PARA Weekly Update – December 16, 2016

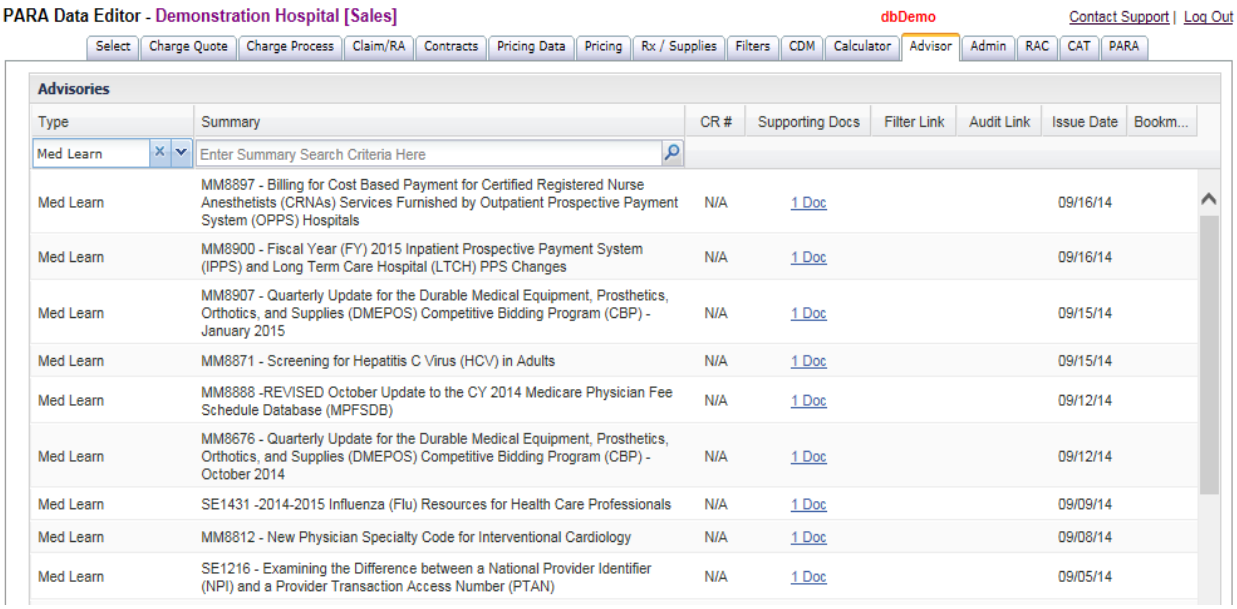
The following Departments are impacted by the contents of this week's update:

- **Patient Financial Services – see pages 1-39**
- **Hospital Administration - see pages 11, 39**
- **PDE Users – see pages 15, 16-18, 19, 20, 21, 22, 30**
- **HIM/Coding Staff – see pages 31-32, 33-34, 35, 36, 37-38**
- **Home Health Providers – see page 2**
- **End Stage Renal Disease (ESRD) Service Providers – see pages 5, 14**
- **Physicians/Professional Fee Billers – see pages 7, 8, 12**
- **Telehealth Providers – see pages 7, 12**
- **Radiology Departments – see pages 7, 12, 35, 37-38**
- **Critical Access Hospitals (CAHs) – see page 11**
- **Supply Departments/DME Providers – see page 13**
- **Wound Care Departments – see page 36**
- **OB/GYN – see pages 31-32, 37-38**
- **All Providers – see pages 23-25, 26-27, 28-29**

Med Learns:

There were eight new or revised Med Learn articles released this week. None of the articles contained 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:



Links to the Med Learns appear on the following pages.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1635.pdf

MLN Matters® Number: SE1635	**Related Change Request (CR) #: N/A**
Article Release Date: December 16, 2016	**Effective Date: Episodes beginning on or after August 1, 2015**
Related CR Transmittal #: N/A	**Implementation Date: N/A**

Continuation of the Home Health Probe and Educate Medical Review Strategy

Provider Types Affected

This Special Edition MLN Matters® article is intended for Home Health Agencies (HHAs) submitting claims to Medicare Administrative Contractors (MACs) for home health services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

MACs, in conjunction with the Centers for Medicare & Medicaid Services (CMS), will be conducting Round 2 of medical review and reporting under the Home Health Probe & Educate medical review strategy. These reviews relate to claims submitted by HHAs related to Medicare home health services and patient eligibility (certification/re-certification), as outlined in CMS-1611-F.

CAUTION – What You Need to Know

Final rule CMS-1611-F eliminates the face-to-face encounter narrative as part of the certification of patient eligibility for home health services.

GO – What You Need to Do

Make sure that your billing staffs are aware of these revised policies.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9776.pdf

MLN Matters® Number: MM9776	**Related Change Request (CR) #: CR 9776**
Related CR Release Date: December 9, 2016	**Effective Date: January 9, 2017**
Related CR Transmittal #: R689PI	**Implementation Date: January 9, 2017**

Clarification of Certification Statement Signature and Contact Person Requirements

Provider Types Affected

This MLN Matters® Article is intended for physicians, non-physician practitioners, other providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

Change Request (CR) 9776 clarifies the certification statement signature requirements for the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) and paper Medicare enrollment applications, and addresses contact person requirements.

CR9776 does not involve any legislative or regulatory policies. Make sure that you are familiar with these requirements.

Background

CR9776 informs the MACs that the Centers for Medicare & Medicaid Services (CMS) is updating Chapter 15 of the "Medicare Program Integrity Manual" in order to clarify the certification statement signature requirements for online and paper Medicare enrollment submissions, and to address contact person requirements. The main points of the updates are summarized below; and you can find the details in the manual's updated Chapter 15 (Medicare Enrollment), which is an attachment to CR9776.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9892.pdf

MLN Matters® Number: MM9892	**Related Change Request (CR) #: CR 9892**
Related CR Release Date: December 9, 2016	**Effective Date: January 1, 2017**
Related CR Transmittal #: R3674CP	**Implementation Date: January 3, 2017**

January 2017 Integrated Outpatient Code Editor (I/OCE) Specifications Version 18.0

Provider Types Affected

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

What You Need to Know

Change Request (CR) 9892 provides instructions and specifications for the Integrated Outpatient Code Editor (I/OCE) used for Outpatient Prospective Payment System (OPPS) and non-OPPS claims. This is 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 (PPS) 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 I/OCE Changes for January 2017

The following table summarizes the modifications of the IOCE for the January 2017 v18.0 release. Note that some I/OCE modifications in the update may be retroactively added to prior releases. If so, the retroactive date appears in the 'Effective Date' column.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9598.pdf

MLN Matters® Number: MM9598	**Related Change Request (CR) #: CR 9598**
Related CR Release Date: December 6, 2016	**Effective Date: January 1, 2017**
Related CR Transmittal #: R1759OTN	**Implementation Date: January 3, 2017**

Changes to the End-Stage Renal Disease (ESRD) Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with Acute Kidney Injury (AKI)

Provider Types Affected

This MLN Matters® Article is intended for End Stage Renal Disease (ESRD) Facilities that submit claims to Medicare Administrative Contractors (MACs) for renal dialysis services provided to Medicare beneficiaries.

What You Need to Know

Change Request (CR) 9598 implements changes to the ESRD Facility claim (Type of Bill 72x) to accommodate dialysis furnished to beneficiaries with Acute Kidney Injury (AKI). This MLN Matters Special Edition Article summarizes these changes. Make sure that your billing staffs are aware of these changes.

Background

On June 29, 2015, The Trade Preferences Extension Act of 2015 was enacted in which Section 808 amended Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) by extending renal dialysis services paid under Section 1881(b)(14) to beneficiaries with AKI effective January 1, 2017.

Beginning January 1, 2017, ESRD facilities will be able to furnish dialysis to AKI patients. The AKI provision was signed into law on June 29, 2015. (See **Sec. 808 Public Law 114-27**.)

The provision provides Medicare payment beginning on dates of service January 1, 2017, and after to ESRD facilities, that is, hospital-based and freestanding, for renal dialysis services furnished to beneficiaries with AKI (both adult and pediatric). Medicare will pay ESRD facilities for the dialysis treatment using the ESRD Prospective Payment System (PPS) base rate adjusted by the applicable geographic adjustment factor, that is, wage index. In addition to the dialysis treatment, the ESRD PPS base rate pays ESRD facilities for the items and services considered to be renal dialysis services as defined in **42 CFR 413.171** and there will be no separate payment for those services.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1631.pdf

MLN Matters® Number: SE1631 Revised	**Related Change Request (CR) #: N/A**
Article Release Date: December 13, 2016	**Effective Date: N/A**
Related CR Transmittal #: N/A	**Implementation Date: N/A**

Sample Hospice Election Statement

Note: This article was revised on December 13, 2016, to clarify that the subject is the Hospice Election Statement and not the notice of election.

Provider Types Affected

This MLN Matters® Special Edition Article is intended for physicians and hospices submitting claims to Home Health & Hospice Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

What You Need to Know

In a September 2016 report (OEI-02-10-00492), the Office of the Inspector General (OIG) noted that hospice election statements lacked required information or had other vulnerabilities in more than one-third of general inpatient care stays. Notably, the statements did not always mention, as required, that the beneficiary was waiving coverage of certain Medicare services by electing hospice care or that hospice care is palliative rather than curative. The OIG report, entitled "Hospices Should Improve Their Election Statements and Certifications of Terminal Illness," also noted deficiencies in certifications of terminal illness required of physicians for hospice patients. In MLN Matters Special Edition Article, SE1628, the Centers for Medicare & Medicaid Services (CMS) details the requirements for and provides further guidance to hospices on certification/recertification of terminal illness. Model Medicare Hospice Election Statement language is included at the end of this article.

Background

As discussed in the "Medicare Benefit Policy Manual," Chapter 9, Section 10, hospice care is a benefit under the hospital insurance program. To be eligible to elect hospice care under Medicare, an individual must be entitled to Part A of Medicare and be certified as being terminally ill. An individual is considered to be terminally ill if the medical prognosis is that the individual's life expectancy is 6 months or less if the illness runs its normal course. Only care provided by (or under arrangements made by) a Medicare certified hospice is covered under the Medicare hospice benefit.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9844.pdf

MLN Matters® Number: MM9844	**Related Change Request (CR) #: CR 9844**
Related CR Release Date: December 16, 2016	**Effective Date: January 1, 2017**
Related CR Transmittal #: R3676CP	**Implementation Date: January 3, 2017**

Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9844 provides a summary of policies in the Calendar Year (CY) 2017 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. Make sure that your billing staffs are aware of these updates.

Background

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary of Health and Human Services to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 2, 2016, that updates payment policies and Medicare payment rates for services furnished by physicians and Non-Physician Practitioners (NPPs) that are paid under the MPFS in CY 2017.

The final rule (CMS-1654-F) also addresses public comments on Medicare payment policies proposed earlier in 2016. The proposed rule, "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017," was published in the Federal Register on July 15, 2016.

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9905.pdf

MLN Matters® Number: MM9905	**Related Change Request (CR) #: CR 9905**
Related CR Release Date: December 16, 2016	**Effective Date: January 1, 2017**
Related CR Transmittal #: R3678CP	**Implementation Date: January 3, 2017**

Prolonged Services Without Direct Face-to-Face Patient Contact Separately Payable Under the Physician Fee Schedule (Manual Update)

Provider Types Affected

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

Provider Action Needed

Change Request (CR) 9905 provides that the Centers for Medicare & Medicaid Services (CMS) revises Chapter 12, Section 30.6.15.2 of the "Medicare Claims Processing Manual" to indicate that beginning Calendar Year (CY) 2017, Current Procedural Terminology (CPT) codes 99358 and 99359 (prolonged services without face-to-face contact) are separately payable under the Medicare Physician Fee Schedule. Make sure your billing staffs are aware of these CPT code changes.

Background

Prior to CY 2017, CPT codes 99358 and 99359 (prolonged services without face-to-face contact) were not separately payable, and were included for payment under the related face-to-face Evaluation and Management (E/M) service code. Practitioners were not permitted to bill the patient for services described by these codes, since they are Medicare covered services and payment was included in the payment for other billable services.

The CPT prefatory language and reporting rules apply for the Medicare billing of these codes, for example, CPT codes 99358 and 99359:

- Cannot be reported during the same service period as complex Chronic Care Management (CCM) services or transitional care management services
- Are not reported for time spent in non-face-to-face care described by more specific codes having no upper time limit in the CPT code set

Med Learns (continued):

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9568.pdf

MLN Matters® Number: MM9568 Revised	**Related Change Request (CR) #: CR 9568**
Related CR Release Date: December 16, 2016	**Effective Date: January 1, 2017**
Related CR Transmittal #: R1763OTN	**Implementation Date: January 3, 2017**

Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits

Note: This article was revised on December 16, 2016, due to a revised CR9568 issued on that date. As a result, the transmittal number, CR release date, and link to the CR are revised in this article. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for Hospitals and Skilled Nursing Facilities (SNFs) working with Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (SSP) and submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 9568 allows the processing of SNF claims without having to meet the 3-day hospital stay requirement for certain designated SNFs that have a relationship with an ACO participating in the SSP. Make sure that your SNF is clear on whether or not it is eligible to participate in this initiative and that your billing staffs are aware of these changes.

Background

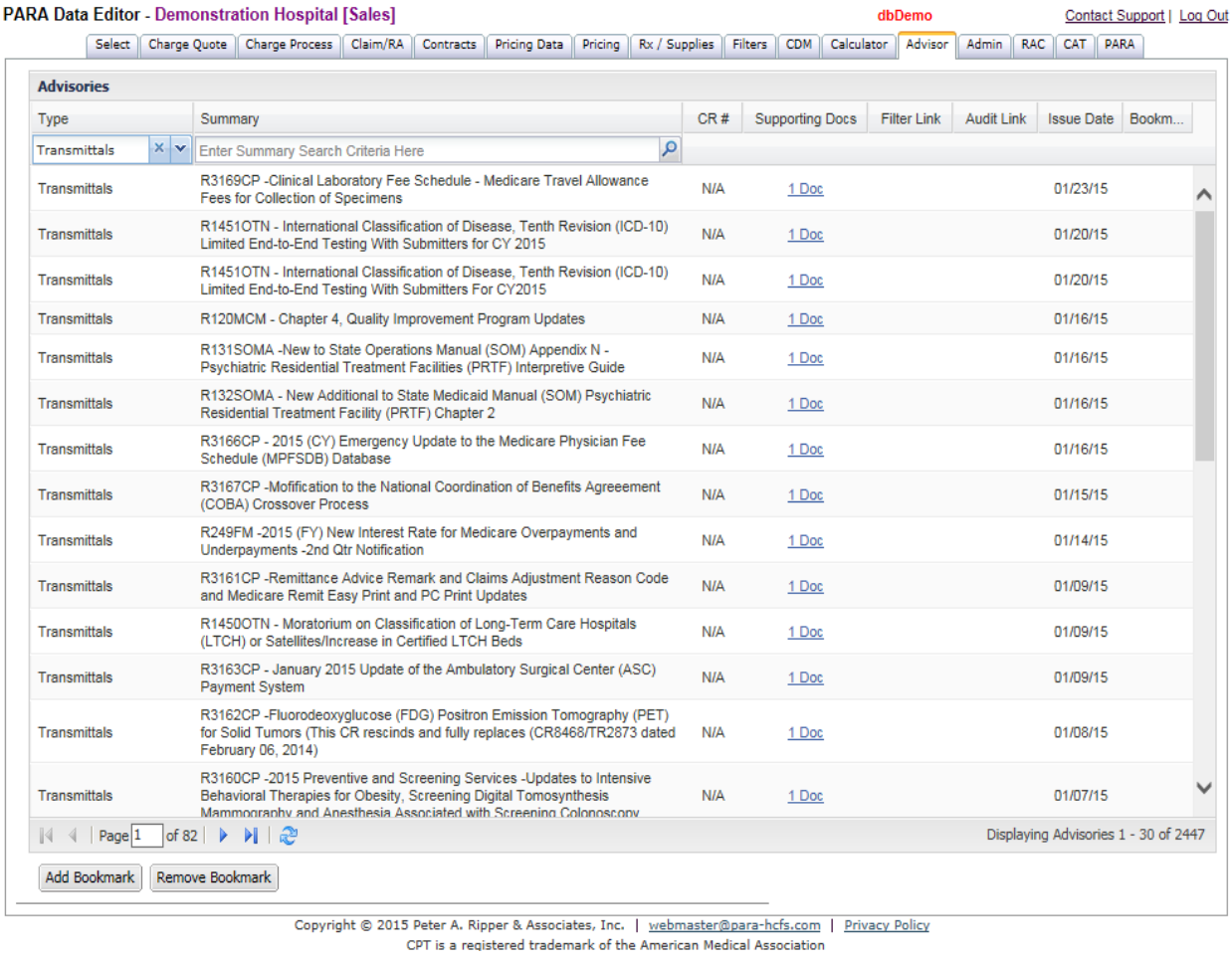
The Medicare SNF benefit is for beneficiaries who require a short-term intensive stay in a SNF, requiring skilled nursing and/or rehabilitation care. Pursuant to Section 1861(i) of the Social Security Act (the Act), beneficiaries must have a prior inpatient hospital stay of no fewer than 3 consecutive days in order to be eligible for Medicare coverage of inpatient SNF care. This has become known as the SNF 3-day rule.

The Centers for Medicare & Medicaid Services (CMS) understands that, in certain circumstances, it could be medically appropriate for some patients to receive skilled nursing care and/or rehabilitation services provided in a SNF without prior hospitalization or with an inpatient hospital length of stay of less than 3 days.

Transmittals:

There were ten new or revised Transmittals released by CMS this week. None of the articles 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/R279FM.pdf

SUBJECT: Instructions to Hospitals on the Election of a Medicare-Supplemental Security Income (SSI) Component of the Disproportionate Share (DSH) Payment Adjustment for Cost Reports that Involve SSI Ratios for Fiscal Year (FY) 2004 and Earlier, or SSI Ratios for Hospital Cost-Reporting Periods for Patient Discharges Occurring Before October 1, 2004

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to direct the contractors to inform hospitals of the requirements for making an election for a particular fiscal period covered by the Centers for Medicare & Medicaid Services' (CMS) Ruling 1498-R (as modified by CMS Ruling 1498-R2).

EFFECTIVE DATE: January 19, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 19, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R691PI.pdf

SUBJECT: Contacting Non-Responders and Documentation Requests

I. SUMMARY OF CHANGES: The purpose of this change request (CR) is to update Chapter 12 of Pub. 100-08 which instructs the Medicare Administrative Contractor (MAC) on how to proceed in response to the display of Error Code 99 on the Comprehensive Error Rate Testing (CERT) Claims Status Website (CSW).

EFFECTIVE DATE: January 19, 2017
**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 19, 2017*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R165SOMA.pdf

SUBJECT: Revisions to State Operations Manual (SOM) Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

I. SUMMARY OF CHANGES: Revisions were made to the regulation language for CAH providers of emergency services in 2004 and 2006 but SOM Appendix W was not revised. This technical corrections at tag C-0207, standards §485.618(d)(1) through §485.618(d)(4) are being revised to reflect the current regulations. In addition language has been added to the survey procedures under this tag.

NEW/REVISED MATERIAL - EFFECTIVE DATE: December 16, 2016
IMPLEMENTATION DATE: December 16, 2016

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R473P122.pdf

Medicare

Provider Reimbursement Manual - Part 1, Chapter 22, Determination of Cost of Services to Beneficiaries

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 473 **Date: December 16, 2016**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
2231 – 2231 (Cont.)	22-71 – 22-72 (2 pp.)	22-71 – 22-72 (2 pp.)

CLARIFIED/UPDATED MATERIAL--*EFFECTIVE DATE:* N/A

Section 2231, Regional Medicare Swing-Bed SNF Rates, adds a crosswalk to clarify the numbering of regions referenced in this chapter with the numbering of divisions identified by the Bureau of the Census. The names of each division and the states that are included in each division are provided for further clarification.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3678CP.pdf

SUBJECT: Prolonged Services Without Direct Face-to-Face Patient Contact Separately Payable Under the Physician Fee Schedule (Manual Update)

I. SUMMARY OF CHANGES: Beginning in CY 2017, CPT codes 99358 and 99359 are separately payable under the Medicare Physician Fee Schedule.

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/R3676CP.pdf

SUBJECT: Summary of Policies in the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, and CT Modifier Reduction List

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of policies in the CY 2017 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached Recurring Update Notification applies to Publication 100-04, Chapter 12, Section 190.5.

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

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1763OTN.pdf

Transmittal 1683, dated July 21, 2016, is being rescinded and replaced by Transmittal 1763, dated December 16, 2016, to update business requirement 9568. 1.5.2.3 to specify the TIN should not be blank. The requirement originally indicated the TIN should be blank. All other information remains the same.

SUBJECT: Shared Savings Program (SSP) Accountable Care Organization (ACO) Qualifying Stay Edits

I. SUMMARY OF CHANGES: This CR is to allow the processing of Skilled Nursing Facility (SNF) claims without having to meet the 3-day hospital stay requirement for a select number of facilities that have a relationship with a Shared Savings Program (SSP) ACO.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 3, 2016 - Split over October 2016 and January 2017. Full implementation is in January 2017.; January 3, 2017 - Split over October 2016 and January 2017. Full implementation is in January 2017.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3679CP.pdf

Transmittal 3649, dated November 10, 2016, is being rescinded and replaced by Transmittal 3679, dated, December 16, 2016 to update the manual attachment. All other information remains the same.

SUBJECT: Payment for Oxygen Volume Adjustments and Portable Oxygen Equipment

I. SUMMARY OF CHANGES: This change request (CR) reminds contractors of instructions located at section 130.6 of chapter 20 of the Medicare Claims Processing Manual (Pub.100-04). The instructions in this section were originally furnished in June 1989, via transmittal 1310, and provide the following instructions for Medicare contractors involved in processing claims for oxygen and oxygen equipment under the Medicare Part B benefit for durable medical equipment.

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

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R278FM.pdf

SUBJECT: Medicare Financial Management Manual, Chapter 7, Internal Control Requirements

I. SUMMARY OF CHANGES: This document updates and provides clarification for the Office of Management and Budget (OMB) A-123 and Internal Controls over Financial Reporting.

EFFECTIVE DATE: October 1, 2016
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 19, 2017

Transmittals (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R231BP.pdf

Transmittal 229, dated November 4, 2016, is being rescinded and replaced by Transmittal 231, dated December 15, 2016, to revise business requirement 9807.9, delete requirement 9807.11.2 and add requirement 9807.13. The Provider Education requirement number is now 9807.14. All other information remains the same.

SUBJECT: Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2017

I. SUMMARY OF CHANGES: This Change Request implements the CY 2017 rate updates for the ESRD PPS and implements the payment for renal dialysis services furnished to beneficiaries with AKI in ESRD facilities. This recurring update notification applies to Pub. 100-02, Medicare Benefit Policy Manual, chapter 11, section 50.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 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
12/20/2016	CMS BLOG: December 2016 preview: Increased transparency and quality information
12/20/2016	CMS Home Health QRP: OASIS-C2 Approved by OMB
12/20/2016	CMS NEWS: Third Biweekly Enrollment Snapshot
12/20/2016	CMS Prepare for 2016 Attestation by Reviewing CMS Materials
12/20/2016	CMS announces additional opportunities for clinicians under the Quality Payment Program
12/20/2016	CMS Medicare-Medicaid ACO Model joins growing number of state-based efforts to improve quality
12/20/2016	CMS 2017 Electronic Clinical Quality Measure (eCQM) Logic Flows for Eligible Clinicians
12/20/2016	CMS Hospice Care – National Average Quality Data Released
12/20/2016	CMS Announces Update on Electronic Clinical Quality Measure (eCQM) Value Sets for 2017
12/20/2016	CMS Finalizes Rules for the Health Insurance Marketplace, Improving Stability
12/20/2016	CMS Hospice QRP: Quality Measure Reports Now Available
12/20/2016	Center for Medicaid and CHIP Services (CMCS) -MBES VIII Group Enrollment and Expenditure Data
12/20/2016	CAHABA GBA: 2017 Medicare Physician Fee Schedules and Open Enrollment
12/20/2016	AHRQ -Strategies to Improve Mental Health Care for Children and Adolescents.
12/19/2016	Anthem Blue Cross Provider Communications -Network Update December 2016
12/19/2016	AHRQ National Scorecard: Hospital-acquired conditions drop 21 percent over a five year period
12/19/2016	AHRQ News Now: AHRQ National Scorecard, new grantee profile, patient safety learning labs
12/19/2016	AHRQ What's New | December 14, 2016
12/19/2016	AHRQ What's New: Opioids' Burden on Hospital Care: A State-by-State Comparison.
12/13/2016	PARA Weekly Update 12/9/2016

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)

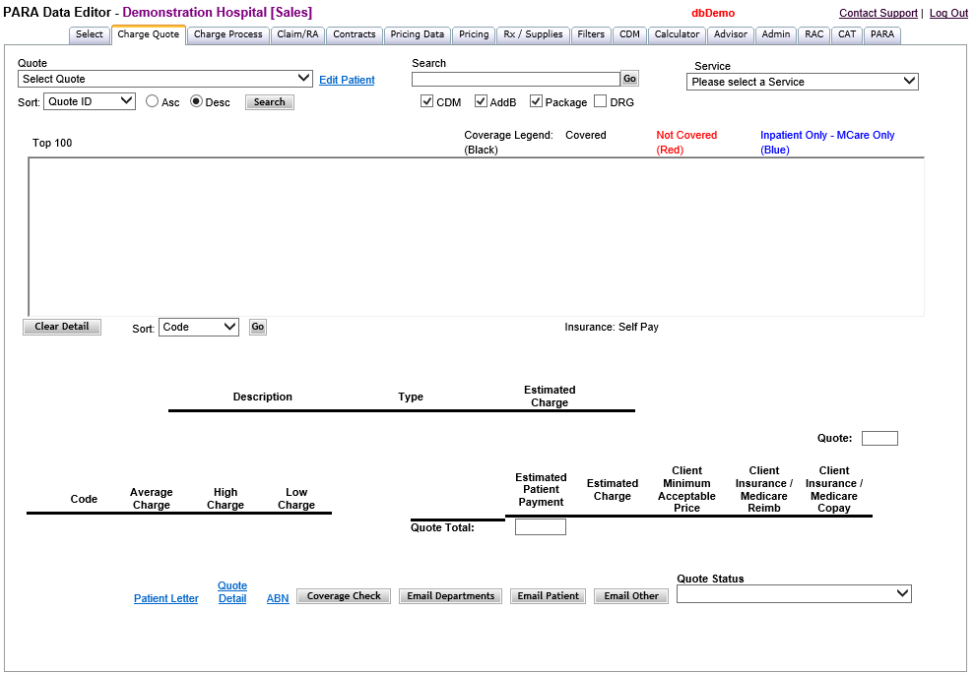
Item Name	Update Frequency
KS Medicaid	Annually
KY Medicaid	Annually
LA Medicaid	Annually
LCD - LMRP	Weekly
ME Medicaid	Annually
Medicaid NCCI Edits	Quarterly
Medically Unlikely Edits	Quarterly
Medicare Preventative Services Quick Reference Chart	Annually
MEDPAR Limited Data Set	Annually
MI Medicaid	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

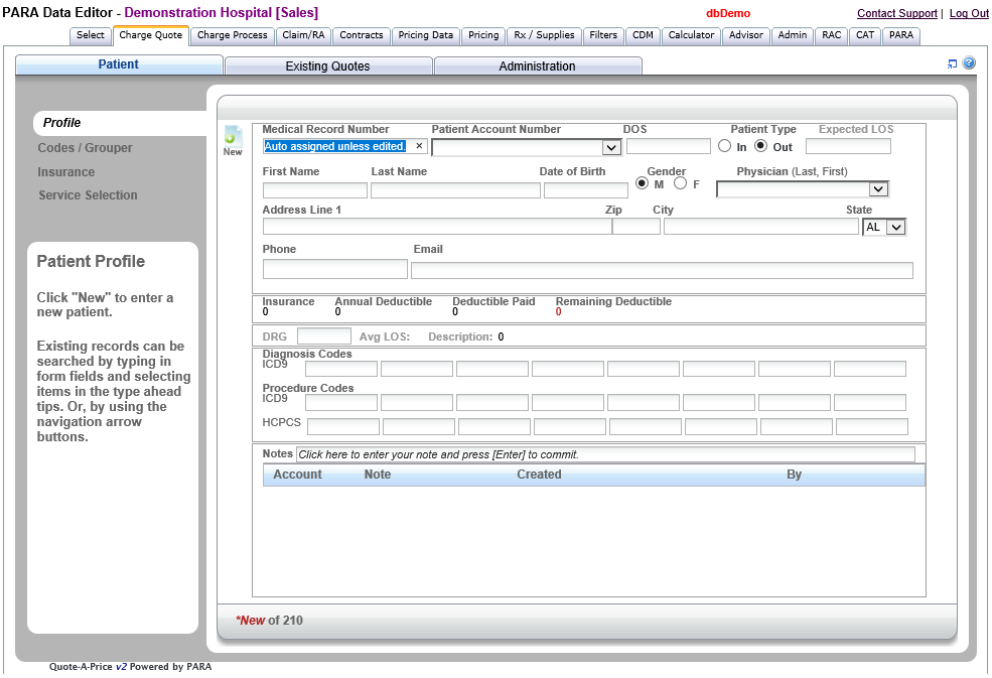
PARA Data Editor (PDE) Data Table Updates (continued)

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

PDE Update – Charge Quote – Discontinuation of older versions

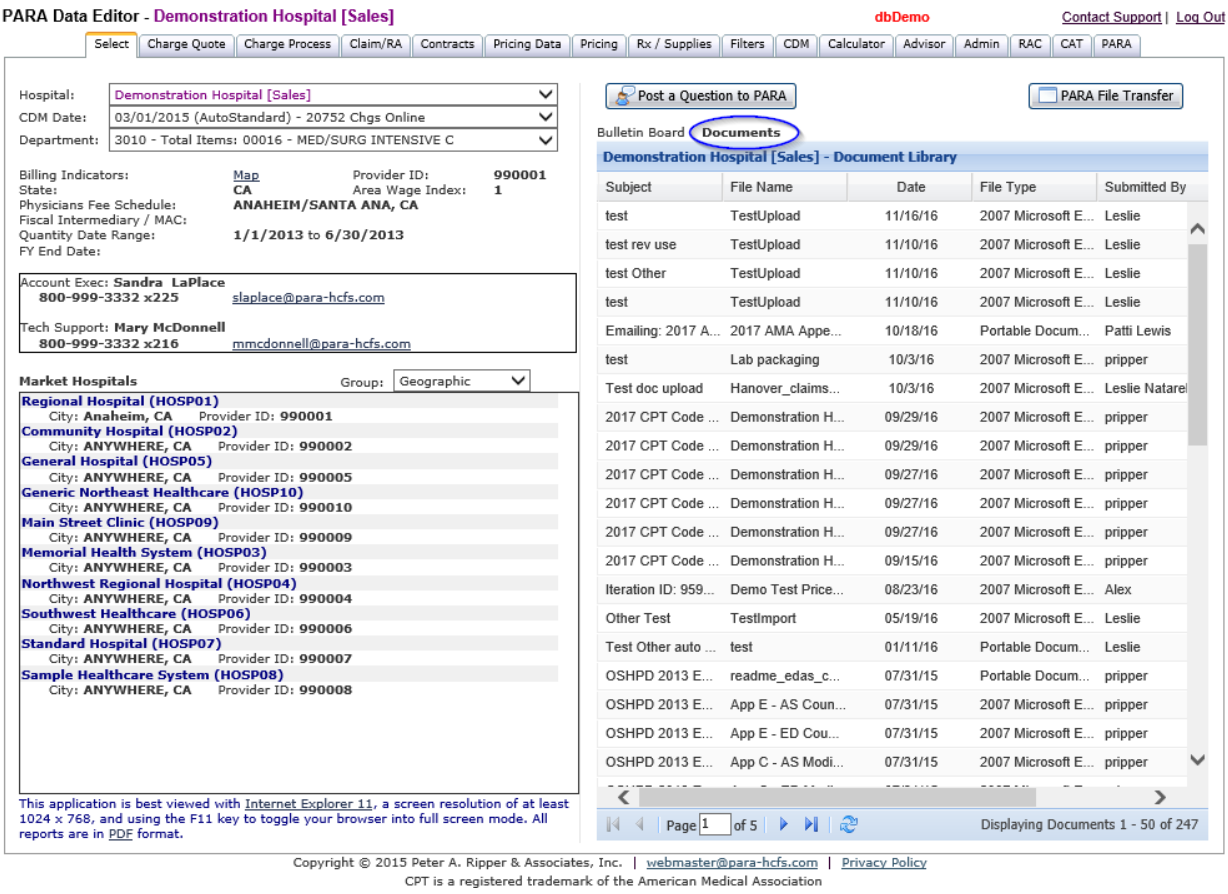
As of December 31st 2016, versions 1 and 2 of the Charge Quote Module will be shut down permanently, with only the current version remaining active. Any Users still accessing the previous versions should contact **PARA** for training on the current version prior to the end of the year.





PDE Update – Select Tab – Access to Documents

Access to client-specific Documents stored within the **PDE** has been added to the Select tab. Previously, it was necessary for Users to go to the "Admin – Docs" sub-tab in order to view or open these documents. A link has been placed just above the Bulletin Board, allowing Users to display the available Documents:

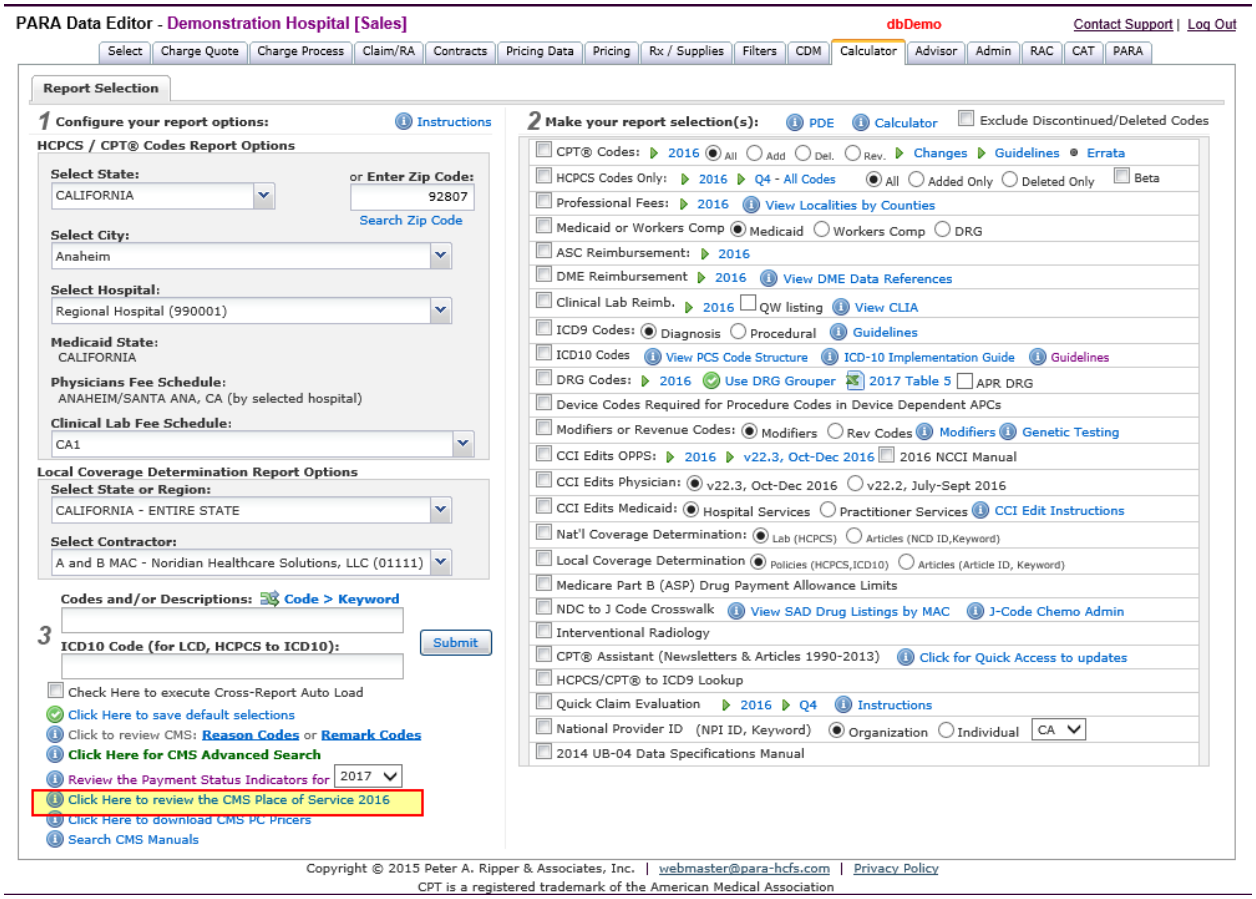


All attachments that are sent to clients, and those received by **PARA**, are available within either access point.

Only those Users who are set up with access to the "Admin – Docs" sub-tab will be able to download the items displayed-if you do not currently have access, please contact your **PARA** Account Executive.

PDE Update – Calculator tab – CMS Place of Service Reference

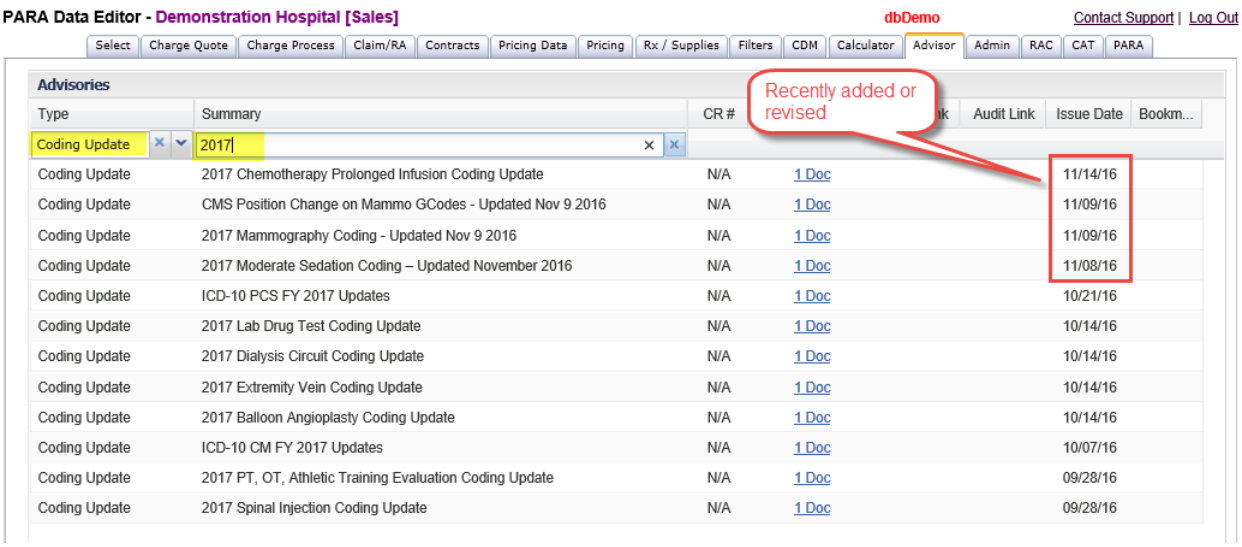
The CMS Place of Service reference file available within the Calculator has been updated with the file released in November 2016:



PARA 2017 Coding Update Documents

PARA has prepared a number of documents to assist our clients in reviewing CPT® coding updates for 2017. The topics are organized around the most common hard-coded charge master line items. Both deleted and new codes are displayed in an easy-to-read format.

PARA Data Editor users may access the 2017 Coding Update documents on the Advisor tab of the **PDE**; enter "2017" in the summary field as displayed in the screenshot below:



Users are encouraged to note the "Issue Date" to stay abreast of updates, enhancements, and revisions.

January 2017 CMS Updates

Below is a list of the Transmittals released by CMS for implementation January 1, 2017:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3668CP.pdf
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3646CP.pdf
Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 23.0, Effective January 1, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3640CP.pdf
January 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R189NCD.pdf
Screening for Cervical Cancer With Human Papillomavirus (HPV) Testing—National Coverage Determination (NCD)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3460CP.pdf
Screening for Cervical Cancer With Human Papillomavirus (HPV) Testing—National Coverage Determination (NCD)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3538CP.pdf
JW Modifier: Drug amount discarded/not administered to any patient

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3547CP.pdf
New Physician Specialty Code for Dentist

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R269FM.pdf
New Physician Specialty Code for Dentist

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3577CP.pdf
New Condition Code To Use When Hospice Recertification Is Untimely and Corrections to Hospice Processing Problems

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3578CP.pdf
Multiple Procedure Payment Reduction (MPPR) on the Professional Component (PC) of Certain Diagnostic Imaging Procedures

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3583CP.pdf
Payment Reduction for X-Rays Taken Using Film

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3586CP.pdf
New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3603CP.pdf
2017 Annual Update of Healthcare Common Procedure Coding System (HCPCS) Codes for Skilled Nursing Facility (SNF) Consolidated Billing (CB) Update

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3607CP.pdf
Annual Clotting Factor Furnishing Fee Update 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3610CP.pdf
2017 Annual Update for the Health Professional Shortage Area (HPSA) Bonus Payments

January 2017 Updates (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3618CP.pdf
Annual Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1725OTN.pdf
Changes to the End-Stage Renal Disease (ESRD) Facility Claim (Type of Bill 72X) to Accommodate Dialysis Furnished to Beneficiaries with Acute Kidney Injury (AKI)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3627CP.pdf
Announcement of Payment Rate Increases for Rural Health Clinics (RHCs) for Calendar Year (CY) 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3624CP.pdf
Home Health Prospective Payment System (HH PPS) Rate Update for Calendar Year (CY) 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R159DEMO.pdf
IVIG Demonstration: Payment Update for 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3640CP.pdf
January 2017 Quarterly Average Sales Price (ASP) Medicare Part B Drug Pricing Files and Revisions to Prior Quarterly Pricing Files

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3638CP.pdf
Update to the Federally Qualified Health Centers (FQHC) Prospective Payment System (PPS) - Recurring File Updates

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R229BP.pdf
Implementation of Changes in the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Payment for Dialysis Furnished for Acute Kidney Injury (AKI) in ESRD Facilities for Calendar Year (CY) 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3646CP.pdf
Quarterly Update to the Correct Coding Initiative (CCI) Edits, Version 23.0, Effective January 1, 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3644CP.pdf
Therapy Cap Values for Calendar Year (CY) 2017

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf
2017 Annual Update to the Therapy Code List

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3655CP.pdf
Implementation of Policy Changes for the CY 2017 Home Health Prospective Payment System

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1753OTN.pdf
Coding Revisions to National Coverage Determination (NCDs)

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3666CP.pdf
New Waived Tests

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3668CP.pdf
Quarterly Update for the Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) - January 2017

January 2017 Updates (continued):

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3571CP.pdf
New Revenue Code 0815 for Allogeneic Stem Cell Acquisition Services

ICD-10 CM FY 2017 Updates Effective 10-1-2016

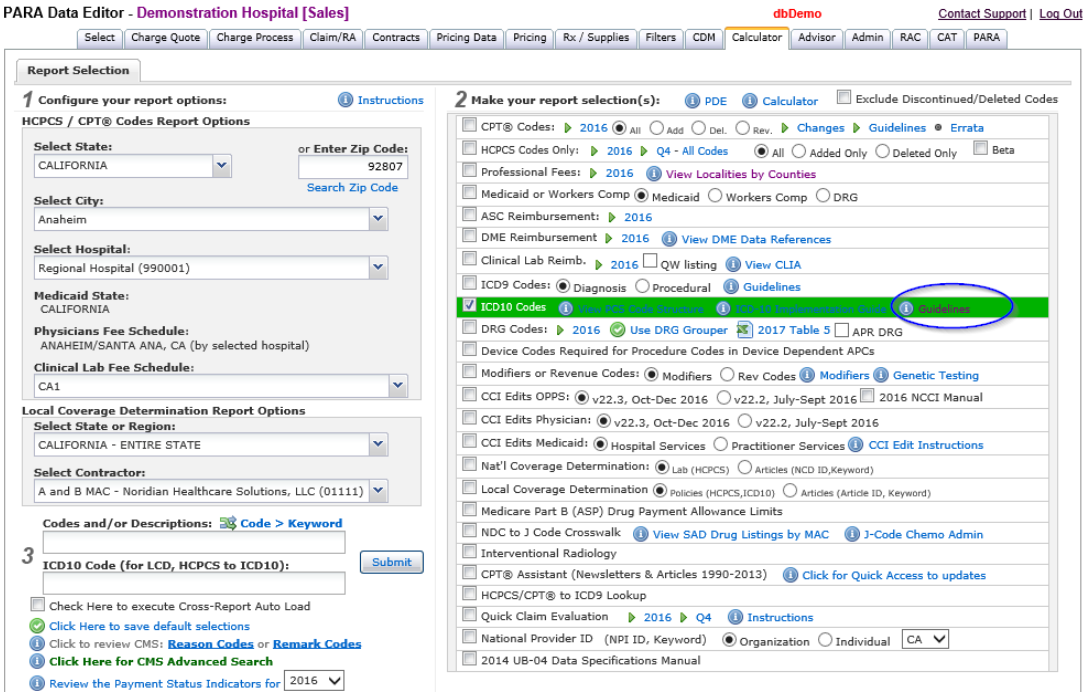
All chapters in the ICD-10 CM Code book were impacted for FY 2017 effective 10-1-16. These changes include:

- 425 revised codes
- 311 deleted codes
- 1974 new codes

  - ✓ 152 new codes added to the Musculoskeletal Chapter including Bunions, Temporomandibular joint conditions, Cervical Spine Disorders and atypical Femoral Fractures;
  - ✓ 885 new codes in Chapter 19, the majority of which are fracture codes including neck, base of skull, facial bones, Salter-Harris calcaneal fractures as well as other physical fractures
  - ✓ 260 new Diabetes combination codes for reporting manifestations. All conditions that follow the term "with" in the Diabetes classification in the alphabet index have an assumed link. Please refer to the 2017 ICD-10 CM Official Coding Guidelines for coding and reporting located in the **PARA Data Editor**.

2017 ICD-10 CM Official Coding Guidelines for Coding and Reporting: Conventions "With":

The word "with" should be interpreted to mean "associated with" or "due to" when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List. The word "with" in the Alphabetic Index is sequenced immediately following the main term, not in alphabetical order.



Additionally, ICD-10 CM FY 2017 has impacted Instructional notes and Guidelines. These changes include:

- Guideline clarification, new guidelines and revised guidelines
- Pertinent background information on new/revised codes
- Specificity in code selection for Nexplanon contraceptive management
- Clinical guidance and examples on the dependence classifications for nicotine, which include:
  - Uncomplicated,
  - In remission,
  - With withdrawal,
  - With other nicotine-induced disorders; and Unspecified nicotine-induced disorders

ICD-10 PCS FY 2017 Updates Effective 10-1-2016

Upon the October 1, 2015 (FY 2016) ICD-10 implementation date, there were a total of 71,974 ICD-10 PCS codes available to identify inpatient procedures. Effective October 1, 2016 (FY 2017), That total has increased to 75,789 codes available to identify inpatient procedures.

2016 Total	New Codes	Revised Titles	Deleted Codes	2017 Total
71,974	3,827	491	12	75,789

ICD-10-PCS FY 2017 Highlights

- There were 3,827 new codes added
  - ✓ 97% located in the cardiovascular system (total of 3,549 codes)
  - ✓ Remaining 3% located in the lower joint body systems and new type of transplants (total of 278 codes)
- There were 12 codes deleted
- There were 491 revised code titles
  - ✓ All revisions were located in the heart and great vessels body system
- There were 2 Root Operation definition revisions in the Medical and Surgical Section
  - ✓ Control - Stopping, or attempting to stop, post-procedural or other acute bleeding
  - ✓ Creation - 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
- There was 1 New Root operation added to the Extracorporeal Therapies section
  - ✓ Perfusion
- Additional Changes
  - ✓ Specificity added to body part character terminology
  - ✓ Coronary arteries terminology changed from “sites” to “vessels”
  - ✓ Intraluminal devices added to some cardiovascular tables
  - ✓ Qualifiers for bifurcation have been added with coronary arteries

A table of the total changes appears on the following page.

FY 2017 Total ICD-10 PCS codes by Section

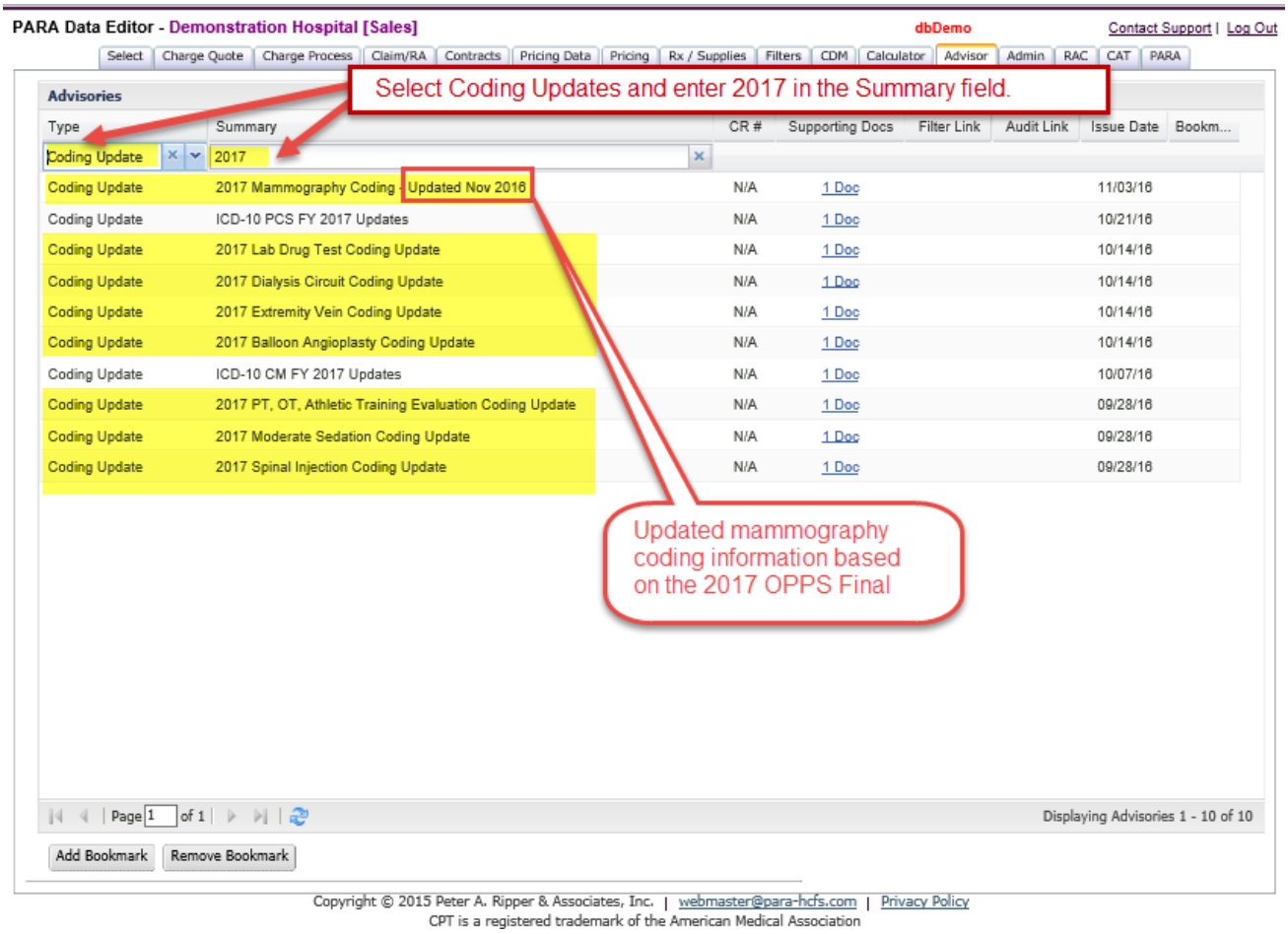
ICD-10-PCS Section	Total PCS codes Available
Medical and Surgical	65,676
Obstetrics	300
Placement	861
Administration	1,427
Measurement and Monitoring	342
Extracorporeal Assistance and Performance	41
Extracorporeal Therapies	46
Osteopathic	100
Other Procedures	60
Chiropractic	90
Imaging	2,943
Nuclear Medicine	463
Radiation Oncology	1,939
Rehabilitation and Diagnostic Audiology	1,380
Mental Health	30
Substance Abuse Treatment	59
New Technology	41
TOTAL	75,789

2017 CPT® Code Updates – Departmental Reports

The 2017 CPT® Code and HCPCS update is just around the corner. Hundreds of HCPCS/CPT® codes will be changed, added or deleted in January 2017. What effect will these changes have on you charge master?

To free up your department managers' time, **PARA** has put together concise handouts summarizing changes to coding in areas that are commonly found on the hospital charge master. The coding updates will be effective on 1/1/2017.

PARA Data Editor (PDE) users can obtain these "cheat-sheets" by logging into the **PDE** system, navigating to the **Advisor** tab and filtering on the Advisory Type "**Coding Update"**, then entering "2017" in the Summary field. Click on the **Supporting Docs** link to retrieve the coding update information.



If you would like to discuss these updates, please contact your Account Executive to set up a time with our Director of Audit Services at your earliest convenience.

Q & A – Using Modifier 22 with Global OB 59400

Question: We have not been able to resolve a professional fee claim denial for global obstetric care with a modifier 22. The medical documentation clearly indicates that a 4th degree tear was present and repaired during delivery. We submitted the claim with 59400-22 because the physician did all the prenatal work, too.

The June 2009 CPT® Assistant guides us to add the -22 modifier as shown below. The denial states "This modifier is defined in the Provider Manual under the Appendix section at the bottom of the table of contents. Click on Appendix A then Modifier 22 for the P&P. Has this reference been reviewed?"

https://unityhealth.com/docs/default-source/docs/providermanual.pdf?sfvrsn=6

Modifier 22 – Increased Procedural Services
Policy and Procedure
Last Revision/Review Date: 4/1/2015

Would we be better off billing each component separately, prenatals, delivery with -22 modifier and then postpartum?

Answer: In this case, we agree that modifier 22 on 59400 is appropriate, although we are generally conservative when considering the use of modifier 22, "Unusual Procedural Service". This modifier is often misunderstood and incorrectly applied. In the language of the denial, the payor requires the billing provider to attest to having read its policy statement, ostensibly in order to have providers review the rules before resubmitting the claim.

Another payor, United Healthcare, has published Reimbursement Guidelines for Global Obstetric Care, found at the following link. It specifically instructs that 59400-22 coding is appropriate when reporting third and fourth degree lacerations:

https://www.uhccommunityplan.com/content/dam/communityplan/healthcareprofessionals/reimbursementpolicies/R0064-ObstetricalServicesPolicy.pdf

"Per ACOG coding guidelines, reporting of third and fourth degree lacerations should be identified by appending modifier 22 to the global OB (59400, 59610) or delivery only (59409, 59410, 59612 and 59614) codes. Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier; please refer to the Increased Procedural

Services section of this policy and United Healthcare Community Plan's "Increased Procedural Services Policy."”

If medical records were not submitted with a copy of the claim, we recommend that the provider resubmit the claim with a copy of the records and a cover letter attesting that the payor's modifier 22 policy has been reviewed, and requesting the appropriate increased payment allowed under the health plan's Modifier 22 policy. You may wish to specifically cite United Healthcare's Reimbursement Policy for Global Obstetric Care at the link provided above as a reference in support of your claim for additional reimbursement.

Using Modifiers for 2017 Moderate Sedation CCI Edits

PARA recommends that facilities report charges for moderate sedation without a HCPCS in revenue code 0370. Moderate sedation CPT® codes 99151-99157 should be used to report professional fees.

The new Moderate/Conscious Sedation codes for 2017 (99151-99157) are reportable by professionals when moderate sedation is performed in support of any surgical procedure. This is a significant change over prior years, since the CPT® code book's Appendix G "Summary of CPT® Codes that Include Moderate (Conscious) Sedation" listed over four hundred surgical codes with which providers were instructed not to separately report moderate sedation, as it was considered an integral component of the procedure. In 2017, there are no codes listed in Appendix G.

However, CPT® instructs that "preservice" activities required prior to administering moderate sedation are included in the moderate sedation code and should not be separately reported. Pre-service work includes the assessment of the patient's history and previous experience with anesthesia to determine whether moderate sedation poses a risk due to known medical conditions, allergies to drugs, current medications, vital signs, a pre-sedation assessment, etc.

Although moderate sedation is billable when performed appropriately in support of any surgical procedure code, the CCI Procedure-to-Procedure files contain edits between Evaluation and Management codes such as ED visits (99281-99285), outpatient hospital visits (G0463), EKGs (93005-93042), pulse oximetry (94760-94762), certain venipuncture codes (36000-36425, but not 36415), and drug administration/IV therapy codes (96360-96377).

The 2017 Medicare National Correct Coding Manual, Chapter 11 states that:

> 6. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999, 62320-62327, or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96377) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.
>
> Medicare allows separate reporting for moderate conscious sedation services (CPT® codes 99151-99153) when provided by the same physician performing a medical or surgical procedure.

When billing for moderate/conscious sedation, it is appropriate to override the CCI edit with a modifier under the following circumstances:

- Append a modifier 25 to the E/M code if a surgical procedure was performed in conjunction with an evaluation and management code such as an emergency department visit; if no surgical procedure was performed, do not bill the moderate sedation codes. Verify that the evaluation

and management service was "separate and distinct" from the surgical procedure before appending modifier 25.

- Append a modifier 59 or XU to the venipuncture, drug administration, or pulse oximetry codes if the venipuncture, drug administration, or pulse oximetry was not performed in support of the moderate sedation codes. The process of accessing a vein, administering drugs, and monitoring the patient's oxygen saturation to appropriately administer moderate sedation is included within the moderate sedation codes.

The 2017 code set to be reported by professionals for moderate sedation are:

99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

See also **PARA**'s paper on the 2017 coding update for moderate sedation at the following link: https://apps.para-hcfs.com/para/Documents/2017%20Moderate%20Sedation%20Coding%20-%20Updated%20Nov%2021%202016.pdf

New Modifier FX Required in 2017 for Film X-Rays

Effective January 1, 2017, hospitals which are paid under Medicare's OPPS APC methodology (which excludes Critical Access Hospitals) must append new modifier FX to any X-ray service HCPCS that is taken using film, as opposed to digital technology. The modifier will trigger a 20% reduction in reimbursement, except when payment for the X-ray service is "packaged" into payment for another reimbursable procedure on the same claim.

The FX modifier applies to any and all radiography that produces images using film. A link and an excerpt from the 2017 OPPS Final Rule is provided below:

https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26515.pdf

> "After consideration of the public comments we received, we are finalizing the use of new modifier, FX, for use on claims for imaging services that are X-rays taken using film that are furnished during CY 2017 and subsequent years. The use of this modifier will result in a 20-percent payment reduction for an imaging service that is an X-ray service taken using film (including the X-ray component of a packaged service), as specified under section 1833(t)(16)(F)(i) of the Act, of the determined OPPS payment amount (without application of subparagraph (F)(i) and before any other adjustments under section 1833(t) of the Act). We note that when payment for an X-ray service taken using film is packaged into the payment for another item or service under the OPPS, no separate payment for the X-ray service taken using film is made. Accordingly, the payment reduction in this instance would be 0 percent (that is, 20 percent of $0)."

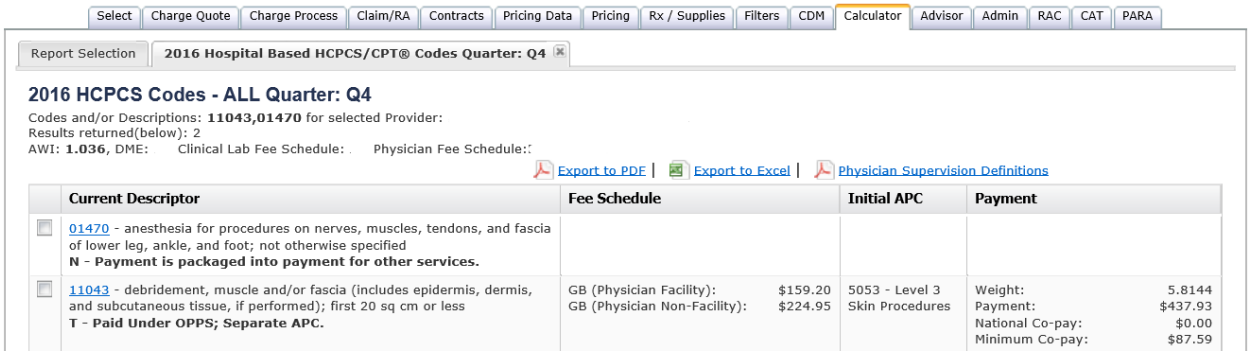
CMS did not identify a list of HCPCS which would require the modifier, but loosely refers to the HCPCS in Addendum B. All services payable under Medicare OPPS are listed in Addendum B. The following excerpt repeats Medicare's reference:

> "The use of the proposed modifier and subsequent reduction in payment under the OPPS is applicable to all imaging services that are X-rays taken using film as opposed to other methods. Each of the imaging services that are x-rays, along with all other codes payable under the OPPS, are included in Addendum B to this final rule with comment period."

Q & A – Anesthesia for Debridement

Question: When the physician performs debridement through the fascia and the muscle of the ankle, and anesthesia is performed, what is the appropriate CPT® code for the anesthesiologist to report?

Answer: Report Anesthesia CPT® code 01470, when documentation supports debridement of the ankle through the fascia or muscle (11043). CPT® code 01470 identifies anesthesia including Nerves, Muscles, Tendons or Fascia of the lower leg/ankle/foot. Instructions for reporting Anesthesia can be found in the 2016 CPT® Book pages 54 - 55. Please refer to the **PARA Data Editor** Anesthesia code descriptions.

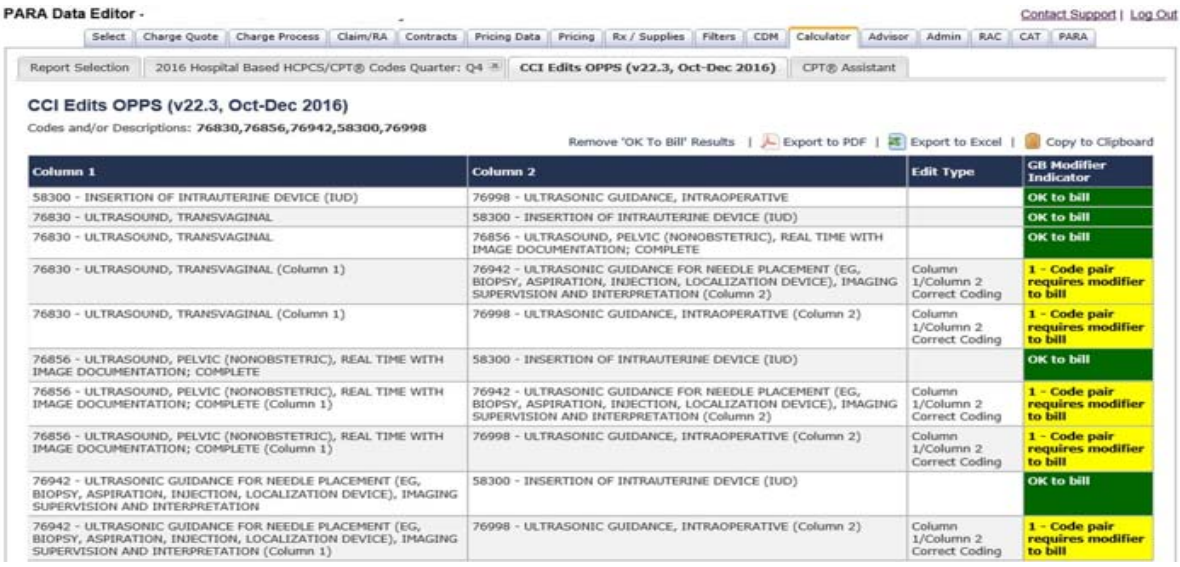


Q & A – IUD Placement with Imaging Guidance

Question: When an Intrauterine Device (IUD) placement with ultrasound guidance is performed, would it be appropriate to report CPT® code 76942 for the guidance or CPT® code 76998? What CPT® code(s) should be reported to identify insertion of IUD with image guidance?

Procedure: The patient was taken to the ultrasound suite and placed on the ultrasound table. Transabdominal and transvaginal images were obtained and described above. The patient was placed in the low dorsal lithotomy position. The cervix was visualized with a sterile speculum. The cervix was swabbed with Betadine ×3. The anterior lip of the cervix was grasped with a single-tooth tenaculum. Ultrasound was placed abdominally and the Mirena IUD was inserted to the uterine fundus under direct visualization with ultrasound. The IUD was deployed per standard protocol. The IUD inserter was removed. Additional images were obtained vaginally showing the IUD in the proper location and properly deployed. The IUD strings were trimmed. The patient tolerated the procedure well. The speculum was removed and she was discharged to home in stable condition with follow-up arranged in clinic. The final sponge and instrument counts were correct at the end of the procedure. The results revealed the following: On abdominal and transvaginal imaging, the uterus is of normal size and shape. The endometrial stripe is normal with no abnormal thickening or irregularity. His is seen on longitudinal and transverse images. Of note, the uterus is significantly retroverted and retroflexed. Small amount of physiologic fluid noted in the pelvis.

Answer: Report CPT® code 58300, Insertion of IUD. Additionally, report CPT® codes 76856, pelvic ultrasound and 76830, transvaginal ultrasound which are supported in the body of the procedure note. Please refer to the **PARA Data Editor** reference AMA CPT® Assistant, February 2009, page 22 which details pelvic US, transabdominal plus transvaginal, and supports reporting these services separately. CPT® code 76942 is not supported by the documentation. The code descriptor for 76942 states needle placement, which was not performed in this case. CPT® code 76998 would not be reported, since it is a component of the comprehensive procedures 76856 and 76830, per the NCCI Manual. Please also refer to the **PARA Data Editor** code descriptions.


PARA Data Editor -

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 | 2016 Hospital Based HCPCS/CPT® Codes Quarter: Q4 | CCI Edits OPPS (v22.3, Oct-Dec 2016) | CPT® Assistant

CCI Edits OPPS (v22.3, Oct-Dec 2016)

Codes and/or Descriptions: **76830,76856,76942,58300,76998**

Remove 'OK To Bill' Results | Export to PDF | Export to Excel | Copy to Clipboard

Column 1	Column 2	Edit Type	GB Modifier Indicator
58300 - INSERTION OF INTRAUTERINE DEVICE (IUD)	76998 - ULTRASONIC GUIDANCE, INTRAOPERATIVE		OK to bill
76830 - ULTRASOUND, TRANSVAGINAL	58300 - INSERTION OF INTRAUTERINE DEVICE (IUD)		OK to bill
76830 - ULTRASOUND, TRANSVAGINAL	76856 - ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE		OK to bill
76830 - ULTRASOUND, TRANSVAGINAL (Column 1)	76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
76830 - ULTRASOUND, TRANSVAGINAL (Column 1)	76998 - ULTRASONIC GUIDANCE, INTRAOPERATIVE (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
76856 - ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE	58300 - INSERTION OF INTRAUTERINE DEVICE (IUD)		OK to bill
76856 - ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (Column 1)	76942 - ULTRASONIC GUIDANCE FOR NEEDLE PLACEMENT (EG, BIOPSY, ASPIRATION, INJECTION, LOCALIZATION DEVICE), IMAGING SUPERVISION AND INTERPRETATION (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
76856 - ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE (Column 1)	76998 - ULTRASONIC GUIDANCE, INTRAOPERATIVE (Column 2)	Column 1/Column 2 Correct Coding	1 - Code pair requires modifier to bill
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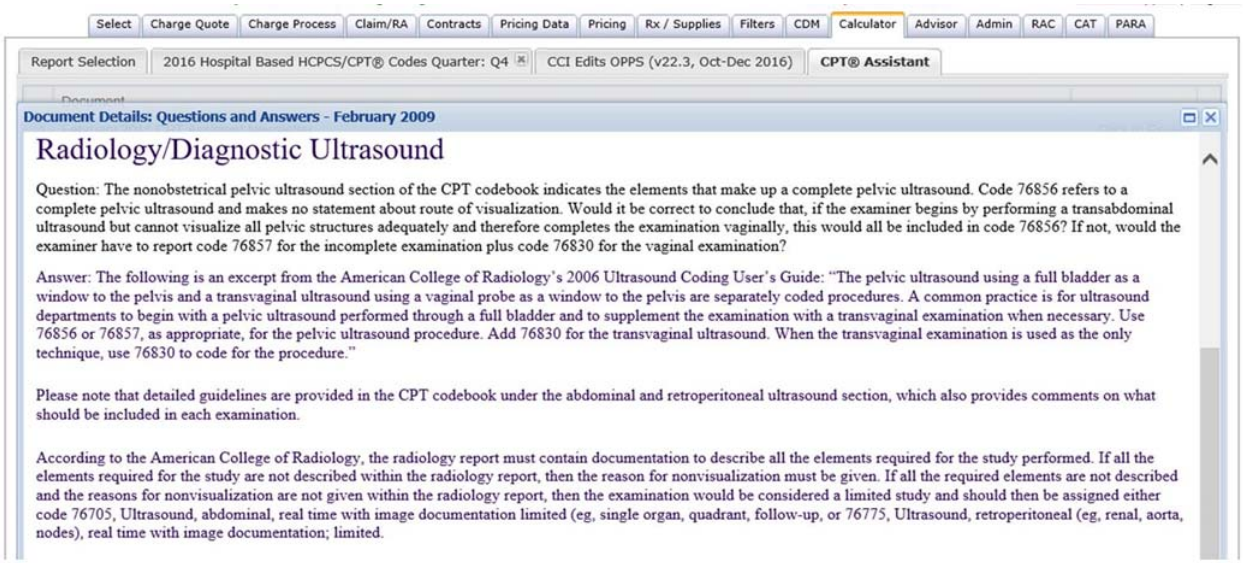
Q & A – IUD Placement with Imaging Guidance



Economical Online Resources for Billers & Coders

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.

PARA Healthcare Financial Services

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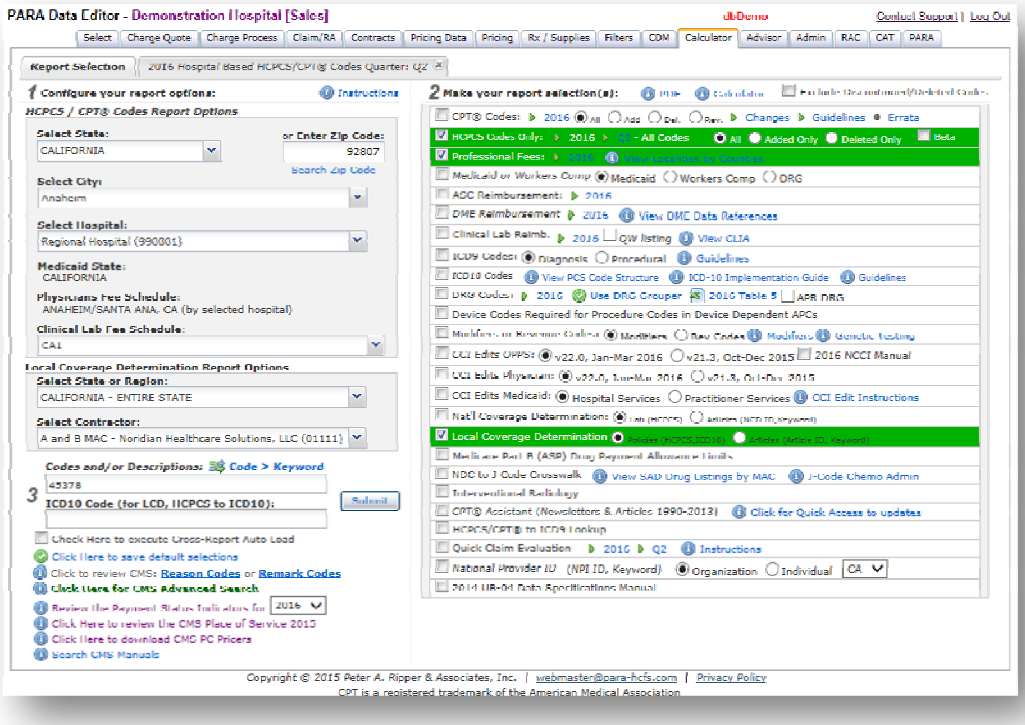
PARA Healthcare Financial Services

Billers and Coders need immediate access to coding and billing manuals to produce clean and compliant claims. While individual subscriptions to multiple books are expensive, the **PARA Data Editor** offers an economical, efficient way to provide up-to-date online references for a wide variety of coding and billing resources.

In addition to an essential ICD9 to ICD10 crosswalk tool, the **PARA Data Editor Calculator** provides online access to multiple years of history for CPT®/HCPCS codes, DRG, APCs, Professional fees, and twenty-five years of CPT® Assistant Archives. The Calculator provides:

1. **2016 CPT® Codes**
2. **HCPCS / CPT® Codes 2009-2016**
3. **Professional Fees 2011-2016**
4. **Medicaid / Workers Comp Fee Schedule**
5. **ASC Reimbursement 2009-2016**
6. **DME Reimbursement 2011-2016**
7. **Clinical Lab Reimbursement 2011-2016**
8. **ICD9 Codes Diagnosis and Procedural**
9. **ICD10 Codes**
10. **DRGs 2011-2016**
11. **Device Dependent Codes**
12. **Modifiers and Revenue codes**
13. **CCI OPPS Edits - 2 periods**
14. **CCI Physician Edits - 2 periods**
15. **CCI Medicaid Edits - Hospital & Practitioner Services**
16. **National Coverage Determination**
17. **Local Coverage Determination**
18. **Medicare Part B ASP Drug Payments**
19. **NDC to J Code Crosswalk**
20. **Interventional Radiology Mapping**
21. **CPT® Assistant - 26 years of history**
22. **HCPCS/CPT® to ICD9 Crosswalk**
23. **Quick Claim Evaluation**
24. **National Provider ID**
25. **2015 UB-04 Data Specifications Manual**



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

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FirstChoice cooperative MHA Ventures, Inc. Mid-America Service Solutions Member driven. VHA supported RWHC Your partner. Your source.