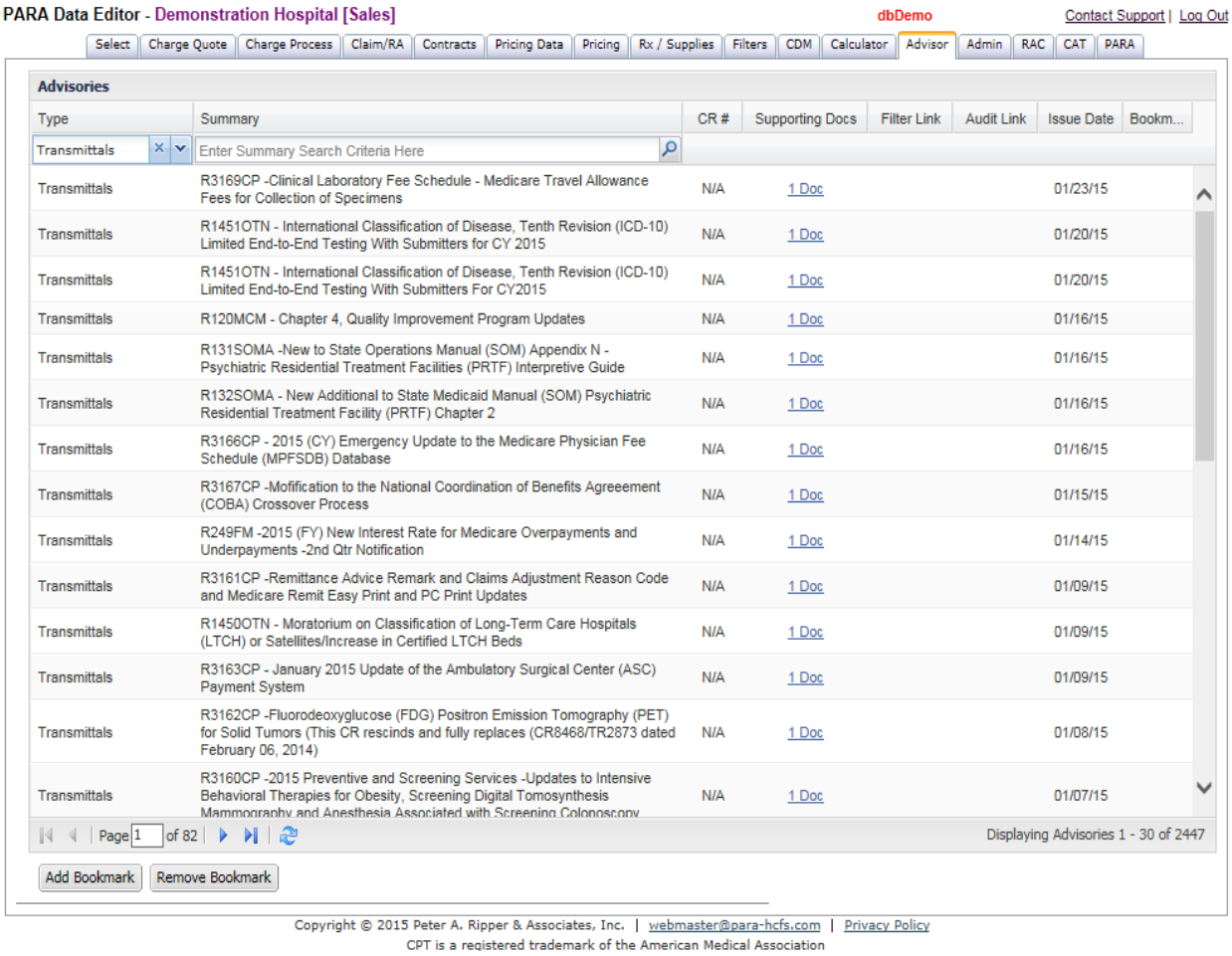
### Key Changes for October 2016 I/OCE

The modifications of the I/OCE for the October 2016 release are summarized in the table below. Readers should also read through the entire document and note the highlighted sections, which also indicate changes from the prior release of the software. Some I/OCE modifications may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

**Transmittals:**

There were four 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/Downloads/R151DEMO.pdf

**SUBJECT: Shared System Enhancement 2015: Archive/Remove Inactive Medicare Demonstration Projects**

**I. SUMMARY OF CHANGES:** The Centers for Medicare & Medicaid Services and its predecessor organization, the Health Care Financing Administration, have implemented Medicare fee for service (FFS) demonstration projects to support the development and implementation of payment systems associated with FFS and hybrid delivery systems, alternative payment structures and health care delivery systems to achieve value based purchasing, health promotion and disease prevention activities for Medicare beneficiaries, the examination of payment and delivery systems of FFS in acute and long term care, and expanded access and develop infrastructure in underserved areas (rural/inner city areas) or populations with special needs or chronic conditions.

Since some Medicare demonstration projects no longer serve a business need and claims processing for the demonstration is complete, CMS has provided a spreadsheet of all inactive demonstrations: "Contractors shall identify Medicare demonstration projects/code that are not active. CMS believes archiving obsolete Medicare demonstration projects/code will reduce system complexity and make future maintenance efforts more efficient.

**EFFECTIVE DATE: January 1, 2017 - Analysis/Coding; April 1, 2017**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 3, 2017 - Analysis/Coding; April 3, 2017**

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3591CP.pdf

**SUBJECT: October 2016 Integrated Outpatient Code Editor (I/OCE) Specifications Version 17.3**

**I. SUMMARY OF CHANGES:** This notification provides the Integrated OCE instructions and specifications for the Integrated OCE that will be utilized under the OPPS and Non-OPPS for hospital outpatient departments, community mental health centers, all non-OPPS providers, and for limited services when provided in a home health agency not under the Home Health Prospective Payment System or to a hospice patient for the treatment of a non-terminal illness. The attached Recurring Update Notification applies to 100-04, Chapter 4, section 40.1.

**EFFECTIVE DATE: October 1, 2016**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: October 3, 2016**

**Transmittals (continued)**:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R152DEMO.pdf

**SUBJECT: Shared System Enhancement 2015: Archive/Remove Inactive Medicare Demonstration Projects**

**I. SUMMARY OF CHANGES:** The Centers for Medicare & Medicaid Services and its predecessor organization, the Health Care Financing Administration, have implemented Medicare fee for service (FFS) demonstration projects to support the development and implementation of payment systems associated with FFS and hybrid delivery systems, alternative payment structures and health care delivery systems to achieve value based purchasing, health promotion and disease prevention activities for Medicare beneficiaries, the examination of payment and delivery systems of FFS in acute and long term care, and expanded access and develop infrastructure in underserved areas (rural/inner city areas) or populations with special needs or chronic conditions.

Since some Medicare demonstration projects no longer serve a business need and claims processing for the demonstration projects/code that are no longer active. CMS is requesting that contractors archive/remove Medicare demonstration projects/code that are no longer active.

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

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1707OTN.pdf

**SUBJECT: eMSN and Alternate Format MSN Service Improvements**

**I. SUMMARY OF CHANGES:** In 2015, the Centers for Medicare & Medicaid Services (CMS) implemented both electronic Medicare Summary Notices (MSNs) and alternate format MSNs as options for Medicare beneficiaries. This Change Request (CR) shall implement the following technical and customer service improvements to these products:

- Include the full unmasked Health Insurance Claim Number (HICN) in a non-printable section of each MSN print file.
- Provide the ability to order MSN reprints in a language and media different from the preferences on file for the beneficiary.
- Produce MSNs in printed form regardless of media preference after the date of death of the beneficiary.

**EFFECTIVE DATE: January 1, 2017**
**Unless otherwise specified, the effective date is the date of service.*
**IMPLEMENTATION DATE: January 3, 2017 - MCS and VMS full implementation of CR9731; April 3, 2017 - FISS full implementation of CR9731**

**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 |
|---|---|
| **8/11/2016** | OSHPD: 2015 NonPublic Patient Data Now Availabl |
| **8/11/2016** | FDA Draft Guidance - Medical X-Ray Imaging Devices Conformance with IEC Standards |
| **8/11/2016** | FDA Consumer Information for Medical Devices Update: |
| **8/11/2016** | FDA and OHRP Issue Joint Draft Guidance on IRB Written Procedures |
| **8/11/2016** | FDA approves first generic version of widely used influenza drug |
| **8/11/2016** | FDA Guidance Documents Update |
| **8/11/2016** | FDA Kratom seized in California by US Marshals Service- Drug Information Update |
| **8/11/2016** | FDA Pembrolizumab (KEYTRUDA |
| **8/11/2016** | CDRH New Update Executive Summary posted for August 16, 2016 Microbiology Devices Panel of the Medical Devices Advisory |
| **8/11/2016** | FDA Updates for Health Professionals |
| **8/11/2016** | CDRH New Update August 11, 2016 |
| **8/11/2016** | FDA The August 2016 MedSun Newsletter |
| **8/11/2016** | AHRQ What's New \| August 10, 2016 |
| **8/10/2016** | HHS. GOV. OIG:Cornerstone Hospital of Austin Incorrectly Billed Medicare Inpatient Claims with Kwashiorkor |
| **8/10/2016** | CMS NEWS: CMS Updates Nursing Home Five-Star Quality Ratings |
| **8/10/2016** | AHRQ New Care Coordination Survey |
| **8/10/2016** | CMS August 2016 CMS National Training Program Update Older Adults Need Vaccines Too |
| **8/10/2016** | CMS Pre-Claim Review Demonstration for Home Health Services Officially Began in Illinois on August 3, 2016 |
| **8/10/2016** | CMS NEWS: Affordable Care Act payment model continues to improve care, lower costs |
| **8/10/2016** | CMS Rural Health Open Door Forum is scheduled for: |
| **8/10/2016** | CAHABA GBA: Chronic Care Management Payment Correction for RHCs and FQHCs – Update |
| **8/10/2016** | AHRQ Newsletter: diagnostic safety summit; HIV hospitalizations; EHR safety webinar |
| **8/10/2016** | AHRQ's New Policymaker Research Summaries Address: Alcohol Use Disorder, and Transitional Care |
| **8/10/2016** | Medi-Cal NewsFlash: Updated Clinic Billing Policy for Managed Care Differential Rate |
| **8/10/2016** | Medi-Cal NewsFlash: Erroneously Denied Claims for Chorionic Gonadotropin |
| **8/10/2016** | Medi-Cal NewsFlash: New Benefit: 9-Valent Human Papillomavirus |
| **8/10/2016** | Medi-Cal NewsFlash: Correction: Polysomnography – Place of Service Code Added and Local Codes |
| **8/10/2016** | Medi-Cal NewsFlash: Medical Transportation Claim Submission Updates |
| **8/10/2016** | Medi-Cal NewsFlash: AB 97 Pharmacy Drug Exemption Status Update |
| **8/10/2016** | Medi-Cal NewsFlash: Correction: CHDP Notice Additional Bright Futures Benefits Reimbursable |
| **8/10/2016** | HHS.GOV. OIG: Advisory Opinion 16-08 (regarding an arrangement in which a hospice received supplemental pmts from SNF |
| **8/10/2016** | HHS. GOV. OIG:Updated Provider Self-Disclosure Settlements |
| **8/10/2016** | HHS.GOV. OIG: Conversions of Startup Loans Into Surplus Notes by Consumer Operated and Oriented Plans Were Allowed |

## 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 |
| Outpatient Limited Data Set (limited) | Annually |
| Outpatient Standard Analytical File (expanded) | Annually |
| Physicians fee schedule | Quarterly |

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

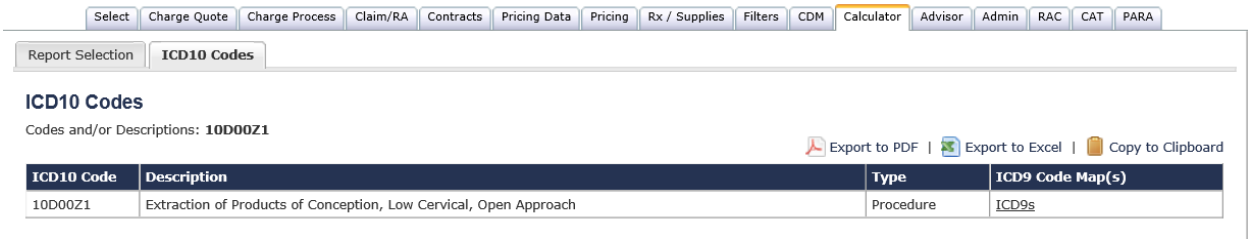
| Item Name | Update Frequency |
|---|---|
| **Physicians RVU** | Quarterly |
| **Provider Compliance Newsletter** | Quarterly |
| **RI Medicaid** | Annually |
| **SD Medicaid** | Annually |
| **Self Administered Drug Quarterly Update- FI/MAC** | Annually |
| **SNF MEDPAR Limited Data Set** | Annually |
| **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 |

# Q & A – ICD-10 PCS for Sterilization by Tubal Ligation

**Question:** What is the appropriate ICD-10 PCS code to report desired sterilization following C-Section delivery?

**Procedure Description:** Following administration of anesthesia, the patient was positioned in dorsal supine position with a leftward tilt and was prepped and draped in sterile fashion. A foley catheter was placed. The abdomen was entered in layers through a pfannenstiel incision. Moderate amount of adhesions were noted at the midline fascial incision. Once the incision was cleared of adhesions an alexis retractor was placed. The lower uterine segment was noted to be extremely thin with a few <0.5cm uterine windows. A low transverse hysterotomy was created sharply to the level of the membranes, then extended bluntly. The fetus was delivered from cephalic presentation onto the field. Bulb suctioning was performed. The cord was doubly clamped and cut. The newborn was passed to the warmer. The placenta was delivered. The uterus was swept free of clots and debris and closed in a running locked fashion with 0-Monocryl. Hemostasis was verified. The patient's left tube was then identified by tracing it to the fimbriated end. An avascular portion of the mesosalpinx was opened below the isthmic portion of tube and a 3cm segment of tube was doubly ligated with 0 plain gut and then excised. Hemostasis was verified. This procedure was repeated on the right side in similar fashion. Hemostasis was again confirmed. The abdomen was irrigated with warmed saline and cleared of clots. Subfascial spaces were inspected and hemostasis assured. The fascia was closed in a running fashion with 0-PDS. The subcutaneous tissues were irrigated and hemostasis assured. The skin was closed with 4-0 vicryl. A sterile bandage was applied. The patient was transferred to PACU. All needle, sponge, and instrument counts were correct at the end of the case.

**Answer:** Report ICD-10 PCS code 10D00Z1, Extraction of products of conception, low cervical to identify the C-Section delivery. Procedures performed on the products of conception are coded to the Obstetrics section. The root operation is extraction (pulling out of or a portion of a body part). Please refer to the 2017 ICD-10 PCS Official Coding Guidelines for Coding and Reporting: Obstetrics located in the **PARA Data Editor** Calculator and the **PARA Data Editor** code description.




**2017 ICD-10 PCS Official Coding Guidelines: Section 1.C. Obstetric: Products of conception**

Procedures performed on the products of conception are coded to the Obstetrics section. Procedures performed on the pregnant female other than the products of conception are coded to the appropriate root operation in the Medical and Surgical section.

Additionally, report ICD-10 PCS code 0UB70ZZ, Excision of bilateral fallopian tubes, open approach. As advised in the AHA coding clinic 3rd quarter 2015, "There are several distinct procedures performed on the fallopian tubes for sterilization including ligation alone, fulguration, and ligation followed by excision. These are coded to the root operations "Occlusion, Destruction, and Excision" respectively."

The procedure notes states ligation followed by excision. Excision is the definitive procedure performed after the ends of each tube are ligated. Please refer to the 2017 ICD-10 PCS Official Coding Guidelines for Coding and Reporting: Multiple procedures located in the **PARA Data Editor** Calculator and the **PARA Data Editor** code description.


**2017 ICD-10 PCS Official Coding Guidelines: Section 0.B3.2 Medical and Surgical Section Guidelines (section 0): Multiple procedures**

During the same operative episode, multiple procedures are coded if:

a. The same root operation is performed on different body parts as defined by distinct values of the body part character.

*Examples*: Diagnostic excision of liver and pancreas are coded separately. Excision of lesion in the ascending colon and excision of lesion in the transverse colon are coded separately.

b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.

*Examples*: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded. Extraction of multiple toenails are coded separately.

c. Multiple root operations with distinct objectives are performed on the same body part.

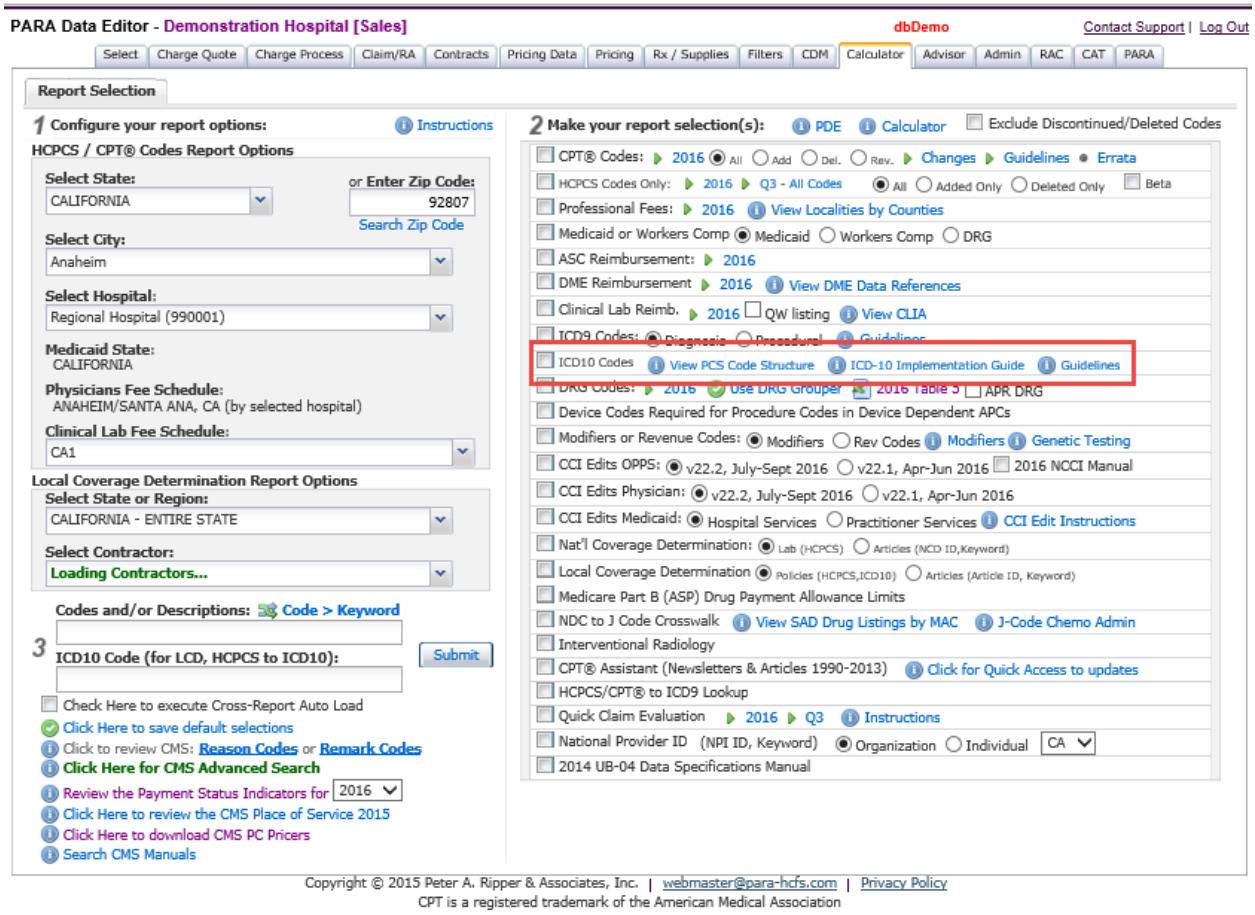
*Example*: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.

*Example*: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.

# Q & A – ICD-10 PCS for Sterilization by Tubal Ligation

The 2017 ICD-10 PCS Official Coding Guidelines are located in the **PARA Data Editor** Calculator.

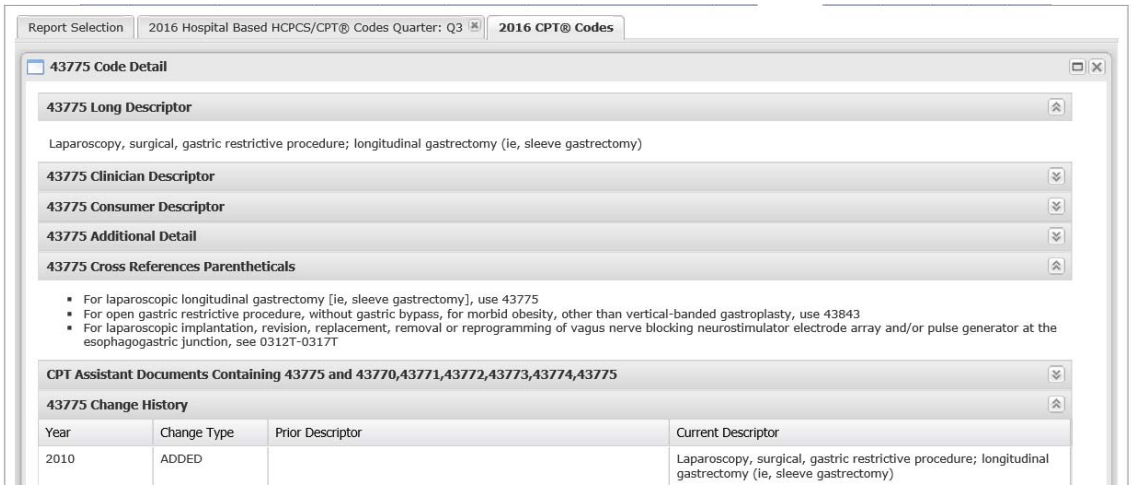


# Q & A – Sleeve Gastrectomy

**Question:** What is the appropriate CPT® code to report a Laparoscopic Sleeve Gastrectomy (LSG) for morbid obesity?

**Procedure Description:** Following appropriate anesthesia, the physician begins the longitudinal gastrectomy by placing a trocar though an incision, above the umbilicus and insufflating the abdominal cavity. The laparoscope and additional trocars are placed through small portal incisions. The physician divides the greater curvature of the stomach from the left crus of the diaphragm to a point distal to the pylorus. The short gastric vessels are coagulated and gastric staples are used. A gastric tube (sleeve) is formed and the remaining 80 percent of the stomach is excised. The instruments are removed and the incisions are closed.

**Answer:** Report CPT® code 43775, Laparoscopic gastric restrictive procedure, longitudinal gastrectomy. The CPT® code description includes "sleeve gastrectomy". The procedure note confirms laparoscopic approach with gastric tube (sleeve). Please refer to the **PARA Data Editor** code descriptions for laparoscopic bariatric surgeries and the **PARA Data Editor** CPT® Parentheticals.



Report Selection | 2016 Hospital Based HCPCS/CPT® Codes Quarter: Q3 | **2016 CPT® Codes**

**43775 Code Detail**

**43775 Long Descriptor**

Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)

**43775 Clinician Descriptor**

**43775 Consumer Descriptor**

**43775 Additional Detail**

**43775 Cross References Parentheticals**

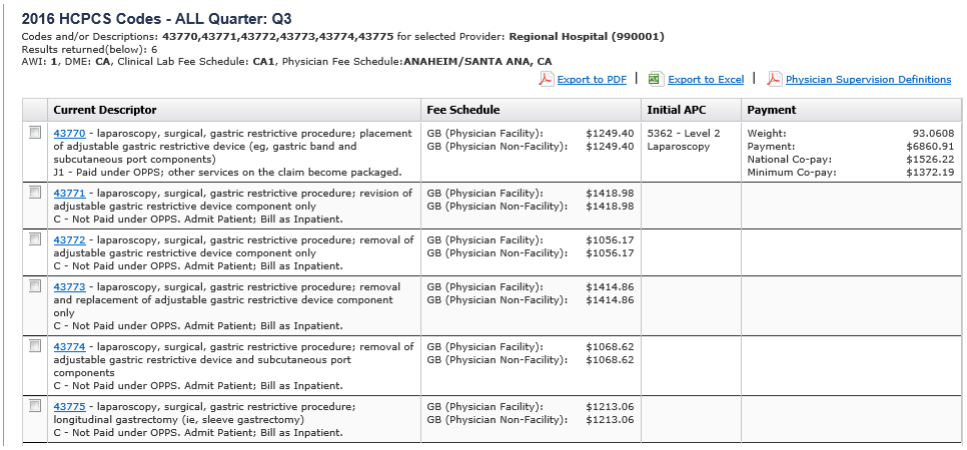
- For laparoscopic longitudinal gastrectomy [ie, sleeve gastrectomy], use 43775
- For open gastric restrictive procedure, without gastric bypass, for morbid obesity, other than vertical-banded gastroplasty, use 43843
- For laparoscopic implantation, revision, replacement, removal or reprogramming of vagus nerve blocking neurostimulator electrode array and/or pulse generator at the esophagogastric junction, see 0312T-0317T

**CPT Assistant Documents Containing 43775 and 43770,43771,43772,43773,43774,43775**

**43775 Change History**

| Year | Change Type | Prior Descriptor | Current Descriptor |
|---|---|---|---|
| 2010 | ADDED | | Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy) |

The **PARA Data Editor** AMA CPT® code selection for laparoscopic bariatric surgeries is provided below. Bariatric surgical procedures may involve the stomach, duodenum, jejunum and/or the ileum.



**2016 HCPCS Codes - ALL Quarter: Q3**

Codes and/or Descriptions: **43770,43771,43772,43773,43774,43775** for selected Provider: **Regional Hospital (990001)**
Results returned(below): 6
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

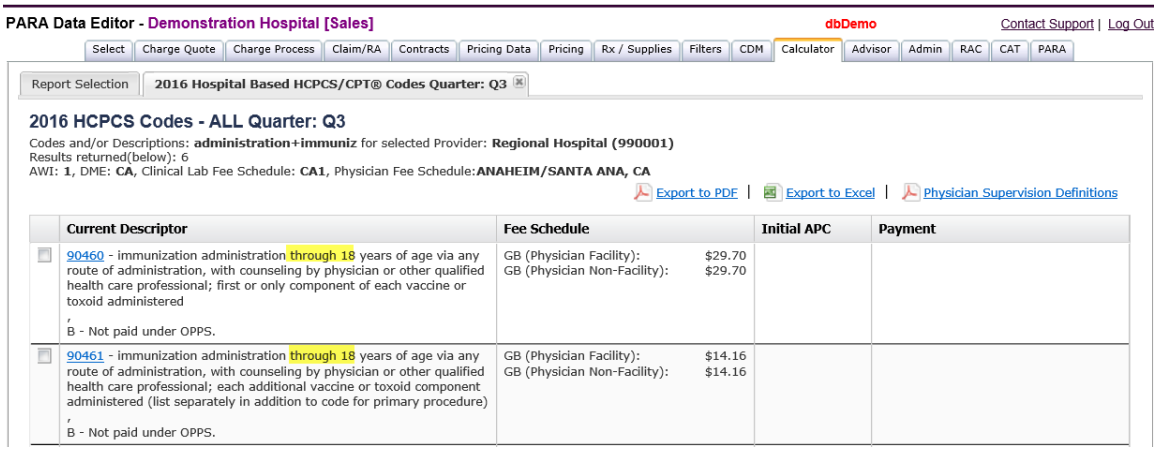
| Current Descriptor | Fee Schedule | Initial APC | Payment |
|---|---|---|---|
| 43770 - laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)<br>J1 - Paid under OPPS; other services on the claim become packaged. | GB (Physician Facility): $1249.40<br>GB (Physician Non-Facility): $1249.40 | 5362 - Level 2 Laparoscopy | Weight: 93.0608<br>Payment: $6860.91<br>National Co-pay: $1526.22<br>Minimum Co-pay: $1372.19 |
| 43771 - laparoscopy, surgical, gastric restrictive procedure; revision of adjustable gastric restrictive device component only<br>C - Not Paid under OPPS. Admit Patient; Bill as Inpatient. | GB (Physician Facility): $1418.98<br>GB (Physician Non-Facility): $1418.98 | | |
| 43772 - laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device component only<br>C - Not Paid under OPPS. Admit Patient; Bill as Inpatient. | GB (Physician Facility): $1056.17<br>GB (Physician Non-Facility): $1056.17 | | |
| 43773 - laparoscopy, surgical, gastric restrictive procedure; removal and replacement of adjustable gastric restrictive device component only<br>C - Not Paid under OPPS. Admit Patient; Bill as Inpatient. | GB (Physician Facility): $1414.86<br>GB (Physician Non-Facility): $1414.86 | | |
| 43774 - laparoscopy, surgical, gastric restrictive procedure; removal of adjustable gastric restrictive device and subcutaneous port components<br>C - Not Paid under OPPS. Admit Patient; Bill as Inpatient. | GB (Physician Facility): $1068.62<br>GB (Physician Non-Facility): $1068.62 | | |
| 43775 - laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)<br>C - Not Paid under OPPS. Admit Patient; Bill as Inpatient. | GB (Physician Facility): $1213.06<br>GB (Physician Non-Facility): $1213.06 | | |

# Coding for Childhood Vaccine Administration

Childhood vaccine administration codes (90460-90461) are billed according to the number of disease components of the vaccine, but unique coding rules often apply to coding state Vaccines for Children (VFC) programs in each state.

For most payors, the vaccine administration code(s) are billed along with the specific vaccine serum code.

The official CPT® code set for vaccine administration, with counseling, for patients through age 18 consists of only two codes, 90460 and 90461, regardless of the route of administration. CPT® Assistant guidelines instruct coders to use 90460 for the first component of each vaccine that is administered with counseling for patients through age 18, and 90461 for each additional component. If administering more than one vaccine on the same day, 90460 may be billed with multiple units. The administration code(s) are billed together with another CPT® indicating the vaccine serum administered.




However, state VFC programs bend the coding rules to fit to the state reimbursement scheme. For example, the chart below compares the administration codes which would apply to non-VFC supplied vaccines and the unique VFC billing requirement for Illinois:

| Vaccine | Component Count | CPT Coding Instructions Administration | Vaccines for Children |
|---|---|---|---|
| HPV | 1 | 90460 | 90460 only |
| Influenza | 1 | 90460 | 90460 only |
| Meningococcal | 1 | 90460 | 90460 only |
| Pneumococcal | 1 | 90460 | 90460 only |
| Td | 2 | 90460 and 90461 | 90460 only |
| DTaP or Tdap | 3 | 90460 and 90461 x 2 | 90460 only |
| MMR 3 90460 | 3 | 90460 and 90461 x 2 | 90460 only |
| MMRV 4 90460 | 4 | 90460 and 90461 x 3 | 90460 only |
| DTaP-Hib-IPV (Pentacel) | 5 | 90460 and 90461 x 4 | 90460 only |
| DTaP-HepB-IPV (Pediarix) | 5 | 90460 and 90461 x 4 | 90460 only |

# Coding for Childhood Vaccine Administration

State by state, the VFC coding and billing rules vary and may differ completely from the CPT® instructions. Providers participating in the VFC program must carefully review the state VFC coding requirements and abide by the coding and billing requirements applicable for the state in which the VFC service is rendered.

For instance, California Medicaid (Medi-Cal) asks providers to bill vaccines supplied through VFC by reporting only the vaccine serum CPT® with the SL modifier, without a separate administration code. Non-VFC claims report both an administration code AND a serum code.

https://files.medi-cal.**ca**.gov/pubsdoco/publications/.../**vaccine**_m00o03o04o11.doc

vaccine
3

CPT-4 Codes Used To Bill VFC

The following CPT-4 codes are used to bill the administration fee for vaccines supplied free by the VFC program. All claims for VFC vaccines require modifier SL (used for VFC program recipients younger than 19 years of age).

| Bill this CPT-4 code when administering | This VFC vaccine |
|---|---|
| 90620 | Meningococcal Vaccine Serogroup B (Bexsero) |
| 90621 | Meningococcal Vaccine Serogroup B (Trumenba) |
| **90630** | **Influenza virus vaccine, quadrivalent, split virus, preservative free, for intradermal use** |
| 90633 | Hepatitis A Vaccine/Pediatric/Adolescent (Vaqta®, Havrix®) |
| 90644 | Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib- |

New York's managed Medicaid payor, United Healthcare, instructs providers to bill only 90460 for VFC administration.

https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/Bulletins/NY-Tips-New-Billing-Requirements-Vaccines-Children-Services.pdf

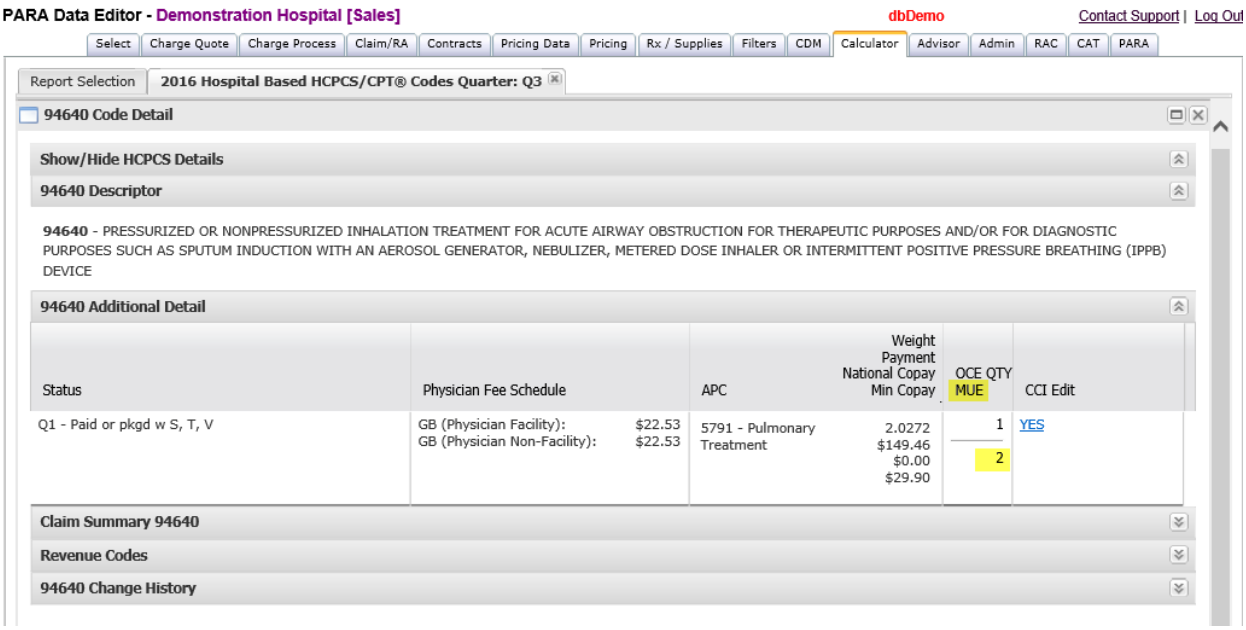
> "The Centers for Medicare & Medicaid Services (CMS) requires state Medicaid programs to reimburse for Vaccines for Children (VFC) services on administration codes 90460, 90471, 90472, 90473, and/or 90474 rather than the serum/toxoid code. Per the Patient Protection and Affordable Care Act (PPACA), CPT code 90461 is not reimbursable for VFC services. **While some states will reimburse for all of these administration codes, NY will only reimburse for 90460**."

For assistance with billing vaccine administration codes, contact your **PARA** account executive.

# Inhalation Treatment MUE Changes for 2016 (Revised)

Hospital billing staff have been struggling in 2016 with a change in the Medically Unlikely Edit (MUE) for a common inhalation treatment code, 94640 - PRESSURIZED OR NONPRESSURIZED INHALATION TREATMENT FOR ACUTE AIRWAY OBSTRUCTION FOR THERAPEUTIC PURPOSES AND/OR FOR DIAGNOSTIC PURPOSES SUCH AS SPUTUM INDUCTION WITH AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR INTERMITTENT POSITIVE PRESSURE BREATHING (IPPB) DEVICE.

The 2016 MUE limit for 94640 is 2; in 2015, it had been 10.




The MUE change follows guidance first published in the 2014 National Correct Coding Edit Manual. The manual states that regardless of the number of treatments in the same outpatient encounter, only one unit of 94640 should be billed. However, if inhalation treatments were performed at two separate encounters on the same date of service, the MUE allows a second unit of 94640.

The NCCI Manual also explains that HCPCS 94664 - DEMONSTRATION AND/OR EVALUATION OF PATIENT UTILIZATION OF AN AEROSOL GENERATOR, NEBULIZER, METERED DOSE INHALER OR IPPB DEVICE is considered “integral to” 94640, and should not be billed separately on the same date of service unless the demonstration used a different device, or if the demonstration/evaluation was performed at a different encounter on the same day. Incidentally, 94664 has an MUE of only 1.

Consequently, respiratory therapy charges for multiple inhalation treatments on the same date of service which were not problematic in 2015 have triggered MUE edits for hospital billing staff. The confusion is compounded by the fact that although the MUE exists for outpatients, including observation patients, there is no limitation on the number of inhalation treatment units or charges that may be billed for inpatients.

# Inhalation Treatment MUE Changes for 2016 (Revised)

Excerpts from the Medicare Claims Processing Manual and CHAPTER XI of The National Correct Coding Initiative Policy Manual for Medicare Services are provided in the following pages.

**PARA recommends** establishing two charges for outpatient inhalation treatments, as the subsequent treatment for outpatient billing will follow different rules than for inpatients:

- The **initial treatment** charge should be priced at the average total charges per account for outpatient inhalation services billed in 2015. For example, if each 94640 were charged in 2015 at $100, and the average number of units billed on outpatient claims in 2015 was 2.5, the value of the "initial" treatment charge in 2016 should be $250.00.
- The **subsequent treatment** charge should be set up at $0.00 cost; this will not appear on the claim. (Note: a second treatment occurring during a separate encounter on the same day may be billed with modifier XE (Separate Encounter, i.e. 94640-XE), however this circumstance is not common.)

In layman's terms, an encounter is a single outpatient visit to the hospital for the duration of the time the patient is in outpatient status. Separate visits by a respiratory therapist to the same patient during a single outpatient visit are not separate encounters. If the patient is discharged and returns on the same day, the second outpatient visit is considered a separate encounter.

Medicare's definition of an outpatient encounter is provided in the Medicare Claims Processing Manual, Chapter 2 - Admission and Registration Requirements.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c02.pdf

90.6 - Definition of Encounter

The term "encounter" means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient. Direct personal contact does not include telephone contacts between a patient and physician. Nor is the compensation arrangement between the physician and the hospital relevant to whether an encounter has occurred. Patients will be treated as hospital outpatients for purposes of billing for certain diagnostic services that are ordered during or as a result of an encounter that occurred while such patients are in an outpatient status at the hospital. If a Medicare outpatient is referred to another provider or supplier for further diagnostic testing or other diagnostic services as a result of an encounter that occurs in this hospital, the hospital is responsible for arranging with the other entity for the furnishing of services. Hospitals are not required to verify that all ordered services are furnished but only to assure that, when it is necessary to refer a patient to an outside entity, the referral is made to a provider or supplier with which the referring hospital an arrangement. This requirement is necessary to assure that billing for services that are furnished is processed through the servicing hospital.

When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing.

A link and an excerpt from the ***NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES*** are provided below:

CHAPTER XI - MEDICINE

EVALUATION AND MANAGEMENT SERVICES

CPT CODES 90000 – 99999

…

7. CPT code 94060 (bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration) describes a diagnostic test that is utilized to assess patient symptoms that might be related to reversible airway obstruction. It does not describe treatment of acute airway obstruction. CPT code 94060 includes the administration of a bronchodilator. It is a misuse of CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) to report 94640 for the administration of the bronchodilator included in CPT code 94060. The bronchodilator medication may be reported separately.

8. CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) describes either treatment of acute airway obstruction with inhaled medication or the use of an inhalation treatment to induce sputum for diagnostic purposes. CPT code 94640 should only be reported once during a single patient encounter regardless of the number of separate inhalation treatments that are administered. If CPT code 94640 is used for treatment of acute airway obstruction, spirometry measurements before and/or after the treatment(s) should not be reported separately. It is a misuse of CPT code 94060 to report it in addition to CPT code 94640. The inhaled medication may be reported separately.

9. CPT code 94640 (pressurized or non-pressurized inhalation treatment for acute airway obstruction...) and CPT code 94664 (demonstration and/or evaluation of patient utilization of an aerosol generator...) generally should not be reported for the same patient encounter. The demonstration and/or evaluation described by CPT code 94664 is included in CPT code 94640 if it utilizes the same device (e.g., aerosol generator) that is used in the performance of CPT code 94640. If performed at separate patient encounters on the same date of service, the two services may be reported separately.

# ICD-10 Code Updates for 2017

With the exception of limited updates due to new technologies and diseases, there has not been an annual ICD-10 code update in four years. This is due to the code freeze in preparation of the October 1, 2015 implementation date. The code freeze has been lifted. The Centers for Medicare and Medicaid (CMS) has announced more than 7,000 changes have been finalized for the ICD-10CM/PCS code set for fiscal year 2017.

The updates to the ICD-10 CM code set will include:

- 1,974 new codes
- 425 revised codes
- 311 deleted codes

The updates to the ICD-10 PCS code set includes

- a total of 3,757 changes in the Medical and Surgical section, which accounts for the majority of the PCS changes
- 39 changes to the Administration section
- 4 new codes in the Extracorporeal Therapies section
- 27 new codes in the New Technology section

Root Operations will be impacted by the 2017 Update as well. The Definition of Control and Creation has expanded.

| **Root Operation: Control** | |
|---|---|
| Original Definition | Stopping, or attempting to stop, postprocedural bleeding |
| Revised Definition | Stopping, or attempting to stop, postprocedural bleeding **or other acute bleeding** |

| **Root Operation: Creation** | |
|---|---|
| Original Definition | Making a new genital structure that does not take over the function of a body part |
| Revised Definition | Putting in or on biological or synthetic material to form a new body part that to the extent possible replicates the anatomic structure or function of an absent body part |

Perfusion has been added as a new root operation to the Extracorporeal Therapies section. Perfusion is defined as extracorporeal treatment by diffusion of therapeutic fluid.

The body part terminology in the Heart and Great Vessels Body System has been extended. The coronary arteries will be identified by the number of arteries treated rather than by site.

Finally, the 2017 ICD-10-PCS Official Coding and Reporting Guidelines have been revised in Section B2.1a, B3.2, B3.4a, B3.6b, B3.6c, B3.7, B3.9, B4.2, and B4.4. The revisions include:

- Guideline B2: The revision provides an alternative when clinical documentation is not present and the coder may use the general anatomic region as an unspecified code. The expectation is that this option will be rarely used.

- Guideline B3.2 (Multiple procedures): The revision includes altered examples to provide clarity when reporting multiple procedures.

- Guideline B3.4a, B3.6b and B3.6c: The revision includes adjusted verbiage to match the changes from coronary sites to coronary arteries in the Tables.

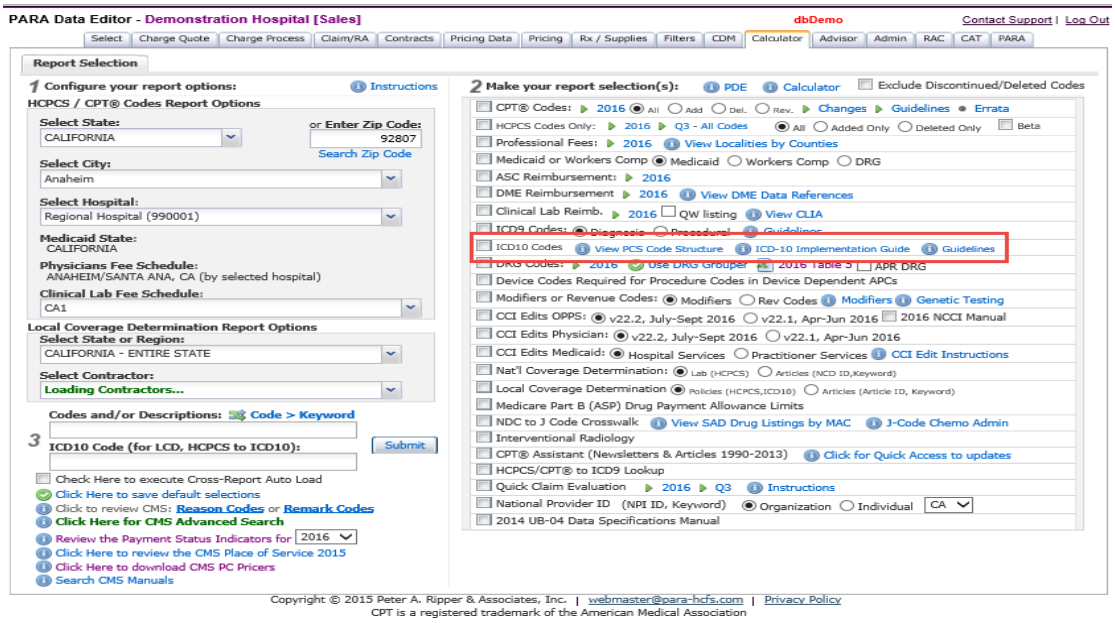
- Guideline B3.7: The addition of "other acute bleeding" was provided to reflect the change in the definition of root operation Control.

- Guideline B3.9: The revision addresses the excision of an autograft. This guideline change provides more specificity to other body part value. Additionally, the guideline includes "different procedure site" rather than other body part value.

- Guideline B4.2: Additional guidance regarding cardiovascular structures that could have branches is provided. Additional guidance regarding how to assign a code when the specific artery or vein is not available in the correct table, but a general body part is available was also added.

- Guideline B4.4: The revision addresses coronary arteries as a body part value.

  Please refer to the **PARA Data Editor** Calculator for the Official Coding Guidelines and full code descriptions.



# Identify Opportunity In Your Purchase Item Master

### When was your last pricing review?

Ask yourself these questions:

- Are you capturing earned reimbursement?
- Are your rates competitive for your market?
- Are your current prices defensible?

The goal of PARA's Market Based Pricing Program is to identify line items in the charge master which have negative patient satisfaction due to high prices, identify gross margin improvement opportunities due to low prices and to establish a rational pricing methodology by setting prices based on fee schedule, APC, cost or competitive market pricing data

### 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.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PARA Healthcare Financial Services

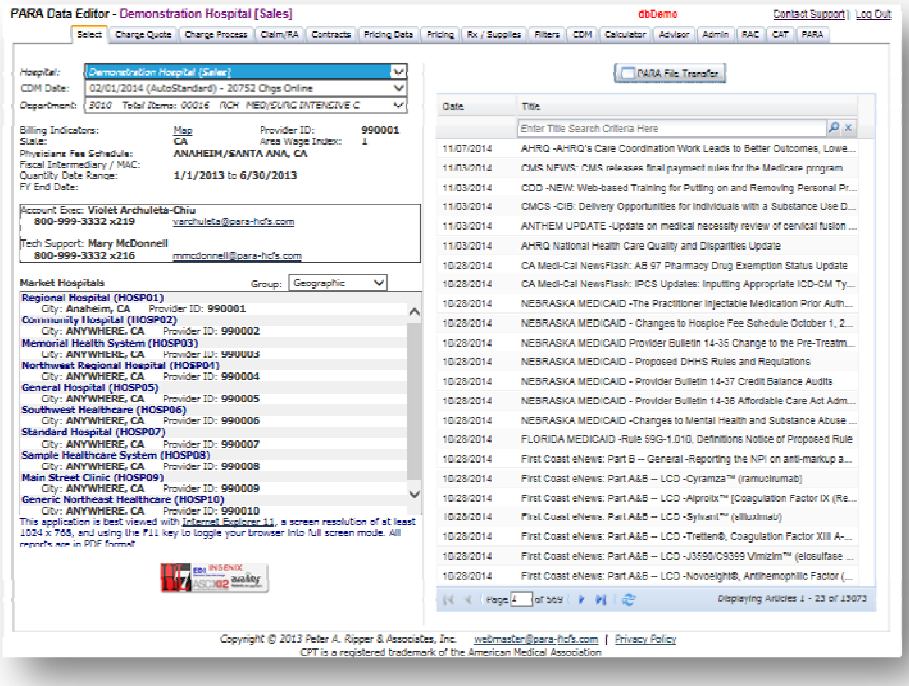
Hospitals are always looking to maximize revenue and efficiency while minimizing cost. It is important to know what you are buying, how much you are paying for it and what you are charging/collecting for those services and making sure they match up strategically.

Traditionally the materials manager's focus on cost reduction. Today, materials management works with the revenue cycle teams and is an integral part of combating decreased reimbursement and making sure all opportunities for revenue are being captured.

Many hospital systems still do not have a way to link their Purchase Item Master to their Charge Master. Linking the supply and revenue sides of an organization together is critical to the hospital's financial and operational success. Many billable items may be on your Purchase Item Master that are not established in the Charge Master. These items can generate potential revenue, if set up correctly in the Charge Master.

**PARA's Purchase Item Master (PIM)** program is a key step to ensuring revenue integrity. The program is designed to:

- Determine which items are billable
- Map billable items to the charge master
- Code billable items assigned to the charge master
- Re-price items based on a mark-up schedule




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

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